

Straightforward Communication: Instructors, Coworkers, and Patients

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Objectives

On completing this chapter, you will be able to do the following:

1. Explain the sender-receiver process in:
 - a. One-way communication
 - b. Two-way communication
2. Discuss how nonverbal and affective communication can support or cancel the meaning of verbal communication.
3. Provide an example of how you use communication strategies in nursing.
4. Give an example of blocking therapeutic communication.
5. List two common differences in male/female communication that have biologic roots.
6. Give an example of a cultural communication difference in the area in which you live.
7. List two common factors related to role change for a hospitalized patient that can create distress.
8. Identify a communication difference for patients in two separate age groups.
9. Explain how common characteristics apply to straightforward communication with all people.
10. Identify the four steps of SBAR and give an example of how it can be used for nurse-physician communication.
11. Discuss ways to resolve conflict between you and another staff member.

Key Terms

active listening (ĀK-tīv, p. 151)

affective communication (ā-FĒK-tīv, p. 150)

belittling (bē-LĪT-līng, p. 153)

chiding (chīd-īng, p. 153)

closed-ended questions (KLOZD-ĒN-dēd, p. 152)

commitment (kō-MĪT-mēnt, p. 156)

communication blocks (kōm-U-nī-kā-shūn blōks, p. 153)

empathy (ĒM-pā-thē, p. 155)

false reassurance (RĒ-ā-shūr-ēns, p. 153)

feedback (FĒD-bāk, p. 150)

focused questions (FO-kūsd, p. 152)

giving advice (GĪV-īng ād-VĪS, p. 153)

honesty (ŌN-ēs-tē, p. 155)

humor (HU-mōr, p. 155)

knowledge (NŌL-ěj, p. 156)

message (MĒS-ěj, p. 150)

nonverbal communication (nōn-VĒR-bāl, p. 150)

one-way communication (wōn-wāy, p. 150)

open-ended questions (O-pēn ēn-dēd, p. 152)

pat answers (pāt ĀN-sērs, p. 153)

patience (PĀ-shēnts, p. 155)

probing (PRO-bīng, p. 153)

purpose (PĒR-pūs, p. 151)

receiver (rē-SĒ-vēr, p. 150)

respect (rē-SPĒKT, p. 155)

SBAR (156)

self-esteem (SĒLF-ā-STĒM, p. 156)

sender (SĒN-dēr, p. 150)

sensitivity (SĒN-sī-TĪV-ī-tē, p. 155)

therapeutic communication (THĒR-ā-pū-tīk, p. 151)

trust (trūst, p. 155)

two-way communication (TOO-wāy, p. 150)

verbal communication (VĒR-bāl, p. 150)



Keep in Mind

Purposeful communication is an integral part of your personal and professional world. Take time to learn, and know that language is never innocent.

COMMUNICATION PROCESS

Sara walked into the patient's room without knocking on the door. "I'm going to measure your blood pressure. Give me your arm," she said. The patient gave her a quizzical look, but he put out his arm. This was Sara's first contact with a patient. When she finally got the cuff

on, her face was flushed, and her own heart was beating so hard that she could not hear the patient's heartbeat.

Try This

Communicating with Your Patient

1. What kind of communication did Sara engage in with the patient?
2. Who was Sara's focus?
3. What steps did Sara skip that resulted in showing disrespect for the patient?

Sara engaged in **one-way communication**, in which the **sender** (Sara) controlled the situation by telling the **receiver** (patient) what she was going to do (the **message**). Sara offered no opportunity for **feedback** (response) from the patient. Feedback would have provided the patient an opportunity to question, agree, or refuse the procedure. Sara was so focused on herself that she omitted common courtesies: a knock on the door, addressing the patient by name, and introducing herself, her position, and reason for being there. The patient's unspoken response may have increased Sara's discomfort.

ONE-WAY VERSUS TWO-WAY COMMUNICATION

One-way communication is used to give a command, as in military service, or information with no expectation of feedback. Sometimes one-way communication must be changed to **two-way communication**, in which there is feedback or discussion. During an emergency a doctor may give an order. Take a few seconds to change the order to two-way communication by repeating the order to the doctor so it is verified for accuracy. Two-way communication is the usual form of conversation. Each person contributes equally, and feedback is both expected and respected.

FACTORS THAT AFFECT COMMUNICATION

Some common factors that can influence communication include the following:

1. Personal characteristics of both the sender and receiver
2. Cultural characteristics
3. Situational influences
4. Context in which the message is sent and received

Personal characteristics can include such things as age, gender, income, and marital status. Life experiences, attitude, and personal opinions are other personal characteristics. *Cultural characteristics* can involve space and distance, language and dialect, use and meaning of touch, bad or good manners, meaning of gestures, and time of day. *Situational influences* can include the physical and emotional state of the patient and nurse, the room temperature, interruptions, background noises, and body odor. *Context* can include the

appropriateness or inappropriateness of the communication. "What can I do to make you more comfortable?" is an appropriate question directed to a dying patient. Discussion by the family about who gets what after the patient dies, within earshot of the patient, is inappropriate communication.

TYPES OF COMMUNICATION

The three types of communication are **verbal** (spoken or written word), **nonverbal** (body language), and **affective** (feeling tone). They may or may not all occur at the same time. When they do occur together, all three must mirror one another (be congruent) for the communication to be honest (Figure 13-1).

VERBAL COMMUNICATION

The spoken word is powerful. A patient may accept what you say as completely as though the team leader or doctor had spoken. Know in advance what you can or cannot discuss with a patient. Sometimes your response will be "I do not know, but I will find someone who does."

Speak as clearly as possible, using proper grammar. Slang is usually not appropriate and may have a different meaning. Depending on age and culture, the patient may not understand slang. Using out-of-date slang also can make you come across as unprofessional or silly.

Medical jargon is rarely helpful. If you truly understand the medical terms, you can translate the words into everyday language. The use of colloquial (common) expressions will be appropriate with some patients. For example, the word "urinate" may be understood by some as pass water, tinkle, or pee-pee. Use the word that the patient understands. Remember that the patient needs a professional he or she can look up to and one who will respect his or her individual differences; the patient does not need the nurse to be a buddy.

Maintain professional boundaries. Interestingly, a patient will respect you and is more likely to follow the directions you are giving than if you are trying to be "familiar" with him or her. When a nurse at a nursing home was asked why she continued to wear her white uniform and cap instead of wearing scrub-type

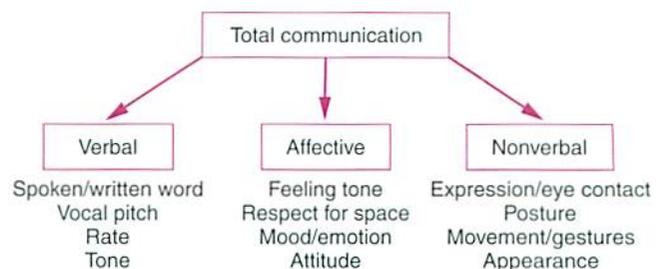


FIGURE 13-1 Communication.

clothes like the rest of the staff, she responded, “The residents take the medications I give them and will follow directions I offer them. They also ask for me by name if they are worried about something or do not understand what is happening to them. They know that they can trust me. Sometimes residents want to know who all these other people are who come into their room! I know that wearing my uniform plays a big part of the rapport I have with the residents.”

Some illnesses also affect a patient’s interpretation of verbalization. Patients diagnosed with schizophrenia interpret words concretely (literally). They experience difficulty with abstract (inferred) meanings. For example, after using a stationary bicycle, a patient was asked by the nurse, “How do you feel now?” He grabbed his buttocks and responded, “My butt is numb; that’s how.” The nurse had been trying to determine change in his stress level. Instead, his response was based on literal interpretation of the question.

NONVERBAL COMMUNICATION

Commonly known as body language, nonverbal communication either supports or cancels out verbal communication. Expressions, posture, movements, and gestures, whether they are your own or the patient’s, give important clues to the truth of the verbalization. Careful observation of body language may clue you in to patient discomfort, even though pain has been denied verbally. Gathering additional data will help clarify the real issue creating the discomfort.

Verbal communication works both ways. Patients tend to observe you closely, as well, looking for clues regarding the seriousness of their illness. For example, your distressed look may be interpreted as disapproval or serious concern about their health. How are they to know that you brought your personal life worries to work?

Physical appearance is a part of nonverbal communication. The patient’s appearance on admission provides signs of personal care plus important clues about the illness. Patients also quickly evaluate you and, based on what you project and even before you speak, will draw conclusions about your competence as a nurse. Arnold and Boggs (2003) explain, “Clothing communicates a nonverbal message about competence and professionalism to a patient, which can influence the nurse-patient relationship.” This is a major reason why most nursing schools continue to have a dress code. It is also the reason why your instructors model appropriate dress and behavior for their students.



Try This

Appropriate Dress Code and Behavior

What kind of statement are you making by the way you dress and behave at the patient’s bedside?

AFFECTIVE COMMUNICATION

“Affect” refers to mood or emotion. The feeling tone that you pick up on as you approach a person or step into a room is real. For every thought you have, there is a physiologic response in your body. The same is true for the patient and others you encounter. We are made up of energy, so we emit energy. The tendency may be to ignore this level of communication because we cannot see, hear, or read it. Affective communication is as significant as verbal and nonverbal communication. Truly honest communication integrates verbal, nonverbal, and affective communications so they all express the same message.



Critical Thinking

Affective Communication

1. Give an example of a time that you stepped into a room or approached a person and, before anyone spoke a word, experienced a feeling of excitement, happiness, sadness, anger, or some other emotion. What was the outcome?
2. Think of a time when you were angry and tried to hide the feeling. Did anyone pick up on your feeling tone and ask you if you were angry? How did you deal with the question?
3. Give examples of how you try to be congruent (together) verbally, nonverbally, and affectively in your communication.

COMMUNICATION STRATEGIES

Please do not interpret the term *strategies* (hints) to mean predetermined script, as in telemarketing. In real life this would be awkward, and even boring. You might even lose track of where you are in your conversation because of the focus on strategies. Work to understand the meaning of **active listening**, active listening behaviors, and types of questions discussed.

ACTIVE LISTENING

Active listening is probably the most important part of any **therapeutic** (health-related) **communication**. Key factors in active listening include purpose, disciplined attention, and focus. **Purpose** refers to the health-related reason for gathering data or giving information. *Disciplined attention* means that you do not assume accuracy of information without checking it out. Clarify what you think you understand the patient to say and ask further questions as needed. This applies both to gathering data and giving health-related information. *Focus* means that all your senses are alert to clues that the patient may be communicating. A common mistake in listening is to listen to the words but not really hear the words (i.e., comprehend [understand] the meaning).

ACTIVE LISTENING BEHAVIORS

The most commonly used active listening behaviors include restating, clarifying, reflecting, paraphrasing, minimal encouraging, remaining silent, summarizing, and validating.

- **Restating** refers to repeating in a slightly different way what the patient has said—for example:
Patient: “My chest hurts. I can’t sleep at night.”
Nurse: “You’ve been unable to sleep at night because of chest pain.”
- **Clarifying** is asking a closed-ended question in response to a patient’s statement to be sure you understand—for example:
Patient: “My chest hurts.”
Nurse: “Exactly where does your chest hurt?”
- **Reflecting** is putting into words the information you are receiving from the patient at an affective communication level—for example:
Patient: “I’m sick of seeing doctors and not getting answers.”
Nurse: “You are upset with the lack of answers to your health problems.”
- **Paraphrasing** refers to expressing in your own words what you think the patient means—for example:
Patient: “I don’t think I’m being told the truth about my condition.”
Nurse: “You think you may be more ill than what the doctor is telling you.”
- **Minimal encouraging** involves using sounds, words, or short phrases to encourage the patient to continue—for example:
Patient: “It just happened so fast. . . .”
Nurse: “Yes. . . . go on. . . . and then what. . . . hmmm. . . . uh huh. . . .”
- **Remaining silent** involves using pauses effectively. The normal tendency is to fill silence with chatter or your speculation. This may cause the patient to “turn off” or change the story. Maintaining disciplined attention and focus during silence lets patients tell the story in their own way. Avoid making interruptions and doing busywork while the patient is speaking.
- **Summarizing** means briefly stating the main data you have gathered—for example:
Nurse: “This is what I heard you say. Is that correct?”
- **Validating** provides the patient with an opportunity to correct information, if necessary, at the time of summary—for example:
Patient: “That is correct” or “No, you got this part wrong. . . .” (This allows the patient to correct the information.)

TYPES OF QUESTIONS

The three types of questions that are commonly used in therapeutic communication are open-ended, closed-ended, and focused questions. **Open-ended questions** permit the patient to respond in a way that is most meaningful to him or her. The questions often begin with what, where, when, how, or why. For example, the nurse might ask, “What happened to your

leg?” **Closed-ended questions** require a specific answer. For example, the nurse might ask, “When did you first notice the pain?” **Focused questions** provide even more definitive information. For example, the nurse might ask, “On a scale of 1 to 10, with 10 as the worst possible pain, how do you rate your pain right now?”

NURSE–PATIENT COMMUNICATION EVALUATION

Communication is far more complex than just talking. Some of the many contributing characteristics are listed in this section, with a brief description in the following learning exercise. Evaluate the characteristics of your communication that are working for you and those you need to work on.

Try This

Self-Evaluation of Personal Characteristics

Characteristic	Desirable	Self-Evaluation
Eye contact	Usually 3-5 seconds. Cultural variations.	_____
Respect for personal space	Approximately 1.5 feet, except for personal care. Cultural variations.	_____
Appropriate touch	Gentle, but firm. Cultural variations.	_____
Attitude	Nonjudgmental. Practices unconditional love.	_____
Voice/tone	Moderate or according to growth and development needs. Example: Newborns	_____
Rate	Paced according to patient’s ability to comprehend.	_____
Appearance	Models positive nursing image. Looks healthy.	_____
Posture	Open, without folded arms or hands on hips. Stands or sits upright.	_____
Gestures	Moderate to enhance conversation.	_____
Language	Speaks effectively and at patient’s level of understanding. Correct grammar.	_____
Expression	Congruent with topic. Nonjudgmental.	_____

Critical Thinking

A Plan for Change

List the personal characteristics that are not working for you. Develop a plan for change and measuring improvement, using the phases of the nursing process.

BLOCKS TO COMMUNICATION

It is sometimes easy to slip into communication styles that block communication. Perhaps the patient reminds you of someone you know, or you have had personal dealings with the patient in the past. Sometimes you do not like the patient or are just plain tired. Whatever the reason, it is worth thinking about the possibility in advance. As a nurse you want to continue to give every patient the best care possible, regardless of your personal response. Common **communication blocks** involve false reassuring, probing, chiding, belittling, giving advice, and providing pat answers.

AVOIDING BLOCKS

- “Why” questions put the patient on the defensive.
- **False reassurance** involves making statements to the patient such as “Everything will be okay,” “You’ll be just fine,” “Don’t worry about anything,” “We’ll make sure you get well,” “This experience will make you stronger,” or “You’ll see the good in this someday.” There is no way you can guarantee what you just told the patient.
- **Probing** means pushing for information beyond what is medically necessary to know. Curiosity takes over, and the patient’s privacy is no longer respected. Ask yourself about the value of the information and how you will use the information once you have it. Think twice before continuing with statements such as “Let’s get to the bottom of this once and for all.”
- **Chiding** (scolding) for behavior such as smoking is of limited value to the patient with severe emphysema or lung cancer (or perhaps the patient never smoked). Your information is hardly an “alert.” You can be sure that she or he has heard the message over and over. Without supporting the behavior you can continue to be therapeutic to the patient.
- **Belittling** involves mimicking or making fun of the patient in some way. It may include downplaying the importance of the symptoms—for example, “You could be having heart surgery! This is just wart removal.” As a physician pointed out, “If you have a tonsillectomy, it’s minor surgery; if I have a tonsillectomy, it’s major surgery.” It is all a matter of perspective.
- **Giving advice** when you know what someone else should do is very tempting. Unsolicited advice is rarely beneficial and closes the door to having the patient solve the problem herself. A more beneficial response, even when the patient asks what you would (or he or she should) do, is “What ideas do you have? I’m sure you’ve thought of ways you might solve this problem.” Listen carefully, summarize what the patient has said, and then ask, “Which one of your ideas do you want to begin with?” After

the patient’s response, you could say, “When do you think you’ll start?”

- **Pat answers** such as “Everyone feels this way” come so easily, but they make patients feel dismissed and misunderstood. Patients do not really care if everyone else feels this way. As far as they are concerned, these feelings are theirs, they are different from everybody else’s, and they need a comforting touch or reassuring words. If you can, offer something you know you can deliver, such as “I’ll be with you the entire time you are having your bone marrow drawn” or “I’ll be in the room when you return.”

MALE/FEMALE DIFFERENCES

Being equal does not mean being the same. Men and women communicate differently for biologic reasons. Although there are examples of similarities between the sexes, most males and females follow certain patterns. According to Sieh and Brentin (1997), four areas that relate to nursing communication are conversation patterns, head movements, smiling, and posture.

CONVERSATION

Men tend to approach a conversation with an eye to maintaining status and independence, to report or to get information, and to solve problems. They express their ideas more assertively; women do so with less certainty. Therefore, male opinions are often valued more highly without validation. Women seek to establish intimacy and develop rapport, share feelings, and establish relationships. Men ask fewer questions, but they readily interrupt during conversations without apology. Women use questions to encourage conversation. They wait for a pause to seek clarification and apologize for the interruption. Men apologize for a wrong, whereas women say “I’m sorry” to indicate regret, sympathy, or concern. Men rarely say, “I don’t know”; women often phrase ideas as questions, such as “Have you thought of . . . ?” Men make decisions, but women look for agreement. Men make demands more often, whereas women express preferences with reasons. Men’s sentences are shorter and fewer; women create longer, more complex sentences, linking more ideas together. Men make declarations, whereas women often end a statement with a question, such as “Don’t you think so?” (Tannen, 1990).

HEAD MOVEMENTS

Men nod if they are in agreement. Women nod to show they are listening. A man may be surprised to discover that a woman does not agree at all with what he said. Men hold their heads erect while speaking; women frequently assume a lower status position by tilting their head to the side or placing their chin down with eyes gazing upward (Sieh and Brentin, 1997).

SMILING

If a woman is smiling, it may or may not denote happiness. A smile is also used to mask unhappiness and other emotions. Reactions by others to her smiles may leave her feeling unheard. Others may acknowledge her nonverbal communication but be unable to interpret that she is feeling sad, angry, or afraid. Sometimes men will mask their emotion with a smile. Usually men tend not to show an outward reaction when criticized, making them seem strong and in control.

POSTURE

A rounded posture with the chest in and chin down gives an appearance of being threatened. Standing tall, with shoulders back and head held high, speaks of confidence and control. Looking at differences in the way men and women communicate has important implications in working with patients, staff, and instructors. Smiling and nodding by a woman does not have to mean she understands the instructions. A lack of questions from a male patient may not mean he knows what the surgery entails. Gather all three types of communication data. Ask the patient to tell you what he or she understands, then summarize and validate. *Use the skills you are learning.*

CULTURAL DIFFERENCES

Members of diverse cultures within our dominant culture embrace and value their beliefs and practices. You need to be respectful of these beliefs and practices and respond therapeutically. Know about cultural differences in communication. Individual patient differences need to be identified. Be sure to read Chapter 16 for a more complete understanding of cultural diversity. Mark the chapter and use it as a reference for the Learning Exercise.



Try This

Cultural Differences

List two cultural differences of someone in the area in which you live.

1. _____
2. _____

Communication patterns change with time, vary with the situation, and differ in public or private settings. It is important to learn as much as possible about the cultures frequently served where you work. Remember also that just because you can identify someone's ethnic background, the families may have been in this country for generations, and differences may be nonexistent.

ROLE CHANGES FOR THE PATIENT

What happens to patients who find themselves in a dependent position after having always been in charge of their lives? The concerns they have go beyond the physical realities into areas we consider in the next section.



Critical Thinking

Immediate Concerns upon Hospitalization

Imagine yourself being hospitalized. List four immediate concerns you would probably have.

1. _____
2. _____
3. _____
4. _____



Professional Pointer

"Err on the side of politeness and use Mr., Mrs., or Ms. until you have established respect" (Pagana, 2008).

IT BEGINS WITH "HELLO, MY NAME IS . . ."

Whatever you communicate verbally, nonverbally, and affectively sets the tone for rapport with the patient. You have some preliminary information (a name), even if the patient is just being admitted. Knock on the door or the door frame; pause briefly to collect data *before* walking in. You begin to pick up nonverbal and affective communication clues. Address the patient as Mr., Mrs., Miss, or Ms., or by a professional title if it applies. Extend your hand (unless culturally improper). Give your name; identify yourself as a student practical/vocational nurse, plus the name of the school and your purpose for being in the room.

It may sound something like this: "Mrs. Hill, my name is Mr. Fry. I am a student practical nurse from the Middle American Technical College. I am here to measure your blood pressure, pulse, and respiration. It is a part of the admission procedure." The patient may request that you address her by her first name, but do not assume this without permission. Some hospitals and other health agencies limit use of the employees' names to first name only. This will dictate how you introduce yourself.

NURSING JARGON

Remember how time-consuming it was to learn all those medical terms? Using the terms may sound impressive to you now and involve a feeling of having arrived, but using unfamiliar terminology can increase patient fears and cause misunderstandings: "What does it mean that I will have an IV started, have a WBC stat, and you'll be doing vitals q2h for now?"

When you really know something, you can explain words and symbols in terms the average layperson can understand. Now *that's* impressive!

FEAR OF THE UNKNOWN

Patients often have numerous unspoken fears about tests, procedures, and possible outcomes. These include, but are not limited to, pain, sleep, needle sticks, thirst, hunger, and being treated respectfully. A pat answer of “Everything will be fine” displays a lack of understanding of the depth of the fears. Patients may not ask questions because they think it might sound silly or that they are bothering the staff. An open-ended question from you, such as “What questions do you have? If I don’t know the answer, I’ll try to find out for you,” can open the way for expression of fears.

PERSONAL FACTORS

A patient’s illness rarely affects the patient alone. Thoughts and concerns may extend to family, work, finances, and so on. For example, the mother of a newly hospitalized child was irritable and inattentive when the nurse was explaining the unit rules. Finally the nurse stopped midsentence and said to the mother, “Tell me what is troubling you.” The mother looked at her and then blurted out that she had a sick child at home, her husband worked nights and slept days, and she had been up most of the last three nights. “Where should I be? Both kids need me, and my neighbor can only come in for two hours a day. I’m at my wits’ end!” The mother could not begin to focus on the unit rules until there were solutions to the problems at home. You may not have a solution, but you can be a catalyst to make needs known to the instructor or team leader. They are aware of additional resources.

ENVIRONMENTAL FACTORS

Health care settings—whether a clinic, hospital, rehabilitation center, or nursing home—are very different from home. There is no true opportunity for privacy. A variety of staff show up at different times throughout a 24-hour period; lights are on day and night; the staff make more noise than they realize; machinery is humming, buzzing, or beeping; staff check out different parts of your body, picking and poking—you get the picture. The patient may have put the light on because of a need to go to the bathroom *now*. By the time someone arrives, it may be too late, much to the patient’s embarrassment.

Advance communication and planning does not take as long as it sounds. You may find out that the patient always has a snack of toast and tea at 9 PM, always gets up to go to the bathroom at 11 PM, always has bran cereal and a banana at 6 AM, and so on. Notes of this nature in the patient’s care plan assist in the continuity of communication and care.

COMMUNICATING WITH INSTRUCTORS AND STAFF

Communication characteristics involve respect, trust, honesty, empathy, **sensitivity**, humor, knowledge, **patience**, commitment, and self-esteem. These characteristics are equally important in communicating with patients, instructors, and staff.

RESPECT

Respect involves both self-respect and respect for others. You communicate self-respect by doing your best each day. When you treat yourself with self-respect, it becomes easy to extend respect to your instructors, staff, and patients. Patients quickly pick up on whether they are being respected during conversation and physical care (e.g., verbal and nonverbal communication, such as eye signals between staff).

TRUST

Trust begins with confidence in your ability to make decisions. You communicate this to instructors and staff by consistently doing the required preliminary preparation for assignments.

HONESTY

Honesty implies that you will not deliberately deceive in order to present yourself in a more favorable light. Arranging a time with the instructor for you to repeat a procedure for more practice is an example of this characteristic in communication.

EMPATHY

Empathy is the ability to understand and appreciate what someone else is feeling without experiencing the emotion itself. When you are sympathetic, as you would be with a family member or dear friend, you actually experience the emotion. Being empathetic permits you to understand how someone is feeling and why he or she feels that way, to maintain control of your emotions, and to think clearly. For example, you might offer to help a staff member who is having a bad day do patient care (a practical intervention), instead of getting pulled into an “Isn’t it awful?” conversation.

SENSITIVITY

Tuning in on nonverbal and affective communication helps you to verify verbalization or a lack thereof. Picking up at nonverbal and affective levels permits you to check them out with the staff or instructor: “Is there something else I need to know?”

HUMOR

Healthy **humor** at the patient’s level of appreciation can help “lighten up” a situation. Offensive humor and poking fun at the patient or at other cultures or races is unacceptable. The staff sometimes privately gets involved in “gallows humor,” which is laughing at

something very serious or medically gross. Look for examples in movies and television programs with medical themes.

KNOWLEDGE

The cornerstone of gathering data and other health-related communication is **knowledge**. Instructors and staff quickly determine your level of knowledge. Instructors communicate the significance of this characteristic by making assignments early enough for you to research the information. You communicate back to the instructor (and staff) by preparing for patient care.

PATIENCE

In this modern world we are often accustomed to instant results and gratification. It is sometimes difficult to provide the time needed to learn, receive explanations from instructors, or follow staff orders. This extends to our work with patients, in whom illness and growth and development levels dictate the need to slow down or repeat directions. The patient (or you) may be tempted to say “I know” when such is not the case. The characteristic of patience takes time to perfect. You may initially feel like you are moving backward in your communication attempts with patients.

COMMITMENT

Commitment means incorporating all the previous characteristics as a part of your nursing communication. Decide that you are in nursing because you really want to be here. Then do the work that needs to be done. It shows, and it pays off. Take time to appreciate the uniqueness of each patient (see Chapter 16).

SELF-ESTEEM, THOUGHTS, AND STRAIGHTFORWARD COMMUNICATION

Self-esteem is earned, not learned. No one can give it to you or take it away! It is that special sense that it is okay to receive credit for something you did well. Self-esteem also gives you permission to recognize that you have something very special to offer in nursing communication—such as being able to communicate effectively with patients and other health workers.

What kinds of thoughts do you have?

- Are they positive or negative when you think about yourself?
- The two basic types of thought are random and active. Random thoughts just show up, but you initiate active thoughts. Random thoughts usually pass through, unless you pick a thought and change it into an active thought.
- What do your active thoughts say about you and the person you are? Do they support your sense of self, or do the thoughts tear you down?
- If your thoughts are not serving you, change them. If you have made a mistake, learn from it and let it go. Do not continue to punish yourself.

- Every day, look for what you have done well and give yourself a cheer for a job well done!
- Thoughts also set the feeling tone for how you communicate with patients and other staff. How you feel about something creates actions that bring about results.
- Actions are the bridge from the inner world to your outer world. Start by changing your inner world (Fuimano, 2004).

Practice makes your conversation meaningful. Make peace with silence. If you find yourself talking just to fill in the silence, *stop!* Learn to say what you mean. Be direct in your conversation, remembering that language is never innocent. When you give patients information or directions, avoid medical jargon. Being long-winded just means that you do not know how to express yourself clearly. Ask the patient what they think you said as a way to avoid misunderstanding. If you are on the receiving end of a lengthy conversation, remember that you can take control. Check out what it is the person really wants you to know and set a time limit if needed: “I have to go in __ minutes.”

Remembering the affective component of conversation helps you to be aware of your and the other person’s feelings. It is not unusual if after a conversation the other person’s feelings mirror what you were experiencing. Fuimano (2004) said the following:

If you take care of the words you chose, if you take the time to be purposeful and intentional, if you practice, knowing that it takes time to become an effective communicator—you’ll become more effective in every area of your life: You’ll experience more joy and satisfaction, and you’ll achieve the results you want.

SITUATION, BACKGROUND, ASSESSMENT, RECOMMENDATION

Nurses are taught to be objective and detailed when providing information. Physicians generally are brief and to the point: They are more interested in the “bottom line.” The situation, background, assessment, and recommendation called **SBAR**, was first developed in the military and has been adopted by some hospitals to facilitate clear communication. For example, if you are calling a physician because of concern about a patient, SBAR can be useful following these guidelines:

- **S** – Situation (about 10 seconds). Identify the following:
 1. The situation
 2. Who you are
 3. Your unit
 4. Patient name and room number
 5. What the problem is (briefly), when it started, and how severe it is

- **B** – Background
 1. Patient's admitting diagnosis
 2. Date of admission
 3. Information related to current status, such as:
 - a. Recent mental status
 - b. Vital signs
 - c. Oximetry
 - d. Oxygen device and flow rate
 - e. Current medication
 - f. Allergies
 - g. IV fluids, lab results
 - h. Code status
- **A** – Assessment (data gathered) includes the following:
 1. What you think is going on
 2. If appropriate, if, based on the signs and symptoms, you believe the problem is life threatening
- **R** – Recommendation involves what you need from the physician. Terms like “could be” and “might be” are usually effective—for example:
 1. Do you want the physician to come and see the patient?
 2. Do you want the physician to give an order for a medication?
 3. Do you want to transfer the patient to a higher level of care?

SBAR FOR THE SHIFT REPORT

SBAR is also a useful tool for the shift report, reporting off when you leave the clinical unit, or transferring a patient to another unit. The process will have some differences, such as the following:

Situation: Include the admission date, chief complaint, and diagnosis.

Background:

1. Patient's medical history
2. Allergy status
3. Code status
4. If patient is in isolation
5. Pain management strategies and response to interventions
6. Imaging studies
7. Lab results or glucometry readings
8. Location of peripheral or central venous line access devices

Assessment (data gathered): Provide relevant information in a systematic manner using a systems approach.

1. Vital signs and range of vital signs since admission
2. Pain assessment and patient's pain goal
3. If patient has diabetes, how frequently monitored and readings since admission
4. Diagnostic studies and results
5. If patient needs turning, how often and whether patient can turn self

6. Fall risk if it applies and any other precautions specific to this patient

Recommendations:

1. The patient's goals of care
2. What needs to be done on the next shift
3. Any procedures that must be done
4. Patient's education and discharge needs

Both the Joint Commission and the Institute for Healthcare Improvement support the use of SBAR in health care facilities.



Try This

Using the SBAR Method

Write an example of how you will have used the SBAR method with a patient you are assigned to when you are on clinical. Identify differences compared to the way you made reports in the past.

LIFE SPAN COMMUNICATION

Growth and development levels, male/female differences, and medical conditions all affect communication with patients. Each age group—whether infant, preschool, school age, teenage, adult, or elderly—has somewhat different communication needs.

INFANT

Infants' communication includes crying, cooing, and body language. They act out their feelings with total body language. As their recognition of words grows, certain words act to soothe or trigger a reaction. Up to that time, infants are most influenced by the sound of voices. As one father pointed out, “I used to put my baby to sleep each night by rocking her and reading *USA Today* aloud in a soothing voice.” Newborns respond favorably to a high-pitched voice, but that changes by the end of the first month. After that, calm, low tones are more soothing.

Parents (caretakers) are the best source for learning the meaning of different cries. They learn quickly to differentiate among wet, hungry, and uncomfortable. Rely on them for specific information on communication style.

PRESCHOOL

We are including toddlers in this category as early preschoolers. They are usually known for magnificent tantrums, and it is no wonder: They have learned some words, but when frustrated, they may not be able to put them together effectively. Thus, the body acts out what the words cannot tell. Laughing at or trying to reason with the preschooler is counterproductive.

When a child has a tantrum, he or she should be removed from the immediate situation and audience. Once preschoolers are more composed, they can communicate by pointing or by showing on their bodies or in a picture what they are upset about. During

procedures, explain briefly and simply what is going to happen. Tell them what they can do to help. For example, preschoolers will often assist and cooperate with receiving injections if they are patiently coached on exactly what to do (e.g., position, what to do with their feet and hands, how long they need to stay still, what to expect during the injection).

SCHOOL AGE

The vocabulary of school-age children has increased considerably. They are ready to be a part of most (but not all) discussions with their parents. Drawings or pictures can be used to explain an illness or procedure. Ask for feedback to avoid misconceptions: “Tell me in your own words what...” The child may not be privy to all information. In that case, go with the parent to a separate area so the child will not overhear the conversation or parts of it. Whispering and misinterpretation can evoke new problems. Remember that younger children think well in the afternoon.

TEENAGE

Teenagers are the easiest or the most difficult to communicate with, depending on your perspective. When ill, they need to believe that someone knows more than they do and that someone is in charge. Deal with them with the same courtesy that you extend to adults. Have similar expectations of them. Encourage expression of feelings, fears, and concerns. Their sense that nothing will happen to them has been shaken. Answer questions within your role. Seek out answers as appropriate. Avoid hiding behind nursing jargon. Using teen slang generally does not work out. Without real knowledge of the meaning, you may end up looking foolish instead of “cool.”

ADULT

Many of the issues discussed in this chapter apply to adult communication. Collecting data at all three levels of communication is essential. Remember to limit your questions to areas that are medically related. Pushing and probing based on curiosity may open a Pandora’s box (i.e., painful issues that have been suppressed). It does not work to probe and then leave the patient to pick up the pieces of what he revealed to you under pressure.

Patients with diminishing memory seem to have a relatively preserved reading ability. Visual information seems to be more permanent. Verbal information is so transient that the person may not have time to process it completely before it is gone (Banotai, 2007). The health care worker or family member can try writing the information in a size that is easy for the patient to read. Written information seems to be more neutral and does not evoke the emotional reaction that words would have.

ELDERLY

How do you picture elderly people in your mind? Unresolved parental issues, for example, can get in the way of quality care. If you can see aging as just another part of the life cycle, you may be able to work effectively with elderly patients. Gurian (1997) states, “Boys and men take in less sensory or proximal data than girls and women. They smell less, taste less, get less soothing and input from tactile information, hear less, and see less.” Most elderly people think more clearly in the morning.

When hearing begins to diminish, it is easier for both men and women to hear lower-frequency sounds. As with younger men, check elderly men to determine which ear has better hearing. Remember that the left eye, even without loss of vision, has more acuity for a man. It works best for explanations and table games to be focused on the left side.

Women see and hear equally well with both eyes and ears. Women can also differentiate sounds from background noises easier. There is some evidence that both men and women recall emotional words better when spoken into their left ear. The elderly man may not hear you if you call when the TV is on. The male brain shuts on and off according to load. Part of it must remain active to continue vital functions. Men may continue to have reading problems, so it is a good idea to read directions aloud to older male patients. You will continue to find that many female patients are orderly and satisfied with a smaller amount of space. The male patient is generally the opposite, and you may have to seek additional space for games and puzzles in the dayroom.

Preparing for discharge begins after admission. The nurse takes advantage of teachable moments to interject information, demonstrate techniques, and have the patient repeat the demonstrations. This includes the patient and any family members or friends who are planning to assist posthospitalization. Listen carefully when the patient describes what is waiting at home. Will adaptive equipment be necessary? Will other health providers have to be involved in making the transition between this facility and home? The best part of being a student in this situation is that the instructor and RN assigned to the patient are available to assist you.

CONFLICT RESOLUTION

In the health setting, conflict can be related to diversity, English as a second language, and differences in gender, generation, and personality. Doctors and nurses often provide information in different formats. According to Federwische (2007), “Nurses are taught to communicate through narrative, through a story, to give a lot of background. Physicians are trained to communicate in bullet points. So they have two totally different styles.” Differences can be magnified in high-

stress situations. It is thought that only about 2% to 3% of physicians and nurses are truly disruptive, but that still creates problems for the rest of the staff. Problems can translate into medication errors, patient safety, and even patient mortality. Some health facilities have set up major programs to teach their staff how to communicate with one another. Keep the following basic steps in mind, and try to focus on a mutually beneficial solution based on shared interests.

1. Accept conflict as a natural part of life. Different points of view, needs, and beliefs are often involved.
2. Temper your own attitude and behaviors. Be aware of your initial reaction, and take a deep breath. (Your automatic defense system wants to dig right in and fight.)
3. Take time to think critically before reacting. For example, did you think through beforehand what you were going to report, or did you come off as rambling?
4. Treat conflict as an opportunity to voice your own opinion and listen to the other side of the story. Know that you may have to take the initiative to approach the physician or nurse (or other person) regarding what you are seeing as a conflict. They may not be aware of how you are being affected, and ultimately feelings may escalate and patient care will suffer.
5. Choose your approach. The winner takes all: A win-lose approach will only escalate the intensity of the feelings involved. The best choice for a solution depends on the situation. There is no “blanket” correct way.
6. Listen and learn. Conflicts are often based on assumptions and a lack of information. If you did happen to be entirely wrong, apologize, and find out how to correct your mistake in future incidences. Take your lumps and get on with it!
7. Discover what is important—that is, the core issue. It can range from hurt feelings to unmet needs. Getting to the root of the problem gets you closer to resolving the conflict.
8. Respect one another. Conflict can be very emotional. Show respect despite the angry and hurt feelings. Stay away from name calling and blaming. Using “I” statements—for example, “I don’t understand what you mean”—lets you own your own statements.
9. Find common ground to create the highest common denominator. In this case, it is generally for the patient’s highest good (see Chapter 21).



Try This

Resolving Conflicts

Think of a time recently when you experienced a conflict with someone. What was the outcome? Are you still upset with the other person, or was the issue resolved in a mutually beneficial way? What part of your behavior are you especially pleased with? What, if anything, would you do differently the next time?

ELECTRONIC COMMUNICATION

Faxes, electronic documentation, and email are all valuable modern methods of communication when used effectively and appropriately. Fax machines, for example, often shorten the time in which information can be sent between agencies and departments. Electronic documentation ideally provides a location where all agency professionals involved in patient care enter the most recent information. Electronic documentation may be part of your basic education for learning to document medications and treatments. Each facility may have slightly different protocols. Email is a popular way of communicating with administration, within departments, and with other departments. Before getting involved in sending email, it is important to review the basics of email etiquette. Some people email things they would never write in a memo or say directly to someone. Box 13-1 lists some email essentials suggested by Lauchman (1999) and Pagana (2008).

CELL PHONES AND TEXT MESSAGING

You are sitting in class or watching a demonstration on clinical, when someone’s cell phone rings. It certainly disturbs the chain of thought for both the students and the instructor. Although the phone can be set to vibrate, the shuffle to see who called is annoying. Who knows—you may have missed something essential for the care of a future patient.

Box 13-1 Email Etiquette

- Consider the content of the email message and to whom you are sending it.
- To emphasize a point, let the sentence stand alone. Special effects, such as boldface, may not show up on someone else’s screen.
- Keep your sentences and paragraphs short.
- Skip a line to separate topics.
- Send your message to the right person.
- Be especially careful filling in the “subject” line. People read this first to decide whether the message is worth opening.
- Be specific. Avoid useless information.
- Avoid using inappropriate language.
- Determine whether email is the best way to send your message.
- Be cautious with humor. The person sees only the written word.
- Check your spelling and punctuation. Proofread all messages before sending them.
- Avoid typing an entire email in uppercase. The message “screams” at the recipient.
- Don’t use lowercase letters. They make you look sloppy and lazy.
- Avoid sending confidential information.

Text messaging has been integrated into student life with astonishing momentum. Some students continue to text during class, often by holding the phone under the desk or in a backpack. An additional concern is not only the distraction but that some students are using it as a way to cheat on exams.

Many programs have adopted a rule of shutting off cell phones during class and clinical. No text messaging is permitted during class either. As a matter of etiquette, it is just plain rude to behave in ways that are disruptive to the instructor and other students.

Get Ready for the NCLEX-PN® Examination

Key Points

- Communication can be one-sided or two-sided. Both forms involve a sender, a receiver, and a message. In one-sided communication, the receiver does not have the opportunity to provide feedback. During two-sided communication, feedback is an expectation.
- Communication involves verbal, nonverbal, and affective communication.
- The most important part of therapeutic communication is active listening. It involves purpose, focus, and disciplined attention.
- Common active listening behaviors involve restating, clarifying, reflecting, paraphrasing, minimal encouraging, remaining silent, summarizing, and validating.
- Common blocks to communication involve false reassuring, probing, chiding, belittling, giving advice, and pat answers.
- Male/female differences do exist. Some differences are “hardwired” biologically. Characteristics can be modified, if desired.
- Cultural differences in communication exist, especially with individuals who are new to the country and/or continue to have strong cultural ties.
- Role changes for the patient during an illness experience can be distressing. Staff attitude, nursing jargon, fear of the unknown, and personal and environmental factors are all involved.
- Communicating with the instructor and staff involves the same characteristics as communicating with a patient. They include trust, honesty, empathy, respect, sensitivity, humor, knowledge, patience, and commitment. Self-worth is earned as your knowledge and skill in application grow.
- SBAR is a way to give precise information when contacting a physician or providing shift report.
- Life span communication differences are related to growth and other issues, male/female differences, and medical problems.
- Be alert to what your thoughts are saying and if they help you or hinder you.
- Take your conversation seriously: Practice saying what you mean, and know that your thinking affects your feelings and the way you communicate with patients and staff.
- Successful conflict management is based on a mutually beneficial solution.
- Email etiquette is essential for effective and efficient electronic communication.
- Many programs have adopted a no private cell phone or text messaging policy during class or clinical.

Additional Learning Resources

Evolve Go to your Evolve website (<http://evolve.elsevier.com/Hill/Success>) for the following FREE learning resources:

- Answers to Critical Thinking Scenarios
- Additional learning activities
- Additional Review Questions for the NCLEX-PN® exam
- Helpful phrases for communicating in Spanish and more!

Review Questions for the NCLEX-PN® Examination

1. What accounts for basic male/female differences in communication?
 1. Socialization
 2. Environment
 3. Acculturation
 4. Biology
2. What is the sender-receiver-feedback process in one-way communication?
 1. It concludes when the message reaches the receiver.
 2. It uses verbal, nonverbal, and affective communication.
 3. Once feedback has been provided, the message is final.
 4. It is useful, shorthand communication in close friendships.
3. Which is an appropriate response to the patient when you pick up affectively and nonverbally on the patient’s anger?
 1. Leave the room and report your observations to the team leader immediately.
 2. Lighten up the situation by sharing some funny email jokes with the patient.
 3. Provide observations of nonverbal behavior and ask the patient what is going on.
 4. Continue what you came in to do silently and leave as soon as you are through.
4. Which statement most accurately reflects a communication difference that is age related?
 1. Speaking in a loud, high voice makes it easier for the elderly patient to hear you.
 2. School-age patients are ready to be included in discussions about their illness.
 3. Distract the toddler having a tantrum by offering a special treat if he or she cooperates.
 4. Using medical jargon and current slang helps the teenager to see you as human.