Communication skills

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Definition

Communication is the two-way process of giving and receiving information, both verbally and non-verbally. It is a key and essential aspect of nursing care. Communication is a core dimension in the *NHS Knowledge and Skills Framework* (Department of Health 2004) and within the Nursing and Midwifery Council (NMC) *Code of Standards* (Nursing and Midwifery Council 2008). Both refer to the requirements for communication with a range of people (colleagues, external agencies, and patients) on a variety of simple and complex matters. The Quality Assurance Agency (2006: 6) also lists communication as a key subject benchmark, stating that health and social care staff should be able to:

- 'Make active, effective and purposeful contact with individuals and organizations, utilizing appropriate means such as verbal, paper-based and electronic communication.
- Build and sustain relationships with individuals, groups and organizations.
- Work with others to effect positive change and deliver professional and service accountability.'

Nurses must be able to assess, identify, and prioritize patients' needs, facilitate the expression of feelings, and build a relationship for effective care (Dougherty and Lister 2008).

It is important to remember that:

- Communication requirements vary dependent on the situation. The nurse must be prepared to adapt to the needs of the situation. Examples include breaking bad news, cultural differences in communication, communicating with children or the elderly, or the specific requirements of those with physical or learning disabilities.
- Communication competence varies depending on an individual's character and background. It is central to the patient's experience and therefore essential that all nurses throughout their career reflect on and (where appropriate) develop their communication skills as an integral part of professional development.

Prior knowledge

Prior to reading the following sections, consider your communication experiences to date, how these have influenced your development, and the skills you will need to develop in your nursing career. For example:

- How do children communicate?
- Do nurses need to adapt their communication skills for the working environment?
- What influences the development of communication styles?
- What forms of communication are there?
- Who are nurses required to communicate with?
- What are the communication barriers?

Background

Effective communication in the health care setting improves recovery rates and reduces pain and complications rates (Wilkinson *et al*. 2003). However, poor communica-

tion is cited in many NHS complaints (Bayer 2003). Catherine McCabe (2004) found that patients felt that nurses' communication skills needed to be improved, as they concentrated more on clinical tasks than talking to patients. She emphasizes the importance of 'patient-centred communication' and its central role in delivering quality patient care.

Models of communication

A number of communication models have been proposed, with descriptions of the processes and templates for best practice. Ellis *et al*. (2003: 5) describe the basic components of communication (shown in Figure 2.1) as being context specific, i.e. they should change depending on the situation. The sender (patient, nurse, doctor) aims to convey a message to a receiver who may or may not interpret it as intended. The message may have been misread due to contradictory body language, misheard or not heard at all, or generally 'lost in translation'.

Effective communicators rely on feedback from the receiver (two-way communication) requiring understanding or additional messages from the sender. Good communicators tend therefore to send messages in a consistent and clear way, their non-verbal and verbal language conveying the same message. For example, 'How are you feeling today Mrs Jones?' is said with empathy and concern, while waiting patiently at the bed for a reply, and then responding appropriately.

Ley (1988) developed a useful evidence-based model for improving patient communication and for improving medication compliance rates. Compliance rates can be quite low, for example Haynes *et al.* (2005) suggest that those prescribed self-administered medication

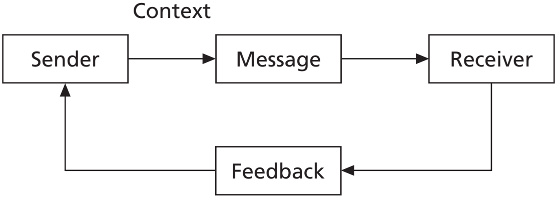

Figure 2.1 The components of communication. In a nursing context; the nurse may act as the 'sender', e.g. explaining to the patient what a procedure will involve, or as the 'receiver', e.g. listening to a patient's description of their pain symptoms.

may take less than half their prescribed medication. Ley found that where understanding and memory were enhanced, patients were more satisfied with their care and more likely to comply with treatment.

Understanding and memory can be improved by avoiding jargon, simplifying language, and highlighting key issues at the start of the consultation, at the end, and where they are important, a process known as primacy, recency, and importance. Written explanations in the form of patient information or mail and e-mail reminders are also important, as well as telephone texting (texting4health 2008). Finally, satisfaction can also be improved by reducing waiting times, maintaining a friendly attitude, and allowing patients to tell their story in their own words and to express their worries and expectations.

A key model and set of skills for managing a patient consultation have been produced in the form of the Calgary–Cambridge Guides (Silverman *et al.* 2005). This model has been well researched and evaluated. The general principles can be used for nurse assessments with patients. Stages of consultation/assessment are listed as:

- 'Initiating the session' – where a rapport is built and the reasons for the meeting established.
- 'Gathering information' – for an exploration of the patient's problems, using skills such as listening to the patient's own story and identifying concerns and expectations.
- 'Building a relationship' – through appropriate verbal and non-verbal behaviour.
- 'Explanation and planning' – through the provision of information and shared decision-making.
- 'Closing the session' – with reference to further action and planning for unexpected outcomes (safety netting).

In the following sections we break down the stages of communication into three phases: the set, dialogue, and closure (Mackway-Jones and Walker 1998).

- 'Set' is the preparation phase – reading the patient's notes, introductions, ensuring that the patient and/or family are comfortable, etc.
- 'Dialogue' is the active communication stage, involving, for example, listening skills, verbal and non-verbal skills, and open and closed questioning.
- 'Closure' is the summary phase, with checks on understanding and safety netting.

Set

Where possible the nurse should become familiar with the patient's history prior to any meeting and should be updated on their condition as long as they remain in the nurse's care. An applicable amount of time should be allocated to each meeting to ensure that it is not rushed. However, where unavoidable interruptions occur, the patient should be reassured of the nurse's return. Special consideration should be given to assessing communication needs, which are categorized by Hilton (2004) as:

- Physical aspects such as hearing, talking, and writing skills.
- Psychological issues such as anxiety, intelligence, and anger.
- Sociocultural aspects in relation to dialect, first language, and cultural and religious issues.
- Environmental constraints such as temperature, noise, safety, and physical barriers to communication such as beds and desks.

In establishing an initial relationship, the nurse should greet the patient (and family if applicable), introduce themselves, and explain their role. Where required, informed consent should be gained for treatment (Dougherty and Lister 2008). Appropriate dress should be worn and the nurse should use a friendly and professional approach, aiming to make patients feel welcomed and supported (Pendleton *et al.* 2003). Particular attention should be paid to the environment, ensuring that the patient is comfortable, warm, and safe, and that privacy and confidentiality are maintained, especially in busy wards where curtains are the only dividers.

The reason for the meeting should be identified and the consultation developed through open questions, e.g. 'What is the problem today?' or 'How can I help you?' and, where appropriate, through closed questions such as 'How old are you?' and 'Where does it hurt?' (Hilton 2004, Silverman *et al.* 2005). The nurse should encourage the patient to discuss their problems/issues openly while listening closely, maintaining an awareness of their emotional state, and 'showing empathy, concern and optimism' (Kruijver *et al.* 2001).

Dialogue

Once the ice is broken and the initial introductions are completed there are a number of communication elements that the nurse should be aware of. The ability to develop rapport is important; treatment goals are more likely to be achieved when the patient is comfortable and relaxed, and where the nurse is non-judgemental, values opinions, and acknowledges individuals' views.

This 'accepting response' is described by Silverman *et al.* (2005) as a process of acknowledgement. It is achieved through the reiteration and clarification of patients' concerns (using comments such as 'So, you're concerned that the tablets have given you an ulcer') and by acknowledging their rights ('I can see that you may want to get a second opinion on that') or by giving them the 'space' to say more, through appropriate pauses and non-verbal behaviour.

This 'acceptance' does not imply agreement but places a value on patients' beliefs. For example, it would be inappropriate to dismiss patients' concerns with a comment such as 'There is nothing to worry about,' and more appropriate to acknowledge their concerns by stating 'I can understand why you are worried; we will make sure we check it out and let you know as soon as possible.'

A second and essential element is the ability to listen actively and demonstrate or clarify that we have 'heard' our patients correctly. In diabetes research, patients claimed that their knowledge about their condition and its management was not heard by health care professionals (Pooley *et al.* 2001). Hawkins and Lindsay (2006) highlight the significance of listening to patients' stories to enhance health professionals' understanding and to improve patients' 'physical and psychological healing'.

Gask and Usherwood (2002) describe a number of communication and active listening skills that should be used during a consultation. These include:

- Open and closed questions. Questions that encourage patients to expand on their answer but give 'yes' or 'no' responses where applicable.
- Checking. Repeat back patient responses to ensure joint understanding.
- Demonstrating empathy. For example, 'I am so sorry, this is clearly a concern to you.'
- Facilitation. Encouraging patient responses by non-verbal responses, e.g. nodding, or by verbal responses, e.g. 'Yes – and then what?'
- Offering support. Questions such as 'How can I support you with this condition?'

- Legitimizing feelings. Expressing your concern and understanding about the problem.
- Negotiating priorities. Decide, with the patient, the key priorities for their care.
- Summarizing. Clarify and summarize your agreement with the patient prior to closing the consultation.

A key element of communication is the nonverbal component (Ellis *et al*. 2003, Dougherty and Lister 2008), which includes your own and the patient's non-verbal behaviour. When working with patients, think about how they respond to you, bearing in mind cultural differences. Consider the following:

- Their body language and personal distance – do they move their chair away from you, or are they reluctant to sit down?
- Level of eye contact (Ruusuvuori 2001). Do they avoid your gaze? Do they constantly look around? What is their facial expression/gaze like?
- What are their voice, tone, inflection, and volume like?
- Do they have an open or closed posture – for example do they look relaxed and casual or do they have tightly folded arms and face away from you? Do they avoid your touch?
- Are they well dressed and groomed or do they look dishevelled and unclean?
- How are they moving? Are they slow and lethargic or is their gait awkward or shuffling?

As a nurse, consider how you may need to adapt your behaviour for specific situations. For example, nurses in elderly care have been found to display more non-verbal behaviours, such as touch, smiling, and patient-directed gaze, than community nurses (Caris-Verhallen *et al*. 1999).

Barriers to effective communication skills

Environmental factors can have major influences on the way we communicate. In hospitals and nursing homes, nurses who care for the elderly have been found to use communication as a means of maintaining power over vulnerable patients (Brown and Draper 2003). Chant *et al*. (2002) found that nursing work and high stress levels can act as 'barriers to empathy and communication skills implementation', while Yam and Rossiter (2000) refer to the hierarchical nature of health care and how this may have negative impacts on communication and patient care. Environmental influences and interruptions, e.g. phones, children, and door bells, may also hinder effective communication.

Throughout all phases, but particularly during the dialogue, consider how communication can be hindered. Think about privacy issues and the patient's level of anxiety, for example are they tachycardic, hypertensive, or perspiring (Grandis *et al*. 2003)? Are there physical restrictions to communication, for example a tracheostomy, or perhaps the patient has had a laryngectomy? Request a translator if the patient or family are non-English speakers (many health providers maintain a list of foreign language speakers for this purpose).

Avoid the use of medical jargon and think about your speech rhythm, pace, emphasis, intonation, pitch, and tone. These are known as paralinguistic features ('features of the spoken message that are not contained in the message alone,' Ellis *et al*. 2003) and care must be taken to ensure that the patient does not misinterpret your meaning. For example, depending on the word emphasis, 'I will see you in the ward at 10 o'clock' may be considered a command to be in the ward at 10 o'clock, or alternatively a friendly and reassuring promise of your return.

It is important to remember that there may be a number of patient-related communication barriers, which Park and Song (2004) list as:

- Tiredness.
- Pre-health conditions (physical disability, poor hearing or sight, impaired levels of understanding).
- Life stresses related and unrelated to the illness.
- A short attention span.
- Low education levels.
- Differing social norms.
- Lack of trust.
- Accent issues.
- The withholding of information.
- Generation gaps.

In summary, Silverman *et al*. (2005) describe the key elements of the 'dialogue' as building a relationship and exploring of the patient's problems, including encouraging them to tell their own story, using open and closed questions, listening, picking up on verbal and non-verbal clues, and clarifying and checking on the story. Explanations should be clear and provided in small 'chunks',

with appropriate use of repetition and checks on patient understanding, aiming for a shared decision by the end of the consultation.

Closure

Appropriate summing up, emphasis, checks on understanding, and future plans are the final essential elements of any patient communication episode. It is important that this phase is relatively short and sharp to ensure that the key elements of the communication remain salient.

Silverman *et al.* (2005) have again produced a very useful template for closing a consultation, suggesting that the 'next steps' should be discussed and safety issues should be raised, covering what to do if the plan is not working and how to seek help (safety nets). Sessions should be summarized with final checks on agreement, plans, and questions.

Where applicable, documentation should be completed, ideally in a multidisciplinary format (Dougherty and Lister 2008) to ensure that all health professionals are kept up to date. Finally, again where applicable, close attention should be given to handover procedures; for example, in the Accident and Emergency setting, Jenkin *et al.* (2007) found that listening skills, repetition, and a phased approach to handover are important. A British Medical Association (2004) report also concludes that multidisciplinary handovers are an important element of good communication and that effective handovers are vital for patient safety – safe handovers = safe patients.

As Information Communication Technology (ICT) develops, the traditional models of communication will need to be reviewed. Health care providers are rapidly investigating how ICT can be utilized in improving health care. Wahlberg *et al.* (2003) discuss the development of 'telephone nurses' and the prospect of e-mail and virtual nurses. This study highlights the importance of supporting nurses who are delivering health care without direct visual contact and the impact this has on telephone nurses' ability to make informed decisions.

These ICT developments bring with them different communication cultures and a requirement for training and development. For example, nurses will need to adapt their approach on the phone to draw out information and to focus on the problem, while being reassuring and confident. In fact, Wahlberg *et al.* (2003) found that 'nurses seemed to lack confidence in their competence' when delivering telephone-based health care, which may be due to the lack of visual contact and communication feedback issues.

Context

In the communication setting there are a number of special considerations that the nurse should be aware of. Below an outline of these is all that is possible, as in all of the following situations there will be individual and context-specific requirements.

Learning disabilities

Key considerations for patients with learning disabilities are their mode of communication and level of understanding (Grandis *et al*. 2003). Their mode of communication includes their likes and dislikes, ways of expressing discomfort and pain, sign language, and level of self-help. The level of understanding and comprehension will influence how the nurse structures information for the patient, and the degree of professional support required.

It may, for example, be necessary to refer the patient for speech therapy or request guidance from a learning disability nurse. As Grandis *et al.* (2003: 213) suggest, 'the responsibility here lies with the nurse to find a suitable and appropriate means of communication in order to establish a mutual frame of reference.'

Workplace violence

Communication is a two-way process, and patients and colleagues have an equal responsibility to communicate with you in an appropriate manner. However, violence in the workplace is increasingly common (Department of Health 2001, International Labour Organization *et al.* 2005), especially in the A & E setting.

Hilton (2004: 168) lists four 'A's for managing aggression, with the objective of awareness and avoidance wherever possible:

- *Awareness* of the likelihood of aggression. For example, patients who have taken drink or drugs, or those who portray unusual or threatening body language.
- *Alertness* to situations and changing moods.
- *Avoidance* if at all possible; being aware of the patient history or the presenting case.

- *Appropriate* and prompt responses. For example, carrying of personal attack alarms and ensuring that there is an escape route and police support.

Braithwaite (2001) also discusses ways of managing aggression, including body language, assertiveness, and diffusion techniques, which Bibby (1995) describes as the calming, reaching, and controlling stages. These stages consist of: 'calming' by talking and listening in an unthreatening posture; 'reaching' the aggressor by encouraging them to explain their grievances; and 'controlling' by working together, setting joint, realistic agreements, and admitting mistakes where applicable.

Breaking bad news

Breaking bad news is one of the most difficult and emotional experiences in the nurse's role and is often poorly managed by health professionals (Dias *et al*. 2003). Faulkner and Maguire (1994) suggest that health professionals tend to 'block' the emotional flow by, for example, ignoring cues, selective attention, inappropriate encouragement, giving premature and false reassurance, and switching topics.

The Resuscitation Council (UK) (2006) provides comprehensive guidance suggesting that wherever possible, bad news should be delivered face to face in a private, quiet, and homely setting without fear of interruption. Key issues for consideration are:

- Where possible, take time to prepare yourself before going into the meeting and, if available, take a colleague with you.
- Allocate a suitable amount of time, so that the exchange is not rushed.
- Check that you are talking to the correct relatives and exchange introductions.
- Maintain eye contact and be direct, honest, and sensitive throughout.
- Give accurate and clear explanations, avoiding the use of terminology, e.g. 'Her heart has stopped', instead of 'She has had a cardiac arrest.' Say '. . . he has died', instead of euphemisms such as '. . . he has gone to a better place.'
- Be prepared for questions and a wide variety of emotions and use touch if it feels right.
- Avoid platitudes such as 'I know what it feels like.'
- Explain and discuss with the family what will happen next and identify any culturally specific requirements, for example the management of the body after death.

Cultural considerations

Nurses deliver health care to a wide range of patients/clients from a wide range of cultural backgrounds. Nurses need to be aware of and respect cultural differences and recognize potential weaknesses in traditional communication methods. Rhodes and Nocon (2003) outline the differences in communication in ethnic minority communities and report that there are gaps in communication when interpreters are used. For example, the interpreter may not speak the dialect, may miss critical information, may lack rapport, or may not pass on information using caring and applicable language. For interpreters to be effective, they need to be integrated within the health care service and gain an understanding of the concerns of patients/clients. However, such integration may prove difficult in rural areas with small ethnic minority communities. It is therefore important to be aware of the services available in each area, for example refugee centres or relevant ethnic community groups.

The elderly

Communicating with the elderly may take time and patience. As with all patients, but especially with the elderly, you should check their previous health care records to determine if their condition will affect their ability to understand and respond to you, for example if they have had a stroke, or have diabetes or dementia. It is then important to establish if the elderly person can hear, see, and understand you.

At all times, avoid behaviour that may be interpreted as patronizing, for example speaking to the individual as if they were a child or carrying out procedures without explanation or permission. Brown and Draper (2003) demonstrated that it is common within elderly health care for nurses to use 'accommodation speech', defined as being simplified, projected in a high pitched tone, and involving increased use of questions, imperatives, and repetition. La Tourette and Meeks (2001) emphasized the need to listen to the elderly and found that nurses were rated more highly when they used non-patronizing speech.

Finally, there is some evidence that technology may help the elderly. For example, Savenstedt *et al.* (2005) found that video conferencing had a positive effect on elderly patients suffering from dementia.

Interdisciplinary/interprofessional working and teamwork

Key to team building and communication within health care is communication between the professions (Molyneux 2001), a process known as interprofessional working. Interprofessional working is described by the Centre for the Advancement of Interprofessional Education (CAIPE 2002) as 'occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care'.

Of course an interprofessional approach should be adopted even where the individual is not a formal member of a 'team'. The need to communicate well with your colleagues, as well as your patient, is critical to the continued development of and improvement in patient care (Ginsbury and Tregunno 2005). For example poor communication between midwives and medical staff can lead to an increase in mortality rates (Revill 2004). Good communication practices between professionals, on the other hand, improve discharge planning (Pethybridge 2004), and in multidisciplinary teams where trained supervisors are allocated to each team, there are improvements in cohesion, joint decision-making, and communication (Hyrkas and Appelqvist-Schmidlechner 2003). Training also makes a difference to communication skills; for example, leadership training improves workplace performance (Cooper 2003).

It is important to remember that the communication skills used with colleagues may differ from the skills used with patients. However, there are core competencies for interprofessional working that are relevant to any communication episodes (CAIPE 2002):

- Equity – all contributions are valued.
- Respect differences.
- Confidentiality.
- Avoid or explain jargon.
- Check understanding.
- Identify mutual goals and where there are differences.
- Discuss the challenges of collaborative working.
- Identify a strategy to deal with disagreements.

Procedure

Box 2.1 lists the key requirements for effective communication. Note that the stages and emphasis may change depending on the situation.

Reflection and evaluation

Reflect on each communication episode you've been involved in and think about the following issues.

- Did you make the patient feel welcome and supported?
- Were you aware of the patient's emotional state?
- Did you encourage the patient to 'open up' and raise any problems and issues?
- Did you recognize and value cultural diversity?
- Did you consider treatment options and agree a plan?
- Did you identify a multiprofessional patient care pathway, where applicable?
- Did you develop a rapport by:
  - Being non-judgemental?
  - Acknowledging that the patient is an individual and has a right to their view?
  - Valuing the patient?

Further learning opportunities

Communication is improved with practice so develop your skills in role play scenario situations with your colleagues. Where communication is likely to be challenging, for example breaking bad news, observe an experienced colleague first and ask for their support on later occasions to develop your competence and confidence.

Reminders

As you practise talking to patients/staff and build your communication skills, remember the following points:

- Communication is critical to the patient experience.
- Adopt a patient-centred communication approach.
- Be culturally aware in your approach and acknowledge that in 'translation' your empathetic

Box 2.1 The key elements of each phase of communication

Set (preparation and lead in)

Preparation

Consider the context of the forthcoming communication by:

- Reading the patient's notes and records.
- Communicating with the multidisciplinary team.

Will it involve patients who have:

- Learning disabilities?
- Understanding or memory problems?
- Specific language requirements?
- Cultural differences?

Or patients who are:

- Elderly or infirm?
- Angry or violent?

Anticipate and rapidly assess communication issues:

- Hearing.
- Verbal communication.
- Anxiety levels.

Lead in

Prepare the environment:

- Personal dress/uniform.
- Temperature.
- Seating.
- Privacy.
- Comfort.

Initiate the session:

- Greet – introductions and preferred names.
- Consent to treatment (where applicable).
- Identify the key issues.
- Jointly plan the agenda.

Dialogue (active communication)

Build a rapport by:

- Being non-judgemental.
- Valuing opinions.
- Acknowledging views.
- Accepting and acknowledging concerns.
- Active listening (maintaining an open posture, eye contact, attention, and waiting and pausing).
- Using open and closed questions.
- Being sensitive and supportive.

Consider your own and the patient's verbal and non-verbal behaviour:

- Personal space.
- Eye contact.
- Posture (open or closed?).
- Movement.
- Dress and grooming.
- Voice, tone, inflection, and volume.

Maintain a structured approach by:

- Considering the sequence of the discussion.
- Exploring problems and issues through the patient's story, using listening skills and open and closed questions.
- Restricting the use of medical terminology.
- Supplying applicable information.
- Repeating information.
- Explanation and feedback.
- Reinforcing information with written and illustrative feedback (e.g. using an anatomical model or showing an X-ray).
- Emphasizing and highlighting key issues at the start and end of the conversation.

Closure (summary)

Close the session by:

- Summarizing the discussion.
- Ensuring that there is shared understanding.
- Safety netting (how to seek additional help and what to do if outcomes are unexpected).
- Confirming final agreed plans.

approach may be lost. It is important therefore to use your non-verbal communication skills to demonstrate concern and openness.

- Actively listen to your patients, 'hearing' what they say and 'seeing' how they feel.
- Ensure excellent communication skills are adopted with your colleagues.
- Make sure you value communication exchanges and seek support where there are difficulties.

Patient scenarios

Consider what you should do in the following situations, then turn to the end of this skill to check your answers.

1. Patient care advice

Miss Kosovich has recently been diagnosed as diabetic. You are responsible for advising her on her diet. However, Miss Kosovich is very outgoing, loves drinking and

smoking, and is extremely depressed that her lifestyle may change. You notice from her records that she has been given health promotion advice but that she appears to be ignoring it. She has collapsed four times during the past month after not taking her insulin and drinking alcohol in excess. How are you going to deal with Miss Kosovich?

2. Patient referral

Mr Dorrington has missed three appointments but managed to turn up today. However, he appears disorientated and his behaviour concerns you. He keeps jumping up and down saying that people are following him. You are a nurse who is advising him on his back pain. What should you do?

3. Communication with colleagues

You are a nurse attending a meeting to discuss one of the patients on the rehabilitation ward where you work. The senior registrar is at the meeting,together with the physiotherapist. The senior registrar and the physiotherapist are discussing the patient's health care and use terms you are not familiar with. You are the lead nurse for this patient's care. How would you approach this situation to ensure maximization of patient care?

4. Patient assessment

Miranda, a frequent attendee, arrives in Alison's (a nurse practitioner) office concerned about numbness in her left hand. Alison ascertains that she has had the symptoms for a week. After a full examination she refers Miranda to her GP for further investigations. She is concerned that Miranda may have the early signs of multiple sclerosis.

Miranda does not keep the GP appointment but returns to Alison's office a few months later complaining of fatigue and feeling more emotional than usual, crying over the smallest issues. Alison focuses on these issues and suggests a number of stress management techniques.

A few days later, while at work, Miranda suddenly finds the numbness in her hand has returned but now also includes her face, and she is unable to focus due to blurred vision. She immediately arranges an appointment with her GP. Her GP is concerned that Alison has not mentioned Miranda and her previous visits. He immediately refers her for further investigations to a colleague who specializes in conditions that affect the nervous system.

Website

http://www.oxfordtextbooks.co.uk/orc/endacott

You may find it helpful to work through our short online quiz and additional scenarios intended to help you to develop and apply the skills in this chapter.

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Useful further reading and websites

Check **http://www.oxfordtextbooks.co.uk/orc/endacott** for updated research and guidelines.

http://www.healthline.com – general communication information.

http://www.skillscascade.com – good resources website.

http://www.bmj.com – free articles on medical communication.

http://www.cisco.com/uk/humannetwork – virtual networking.

http://www.cardiff.ac.uk/encap/hcrc/helcomassoc.html – health communications research centre.

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Answers to patient scenarios

1. Miss Kosovich has concerns regarding her diagnosis, and fears that being diabetic means her life will dramatically change. You need to adopt a communication approach that recognizes Miss Kosovich's dilemma and values her views, even if they conflict with your own. You both need to discuss relevant role models and management of diabetes within her lifestyle. She needs to know that life can still be exciting and that her character does not need to change, but that her view on diabetes may need to be integrated into her social activities so she can enjoy her life long term.
2. As a general nurse, mental health issues are outside your professional expertise, but you may have colleagues within your multiprofessional team who have the necessary experience. If you don't, you can make an appropriate referral, but you need to identify the most effective way to proceed. Referral and support is the key in the long term. If it is possible to continue the current appointment then adopt a reassuring communication method, acknowledge his anxiety, but focus on his back pain. If this fails, the most appropriate step would be to stop the appointment and arrange another date. In the interim contact other health care professionals for advice.
3. It is important that you do not feel devalued or undermined as this may lead to defensive behaviour, which will limit communication. Ask your colleagues to explain terms that you are not familiar with and describe your experience of the patient in full.
4. Emphasis on the importance of keeping referral appointments is essential and it is good practice to check that appointments have been kept. Communicating with other health care professionals is also essential.