Communication: fundamental skills
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Clinical competence is the ability to integrate several important clinical skills – history-taking, problem-solving, assessment and knowledge – all underpinned by effective communication. Communication with others is an innate skill that is variably developed in all human beings. This chapter introduces students to the exploration of the communication that occurs between health professionals and patients. It aims to provide students with a basic understanding of different modes of communicating and to enable critical analysis of health professional–patient interactions. Students will also be introduced to the concept of a structure for interactions and consultations, with activities and topics for reflection to assist the concepts discussed. The skills learned from this chapter are transferable to many areas of work including communication in teams, teaching and social interaction.

Learning outcomes
By the end of this chapter you should be able to:
1. Describe the attributes of effective communication.
2. Develop a structured approach to patient encounters.
3. Develop the skills to critically analyse interactions with patients, whether observed or undertaken by the student.

Introduction
Communication is often taken for granted as it is a part of daily life. In the healthcare setting particularly, it can have disastrous outcomes when it is ineffective. It is accepted that history-taking is far more important than examination in making a diagnosis (Hampton et al. 1975), yet it is only recently that communication has been recognized as a clinical skill that, like all other clinical skills, should be formally taught (Duffy 1998).

Terminology: assessment or consultation?
Given that effective communication has long been recognized as the cornerstone of high-quality care, it follows that patient assessment – the first part of the nursing
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process – requires practitioners to be skilled communicators (McCabe and Timmins 2006; Field and Smith 2008; Kydd 2009). This is particularly important when initiating a patient encounter. At these times, anxiety and uncertainty are often high – even among people experienced in using the healthcare system. Sensitive, responsive and thoughtful communication helps to address the anxieties and ensure that the care the patient subsequently receives meets both their needs and aspirations.

What is assessment?

The term ‘assessment’ is used so frequently in healthcare that it is easy to assume everyone understands it in the same way – an assumption far from the truth. Some, for example, see assessment as a very formal and structured activity involving interviewing and examining a patient, identifying signs and symptoms, proposing a diagnosis and possibly treatment or a treatment plan. Others see it as a less formal but ongoing process whereby data about a patient is gathered and analysed as the patient–practitioner relationship develops. Different models may be adopted and these influence not only the type of information collected, but how it is collected.

Some would argue that every nurse–patient encounter involves assessment. In fact, even a simple ‘hello’ can be assessed. Just one word can reveal a vast amount about the person who has spoken it, from their mood or need to engage others, to their understanding of time and whether it is an appropriate moment to speak. We hear a voice and a message, not just words but emotions, accents and tones. Sometimes we can even guess at the thoughts behind them! This type of assessment tends to go on subconsciously, but should not be underestimated since it involves the subtle, almost intuitive reading of cues – the essence of effective communication (Benner 1994; RCN 2004; Fairly and Closs 2006).

Generally, the term ‘assessment’ is used in nursing to describe the first phase of the nursing process, where data is collected so a plan of care can be developed and goals set (Miller 2002; Uys and Habermann 2005). Clear examples of this include initial assessments on hospital admission, or a first encounter with a community nurse. However, nursing assessment is not a ‘once-only’ procedure, it is a dynamic, continuous and developmental process.

The widening scope of practice means that nurses are increasingly involved in more complex interactions with patients (Lloyd and Craig 2007). Practice nurses, nurse practitioners in various specialties and community nurses are examples of nurses whose interactions with patients could be described as ‘consultations’. Thus, as in clinical practice, assessment and consultation are used interchangeably in this chapter and the activity below will help to illustrate the point.

Activity

Identify members of the interprofessional team within your current placement. For example, speech and language therapist, physiotherapist, doctor, nurse practitioner.
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- Ask each one what they call the interaction they have with patients.
- Ask if they could summarize the elements of the interaction and what they think is different to what you would do as a student or newly-qualified nurse.
- Write down their answers and reflect on the similarities and differences.

Modes of communication

Communication is usually divided into two categories, verbal and non-verbal. There is also an equally important third category, known as ‘paralinguistic’ or ‘para-verbal’. All three modes of communication are usually used together. Mehrabian’s (1981) research into body language and non-verbal communication found that only 7 per cent of a message is conveyed by the actual words we speak, 38 per cent by paralinguistic features (e.g. tone and pitch) and 55 per cent by other non-verbal factors.

Verbal communication

In this category of communication, the actual words used are considered. Nurses need to choose their words carefully so that they match the patient’s ability to understand them. This is particularly important when giving information to patients. It is very easy to slip into medical jargon, especially when explaining a complex situation which may only be partially understood by the general population. The possibility for misunderstanding is increased when either party does not have English as a first language, and is even more likely when neither speak English fluently. Even when English is spoken fluently, accents, dialects, euphemisms, colloquialisms and acronyms (see Chapter 3) can obscure the understanding to the point where the patient may be disappointed, alienated or, worse still, their healthcare may be compromised (Lloyd and Craig 2007).

Patient perspective

A 65-year-old widow has just started a new relationship and had sexual intercourse for the first time after many years which resulted in vaginal bleeding. As she waits to see the practice nurse in the walk-in centre, she may be thinking: ‘How am I going to tell the young nurse what’s wrong with me and how it happened? I hope she doesn’t say she can’t deal with it and that I have to see the doctor . . .’
Activity

When the widow sees the nurse she says, 'It's me down belows.'

- What do you think the patient means?
- Can you think of any other colloquialisms or euphemisms that could obscure something that you would need to tell the patient? Write them down and check with a colleague from another part of the UK what they understand by these terms.

Paraverbal communication

Paraverbal communication can be described as the attributes that ‘dress’ the words. For example, the volume at which an assessment is conducted might have to be high because the patient is hard of hearing. However, it is possible that the nurse may raise their voice in response to a patient speaking loudly, which could inflame an already tense situation. The volume of the consultation is important as it is already difficult in many healthcare settings to achieve privacy.

The tone of voice is also important as this can impart an unintentional message which reflects how the sender is feeling, despite trying to be neutral. For example, when a long-standing patient says to the nurse, ‘You must be so fed up seeing me!’, the nurse may try to answer politely but the tone of voice may convey boredom. The emphasis on a particular word could have significant meaning. Reflect on the conversation below and think about what meanings there might be to the patient’s response.

Reflection point

Consider what you might be able to infer from the following.

**Nurse:** I’m wondering if your father has ever hurt you?

**Patient:** No, not him!

Speed of speech is another characteristic that can emphasize the meaning provided by the words. For example, it is quite normal for adolescents to speak very quickly and use jargon to the point where adults find it difficult to understand them. In a different context, for example on a mental health ward, fast speech is described as ‘pressured speech’.

Health professionals often do not tolerate pauses and silences when interacting with patients. This may be due to time pressure, but it is still vital to recognize the need to develop sufficient rapport for a ‘companionable silence’. Silences often seem longer than they actually are, yet it is important to appreciate that health professionals ask complex questions which patients need time to reflect on.
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Non-verbal communication

The terminology used in describing non-verbal communication is not rigid and there will be overlap between the descriptions given here and those in other chapters. Non-verbal communication can be described as those messages that are transmitted without using any words. Non-verbal communication is very powerful – a look, a gesture, facial expression or touch can set the tone for an encounter before a word is uttered. Many researchers agree that the receiver of the message will usually pay more attention to the non-verbal than the verbal communication. Thus as health professionals it is essential to consider the non-verbal messages we transmit, and to be sensitive to those we receive from others.

Positioning is another issue that is not always sufficiently considered. Health professionals are now advised to arrange the assessment area so that they are the same height as patients in order to minimize perceptions of superiority or inferiority. In hospital settings, staff often stand by the bedside while they discuss sensitive issues with a patient. While time is often short, it is worth making the effort to find a chair and sit down next to the patient, at least for important discussions such as care and treatment options. Ambulatory patients have more control and may position their seat closer than the health professional finds comfortable. They may use it to be threatening or familiar, depending on how they perceive they will get what they want. Chapter 7 addresses communication skills that will help in such challenging situations. However, it is important for individuals to consider safety issues when designing consultation areas. Many consulting rooms are arranged so that the patient is between the health professional and the door. On the other hand, if there are several chairs in the room the patient may choose a seat at a distance from the consulter. While this may be a simple mistake, it should alert the health professional to pay more attention to the patient’s feelings about personal space.

Gestures may convey nervousness or mean very little unless read as part of the whole communication. McNeill (2005) showed that gesturing is an active part of both speaking and thinking. Gestures may be culturally influenced, thus it is worth spending time to interpret them correctly as they may reveal what a patient is thinking but not necessarily saying.

Reflection point

Have you observed different cultural behaviours? For example:

- Men kissing each other on the cheek in greeting.
- People expecting to shake hands.
- Being asked by relatives not to tell a patient when the diagnosis is terminal.

Can you think of any others?

Much has been written about eye contact, but care must be taken not to put meaning where it does not exist. In western culture it is acceptable, indeed expected, that eye contact will be made. In some cultures it is rude for younger people to make
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eye contact with their elders, while in others men and women do not make eye contact unless they are very close relatives. Generalizations are dangerous and it is perfectly reasonable for a western woman to not make eye contact because she is shy, not because she is depressed.

‘Body language’ includes all the attributes described above as part of non-verbal language. It is also used to describe the message given by the way the body is used when communicating. Thus, in addition to the behaviours described above, whether the legs are crossed or not, whether the head is nodded or shaken, can give messages to the other person.

Touch is another form of non-verbal communication that needs to be used judiciously. Appropriately expressed, it can convey empathy more eloquently than words. However, healthcare professionals are increasingly wary of touching patients when it is not part of recognized treatments such as bathing, applying dressings and giving an injection, in case it is misconstrued. There is a dearth of research evidence on which to base touch as a therapeutic communication (Gleeson and Timmins 2005). Thus student nurses will have to rely on their instincts and develop experience to judge when it is prudent to touch patients as an expression of empathy.

Active listening

Active listening is a core skill in communicating with patients. It is important to contemplate what the patient’s words and body language really say, and to listen to the answer. The simple wisdom of the old adage, ‘when communicating, never forget we have two ears, two eyes and only one mouth’ remains as sound as ever. To develop trust and gather meaningful information generally involves giving full attention, asking open-ended questions, listening carefully and concentrating on what is being said. A useful mnemonic for this is SOLER –see Table 1.1.

Listening skills need to be developed so that patients can tell their story in sufficient detail to facilitate good quality care. Often described as active listening, the

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<th>Table 1.1 Becoming a better listener</th>
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<td>There are many ways to communicate to a person that we are giving them our full attention. These simple behaviours can help us to create the comfortable, secure and relaxed atmosphere that enables a patient to talk freely. The acronym SOLER is used to summarize some of the important behaviours – as follows:</td>
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<td>• <strong>S</strong> = <strong>squarely</strong> face the person. Facing them in this way makes your posture say ‘I am ready to listen to you’.</td>
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<td>• <strong>O</strong> = <strong>open</strong> your posture. This is a non-defensive position – it shows you are open to the other person’s words. Crossed arms and legs can represent less involvement.</td>
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<td>• <strong>L</strong> = <strong>lean</strong> forward to the other person. This again shows that you are listening.</td>
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<td>• <strong>E</strong> = <strong>eye contact</strong> maintained. As you listen, use your eyes to show you are looking at the person. In this way, they know you are concentrating on what they are saying.</td>
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<td>• <strong>R</strong> = <strong>relax</strong> while attending. It is entirely possible to be both concentrating and relaxed. In turn, this will help the other person to feel comfortable and relaxed.</td>
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nurse is not required to sit silently while the patient rambles for an indefinite period of time. The listener needs to give non-verbal messages which encourage the patient to share, while feeling safe and cared for. The patient also needs to know that the listener will not judge and will be honest. While listening, the information received needs to be processed, sorted and used to plan the next step of the interaction while demonstrating that the patient has the listener's full attention. Interestingly, ‘silent’ and ‘listen’ are anagrams of each other, and this corroborates Morton Kelsey's statement that listening is being silent in an active way (Kelsey 1976).

In summary, it is important for the nurse to appreciate that communication consists of sending messages between the patient and the healthcare professional. There could be many factors in both parties that result in the message that is received being very different from the intended message sent. It is by learning to read the non-verbal language of patients, and the health professional being aware of the non-verbal messages they might be transmitting, that truly effective communication can occur.

Consulting effectively with patients

The consultation is the unit of work undertaken by any healthcare professional, whether it is very task-focused or involving complex diagnostic and prescribing skills. It has been calculated that a healthcare professional, working full-time for most of their professional life, could undertake approximately 150,000–200,000 consultations with patients. While each interaction is different, healthcare professionals have found that there are some common occurrences in each interaction. This thinking has led to the idea that if an overarching structure for a generic interaction could be developed, it would be a useful tool to discuss, analyse and improve all exchanges. These structures are known as models, frameworks or maps.

Using a model or framework for patient assessment

In order to achieve an effective assessment, most nurses use a framework, model or written prompt to guide them. Of course, very experienced nurses may assess a patient without immediate reference to any document or guidelines, but even so, aspects of a nursing model are likely to be used, albeit implicitly.

The frameworks used take many forms but their role is to clarify thinking so that each patient can be assessed in a systematic and comprehensive way. Most hospitals or organizations have pre-printed assessment documentation that reflects a model and provides such a framework (Kozier et al. 2008).

One commonly used framework derives from the Roper, Logan and Tierney (2000) model, and requires nurses to assess each patient in relation to 12 activities of living (ALs); in fact, the model contains five ‘conceptual’ components altogether, and all of these are illustrated in Table 1.2.

According to Roper et al. (2000), this model promotes individualized, systematic nursing. However, there are many other models and it is worth investigating them. For example, Orem's (1991) and Roy's (1976) models are both relevant to adult nursing, offering different perspectives and insights for practice.
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Table 1.2 Components of the Roper, Logan, Tierney model for nursing

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<th>Activities of living (ALs)</th>
<th>Maintaining a safe environment</th>
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<td>Dying</td>
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2 A lifespan continuum People may require nursing at any point of the lifespan – from birth to death

3 A dependence/independence continuum We need to assess the patient’s level of dependence in each AL so that goals can be set to help towards independence or acceptance of dependence

4 Factors influencing the ALs Each AL should be considered from five perspectives – biological, psychological, sociocultural, environmental and politico-economic

5 Individuality in living Each individual is unique and nursing must take account of this when assessing and planning care.

Interestingly, not everyone sees nursing models as useful and there has been some contention over their value. Some argue that models tend to be ‘reductionist’ in nature, encouraging nurses to adopt a ‘checklist approach’ to assessment (Kelly 1988; Kenny 1993; van Maanen 1990).

One criticism levelled at the Roper, Logan, Tierney model is that it concentrates on physical aspects of patient care (Ellson 2008). However, the issue is one of interpretation; while the ALs may seem physiologically based, if the model is used as designed, then broader psychosocial perspectives are addressed.

Activity

Select two of the ALs from the Roper, Logan, Tierney model.

- For each, identify how you might assess a patient, including observations you would make and questions you would ask.
- Make a list of your ideas.
- Now consider the five perspectives: biological, psychological, sociocultural, environmental and politico-economic.
- Look at your list and see how you addressed each of these perspectives. What changes might you make as a result?
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Having a framework may well be essential to guide thinking and the type of information gathered, but the question remains: how should assessment be conducted?

Other models

There are several other consultation models (e.g. see www.commscascade.medschl.cam.ac.uk) and it is useful to get to know one or two of them in depth. Using these models at the beginning of a career will enable health professionals to develop a personal style based on good practice and underpinned by evidence.

There are broad similarities between models, and the Calgary Cambridge Framework (Silverman et al, 2005) is one that can be applied to most healthcare professions. The Calgary Cambridge Framework is used mainly by doctors (70 per cent of the 33 medical schools in the UK now use it). However, it has also been discussed and introduced into nursing and pharmacy schools. The basic framework of this model is shown in Figure 1.1, but the Appendix on page 20 of this chapter contains further information which provides more detail (reproduced with the kind permission of the authors). The full model goes on to list all the evidence-based skills and explains their practical application. While the model at first sight looks

![Figure 1.1 The enhanced Calgary Cambridge guide to the medical interview – the basic framework](image-url)
It is not possible in this book to do more than highlight the most important skills that will provide the student with a firm foundation. *Skills for Communicating with Patients* (Silverman et al. 2005) gives further details about individual communication skills. The subsequent chapters of this book will help the student build on this basic introduction. The above frameworks will now be used as the basis for exploring specific skills for effective communication in assessing/consulting with patients. The two main activities that run throughout a consultation are explored first.

**Building relationships**

It can be daunting for patients to see health professionals arrive with a clipboard and set of notes. Not knowing what to expect or being concerned that others will overhear can inhibit communication, so it is important to explain briefly that assessment involves discussion of personal information that will be kept confidential.

A comfortable environment is essential – preferably a private and soundproof room (Barnes 2009). The nurse should position themselves at the patient’s level, so there can be good eye contact and the ‘safe’ closeness that is necessary to share personal information. Sharing is an important concept here – the emphasis is on establishing a rapport where patients feel they are collaborating with the nurse, not being subjected to an interview or test. Although many patients expect nurses to take the lead, ‘supported participation’ and partnership usually make for the most effective care, so it is often worth showing patients the relevant forms, and in some cases sitting side by side to address the various requirements.

General questions about name, address and other biographical details are always essential, so they are the usual starting point. Within seconds, however, a conversation can begin – asking a person how they like to be addressed, for example, will demonstrate respect for their choices and can pave the way for a relaxed conversation.

The more experienced nurses become, the less they need to refer to pre-printed forms. In fact, as confidence develops, nurses can listen and observe more, concentrating less on documentation and much more on what the patient says and how they appear or are behaving. This does not mean that documentation is not a vital part of assessment – quite the reverse. Record-keeping is critical to effective communication (Ellson 2008). However, if nurses spend time actively listening, observing the patient and conversing with them, then the records produced are likely to be a more accurate reflection of the patient’s needs.

**Vignette**

**Shared understanding?**

_Nurse:_ Hello Mr Peters. My name is Nurse Smith, I’m going to do a holistic assessment and find out your nursing needs. Is that okay? [Nurse looks down at paper, pen poised]
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Patient: All right Nurse Smith. I see ... nursing needs ... I see ... a 'whole' assessment?
Nurse: Yes. First of all – can you tell me about your environment?
Patient: My environment? You mean our house? Where we live?
Nurse: Yes, your house. I mean, do you have stairs? And is your toilet upstairs? That sort of thing.
Patient: Well it's a house but we have moved downstairs now. We have a bathroom downstairs. My wife has arthritis, you see, and ... it's much easier.
Nurse: I see. So is it just you and your wife?
Patient: Yes. It's just us two ...
Nurse: Do you need help?
Patient: Help? Help at home? With the house and all that? Well, our daughter does our shopping. We manage, you know. We get by. Our neighbour does the lawn.
Nurse: Yes, yes, I see. Okay. [Nurse looks down, writes on sheet, then looks up] Do you have any carers?
Patient: No, like I said, our daughter does all the heavy shopping. My wife doesn't really want anyone else. Our daughter is good, you know. She calls in nearly every day.
Nurse: Okay. So I will write 'daughter looks after your care needs at home'.
Patient: Well, she does help out but I still manage for myself really.
Nurse: Good. How about your breathing? Do you have any problems?
Patient: My breathing? Sorry! Say it again, nurse ...
Nurse: Any shortness of breath? [Nurse looks at chart at bottom of the bed, writes on notes]

Activity

This activity would be most effective undertaken as a trio. One nurse to role-play the patient, one to play Nurse Smith and a third as an observer. Use the transcript above to conduct the initial role play. After the role play, the ‘patient’ should feed back on how it felt, then the nurse and finally the observer. Swap roles and try different ways of playing the nurse to see how it alters the patient’s behaviour and the way the nurse feels. Specifically, what is the effect of ignoring or picking up cues?

From the transcript above, it is easy to see how several poorly phrased questions ‘aimed at’ a patient can ultimately become a series of missed opportunities and provide almost meaningless details. The key, therefore, is always to listen actively to the patient.
Effective questioning is a skill worth developing and the use of both open and closed questions is useful in the assessment process. An open question will enable the patient to start where they like and that may provide very useful information. An open question will enable a patient to offer their own perspectives, opinions and feelings, which will support the healthcare professional in undertaking assessment. Closed questions are also useful and can be used to elicit particular details or explore specific issues. They would generally follow the use of open questions in an assessment process.

**Reflection point**

‘Would you mind telling me about your pain?’ is an example of an open question. ‘How long have you had your pain?’ is an example of a closed question. Think about the different answers you would get to each type of question and how they might affect your relationship with a patient you have just met.

**Picking up cues**

Attending to the comfort of the patient, picking up on non-verbal cues and managing your own non-verbal cues all contribute to the building of rapport. Patients may, for example, give non-verbal cues that they are very uncomfortable discussing sensitive matters on an open ward, so the veracity and depth of information obtained may be poor. Physical discomfort such as being too short to sit comfortably in the chair provided may not be easily resolved, but acknowledging that there is a problem coupled with an apology that it cannot be rectified will make the person feel valued. This links with preserving the dignity of the patient, discussed in Chapter 3.

The choice of words and phrasing is important. Using expressions like ‘holistic assessment’ can be disconcerting, and ambiguous questions should be avoided. It is usually better to use the patient’s own words, keeping language simple and concise. How much clearer to say, ‘Please tell me about where you live?’ and ‘I am asking some questions to get to know you and see how we can help.’

Looking at the transcript above once again, Nurse Smith could have found out much more by following the cues that were given. For instance, by following up on the point about the daughter, she could have asked whether she lives nearby or if she has her own family. Mr Peters may then have felt that the nurse was genuinely interested, and would have been more likely to disclose more. It would have certainly showed that the nurse was listening – hearing what the patient wanted to say, not just what had to be asked.

Of course, assessment does not only involve questioning and interviewing. Sometimes we need to examine the patient and this needs to be explained so that the patient can give consent. For example, if the patient has a wound or requires blood pressure measurement, these observations are part of the assessment process (Kozier et al. 2008).
Health professionals are often rushed, tired and hungry. They may be irritated because they feel that they are working harder than other colleagues or have issues that may be detrimental to their performance. Unless a nurse is aware of these feelings and the impact they may have on the patient, the patient may react negatively without the nurse understanding why. In his five-step consultation model, Roger Neighbour (2005) urges the health professional to stop momentarily and ask if they are in good enough shape to move to the next patient. Issues left over from a previous consultation or encounter may be a block to building rapport in the current one.

Providing structure

When undertaking consultation and assessment, using a structure to guide the process can also help the health professional develop their skills in time management. This ensures that the time a nurse has with a patient is used effectively and important elements are not overlooked. A useful skill here is called ‘signposting’. It can be described as holding the patient’s hands (metaphorically speaking) and leading them through the consultation step-by-step. This helps to avoid repetition and signals a move to another topic or another activity, such as being examined.

Examples of signposting

From the patient:

- ‘There are three things I wish to discuss with you today, nurse . . .’
- ‘When you’ve finished changing my dressing, there’s something I’d like to ask you.’

From the nurse:

- ‘We need to finish our discussion soon so that the blood I have taken will catch the next collection.’
- ‘If you’re happy that I have answered all your questions about your cough, we can move on to talk about you going home.’

The Calgary Cambridge Framework describes five steps of the consultation which, supported by building rapport and providing structure, help the nurse to develop a holistic approach to patients. The important skills in each of these stages are now briefly highlighted.

Initiating the session

It is often said that judgement should not be made on first impressions. Nevertheless, the initial welcome a patient receives will leave a lasting impression; getting it right is important. That does not mean that people will not forgive an obviously busy nurse if, for example, they have to wait a few minutes. All the same, simple courtesies really do matter – a smile, being shown to a seat, a ‘Hello, how are you?’
spoken with genuine concern all convey a respect that only helps in developing relationships (see also Chapter 3).

Furthermore, these courtesies should never be dismissed as ‘the basics’. Repeatedly, ombudsman reports highlight inadequate communication as a major source of complaints about healthcare, and invariably communication failures are at the root of things when treatment goes wrong (Oxtoby 2005; Health Service Ombudsman 2008).

There may be many reasons for this, but in terms of assessments and admissions it is important to acknowledge how overwhelming the experience may be for a patient. Aside from the often complex problems patients may be experiencing, today’s healthcare environments are increasingly busy and pressurized. Some are full of sophisticated pieces of technology that bleep, alarm and distort perceptions of what is happening. In such a dehumanizing environment, people may feel bewildered and isolated. At the risk of stating the obvious, staff who smile, introduce themselves and engage patients with appropriate eye contact and an open posture are likely to make a real difference as far as patients are concerned.

**Vignette  A home visit**

Consider the following situation.

Mr Carter has arrived at the doctor’s surgery and needs to find out how he can request a home visit for his wife, as he has been unable to get through to the surgery by telephone. When he arrives, two receptionists are sitting at the reception desk. One receptionist is talking on the telephone and the other is looking intently at her computer screen. The practice nurse is also in reception but has her back turned, filing a set of notes. As Mr Carter approaches the desk, the receptionist on the telephone holds up her hand in a ‘stop’ gesture and then points to the touch-screen where patients are expected to ‘check in’ on arrival for their appointments. She continues her telephone conversation but nudges the other receptionist to get her attention – unsuccessfully. Mr Carter waits a couple of minutes before the other receptionist sees him and asks how she can help him.

**Patient perspective**

Mr Carter might be thinking, ‘I really can’t cope with this. My Anne is really unwell and I need to get back to her. Now I am here they don’t even want to speak with me. I don’t need to use the machine as I don’t have an appointment. I bet they’ll tell me the doctor is too busy to come home to Anne. I think I’ll hang around in the corridor and see if I can catch the nurse for a quick word.’

**Reflection point**

Think about how patients and visitors are greeted in the service in which you work.
Setting the agenda

Having greeted a patient, the next part of assessment involves establishing any immediate or ‘emergency’ needs. These obviously take precedence, although much depends on the issues bringing the patient to the care service. A person with severe pain or shortness of breath, for example, will clearly be unable to answer lots of questions and in some circumstances it may be inappropriate to do much more than a visual assessment and baseline observations before treatment is commenced.

For the majority of patients, however, it is entirely appropriate to begin a more in depth assessment shortly after or as part of the initial meeting. With introductions made, the next step may need to be the negotiation of an agenda as it is important to work out and agree what can reasonably be covered in the time available. The patient needs to be involved in agreeing what is going to be dealt with, otherwise the health professional will experience that sinking feeling in the pit of their stomach as the patient says, ‘While I’m here nurse . . .’. Often the health professional will work on the first problem presented by the patient. Starfield et al. (1981) found that in 50 per cent of visits patient and doctor do not agree on the main presenting problem. Their findings confirm that practitioner–patient agreement about problems is associated with a better outcome as perceived by the patient. In addition, they indicate that practitioners also report better outcomes under the same circumstances.

Sometimes the patient may separate symptoms and present them individually, while together, as a clinical pattern, they may suggest a single diagnosis. For example, eliciting a list of symptoms such as tiredness, nausea, slight right upper abdominal pain, dark urine and light-coloured stools immediately leads one to think of liver-related disorders. Delving deeply into the first symptom of tiredness at the outset could mean that the health professional does not get all the other symptoms in good time and the consultation travels down a very different path.

Gathering information

Once the agenda is set, it is important to explore each item in turn to develop and test the patient’s thoughts about a provisional diagnosis. Most health professionals are good at learning the specific ‘scientific’ questions that relate to a symptom. These ‘systematic questions’, as they are called, are very useful as they give clinicians a structure that helps them practise safely and not miss any dangerous symptoms. However, it is also really important to understand how the patient views what is going on. Disease as diagnosed is very different from illness as lived, and people respond differently. The acronym ICE (ideas, concerns and expectations) is often used glibly without putting the skills required into practice.

Activity

With a colleague, ask each other the following questions and discuss the effect on each of you and what you think the effect might be on your patients.

- ‘What are your ideas, concerns and expectations?’
Finally, it is important to put all the information gleaned into the patient’s context, so that the treatment suggested is accepted by the patient. For example, telling a man to take time off work without realizing he is the sole breadwinner, with an employer who does not pay sick leave, just will not work. It is vital to learn enough about the patient as a person by gathering appropriate background information. If the information required is very personal, it helps to tell the patient why and to signpost and perhaps normalize that part of the consultation. For example, in a sexual health clinic: ‘I am now going to ask you a series of personal questions that we ask everyone with your kind of problem. It will help us decide what further tests you may need, if you need any at all . . . ’

Physical examination
Nurses in their daily roles examine patients. It may be an everyday activity such as inspecting a wound or taking readings of vital signs, or indeed, for those working in extended roles, listening to the patient’s chest or undertaking a vaginal examination prior to taking a swab or cervical cytology. The patient needs to give explicit consent. The nurse needs to explain to the patient what the examination entails and obtain the patient’s agreement. If there is a procedure linked with the examination then that needs to be explained before starting. The nurse needs to consider whether the offer of a chaperone is appropriate (NMC 2008).

Chapter 3 will help the student embed the concepts of treating patients with dignity before during and after the examination. Offering help with dressing sensitively, for example, may be overlooked when time is short. It is often assumed that an elderly person will welcome help with undressing, but if this is not the case they are robbed of their dignity. This scenario may diminish any rapport that may have been built up in the earlier part of the interaction.

Explanation and planning
This is the part of the assessment where the health professional collates the information, comes to an idea of what is going on and needs to enter into a discussion with the patient about what might be wrong, what can be done, and what the patient thinks and will agree to, so that a plan can be made. This can be the most time-consuming part of the consultation/assessment as it is what the patient is really waiting for – or fearing.

Apart from using plain language without jargon, the nurse has to ensure that the patient does not get lost and has ample opportunity to ask questions, while avoiding being patronizing.
Communication: fundamental skills

Health professionals need to practise explaining risk until they find a form of words that patients can relate to. Many patients access the internet prior to their appointment or admission which makes this part of assessment much more of a discussion and negotiation than it used to be. When the patient and the health professional are speaking in equal proportion, or if the patient is speaking more, it means that the patient is engaged in the development of the plan and therefore it is more likely to be executed. A lecture ending with ‘Any questions?’ leaves the stunned patient with very little understanding or recall.

Information must be broken up into manageable chunks, with time for the patient to digest and question before moving on to the next bit. It is also necessary to find out where the patient is starting from, otherwise unnecessary information may be given, without addressing the patient’s real information needs.

Activity

Mrs Brown has just been diagnosed with type 2 diabetes and has been sent to the nurse to learn how to manage her disease. Diabetes is a huge topic for a patient to learn about.

- Think for a minute about how you would undertake this task. It would be helpful to role-play with a colleague.
- Think about how you would start and how would you decide what to tell her.
- If she were obese, as is likely, it might be obvious to you that she has to lose weight. But how do you know that is her priority?

Closing the session

This section overlaps with the previous one. Having developed a plan for managing the problem with the patient, a plan for the future needs to be made. What does the patient need to do? When does the patient need to come back, if at all? ‘Safety netting’ is a phrase that is often bandied about, but to be performed well it has to be more detailed than, ‘If it doesn’t get better, come back.’ Most patients are not nurses and may not realize when their symptoms become dangerous. Equally, and detrimentally for the healthcare system, if they do not have clear guidance they may come back too soon, straining resources.

Patient perspective

Alfonso Vadini, a 46-year-old man, passed blood in his urine and went to his local accident and emergency (A&E) department because he was so alarmed. His father died of prostate cancer and Alfonso knew he had blood in his urine.
He saw a nurse practitioner who diagnosed a urine infection, gave him five
days’ supply of antibiotics and told him to see his GP if it did not get better. Six
days later, his urine was still dark, but there was no blood. On reflection Alfonso
realized he had been feeling tired for a few months. He might have been thinking,
‘I wish the hospital had not been busy that night, I could not say how worried
I was. The nurse might have thought I was being weak. What did she mean
by “better”? I am “better” but not quite well. I don’t want to waste anybody’s
time’.

It is also very useful to offer clearly-written evidence-based information for the
patient to take away. Encouraging the patient to read the information and note
any questions or concerns to discuss on a return visit is not only reassuring for
the patient, but also helps to build rapport. It gives the patient permission to ‘not
understand or remember fully’. It can also empower patients to take more control of
a chronic condition if they have a written plan – for example, asthma management
plans which guide the patient to increase or reduce medication according to the
severity of their symptoms.

Once the interaction has ended, it is important for the health professional to
take stock momentarily to see if there is anything that might be carried over into
the next consultation. Is there a fear that something was forgotten or should have
been done differently? Was a practical skill mastered after many failed attempts? Is
a comfort break needed?

If all these aspects are not addressed, the next assessment can be a disaster, because
of tensions or emotions within the health professional. While it may seem a luxury,
this brief self-check could save a lot of time in the future.

**Conclusion**

Effective communication with patients is a huge topic, underpinned by a vast body
of research. It is a skill set that needs to be continually brushed up and developed
throughout any health practitioner’s career. This chapter has only highlighted the
most important topics and concepts for the student nurse:

- learn to listen actively;
- explore the use of a nursing model – this will give a structure for learning,
  working and updating;
- always try to keep the patient’s perspective in mind;
- be aware of how your communication skills can be affected by your own emo-
  tions and thoughts;
- identify potential learning from every human interaction regardless of the set-
  ting.
References


RCN (Royal College of Nursing) (2004) Nursing Assessment and Older People: A Royal College of Nursing Toolkit. London: Royal College of Nursing.


Appendix

**Figure 1.2** The enhanced Calgary Cambridge guide to the medical interview – the expanded framework (Silverman et al. 2005)
## Gathering Information

**Process skills for exploration of the patient’s problems**

- patient’s narrative
- question style: open to closed cone
- attentive listening
- facilitative response
- picking up cues
- clarification
- time-framing
- internal summary
- appropriate use of language
- additional skills for understanding patient’s perspective

**Content to be discovered**

- The biomedical perspective (disease)
- The patient’s perspective (illness)

**Sequence of events**

- Symptom analysis
- Relevant systems review
- Effects on life
- Feelings

**Background information - context**

- Past medical history
- Drug and allergy history
- Family history

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*Figure 1.3 An example of the interrelationship between content and process* 
(Silverman et al. 2005)
<table>
<thead>
<tr>
<th>Medical perspective–disease</th>
<th>Patient’s perspective–illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sequence of events</td>
<td>Ideas and beliefs</td>
</tr>
<tr>
<td>Symptom analysis</td>
<td>Concerns</td>
</tr>
<tr>
<td>Relevant systems review</td>
<td>Expectations</td>
</tr>
<tr>
<td></td>
<td>Effects on life</td>
</tr>
<tr>
<td></td>
<td>Feelings</td>
</tr>
</tbody>
</table>

**Patient’s problem list**

**Exploration of patient’s problems**

**Background information – context**
- Past medical history
- Drug and allergy history
- Family history
- Personal and social history
- Review of systems

**Physical examination**

**Differential diagnosis – hypotheses**
- Including both disease and illness issues

**Physician’s plan of management**
- Investigations
- Treatment alternatives

**Explanation and planning with patient**
- What the patient has been told
- Plan of action negotiated

*Figure 1.4 Revised content guide to the medical interview (Silverman et al. 2005)*