10TH EDITION

CLINICAL NURSING SKILLS & TECHNIQUES

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As always, this book is dedicated to my children. To be their mother brings more joy, honor, and sense of pride than I could ever imagine. They and their loved ones are truly my shining stars. As they grow, things change, and I now dedicate this book to:
My daughter, Rebecca Lacey Perry Bryan; her husband, Robert Donald Bryan;
their three daughters Cora Elizabeth Bryan, Amalie Mary Bryan, and Noelle Anne Bryan;
and their son Shepherd Charles Bryan.
And to my son, Mitch Perry-Cox; and his husband, Samuel Perry-Cox.
Anne Griffin Perry

Registered nurses, LPNs, and assistive personnel have sacrificed a great deal this year while displaying compassion and strength in caring for COVID patients. I salute you all for your dedication and resolve. This dedication is a small way of thanking you.
Patricia A. Potter

For Toba and Harris, who never saw this achievement but would be proud of its influence on today's and tomorrow's nurses. And, as always, for my always supportive and patient husband, who inspires me daily.
Wendy R. Ostendorf

I dedicate this textbook first to my husband, Phil, who is my greatest support system and a wonderful partner to share this life with. I also dedicate this textbook to my children, Chris and Charlotte, who have grown into adults that I respect and love more each and every day. I am blessed to have this family.
Nancy Laplante

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Dr. Anne G. Perry, Professor Emerita at Southern Illinois University—Edwardsville, is a Fellow in the American Academy of Nursing. She received her BSN from the University of Michigan, her MSN from Saint Louis University, and her EdD from Southern Illinois University—Edwardsville. Dr. Perry is a prolific and influential author and speaker. An author for more than 40 years, her work includes four major textbooks (*Essentials for Nursing Practice*, *Fundamentals of Nursing*, *Nursing Interventions & Clinical Skills*, and *Clinical Nursing Skills & Techniques*) and numerous journal articles, abstracts, and nursing research and education grants. She has presented numerous papers at conferences across the United States and internationally. She was one of a few key consultants on *Mosby's Nursing Video Skills* and *Mosby's Nursing Skills Online*.

Dr. Perry is passionate about nursing education and has been involved in education since 1973, first as an instructor and then achieving the rank of Professor and assuming various leadership roles at Saint Louis University School of Nursing. She was a Professor and Associate Dean and Interim Dean at Southern Illinois University—Edwardsville. As a clinician and researcher, Dr. Perry's contributions to pulmonary nursing and nursing language development involve both research and policy making. She has investigated and published findings regarding topics that include weaning from mechanical ventilation, use of the therapeutic intervention scoring system, critical care, and validation of nursing diagnoses.

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Dr. Patricia Potter received her BSN at the University of Washington in Seattle and her MSN and PhD at Saint Louis University in St. Louis, Missouri. A groundbreaking author for more than 30 years, her work includes four major textbooks (*Essentials for Nursing Practice*, *Fundamentals of Nursing*, *Nursing Interventions & Clinical Skills*, and *Clinical Nursing Skills & Techniques*) and publications in numerous professional journals. She has been an unceasing advocate of evidence-based practice and quality improvement in her roles as administrator, educator and, more recently, director of research.

Dr. Potter has devoted a lifetime to nursing education, practice, and research. She spent a decade teaching at Barnes Hospital School of Nursing and Saint Louis University. She entered into a variety of managerial and administrative roles, ultimately becoming the director of nursing practice at Barnes-Jewish Hospital. In that capacity she sharpened her interest in the development of nursing practice standards and the measurement of patient outcomes in defining nursing practice. Her most recent passion has been in the area of nursing research, specifically cancer family caregiving, the cancer patient symptom experience, fall prevention, and the effects of compassion fatigue on nurses. Recently Dr. Potter has worked with colleagues to develop an inpatient Innovation Unit, which is designed to incorporate current evidence into the selection and development of a unique work team and the creation of a care delivery model and innovative care practices. Dr. Potter was most recently the Director of Research for Patient Care Services at Barnes-Jewish Hospital in St. Louis, Missouri, before her retirement in 2017.

WENDY R. OSTENDORF, RN, MS, EdD, CNE

Dr. Wendy R. Ostendorf received her BSN from Villanova University, her MS from the University of Delaware, and her EdD from the University of Sarasota. She currently serves as a contributing faculty in the Master of Science in Nursing at Walden University. She has contributed more than 30 chapters to multiple nursing textbooks and has served as author for two major textbooks: *Nursing Interventions & Clinical Skills* and *Clinical Nursing Skills & Techniques*. She has presented more than 25 papers at conferences at the local, national, and international levels.

Professionally, Dr. Ostendorf has a diverse background in pediatric and adult critical care. She has taught at the undergraduate, master's and doctoral levels for 35 years. With decades of practice as a clinician, her educational experiences have influenced her teaching philosophy and perceptions of the nursing profession.

NANCY LAPLANTE PhD, RN, AHN-BC

Dr. Nancy Laplante received her BSN from William Paterson University, Wayne, New Jersey; her MSN in Community Health from West Chester University, West Chester, Pennsylvania; and her PhD from Widener University, Chester, Pennsylvania. Dr. Laplante is also a board certified advanced holistic nurse.

Dr. Laplante is an Associate Professor of Nursing at Widener University and also serves as the Director of the Accelerated RN to BSN to MSN program and Director of the RN to MSN bridge program. She teaches undergraduate courses in self-care, health policy, and gerontology and teaches graduate courses in technology, health policy, assessment and evaluation, population health, and epidemiology. Dr. Laplante teaches primarily in online formats and enjoys being able to connect with a diverse group of students both nationally and internationally.

Dr. Laplante strives to engage all students in respectful dialogue. She believes teaching is a collaborative process between students and faculty and that there is a reciprocal relationship as we learn from one another. As an advanced holistic nurse, she incorporates self-care, self-responsibility, spirituality, and reflection in her teaching and seeks to be a role model for her students.

Dr. Laplante's research interests include creating a presence in online learning environments, health care applications of the Internet of Things (IoT), the image of nursing, and self-care practices for students and peers. Dr. Laplante has presented at local, national, and international conferences and has published recently in the areas of IoT and holistic nursing practice. In addition to her teaching and Director responsibilities, Dr. Laplante serves as a committee member and reader for doctoral nursing students. She believes this role is important to mentor and support the next generation of nursing scientists.

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Preface

The evolution of technology and knowledge influences the way we teach clinical skills to nursing students and improves the quality of care possible for every patient. However, the foundation for success in performing nursing skills remains having a competent, well-informed nurse who thinks critically, uses clinical judgment, asks the right questions at the right time, and makes timely decisions. That outcome is the driving factor behind this new edition.

In this tenth edition of *Clinical Nursing Skills & Techniques*, we have maintained the same format developed for our ninth edition of the textbook. These features were proven popular among students and faculty. Each chapter opens by introducing students to key concepts: Practice Standards, Principles for Practice, Patient-Centered Care, Evidence-Based Practice, and Safety Guidelines. These are streamlined into a quick, easy-to-read bulleted format. Our approach emphasizes yet simplifies these important concepts.

In addition, these concepts align with the *Quality and Safety Education for Nurses* (QSEN) initiative. Chapter 1, Using Evidence in Nursing Practice, prepares students to understand and use the evidence-based practice information included in every chapter.

Your students will find that this edition of *Clinical Nursing Skills & Techniques* provides a comprehensive resource that will serve them well through their nursing education and right into their clinical practice careers. Recently the National Council of State Boards of Nursing (NCSBN) has emphasized the importance of sound nursing clinical judgment as the core of competent and safe patient care. In support of the NCSBN initiative, *Clinical Nursing Skills and Techniques* has a **NEW Feature** that introduces unit openers. Each unit opener is designed to emphasize the importance of clinical judgment when applying specific knowledge and standards of care in order to perform the skills within the unit safely and correctly. In addition, each unit has a Next-Generation NCLEX® (NGN)–style unfolding case study. Each case study challenges students to apply critical thinking and clinical judgment while using the nursing process: recognizing and analyzing assessment cues, priority setting, and selecting interventions and evaluating outcomes.

CLASSIC FEATURES

- **Comprehensive coverage** is given to basic, intermediate, and advanced nursing skills and procedures.
- **The nursing process format** provides a consistent presentation that helps students apply the process while learning each skill.
- A **Skills and Procedures** list and **Objectives** open each chapter.
- An **extensive full-color art program** helps students master the material covered.
- **Practice Standards** highlight the evidence-based standards incorporated into skills content. **Supplemental Standards** include additional scientific resources pertaining to the chapter topic.
- **Evidence-Based Practice** sections in each chapter present students with the newest scientific evidence for topics related to the procedures presented. Recent research findings are discussed, and their implications for patient care are explored. Newest evidence is also incorporated into the skills steps.
- **Patient-Centered Care** sections prepare students to recognize the importance of having patients partner in performing skills in a compassionate and coordinated way based on respect for a patient's cultural preferences, values, and needs (QSEN core competency).
- **Safety Guidelines** sections cover global recommendations on the safe execution of the particular skill sets covered in each chapter (QSEN core competency).
- **Rationales** are given for steps within skills so students learn the *why* as well as the *how* of each skill. Rationales include citations from the current literature.
- **Delegation** guidelines define communication within the patient care team and the nurse's responsibility when delegating to assistive personnel.
- **Interdisciplinary Collaboration** is a **NEW Feature** and a subset of Delegation that focuses on the role other health care team members play in supporting patient care.
- **Clinical Judgment** alerts are a **NEW Feature** that notifies students of the key steps that affect patient outcomes and help them modify care as needed to meet individual patient needs.
- **Evaluation** sections highlight the steps students must take to evaluate the outcomes of the skills performed.
- **Teach-Back** is included in each evaluation section, where we demonstrate to students how to phrase a Teach-Back question appropriately.
- **Unexpected Outcomes and Related Interventions** sections inform students to be alert for potential problems and help them determine appropriate nursing interventions.
- **Recording** sections follow the evaluation discussion and alert students to what information should be documented.
- **Hand-off Reporting** follows the recording section and alerts students to what is reported during patient handoff.
- **Special Considerations** sections include additional considerations when performing the skill for specific populations of patients or in specific settings and may include:
  - **Patient Education**
  - **Vulnerable Populations:** This **new subheading** includes **pediatric** and **gerontological** sections and adds a section on patients who are **disabled**.
  - **Home Care**
- **Quick Response codes** (scan with smartphone or tablet with camera to view video clips) on the text pages link video clips to the appropriate skill or procedure, allowing students to view the video immediately after reading the implementation section of the skill.
- **Glossary** (on Evolve) defines key terms.
- **Additional review questions** (on Evolve) include a brand-new set of unique questions for every chapter.
- **TEACH for RN Instructor Manual** helps you capitalize on the new clinical material in the text, skills video series, and online course.
- As with the ninth edition, an **Image Collection** is available with *Clinical Nursing Skills & Techniques*.

NEW TO THIS EDITION

This tenth edition adds the following new elements to enhance student learning:

- **Clinical Review Questions**
  - Each chapter ends with five chapter-specific, reflective clinical review questions. These questions are designed to have the student reflect on chapter-specific content. Some of these questions require the students to select the correct option(s). Other questions are open ended and require the student to apply chapter information to a recent clinical or laboratory experience. These questions also provide the instructor excellent discussion points for postclinical conference or self-study. Answers with rationales are included at the end of the text.
- **Unit Openers and End-of-Unit Next-Generation NCLEX® (NGN)–style questions reflecting the six new format questions for the Next-Generation NCLEX® Examination**
  - Unit openers describe to the student the importance of clinical judgment to perform the skills safely and correctly within the unit. This knowledge comes from biological, physical, and psychosocial sciences from nursing and prerequisite courses. These openers also demonstrate to the student the impact of environmental factors and interdisciplinary collaboration on safe patient care.
  - End-of-unit Next-Generation NCLEX (NGN)–style case studies challenge students to apply critical thinking and clinical judgment. These case studies include the six new format questions developed for the Next-Generation NCLEX® Examination. Answers for each question are included at the end of the text.

Contents

Brief Contents

Next-Generation NCLEX® (NGN)–Style Unfolding Case Studies appear at the end of every unit!

UNIT 1
Supporting the Patient Through the Health Care System

The skills in Unit 1 include evidence-based practice and communication—both essential knowledge elements that enable you to think critically in selection and performance of skills. Patients enter the health care system through a variety of settings and in various levels of health. When nurses apply therapeutic communication principles, they are better able to perform the nursing process and make the clinical judgments needed to help patients transition through all health care settings. For example, applying therapeutic communication during assessment is needed to gather data to gain a full picture of a patient's needs when being admitted to a health care setting, during a transition period, and also prior to discharge.

Scientific evidence informs us and provides a scope of knowledge that directs us in the type of assessment information we need to learn when communicating with patients and families. For example, the newest scientific evidence recommends the frequency of certain types of health screenings. In an outpatient center, during an initial admission, such evidence-based knowledge directs how a nurse interacts with patients to learn what they know about a particular screening and their own screening habits. The screening guidelines direct the type of questions a nurse poses (e.g., What does the patient know about the frequency of screening or its purpose?).

Sound clinical judgments cannot be made without applying evidence and using excellent communication skills with patients, families, and health care team members. Therapeutic and collaborative communication enables us to become recipients of the type and depth of information we need to make informed clinical decisions. Effective communication is also a part of professional documentation—the conveying of relevant and accurate information that describes a patient's clinical course and response to nursing care.

The transition of patients through admission, transfer, and discharge, regardless of setting, requires an organized approach and emphasis on having accurate assessment information about patients. The methods we use to support patients in these phases of care depend in part on what we have learned from patients by using therapeutic communication. The same applies to our ability to collaborate effectively with colleagues. When a patient enters a hospital, the nurse becomes responsible for gathering as thorough a health history as possible to form a meaningful patient database. That database changes over time. During transfers within or between other health care settings, the information pertinent to a patient's clinical care must be communicated and documented for other health care providers to use. Discharge is a critical time, requiring nurses to fully understand a patient and family caregiver's willingness and ability to follow the health care guidelines and restrictions needed for successful recovery.

When a patient enters a hospital setting, consider the stress involved. There is uncertainty about a disease condition, procedures to be performed, and competence of health care staff, to name a few. Therapeutic communication can defuse some of that stress, enabling a nurse to form trust and then be able to obtain a thorough history database. Communication techniques are essential to help patients who have difficulty coping or understanding the hospital experience. The exchange of information we learn about patients with other health care providers then becomes important for continuity of care and maintenance of quality care standards.

1 Using Evidence in Nursing Practice

OUTLINE

OBJECTIVES

Mastery of content in this chapter will enable the nurse to:

- Discuss how scientific evidence improves the relevance and efficacy of nursing skills.
- Explain the differences between research- and non–research-based evidence.
- Describe the seven steps of evidence-based practice.
- Explain the components of a PICO(T) question.
- Discuss the process for critiquing evidence in the literature.
- Identify the elements to review when critiquing a scientific article.
- Discuss ways to apply evidence in nursing practice.
- Explain the importance of identifying outcomes in the evaluation of an evidence-based practice change.

MEDIA RESOURCES

- http://evolve.elsevier.com/Perry/skills
- Review Questions
- Audio Glossary
- Case Studies
- Answers to Clinical Review Questions
- Printable Key Points

PURPOSE

One of the key messages in the 2010 report of the Institute of Medicine (IOM), The Future of Nursing: Leading Change, Advancing Health, is for nurses to be full partners with physicians and other health care professionals in redesigning health care in the United States (IOM, 2011). To achieve better patient outcomes, new knowledge must be transformed into clinically useful approaches and then successfully implemented across the entire health care team and measured in terms of meaningful impact on performance and health outcomes (Saunders et al., 2019). Nursing is positioned to lead change and advance health through the use of evidence-based practice (EBP), a process that makes nurses more autonomous in changing health care practices. EBP is a problem-solving approach to clinical practice that combines the best available evidence in combination with a clinician's expertise, patient preferences and values, and available health care resources in making decisions about patient care (Melnyk and Fineout-Overholt, 2019). Through the use of current and relevant scientific evidence, nurses ensure that the skills and procedures performed on patients incorporate best practices for efficiency, patient safety, and clinical effectiveness.

PRACTICE STANDARDS

- Quality and Safety Education for Nurses (QSEN) Institute: *Pre-Licensure KSAs*, 2014—QSEN competencies

SUPPLEMENTAL STANDARDS

- National League for Nursing (NLN)—2012 Outcomes and competencies for graduates of practical/vocational, diploma, associate degree, baccalaureate, master's, practice doctorate, and research doctorate programs in nursing

PRINCIPLES FOR PRACTICE

Mary works on a surgical intensive care unit (SICU) where patients recover from thoracic surgery, surgical oncology, and emergency surgery. Because of surgery, elderly patients are at higher risk for developing delirium postoperatively. Delirium usually develops abruptly in an elderly surgical patient and manifests as a fluctuating change in attention, cognition, and consciousness level. This change results in patient confusion and reduced awareness of the environment. Mary recently cared for an 84-year-old woman who abruptly became confused and inattentive, and then fell when she attempted to climb out of bed, resulting in a fracture of her hip. Mary discusses the situation with two nurse colleagues and asks, "How can we identify delirium sooner to prevent injuries to our patients on the SICU?" The nurse specialist for the unit tells Mary, "I know that there are different evidence-based assessment scales available to identify delirium than our current Confusion Assessment Method-ICU (CAM-ICU) scale. There may be a more reliable and valid assessment scale to detect delirium in our elderly intensive care patients. Let us ask this question: 'In elderly intensive care patients, which assessment scale for delirium, compared with

the current CAM-ICU scale, will be most reliable and valid to detect delirium during an ICU stay?'" Feeling frustrated that their patient has a serious injury because her delirium was not identified prior to the fall, the group agrees that the question is the right one to search in the literature.

This clinical case study highlights how professional nurses identify and address problems in their practice. EBP is a process of making informed decisions about the way nurses care for patients. It all begins with asking clinical questions. Clinical questions lead nurses such as Mary and her colleagues to find evidence from the research literature, clinical papers, quality improvement (QI) data, risk-management trends, and the opinions of nurse experts. Nurses then apply the evidence to make relevant and informed changes in practice such as fall prevention in the case study.

There are elements of all nursing procedures within this textbook that are evidence based. For example, the length of time necessary to wash hands, the application and removal of gloves, positioning of a patient to prevent aspiration, and the technique for giving an intramuscular injection are based on evidence. Nursing research led to the answers for how these nursing procedures should be performed. The use of such evidence in practice enables nurse clinicians to provide the highest quality of care to their patients and families.

Quality Health Care

Emphasis in health care today for evidence-based QI and health care transformation underscores the need for redesigning care that is effective, safe, and efficient (Melnyk et al., 2018). The use of EBP is key to achieving quality health care, defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (LoBiondo-Wood and Haber, 2018). Implementing health care processes or practices that are based on scientific evidence and known to work in a reliable way is a feature of "quality care." Implementing new knowledge into practice requires a systematic approach that applies evidence to clinical, educational, and administrative practices. EBP is one of the QSEN competencies, with the goal for the QSEN project being to prepare nurses to have the knowledge, skills, and attitudes to continuously improve the quality and safety of the health care systems within which they work (QSEN Institute, 2019). Perhaps what is most important about EBP is that the process encourages all health care providers to question practices and to use evidence in deciding which interventions produce the best outcomes and which do not. Nurses play a key role at the bedside in questioning outdated, illogical, or unsafe practices and then adopting evidence-based interventions that will change patients' health status and achieve desired outcomes.

A Case for Evidence

EBP is a guide for making accurate, timely, and appropriate clinical decisions. It is an interdisciplinary process for applying the newest knowledge available in health care sciences to the patient's bedside. For example, checking the pH of gastric content prior to feeding a patient through an enteral tube and using the research-based Braden Scale to routinely assess a patient's risk for skin breakdown are examples of using evidence at the bedside. This textbook demonstrates how to use evidence in nursing procedures or skills and provides the scientific guidelines to perform skills more effectively and improve patient outcomes.

As a professional nurse you need to stay informed and be aware of the most current evidence. Typically, new students diligently read their textbooks and assigned scientific articles. A good textbook incorporates current evidence into the practice guidelines and nursing skills at the time it is published. However, because a textbook relies on the scientific literature, some information can become outdated by the time it is published. Articles from nursing and the health care literature are available on almost any topic involving nursing practice. New research is reported every day. Although the scientific basis of nursing practice has grown, there are practices that are still not "research based" (based on findings from well-designed research studies) because findings are inconclusive or researchers have not yet studied the practices. For example, in the past, nurses changed intravenous (IV) site dressings daily and applied antibiotic ointment to reduce the incidence of infection at a site. However, there was no evidence at the time to support this practice. IV care was based on tradition. Recent research has shown that topical antibiotics offer no benefit and daily dressing changes are not beneficial unless a dressing becomes soiled or compromised. Today the current standard of care is to cleanse an adult's IV site with chlorhexidine antiseptic solution, not antibiotic ointment, and to change dressings on peripheral catheters if the dressing is damp, loosened, and/or visibly soiled and at least every 5 to 7 days (Infusion Nurses Society [INS], 2016). The challenge is to obtain the very best, most current information at the right time, when you need it for patient care.

The best evidence comes from well-designed, systematically conducted research studies that are reported in scientific journals. Unfortunately, many health care settings do not have a process to help staff adopt new evidence in practice. Nurses in practice settings, unlike educational settings, may not have easy access to databases for scientific literature. Instead they often care for patients on the basis of tradition, preferences, or convenience. Because there are often obstacles to research-based practice in clinical settings, it is important for administrators to provide a supportive environment and adequate facilitation of change. Researchers have found that leadership within health care institutions is vital for the process of implementing EBP in nursing (Välimäki et al., 2018). Some hospitals have created councils in which nurses lead initiatives to implement and study measures that promote the best standards of care. Hospital-based evidence practice centers have also helped sustain a culture of EBP, something that hospitals are focusing on as they move to apply for Magnet® designation or redesignation (Lavenberg et al., 2019).

One thing that is unique about EBP is that it includes multiple sources of evidence. When there is no research evidence for a practice question or issue, nurses have a range of non–research-based evidence available (LoBiondo-Wood and Haber, 2018). Examples of non–research-based evidence include consensus or position statements, general literature reviews, QI and risk management data, retrospective or concurrent chart review, and clinicians' expertise. Research-based evidence is more likely to be timely, accurate, and relevant.

Even when you use the best evidence available, application and outcomes will differ on the basis of your patients' values, preferences, concerns, and/or expectations. Apply critical thinking competencies to determine whether evidence is relevant and appropriate to your patients and to a clinical situation. For example, some research suggests that spirituality positively affects and enhances elderly patients' psychological health and health promotion behaviors (Heidari et al., 2019). However, if a patient is reluctant to discuss his or her spirituality and you are unsure of his or her beliefs, an attempt to use spiritual health interventions is inappropriate. Using your clinical expertise and considering patients' cultures, values, and preferences, ensure that you apply new

evidence in practice both ethically and appropriately. EBP requires good nursing judgment; it is not finding research evidence and applying it blindly.

Steps of Evidence-Based Practice

There are different models for using EBP. The Johns Hopkins Model includes three phases described as *p*ractice question, *e*vidence, and *t*ranslation (PET) using 19 steps within each phase (Dang and Dearholt, 2018). A simpler model is one described by Melnyk and Fineout-Overholt (2019) that includes seven steps, numbered 0 through 6:

0. Cultivate a spirit of inquiry within an EBP culture and environment.
1. Ask a clinical question in PICO(T) format.
2. Search for the most relevant and best evidence that applies to the question.
3. Critically appraise the evidence.
4. Apply or integrate evidence along with your clinical expertise, patient preferences, and values in making a practice decision or change.
5. Evaluate the outcomes of practice decision or change.
6. Communicate and disseminate results.

Cultivate a Spirit of Inquiry Within an EBP Culture and Environment

Nurses who ask questions about nursing practice and seek to confirm or change practice based on evidence demonstrate a spirit of inquiry. Consistently questioning or challenging what we do as nurses is the basis of Step 0. However, just asking questions about nursing practice is not enough. A work environment that embeds EBP philosophy, mission, and processes supports a culture of inquiry for nursing practice (Melnyk and Fineout-Overholt, 2019). Key elements to sustain a spirit of inquiry include EBP mentors, resource tools such as databases and librarians, and organizational leadership (Melnyk and Fineout-Overholt, 2019).

Ask a Clinical Question

Asking a clinical question is most important because how a problem is posed drives the remaining steps of the EBP process (LoBiondo-Wood and Haber, 2018). Every day, nurses perform interventions (e.g., providing comfort measures, caring for wounds, and offering grief support) that stimulate questions such as, "Why do we use this approach?" and "Is there a better way?" or "This step causes patients distress. What other options are available?" Always think about your practice when caring for patients. Question what does not make sense to you and what you think needs clarification. Include colleagues from other disciplines whose perceptions might help to clarify or examine the clinical problem or issue. As shown in the case study, think about a patient care problem or an area of interest that is time consuming, costly, or not logical. Often standards of care, such as The Joint Commission (TJC) standards for patient safety, spark questions for you to pose about whether you are providing high-quality care to your patients.

Clinical questions often arise as a result of either a problem- or a knowledge-focused trigger. A problem-focused trigger develops as you care for a patient or notice a trend on a nursing unit. For example, a problem-focused trigger might arise while caring for an unconscious patient: "Which is the best antiinfective solution to use when giving oral care to patients on a ventilator?" Examples of problem-focused trends include the increase in the number of pressure injuries to patients' skin or tissues or the incidence of urinary tract infections on a nursing unit. A knowledge-focused trigger arises when you ask a question regarding new information about a topic—for example, "What is the current evidence to reduce incidences of postoperative delirium in patients over the age of 70 years?" Important knowledge sources often include standards and practice guidelines available from national agencies such as the Agency for Healthcare Research and Quality (AHRQ), the INS, the American Association of Critical-Care Nurses (AACN), and TJC's 2021 National Patient Safety Goals (TJC, 2020).

There are two types of clinical questions: background and foreground (Dang and Dearholt, 2018; Melnyk and Fineout-Overholt, 2019). Think of a forest and the trees. A background question gives us a view of a forest. It is broad and general about a condition or idea. For example, "Which interventions reduce falls in oncology patients?" The answer to the question provides general knowledge about the problem, concepts, or topic of interest (e.g., falls, fall occurrence among oncology patients, reasons oncology patients fall). A background question is useful in providing a general understanding of what is known about a problem or practice issues. In contrast, a foreground question gives us a closer look at the trees in a forest. It is a more specific and focused question that includes specific comparisons (Dang and Dearholt, 2018). A foreground question asks which of two interventions is likely the more effective in addressing a practice issue. For example, "Does hourly rounding compared with a standard fall prevention protocol affect the incidence of falls?" A background question allows you to explore a vast array of options in the literature, whereas a foreground question produces a refined and limited body of evidence specific to your area of interest. In day-to-day clinical practice it helps to be able to identify foreground questions so that the extent of the literature to review is limited.

A well-stated foreground question is clearly worded when you use a PICO(T) format. Box 1.1 summarizes the elements of a PICO(T) question. Using key words in a PICO(T) question makes it easier to search for evidence in the scientific literature because it restricts a search to only articles pertinent to the PICO(T) terms. The words used in the PICO(T) question are the

BOX 1.1

Developing a PICO(T) Question

P	**Patient, population, or problem** Be succinct. Identify your patients by age, gender, ethnicity, disease, or symptoms.
I	**Intervention or issue of interest** Which intervention do you think is worthwhile to use in practice? It can be a treatment; a clinical, educational, or administrative intervention; a process of care; an education strategy; or an assessment approach.
C	**Comparison with other intervention(s)** Does a comparison intervention exist? Which standard of care or current intervention do you usually use now in practice?
O	**Outcomes (that are measurable)** Which result do you wish to achieve or observe as a result of an intervention (e.g., change in patient's behavior, quality of life, physical finding; change in patient's perception, rate of adverse events, costs)?
T	**Time (an optional component for a clinical question)** What is the time needed for an intervention to meet the expected outcomes? Or, what is the customary time for observation of the population to attain outcomes?

Adapted from Dang D, Dearholt SL: *Johns Hopkins nursing evidence-based practice: model and guidelines,* ed 3, Indianapolis, 2018, Sigma Theta Tau International.

key terms for your literature search. Examples of PICO(T) questions follow: *For patients in intensive care units (P), does the Confusion Assessment Method for the ICU (I) compared with the Nursing Delirium Screening Scale (C) detect incidences of delirium (O) earlier during the ICU stay (T)? In medical patients (P), does the use of teach-back (I) compared with teach-back and a follow-up call-back system (C) improve patient medication adherence (O) during the first 60 days after discharge (T)?*

When formulating a PICO(T) question, the use of the "T" for timing is considered optional. However, the addition of a timing factor in a PICO(T) question allows you to further narrow your question. For example, timing might refer to when an intervention is to be used or a time frame for outcome achievement. Here is another example: *In abdominal surgery patients (P), does epidural analgesia (I) compared with patient-controlled analgesia (C) affect pain severity (O) in the first 48 hours after surgery (T)?* Well-designed PICO(T) questions do not have to include all elements. For example, a comparison intervention is not pertinent when a PICO(T) question is about meaning such as, *Do family caregivers (P) of patients with dementia feel sadness (O) when providing hands-on care (I)?* Also, if there is no comparison intervention, only the standard of care, a (C) is not required. The elements of Population, an Intervention or issue of interest, and Outcome are essential for a well-designed PICO(T) question involving an intervention.

A clearly stated PICO(T) question helps to identify knowledge gaps for a specific clinical, educational, or managerial problem or situation. When you form well–thought-out questions, the type of evidence you lack for clinical practice becomes clearer when you search the literature. Examples of different knowledge gaps include the following:

- *Diagnosis:* Questions about the selection and interpretation of diagnostic equipment. *Example:* Does the use of a smartphone app–assisted home blood pressure monitoring system compared with a standard home blood pressure monitoring system measure blood pressure more accurately for a client at home?
- *Prognosis:* Questions about a patient's likely clinical outcome. *Example:* Is there a difference in the level of functional decline in hospitalized elderly patients who are admitted to an acute care for elders unit compared with those who are admitted to a general medical-surgical unit?
- *Therapy:* Questions about the selection of the most beneficial treatments. *Example:* Which bowel regimen is most effective in relieving constipation caused by the administration of opioid therapy in oncology patients with chronic pain?
- *Prevention:* Questions about screening and prevention methods to reduce the risk of disease. *Example:* Does the use of social media with education messages compared with informational brochures reduce the incidence of vaping in adolescents?
- *Education:* Questions about best teaching strategies for colleagues, patients, or family caregivers. *Example:* Is there a difference in colon emptying from a bowel preparation regimen in preoperative patients receiving paper directions and follow-up text messages compared with those receiving paper directions only?
- *Meaning:* Questions that seek understanding of a phenomenon. *Example:* How do nurses perceive how pain is expressed in patients with opioid addiction?

Search for the Best Evidence

Once you have a clear and concise PICO(T) question, you are ready to search for evidence. Numerous research and nonresearch resources are available to aid in your search, including government and professional websites, agency procedure manuals, performance improvement reports, and computerized bibliographical databases. Non–research-based evidence is valuable in informing you about practice issues in your setting (e.g., fall or infection rates). Remember, though, that it is important that you *not* rely on non–research-based evidence alone. When you face a clinical problem, seek out all sources of evidence to find the best solution in caring for patients. Do not hesitate to ask for help to find appropriate evidence. A reference librarian is an excellent resource with whom to collaborate to conduct a literature search. If one is not available, go to your faculty member or an advanced practice nurse within the health care institution.

A reference librarian knows the relevant databases available to you for a literature search about your PICO(T) question (Box 1.2). The databases are repositories of published scientific studies, including peer-reviewed research. A peer-reviewed article is preferable for retrieval because it has been evaluated by a panel of experts familiar with the topic or subject matter of the article. Working with the librarian, you translate the elements of your PICO(T) question into the language or key words that will yield the best articles for your evidence search. For example,

BOX 1.2

Searchable Scientific Literature Databases and Sources

CINAHL	Cumulative Index to Nursing and Allied Health Literature; database for EBSCO nursing resources; includes studies in nursing, allied health, and biomedicine http://www.cinahl.com
MEDLINE	U.S. National Library of Medicine; bibliographical database that contains more than 22 million references to journal articles in life sciences with a concentration on biomedicine https://www.nlm.nih.gov/bsd/medline.html
Embase	Biomedical and pharmaceutical studies and abstracts and articles from biomedical, drug, and medical device conferences https://www.elsevier.com/solutions/embase-biomedical-research
PsycInfo	Interprofessional bibliographical resources in psychology and the behavioral and social sciences https://www.apa.org/pubs/databases/psycinfo/
Cochrane Community—Database of Systematic Reviews	Full text of regularly updated systematic reviews prepared by the Cochrane Collaboration; includes completed reviews and protocols https://community.cochrane.org/
PubMed	Health science library at the U.S. National Library of Medicine; free access to more than 24 million citations for biomedical literature from MEDLINE, life science journals, and online books https://pubmed.ncbi.nlm.nih.gov/

consider this PICO(T) question: "Does motivational interviewing (I) compared with teach-back (C) improve heart failure patients' (P) adherence to cardiac medications (O) over a 6-month period (T)?" The key words include *heart failure patient*, *motivational interviewing*, *teach-back*, *cardiac medications*, and *adherence*. A good librarian will recommend using the indexing language or controlled vocabulary of the database you are searching. The controlled vocabulary known as Medical Subject Headings (MeSH®) is updated annually from the U.S. National Library of Medicine (U.S. National Library of Medicine, 2018). Proper use of MeSH® terms facilitates a more thorough and focused literature search than one you might get from simply trying to search combinations of key words on Google or Yahoo. In the previous example the word *cardiac medications* might be entered instead as *cardiovascular medications* to fit the database language, or *adherence* might be also entered as *compliance*.

When you work within a database you enter key words to search for articles. Because the vocabulary within published articles is often vague, the words that you select sometimes have one meaning to one author and a very different meaning to another. Each key word generates a set of articles. For example, in the PubMed database, *heart failure* generates over 239,240 articles, *adherence* generates 147,214 articles, and *cardiovascular medications* generates over 127,000 articles. That's a lot of reading! In this example you want to read only articles that address all three of the topics in the same article. There are several ways to reduce those thousands of articles to a more manageable number. One is by using Boolean operators or the function of Search Limits. You narrow a search by combining key terms from your PICO(T) question using the Boolean connectors *and*, *or*, and *not*. For example, by entering the combination of "heart failure patient and cardiovascular medications and adherence" into the literature database, you will obtain only a listing of the articles that contain all three terms; in this case it is 278 articles, which is still quite a few. A librarian can also show you how to use the Search Limits function. Your search can be further narrowed by limiting it by certain categories such as the time frame during which the article was written, types of studies, English language publications, or age of patients. In this example, using limits of *humans*, *5 years*, *English*, and *clinical trial*, the search now yields 21 articles. Use of Boolean connectors and Search Limits reduces the number of articles to a manageable number to review for a PICO(T) question.

The pyramid in Fig. 1.1 represents a hierarchy for rating available scientific evidence that you obtain in your search. It is important to learn about the types of studies to help you know which ones have the best scientific evidence and thus which ones you choose to review. The strongest level of evidence is at the top of the pyramid; the weakest is at the bottom. You can use the rating scale of I to VIII when you later critique each article that you obtain in your search of the literature. Table 1.1 describes types of and provides examples of studies in the evidence hierarchy, beginning with the study at the top of the hierarchy, a systematic review.

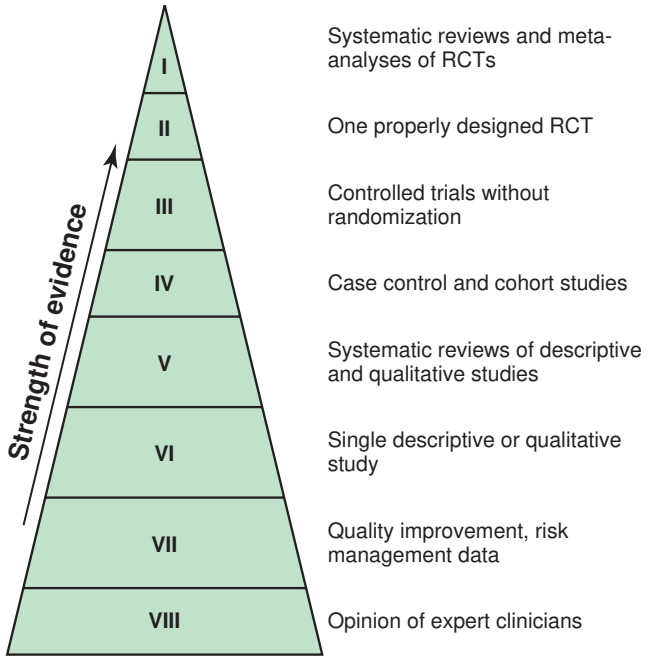

FIG. 1.1 The evidence pyramid. *RCT*, Randomized controlled trial.

If your PICO(T) question leads you to an article that is a systematic review, celebrate! A systematic review is the perfect answer to a PICO(T) question. Basically a researcher has asked the same PICO(T) question you have asked and then has examined all the well-designed relevant research studies that ask the same question. The researcher creates a detailed and comprehensive plan and search strategy with the goal of reducing bias in any findings by identifying, appraising, and synthesizing all relevant studies on the topic (Buccheri and Sharifi, 2017; Dang and Dearholt, 2018). The researcher sets criteria for the type of studies to review in the search. A systematic review explains whether the evidence for which you are searching about a specific question exists, and

TABLE 1.1

Types of Studies in the Evidence Hierarchy

Study Type	Description	Example
Systematic review or meta-analysis	An author or panel of experts reviews the evidence from randomized controlled trials (RCTs) (and other defined types of research studies) about a specific clinical question and summarizes the state of the science. A meta-analysis is the addition of a statistical analysis that combines data from all systematic reviews.	A study summarized and synthesized the current state of evidence-based competencies adopted in clinical practice by health care professionals. Eleven systematic reviews were eligible for critical appraisal from the 3947 publications found in four databases. Evidence-based practice (EBP) was not fully implemented in clinical practice, even though health care professionals' self-report of knowledge, skills, attitudes, and beliefs toward EBP was rated at a moderate to high level. Health care professionals' competencies were difficult to compare across studies because there were a variety of measurement tools to measure competencies. Practice changes to improve processes or patient care outcomes were minimally discussed in the 11 studies reviewed. The use of interdisciplinary evidence-based competencies and common outcome measures can strengthen the implementation of EBP (Saunders et al., 2019).

TABLE 1.1

Types of Studies in the Evidence Hierarchy—cont'd

Study Type	Description	Example
RCT	A researcher tests an intervention against the usual standard of care. Participants are randomly assigned to either a control group (receives standard care) or a treatment group (receives the experimental intervention), with both measured on the same outcomes to see if there is a difference.	This study, focusing on female incontinence in 12 nursing homes, evaluated the impact of implementing evidence-based interventions for the treatment of incontinence. The nursing homes were randomly assigned to one of two groups. A control group received the current standard of care; the second group had nursing staff participate in incontinence education, and then these individuals were given handouts with urinary incontinence evidence-based interventions. Supplemental content for their patients included posters with the interventions, bladder diaries, and questionnaires about quality of life with incontinence. Outcome measurements included number of urinary incontinence events, urinary incontinence diagnoses, and the number of nursing interventions for urinary incontinence. The 218 patients receiving care from the intervention group had significantly less use of incontinence pads and lower risk for episodes of urinary incontinence when compared with the control group of 165 patients (Hödl et al., 2019).
Quasi-experimental study	This research approach tries to show that an intervention causes a particular outcome without randomization (LoBiondo-Wood and Haber, 2018).	Bani Younis and et al. (2019), in a quasiexperimental study (N = 103), investigated the effectiveness of eye mask and earplugs on quality of sleep among patients in intensive care units (ICUs). The intervention group received eye mask and earplugs for sleep; the control group received routine sleep care such as noise reduction. Subjects were not randomized to the groups. The researchers hypothesized that the intervention group (n = 52) would report better quality of sleep when compared with the control group (n = 51). All subjects received routine sleep care on day 1 followed by a pretest sleep questionnaire. On day 2, the intervention group used the eye mask and earplugs and the control group received routine sleep care followed by a posttest questionnaire for all subjects. The findings suggest that the implementation of eye masks and earplugs may improve sleep among patients in the ICU, but the quality of sleep still remains low. Further research is needed (Bani Younis et al., 2019).
Case control or cohort study	Researchers study one group of subjects with a certain condition (e.g., obesity) at the same time as another group of subjects who do not have the condition, to determine if there is an association between the condition and predictor variables (e.g., exercise pattern, family history, history of depression).	A study examined the effectiveness of a nurse-led outpatient program for a cohort of patients who developed a low neutrophil (white blood cell) count after chemotherapy treatment and became febrile. Specific nursing protocols to safely care for the cohort were developed. Of the 38 patients enrolled in the study, 36 patients were successfully treated on an outpatient basis that included nurse-led clinic visits and phone calls. The cohort's results were then compared with the results in a retrospective cohort of patients who were admitted to the hospital for comparable symptoms. There was no significant difference between the two cohorts' patient outcomes. The findings support the use of a nurse-led clinic to manage low-risk febrile neutropenia (Ying et al., 2018).
Descriptive study	Study describes the concepts under study. It sometimes examines the prevalence, magnitude, and/or characteristics of a concept.	This study assessed oncology nurses' adherence to personal protective equipment (PPE) guidelines when handling and administering hazardous chemotherapy drugs. Data were collected using a valid and reliable research instrument tool—the Hazardous Drug Handling Questionnaire. Nurses' adherence with recommended guidelines for hazardous chemotherapy drugs was assessed during administration, disposal, and handling of excreta. Findings from this descriptive study indicate that nurses are not completely adhering to recommended hazardous drug administration guidelines for PPE with chemotherapy drugs (Menonna-Quinn et al., 2019).
Qualitative study	Study examines individuals' perceptions of experiences with health problems or life events and the contexts in which the experiences occur. A qualitative study provides narrative data from extensive interviews with subjects. A qualitative researcher encourages subjects to tell their story about an event or condition to obtain a full and rich description.	Researchers interviewed two oncology nurse focus groups to understand nurses' perceptions about using e-health content from the Oncology Interactive Navigator ™ (OIN) to improve patient outcomes. The researchers of this descriptive qualitative study interviewed eight nurses prior to exposure to OIN content and then seven nurses 4 weeks after exposure. Three themes emerged from the interviews: (1) evolving and dynamic process; (2) supports clinical practice and patient care; and (3) provides a platform for professional development and networking (Lau and Loiselle, 2018).
Clinical experts	Accessing clinical experts on a nursing unit is an excellent way to learn about current evidence. Clinical experts often write clinical articles on topics that require application of evidence in the literature.	Telehealth nursing is a growing specialty in the nursing profession. The authors discuss the value of telehealth nursing for communities, education and credentialing for nurses, and specific competencies expected in telehealth nursing (Mataxen and Webb, 2019).

whether it supports a change in practice. A systematic review of well-designed research studies provides the best evidence of the effectiveness of different interventions. A meta-analysis involves using statistical techniques to analyze the data from the studies in the systematic review to determine statistically the strength of the evidence.

A randomized controlled trial (RCT) is a formal experiment for testing therapies and establishing cause and effect. A researcher tests an intervention (e.g., a mobility program or new type of wound covering) against the usual standard of care. Researchers randomly assign subjects in an RCT to either a control or a treatment group. In other words, all the subjects in the study have an equal chance of being assigned to either group. In that way it is not likely for the two groups to be highly different. The treatment group receives the experimental intervention at the same time the control group receives the usual standard of care. Both groups are measured for the same outcomes to determine if the experimental intervention made a difference. Following completion of an RCT, the researcher knows whether the intervention leads to better outcomes than the standard of care. An RCT is an example of a clinical trial, a research study in which one or more human subjects are prospectively assigned to one or more interventions to evaluate the effects of those interventions on health-related biomedical or behavioral outcomes (National Institutes of Health [NIH], 2019).

More often you will find articles in the nursing literature that involve controlled trials without randomization (i.e., quasiexperimental studies) or involve descriptive studies. Even though these types of studies represent a lower level of evidence than RCTs, a study with relevant results helps you decide if your PICO(T) question can be answered. For example, if a quasiexperimental study resulted in a positive clinical improvement, even though it was not a statistically significant change, the clinical change might be worth strong consideration for reliable evidence.

The use of clinical experts is located at the bottom of the evidence pyramid, but do not consider clinical experts a poor source of evidence. Expert clinicians frequently use evidence as they build their own practice, and they are rich sources of information for clinical problems as a result of their clinical experience.

Critique the Evidence

In the case study the nurses on the SICU conduct their unit practice committee (UPC) meeting. During the meeting Mary and her colleagues decide that it is important to include key members of their interdisciplinary team (health care provider, respiratory therapist, and pharmacist). The UPC then reviews each article carefully, using a rapid-appraisal checklist, which includes criteria for evaluating strength of an article. After the group evaluates the articles for the strength of evidence and synthesizes the findings, they decide that there is evidence for considering a different assessment scale for delirium, the Intensive Care Delirium Screening Checklist (ICDSC). The staff notes that one of the articles recommends other considerations such as the importance of staff education to ensure an understanding of the assessment criteria and then checking that the clinicians are applying the criteria to patients in the same way. Another article summarizes the risk factors for patients developing delirium during a hospitalization and highlights criteria to flag in a nursing assessment, such as decreased mobility or visual or hearing impairment. Another article suggests increasing the frequency of the delirium assessment.

Critically reviewing and analyzing the available evidence requires a systematic approach including review of each source of evidence to determine its value, feasibility, and utility of evidence for making a practice change. Your review should allow you to determine if there is evidence that answers your question. It is important to use an approach that does not bog you down by reviewing every single element of each article. The use of critical appraisal checklists allows you to rapidly review each article from your search and to answer four important questions (Centre for Evidence-Based Medicine, 2019):

1. Does this study address a clearly focused question?
2. Did the study use valid methods to address this question?
3. Are the results of the study valid and important?
4. Will the results help you provide better care for your patients?

Many agencies use appraisal checklists (Fig. 1.2) for recording article reviews. You begin an article review by determining if the question posed by the researcher is clear and concise. Does the article clearly explain the purpose, the research questions addressed, or the aims of the study? Is the purpose of the article relevant to your PICO(T) question? Next, is the research study well designed? This question requires knowing the type of study, using the evidence pyramid. For example, if you have an article on an RCT to review, were subjects randomized in the study? Was the sample of subjects large enough to test the intervention effectively? What approach was used in delivering the intervention and measuring the effects? Were all subjects measured for the same outcomes? In contrast, if you read a qualitative study, did the researcher study a sufficient number and representation of subjects, and did the approach allow for a thorough and objective review of findings? Studies that are not designed well cannot provide definitive support for the evidence they aim to produce.

As you read each article, you ask the next question: What are the results and were they important? Do the findings apply to your patients and practice setting? If you have an RCT, you want to know if an intervention worked or not, to help decide if it potentially makes sense to use it in your practice. Your analysis of statistics will help. For example, if an intervention was shown to be "statistically significant," the intervention shows benefit. If instead there was no statistically significant difference, you may reject the value of the intervention. However, if the intervention led to improvement even though not statistically significant, you might still consider it to have clinical value. If you have a descriptive study, you will decide if the information is relevant to your PICO(T) question. For example, were characteristics of the patients in the study similar to those of your own patients?

You might also choose to review a clinical article that explains a clinical practice topic relevant to your PICO(T) question. A clinical article is not rated for its level of evidence, but it can offer useful information, especially if you decide to implement a change related to the practice topic. To learn how to read research and clinical articles, know each of the common elements. This will help you decide if an article is complete and well explained. Articles should include the following elements:

- *Abstract:* A brief summary of the article that tells you if the article is research or clinically based. An abstract summarizes the purpose of the study or clinical topic, the major themes or findings, and the implications for practice.
- *Introduction:* Contains information about the purpose of the article and the importance of the topic for the audience who reads it. There is usually a brief discussion of supporting evidence about why the topic is important from the author's point of view.

After reading the abstract and introduction, decide if you want to continue to read the entire article. You will know if the topic of the article is similar to your PICO(T) question or related closely enough to provide you useful information. Remember that the research question does not need to be the same as yours but should

Example of a Rapid Critical Appraisal Form

- Why was the study done? (Is there a clear explanation of the study purpose?)
- Are the study findings valid?
  - How were study participants chosen? How many were chosen?
  - Are the study instruments valid and reliable?
  - Does the research approach fit the purpose of the study?
  - How were accuracy and completeness of data ensured?
  - Do the study findings fit the data that were generated?
- What are the results of the study, and are they important?
  - Yes
  - No
  - Unknown
- Is the finding from the study clearly identified?
- Are the results logical, consistent, and easy to follow?
- Are the results plausible and believable?
- How do the results fit with previous research in the area?
- Will the results help me in caring for my patients?
- Do the results apply to my patients?
- How would I use the findings in my practice?
- How would patient and family values be considered in applying these results?
- Do we have the resources to apply this in our practice setting?

FIG. 1.2 Example of a rapid critical appraisal form. (Adapted from Melnyk B, et al: *Evidence-based practice in nursing and health care: a guide to best practice*, ed 4, Philadelphia, 2019, Wolters Kluwer; and Fineout-Overholt E, et al: Evidence-based practice step by step: critical appraisal of the evidence, Part 1, *Am J Nurs* 110[7]:47, 2010.)

be close enough to offer useful information. If this is the case, continue to read the next elements of the article:

- *Literature review or background:* A good author offers a detailed background of the level of scientific or clinical information that exists about the topic of the article. The review explains what led the author to conduct a study or report on a clinical topic. Perhaps the article itself does not address your PICO(T) question the way you desire but possibly leads you to other more useful articles. The literature review gives you a good idea of how past research led to the researcher's question.
- *Article narrative:* The "middle section" or narrative of an article differs, depending on whether it is clinical or research based (Melnyk and Fineout-Overholt, 2019). A clinical article describes a clinical topic, which often includes a description of a patient population, the nature of a certain disease or health problem, how it affects patients, and implications for nursing care. Clinical articles often describe how to use a therapy or new technology. A research article describes the conduct of a research study, including its purpose, how the study was designed, and the results. A narrative of a research article contains several standard subsections:
  - *Purpose statement:* Explains the focus or intent of a study. It identifies which concepts will be researched.
  - *Methods or design:* Explains how a research study is organized and conducted to answer the research question(s). This is where you learn the type of study (e.g., RCT, case control study, or qualitative study). You also learn how many subjects or people are in a study. In health care studies subjects sometimes include patients, family caregivers, or health care staff. The language in the methods section is sometimes confusing if it explains details about how the researcher designs the study to minimize bias so as to obtain the most accurate results possible. Use your faculty member as a resource to help interpret this section.
  - *Results or findings:* Clinical and research articles have a summary section. In a clinical article the author explains the clinical implications for the topic. In a research article the author explains the results and how the research question was answered. For example, in a qualitative study there is a thorough summary of subject narratives, which provide a description of themes and ideas that arise from the researcher's analysis of data. There is no statistical analysis of the data collected. A quantitative study includes a full description of the study subjects, the statistics used for analysis, and the results of that analysis. It is important to learn some of the common statistical terms (Box 1.3). A good author discusses limitations to a study in the results section. The information on limitations helps you decide if you want to use the evidence from the article with your patients.
  - *Clinical implications:* A research article includes a section that explains whether the findings from the study have clinical implications. The researcher explains how to

BOX 1.3

Common Statistical Terms

Sample size: Number (n) of individuals in a study.

Significance: A measure that gives the likelihood that a finding or a result of a study is caused by the intervention being tested and not simply by chance. Most researchers set the level of significance at a *P* value of .05 or .01. For example, if the effects of an intervention (e.g., hourly rounding) are significant at $P < .05$, it means that the likelihood of the effect (fewer falls) occurring by chance is less than 5%; thus it is 95% more likely that the intervention truly had an effect in reducing falls. When a study result has a *P* value (0.61) that is greater than that set (e.g., $P = .05$), the researcher has to conclude that the results were possibly by chance and the intervention had no effect.

Confidence interval (CI): The range (e.g., range of a mean score) in which clinicians can expect to get results if they present an intervention in the same way as it was in a study (LoBiondo-Wood and Haber, 2018). The CI tells you the precision of a study. A 95% CI means that clinicians can be 95% confident that their findings will be within the range given in the study.

Effect size: When the effect of an intervention is statistically significant, it does not necessarily mean that it is big, important, or helpful in decision making. It simply means that you can be confident that there is a difference. An effect size greater than 0.05 is considered a large effect.

apply findings in a practice setting for the type of subjects studied.

- *Limitations:* Limitations are the identified weaknesses of a study. The researcher suggests possible issues with the study such as bias or missed procedural steps.

As you critique each article, complete your critical appraisal checklist. You may choose to rate each article by its level and strength of evidence, using the scale of I to VIII from the evidence pyramid (see Fig. 1.1). It also helps to review multiple articles with a group of colleagues involved in and familiar with the EBP process. Each person can review a single article; then you can come together as a group to review your total findings. Remember, when reviewing evidence, a recommendation to change practice should not rely solely on a single study or the opinion of a single expert (Buckwalter et al., 2017; Dang and Dearholt, 2018). Once all evidence has been reviewed, it is time to discuss the third important question: Will the results help you care for your patients?

Use critical thinking to consider the scientific rigor of the evidence and how well it answers your area of interest. Scientific rigor is the extent to which the findings of a study are valid, reliable, and relevant to a patient population of interest. Consider the evidence in light of your patients' concerns and preferences. Your review of articles offers a snapshot conclusion based on combined evidence about one focused topical area. As a clinician, judge whether to use the evidence for a particular patient or group of patients who usually have complex medical histories and patterns of responses (Melnyk and Fineout-Overholt, 2019). Ethically always consider evidence that will benefit patients and do no harm. Decide if the evidence is relevant, is easily applicable in your setting of practice, is likely to be implemented, and has the potential for improving patient outcomes.

There will be times when you find that there is insufficient or no evidence to answer a PICO(T) question. This finding warrants no change in practice because the evidence is weak and inconsistent or absent.

Apply the Evidence—Project Management

If a literature review and critique yield evidence that answers your PICO(T) question and offer evidence that can be applied to practice, the next step is to implement an EBP project. An EBP team must be able to manage an EBP project (such as a new hand-off reporting protocol) to ensure completion of project tasks and translation of the evidence findings into daily practice (Buckwalter et al., 2017; Dang and Dearholt, 2018). It is recommended to implement an EBP project by conducting a pilot project. This allows you to test a new intervention or practice change for 3 to 6 months and evaluate outcomes. A team must introduce practice changes successfully. A successful EBP project involves the following:

1. A sponsor (e.g., an advanced practice nurse, nurse manager, nurse researcher, or senior staff nurse) who has the commitment and expertise to make the project succeed.
2. Sufficient resources to accomplish the project, including time (e.g., staff having time to attend meetings, collect data), support of all team members, infrastructure of the unit where change will occur (e.g., how procedures are performed, unit setting), and equipment and supplies (depending on project).
3. Clear identification of outcomes to be measured to determine if the EBP practice change is a success (outcomes are a component of the PICO(T) question, but a team must know how to measure them consistently). **NOTE:** Outcomes should be measured before the pilot to have a baseline to determine if the intervention leads to a change.
4. Time schedule for project. It is recommended that you pilot test a practice change for a minimum of 3 months and gather outcome measures throughout this time.
5. Communication and orientation plan. It is critical to ensure that all staff involved in any EBP change are informed and educated (if necessary) to be able to perform the practice change (Dang and Dearholt, 2018; LoBiondo-Wood and Haber, 2018).

> In the case study, the SICU UPC has completed the literature review. The nurse specialist takes the lead for the team. The UPC decides to implement reeducation for the staff on the CAM-ICU scale on the basis of the evidence, the committee members' experiences, a review of the unit reports of delirium incidences, and knowledge of their patients' risk factors, In addition, the SICU staff members will use the scale to score the same patients and check for comparable results. This process of verifying the clinicians' scoring of the CAM-ICU is called interrater reliability. It is the degree of agreement among raters and shows how much homogeneity or consensus exists in the ratings given by the various judges. Interrater reliability helps establish reliability of the CAM-ICU scale.
>
> The UPC also recommends monitoring the incidence of delirium and injuries for 6 months after the education and validation of interrater reliability have occurred. One member of the team disagrees with the decision because the ICDSC scale is also evidence based. The nurse specialist explains that the current evidence supports the use of both scales for a delirium assessment of critically ill patients. The evidence also supports improved reliability if 30 minutes of education on the CAM-ICU scale is given to nurses (Gélinas et al., 2018). The committee agrees with the nurse specialist because the CAM-ICU is evidence based, is known to the nurses, and can be administered in less than 2 minutes to most patients. The committee also recognizes that they never verified that all staff were consistently using the CAM-ICU correctly.

A project should apply evidence in a manner that integrates well with existing practice for all affected disciplines.

In the case study, if a patient's score qualifies for delirium, the interdisciplinary team will quickly assess the patient and make recommendations such as obtaining laboratory tests to evaluate the patient's electrolyte and fluid balance. The pharmacy will place alerts on any medications that increase delirium signs and symptoms, and the nurses will recommend increasing the frequency of monitoring. Assistive personnel (AP) may be assigned for constant observation to be sure that the patient remains safe until the signs and symptoms of delirium have abated. Patients will be oriented to place and time when interacting with staff.

The nurse specialist has talked with the unit manager, presented the plan, and obtained commitment from the manager to move forward with the project. The UPC works with the manager to create a staff education schedule and sets a date for the start of the interrater reliability scoring. Before the start date, the nurse specialist gathers the data about delirium and injuries associated with cases of delirium from the last 6 months for baseline measures. There are no baseline data on interrater reliability because this was not done when the unit first began using the CAM-ICU scale. To evaluate the process for the project, the team will also collect short surveys from staff members to determine their reactions to and acceptance of the education and interrater reliability scoring.

It is important to have a well-organized EBP project management plan. If the barriers to practice change are excessive, adopting a practice change can be difficult, if not impossible. For example, if the unit's education program is too difficult for staff to complete, if there is inadequate staffing, or if not all staff are able to attend education sessions or participate in the interrater reliability scoring, the program may not be successful.

Outcome Measurement

During an EBP pilot project, collection of outcome measures is critical. This involves knowing the measures to collect and having a process for consistent reliable data collection. Plan how to collect baseline data on the outcomes that will evaluate the effect of your practice change (e.g., The oncology nurse specialist will be able to use the unit's monthly quality performance report that includes fall rate and fall with injuries. The nurse specialist collects values for 3 months before implementation of the program. The nurse specialist will continue to collect the fall rate and the fall-related injury rate each month, once the new program pilot begins).

Keep in mind the following points for collection of outcomes measures:

- Know which outcomes to measure and how to collect the measures consistently (e.g., to measure pain acuity use a self-report pain scale; to measure ambulation determine the distance a patient walks each time).
- Be sure that the outcomes are measurable (Box 1.4). Use scales (e.g., pain and fall-risk scales), physiological measures (e.g., temperature, blood pressure, pulse oximetry), survey tools, and performance improvement reports.
- Choose outcomes that are not costly to collect. Use existing equipment if you can.
- Educate team members on the approach to use to collect and record outcomes. Have the team members practice the process before implementation.
- Limit the number of staff who collect data to ensure better accuracy and consistency in measurement. Be sure that each person collects data the same way, at the same time or with the same frequency, and accurately.
- Establish a way (database) to record all data.

The goal of any EBP change is to ensure the highest quality of care by using evidence that promotes the best outcomes (Dang and Dearholt, 2018; LoBiondo-Wood and Haber, 2018). Proper planning is essential before and as you implement your practice change. Once you implement your intervention, monitor the project closely and consider how staff and patients are responding.

BOX 1.4

Outcome Measurements

Outcome	Outcome Measure
Fall occurrence	Fall index, falls with injuries
Functional abilities	Performance of daily activities including bathing, dressing, toileting, transferring, and feeding
Medication adherence	Pill counts, patient self-report, number of filled prescriptions
Learning discharge instructions (topic specific)	Patient surveys, including questions on topic; nurse observations of patients performing skills (using a rating scale); patient self-report during a follow-up phone call
Infection occurrence	Monthly infection control reports of laboratory tests on infection incidence

Evaluate the Practice Decision or Change

After implementing a practice change, your next step is to evaluate the outcomes. You do this by analyzing the outcome data that you collected before and during the pilot project. Outcome evaluation tells you if your practice change improved conditions, created no change, or worsened conditions. Here are some examples:

- After using new video surveillance equipment for patients at risk for drain, line, or tube dislodgement and falls, the staff analyzed their audits, which included the incidence of dislodged drains, lines, and tubes along with falls. Their findings showed reduction in the number of dislodgements and falls. The recommendation for this project would be to continue use of the new video equipment.
- After using a new approach to educating clinic patients about medications and administration schedules, follow-up phone calls to patients revealed an improved understanding of doses and times to administer. However, patients were not able to explain which side effects to expect. The staff involved with this EBP project created single-page bullet points about common side effects of medications and continued to evaluate the pilot program for an additional 3 months.

Once an evaluation is complete, you must decide whether to continue the EBP, make a revision, or discontinue the practice change. Consider not only whether the outcomes were met but also whether or not patients, families, or staff were affected in other ways by the change. Analysis of an EBP change may require assistance from statisticians if you or your team members collect extensive data. Be sure to use reliable resources and be thorough in examining all data.

On the SICU unit the UPC made sure that outcome measures were in place before implementing the CAM-ICU education program. The delirium rate and associated injuries were collected from monthly quality performance reports and included each of the 6 months before implementation and then for 6 months after the program began. The UPC designated three staff members to also collect surveys from staff at 1 month, 3 months, and 6 months to see how their colleagues were reacting to the education and using the CAM-ICU with patients. Six months after implementing the

program, the SICU staff was cautiously optimistic. The interrater reliability with the CAM-ICU was 96% after education, and the injury rate associated with delirium dropped to 1 after the education program. Based on the evidence that staff was consistently using the CAM-ICU as intended, the accuracy of detecting delirium improved. Although it was not an outcome measure, the nurses observed an interdisciplinary commitment to the project. The nursing staff surveys revealed that the majority were enthused and agreed that the education and verifying their use of the scale needed to be a routine part of their annual education. The nursing staff was able to see that the education program and validation process to use the scale improved patient outcomes and gave them more time to coordinate safe care because of earlier detection of delirium.

Communicate and Disseminate a Practice Change

Nine months after initiation of the project, the ability to accurately detect delirium with the CAM-ICU scale and minimize patient injuries continues to remain low for the SICU. An added outcome is an improvement in nursing satisfaction scores. Mary submits the protocol for an abstract in the hospital publication, *Nursing Practice*. The outcomes of the UPC project result in the development of a hospital-wide initiative to detect delirium. Other units reviewed the literature to customize a delirium assessment to their particular patient needs. The methodical and well-designed EBP project led by the SICU UPC resulted in establishment of an evidence-based standard for other nursing units in the hospital.

After applying evidence, it is important to communicate the change in practice and the results to nursing and other health care colleagues. This is true whether the results are successful or unsuccessful. There are many ways to communicate the outcomes of EBP: talking with a colleague, sharing results in staff meetings, presenting in workshops or seminars, submitting an abstract for a poster presentation, and publishing an article. As a professional you are responsible for communicating important information about nursing practice. Sharing evidence and the effects of any practice change motivates others within a health care setting and makes them excited about potential practice improvements on their work units. When you successfully adopt an EBP way of thinking, it becomes very natural to talk about available evidence and continue seeking solutions for problems in patient care.

SUSTAINING EVIDENCE-BASED PRACTICE CHANGES

Implementing EBP changes in a health care setting takes time and commitment to do it well. What is even more difficult is sustaining the changes over time. Chambers and Norton (2016) describe an important process called dynamic sustainability. The process involves continued learning and problem solving and ongoing adaptation of interventions so they continue to fit the practice environments and needs of patients and expectations for ongoing improvement as opposed to diminishing outcomes over time. Competency in EBP requires a commitment to learning new scientific knowledge, working with teams to appropriately apply and later adapt new interventions in practice, and then maintaining and continuing interventions that are consistently effective. Patients expect nursing professionals to be informed and to use the safest and most appropriate interventions. Use of evidence enhances nursing practice and improves patients' outcomes.

✦ CLINICAL REVIEW QUESTIONS

An oncology interdisciplinary team composed of staff nurses, a physical therapist, a social worker, and a health care provider discussed the increased incidence of falls for patients on the inpatient oncology unit. The staff nurses and social worker believe more nursing staff is needed to decrease the incidence of falls. They currently have a standard fall protocol, but falls continue to occur. The physical therapist thinks a different scale to determine patients' risk for falling will be helpful, in addition to encouraging early supervised ambulation. The interdisciplinary team decides to use an evidence-based approach to improve care for these patients.

1. What would be important for the oncology team to initially address for their evidence-based approach to improve patient care?
2. Which of the following questions describes a comprehensive PICO(T) question for the interdisciplinary team to use?
   1. For patients on an inpatient oncology unit, which fall prevention intervention strategies are most effective to reduce the incidence of falls during hospitalization?
   2. Does the use of increased fall risk screening compared with use of a standard fall prevention protocol reduce the incidence of falls?
   3. On an inpatient oncology unit, which fall prevention strategies are most effective to change the incidence of falls?
   4. Which scale best predicts the incidence of falls for hospitalized patients?
3. The unit practice committee chair contacts the hospital librarian to collaborate on a literature search to find articles pertinent to the clinical question. The nurse tells the librarian that the team wants to see if there is evidence for their approach to reduce falls in their patients diagnosed with cancer. Which of the alternative MeSH® terms will capture key concepts from your PICO(T) question?
   1. Patients and oncology
   2. Chronic care and patient safety
   3. Fall risk and injuries
   4. Cancer patients and fall prevention
4. The committee meets to review the articles obtained from the literature review. Which type of article is likely to be the most useful to the committee?
   1. Clinical article discussing an evidence-based project on fall prevention
   2. Systematic review of studies testing the effects of early ambulation on falls
   3. Qualitative study exploring patients' perceptions of their own fall risks
   4. Quasiexperimental study comparing use of two different fall screening tools
5. What are the elements of a successful EBP project? (Select all that apply.)
   1. Baseline data collected before implementation
   2. Time schedule for project
   3. Orientation plan for staff involved in the project
   4. Measurement decision after implementation
   5. Sponsor with expertise and commitment to the project
   6. Adequate resources to address all steps of the project
   7. Identification of outcome measurement prior to initiating project

Visit the Evolve site for Answers to Clinical Review Questions.

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2 Communication and Collaboration

SKILLS AND PROCEDURES

OBJECTIVES

Mastery of content in this chapter will enable the nurse to:

- Select guidelines to use in therapeutic communication.
- Explain the communication process.
- Identify the purposes of therapeutic communication in various phases of the nurse-patient relationship.
- Develop skills for therapeutic communication in various phases of the nurse-patient relationship.
- Communicate therapeutically with patients or family caregivers who have difficulty coping because of feelings such as anxiety, anger, and depression.
- Develop therapeutic communication skills for communication with cognitively impaired patients.
- Develop skills for effective communication with colleagues.

MEDIA RESOURCES

- http://evolve.elsevier.com/Perry/skills
- Review Questions
- Audio Glossary
- Answers to Clinical Review Questions
- Case Studies
- Skills Performance Checklists
- Printable Key Points

PURPOSE

Communication is the interaction between two or more people. Effective communication positively influences how nursing care is delivered and how satisfied patients are with that care. A nurse's responsibility to effectively communicate extends beyond the patient to include family members and all members of the health care team. The purpose of this chapter is to provide a framework to develop effective communication skills that are essential to the delivery of patient-centered care.

PRACTICE STANDARDS

- The Joint Commission (TJC), 2021: National Patient Safety Goals—Patient identification

SUPPLEMENTAL STANDARDS

- U.S. Department of Health and Human Services, 2018—Cultural and linguistic competency

PRINCIPLES FOR PRACTICE

- Communication is an interaction between two or more people that involves the exchange of information between a sender and a receiver, involving the expression of emotions, ideas, and thoughts through verbal (words or written language) and nonverbal (behaviors) exchanges (Fig. 2.1).
- Therapeutic communication is a holistic practice that helps to form a health-focused and stress-reducing collaborative relationship between the nurse and the patient (Martin and Chanda, 2016).
- The primary goal of therapeutic communication is to establish trust to create a meaningful exchange and relationship between the nurse and patient (Martin and Chanda, 2016).
- Communication skills provide information and comfort, promote understanding, clarify misinformation, help in developing plans of care, promote interdisciplinary collaboration, and facilitate wellness through patient and family caregiver teaching.
- Communication includes both spoken and written words. To send an accurate message, the sender of verbal communication needs to be aware of the tone, volume, and cadence (pace or rate) of his or her voice.

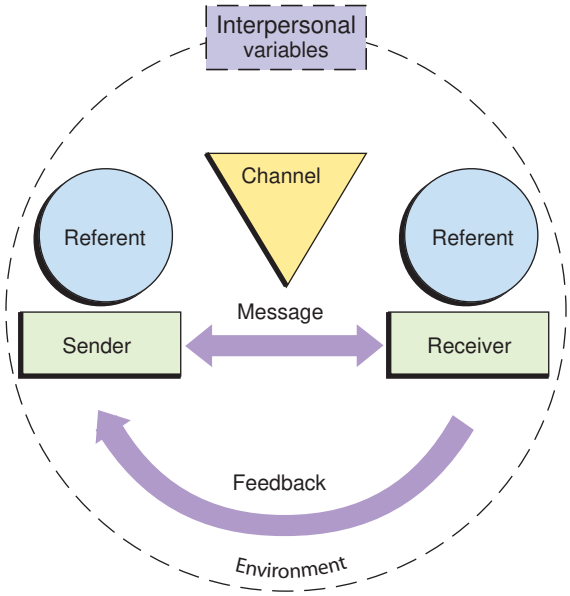


FIG. 2.1 Communication is a two-way process.

FIG. 2.2 An open, relaxed posture conveys interest.

- Nonverbal communication is all behavior that conveys messages without the use of words. This type of communication includes body movement, physical appearance, personal space, and touch. Be aware of body language, which includes posture, body position, gestures, eye contact, facial expression, and movement. For clarity, make sure that nonverbal communication is consistent with the spoken word.

PATIENT-CENTERED CARE

- Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. Inform all patients of the availability of language assistance services clearly and in their preferred language, verbally and in writing (U.S. Department of Health and Human Services [DHHS], 2018) (Box 2.1).
- One of the most significant aspects of patient care is ethical behavior, and this care begins with communication (Abdolrahimi et al., 2017).
- During therapeutic communication, use interpersonal skills such as listening for connecting with the patient or family caregiver and answering questions correctly (Abdolrahimi et al., 2017).
- Communication and documentation include all interactions between the nurse and patient, as well as with family caregivers and other members of the health care team (National Council of State Boards of Nursing [NCSBN], 2019).
- Therapeutic communication: assess verbal and nonverbal patient communication needs, respect the patient's personal values and beliefs, allow time for communication, encourage the patient to verbalize feelings, and evaluate the effectiveness of communication (NCSBN, 2019).
- Create a therapeutic environment: identify external factors (e.g., stressors, family dynamics) that could interfere with the patient's recovery; make appropriate patient room assignments (NCSBN, 2019).
- Understand how culture affects a patient and his or her knowledge and values about health. Assess your own personal beliefs surrounding patients from different cultures, and set aside any values, biases, attitudes, or ideas that are judgmental and can impact the care you provide (Giger, 2016).
- Be aware of cultural differences such as the use of touch and religious and ethnic practices because these influence methods of communication (Fig. 2.2).
- Modify communication to meet cultural needs; be reassuring and be aware of signs of fear, anxiety, and confusion in the patient (Giger, 2016).
- Adopt a flexible, respectful attitude that also communicates interest in a patient to bridge any communication barriers that exist because of cultural differences between a patient and caregiver.
- Provide easy-to-understand print and multimedia materials and signage in languages commonly used by populations in the health care agency service area (U.S. Department of Health and Human Services [DHHS], 2018).

BOX 2.1

Communicating With Patients Who Speak Different Languages

- Federal law requires linguistic services for patients with limited English proficiency (LEP).
- Health care organizations that receive federal funds are required to provide services in a language that a patient with LEP can understand.
- Professional interpreters improve communication, promote appropriate use of resources, and significantly increase patient and clinician satisfaction.
- Language interpretation requires bilingual fluency and the ability to switch fluidly between two languages while interpreting the meaning and tone of what has been said from one language to another.
- In choosing in-person, telephonic, or video interpreter, consider resources available and the needs for your specific type of clinical situation.
- Talk in short units and pause frequently to promote accuracy of interpretation.

From Karliner LS: *When patients and providers speak different languages,* 2018. https://psnet.ahrq.gov/web-mm/when-patients-and-providers-speak-different-languages. Accessed June 2020.

EVIDENCE-BASED PRACTICE

Bullying—Nursing Professionals and Students

Bullying has implications for recruitment and retention for the health care profession. There are a wide range of disruptive, repetitive, and ineffective behaviors that can occur, including criticism and humiliation, and negative acts by an individual in a position of power with the intention to cause fear (Rutherford et al., 2019). Research findings have highlighted the impact of bullying, and interventions that are aimed at addressing these behaviors have been developed:

- Physical responses to bullying include somatic disturbances, fatigue, and risk for hypertension, heart disease, and maladaptive responses to stress. Psychological impacts include anxiety, depression, and posttraumatic stress disorder, which can occur even years after a bullying incident (Rutherford et al., 2019).
- Additional disorders and symptoms reported by victims include sleep disorders; reduced self-esteem; fear or lack of desire to go to work; excessive food consumption or reduced appetite; increased consumption of tobacco, alcohol, and/or drugs; and repeated sensations of irritability and anger (Bambi et al., 2019).
- There is a correlation between the quality of care delivered to patients and adverse events. Bullying has also been directly related to nosocomial infections, perceived risk for patients, and relatives' complaints for patients including safety risks (Bambi et al., 2019).
- Victims often choose to transfer units, leave their organization, or leave the nursing profession entirely (Bambi et al., 2019). There are financial implications for health care organizations for paid sick leave and the use of employee assistance programs. Hiring new nurses because victims have left their positions can cost an organization over $20,000 per person (Rutherford et al., 2019).
- Education needs to begin in prelicensure nursing programs to show students that bullying is not acceptable and should not be tolerated. Problem-based learning (PBL) is another strategy for students to provide self-directed study and group discussion to increase understanding of the dilemma or problem. PBL also was found to help address incivility and the realities of real workplace settings (Rutherford et al., 2019).
- Nursing students and professionals have used journaling to lessen the effects of bullying and create greater awareness to help them be part of creating a civil environment. Education to enhance awareness has also been highlighted as a means to prevent bullying (Bambi et al., 2019; Rutherford et al., 2019).
- Interventions to confront these problems include sensitizing nurses, managers, and administrators; organizing prevention education events; acquiring communication and conflict management skills; adopting zero tolerance strategies; and establishing codes of conduct that explicitly condemn unacceptable behaviors (Bambi et al., 2019).
- Prevention of nursing cliques, implementation of an anonymous reporting system, and interdisciplinary collaboration with psychologists for units that have high incidences of bullying are strategies to prevent bullying and assist nursing staff to take a more proactive role (Bambi et al., 2019).

SAFETY GUIDELINES

- Establish and understand the purpose of personal interaction. This is an essential quality of effective communication.
- Guide an interaction depending on the patient's condition and response. Patient needs remain the focus. For example, you establish that the purpose of the interaction is patient teaching. However, if the patient has just learned about the death of a loved one and expresses the need to talk about the death, you encourage him or her to talk and remain flexible and creative in the interaction. Or, if the patient complains of increased pain, provide an analgesic prior to implementing additional care plan needs.
- Listen to what and how a patient communicates, including content and verbal and nonverbal messages. Some patients express themselves clearly without difficulty. However, indirect and nonverbal cues communicate a patient's needs (e.g., pain, perceived stress).
- Therapeutic communication, the primary form of communication between nurses and patients, is a patient right. Miscommunication can lead to misinterpretation of information and risks to patients (Abdolrahimi et al., 2017).
- Control external factors in both the environmental setting (temperature of room, privacy issues) and the psychological setting (emotional state of the nurse and patient) that influence or hinder communication. When you are talking with a patient about his or her personal concerns, privacy is important.
- When teaching, try to have a family caregiver present with whom to reinforce the content of the instruction. Use language-appropriate print and multimedia materials. This is necessary for family caregivers to provide needed support when patients return home.

✦ SKILL 2.1 Establishing the Nurse-Patient Relationship

A therapeutic nurse-patient relationship is the foundation of nursing care and involves using a variety of patient-centered therapeutic communication skills (Box 2.2). The primary goal of therapeutic communication for a nurse is to promote patients' wellness and personal growth. Therapeutic communication empowers patients to make decisions but differs from social communication in that it is patient centered, and goal directed with limited personal disclosure from the professional.

Social communication involves equal opportunity for personal disclosure, and both participants seek to have personal needs met (Keltner and Steele, 2018). Nurses do not routinely share intimate details of their personal lives with patients. However, they use personal self-disclosure (e.g., outside interests, thoughts about local news, experience as a nurse) cautiously in selected situations. There are times when empathy is essential to establishing and maintaining the nurse-patient relationship. Empathy is being sensitive; it conveys an understanding of a patient's and/or family's feelings and communicating this understanding to them.

Barriers to therapeutic communication include giving an opinion, offering false reassurance, making disingenuous or insincere comments, being defensive, showing approval or disapproval, stereotyping, and asking, "Why?" The use of "why" questions causes increased defensiveness in patients and hinders communication. The therapeutic nurse-patient relationship is goal directed, with a patient moving toward productive modes of interpersonal functioning.

BOX 2.2

Therapeutic Communication Techniques

Technique: Active Listening
Definition: An active process of receiving information and examining one's reaction to messages received
Example: Consider the cultural practices of your patient, maintain appropriate eye contact, and be receptive to nonverbal communications.
Therapeutic Value: Nonverbally communicates your interest and acceptance to a patient
Nontherapeutic Threat: Failure to listen, interrupting patient

Technique: Broad Openings
Definition: Encouraging patient to select topics for discussion
Example: "Can you tell me what you're thinking about?"
Therapeutic Value: Indicates your acceptance and valuing of patient's initiative
Nontherapeutic Threat: Domination of interaction by nurse; rejecting responses

Technique: Restating
Definition: Repeating main thought that patient has expressed
Example: "You say that your mother left you when you were 5 years old."
Therapeutic Value: Indicates that you are listening and validates, reinforces, or calls attention to something important that has been said
Nontherapeutic Threat: Lack of validation of your interpretation of message; being judgmental; reassuring; defending

Technique: Clarification
Definition: Attempting to improve your understanding of words, vague ideas, or patient's unclear thoughts or asking patient to explain what he or she means
Example: "I'm not sure what you mean. Could you tell me again?"
Therapeutic Value: Helps to clarify patient's feelings, ideas, and perceptions and provide an explicit correlation between them and patient's actions
Nontherapeutic Threat: Failure to probe; assumed understanding

Technique: Reflection
Definition: Directing back to patient ideas, feelings, questions, or content
Example: "You're feeling tense and anxious, and it's related to a conversation you had with your sister last night?"
Therapeutic Value: Validates your understanding of what patient is saying and signifies empathy, interest, and respect for patient
Nontherapeutic Threat: Stereotyping patient's responses; inappropriate timing of reflections; inappropriate depth of feeling of reflections; inappropriate to the cultural experience and educational level of the patient

Technique: Humor
Definition: Discharging energy through comic enjoyment of the imperfect
Example: "This gives a whole new meaning to 'Just relax'."
Therapeutic Value: Can promote insight by making conscious any repressed material, resolving paradoxes, tempering aggression, and revealing new options; is a socially acceptable form of sublimation
Nontherapeutic Threat: Indiscriminate use; belittling patient; screen to avoid therapeutic intimacy

Technique: Informing
Definition: Demonstrating skills or giving information
Example: "I think it would be helpful for you to know more about how your medication works."
Therapeutic Value: Helpful in patient education about relevant aspects of patient's well-being and self-care
Nontherapeutic Threat: Giving advice

Technique: Refocusing
Definition: Asking questions or making statements that help patient expand on a topic of importance
Example: "I think it would be helpful if we talk more about your relationship with your father."
Therapeutic Value: Allows patient to discuss central issues related to problem and keeps communication process goal directed
Nontherapeutic Threat: Allowing abstractions and generalizations; changing topics

Technique: Sharing Perceptions
Definition: Asking patient to verify your understanding of what patient is thinking or feeling
Example: "You're smiling, but I sense that you're really very angry with me."
Therapeutic Value: Conveys your understanding to patient and has potential for clearing up confusing communication
Nontherapeutic Threat: Challenging patient; accepting literal responses; reassuring; testing; defending

Technique: Theme Identification
Definition: Clarifying underlying issues or problems experienced by patient that emerge repeatedly during nurse-patient relationship
Example: "I've noticed that in all the relationships that you've described you've been hurt or rejected by the man. Do you think this is an underlying issue?"
Therapeutic Value: Allows you to best promote patient's exploration and understanding of important problems
Nontherapeutic Threat: Giving advice; reassuring; disapproving

Technique: Silence
Definition: Using silence or nonverbal communication for a therapeutic reason
Example: Sitting with patient and nonverbally communicating interest and involvement
Therapeutic Value: Allows patient time to think and gain insights, slows the pace of the interaction, and encourages patient to initiate conversation while conveying your support, understanding, and acceptance
Nontherapeutic Threat: Questioning patient; asking for "why" responses; failing to break a nontherapeutic silence

Technique: Suggesting
Definition: Presenting alternative ideas for patient's consideration relative to problem solving
Example: "Have you thought about organizing your medications on a daily schedule? For example, you could use a pill organizer that allows you to sort out medicines to be taken each day or over a week."
Therapeutic Value: Increases patient's perceived options or choices
Nontherapeutic Threat: Giving advice; inappropriate timing; being judgmental

Adapted from Keltner NL, et al: *Psychiatric nursing*, ed 8, St. Louis, 2018, Mosby.

Delegation

All health care providers must practice effective communication. The skill of establishing therapeutic communication cannot be delegated to assistive personnel (AP). The nurse directs the AP about:

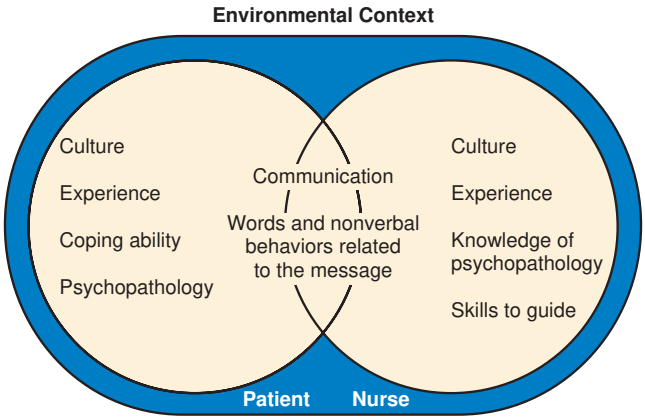
- The proper way to interact verbally and nonverbally with select patients
- The need to keep all patient communication confidential
- Ways to arrange the environment to ensure privacy and confidentiality
- Special considerations pertaining to communication with patients who are cognitively or sensorially impaired, older adults, children, or anxious and potentially violent

Interdisciplinary Collaboration

The nurse provides a role model for effective communication for members of the health care team.

STEP	RATIONALE
ASSESSMENT	
1. Prepare for orientation phase of therapeutic communication. Formulate individualized goals for what you want to learn about the patient, consider time allocation (e.g., patient acuity and medical priorities), form initial questions, and mentally prepare to keep one's mind clear of other concerns or distractions. Select the assessment questions most relevant to the clinical situation.	Preparation is part of a planned communication process that facilitates interaction. Planning for the orientation phase helps to identify actual or potential problems, current health status, and experience. Without preparation, a risk exists for casual, non–goal-oriented communication.
2. Identify the patient using at least two identifiers (e.g., name and birthday, or name and medical record number) according to agency policy.	Complies with The Joint Commission (TJC) standards and improves patient safety (TJC, 2021).
3. Assess patient and family caregiver health literacy. What is the patient's primary language? *Option:* Use a standardized health literacy assessment tool such as the Short Assessment of Health Literacy—Spanish and English (SAHL-S&E); Rapid Estimate of Adult Literacy in Medicine—Short Form (REALM-SF); or Short Assessment of Health Literacy for Spanish Adults (SAHLSA-50) (Centers for Disease Control and Prevention [CDC], 2020).	Assessing level of health literacy ensures that the patient has the capacity to obtain, communicate, process, and understand basic health information (CDC, 2020). Tools provide a direct comparison of health literacy in speakers of English and Spanish, the languages most frequently spoken in the United States (CDC, 2020).
4. Assess patient's ability to hear. Be sure that hearing aid is functional if worn. Be sure that patient hears and understands words (see Chapter 19).	Patients with hearing deficits require techniques to enhance hearing reception (e.g., speaking in normal tone, speaking so patient can see face).
5. Determine how the patient would like to be addressed. Address patient by name and introduce yourself and your role on health care team ("Hello, my name is Jane Smith, and I am the registered nurse assigned to take care of you today.") Use clear, specific communication, including verbal and nonverbal techniques (e.g., good eye contact; relaxed, comfortable position) to provide information and clarify concerns (see Fig. 2.2). Create a climate of warmth and acceptance.	Congruent verbal and nonverbal communication expresses warmth and respect and helps to establish rapport. The quality of communication in interactions between nurse and patient has important influences on patient outcomes (Abdolrahimi et al., 2017).
6. Assess the following during initial interaction: patient's perceived needs, coping strategies, defenses, and adaptation styles.	Recurrent themes in patient's responses help to identify problem areas related to health status (e.g., avoidance of questions, request for information, expression of a loss).
7. Determine patient's need to communicate (e.g., constant use of call light, crying, patient who does not understand an illness or who has just been admitted).	Patients in need of support, comfort, knowledge, or encouragement benefit from individualized meaningful communication.
8. Observe patient's pattern of communication and verbal or nonverbal behavior (e.g., gestures, tone of voice, eye contact).	Observation determines type and manner of communication that you will use.
a. Observe for signs that patient has barriers in being allowed to communicate that may indicate abuse or human trafficking.	Avoiding eye contact and social interaction and not being allowed to be by themselves or speak for themselves are indications of abuse and human trafficking (State of Nevada, 2019).
9. Assess reason patient needs health care. Ask patient about health status, lifestyle, support systems, patterns of health and illness, and strengths and limitations.	Nature of illness affects patient's coping ability and effectiveness in communicating needs and concerns. For example, patients who are fearful of a cancer diagnosis and patients who are having joint replacement surgeries probably have differing needs and concerns.
10. Assess for variables about yourself and patient that normally influence communication. Examples of these variables include culture, experience, coping ability, and verbal/nonverbal behaviors (see illustration).	Communication is a dynamic process influenced by interpersonal and intrapersonal variables. By assessing factors that influence communication, you can more accurately assess a patient's perception of health status (Keltner and Steele, 2018).

STEP	RATIONALE



STEP 10 Essential and influencing variables of the therapeutic communication environment. *(Adapted from Keltner N, et al: Psychiatric nursing, ed 8, St. Louis, 2018, Mosby.)*

11. Assess personal barriers to communicating with a patient (e.g., bias toward patient's condition, anxiety from inexperience).

Barriers prevent you from conveying empathy and caring and obtaining relevant assessment information.

12. Assess patient's use of language and ability to speak. Does patient have difficulty finding words or associating ideas with accurate word symbols? Does patient have difficulty with expression of language and/or reception of messages?

Assessment determines need for special techniques to address the communication needs of patients with limited English proficiency (LEP), hearing impairments, or literacy levels (DHHS, 2018). Examples include picture boards, computers, sign language, or a medical interpreter (see illustration).

STEP 12 Communication tools for patient who cannot speak.

13. Assess resources available in selecting communication methods:

a. Review information in medical record and reflect on your past patient communication experiences.

Relying totally on information from patient restricts the quality of interaction. Additional resources provide insight into best methods of communicating.

b. Consult with family, health care provider, and other health care team members concerning patient's condition, problems, and impressions.

Collaboration with health care team members facilitates your response to patient based on integration of knowledge. Seek information from family after patient approval. Patient privacy must be maintained.

14. Before initiating the working phase of nurse-patient relationship, assess patient's readiness to work toward goal attainment. "We want to work together with you to improve your health. Tell me your expectations of care and goals that you feel are important for you to recover."

Patient's goals are identified and agreed on by effective communication skills such as restating and clarifying.

15. Consider when patient is due to be discharged or transferred from health care agency. Share that information with patient and family caregiver.

This allows you to anticipate the amount of time available to work with patient and when termination of relationship is to occur.

STEP	RATIONALE
PLANNING	
1. Expected outcomes following completion of procedure:	
• Patient expresses ideas, fears, and concerns clearly, asks questions, and openly expresses relief of anxiety.	Once patients are able to talk directly about emotions, the focus is on coping more effectively with them (Keltner & Steele, 2018). Asking questions shows an openness to communication.
• Patient health care goals are identified and achieved.	Interaction remains patient focused.
• Patient verbalizes understanding of information communicated by nurse.	This provides a means to build trust and develop a knowledge base for patient to make decisions.
2. Before engaging in the working phase, prepare patient physically (e.g., provide comfort and pain relief measures, provide for hygiene or elimination), provide a quiet environment, maintain privacy, and reduce distractions or interruptions before beginning discussion.	Taking care of basic needs promotes an environment for interaction and decreases patient distractions and interruptions.
3. Prepare necessary communication aids and initial communication approach.	
a. Use appropriate communication tools such as iPads or other electronic devices for patients whose initial language is not English.	Electronic devices such as iPads help with communication and provide translation resources.
b. Prepare open-ended questions to identify strategies for developing a realistic plan to meet identified health goals of patients (e.g., "Let's talk more about the goals you shared earlier for this hospitalization/visit to the health care agency").	Open-ended questions promote goal attainment and avoid risk of misinterpretation.
IMPLEMENTATION	
1. Working phase:	
a. Observe patient's nonverbal behaviors, including body language.	Congruence between patient's verbal and nonverbal behaviors ensures that you receive the correct message.
b. If verbal behaviors do not match nonverbal behaviors, seek clarification from patient.	
2. Explain purpose of interaction when information is to be shared.	Information and explanation decrease anxiety about the unknown.
3. Use therapeutic communication skills throughout working phase (see Box 2.2).	Fosters open, interactive communication, with patient as a participant and the focus of the discussion.
4. Use questions carefully and appropriately. Ask one question at a time and allow sufficient time to answer. Use direct questions. Use open-ended statements as much as possible, such as, "Tell me about how you're feeling today."	This helps patient express himself or herself and allows you to obtain thorough information about his or her needs and concerns.
5. Explore ways the health care team can meet patient's expectations in seeking health care.	Conducting interactions focused on patient's expectations conveys a level of interest in patient's needs.
6. Encourage patient to ask for clarification at any time during the communication.	This gives patient a sense of control and keeps channels of communication open.
7. Set mutual goals.	
a. Use therapeutic communication skills such as restating, reflecting, and paraphrasing to identify and clarify strategies for attainment of mutually agreed-on goals (see Box 2.2).	For communication between nurse and patient to be effective, both need to possess the skills and knowledge required for participation within the communicative interaction.
b. Discuss and prioritize problem areas.	A patient, nonjudgmental, supportive approach minimizes patient anxiety.
c. Provide information to patient and help him or her to express needs and feelings.	Patient can respond to help, develop workable solutions based on goals, and fully participate in a realistic plan for his or her well-being.
Clinical Judgment *Avoid asking questions about information that may not yet have been disclosed to the patient (e.g., human immunodeficiency virus [HIV] status, diagnostic test results). Avoid asking "why" questions; this causes increased defensiveness in the patient and prevents communication.*	
d. Avoid communication barriers (see Box 2.2).	Barriers result in a message not being received, being distorted, or not being understood.
8. Termination phase: .	
a. Prepare by identifying methods of summarizing and synthesizing information pertinent for patient's aftercare (e.g., "What are your plans for follow-up once you return home to maintain your health status?").	Effective communication by summarizing and synthesizing information reinforces behavior change.

STEP	RATIONALE
b. Use therapeutic communication skills to discuss discharge or termination issues and guide discussion related to specific patient changes in thoughts and behaviors.	Reinforces behaviors/skills learned during working phase of relationship.
c. Summarize with patient what you discussed during interaction, including goal achievement.	Signals the close of interaction and allows you and patient to depart with the same idea. The termination phase consists of evaluation and summary of progress toward prescribed goals. Provides a sense of closure and mutual understanding.
9. For hospitalized patients be sure nurse call system is within patient's reach and the bed is in the lowest position and raise the side rails as appropriate.	Maintains patient safety.

EVALUATION

1. Observe patient's verbal and nonverbal responses to your communication, noting his or her willingness to share information and concerns during orientation phase.	Verbal and nonverbal feedback reveals patient's interest and willingness to communicate and reflects his or her ability to form a therapeutic relationship.
2. Note your response to patient and patient's response to you. Reflect on effectiveness of therapeutic techniques used in establishing rapport with patient.	Sensitivity to one's ability in using therapeutic communication skills improves ability to adjust techniques when necessary.
3. During working phase evaluate patient's ability to work toward identified goals. Elicit feedback (verbal and nonverbal) to determine success of goal attainment. Evaluate patient's health status in relation to identified goals. Reevaluate and identify barriers if patient goals are not met.	Feedback is an essential step in evaluating new behaviors. Modifications are necessary if goals cannot be met.
4. During termination phase summarize and restate. Reinforce patient's strengths, outline issues still requiring work, and develop an action plan.	Evaluates patient progress in terms of attainment of mutually agreed-on goals.
5. Use Teach-Back: "I want to be sure that you understand the action plan following your discharge. We developed it together, taking into consideration your progress thus far and your strengths and limitations. Describe your action plan." Review the action plan or give patient/family caregiver the plan in a written/other format if he or she is not able to teach back correctly.	Teach-back is an evidence-based health literacy intervention that promotes patient engagement, patient safety, adherence, and quality. The goal of teach-back is to ensure that you have explained medical information clearly so that patients and their families understand what you communicated to them (AHRQ, 2020).

Unexpected Outcomes	Related Interventions
1. Patient continues to verbally and nonverbally express feelings of anxiety, fear, anger, confusion, distrust, and helplessness. Patient often responds to internal and external factors and cues.	• Reassess patient's level of anxiety, fear, and distrust. Attempt to determine the cause of anxiety or fear. • Repeat message to patient at a later time. • Determine influence affecting clear communication (e.g., cultural issues, language issues, literacy issues, physical limitations).
2. Feedback between you and the patient reveals a lack of understanding and ineffective communication.	• Assess for and remove barriers to communication, such as literacy level, foreign language issues (DHHS, 2018). • Repeat message using another approach if possible. • Consider cultural norms associated with eye contact, use of touch, personal space, and nonverbal behaviors (Giger, 2016). • Avoid using medical terms that patient does not understand.
3. You are unable to acquire information about patient's ideas, fears, and concerns. Communication techniques do not promote patient's willingness to communicate openly. Trust is not established. Goals are not identified and therefore cannot be achieved.	• Use alternative communication techniques to promote patient's willingness to communicate openly. • Offer another professional with whom patient can talk to obtain necessary information.
4. Family caregiver answers for patient even when patient can answer.	• Direct question to patient, using his or her name. • Acknowledge answer given by family caregiver; then state that you are interested in patient's response. • Resume interaction after family caregiver has left or encourage family caregiver to take a break for coffee or a meal.

Recording
- Record the communication pertinent to patient's health, response to illness or therapies, and responses that demonstrate understanding or lack of understanding (include verbal and nonverbal cues).
- Document teach-back and any changes to teaching plan.

Hand-off Reporting
- Report any relevant information obtained through patient's verbal and nonverbal behaviors to members of health care team.

Special Considerations

Patient Education
- Use gestures, pictures, and role playing to help patient understand educational topic. Consider literacy status; determine if patient can access health information adequately. Be alert to words that patient seems to understand, and use them frequently.
- Individualize patient teaching to meet patient needs. Always conduct teaching with the purpose of meeting patient's learning needs with consideration for his or her preferred methods for learning.

Vulnerable Populations
Pediatric
- Communicating with children requires an understanding of feelings and thought processes from the child's perspective (Hockenberry et al., 2019).
- Use vocabulary that is familiar to the child, based on his or her level of understanding (age and developmental level). Try to be on same eye level as patient.
- Understand the child's cognitive, developmental, and functional level to select most appropriate communication techniques. Some age-appropriate communication techniques include storytelling and drawing (Hockenberry et al., 2019).

Gerontological
- Make sure that older-adult patient with visual or hearing impairment uses assistive devices such as eyeglasses, large-print reading material, or hearing aids to assist in communication (Touhy and Jett, 2018).
- Be aware of any cognitive or sensory impairment. Assess each patient individually and avoid stereotyping older adults who have cognitive or sensory impairments (Touhy and Jett, 2018).
- It is important to understand the value of effective communication skills, history, and personality among older adults in terms of providing both human and therapeutic responses. Regression to earlier defenses is normal and adaptive with this population, particularly when facing illness.

Disabled
- Patients with intellectual and developmental disabilities (IDDs) may require you to take more time to get to know them as a person, their community, and their needs for additional support (Sullivan et al., 2018).
- Address the patient directly; use the patient's preferred communication method and tools; slow down communication; involve family caregivers but be attentive to inappropriate taking over of decision making (Sullivan et al., 2018).

Home Care
- Identify primary family caregiver for patient and adapt techniques to assess level of understanding regarding patient's condition.
- Incorporate communication into patient's daily activities (e.g., bathing and dressing).

✦ SKILL 2.2 Communicating With Patients Who Have Difficulty Coping

Patients in the health care setting sometimes may have difficulty coping for a variety of reasons and thus experience anxiety, anger, and/or depression. You can help the patient decrease or manage ineffective coping symptoms and behaviors through therapeutic communication. Examples of factors that cause anxiety are newly diagnosed illness, separation from loved ones, threat associated with diagnostic tests or surgical procedures, and expectations of life changes. How successfully a patient copes with anxiety depends in part on previous experiences, the presence of other stressors, the significance of the event causing anxiety, and the availability of supportive resources. There are four stages of anxiety with corresponding behavioral manifestations: mild, moderate, severe, and panic (Box 2.3).

Anger is the common underlying factor associated with potential for violence. Patients become angry for a variety of reasons. Anger is often directly related to a patient's experience with illness, or it is associated with previous problems. In the health care setting the nurse has frequent contact with a patient and thus often becomes the target of his or her anger. Understanding how to use de-escalation skills is a useful technique to manage an angry or violent patient and help ensure a safe health care environment for other patients and health care personnel.

Depression is a state of feelings that is more than just sadness. It is a common psychiatric condition that affects a person's ability to function in day-to-day activities. There are many symptoms of depression, the most common being apathy, feelings of sadness, fatigue, guilt, poor concentration, sleep disturbances, and suicidal thoughts. Depression results in both subjective and objective behaviors and patient reports of increased physical complaints (Box 2.4). Some patients report feeling anxious when depressed.

BOX 2.3

Behavioral Manifestations of Anxiety: Stages of Anxiety

Mild Anxiety
- Increased auditory and visual perception
- Increased awareness of relationships
- Increased alertness
- Able to problem solve

Moderate Anxiety
- Selective inattention
- Decreased perceptual field
- Focus only on relevant information
- Muscle tension; diaphoresis

Severe Anxiety
- Focus on fragmented details
- Headache, nausea, dizziness
- Unable to see connections between details
- Poor recall

Panic State of Anxiety
- Does not notice surroundings
- Feeling of terror
- Unable to cope with any problem

BOX 2.4

Symptoms of Depression

Common Symptoms
- Apathy
- Decreased socialization
- Sadness
- Sleep disturbances
- Hopelessness
- Helplessness
- Worthlessness
- Guilt
- Anger

Other Symptoms
- Fatigue
- Decrease in performance of activities of daily living
- Thoughts of death
- Decreased libido
- Feeling inadequate
- Psychomotor agitation
- Verbal berating of self
- Spontaneous crying
- Dependency, passiveness

From Keltner NL, Steele D: *Psychiatric nursing*, ed 8, St. Louis, 2018, Mosby.

Delegation

The skill of communicating therapeutically with a patient who has difficulty coping cannot be delegated to assistive personnel (AP). The nurse instructs the AP about:

- Basic communication skills needed to interact verbally and nonverbally with anxious, angry, or depressed patients
- When to contact the nurse if patient's behavior or mood changes
- Their role in the use of de-escalation techniques
- Appropriate safety measures for themselves and other patients

Interdisciplinary Collaboration

- The nurse collaborates with the health care team to identify effective coping mechanisms.

STEP	RATIONALE
ASSESSMENT	
1. Identify patient using at least two identifiers (e.g., name and birthday or name and medical record number) according to agency policy. Then provide a brief, simple introduction; introduce yourself and explain purpose of interaction.	Ensures correct patient. Complies with The Joint Commission standards and improves patient safety (TJC, 2021).
2. Assess patient's/family caregiver's health literacy.	Ineffective coping behaviors may limit amount of information patient can understand. Ensures that patient/family caregiver has the capacity to obtain, communicate, process, and understand basic health information (CDC, 2020).
3. Assess factors influencing communication with patient (e.g., environment, timing, presence of others, values, experiences, need for personal space because of heightened anxiety).	Identifies effective communication strategies.
4. Observe for physical, behavioral, and verbal cues that indicate that patient is anxious, such as dry mouth, sweaty palms, anxious tone of voice, frequent use of call light, difficulty concentrating, wringing of hands, and statements such as, "I'm scared."	Anxiety interferes with usual manner of communication and thus interferes with patient's care and treatment. Extreme anxiety interferes with comprehension, attention, and problem-solving abilities.
5. Assess for possible factors causing patient anxiety (e.g., hospitalization, unknown diagnosis, fatigue).	Understanding the source of anxiety helps in patient support and communication.
6. Discuss possible causes of patient's anxiety, anger, or depression with family members, including past history of the illness, if necessary.	Gathering information about patient from a family perspective is useful because family provides new information or understanding of the situation (Keltner and Steele, 2018).
7. Assess for physical, behavioral, and verbal cues that indicate that patient is depressed, such as feelings of sadness, tearfulness, difficulty concentrating, increase in reports of physical complaints, and statements such as "I'm sad/depressed."	Depression interferes with usual manner of communication and thus with patient's care and treatment. If depression is severe, it interferes with comprehension, attention, and problem-solving abilities.
8. Assess for possible factors causing patient's depression (e.g., acute or chronic illness, personal vulnerability, recent loss).	Patient's depressive state is sometimes unknown. Understanding the possible cause of depression helps in patient support and communication.
9. Observe for behaviors that indicate that the patient is angry (e.g., pacing, clenched fist, loud voice, throwing objects) and/or expressions that indicate anger (e.g., repeated questioning of nurse, not following requests, aggressive outbursts, threats).	Anger is a normal expression of frustration or response to feeling threatened. However, its expression often interferes with or blocks communication and interactions.
10. Assess factors that influence the angry patient's communication, such as refusal to adhere to treatment goals, use of sarcasm or displaying hostile behavior, having a low frustration level, or being emotionally immature.	Allows you to accurately evaluate the situation or patient experiences that block or facilitate communication.
11. Assess for resources (e.g., social worker, pastoral care, or family) available to help in communicating with potentially violent patient.	This helps to clarify cause and intervention required to deal with patient's anger.
12. Assess for underlying medical conditions that may potentially lead to violent behavior.	Patients with medical conditions such as traumatic brain injury (TBI), dementia, or drug/alcohol withdrawal may exhibit hostile, aggressive behaviors.

Clinical Judgment *With some violent behaviors (e.g., physical aggression) you may not be able to de-escalate the situation. When this potential exists, know whom to call for assistance (e.g., trained psychology technicians, security staff). Personal safety is paramount.*

PLANNING	
1. Expected outcomes following completion of procedure: • Patient discusses factors causing anxiety, anger, or depression.	Reflects success in making patient sense trust and ability to communicate openly.

STEP	RATIONALE
• Patient can discuss methods to cope with anxiety, anger, or depression.	Reflects knowledge about resources (e.g., use of deep-breathing exercises, guided imagery) to cope with situations that cause anxiety, anger, or depression.
• Patient states that sensations of anxiety or depression are reduced.	Communication techniques ease symptoms associated with anxiety and depression and allow patient to focus on problem.

Clinical Judgment *First acknowledge and take care of anxious patient's physical and emotional discomfort, but avoid dwelling on physical complaints. Focus on understanding patient; providing feedback and helping to problem solve; and providing atmosphere of warmth and acceptance.*

• Patient no longer exhibits verbal and nonverbal expressions of anger.	De-escalation techniques successfully allow patient to express anger in a constructive way.
2. Prepare for therapeutic intervention by considering patient goals, time allocation, and resources.	Allows patient to establish rapport, achieve a sense of calm, and begin to analyze source of anxiety, depression, and anger.
3. Recognize personal level of anxiety and consciously try to remain calm (breathe slowly and deeply, relax pelvic floor muscles) when communicating with an anxious, angry, or depressed patient. Be aware of nonverbal cues that indicate own anxiety (e.g., body language, posture, cadence of speech). Remain nonjudgmental.	Your anxiety can increase a patient's anxiety. Your personal feelings and values may negatively affect interaction with patient.
4. Prepare a quiet, calm area, allowing ample personal space.	Decreasing stimuli has a calming effect. Invasion of personal space increases anxiety, anger, or depression.
5. Prepare for de-escalation for an angry patient.	
a. Pause to collect own thoughts, feelings, and reactions.	Awareness and control of your reaction and responses facilitate more constructive interaction.
b. Listen carefully to determine what patient is saying.	Clarification of patient need or concern may help to de-escalate situation.
c. Prepare the environment to de-escalate a potentially violent patient:	Potentially violent patient needs to be in an environment with decreased stimuli and have protection from injury to self or against others.
(1) Encourage other people, particularly those who provoke anger, to leave room or area.	Encourages patient's expression of anger rather than provokes it. Avoids pressuring patient; helps to prevent injury if anger becomes out of control.
(2) Maintain an adequate distance and open exit. Position yourself closest to door to facilitate escape from a potentially violent situation. Do not block exit so patient feels that escape is unattainable.	Prevents feeling of being trapped for both you and patient. Feeling trapped may cause a violent outburst. Safety of both parties is paramount.
(3) When anger begins to disturb others, close door. This is particularly important when patient becomes agitated.	Agitation and anxiety can spread to others. Some hospital rooms are equipped with security windows and cameras to allow for observation of patients.

Clinical Judgment *Some patients are disruptive to one another, especially those who are hyperactive, intrusive, or threatening or exhibit bizarre behaviors. For these patients, first try the least-restrictive measures before using more restrictive measures such as seclusion.*

(4) Reduce disturbing factors in room (e.g., noise, drafts, inadequate lighting).	Reduces irritants that may heighten anger.

IMPLEMENTATION

1. Use appropriate nonverbal behaviors and active listening skills such as staying with patient at bedside and having a relaxed posture. Focus on understanding the patient's issues.	Patients experiencing emotionally charged situation may not comprehend a verbally delivered message. Nonverbal messages to patient express interest and help alleviate anxiety.
2. Use appropriate verbal techniques that are clear and concise to respond to anxious patient. Use brief statements that acknowledge current state of feelings and provide direction to patient such as, "It seems to me that you're anxious" or "I notice that you seem to want to be alone. Would you like to go to your room to rest?"	Promotes effective communication so patient can explore reasons for anxiety, anger, or depression. Appropriate techniques and statements provide reassurance.
3. Help patient acquire alternative coping strategies such as progressive relaxation, slow deep-breathing exercises, and visual imagery (see Chapter 16).	Coping strategies are nonpharmacological mechanisms to help the patient reduce anxiety and depression and, in some cases, reduce anger.

STEP	RATIONALE
4. Provide necessary comfort measures such as analgesics, positioning, or hygiene.	Pain heightens patient's anxiety or depression and can contribute to his or her anger.
5. Use open-ended questions such as, "Tell me about how you're feeling" or "You seem sad. Tell me about your sadness."	Encourages patient to continue talking, facilitating an in-depth discussion of symptoms.
6. Encourage and reward small decisions and independent actions. When necessary, make decisions that patients are not ready to make. Present situations that require no decision making.	Depressed patients are often overly dependent and indecisive.
7. Accept patient as he or she is and focus on his or her positive aspects. Provide positive feedback.	Depressed patients often have low self-esteem. This approach helps to focus on their strengths.
8. Be honest and empathic.	Honesty and empathy facilitate the development of trust.

Clinical Judgment *If your patient seems depressed, ask him or her about suicidal ideation. Ask, "Have you thought about hurting yourself? Tell me how you would do it." Refer to appropriate mental health professional in agency (if available), and institute measures to ensure safety of patient. Depressed patients are at increased risk for suicide. Other risk factors include general medical conditions, hopelessness, male gender, and increased age. The more developed the plan, the greater the risk of suicide (Keltner and Steele, 2018).*

9. De-escalation for an angry patient	
a. Maintain personal space. It may be necessary to have someone with you and to keep the room door open. Position yourself between patient and the exit.	Use of personal space may help to de-escalate patient's anger. Positioning promotes health care provider's safety if patient continues to escalate and becomes violent.
b. Maintain nonthreatening verbal and nonverbal approach using a calm, reassuring tone of voice. Use open body language with a concerned, nonthreatening facial expression, maintain eye contact, open unfolded arms, relaxed posture, and a safe distance. Use gestures that are slow and deliberate rather than sudden and abrupt.	Decreases chance of misinterpretation of message and is less threatening. A relaxed atmosphere prevents further escalation. Creates climate of acceptance for patient.
c. Use therapeutic silence and allow patient to vent feelings. Use active listening for understanding. Do not argue with patient.	Often de-escalates anger. Anger expends emotional and physical energy; patient runs out of momentum and energy to maintain anger at high level. Arguing escalates anger.
d. Respond to anger therapeutically; avoid becoming defensive or angry, and encourage verbal expression of anger.	Some depressed patients are angry; understand that anger is a symptom of their depression. Verbal expression often reduces tension.
e. Answer questions calmly and honestly as appropriate. If patient asks power-struggle type of question (challenging or confrontational type) (e.g., "Who said you were in charge?"), redirect and set limits by giving clear, concise expectations. Inform patient of potential consequences without sounding threatening, and follow through with consequences if patient does not change behaviors.	A calm, clear communication style helps to set limits on power-struggle types of questions, provides structure for the interaction, and helps defuse anger (Keltner and Steele, 2018).
f. If patient is making verbal threats to harm others, remain calm yet professional and continue to set limits on inappropriate behavior.	Angry patient loses ability to process information rationally and therefore may impulsively express anger through intimidation.

Clinical Judgment *If imminent harm to another is present on discharge, notify proper authorities (e.g., nurse manager, security). A potentially violent patient can be impulsive and explosive; therefore you need to keep personal safety skills in mind. In this case avoid touch.*

g. If patient appears to be calm and anger is defused, explore alternatives to situation or feelings of anger.	Processing with patient can prevent future explosive outbursts and teach patient effective ways of dealing with anger.

EVALUATION

1. Observe for continuing presence of physical signs and symptoms or behaviors reflecting anxiety, anger, or depression.	Observation determines extent to which planned interaction relieved patient's emotions.
2. Ask patient to describe ways to cope with anxiety, depression, or anger in the future and make decisions about own care.	This measures patient's ability to assume more health-promoting behavior.
3. Evaluate patient's ability to discuss factors causing anxiety, depression, or anger.	This measures patient's ability to attend to or focus on area of concern.

STEP	RATIONALE
4. Note patient's ability to answer questions and problem solve.	Determines whether anger has lessened so patient is able to focus on alternative coping skills.
5. **Use Teach-Back:** "I want to be sure I explained options that will help you manage your anxiety in addition to medication. Describe a few of the exercises we discussed that will help you manage your anxiety." Revise your instruction now or develop a plan for revised patient/family caregiver teaching if patient/family caregiver is not able to teach back correctly.	Teach-back is an evidence-based health literacy intervention that promotes patient engagement, patient safety, adherence, and quality. The goal of teach-back is to ensure that you have explained medical information clearly so that patients and their families understand what you communicated to them (AHRQ, 2020).

Unexpected Outcomes	Related Interventions
1. Physical signs and symptoms of anxiety/anger continue. Your interaction has increased patient's anxiety/anger; source of anxiety/anger is not resolved.	• Use refocusing or distraction skills such as relaxation or guided imagery to reduce anxiety (Keltner and Steele, 2018). • Reassess factors and remove or alter factors contributing to anxiety/anger. • Take charge with calm, firm directions. Give as-needed (prn) medications as ordered for anxiety/agitation/escalating behaviors. • Make sure that fellow staff members are available to help if necessary.
2. Patient displays difficulty making decisions by avoiding your efforts at focusing discussion or is unable to discuss real concerns. Anxiety/anger/depression continues to prevent problem solving.	• Be clear and direct when communicating with patient to avoid misunderstanding. • When used appropriately, touch helps control feelings of panic.
3. Depressive behaviors continue; interaction has been ineffective at relieving depressive symptoms or patient reports suicidal ideation with or without plan.	• Continue to use therapeutic communication skills but try different techniques. • Refer patient to mental health professional for consultation regarding use of pharmacological agents and/or formal psychotherapy to treat depression. • Refer patient to mental health professional for evaluation and possible admission to an inpatient psychiatric treatment facility.

Recording

- Record cause of patient's anxiety/anger/depression, any exhibited signs and symptoms of behaviors, and any methods used to enhance coping. Include direct quotes from patient demonstrating his or her viewpoint.
- Record de-escalation technique used and patient's response to de-escalation efforts.

Hand-off Reporting

- Report methods used to relieve anxiety/anger/depression and patient's response to ensure continuity of care between nurses.
- Report technique used to de-escalate and patient's response to nurse in charge.
- Document your evaluation of patient and family caregiver learning.

Special Considerations

Patient Education

- Teaching patient and family caregiver to identify possible sources of anxiety such as illness, hospitalization, knowledge deficits, or other known stressors gives patient knowledge of anxiety and increases his or her sense of control.
- Patients experiencing emotionally charged situations do not always comprehend instruction. Focus on understanding patient, making sure the patient correctly understands information, providing feedback, and helping patient to problem solve; and providing an atmosphere of safety, warmth, and acceptance.
- Teaching patient and family caregiver to identify possible factors that contribute to angry outbursts such as inadequate coping skills, low frustration levels, illness, hospitalization, knowledge deficits, or other known stressors may give patient a sense of control.
- Once anger has been de-escalated, teach patient new adaptive methods of coping with anger.
- Teach patient and family caregiver to identify possible sources and signs of depression. Knowledge of depression increases patient's sense of control over feelings of depression.

Vulnerable Populations

Pediatric

- Children often demonstrate anxiety through physical and behavioral signs but are unable to express anxiety verbally. Some children express anxiety through restless behavior, physical complaints, or behavioral regression. Note any changes in child's behavior that occur during illness or hospitalization (Hockenberry et al., 2019).
- Set limits for inappropriate behaviors exhibited by child, such as a time-out. Apply such limits immediately because children tend to have less internal control over their own behaviors (Hockenberry et al., 2019).
- Children often demonstrate symptoms of depression that differ from those of adults. They manifest depression through physical (increased somatic complaints) and behavioral (poor school performance, social isolation) signs and are often unable to express it verbally. Some children express

depression through restless behavior or behavioral regression. It is important to note any changes in child's behavior that occur during illness or hospitalization (Hockenberry et al., 2019).

Gerontological

- Anxiety is common in older adults. Patients often become ritualistic and intent on performing activities a certain way. Anxiety develops as a result of a specific event or a general pattern of change (e.g., decline in health) (Touhy and Jett, 2018).
- Psychosocial factors such as anxiety and confusion, lack of mobility, and spatial organization of a long-term care facility are factors that decrease social contacts, thus hindering communication with peers and health care providers. This leads to further feelings of isolation, boredom, and increased anxiety.
- Older adults who are socially isolated have multiple medical problems and are more likely to have anxious and/or depressive symptoms. In addition, they are less likely to seek care for these symptoms.
- Depression among older adults is a major health concern. It is important to differentiate between depression and any underlying medical illness such as cognitive impairment (Touhy and Jett, 2018).
- Suicide risk is increased in older adults because of loss of life partner, health status, independence, and social support system or financial losses (Keltner and Steele, 2018).

Disabled

- Change in needs or a negative life event, such as loss of a support animal, loved one, or special caregiver can lead to crisis. Assess and monitor family caregivers for stress, and advocate for respite care as needed (Sullivan et al., 2018).

Home Care

- Anticipation of a home care visit may increase a patient's anxiety and leads to exacerbation of symptoms.
- Personal safety for nurse against potentially violent patient or family caregiver extends to all health care settings, including patient's home. Assess patient's home and physical surroundings, including possible exits. You may be in a potentially dangerous situation while giving care to patient at home because you are without support from other staff members. Do not enter the home if you feel unsafe; call for help.
- Depression is often present in home care settings. Educate family caregivers about how to identify symptoms. Manage depression based on patient's presenting behaviors, with consideration of any cognitive/physical impairment.

✦ SKILL 2.3 Communicating With a Cognitively Impaired Patient

The act of communicating and expressing oneself is affected by a person's cognitive ability. Patients with cognitive impairments pose a challenge for nurses because these patients may have disabilities that negatively affect communication (National Institute on Aging [NIA], 2017). Acute cognitive impairment or delirium is largely reversible and may be caused by conditions such as infection, polypharmacy, and metabolic changes. Once the cause is identified and treated, the patient's mental status returns to a baseline condition. Chronic types of cognitive impairments are irreversible and progressive. These include dementia (Alzheimer disease, vascular dementia, frontotemporal dementia), traumatic brain injury (TBI), and human immunodeficiency virus (HIV)–related cognitive dysfunction.

Cognitive impairments accompanied by communication deficits hinder a patient's ability to initiate conversation, communicate needs, and participate in self-care. Because it is time-consuming to interact with these patients, they may be deprived of human contact, which leads to depression, detachment, and isolation. Patients with cognitive impairments may also be at risk for physical status changes such as infection, falls and injury, and poor nutrition.

Delegation

The skill of communicating therapeutically with a cognitively impaired patient cannot be delegated to assistive personnel (AP). The nurse instructs the AP about:

- The proper communication skills needed to interact verbally and nonverbally with the cognitively impaired patient
- Notify nurse if patient's ability to communicate worsens
- The possible causes and signs and symptoms of the patient's cognitive impairment and implications for communicating

Interdisciplinary Collaboration

- Lack of a high-quality relationship with the patient can negatively affect patient outcomes; collaborate with health care providers to communicate effectively.

STEP	RATIONALE
ASSESSMENT	
1. Identify patient using at least two identifiers (e.g., name and birthday or name and medical record number) according to agency policy.	Ensures correct patient. Complies with The Joint Commission standards and improves patient safety (TJC, 2021).
2. When you first meet a patient whom you expect to be cognitively impaired, approach from the front. Assess for the physical, behavioral, and verbal cues that indicate that a patient is cognitively impaired. Assess orientation status of patient (person, place, time) and perform a mini-mental examination (see Chapter 6).	You may startle and upset a patient if you touch him or her unexpectedly or approach from behind. If the patient is unable to think, speak, or understand, you need to adjust communication strategies to communicate effectively.
3. Assess patient's/family caregiver's health literacy with the simplest literacy screening tool.	Ensures that patient or family caregiver has the capacity to obtain, communicate, process, and understand basic health information (CDC, 2020). Memory and verbal fluency are strongly associated with health literacy even among those with subtle cognitive dysfunction (Federman et al., 2009). A lower level of literacy is associated with lower memory and verbal fluency.

STEP	RATIONALE
4. Review EHR and assess for possible factors causing patient's cognitive impairment (e.g., acute or chronic illness, fever, medications, fluid and electrolyte imbalance).	Understanding the possible cause of mental decline helps in conferring with medical team on appropriate therapy and has implications for short-term and long-term communication strategies.
5. Assess factors influencing communication with patient (e.g., environment, timing, presence of others, values, experiences, prior sensory loss, poor concentration).	Understanding factors that influence communication helps you to identify effective communication strategies (NIA, 2017).
6. Discuss possible causes of patient's cognitive impairment with family members or caregivers, including current illness, duration, treatment regimen, and past medical history.	Gathering information about patient from a family perspective is useful because family provides new information or understanding of the situation. It is important to establish patient's baseline mental status.
7. Discuss with family how patient typically communicates with them. Consider these questions: Does the patient lose his or her train of thought, struggle to organize words logically, need more time to understand what you're saying, or curse or use offensive language? (Mayo Clinic, 2019).	Allows you to anticipate pattern of patient's communication so you can use effective communication strategies.
8. Ascertain the most effective means of communication with patient (e.g., verbal or written communication, picture board).	Knowing how best to communicate and using alternative communication methods can help identify patient's needs.
PLANNING	
1. Expected outcome following completion of procedure: • Patient can communicate physical and emotional discomfort needs to nurse.	Use of relevant communication techniques enables patient to express needs (e.g., physical and emotional discomforts) effectively, given the limitations related to cognitive impairment.
2. Prepare for communication by considering type of cognitive impairment, communication impairments, time allocation, and resources.	Effective communication allows you to establish rapport with patient and have a high-quality nurse-patient interaction.
3. Be aware of your nonverbal cues that affect communication with the cognitively impaired patient (e.g., body language, posture, cadence of speech). Remain nonjudgmental.	Frustration in communication with patients with cognitive impairment may negatively affect interaction with patient.
4. Prepare environment physically by providing a quiet, calm area. Reduce distractions such as external noises.	Decreasing stimuli has a calming effect. Ensuring that the environment is quiet and free from distractions enhances the communication experience.
IMPLEMENTATION	
1. Approach patient from the front and face him or her when speaking.	This strategy avoids startling the patient and helps to ensure that patient both sees and hears you.
2. Provide brief, simple introduction. Introduce yourself, show respect, and explain purpose of interaction (NIA, 2017).	Symptoms associated with cognitive impairment limit amount of information that patient can understand.
3. Use appropriate nonverbal behaviors and active listening skills such as staying with patient at bedside or using touch appropriately.	Nonverbal messages to patient express your interest and convey empathy. Use of touch may help with concentration and reassurance.
4. Use clear and concise verbal techniques to respond to patient (Mayo Clinic, 2019). Use simple language and speak slowly; use short and simple sentences. Ask yes-or-no questions.	Appropriate techniques and statements provide reassurance to cognitively impaired patient.
5. Ask one question at a time and allow time for response. Avoid rushing patient. Do not interrupt patient (NIA, 2017).	This gives patient time to process the information and respond.
6. Repeat sentences using a steady voice and avoid raising your voice or being too quick to guess what patient is trying to express.	Repetition allows time for patient to respond. Attempting to guess what the patient is saying is frustrating for the patient if you misinterpret his or her message or pressure him or her to respond.
7. Use augmentative and assistive communication (AAC) devices such as pictogram grid, talking mats, objects, and iPads to facilitate communication.	Talking mats are communication aids that use picture symbols so the patient can place relevant images below a visual scale to indicate feelings.
8. Make sure that patient is wearing eyeglasses or hearing aids to help with communication.	Some patients with cognitive impairments forget about eyeglasses or hearing aids and need to be reminded to use these to improve clarity of communication.

STEP	RATIONALE
9. Do not argue with patient or correct him or her if mistakes are made.	Arguing can lead to increased frustration and agitation.
10. Maintain meaningful interactions with patients and use creative modes of communication based on patient's comfort level and abilities.	Meaningful interactions help patient engage with family or community and surroundings and help reduce a sense of isolation and detachment.
11. Use individualized coping strategies such as progressive relaxation, slow deep-breathing exercises, or visual imagery.	Helps to reduce some anxiety associated with confusion and difficulties in communication.

EVALUATION

1. Observe patient's response for clarity and understanding of messages sent and received.	Observation determines extent to which cognitively impaired patient can express himself or herself.
2. Observe verbal and nonverbal behaviors.	Observation reveals if patient is comfortable and needs have been met.
3. **Use Teach-Back:** "I want to be sure I explained how this picture board will help you communicate with your family. Tell me how to use the picture board to show your wife that you want to take a shower or take a walk together." Revise your instruction now or develop a plan for revised patient/family caregiver teaching to be implemented at an appropriate time if patient/family caregiver is not able to teach back correctly.	Teach-back is an evidence-based health literacy intervention that promotes patient engagement, patient safety, adherence, and quality. The goal of teach-back is to ensure that you have explained medical information clearly so that patients and their families understand what you communicated to them (AHRQ, 2020).

Unexpected Outcomes	Related Interventions
1. Messages that are sent and received are not understood.	• Continue to use therapeutic communication skills when interacting with cognitively impaired patient. Be creative in using alternative strategies (e.g., involving family members).
2. Patient becomes frustrated, and communication with nurse becomes more challenging.	• Speak to patient as an adult and give time to process information. • Use verbal and nonverbal methods to convey empathy with his or her frustration. • Allow for periods of adequate rest; make frequent attempts to interact to minimize social isolation.

Recording

- Record both objective and subjective behaviors (associated with cognitive impairment) that patient is displaying and objective behaviors (associated with cognitive impairment) observed.
- Record the methods used to communicate with the patient, and patient's response.
- Document your evaluation of patient and family caregiver learning.

Hand-off Reporting

- Report the methods used to communicate and patient's response.

Special Considerations

Patient Education

- Teach patient and family caregiver how to use various methods to communicate such as pictorial board or communication aids.
- Make teaching modifications with a consideration of impaired concentration and memory related to patient's cognitive status (e.g., present a small amount of material at a time; use simple and short phrases; repeat information as needed).

Vulnerable Populations

Pediatric

- Children may exhibit cognitive impairments because of acute or chronic metabolic or neurological conditions. Know the child's developmental level when identifying communication strategies. Use pictures and drawings for patients who are unable to read.

Gerontological

- Many older adults have cognitive impairments that can pose serious barriers to the reliability of your assessment findings; therefore it is important to use effective verbal and nonverbal communication strategies. Poor communication can compromise care, leading to increased anxiety and frustration.
- Patients who have cognitive impairments may exhibit tantrum-like behaviors in response to real or perceived frustration. Use distraction techniques to remove a cognitively impaired older-adult patient from disturbing stimuli or redirect patient to activity that is pleasurable (Touhy and Jett, 2018).

Disabled

- Assess patient's ability for decision making—many patients can participate to some extent if provided accommodations (Sullivan et al., 2018).

Home Care

- Include the family caregiver and friends in using effective communication strategies.
- Address potential issues of driving, getting lost, and home safety each time you see the patient (NIA, 2017).
- Encourage regular physical activity, social activity, hobbies, and intellectual stimulation, as well as a healthy diet. Research links these approaches to the maintenance of cognitive function (NIA, 2017).

✦ SKILL 2.4 Communicating With Colleagues

In health care settings communicating is a key part of everyday practice. You communicate with patients, members of the interdisciplinary health care team, and external colleagues. This communication occurs face-to-face, over the phone, and in writing. The quality of these interactions is a key component of error prevention; clarity, comprehension, and adherence to treatment plans; and patient outcomes. The Joint Commission (TJC) publishes National Patient Safety Goals, one of which is to "improve the effectiveness of communication among caregivers" (TJC, 2021). Collaboration among physicians, nurses, and other health care professionals increases team members' awareness of one another's type of knowledge and skills, leading to continued improvement in decision making and patient outcomes.

SBAR (*S*ituation, *B*ackground, *A*ssessment, *R*ecommendation) is one system that allows for structured communication among team members, allowing a way to set expectations for communication and provide a means to avoid omitting important information in hand-off reporting (see Chapters 3 and 4). SBAR creates a common language for communication of key patient care information; increases confidence of speaker and receiver of hand-off report; improves efficiency, efficacy, and accuracy of hand-off report; improves perception of effective communication; and is well received among health care staff (Stewart and Hand, 2017). SBAR is an interdisciplinary, simple communication technique that can improve the culture of safety.

Creating a civil and just work environment is a first step to avoid incivility in the workplace (Kaiser Permanente Southern California [KPSC], 2017). Civil behavior descriptions and policies should be used consistently throughout an agency, and educational offerings should include topics on incivility, civility, respect, and coping strategies for new and practicing nurses (KPSC, 2017). Conflicts among colleagues can indirectly influence the therapeutic nurse-patient relationship and negatively affect the delivery of care and patient and health care provider satisfaction. If conflicts are not resolved, they can escalate into workplace bullying, which is abusive conduct that is threatening, humiliating, or intimidating and interferes with a productive work environment (Clark, 2019). Effective communication is necessary to resolve conflict among members of the health care team before situations escalate. Good communication in the form of conflict resolution skills can decrease the risk of conflict and its negative effects. Health care agencies need to be proactive to create healthy work environments, with a shared philosophy of civility and respect (Clark, 2019).

Delegation

The skill of communicating effectively with colleagues can be delegated to assistive personnel (AP). The nurse instructs the AP about:

- The proper communication skills needed to effectively interact verbally and nonverbally with colleagues.

Interdisciplinary Collaboration

All members of the health care team should be expected to practice effective and respectful communication.

- Reflection on the way one wishes to live and practice can help create civil work environments and patient safety (KPSC, 2017).
- Self-care workshops can be a means to enhance resilience and well-being and to create healing and healthy work environments (Barrett, 2019).

STEP	RATIONALE
ASSESSMENT	
1. Identify purpose of interaction with colleague.	This sets the stage for the interaction; all members of the communication exchange are aware of purpose of conversation.
2. Assess factors influencing communication with others (e.g., environment, timing, presence of others' cultural beliefs and values, prior experiences).	Assessment allows you to accurately evaluate any barriers to communication or issues that may need to be considered to maintain open, clear channels of communication.
3. Consider level of stress in the situation; do you feel threatened?	Feeling threatened results in a sympathetic stress response that can impair judgment, emotional control, and ability to communicate clearly.
PLANNING	
1. Prepare for communication with members of the health care team who may have differing needs or concerns. Example: If you feel stressed, try to relax and to consciously relax muscles of pelvic floor.	Effective communication allows members of the health care team to establish rapport and have a quality interaction. Adapt own style of communicating (e.g., relaxation) to meet the needs of the health care team.
2. Be aware of your nonverbal cues that affect communication with others. Remain nonjudgmental.	Frustration in communication may negatively affect interaction with others.
3. Prepare environment physically; go to a quiet, calm area. Reduce distractions such as external noises.	Factors to consider include privacy, noise control, seating space, and convenience to help to ensure the space needed for effective teamwork.
4. Be aware of hierarchical differences among members of the health care team as a common barrier to effective communication and collaboration.	The hierarchical nature of health care can be a barrier to effective communication (Stewart and Hand, 2017).

STEP	RATIONALE
IMPLEMENTATION	
1. Approach colleague from the front and face him or her when speaking. Maintain appropriate eye contact.	This strategy ensures that colleague both sees and hears you and conveys an attitude of respect.
2. Provide brief, simple introduction; introduce yourself and explain purpose of interaction.	This strategy ensures that colleague understands purpose of interaction.
3. Be aware of your own body language and tone. Assume an open stance; do not fold arms across your chest.	Nonverbal messages convey empathy. Be aware of how your nonverbal communication style may impact others.
4. Acknowledge and respond to a range of views. Allow for equal time for all parties to participate in expressing opinions.	Understand the perspectives of others and support the value of collaboration and teamwork.
5. Use oral communication skills such as: ask open-ended questions; do not assume; do not interrupt; do not blame others. Provide feedback. Use active listening and recognize nonverbal triggers. Ask for clarification when necessary.	Effective communication skills are essential for communicating information and resolving conflict.
6. Use a range of workplace written communication methods (e.g., oral, written notes, memos, letters, charts, diagrams).	Standardized communication such as the SBAR method of communication can help streamline information exchanges and promote patient safety (Stewart and Hand, 2017).
7. Encourage discussion of both positive and negative feelings to increase the chances of both parties expressing all of their concerns.	Discussion fosters active listening and understanding. All members of the exchange are valued, and their contributions are recognized.
8. Summarize key themes in the discussion and help to develop alternative solutions to the issue.	Conflict resolution involves examining alternative solutions to an issue. It values the influence of system solutions in achieving effective functioning among colleagues (Clark, 2019).
EVALUATION	
1. Confirm clarity and understanding of messages sent and received.	Determines extent to which members of the exchange understand.
2. Observe verbal and nonverbal behaviors.	Observation reveals if there are any negative emotions or further concerns that contradict a message.

Unexpected Outcomes	Related Interventions
1. Messages that are sent and received are not understood.	• Continue to use therapeutic communication skills when interacting with others. Be creative in using alternative strategies.
2. Frustration among colleagues persists, and communication becomes more challenging.	• Continue to have empathy and use active listening to better understand colleagues.
3. Bullying behaviors (verbal attacks, threats, spreading rumors and gossip, public ridicule, purposefully withholding vital information) occur (Clark, 2019).	• Follow agency protocol to report behaviors immediately and seek assistance of agency security personnel.

✦ SKILL 2.5 Workplace Violence and Safety

Workplace violence targeting health care workers is a widely recognized problem. Examples of workplace violence include direct physical assaults (with or without weapons), written or verbal threats, physical or verbal harassment, and homicide (Occupational Safety and Health Administration [OSHA], 2016). The American Organization of Nurse Executives (AONE) and the Emergency Nurses Association support a zero tolerance workplace violence policy that sends a clear message to everyone working in a hospital that all threats or incidents of violence will be taken seriously (AONE, 2019). Exposure to violence negatively impacts the emotional and physical health of all members of the health care team. Consequently, it is imperative that workplace violence prevention programs be implemented to ensure a safe working environment. A workplace violence hazard assessment must be conducted to assess risk factors prior to implementing de-escalation techniques. De-escalation is the ability to organize one's thinking and calmly respond to a threatening situation that helps one avoid a potential crisis (Crisis Prevention Institute [CPI], 2020; Moore et al., 2018). Services should be implemented to investigate any violent incident as well as to provide debriefing for health care staff involved in an incident.

Delegation

The skill of workplace safety can be delegated to assistive personnel (AP). The nurse assists the AP by:

- Directing the AP to assess for potential hazards and risk factors for patient violence
- Notifying nurse of any hazards or risk factors
- Confirming understanding of de-escalation techniques

Interdisciplinary Collaboration

Workplace safety is the responsibility and concern of all members of the health care team.

- The nurse will participate in prevention, identification, and interventions to promote safety and address workplace violence.

STEP	RATIONALE
ASSESSMENT	
1. Assess baseline knowledge of hospital staff regarding workplace violence.	It is imperative that staff are aware of the agency's emergency management plan to maintain a safe environment for patients, family caregivers, and health care staff.
2. Identify organizational risk factors for workplace violence: • Lack of agency policies and staff training for recognizing and managing escalating hostile and assaultive behaviors from patients, clients, visitors, or staff • Working when understaffed—especially during mealtimes and visiting hours • High worker turnover • Inadequate security and mental health personnel (OSHA, 2016)	Identifies factors in a work setting that if not addressed make health care staff unequipped to manage violent situation.
3. Identify patient- and setting-related risk factors for workplace violence: patients who are experiencing pain, showing mood-altering behaviors, or impaired due to ethyl alcohol (ETOH)/drugs. High-risk settings include the emergency department, psychiatric units, and geriatric long-term care facilities (OSHA, 2016).	Identifies factors within a work setting that increase risk of health care workers being exposed to violent behavior.
4. Assess patient for signs and symptoms of potentially violent behavior: recent stressors or losses (e.g., job loss, divorce); history of confirmed psychiatric disorder; history of drug or alcohol (ETOH) abuse or aggression; content of speech and tone of voice indicating agitated state (loud voice, angry tone); escalating verbal and nonverbal behaviors, including cursing or name-calling, pacing, and clenched fists.	All are risk factors for violence.
PLANNING	
1. Expected outcomes following completion of procedure: • Staff are educated on violence prevention and de-escalation strategies.	De-escalation training raises the overall safety and health knowledge across the workforce and provides employees with the tools needed to identify workplace safety and security hazards.
• Potentially violent patient situations are avoided and/or minimized.	Participation in workplace violence prevention programs helps nurses to address potential problems before they arise and ultimately reduces the likelihood of workers being assaulted (AONE, 2019).
• Incident reporting and debriefing occur when indicated.	Established policies ensure the reporting, recording, and monitoring of incidents and near misses to help identify root causes and help prevent future incidents of violence (OSHA, 2016).
IMPLEMENTATION	
1. Use notification system for identifying high-risk patients: label or color-code medical records; supply potentially violent patients with different colored socks.	Indicates to health care team patients most likely to commit a violent act. Acknowledges the value of a safe, healthful, violence-free workplace.
2. Remove opportunity for any type of weapon to be used by patients or visitors (fists, teeth, bodily fluids, medical supplies, meal tray, furniture). Be aware of personal space with patient who may try to bite, hit with fists, or throw bodily fluids. Observe body stance (clenched fists, feces in hands).	Managing threats of violence involves recognizing potential weapons and taking a proactive approach to minimizing use of those items (AONE, 2019). Removing the potential risk and stimulus can eliminate and block the opportunity to act.

STEP	RATIONALE
3. Do not work alone if feeling uncomfortable with a patient. Use measures to prevent or control workplace hazards.	Use of physical barriers (guards, door locks), metal detectors, panic buttons, better lighting, and accessible exits can reduce employee exposure.
4. Make sure all staff are trained to cope with physical and verbal abuse by using the following de-escalation techniques (CPI, 2020; Moore et al., 2018):	Victims of hospital violence are most often untrained or newly hired nurses, so prepare by training them with proven strategies for safely defusing anxious, hostile, or violent behavior at the earliest possible stage. This includes teaching them to look for warning signs, ask for help if they feel unsafe, and report any violent or suspicious behavior to a supervisor.
a. Be empathetic and nonjudgmental.	When someone says or does something you perceive as weird or irrational, try not to judge or discount his or her feelings. Whether you think those feelings are justified, they are real to the other person. Pay attention to them (CPI, 2020).
b. Respect personal space.	If possible, stand 1½ to 3 feet away from a person who is escalating. Allowing personal space tends to decrease a person's anxiety and can help you prevent acting-out behavior (CPI, 2020; Moore et al., 2018).
c. Use nonthreatening nonverbal behaviors.	The more a person loses control, the less he or she hears your words—and the more the person reacts to your nonverbal communication. Be mindful of your gestures, facial expressions, movements, and tone of voice (CPI, 2020).
d. Avoid overreacting. Remain calm, rational, and professional.	Although you cannot control the person's behavior, how you respond to that behavior will have a direct effect on whether the situation escalates or defuses (CPI, 2020; Moore et al., 2018).
e. Focus on feelings.	Facts are important, but how a person feels is the heart of the matter. Yet some people have trouble identifying how they feel about what is happening to them (CPI, 2020).
f. Ignore challenging questions.	Answering challenging questions often results in a power struggle. When a person challenges your authority, redirect his or her attention to the issue at hand (CPI, 2020).
g. Set limits.	If a person's behavior is belligerent, defensive, or disruptive, give him or her clear, simple, and enforceable limits. Offer concise and respectful choices and consequences (CPI, 2020).
h. Choose wisely what you insist on.	It is important to be thoughtful in deciding which rules are negotiable and which are not. For example, if a person does not want to shower in the morning, try to allow him or her to choose the time of day that feels best (CPI, 2020).
i. Allow silence for reflection.	Although it may seem counterintuitive to let moments of silence occur, sometimes it is the best choice. It can give a person a chance to reflect on what is happening and how he or she needs to proceed (CPI, 2020).
j. Allow time for decisions.	When a person is upset, he or she may not be able to think clearly. Give him or her a few moments to think through what you have said (CPI, 2020).
k. Use concise, simple language.	Elaborate and technical terms are difficult for an impaired person to understand (Moore et al., 2018).
5. Notify security staff to intervene if patient begins unruly behavior or if additional information is needed to determine potential for violence. (See agency policy for how to notify security.)	If a patient begins to exhibit unruly behavior, you may request a security consultation to determine whether the patient poses a threat. If officers identify danger, a patient will undergo a safety assessment including a detailed search of personal effects for any weapons or dangerous items.
6. If an incident occurs, initial steps are first aid and emergency care for the injured workers and prevention of further injury.	Following a violent incident, first determine the extent of injuries and establish priorities of treatment.
7. Debrief using standard postincident procedures and services. The purpose of an investigation should be to identify the root cause of the incident.	Root causes refer to all possible causes associated with the incident of violence. If the root cause is not addressed and/or corrected, it will inevitably recreate the conditions for another incident to occur (OSHA, 2016).

STEP	RATIONALE
8. Implement comprehensive program of medical and psychological counseling and debriefing for staff who have experienced and witnessed assaults or violent incidents.	A strong follow-up program for these workers will not only help them address these problems but also help prepare them to confront or prevent future incidents of violence (OSHA, 2016).

EVALUATION

1. Evaluate staff comprehension of workplace violence program and de-escalation strategies.	Ensures staff preparation for any violent events. Require annual certification for all staff in safety training.
2. Monitor prevention impact. Evaluate prevalence of such incidents on a regular basis.	Data determine need to revise training or to assist select individuals with prevention techniques.
3. If there is a violent incident, evaluate safety of all persons involved. Provide prompt medical treatment for victims of workplace violence.	Worker well-being is critical to maintain safety and stability of work environment.
4. If there is an incident, immediately evaluate the effectiveness of the de-escalation techniques implemented. Victims of an assault, as well as their co-workers, need the opportunity to discuss their concerns and feelings about the event.	A critical incident debriefing suggests ways to prevent similar incidents in the future. Critical incidents can cause emotional reactions that affect health care workers' ability to function.
5. Use Teach-Back: "Tell me about the use of de-escalation techniques (from a patient/family caregiver and staff perspective) used to prevent an incident of workplace violence. How effective were they?" Revise your instruction now or develop a plan for revised patient/family caregiver and staff teaching if patient/family caregiver and staff are not able to teach back correctly.	Teach-back is an evidence-based health literacy intervention that promotes patient engagement, patient safety, adherence, and quality. The goal of teach-back is to ensure that you have explained medical information clearly so that patients and their families understand what you communicated to them (AHRQ, 2020).

Unexpected Outcomes	Related Interventions
1. There is a violent incident between patient and nursing staff.	• Notify the agency's interdisciplinary response team. • Provide immediate treatment to persons injured. • Report the presence of a weapon immediately to a manager, a supervisor, or security (AONE, 2019). • Implement postincident procedures (root cause analysis and follow-up debriefing for staff).
2. De-escalation techniques are ineffective.	Further workplace violence prevention training is necessary for staff.

Recording

- Record staff attendance at workplace violence prevention programs.
- Record hazard assessment and strategies used to promote a safe environment.
- Record escalating behaviors exhibited by patient.
- Record any injuries and treatments offered.
- Record root cause analysis of violent incident.
- Record follow-up program services offered.

Hand-off Reporting

- Provide detailed assessment of potentially hazardous situation.
- Report patients who are flagged as high risk for potentially violent behaviors.
- Report strategies implemented to prevent escalating behaviors.
- Report any violent incidents and outcomes associated with the incidents.

✦ CLINICAL REVIEW QUESTIONS

You are caring for an 89-year-old male patient who has a history of Alzheimer disease. He was admitted to your unit after becoming violent at home and attempting to punch his 50-year-old daughter, who is his primary family caregiver. The daughter called the police and emergency services to assist her in calming her father. He was transferred to the hospital because of a hand injury he sustained in the altercation and a heightened level of confusion and expressions of anger.

1. What additional assessment findings are needed to effectively communicate with this patient?
2. Which approach could be an obstacle to effective communication with this patient or the family caregiver? (Select all that apply.)
   1. Discussing the patient with members of the health care team
   2. Interrupting the patient when he does not answer the question posed

3. Telling the patient's daughter she should institutionalize her father
4. Giving advice to patient, since you are a health care professional
5. Paying attention to the concerns the patient is expressing

3. What communication strategies should be used for this patient? (Select all that apply.)
1. Approach the patient from his side to begin speaking.
2. Use active listening strategies.
3. Repeat sentences as needed using a steady voice.
4. Insist the patient use an iPad for communication.
5. Encourage deep breathing exercises if tolerated.

4. The patient's daughter has asked to talk with you regarding concerns about her father and her continued ability to care for him. You use the therapeutic communication techniques of clarification and reflection. Which of the following statements would be inappropriate for you to make to this family caregiver? (Select all that apply.)
1. "I assume you understand your father's condition."
2. "I'm not sure what you mean."
3. "You're feeling tense and anxious."
4. "I think you are being too hard on your father."
5. "I can empathize with how you're feeling."

5. The patient is becoming more aggressive, and the staff attempt de-escalation techniques. Which techniques would be appropriate in this situation? (Select all that apply.)
1. Respect the patient's personal space.
2. Scold the patient for his behavior.
3. Ignore challenging questions that the patient poses.
4. Suggest the daughter intervene first.
5. Avoid overreacting to the patient's behavior.

Visit the Evolve site for Answers to Clinical Review Questions.

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