Fundamentals of palliative care

Communication skills
WELCOME FROM HOSPICE NZ

Welcome to this training package – we do hope that you enjoy this learning experience and the information here is useful to you in your work.

We would like to take this opportunity to put this education package in context and give you some background to this overall education programme.

In 2009 the Ministry of Health and Hospice New Zealand considered the results of a national stock-take into palliative care service provision.

Nationally, there were two areas of need that required our focus;

- The need for nationally consistent education programmes that support primary palliative care providers.
- The need for revised palliative care standards and an ongoing implementation programme to ensure consistency in the quality of service regardless of locality.

It was agreed Hospice New Zealand was well placed to work on two specific projects to address these needs due to our previous experience and a recent commitment from member hospices throughout the country that these were also priorities for them.

The Minister of Health then allocated a portion of the funding that was available to address difficulties in accessing palliative care services to Hospice NZ for the two projects, this funding commenced on 1 January 2010.

The outcome of both projects will improve the quality and equity of palliative care services available to people and their families and whānau, regardless of the care setting.

This package is part of a 10 part learning series – each contributing to the overall Fundamentals of Palliative Care.

Warm regards,

Mary Schumacher
CEO, Hospice NZ
ABOUT HOSPICE NZ

Hospice NZ exists to support member hospices in their work caring for people who are dying. We are the national organisation whose primary goal is to give voice to the interests, view and concerns of our member hospices.

All hospice services throughout the country are members of Hospice NZ – 30 full members and 4 associate members.

Our purpose is to lead the hospice movement to ensure that every New Zealander has access to quality palliative care.

Our vision is that everyone with a life limiting condition and their families have access to the best possible care.

Our goals;

1. Community engagement – raise awareness and understanding of hospice care through community engagement
2. Leadership – provide national leadership, direction and support through collaboration with members and the wider sector
3. Advocacy – ensure equitable funding and delivery of hospice care
4. Workforce development – support a high performing hospice and palliative care workforce
5. Quality and standards – enhance the quality and standard of palliative care by supporting members to deliver good outcomes for patients, families and whānau.

Our organisational values are a cornerstone to our work;

• Professional
• Respectful
• Caring
• Collaborative
• Honour diversity

www.hospice.org.nz
ACKNOWLEDGEMENTS

Hospice New Zealand was assisted in developing this resource through collaboration with the hospice, primary health, hospital, aged residential care, health of older people and home based support sectors, ensuring the learning packages are ‘fit for purpose’. Both the governance and project teams represent this approach.

Hospice New Zealand wishes to acknowledge the expertise, experience and commitment of members of the Hospice New Zealand Education Governance Group and Education Working Group in developing this version of the Hospice New Zealand Fundamentals of Palliative Care education resource. We sincerely thank them and their trust boards for their contributions of knowledge and time.

The Education Governance Group, chaired by Mary Schumacher, CEO Hospice New Zealand, provided strategic advice on palliative care education and informed the planning of the education programme. The Education Governance Group members were:

Dr Michal Boyd – Senior Lecturer, Freemasons’ Department of Geriatric Medicine, University of Auckland and Gerontology Nurse Practitioner, Community Services for Older Adults, Waitemata District Health Board

Julie Haggie – CEO, Home and Community Health Association New Zealand

Dr Marion Taylor – General Practitioner, Wicksteed House Medical Centre Wanganui and Senior Medical Officer, Hospice Wanganui

Kate Gibb – Nursing Director for Older People, Population Health, Canterbury District Health Board

Dr Brian Ensor – Director of Palliative Care, Mary Potter Hospice and Clinical Advisor to the Hospice New Zealand Board of Trustees

The Education Working Group assisted Hospice New Zealand with developing the content of the education resource through clinical and technical advice, and expert content advice. The Working Group members were:

Rachel Hale – Nurse Practitioner for Older People, Matamata Medical Centre

Liz Angus – Community Team Leader, Access Homehealth Limited

Gayle Elliott – Clinical Nurse Specialist, Specialist Hospital Palliative Care Service, Southern District Health Board

Trish Fleming – Manager, Learning and Development Team, Hospice West Auckland

Jenny Blyde – Team Leader, Counselling and Bereavement Service, Hospice Taranaki

Jan Waldock – Lead Clinical Nurse Educator, Arohanui Hospice

Chris Murphy – Community Liaison and Educator, Mary Potter Hospice

Dr Oleg Kiriaev – Geriatrician and Palliative Care Consultant, Totara Hospice South Auckland and Mental Health Service for Older People, Waitemata District Health Board
Sylvia Meijer – Nurse Practitioner and Team Leader, Health of Older Adults, Central Primary Health Organisation

Anne Hampton – Nurse Specialist/Manager, Te Amo Health, Motueka
(also representing Te Kaunihera o Nga Neeti Maori – National Maori Nurses Organisation)

We thank Anne Morgan, Hospice New Zealand Practice Development Advisor, for her role as content coordinator and writer of the education resource.

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Teaching time: 1-2 hours

LEARNING OUTCOMES

This will be a mainly experiential session with discussion and role play as a method of imparting knowledge.

At the end of the session the participants will be able to;

1. Outline the communication process and recognise barriers to good communication
2. Discuss how to communicate with the dying person and how to address family/whānau concerns
3. Describe how to build partnerships with families and whānau
4. Advocate wisely for people and their families and whānau
5. Discuss the importance of good interprofessional team communication and strategies to build good team communication

“The problem with communication is the illusion it has occurred”.

George Bernard Shaw
PRE-SESSION READING AND REFLECTION

We all communicate. We can’t help it. Whenever we are in contact with other people, we send and receive messages and they are not always the messages we intend to send. Because we all communicate we tend to take it for granted. Misunderstandings can easily occur and lead to conflict and upset. Communication can be emotionally charged but absolutely vital for providing good palliative care (Hallenback, 2003).

Communication is the exchange of information between two or more people; you and a person/family/whānau/other team members. With any communication the most important thing to remember is not what you are saying but how you say it; the how it will give it meaning. People interpret things in very different ways and it is the interpretation that can cause issues no matter how clear you think you were when you communicated.

Interpersonal communication is essential in every area of life, but it is especially critical in the field of nursing. Communication skills have been identified as the main cause of health care issues. This is based on studies in the last three decades according to Andy Betts, a professor of nursing at the University of Lincoln in the United Kingdom.

Caring is collaborative by nature. All members of the multidisciplinary team must communicate effectively in order to provide the appropriate treatment and care for people.

We learn to communicate in childhood. We have ways of communicating based on our life experiences, culture, ethnicity, origins and gender and we bring this learning to our workplace and integrate a whole lot of new experiences and ways of communicating. We learn to pay attention to some things and to ignore others.

In this session we are going to explore how we communicate and what can cause challenges as we communicate with people and their families and whānau and the other members of the team. We will look at the process of communication and look at possible barriers to the process.

The barriers to good communication skills are many and include: time pressures, busy staff may not be able to get time to sit and talk with people; lack of privacy; the skill mix in care settings can mean there is a shortage of qualified nurses who are available to talk to people; lack of training; and different languages.

Useful things to remember in having good communication include: being prepared to know what you are going to say; having the right information to hand when people ask questions; maintaining eye contact and observing the person’s body language; listening properly; picking up on the non-verbal signs as well as the verbal ones and avoiding the use of medical jargon. When you are breaking bad news, be prepared emotionally, try to find the right environment, and be sensitive, honest and compassionate.
Just look at this cartoon and see how easily things can be misinterpreted.

NON–VERBAL COMMUNICATION

A study done in the early 1980’s (and still relevant) showed the effectiveness of how we communicate:

• Words are 7% effective
• Tone is 38% effective (tone is how we say things e.g. too loud, quickly, impatiently, lacking sincerity, disrespectfully)
• Body language or nonverbal communication is 55% effective.
  (Mehrabian, 1981)

Nonverbal communication is all forms of communication that are not verbal and includes the most subtle movements that we are not always aware of, such as slight movements of the eyebrows. People will respond more to your non-verbal communication than to what you say. Positive body language shows you care. A smile or touch of a hand can demonstrate caring whereas hands on your hips or frowning can be interpreted as aggressive behaviour. You need to become aware of your body language; looking at your watch tells the person you are too busy to help them and they may fail to ask for what they need.

Everyone has their own way of communicating based on their life experiences. Body language and the tone of voice affects how the message is heard.

Personalities also affect our communication, as do cultural differences and generational differences. This will be discussed more during the teaching session.
ACTIVE LISTENING AND CONNECTING

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

There is a process to communication and interrelated elements work together to achieve a desired outcome.

One of the best ways to communicate is to stop talking and start listening, but listening is more than just not talking. It means paying attention to the person who is speaking and attempting to understand what lies behind the words.

It is about connecting with the other person, e.g. the patient, in order to understand what their experience might be:

• If you were in their position, how might you react or behave?
• What might you be hoping for?
• What might you be concerned about?

This doesn’t mean you try to take on that person’s suffering as your own, or actually experience what they are going through, but rather that you understand what they are telling you.

Empathetic listening comes from an open heart and staying focused. You will be mostly silent as you listen. Ask open ended questions when appropriate.

• How does that make you feel?
• Can you tell me more about that?
• What do you think that means?

LISTENING

Listening in dialogue is listening more to the meaning than to words.

In true listening, we reach behind the words, see through them, to find the person who is being revealed.

Listening is a search to find the treasure of the true person as revealed verbally and non verbally.

There is the semantic problem of course. The words bear a different connotation for you than they do for me. Consequently, I can never tell you what you said, but only what I heard.

I will have to rephrase what you have said, and check it out with you to make sure that what left your mind and heart arrived in mind and heart intact and without distortion.

(John Powell ‘People Skills’, 1998)
EXAMPLES OF ROAD BLOCKS TO EFFECTIVE COMMUNICATION

The following, while not always bad to use, have a tendency to close down communication rather than open up communication and should be avoided in conversations. These could apply to a patient, loved one or other team members.

Ordering, directing, commanding
Telling the person to do something; giving them an order or command.
“You must get up now.”

Moralising, preaching
Shoulds and oughts are degrading to the older person and their loved ones.
“You shouldn’t act like that.”
“You shouldn’t speak to your mother like that.”
“You ought to have a shower.”

Teaching, lecturing, giving logical arguments
Trying to influence a person with facts, counter-arguments, information or your own opinion.
“You need to have your shower now or there won’t be time and then you won’t be dressed in time for lunch.”
“You have to take your pills or you won’t get any better.”

Judging, criticizing, disagreeing, blaming
Making a negative judgment or evaluation to another member of the team.
“You’re not thinking clearly.”
“That’s an immature point of view.” “You’re very wrong about that.”
“I couldn’t disagree with you more.”

Withdrawing, distracting, sarcasm, humoring, diverting
Trying to get the person away from the problem, withdrawing from the problem yourself, distracting them, pushing the problem aside.
“Just forget it.”
“Let’s not talk about that now.”
“Come on – let’s talk about something more pleasant.”

Distancing
Distancing is behaviour by which health workers avoid becoming involved with a person or the family on a psychosocial level, generally without being aware of it. The focus may be on the task they are doing rather than on what is happening in the room and they choose not to respond to cues the person is giving such as “I am really afraid I am dying.”
Confidentiality
This is an essential part of communication in the health care setting and we must take care what we discuss in earshot of others. Imagine if you went to your GP with a personal health issue and in front of a crowded waiting room the receptionist, in a loud voice, asks What is wrong with you?

First impressions
First impressions are vital and can stay with you for a long time. They can influence the relationship you have with a person and can be very difficult to alter. A smile of welcome and acknowledgement of someone is as important as how efficiently you complete a task.

Hope
Maintaining hope is an important aspect of communication. What is hope? It means looking beyond the present, desiring something better or beyond the current situation. They may be dreams and goals to make life worth living.

People who are dying may express hopes such as keeping a sense of control until the end, hope for relief from suffering or hope to live long enough for a particular milestone and hope for a peaceful, painless death.

All health workers must effectively communicate with people, their family members and loved ones as well as other people involved in the person’s care. You must communicate in a variety of ways: via written order, telephone, and in person. Each means of communication is important in a healthcare setting and we need to practice the skills.

A story follows for you to read to highlight the magic of good communication.

THE LISTENER
Outside a gentle morning breeze sighed through the trees and a branch tapped softly on the window, neither of us had spoken for some minutes. My eyes were drawn again to the worn photos in the pale, almost translucent, hands resting on the covers. Each small black and white picture was the key to a memory, every memory a story, stories that had built a lifetime.

This morning had been the same as any other morning; you probably know the routines as well as I do, there’s barely enough time to complete essential tasks and conversation isn’t considered to be one of them. It was my last call for the morning and I had said all of the usual things, half listening to the responses, when suddenly the room was quiet and the words seemed to hang in the air, “I’m dying, and I just don’t understand.” The despair and longing in the voice was reflected in the hurt of those deep eyes.

I desperately wanted to help and my mind was racing with things that I could say, but what actually came out of my mouth surprised me, “You sound hurt
and bewildered," I said. The eyes softened a little and a long sigh seemed to release something deep inside, "It’s more frustrated than bewildered. I thought I had my life ahead of me and now this."

The fingers shuffled slowly through the photos bringing new ones into view.

I saw a house in the country, a cloudless sky, children and dogs playing under the trees, a stream winding its way out of the picture. "I was seven then, invincible. We’d save the world at least twice before lunchtime and still have time for a swim."

And so, as I listened the stories began and I was invited into the world of each memory; family, friends, special days and ordinary days, laughter, celebrations, triumphs and tragedies. In companionship we shared those worlds and walked the paths of time together; together we celebrated each step on that journey and together we approached the future, with all of its uncertainties.

At first the voice had been somewhat controlled and harsh, the muscles about those deep-set eyes tight, face drawn into a frown. Now, as each memory honoured the past, adding its inevitable treasures to be cherished, the wholeness of this journey began to emerge, bringing the beginnings of peace for body and soul; change began. Muscles relaxed, the voice softened and seemed to take on new strength, and the stories began to talk with purpose of things yet to be done.

This transformation seemed magical, and if it was then it is a magic that we all possess. A story only comes to life in the active mind of a listener, for without a listener the story cannot be told. Listening was the magic that encouraged the stories to unfold and reveal the integrated wealth and beauty of a life.

As we sat together in the quiet I thought about this day and how different it could have been. When those words had echoed in my mind, "I’m dying, and I just don’t understand," I had wanted so much to help and my mind had already begun to form the explanation that I would give. The tragedy is that an explanation would probably have been accepted and then, without a listener, these life-changing stories would never have been told.

Outside, birds called, the soft wind riffled through the branches and cicadas chirred in the morning’s heat. Far away a dog barked and the monotonous buzz of a tractor faded over a hill. In this room, resting in companionable silence, the sparkling dust of magic was everywhere.

NLP Masterpractitioner and Trainer Story by: Barry Amer 2003©
REFLECTION TO BRING TO THE TEACHING SESSION

1. What were the communication ‘rules’ as you grew up?

2. You have gone into a shop and you need some advice about your purchase. The shop assistants ignore you and just keep talking to each other. You are in a hurry to get to work.
   a) What barriers are there to communication?
   b) How do you feel?
   c) What would you do?
   d) Would you go back to the shop?

Remember the people we care for cannot walk away and are dependent on the people caring for them to communicate well.

3. How comfortable do you feel speaking to people you don’t know?

4. When a person dies, who gives the news to the family? If it is you how do you do that? How do you support the family – what do you say? How comfortable do you feel with this?

5. Make a list of any challenging communication situations that you would like to discuss during the teaching session.

POST-SESSION EXERCISE

As a multidisciplinary team, discuss the following, thinking about what you learnt about communication in the recent teaching session:

Patient issues:

• You have a family member on the phone who is very angry and still swearing 5 minutes into the conversation – how do you deal with this?

• A patient tells you something about another staff member – how do you handle it?

• You get anxious prior to discussing bad news with a patient and/or family – how do you prepare for this?

• You are asked to go in after a person has heard some upsetting news – how do you approach the scene?

Staff issues:

• It is lunchtime and you can’t find someone you need to help with someone in your care – how do you manage this?

• You answer a person’s call bell some minutes after it first went off and you are berated for not answering immediately – how do you feel in this situation? How do you manage this situation?
• You are upset with a fellow staff member – what do you do?
• Do you know who to raise issues with in the workplace?
• Do you feel you have too much on your plate? How will you approach this?

KEY REFERENCES


Communication skills

1. Outline the communication process and recognise barriers to good communication.
2. Discuss how to communicate with the dying person and how to address family/wānanga concerns.
3. Describe how to build partnerships with families/wānanga.
4. Advocate wisely for people and their families/wānanga.
5. Discuss the importance of good interprofessional team communication and strategies to build good team communication.

Communication

- Communication is the exchange of information whenever two or more individuals are together; communication is taking place.
- Communication means different things to different people and there are many methods of communication some of which are more effective than others.
**Models of care**

- Patient and family
- Staff
- Community
- Volunteers

**Cultural considerations when communicating**

- What are the attitudes, values and beliefs you bring to your practice?
- What are the rituals that are important to you when communicating with persons and other team members?
- What is the organisational culture?
- Discuss the important role of the family at this time

*Adapted from Waitemata Palliative Care Education Programme 2017*

**Culture, race and ethnicity**

- **Culture**: the learned and shared beliefs, values, and life ways of a designated or particular group which are generally transmitted intergenerationally and influence one’s thinking and action modes.

- **Ethnicity**: people whose members identify with each other through a common heritage, consisting of a common language, a common culture and a tradition of common ancestry

- **Race**: a group of people united or classified together on the basis of common history, nationality, or geographic distribution
Communication skills

Communication process

- Barriers
  - Sender
  - Message
  - Channel
  - Receiver
- Feedback
  - Verbal and Non-Verbal

The aims of communication

- Reveal and clarify information
- Reduce uncertainty
- Enhance relationships
- Give the patient and the family a direction in which to move

The most important message a patient wants to hear at a time of increasing uncertainty is:
- No matter what we will not desert you (acceptance)
- You may be dying, but you are still important to us (affirmation)

Body language

- Being able to read body language is one of the most significant skills of good listening
- Body language is a very important medium of communication
- 7% of the impact of communication is verbal
- 38% of the impact of communication involves the sounds of language (speed, volume, pitch, pause)
- 55% of the impact of communication involves body language
What is listening?

**Is**
- A priceless gift
- Visible by your body, gestures, and eye contact
- Willingness to be involved in another’s feelings
- Being comfortable with silence
- Hearing

**Is not**
- About advice
- One-liners and cliches
- Criticising what you have heard
- Changing the subject
- Minimising the event
- Fixing the hurt or curing the grief

Connecting

- An important component of effective communication is to connect and engage with the person... try to understand what their experience might be
- Empathy – walking in their shoes
- This doesn’t mean you try to take on that person’s suffering as your own or actually experience what they are going through – you journey alongside the person in a supportive role
- Personal boundaries are important

Maintaining boundaries

- ‘Being with the person, not becoming the person or their family whanau
- Being friendly, not friends
- Having a clear understanding of the limits and responsibilities of your role
- Avoiding ‘burnout’ (compassion fatigue)
- Maintaining personal physical and emotional safety
- It’s about maintaining a healthy, open, communication with all the team
Communication skills

Active listening
- Listening is an active process that requires your participation.
- To understand someone fully, you usually have to ask questions and give feedback.
- When listening, you should not be passively absorbing.

How do we actively listen?
- Nod from time to time (minimal encourager).
- If the person stops, repeat their last few words. This gives permission to continue.
- Pick up on cues.
- Reflect questions back.
- Ask about feelings.
- Validate feelings.
- Watch body language.
- Summarise and check for accuracy of your understanding of what the patient has said.
- Prioritise problems with the person.

Open-ended questions
Open-ended questions allow the person/family/whānau to tell their story and express their needs and fears and shows them that you are interested in what they have to say.
- How...?
- Tell me about...?
- What do you think is happening...?
- Why...?

Make sure you have the time to listen.
Give minimal encouragers to encourage them to continue.
Stories are so important

Stories move in circles,
They don’t go in straight lines,
So it helps if you listen in circles.
There are stories inside stories, and stories
between stories, and finding your way
through them is as easy and as hard
as finding your way home.
And part of the finding is the getting lost.
And when you’re lost, you start
to look around
and LISTEN

When people decline information

- Don’t just respond with “it’s their right to know” and tell them anyway
- Some people want to know everything, they can about their health
results, prognosis, what to expect. Others don’t want to know very
much at all or only want their family to know.
- Both scenarios are fine and therefore early on we need to establish
just how much the person wants to know.
- Explore reasons/moments of the person, their family and whanau and
how they communicate as a family.
- A trusting therapeutic relationship will enable this conversation to
happen.
- It’s about partnership.

To tell or not to tell?

- Several studies show that most
people want to be told.
- There is nothing to show that telling
the truth is detrimental.
- It allows people to complete;
- unfinished business
- deal with spiritual issues
- say their “goodbyes.”
- Staff cannot presume that full
disclosure is appropriate but it must
be decided with the individual
person and their significant others.
Communication skills

Person’s preference for care

- We need to have the ability to honour and respect people’s wishes and preferences for:
  - future treatment and care
  - who they want involved in future decision making
  - types of medical treatment which may or may not be wanted
  - the place of care
- Good communication will allow the person, family and whānau to express their wishes
- Documentation essential

Initiating end of life discussions

- Often difficult
- People, families, whānau & clinicians feel to avoid mentioning death or dying
- Death is a scary word for many, but we all have to do it sometime
- Timely, sensitive discussions with seriousness if concerns regarding medical, psychosocial and spiritual needs at the end of life are both an obligation and privilege

Indications for discussing end of life care

- Imminent death
- Person talking about wanting to die
- Person, family or whānau inquiring about hospice or palliative care
- Severe progressive disease
- Suffering and poor prognosis

In an effort to remain hopeful, doctors tend to focus on treatments and may inadvertently give people with life-limiting illness a false sense of optimism and hope.
How should bad news be delivered?

A. Advance preparation
B. Build a therapeutic environment/relationship
C. Communicate well
D. Deal with persons, family, and whakawau reactions
E. Encourage and validate emotions

Responding to difficult questions

- You may find it difficult when a person asks a very direct and difficult question:
  - How long have I got?
  - Am I dying?
  - Why can’t you just give me something to end it right now?
  - Am I going to get better?
- Don’t rush in and try to answer the question but reframe the question and get more information and ensure you are both talking about the same thing—what has prompted you to ask this question?
- Gently explore their thoughts by asking them to tell you more about what they are feeling.
- If you are unable to provide a satisfactory answer then be honest and tell them you will find someone who can discuss their concerns with them.

Decisions can be very difficult
Communication skills

**Someone observed**

“Those who have the strength and the love to sit with a dying patient in the silence that goes beyond words will know that this moment is neither frightening nor painful, but a peaceful cessation of the functioning of the body.

Watching a peaceful death of a human being reminds us of a falling star, one of the millions of lights in a vast sky that flashes up for a brief moment only to disappear into the endless night forever.”

**Conclusion**

Important communication strategies to remember:
- Touch – shows companionship and reduces isolation
- Make time to communicate
- Honestly and trust
- Appropriate time and place
- Sit down to show that you have time
- Make eye contact if culturally appropriate
- Avoid medical jargon
- Enjoy communicating with the person – they have interesting stories to share
- Be prepared to tackle the hard conversations