Finding common ground: Surviving wound care communication

The author describes how to overcome challenges to effective communication in the healthcare setting.

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Accurate communication among healthcare professionals can spell the difference between patient safety and patient harm. Communication can be a challenge, especially when done electronically. With an e-mail or a text, you can't hear the other person's voice or see the body language, so it's easy to misinterpret the words.

Are you sure your colleagues accurately understand the messages you're conveying? When you communicate effectively with the people you work with, life gets easier. This article suggests ways to

overcome communication challenges in the wound care workplace, whether you're communicating with prescribing authorities or wound care colleagues.

Communication can be verbal or nonverbal. (See *Verbal and nonverbal communication.*) Regardless of the type or means of communication, sender and receiver need to have a shared understanding of the communication between them. The information you convey needs to be complete, concise, concrete, clear, and accurate.

Courtesy counts

In a busy healthcare setting, we may overlook the need for—and value of—courtesy. Learn how to listen. Too often, instead of fully listening to the other person, we're busy formulating our reply. Try this: Listen as someone speaks to you; then reiterate their words back to that person to show you heard and understand. Then offer your reply.

Try smiling, too, even when you're on the telephone. Chances are, the person on the other end will hear the smile in your voice.

Types of communicators

People communicate in different styles. Identifying the communication style of your colleagues and understanding how they want information to be conveyed to them can create a better workplace. (See *Classifying communicators.*)

Communication barriers

Multiple barriers to effective communication exist. Everyday distractions are high on the list. These include ringing tele-

phones, beeping alarms, patient call bells, multiple job responsibilities, documentation tasks, and the general hustle-bustle of the healthcare workplace. When using a mobile device, interference and bad connections may pose a barrier. Even understanding a colleague's accent can be a struggle, as can background noises that threaten to drown out phone or face-to-face conversation.

Gender, social, and cultural differences also can pose communication barriers. Studies show males communicate differently than females. Males prefer quick, fact-based communication; females prefer more in-depth discussion.

One of the biggest barriers we encounter is between the physician or prescribing authority and the nurse or wound care clinician. In some cases, the physician doesn't understand the true scope of the nurse's or wound care clinician's practice. The Joint Commission reports 60% of medical errors result from direct communication breakdown between the physician and nurse. The physician-nurse (or prescribing authority–wound care clinician) divide can make clinicians feel uncomfortable about speaking up to those with more education or a higher supervisory status.

What's more, different healthcare specialties seem to have their own special language. Even within the wound care world, medical jargon can differ. Not all wound care clinicians are familiar with our own terminology, and this can be a barrier to a covering or on-call provider.

Overcoming barriers

To move beyond these barriers, we can start by managing our personal stressors and workloads. Know the type of communicator you're dealing with, as well as the how, what, when, and why of the information they want to be notified about. For example, do they want you to notify them for emergencies only, or if the wound enlarges and treatment orders need to be changed?

Also, make sure the receiver of your communication knows who you are. Introduce yourself and include your credentials to let them know you're an expert in wound care.

Be respectful and try to manage conflict wisely. We all strive for leadership on our team, and it doesn't necessarily come from the prescribing authority. Remain confident in the power of your expertise and the meaningful contributions you make to the team. At the same time, always follow the chain of command; don't go over other clinicians' heads to get faster action.

On the healthcare team, everyone must have the freedom to disagree and voice their opinion. When people express their opinions, creative problem solving can occur if conflicting opinions are managed properly. This keeps us on our toes and helps us come up with multiple solutions—as long as we're communicating effectively.

How to handle difficult communications

Not all communications are easy or planned in health care. You don't always

Verbal and nonverbal communication

- Verbal communication occurs face to face, by telephone, or in a video chat.
- Nonverbal communication occurs through written means—e-mail, texting, documentation in the medical record, and social media (such as a Facebook page or a Tweet)—and through body language (gestures and mannerisms), tone of voice, touch, eye contact, and use of the personal space between us.

We all need to be aware of the nonverbal messages we convey. Think about your body language: Is it open or closed? And remember—you have just a few seconds after meeting someone to make a first impression.

Classifying communicators

According to author Louie Mace in the book *Communication Strategies*, people fall into four basic categories of communicators. You can use this knowledge to communicate more effectively.

Analyzers. These detail-oriented people like to hear the details of the topic at hand. Make sure you present those details in a well-organized way. Give them the particulars about the patient and product studies, as appropriate, and make sure to comply with your facility's protocols.

Controllers. Controllers can come across as rude as they try to take control of the situation and "lead" through force. You need to earn respect from these highly goal-oriented people. When communicating with them, have your facts straight and at the ready. Present them in a confident, matter-of-fact way. Otherwise, Controllers will sense your uncertainty and may tear you apart. When closing the conversation, thank them for their time. Controllers like to feel they're important; it never hurts to stroke their ego a little when it's deserved.

Promoters. These people like to be the center of attention and may take it personally if they don't get enough attention. They also like to have fun. When communicating with them, let them do most of the talking. Act like you're interested in what they're saying, and don't interrupt. You can "plant the seed" for what you want (such as a change in a patient's dressing or the overall treatment plan) by bringing it up in a casual discussion unrelated to the patient. For instance, give them ideas about products you'd like to use or advanced modalities. Later, Promoters can turn these suggestions into a "great idea" of their own. The key is they need to think the idea is theirs. If you "plant the seed" about a new dressing that absorbs a lot of exudate, the next time the Promoter sees the patient, he or she will remember what you said and think, "Wow! I know a product that would be great for this patient."

Supporters. Supporters tend to take the safe route, going along with whatever the strongest personality in the group says. They may put their patients' interests above their own; also, they may shy away from high-pressure situations. When communicating with them, don't dominate the conversation, be confrontational, or act like you know it all. Give them time to make a decision. Let them know you have the patient's best interest at heart.

have time to gather information or map out exactly what you'll say to the prescribing authority, your supervisor, or even the patient's family.

Sometimes difficult or unplanned conversations are necessary, and some may take place at inopportune times, such as the middle of the night. You may be talking to a patient on the phone when a disgruntled family member cuts in on the extension.

When something like this happens, take a deep breath and practice empathy by putting yourself in the other person's shoes. You may encounter aggression or frustration on the other end of the phone or from across the room. Listen, accept the other person's feelings, and offer polite formalities: "I understand this is hard to hear" or "I'm sorry to have to deliver this news over the phone. I can't imagine what you're going through." To remind them that you're human, too, use statements that start with "I feel." And don't take verbal attacks personally.

Abusive communication

Don't tolerate disruptive, disrespectful, or abusive behavior from colleagues. Address workplace harassment on the spot. Use such phrases as "I'm not challenging your expertise; however…" or "May I please tell you why I have additional concerns about this patient?" Stand up for yourself and call out the colleague on his or her behavior. Frequently, people don't realize they're speaking or acting inappropriately until someone calls them out on it.

If an abusive conversation escalates, walk away. Document the conversation and submit a written statement to report the abuse to the administration. The worst thing to do is to say nothing. Keep in mind that social influence can be incredibly powerful. Nobody wants to be labeled a workplace bully or be disciplined for harassment. Help shape the behavioral norms of your organization and use peer pressure to address inappropriate codes of conduct.

Specific communication challenges in wound care

Certain wound care orders can lead to communication problems.

Orders for a wet-to-dry dressing on a granulating clean wound

Many misconceptions about wet-to-dry dressings exist. The biggest misconception is that they promote moist wound healing. In fact, they don't. Remember—when gauze dries, the tissue also dries, which leads to cooling of the wound bed, in turn increasing the infection risk. Wet-to-dry dressings are labor intensive; they need to be changed every 4 to 6 hours. They're also costly. Bacteria can penetrate 64 layers of gauze.

Using wet-to-dry dressings isn't evidence-based practice. In fact, it's substandard practice for moist wound healing. The only evidence-based use for wet-to-dry dressings is mechanical debridement; this means we should use this type of dressing only on necrotic wounds. Yet how often do we see orders for wet-to-dry dressings for healthy, granulating wound beds?

As wound care clinicians, it's our responsibility to help prescribing authorities use these dressings only when appropriate. If you get an order for a wet-to-dry dressing, inform the prescribing authority of the evidence against their use; for instance, cite such articles as "**Hanging wet-to-dry dressings out to dry**," George Winter's pivotal **1962 studies** on moist wound-healing principles, and **international guidelines** that don't recommend wet-to-dry dressings for moist wound healing. At the same time, offer appropriate suggestions for your patient's treatment; prescribing authorities can't read our minds and may be unfamiliar with newer products on the market.

Orders for topical metronidazole

Suppose you have an order to crush Flagyl (metronidazole) and sprinkle it into the wound bed to help control wound odor. Flagyl is an oral medication; even though drug books say it's safe to crush this medication, they mean it's safe to crush and administer it *orally*. No studies have shown it's safe to apply Flagyl on a patient's wound bed, nor is the drug approved for use in this manner. You can't mix it with hydrogel and call it an ointment of your own making, either, because that would constitute compounding, which is out of your practice scope.

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In this case, suggest the prescriber change the order to MetroGel 75 (metronidazole 75%), which the Food and Drug Administration has approved for topical administration. Or if MetroGel isn't appropriate for your patient, try switching to a charcoal dressing, which helps decrease

odor. Try to find out what's causing the wound odor (bacteria or necrotic tissue, for instance) and intervene appropriately.

Other inappropriate orders for your patient's specific wound

Suppose your patient has a heavily exudative wound and the prescriber orders a transparent film. You know the film won't hold the exudate and you'll end up with a soupy mess. What should you do? Contact the prescriber to suggest a change; provide your rationale, validate your position, and cite your sources. Also, if appropriate, share your ideas for alternative treatment. Sometimes just asking for a trial period works out well. "Hi, Dr. Smith? Could we try it for a 2-week period? Thank you for your time."

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Jones. It's Jennifer, the wound care certified nurse from the nursing home. I'm calling about Patient Smith. I see this morning you ordered a transparent film for her stage 3 pressure ulcer. I'm not sure if you're aware of the large amount of exudate the patient is having. Per the package insert, a transparent film won't accommodate that amount of drainage. Normally with such a large amount of exudate, we get good results by using a specialty absorptive product such as _____. May I suggest this product for Mrs.

The need to reeducate staff

Consider this scenario: When reviewing your patient's documentation on wound rounds, you note that last week the clinician documented the pressure ulcer as stage 2 with 5% slough in the wound bed. But you know there can't be slough in a partial-thickness wound.

This means it's time for staff reeducation. You can handle this in several ways. Promptly address it on a one-to-one basis with the staff member who documented the ulcer, so that person doesn't stage wounds incorrectly again. But keep in mind that if one staff member stages wounds incorrectly, other colleagues are probably doing it, too. This situation calls for facility-wide or clinic-wide reeducation.

Refer to the National Pressure Ulcer Advisory Panel's (NPUAP) pressure ulcer definitions of stages (**www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/**). Print out NPUAP's illustrations of the stages in treatment books (**www.npuap.org/resources/educational-and-clinical-resources/pressure-ulcer-categorystaging-illustrations/**). Perform one-on-one evaluation of clinicians' bedside wound assessments, checking for competency. Hold facility-wide in-services for staff members performing appropriate wound and skin assessments; make such assessments a mandatory skills check-off.

Accurate tissue type identification and pressure ulcer staging are critical for documentation and proper reimbursement. Correct communication across the healthcare continuum is a must.

An ongoing challenge

Effective communication in the healthcare setting is an ongoing challenge. Know what to expect from colleagues in terms of communication—and be sure

you understand what they expect of you. Be mindful of your own and others' nonverbal communication, including body language. Keep in mind that it's easy to misinterpret the tone of an e-mail or text message. Finally, practice good listening; it's a great way to start building better communication skills. Remember, teamwork is what makes the dream work! ■

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