

Communications

**EMS Continuing Education
Technician through Technician-Advanced Paramedic**

**Consistent with the
National Occupational Competency Profiles
as developed by
Paramedic Association of Canada
and
“An Alternate Route to Maintenance of Licensure”
as developed by Manitoba Health**

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Disclaimer

These documents were developed for improved accessibility to “An Alternative Route to Maintenance of Licensure” for all paramedics in Manitoba. Regional implementation of Alternate Route is at the discretion of the local EMS Director.

This is a supportive document to the National Occupational Competency Profiles and “An Alternative Route to Maintenance of Licensure.” It is not the intent that this package be used as a stand-alone teaching tool. It is understood that the user has prior learning in this subject area, and that this document is strictly for supplemental continuing medical education. To this end, the Paramedic Association of Manitoba assumes no responsibility for the completeness of information contained within this package.

It is neither the intent of this package to supercede local or provincial protocols, nor to assume responsibility for patient care issues pertaining to the information found herein. Always follow local or provincial guidelines in the care and treatment of any patient.

This package is to be used in conjunction with accepted models for education delivery and assessment, as outlined in “An Alternative Route to Maintenance of Licensure”.

This document was designed to encompass all licensed training levels in the province Technician, Technician-Paramedic, Technician-Advanced Paramedic. Paramedics are encouraged to read beyond their training levels. However, the written test will only be administered at the paramedic’s current level of practice.

All packages have been reviewed by the Paramedic Association of Manitoba’s Educational Subcommittee and physician(s) for medical content.

As the industry of EMS is as dynamic as individual patient care, the profession is constantly evolving to deliver enhanced patient care through education and standards. The Paramedic Association of Manitoba would like to thank those practitioners instrumental in the creation, distribution, and maintenance of these packages. Through your efforts, our patient care improves.

This document will be amended in as timely a manner as possible to reflect changes to the National Occupational Competency Profiles, provincial protocols/Emergency Treatment Guidelines, or the Cognitive Elements outlined in the Alternate Route document.

Any comments, suggestions, errors, omissions, or questions regarding this document may be referred to info@paramedicsofmanitoba.ca , attention Director of Education and Standards.

Communications

This module deals with Communications. Components discussed in this module include: medical terminology, patient care documentation, radio and interpersonal communication.

Conventions Used in this Manual

The cognitive elements contained in this training module apply to all EMS licensure levels.

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COMMUNICATION

Introduction

Medical terminology is the language of medicine. Like other fields, medicine uses specialized terms and abbreviations. To communicate effectively, those who work in medicine must speak and understand the same language. Knowledge of medical terminology will help you to comprehend reading material and get more benefit from classes and lectures. Knowledge of medical terminology will also facilitate communication with physicians, nurses, and other health care personnel.

Initially, medical terminology may look like a foreign language and in some ways it is so. The Greeks helped found modern medicine, and many of their terms still remain in use. When the seat of medicine passed to ancient Rome, Latin became the universal language of medicine. In the centuries that followed, Greek and Latin terms slipped into common usage. Even today, many new medical terms are derived from Greek or Latin.

Medical Dictionary

A medical dictionary is a valuable tool, both in the classroom and on the job. Medical dictionaries not only define and spell terms, they also provide medical information. Some of the main features of a medical dictionary include: correct spelling, phonetic pronunciation (in parentheses), definitions, meanings, subtopics, etymologies, and medical synonyms. Subtopics in the dictionary offer related words; etymologies give the derivatives of words and their Greek or Latin meanings. After definition of the word will come a list of associated words or synonyms. Most medical dictionaries also provide sections on first aid, diseases, drugs, and anatomy.

Medical Terminology

The three parts of a medical term are the prefix, root word, and the suffix. These terms are defined below.

Prefix: one or more syllables affixed to the beginning of a word to modify its meaning.

Root word: a word to which a suffix, prefix, or both is affixed.

Suffix: one or more syllables affixed to the end of a word to modify its meaning.

Root Words

A root word is defined as the part of a word that conveys its essential meaning. It is distinguished from other word parts that modify this meaning. Roots may be attached to other roots to form words, or prefixes and suffixes may be attached to roots to form words. The following examples show how a root word may be modified by the addition of another root word or by a prefix or suffix.

Examples of Root Words

algia (pain) + caus (burn)	causalgia (burning pain)
partus (labor)	postpartum (after birth)
tropho (nourish)	hypertrophy (over nourishment)

Prefixes and Suffixes

A root word's meaning may be modified by the placement of additional phrases either before or after the word. Phrases placed before root words are called prefixes, while phrases placed after the root words are called suffixes.

Prefixes

Prefixes are placed at the beginning of root words to modify a word's meaning. They are never used alone. If the root word starts with a vowel, and the prefix ends with one, then the final vowel of the prefix is dropped.

“Dys” is a prefix meaning disordered, painful, or difficult. Dysrhythmia would imply a disorder of a heart rhythm. Some other examples of prefixes include:

a (without or lack of)	apnea (without breath)
tachy (fast)	tachycardia (fast heart rate)
derma (skin)	dermatitis (inflammation of the skin)
erythro (red)	erythrocytes (red cell)

Suffixes

Suffixes are placed at the end of the root word or prefix to alter the meaning of a word. Pronunciation sometimes requires changing the last letter or letters of the root word when the suffix is added. Also, it may be necessary to change the last vowel. An example is the word cardiology, derived from “cardia.” The word neuritis, derived from “neuro,” is an example of dropping the final vowel in the root word to add a suffix that begins with a vowel. Other examples of suffixes include:

‘pnea (breathing)	dyspnea (difficulty breathing)
‘ology (science of)	cardiology (science of the heart)
‘cyte (cell)	leukocyte (white cell)
‘rrhagia (bursting forth)	hemorrhage (burst forth of blood)

By learning root words, prefixes, and suffixes common to medical terms, and by consulting the medical dictionary regularly, you will gain a command of medical terminology. Knowing medical terminology is essential for preparing medical records, learning new material, and communicating with other health care personnel.

Abbreviations

Medical documentation tends to be lengthy and time-consuming. As a result, abbreviations become routine. The following are examples of common abbreviations used in prehospital care.

abd.	abdomen
b.i.d.	twice a day
CHF	congestive heart failure

The use of abbreviations is not allowed by some EMS systems or Regional Health Authorities. It is your responsibility to know the policy for your area.

Documentation on Manitoba Patient Care Report

The importance of accurate and complete documentation cannot be overemphasized. Proper record keeping helps to ensure continuity of patient care from the prehospital to the hospital setting. To avoid potential legal problems and embarrassing court situations, the paramedic should record observations only on the patient care report (eg. the patient had an odor of alcohol on his breath), not opinions (the patient was drunk). The former cannot be disputed and the latter cannot be proved.

Overview of Manitoba Patient Care Report

Manitoba Health would encourage you to take the time to complete each Patient Care Report in the greatest possible detail. The information captured from this form will allow each local Emergency Medical Response Program to do a thorough needs-assessment and service planning on an ongoing basis. At the regional level, and for Manitoba Health, the information captured from these reports will allow planning for optimal deployment of resources to provide the best possible EMS system, will identify education needs, and will be essential in identifying the need for, and sustainability of advanced skills modalities in various services.

The information gathered from these reports is also used to bill for services provided to a patient by an Emergency Medical Response Program, and for monitoring the experience status and activity of individual license holders.

There are also a number of areas on the Patient Care Report that are mandatory if a corresponding area of the form has been completed. For example: An attendant license number must be recorded if a transfer of function skill has been utilized.

Medical Liability Protection

The best protection from potential liability is practicing good prehospital care. In addition, all actions, procedures, and medication should be adequately documented on the Patient Care Report. A complete, well-written run report is your best protection in a malpractice proceeding. To the court, observations and treatments not documented on the run report were not performed.

The medical record should never be altered. An intentional alteration amounts to an admission of guilt by the attendant. If a medical run report is inaccurate, a written amendment should be attached to the report. The date and time, the amendment was written – not the date of the original report - should be noted on the paper.

Paramedics cannot avoid becoming involved in the legal system. The nature of the job requires interaction with law enforcement authorities. It also requires paramedics to be at scenes where they may be material witnesses to a crime or domestic dispute. The paramedic is not immune from allegations of malpractice. However, malpractice charges may be avoided by adhering to the following guidelines.

- Always obtain informed consent before initiating treatment.
- Practice only those skills and procedures that a reasonable and prudent paramedic would, given the same or similar circumstances.
- Practice only those procedures authorized directly to you through your medical director.
- Prepare accurate and legible medical records that thoroughly document the entire EMS incident – from scene response to hospital emergency department.
- Discuss patient information with only those who need to know. Limit writings and oral reports to information essential to patient care.

High-quality patient care is always your best protection.

Elements of a Properly Written EMS Document

A properly written EMS document is accurate, legible, timely, unaltered, and free of nonprofessional or extraneous information. A brief description of each of these elements is listed as follows:

1. Accurate and complete. For accurate documentation, all pertinent information must be provided in both the narrative and check-box sections of the report. Completing all areas of the report (even if a section was unused) demonstrates a precise and

comprehensive document. The paramedic should ensure that medical terms, abbreviations, acronyms are properly used and correctly spelled. (See Appendices A-14 in Manitoba Health Emergency Treatment Guidelines for abbreviations)

2. Legible. Legibility means that others can read handwriting, especially in the narrative portion of the report, without difficulty. Check-box markings should be clear and consistent from the top page of the report to all underlying pages.

3. Timely. Ideally, documentation should be completed immediately after the patient interaction. Delays in recording can result in serious omissions and may be interpreted as negligence.

4. Unaltered. If errors are made while writing the report, the paramedic should draw a single line through the error, and date and initial it. Any alterations to a completed report should be accompanied by an appropriate “revision/correction” supplement with the date and time of revision.

5. Free of nonprofessional/extraneous information. The PCR must be free of jargon, slang, personal bias, libelous or slanderous remarks, and irrelevant opinion or impression.

Systems of Narrative Writing

As with all other aspects of emergency care, the paramedic should develop a systematic approach for writing the narrative portion of the patient care report. Many approaches for writing the narrative can be used; however, the paramedic should adopt only one approach and use it consistently to avoid omissions in report writing. Examples of systems that are used to write the narrative include the SOAP method; SAMPLE history; a physical approach from head to toe; a review of primary body systems; a chronological, call incident approach; a patient management approach; and others. Regardless of the system used to organize the narrative, the paramedic must ensure that objective (versus subjective) elements of documentation comprise the report.

Special Considerations Regarding Patient Refusal

(Manitoba Health Emergency Treatment Guideline G14)

The non-transport of patients because of refusal of care is a common occurrence in prehospital care. The EMS personnel must attempt to obtain as thorough a history and patient assessments as possible so that the patient who refuses medical evaluation and treatment has an opportunity to make an informed decision on refusing care. Careful documentation is required whenever care is refused.

While patients have the right to refuse medical evaluation and treatment, it is incumbent on the EMS personnel to first attempt to ensure the following:

- The patient must be oriented to person, place, and time.
- There are no signs of significant impairment due to alcohol, drugs, or mental or organic illness.
- Vital signs must be normal.

- Patient must have a reasonable understanding of the provisional diagnosis and the risks of refusing treatment.

EMS personnel must take care to ensure that the instructions given to the patient and the family member or friend present who is willing to assume responsibility for the patient's care are clearly understood. This information must include:

- A reasonable plan of action should the patient's condition deteriorate.
- How to activate the EMS system if the patient wishes to seek medical evaluation and transport.

The patient should be encouraged to seek medical follow-up.

The following information must be documented on the patient care report:

- Date, time, and location where patient is found.
- Presenting complaint.
- History and physical examination, including vital signs.
- Mental status examination.
- Patient not under influence of alcohol, drugs, other substances, or injuries that may impair ability to make decisions.
- Patient is clearly not a risk to self or others.
- Reason(s) for refusal.
- Consequences of refusal of care reviewed with the patient.
- Information on how to contact EMS if patient changes mind about seeking medical care and transport.
- Other advise given to the patient.
- Identification of police on scene (if applicable).
- Name of family member or other adult present as witnesses.
- Record of name of person(s) present with patient at disposition.
- A copy of the refusal of care must be completed on the patient care report.

If the patient does not meet the above criteria and subsequent to the EMS personnel's evaluation and assessment of the patient that, in the EMS personnel's judgment, the patient should receive medical assessment, then the following actions should be considered:

- Responsible family members or friends who are present should be enlisted to encourage the patient to accept transportation.
- If this fails, the Regional EMS Medical Director or physician designate should be contacted to discuss the situation.
- If required, direct communication between the physician and the patient could be conducted to ensure the patient clearly understands the consequences of their decision to refuse care and to assist in convincing the patient to accept transport for medical assessment.

If these measures fail and the EMS personnel have concerns about the patient's capacity to decide and ability to make an informed decision to refuse care and transport, the police should be contacted for assistance.

If a decision is made that a patient requires medical assessment and is unable to make an informed decision, and the patient must be transported against their wishes, then EMS personnel should request that the police restrain the patient. **Restraining a patient is not an EMS function.**

Procedure for Restraining a Patient

- Explain restraining actions to the patient, family, and others at the scene.
- Use all reasonable precautions to safeguard the welfare of the patient and others.
- Apply only reasonable therapeutic force.
- Ensure the patient is not injured in the restraining process or by the restraints.
- Ensure the airway is maintained.
- Position the patient in the recovery position, if possible.
- Documents the indication(s) for restraint and action(s) taken.
- Record serial examinations at regular, frequent intervals while the patient is restrained.
- Police assisting in patient restraint must accompany the patient in the ambulance in case the restraints need to be removed.

A number of patients must be transported even if they meet all the criteria for discharge in the field, including:

- Patients who are a danger to themselves or others.
- The decision to transport is done in consultation with the police.
- Victims of child abuse if there is the potential for further abuse.
- Patients who are critically ill or injured.
- Critically ill patients may have an advance directive expressing a wish not to be treated or transported. EMS personnel may refer to Do Not Resuscitate Protocol or Medico legal Guideline for further information.
- Required information for documentation on the patient care report is the same as mentioned earlier.

Additional Points:

- In all but the most minor situations, the patient should be encouraged to accept transportation for medical evaluation.
- If there are any doubts regarding transportation, then EMS personnel should err on the side of caution and safety and undertake transport of the patient, if possible.
- Patients who are not transported should always be advised to seek further medical attention as indicated by their circumstances or to call for EMS if they wish transportation at a later time.

- If the patient initially refuses transport but later changes their mind and requests transport, the EMS personnel cannot refuse to transport the patient.
- EMS personnel must not attempt to dissuade the patient from transport.
- Whenever possible, EMS personnel should attempt to obtain a signature from the patient, the patient's care giver, the patient's proxy or responsible family member confirming refusal of care.
- All patients who refuse care must sign a completed refusal of care form.
- EMS personnel must recognize that the form does not absolve them of the EMS system of medico legal responsibility.
- A person is determined to have the capacity to make health care decisions if he or she is able to understand the information that is relevant to making a decision and is able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.
- EMS personnel should follow the information laid out in a Health Care Directive or information that is provided by the patient's proxy regarding instructions contained within the patient's Health Care Directive. There is no onus on the EMS personnel to inquire whether a Health Care Directive exists or whether the Directive has been revoked.
- Obtaining the reason for refusal may be useful for the EMS personnel in order to persuade the patient to be transported.
- EMS personnel may be required to use creativity and compromise to persuade patients to cooperate with further evaluation, management, and transportation.
- There may be reluctance on the part of EMS personnel to contact the police to assist in the transport of a patient.
- The risk of legal action against EMS personnel for unlawful confinement or battery must be balanced against the risk of malpractice and fundamental needs of a patient who is unable to make an informed decision.
- Despite all efforts to remain at a safe distance or to avoid becoming involved in a violent situation, there may be times when EMS personnel find themselves confronted by a violent non-competent patient while attending the patient.
 - If necessary EMS personnel should leave the scene until the police arrive.
 - If they cannot leave the scene then protective actions should be taken.
 - To protect themselves, the patient's family, friends, and the patient from harm it may be necessary for EMS personnel to temporarily physically restrain the patient.
- Though restraint of a non-competent patient is normally a police function, the police may be delayed or not immediately available to undertake the immediate restraint of a suddenly violent patient.
 - EMS personnel should use only the minimum amount of physical restraint required to prevent injury to all involved.

Communication Systems

EMS personnel must be able to determine a chief complaint, obtain a medical history, and properly reassure and comfort the patient. You must also be able to update incoming EMS units on your patient's status, request help from dispatch, ask the medical director for advice, and provide a hand-off report to the personnel taking over patient care. All these tasks take skill, including communication skills.

You will have opportunities to communicate with other EMS personnel on the radio, or phone, as well as in person. In these situations, it is important for you to be accurate and to speak slowly and clearly. Providing inaccurate information, omitting key information, or speaking in any way other than clearly could result in harm to your patient.

Radio Communication

Radios operate on frequencies that are regulated and licensed by Industry Canada's Spectrum Management. Spectrum Management makes sure that unauthorized persons do not disrupt emergency radio traffic.

There are many components to a radio system. They usually include the following:

- A base station. This is a stationary radio located in a dispatch centre, station, or hospital.
- Mobile radios. These are radios mounted in vehicles.
- Portable radios. These are hand-held radios, which may be carried on your belt or elsewhere on your person.
- Repeaters. These devices receive a low-power radio transmission and rebroadcast it with increased power.
- Cellular phones. These phones may be used to contact the medical director or the dispatcher. They are often used where radio coverage is not available.

If your EMS system has a dispatch centre and radios, you may be required to advise the dispatcher of your activities during an emergency call. You may be required to report when you:

- Are en route to a call;
- Arrive at the scene of a call;
- Require additional assistance or specialized personnel; and
- Return to service and are available for the next call.



You will also use the radio when you update incoming EMS units or need to speak with the medical director.

Using a radio can cause some anxiety, especially the first few times. It is important to remember to speak slowly and clearly. Push the “push to talk” button one second before you begin to speak. Talk with your mouth five to seven centimeters away from the microphone. It is best to keep a transmission brief to allow others to use the frequency. Listen before you transmit so that you do not disrupt another conversation.

Remember that people with scanners can hear what you say over the radio. Never use a patient’s name or say anything over the radio of a personal or confidential nature. Of course, you should never use profanities or speak in a less than professional tone of voice.

Effective Verbal Communication Techniques

Communications is the basic element of human interaction. It refers to nonverbal and verbal behavior and includes all symbols and clues used by persons when giving and receiving meaning. The process of communications incorporates several elements. EMS personnel must be conscious and aware of each element to interact effectively with a patient. Each element is crucial, and information and meaning can be gained or lost if any one of the elements is altered.

Effective verbal communication techniques include the following:

1. Use fewer words to avoid confusion.
2. Use words that express an idea simply.
3. Avoid vague phrases.
4. Use examples (including demonstrations) if the message will be easier to understand.
5. Repeat important parts of a message.
6. Avoid technical jargon.
7. Use an appropriate speed or pace; avoid long pauses or rapid shifts to another subject.



Medical Direction and Control

Each EMS system has a medical director who authorizes the EMS personnel in the service to provide medical care in the field. The appropriate care for each injury, condition, or illness that you will encounter in the field is determined by the medical director and is described in either the Manitoba Health Emergency Treatment Guidelines or protocols. Standing orders are known as indirect medical direction. All EMS personnel must know and follow the protocols prescribed by his or her medical director.

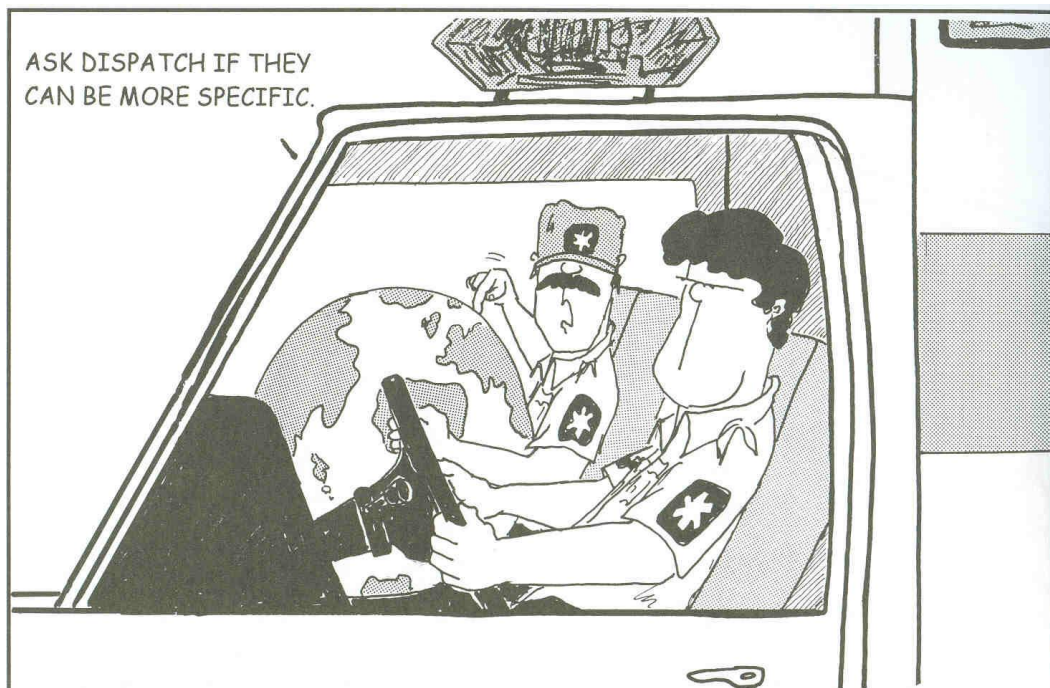
Consulting with a physician while you are on the scene can help you and your patient. On-line (direct) medical direction should be accessed whenever you have questions about a patient that cannot be resolved by protocols.

Since the physician may be many miles away, it is up to you to present information clearly and concisely. Be prepared to give a report that includes the following:

- Your name and unit identifier and your education or licensing level.
- Patient's age, gender and chief complaint.
- Brief, pertinent history of the events leading to the injury or illness.
- Results of the patient's physical exam, including vital signs.
- Care given to the patient and the patient's response to that care.
- The reason for calling.

If the physician gives you orders, repeat the orders back to verify them. Be sure all orders and advice given to you by the physician are clear. If you have any questions, ask the physician for clarification.

Dispatch Systems



There are two general systems by which the public can access the EMS system: 9-1-1 and non-9-1-1. Often called the “universal number,” 9-1-1 is used in many areas to access police, fire, rescue, and ambulance services. Generally, calls are received at a public safety answering point (PSAP). There, a dispatcher decides which service is to be activated and alerts that service.

There are two main benefits of a universal number. First, the PSAP is generally staffed by trained technicians. They may offer medical advice over the phone while the patient waits for rescuers to arrive. This is referred to as “emergency medical dispatching.” The second benefit of a universal number is that it minimizes delay. Callers do not have to look up a number, and it is easy enough to be remembered by even the youngest caller.

With enhanced 9-1-1, or E-9-1-1, the EMS dispatcher is able to see the street address and phone number of the caller on a computer screen. This is valuable when a patient becomes unconscious before giving the address.

In areas not served by 9-1-1, callers either call a dispatch centre or the specific service they need (police, fire, etc.). Probably the most serious drawback of a non-9-1-1 system is the delay in reaching the appropriate services.

Verbal Report of Patient Information

EMS is the first step in what is often a long and involved series of treatment phases. Effective communication between the EMS personnel and health care professionals in the

receiving facility is an essential cornerstone of efficient, effective, and appropriate patient care.

Your reporting responsibilities do not end when you arrive at the hospital. In fact, they have just begun. The transfer of care officially occurs during your oral report at the hospital, not as a result of your radio report en route. Once you arrive at the hospital, a hospital staff member will take responsibility of the patient from you. Depending on the hospital and the condition of the patient, the training of the person who takes over the care of the patient varies. However, you may transfer the care of your patient only to someone with at least your level of training. Once a hospital staff member is ready to take responsibility for the patient, you must provide that person with a formal oral report of the patient's condition.

Giving a report is a longstanding and well-documented part of transferring the patient's care from one provider to another. Your oral report is usually given at the same time that the staff member is doing something for the patient. For example, a nurse or physician may be looking at the patient, beginning assessment, or helping you to move the patient from the stretcher to an examination table. Therefore, you must report important information in a complete, precise way. The following six components must be included in the oral report:

1. The patient's name (if you know it) and the chief complaint, nature of illness, or mechanism of injury. Example: "This is Mr. Campbell. His wife told us that he has been acting confused all day."
2. A summary of the information that you gave in your radio report. Example: "He has a history of high blood pressure and had a stroke 4 years ago. He has little permanent damage from the stroke. His wife states that he is usually alert and oriented."
3. Any important history that was not given already. Example: "His wife told us that he takes his medicine regularly. On the way in, she told us that Mr. Campbell's medicine was just changed 2 days ago."
4. The patient's response to treatment given en route. It is especially important to report any changes in the patient or the treatment provided since your radio report. Example: "We started oxygen by face mask at 10 L/min. His LOC improved, and he started to fight the mask. We were able to get him to hold the mask next to his mouth and nose for the rest of the trip."
5. The vital signs assessed during transport and after the radio report. Example: "His vitals during transport were blood pressure 184 over 110, pulse 96, ventilations 22. They are generally unchanged since we reported earlier."
6. Any other information that you may have gathered that was not important enough to report sooner. Information that was gathered during transport, any patient medications you have brought with you, and any other details about the patient that was provided by family members or friends may be included. Example: "Mrs. Jones's husband rode in with us. Her daughter is coming from home and should be here soon."

Communication Considerations

Communicating with Patients and Their Families



Your communication skills will be tested when you communicate with patients and/or families. Remember that someone who is sick or injured is scared and might not understand what you are doing and saying. Therefore, your gestures, body movements, and attitude toward the patient are critically important in gaining the trust of both patient and family. These Ten Golden Rules will help you to calm and reassure your patients:

1. **Make and keep eye contact** with your patient at all times. Give the patient your undivided attention. This will let the patient know that he or she is your top priority. Look the patient straight in the eye to establish rapport. Establishing rapport is building a trusting relationship with your patient. This will make the job of caring for the patient much easier for both you and the patient.
2. **Use the patient's proper name** when you know it. Ask the patient what he or she wishes to be called. Do not use terms such as "Pops," "Lady," "Kid," or "Dear." Avoid using a patient's first name unless the patient is a child or the patient asks you to use his or her first name. Rather, use a courtesy title, such as "Mr. Peters," "Mrs. Smith," or "Ms."
3. **Tell the patient the truth.** Even if you have to say something very unpleasant, telling the truth is better than lying. Lying will destroy the patient's trust in you and decrease your own confidence. You might not always tell the patient

- everything, but if the patient or a family member asks a specific question, you should answer truthfully. A direct question deserves a direct answer. If you do not know the answer to the patient's question, say so. For example, a patient may ask, "Am I having a heart attack?" "I don't know" is an adequate answer.
4. **Use language that the patient can understand.** Do not talk up or down to the patient in any way. Avoid technical medical terms that the patient might not understand. For example, ask the patient whether he or she has a history of "heart problems." This will usually result in more accurate information than if you ask about "previous episodes of myocardial infarction" or a "history of cardiomyopathy."
 5. **Be careful of what you say** about the patient to others. A patient might hear only part of what is said. As a result, the patient might seriously misinterpret (and remember for a long time) what was said. Therefore assume that the patient can hear every word you say even if you are speaking to others and even if the patient appears to be unconscious or unresponsive.
 6. **Be aware of your body language.** Nonverbal communication is extremely important in dealing with patients. In stressful situation, patients may misinterpret your gestures and movements. Be particularly careful not to appear threatening. Instead, position yourself at the lower level that the patient when practical. Remember that you should always, always conduct yourself in a calm, professional manner.
 7. **Always speak slowly, clearly and distinctly.**
 8. **If the patient is hearing impaired, speak clearly,** and face the person so that he or she can read you lips. Do not shout at a person who is hearing impaired. Shouting will not make it any easier for the patient to understand you. Instead, it may frighten the patient and make it even more difficult for the patient to understand you. Never assume that an elderly patient is hearing impaired or otherwise unable to understand you. Also, never use baby talk with elderly patients or with anyone but babies.
 9. **Allow time for the patient to answer or respond to your questions.** Do not rush a patient unless there is immediate danger. Sick and injured people may not be thinking clearly and may need time to answer even simple question. This is especially true in treating elderly patients.
 10. **Act and speak in a calm confident manner while caring for the patient.** Make sure that you attend to the patient's pains and needs. Try to make the patient physically comfortable and relaxed. Find out whether the patient is more comfortable sitting or lying down. Is the patient cold or hot? Does the patient want a friend or relative nearby?

Communicating with Elderly Patients

A person's actual age might not be the most important factor in making him or her "elderly." It is more important to determine a person's functional age. The functional age relates to the person's ability to function in daily activities, the person's mental state, and activity pattern.

Most elderly people think clearly, can give you a clear medical history, and can answer your questions. Do not assume that an elderly patient is senile or confused. Remember, though, that communicating with some elderly patients is extremely difficult. Some may be hostile, irritable, and/or confused. Others may have difficulty hearing or seeing you. You need great patience and compassion when you are called upon to care for such a patient. Think of the patient as someone's grandmother or grandfather-or even as yourself when you reach that age.

Approach an elderly patient slowly and calmly. Allow plenty of time for the patient to respond to your questions. Watch for signs of confusion, anxiety, or impaired hearing or vision. The patient should feel confident that you are in charge and that everything possible is being done for him or her.

Elderly patients often do not feel much pain. An elderly person who has fallen or been injured may report no pain. In addition, elderly patients might not be fully aware of important changes in other body systems. As a result, be especially vigilant for objective changes-no matter how subtle-in their condition. Even minor changes in breathing or mental state may signal major problems.

Remember to attend to an elderly patient's family members and friends. Seeing a loved one taken away in an ambulance can be a particularly frightening experience. Take a few minutes to explain to an elderly patient's spouse or family what is being done and why such action is being taken. When possible (which is more often than you'd think), give the patient some time to pack a few personal items before leaving for the hospital. Be sure to get any hearing aids, glasses, or dentures packed before departure; it will make the patient's hospital stay much more pleasant. You might want to document on the pre-hospital care report that these items accompanied the patient to the hospital and were given to a specific staff person in the emergency department.

Communicating with Children

Everyone who is thrust into an emergency situation becomes frightened to some degree. However, fear is probably most severe and most obvious in children. Your uniform, the ambulance, and the number of people who have suddenly gathered around may frighten children. Even a child who says little may be very much aware of all that is going on.

Familiar objects and faces will help to reduce this fright. Let a child keep a favorite toy, doll, or security blanket to give the child some sense of control and comfort. Having a family member or friend nearby is also helpful. When not contraindicated by the child's condition, it is often helpful to let the parent or an adult friend hold the child during your evaluation and treatment. However, you will have to make sure that this person will not upset the child. Sometimes, adult family members are not helpful because they become too upset by what has happened. An overly anxious parent or relative can make things worse. Be careful about selecting the proper adult for this role.

Children can easily see through lies or deceptions, so you must always be honest with them. Make sure that you explain to the child over and over again what and why certain things are happening. If treatment is going to hurt, such as applying a splint, tell the child ahead of time. Also tell the child that it will not hurt for long and that it will help "make it better."

Respect a child's modesty. Both little girls and little boys are often embarrassed if they have to undress or be undressed in front of strangers. This phobia further intensifies during adolescence. When a wound or site of injury has to be exposed, try to do so out of sight of strangers. Again, it is extremely important to tell the child what you are doing and why you are doing it.

You should speak to a child in a professional yet friendly way. A child should feel reassured that you are there to help in every way possible. Maintain eye contact with a child, as you would with an adult, to let the child know that you are helping and that you can be trusted. It is helpful to position yourself at their level so that you do not appear to tower above them.

Communicating with Hearing Impaired Patients

Patients who are hearing impaired or deaf are usually not ashamed or embarrassed by their disability. Often, it is the people around a deaf or hearing-impaired person who have the problem coping. Remember that you must be able to communicate with hearing-impaired patients so that you can provide necessary or even lifesaving care.

First, you should always assume that hearing impaired patients have normal intelligence. These patients can usually understand what is going on around them;-provided that you can successfully communicate with them. Second, most patients who are hearing impaired can read lips to some extent. Therefore, you should place yourself in a position so that the patient can see your lips. Third, many hearing impaired patients have hearing aids that may have been lost in an accident or fall. Hearing aids may also be forgotten if the patient is confused or ill. Look around, or ask the patient or the family about a hearing aid.

Remember the following five steps to help you efficiently communicate with patients who are hearing impaired:

- Have paper and a pen available. This way, you can write down questions and the patient can write down answers if necessary. Be sure to print so that your handwriting is not a communications barrier.
- If the patient can read lips, you should face the patient and speak slowly and distinctly. Do not cover your mouth or mumble. If it is night or dark, consider shining a light on your face.
- Never shout!
- Be sure to listen carefully, ask short questions, and give short answers. Remember that although many hearing-impaired patients can speak distinctly, some cannot.
- Learn some simple phrases in sign language. For example, knowing the signs for "sick," "hurt," and "help" may be useful if you cannot communicate in any other way.

Communicating with Visually Impaired Patients

Like hearing-impaired patients, visually impaired and blind patients have usually accepted and learned to deal with their disability.. Of course, not all visually impaired patients are completely blind. Many can perceive light and dark or can see shadows or movement. Ask the patient whether he or she can see at all. Also remember that, as with other patients who have disabilities, you should expect that visually impaired patients have normal intelligence.

As you begin caring for a visually impaired patient, explain everything that you are doing in detail as you are doing it. Be sure to stay in physical contact with the patient as you begin your care. Hold your hand lightly on the patient's shoulder or arm. Try to avoid sudden movements. If the patient can walk to the ambulance, place his or her hand on your arm, taking care not to rush. Transport any mobility aids, such as a cane, with the patient to the hospital. A visually impaired person may have a guide dog. Their special harnesses easily identify guide dogs. They are trained not to leave their masters and not to respond to strangers. A visually impaired patient who is conscious can tell you about the dog and give instructions for its care, if circumstances permit, bring the guide dog to the hospital with the patient. If the dog has to be left behind, you should arrange for its care.

Communicating with Non-English-Speaking Patients

As part of the focused physical exam, you must obtain a medical history from the patient. You cannot skip this step simply because the patient does not speak English. Most patients who do not speak English fluently will still know certain important words or phrases.

Your first step is to find out how much English the patient can speak. Use short, simple questions and simple words whenever possible. Avoid difficult medical terms. You can

help patients to better understand if you point to specific parts of the body as you ask questions.

In many areas, particularly large urban centers, major segments of the population do not speak English. Your job will be much easier if you learn some common words and phrases in their language, especially common medical terms. Pocket cards are available that show the pronunciation of these terms. If the patient does not speak any English, find a family member or friend to act as an interpreter.

Communicating with the Mentally Challenged

Some patients with behavioral or psychiatric disorders are difficult to interview. For example, a patient may refuse to talk to the paramedic (especially if the family requested EMS assistance without the patient's consent), may be extremely talkative with disorganized speech, or may be confrontational. If a patient refuses to be interviewed, the paramedic should speak to the patient in a quiet voice, avoid questions that may be interpreted by the patient as an interrogation, and allow extra time for the patient to respond. Patients who are too talkative will need to be focused on the interview (by calling out their names, raising your hand to get their attention). A patient who is confrontational may sometimes require restraint.

Communicating with the Dying

It is uncomfortable to be in a situation involving death and dying, and communication with the patient and loved ones may be difficult. The following recommendations for communications and activities may help a paramedic deal with dying patients and their families:

- Answer questions honestly for the patient and family, and explain all activities.
- Do not initiate the subject of dying; let it come from the patient or family.
- If the patient or family asks you if the patient is going to die, advise that you are doing everything you possibly can but that the situation is critical. This allows a brief time for the patient and family to prepare themselves.
- Do not falsely reassure the patient or family (everything's going to be okay).
- Use compassionate, nonverbal communication (facial expression, touching).
- Offer to contact someone if the patient is alone.
- If family is not present, assure the patient that emergency department personnel will notify them. If they are nearby, encourage the family to come to the patient immediately or to meet the patient at the emergency department.
- Allow the family to stay with the patient when appropriate.

Cultural Differences and Special Considerations

When communicating with a patient from another culture, the paramedic should make a personal introduction and ask the patient to do the same. The paramedic must be aware that he or she may be viewed as a cultural stereotype to the patient and family.

Personal space is culturally defined and varies by individual. Other considerations for communicating with these patients include the following:

- Some cultures expect health care workers to have all the answers to their illness.
- Different cultures accept illness or injury in different ways.
- Nonverbal communications (handshaking and touching) may be perceived differently in different cultures.
- Asian, Native Americans, Indochinese, and Arabs may consider direct eye contact impolite or aggressive; they may avert their eyes during an interview.
- The paramedic should refrain from using touch as nonverbal communications between members of different culture groups because of the ease of unintended miscommunications.
- Language barriers may present communications difficulties.

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