



SHORT NOTES | QUICK REVISION

BP103T

Healthcare Psychology and Communication Skills

UNIT IV

Professional Communication in Healthcare Settings

— • SBAR — Structured Handoff Communication • —

S	 Situation	What is happening right now? <i>"Mrs Sharma is in Bed 4 has developed a rash after her second dose."</i>
B	 Background	What is the clinical context? Relevant history, current medications, allergies
A	 Assessment	What do you think the problem is? Your clinical judgement of the situation
R	 Recommendation	What do you need from the listener? A specific action or decision requested



SBAR gives a shared, predictable structure so critical information is never lost between shifts, departments, or professions

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Unit IV: Professional Communication in Healthcare Settings

Moving from theory into professional practice, this unit addresses the real situations a pharmacist and healthcare professional face daily: coordinating with patients, families, and colleagues; delivering news that changes a person's life; navigating the legal boundaries of what can and cannot be shared; writing records that other professionals will rely on completely; and using the growing range of digital tools that now mediate much of healthcare communication.

1. Communication with Patients, Caregivers and Interdisciplinary Teams

1.1 Patient-Centred Communication in Professional Practice

Patient-centred communication places the patient's own values, preferences, and understanding at the centre of every interaction, rather than treating them as a passive recipient of instructions. In professional practice this means adapting explanations to the individual, inviting questions, and confirming understanding rather than assuming it.

- Introduce yourself and your role clearly at the start of every new interaction
- Match your language to the patient's health literacy level, not your own comfort with jargon
- Invite the patient to participate in decisions about their own care wherever possible
- Close every interaction by confirming the patient knows what happens next

Professional communication in a clinical setting differs from everyday personal conversation in several important ways, and new practitioners often need to consciously unlearn casual habits that do not transfer well to clinical practice.

Personal Communication	Professional Healthcare Communication
Assumes shared context and background	Explicitly confirms understanding rather than assuming it
Casual, unstructured turn-taking	Often follows a structure (e.g. SBAR, SOAP) for reliability
Emotional reactions freely expressed	Emotion is regulated and channelled constructively
Informal record, if any, of what was said	Formally documented, since the record has legal weight

Applied Insight

New graduates often find the shift to structured, documented communication uncomfortable at first, since it can feel less 'natural' than everyday conversation — but this structure exists precisely because casual habits that work fine between friends create real risk when the stakes involve a patient's health and a permanent legal record.

The Circle of Care Around a Patient

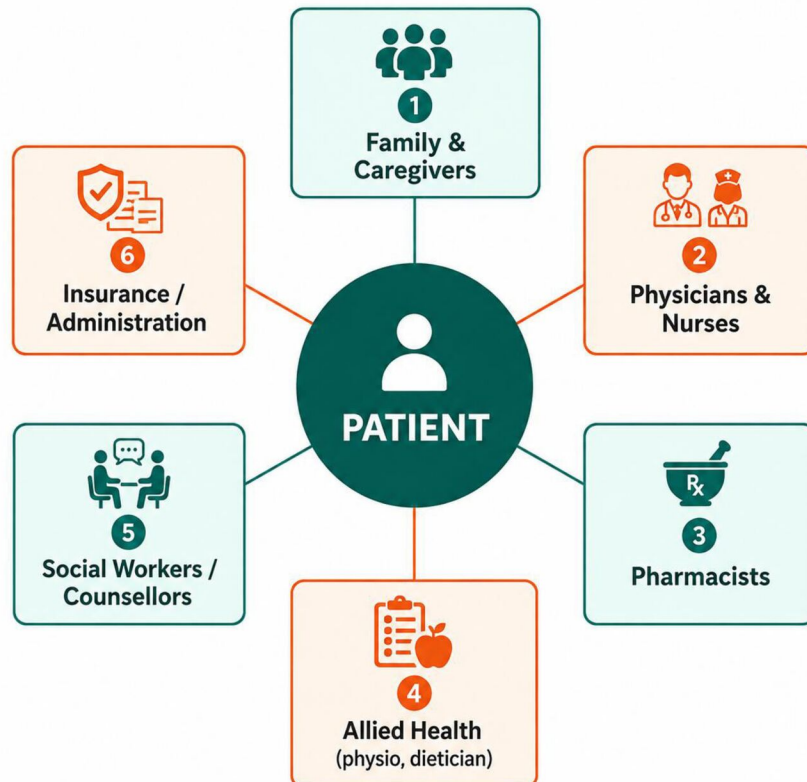


Fig 1.1 — The circle of care around a patient

As the diagram shows, a patient's care is rarely a single conversation with a single provider — it is a network of interconnected communication relationships, each of which affects the others. A message that is unclear between the physician and pharmacist, for example, eventually reaches the patient as confusion or a medication error. — Smart Notes, Bright Future —

Note

A community pharmacist notices that an elderly patient's new prescription conflicts with a medication already documented in her records from another clinic. Rather than simply dispensing or refusing, patient-centred practice means explaining the concern to the patient in plain language, contacting the prescriber to clarify, and looping back to the patient once resolved — treating her as an active participant in resolving the discrepancy rather than a bystander to a conversation happening around her.

1.2 Communicating with Caregivers and Family Members

Family members and informal caregivers are often the ones actually administering medication, monitoring symptoms, and making daily care decisions — particularly for paediatric, elderly, or cognitively impaired patients. Effective caregiver communication requires its own set of considerations distinct from patient communication.

- Clarify, with the patient's consent, who is authorised to receive information and make decisions
- Recognise caregiver burden — fatigue, stress, and emotional strain affect how well information is absorbed
- Provide written instructions the caregiver can reference later, not just verbal advice given once

- Balance the patient's autonomy with the caregiver's practical need for information, especially in shared-care situations

Pharmacist's Role

When a patient's capacity is intact, information should still be directed primarily to the patient, with the caregiver included as a support — defaulting to speaking only to the caregiver can unintentionally strip the patient of their own agency.

Caregiver burden itself is worth actively watching for, since a burnt-out caregiver becomes an unreliable link in the patient's care. Warning signs include missed appointments, visible exhaustion, irritability when questioned about the patient's care, and a caregiver who cannot answer basic questions about the current medication regimen — each of these is a cue to slow down, simplify instructions, and ask directly how the caregiver themselves is coping.

1.3 Interdisciplinary Team Communication — The SBAR Framework

When multiple professions — pharmacy, nursing, medicine, allied health — must exchange clinical information quickly and accurately, an unstructured conversation risks losing critical details. SBAR (Situation, Background, Assessment, Recommendation) is the most widely adopted structured communication tool for this purpose.

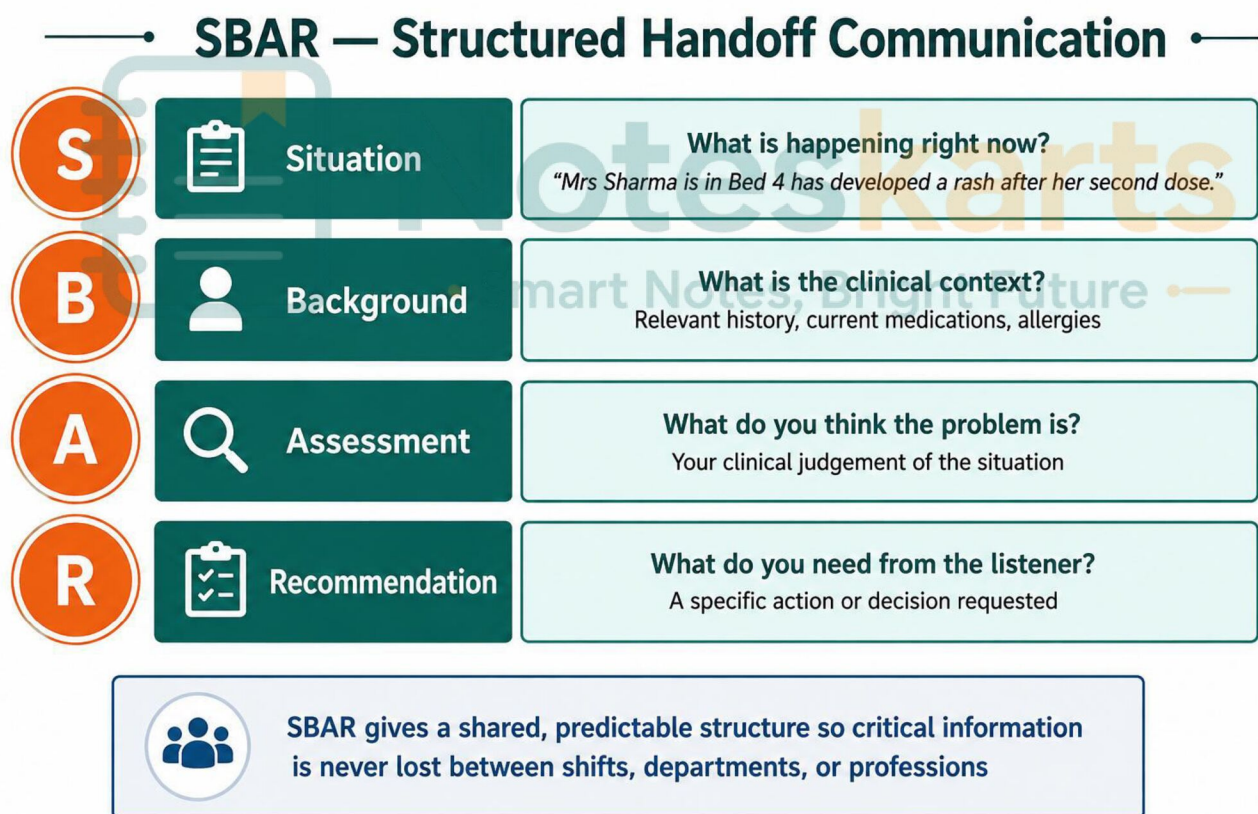


Fig 1.2 — The SBAR framework for structured handoff communication

SBAR is especially valuable because it forces the communicator to move beyond simply describing a situation to actually stating what they want the listener to do — a step often skipped in casual clinical conversation, leading to delayed or missed action.

SBAR Step	Worked Example — Pharmacist Calling a Physician
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Situation	"I'm calling about Mr Verma in Room 12 — his potassium came back at 6.1."
Background	"He's on lisinopril and spironolactone for heart failure, started three days ago."
Assessment	"I think this combination is causing hyperkalaemia and needs urgent attention."
Recommendation	"Could we hold the spironolactone and recheck potassium in 4 hours?"

A closely related discipline is closed-loop communication: the receiver repeats back critical instructions in their own words, and the original sender confirms the repetition is correct, before the action is taken. This 'read-back' step is standard practice for verbal orders (such as a phoned-in prescription change) precisely because a single mishearing at this stage can directly cause a medication error.

Exam Focus

Closed-loop communication has three steps: (1) sender gives the message, (2) receiver repeats it back, (3) sender confirms it is correct. Skipping the confirmation step is the most common — and most dangerous — shortcut taken under time pressure.

1.4 Handoff and Shift-Change Communication

A handoff is the transfer of patient care responsibility and information from one provider or shift to another. Handoffs are recognised as one of the highest-risk points for communication failure in healthcare, since incomplete or rushed handoffs can cause information to simply disappear from the patient's care record.

- Use a standard structure (such as SBAR) for every handoff, without exception
- Allow time for questions — a one-way report is not a completed handoff
- Highlight anything abnormal, pending, or time-sensitive explicitly, rather than assuming it will be noticed
- Where possible, conduct handoffs at the bedside so the patient can also confirm details

Handoff Type	Advantage	Risk
Verbal only	Fast; allows immediate questions	No permanent record; details easily forgotten
Written only	Permanent record; can be reviewed later	No opportunity to clarify ambiguity in real time
Verbal + Written	Combines a permanent record with real-time clarification	Takes longer; can be skipped under time pressure
Bedside handoff	Patient can confirm details directly; increases transparency	Requires patient to be alert and willing to participate

2. Delivering Difficult News and Handling Emotionally Charged Situations

2.1 The SPIKES Protocol for Breaking Bad News

Delivering difficult news — a serious diagnosis, treatment failure, or unexpected complication — is one of the most challenging communication tasks in healthcare. The SPIKES protocol, developed by Baile and colleagues, provides a widely-taught six-step structure that balances honesty with compassion.

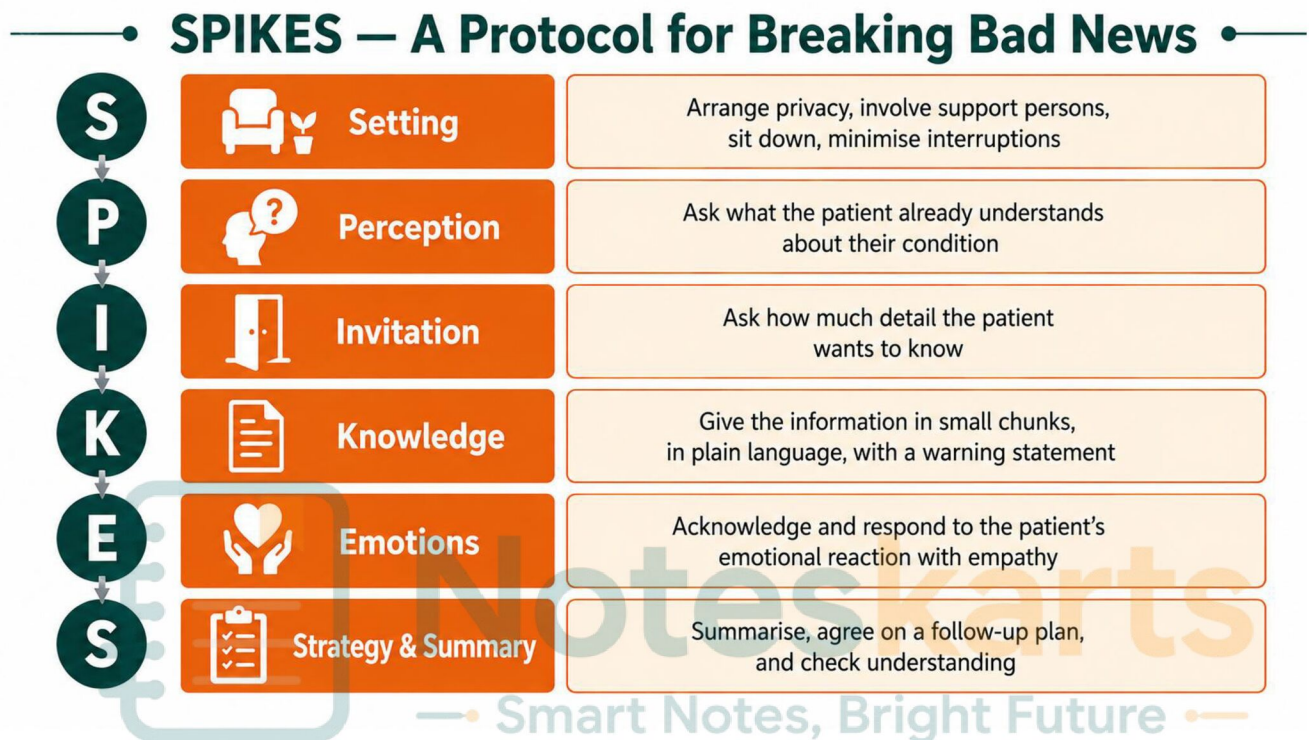


Fig 2.1 — The SPIKES protocol for breaking bad news

Exam Focus

SPIKES stands for Setting, Perception, Invitation, Knowledge, Emotions, and Strategy/Summary — the order matters, since assessing what the patient already knows (Perception) before delivering new information (Knowledge) prevents both over-explaining and under-explaining.

Note

A pharmacist reviewing a patient's recent lab results notices a dangerously abnormal value that the patient does not yet know about. Rather than blurting it out at the counter, applying SPIKES means arranging a private moment (Setting), asking what the patient already understands about their recent tests (Perception), asking if they want the details now or with family present (Invitation), explaining the finding in plain language with a brief warning statement first — "I'm afraid I have some concerning news" (Knowledge) — pausing to let the reaction happen (Emotions), and closing with a clear next step: contacting their physician immediately (Strategy).

A 'warning shot' — a brief statement that signals difficult news is coming, such as "I'm afraid the results aren't what we hoped for" — is a small but important technique within the Knowledge step. It gives the listener a moment to brace emotionally, which measurably improves how well they absorb the detailed information that follows.

2.2 Common Reactions to Difficult News

Patients and families react to difficult news in highly individual ways, and no single reaction is 'wrong.' Recognising common patterns helps a healthcare professional respond appropriately rather than being caught off guard.

Reaction	What It Looks Like	How to Respond
Shock/Numbness	Silence, flat affect, appearing to not react at all	Allow silence; do not rush to fill it with more information
Denial	Disbelief, requesting repeat tests, minimising severity	Avoid confrontation; gently repeat facts over time as needed
Anger	Raised voice, blaming, directed at staff or the situation	Stay calm; avoid taking it personally; validate the underlying pain
Bargaining	"What if we tried..." seeking alternative explanations	Listen without dismissing; redirect gently to the clinical reality
Grief/Sadness	Crying, withdrawal, expressions of loss	Offer presence and tissues; avoid minimising with false reassurance

2.3 De-escalating Anger and Conflict

Fear, pain, and loss of control can present as anger directed at healthcare staff. De-escalation is a skill that redirects this energy toward resolution rather than confrontation.

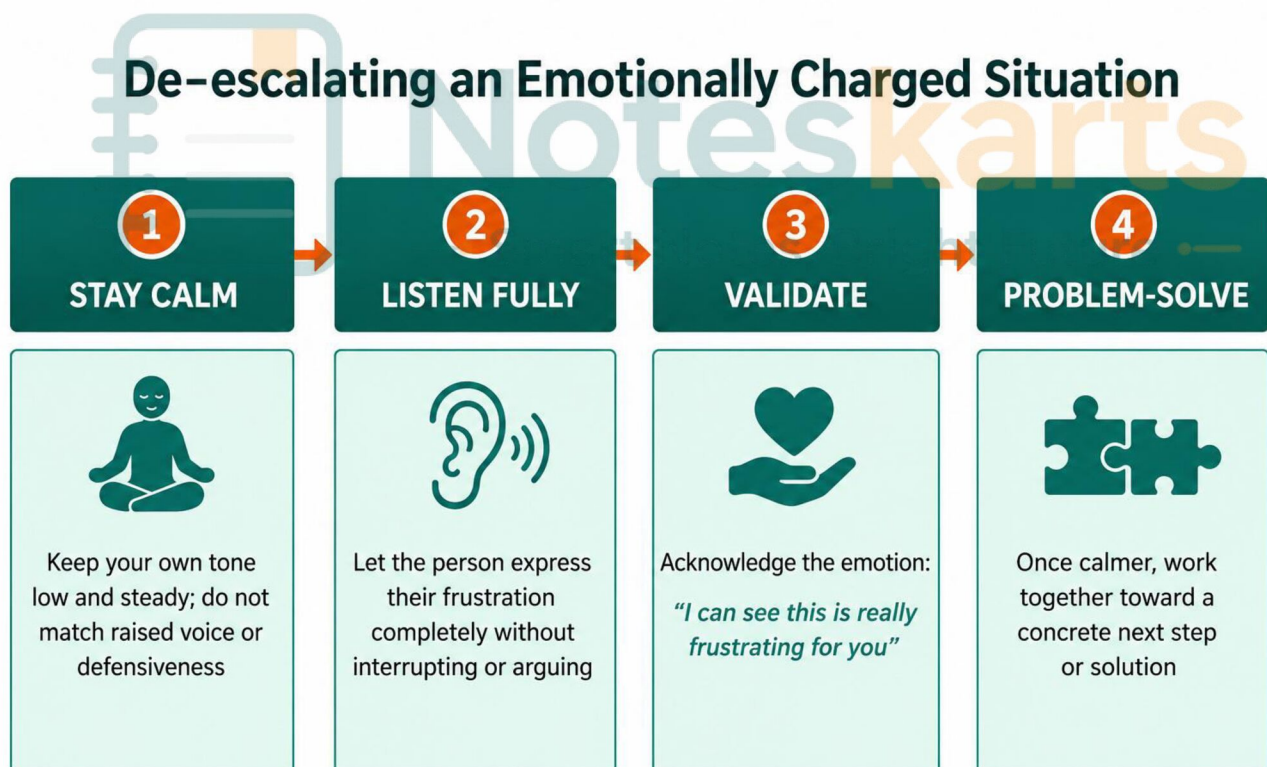


Fig 2.2 — A four-step approach to de-escalating an emotionally charged situation

- Maintain non-threatening body language — open posture, appropriate distance, hands visible
- Never argue back or match a raised voice, even when the anger feels unfair or misdirected

- If a situation feels physically unsafe, prioritise safety and involve security or a colleague rather than continuing alone

Do	Don't
Keep your voice low, slow, and steady	Raise your voice to be heard over theirs
Give the person space and time to vent	Interrupt or rush them to "calm down"
Use the person's name and make eye contact	Turn away or appear distracted
Acknowledge the emotion before the facts	Jump straight to defending the institution or yourself
Offer a concrete next step once calmer	Make promises you cannot actually keep

2.4 Self-Care for the Healthcare Communicator

Repeatedly delivering difficult news and absorbing patients' distress carries a real emotional cost, sometimes called compassion fatigue. Sustainable professional communication depends on healthcare workers also attending to their own wellbeing.

- Debrief with colleagues after emotionally difficult encounters rather than carrying the weight alone
- Recognise personal warning signs of burnout — exhaustion, cynicism, reduced empathy — early
- Use institutional support resources (peer support, counselling services) when available

Self-Care Technique	Why It Helps
Structured debriefing after hard cases	Processes the experience rather than suppressing it
Setting boundaries around after-hours contact	Protects recovery time and prevents chronic overload
Peer support groups within the profession	Normalises difficult reactions and reduces isolation
Regular physical activity and adequate sleep	Builds baseline resilience against cumulative stress

3. Legal and Ethical Issues in Health Communication

3.1 Confidentiality in Healthcare Communication

Confidentiality is the ethical and legal obligation to protect a patient's personal health information from unauthorised disclosure. It is foundational to trust — patients must be able to share sensitive information honestly, knowing it will not be shared without their permission.

- Discuss patient information only in private, appropriate settings — never in public areas, lifts, or within earshot of others
- Share information on a strict need-to-know basis, even among colleagues within the same institution
- Secure both physical records and digital systems against unauthorised access

In India, patient confidentiality is protected through professional codes of conduct (such as the Pharmacy Practice Regulations and Indian Medical Council guidelines) and increasingly through data

protection law, including the Digital Personal Data Protection Act, 2023, which governs how personal data — including health data — must be collected, stored, and used.

Legal/Regulatory Source	Relevance to Health Communication
Pharmacy Practice Regulations, 2015	Requires pharmacists to maintain patient confidentiality as a professional duty
Indian Medical Council (Professional Conduct) Regulations	Sets ethical standards for confidentiality and disclosure by physicians
Digital Personal Data Protection Act, 2023	Governs consent, collection, storage, and security of personal data, including health data
Information Technology Act, 2000	Covers penalties for unauthorised access or disclosure of electronic records

3.2 Exceptions to Confidentiality

Confidentiality is not absolute. Recognised exceptions exist where the duty to protect others or comply with the law outweighs the general duty of confidentiality.

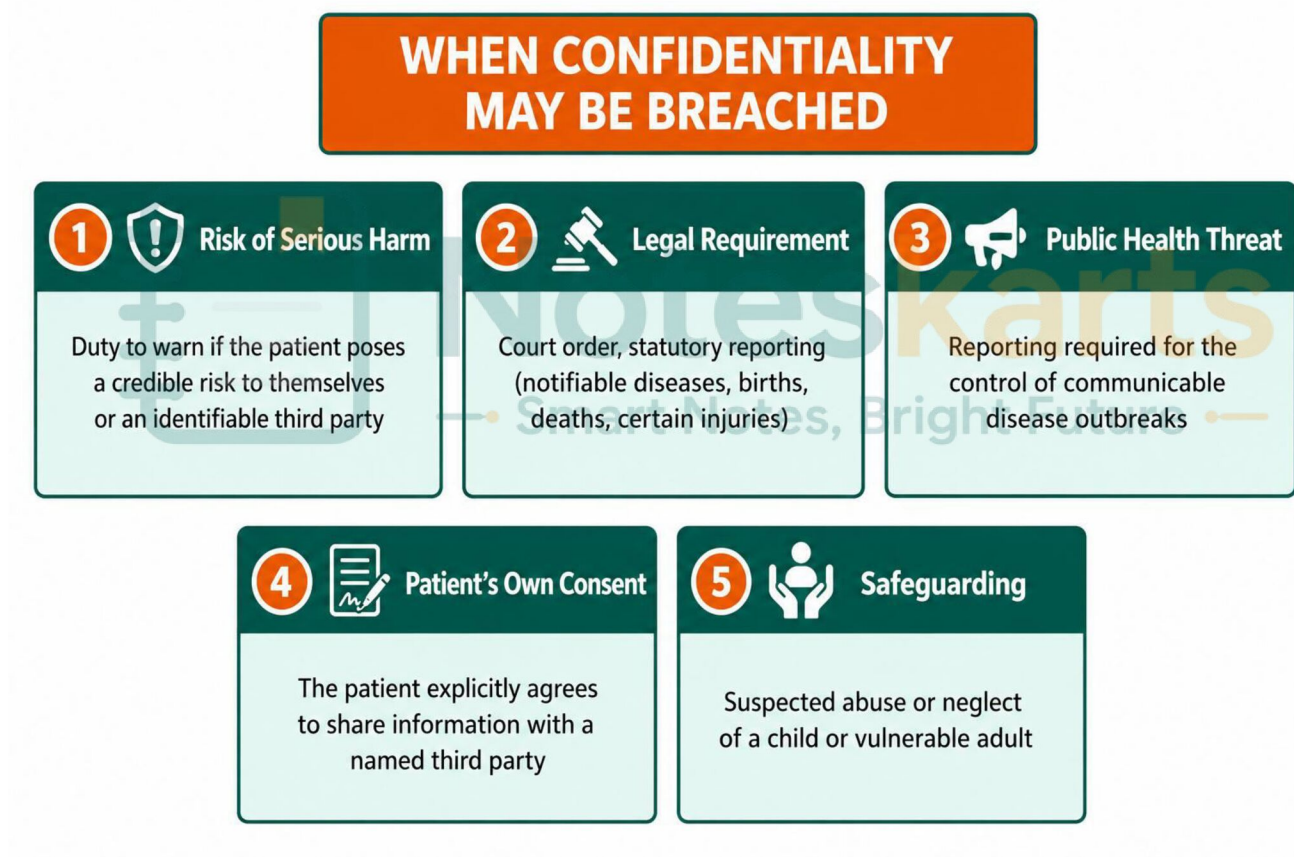


Fig 3.1 — Recognised exceptions to patient confidentiality

Applied Insight

Even when disclosure is justified, only the minimum necessary information should be shared, with the specific recipient who needs it — a duty to warn does not become a licence to discuss the patient's case broadly.

Note

A patient tells a pharmacist, in the course of a routine consultation, that they intend to stop taking their psychiatric medication and have expressed thoughts of harming a specific family member. This crosses from ordinary confidentiality into the 'risk of serious harm' exception — the pharmacist has a duty to escalate this promptly to the prescribing physician or appropriate emergency services, sharing only what is necessary to protect the people at risk.

3.3 Informed Consent — Elements and Types

Informed consent is the process by which a patient voluntarily agrees to a proposed treatment or intervention after understanding its nature, risks, benefits, and alternatives. It is both an ethical requirement and, in most cases, a legal one.

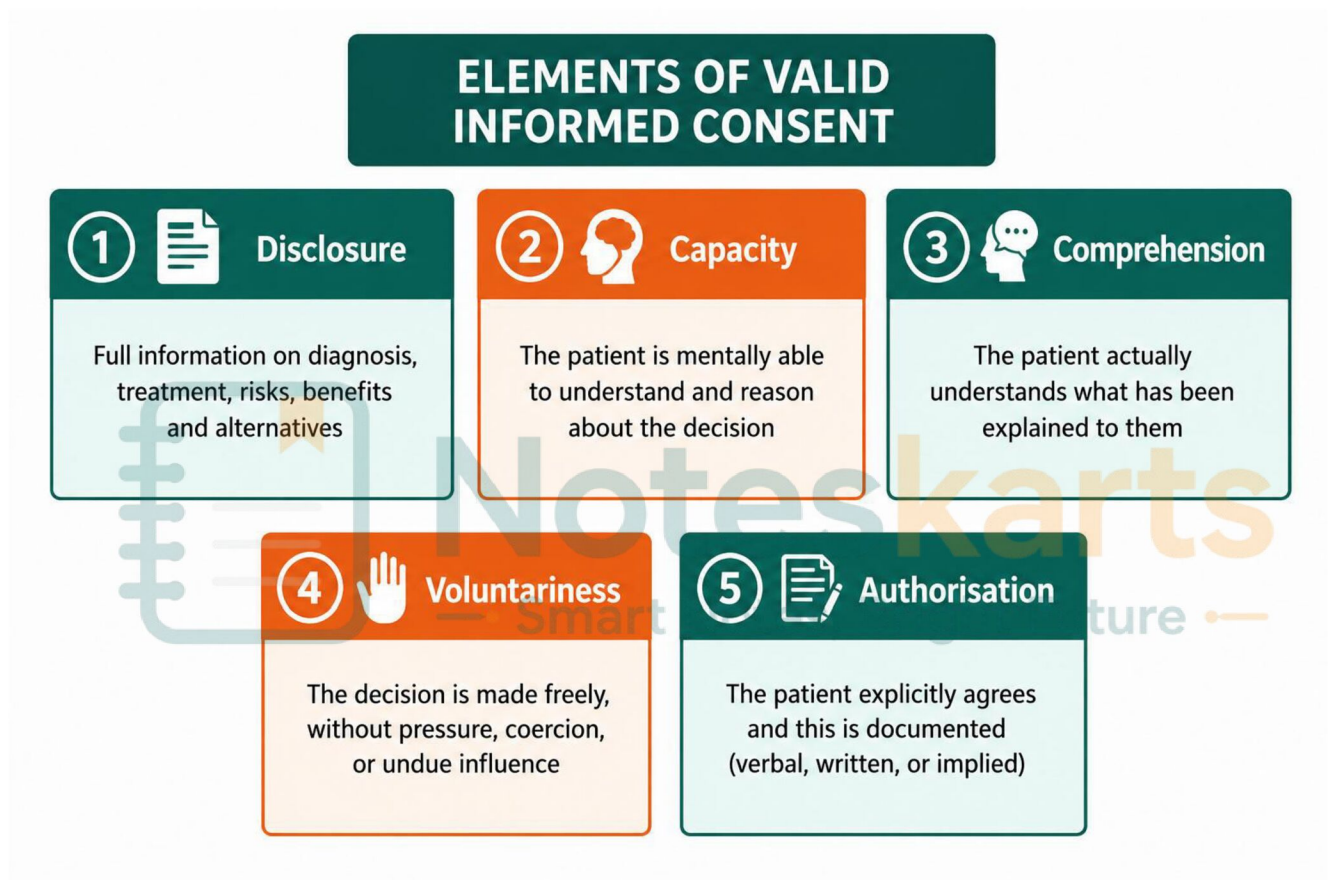


Fig 3.2 — The five elements of valid informed consent

Consent can take different forms depending on the situation, ranging from an action that implies agreement to a fully documented, detailed discussion.

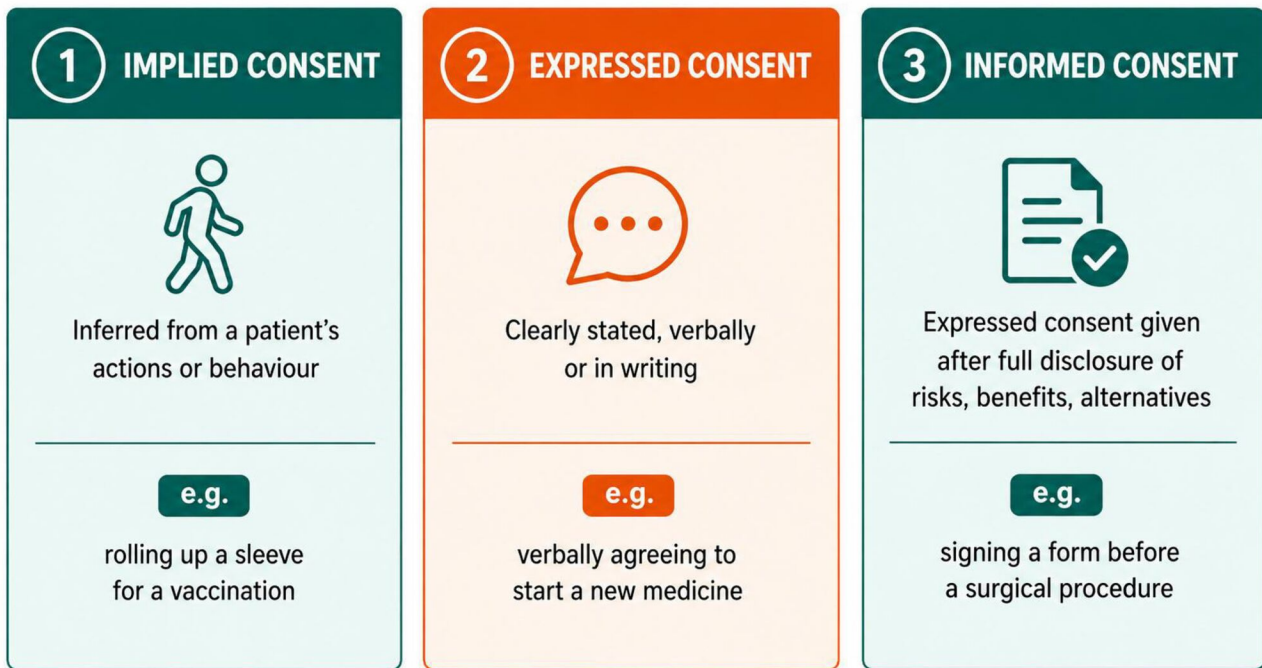


Fig 3.3 — Implied, expressed, and informed consent

Situation	Appropriate Consent Type
Routine vaccination after discussion	Expressed (verbal) consent
Starting a new long-term prescription medicine	Informed consent, ideally documented
Taking a patient's temperature or pulse	Implied consent
Surgical or invasive procedure	Written informed consent

3.4 Consent for Special Populations Smart Notes, Bright Future

- Minors: consent is generally obtained from a parent or legal guardian, though many settings also seek the child's own 'assent' (age-appropriate agreement) alongside guardian consent
- Emergency situations: where a patient cannot consent and delay would cause serious harm, treatment may proceed under the principle of implied emergency consent, with full disclosure given as soon as possible afterward
- Incapacitated adults: consent is sought from a legally authorised representative or next of kin, following applicable local guardianship provisions
- Patients with fluctuating capacity: consent should be sought during a lucid interval wherever possible, and capacity should be reassessed rather than assumed to be permanently absent

3.5 Documentation as Legal Protection

From a legal standpoint, an action or communication that is not documented is often treated as if it did not happen. Accurate, timely documentation protects both the patient and the healthcare professional by creating a reliable record of what was communicated, decided, and done.

- Document consent discussions, including what information was given and any questions the patient asked

- Record refusals of treatment or advice just as carefully as agreements, including the reasoning given
- Never alter a record retrospectively without a clearly dated, signed addendum explaining the correction

Common Documentation Error	Why It Matters
Vague language ("patient seems fine")	Provides no objective, reproducible information for the next reader
Late entries with no timestamp explanation	Undermines the credibility and legal reliability of the record
Copy-pasting previous notes without review	Perpetuates outdated or incorrect information forward in time
Using non-standard abbreviations	Risks misinterpretation by a different professional or institution

4. Writing Patient Records, Reports and Discharge Summaries

4.1 Principles of Good Clinical Documentation

Clinical records serve multiple audiences at once — the treating team today, other professionals who will read them later, and potentially legal or regulatory reviewers. Good documentation follows a consistent set of principles regardless of format.

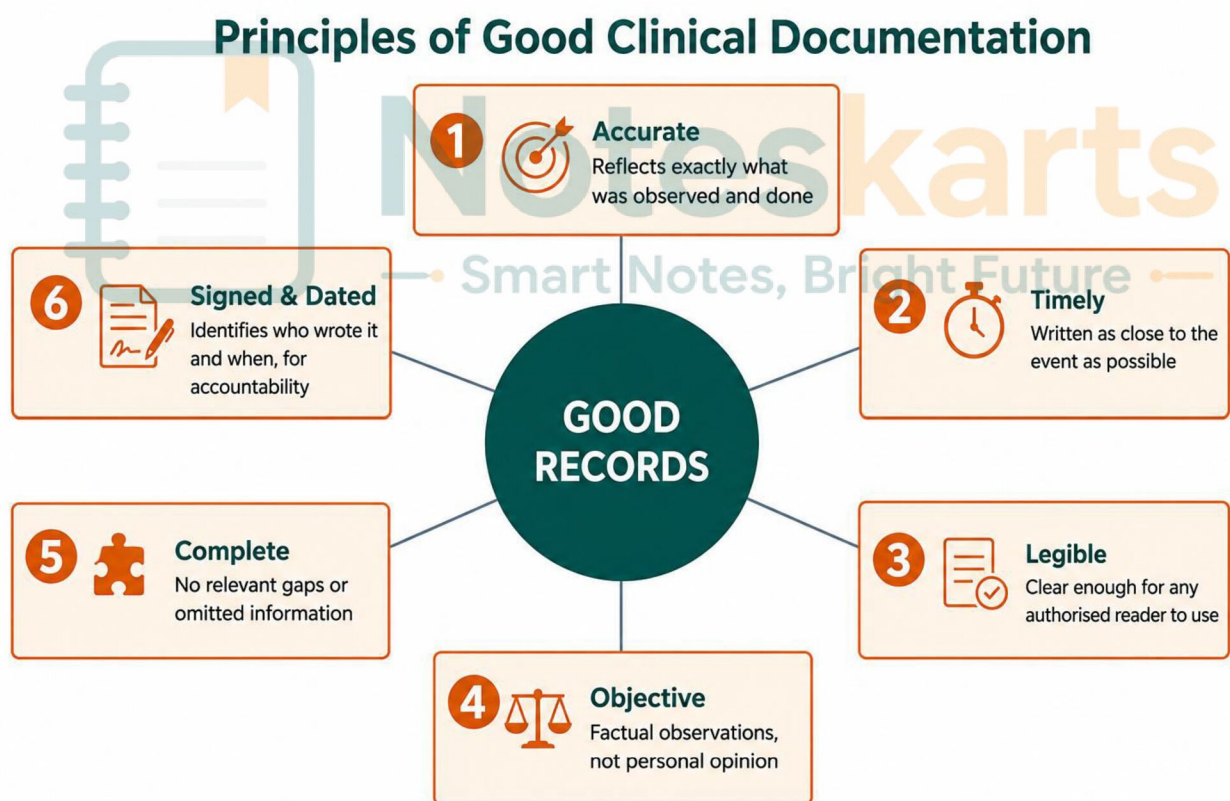


Fig 4.1 — Principles of good clinical documentation

Different types of clinical records serve different purposes within the same episode of care, and a pharmacist should recognise which type is appropriate to the situation.

Record Type	Purpose
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Progress note	Ongoing narrative of a patient's condition and care over time
Medication administration record	Timestamped record of every dose actually given
Incident report	Documents an error, near-miss, or adverse event for review and learning
Referral letter	Communicates relevant history and reason for referral to another provider

4.2 The SOAP Note Format

SOAP (Subjective, Objective, Assessment, Plan) is the most widely used structure for clinical progress notes across medicine, nursing, and pharmacy practice, because it separates what the patient reports from what is objectively observed, and clearly links clinical reasoning to the resulting plan.

The SOAP Note Format

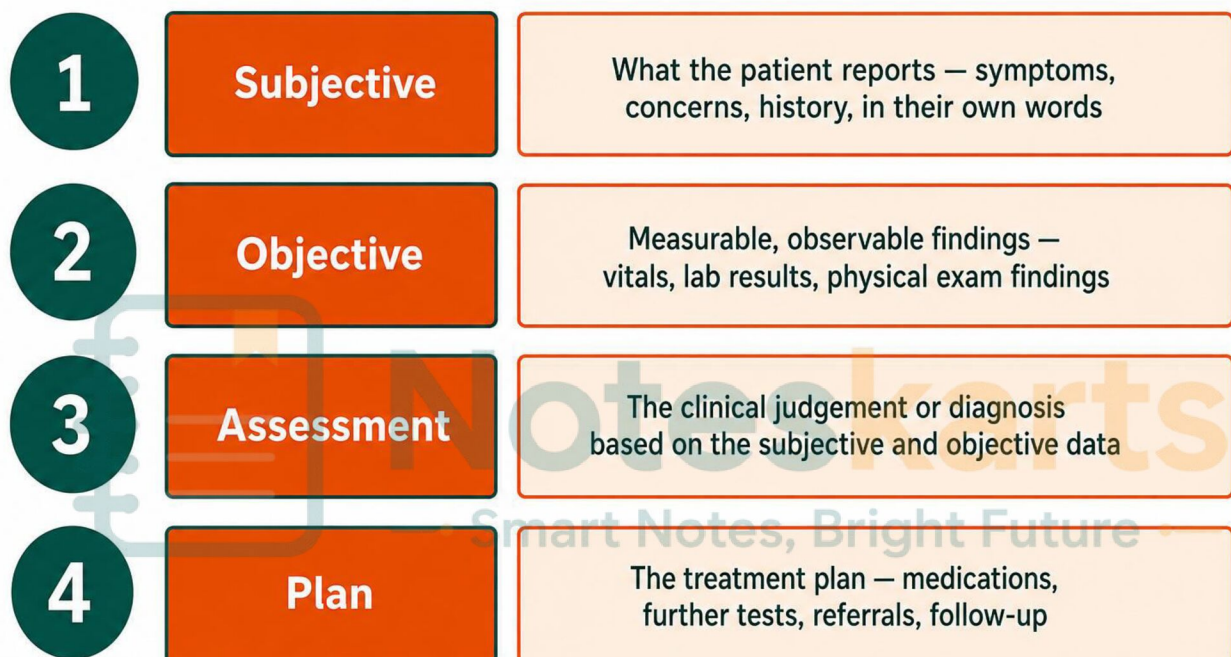


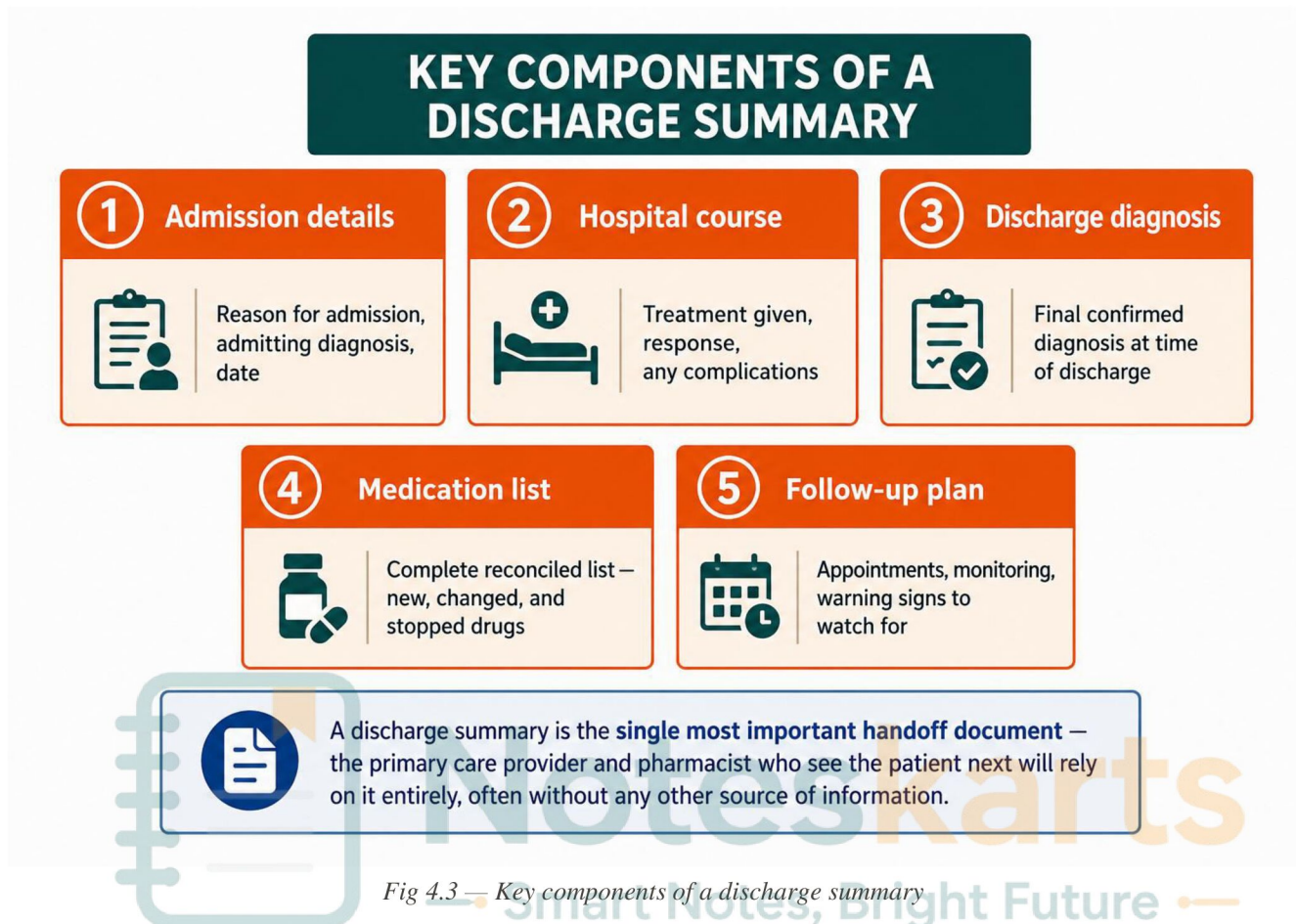
Fig 4.2 — The SOAP note format

For a pharmacist, a SOAP-style note documenting a medication review might record the patient's reported side effects (Subjective), relevant lab values (Objective), the pharmacist's assessment of whether the current regimen is appropriate (Assessment), and any recommended dose change or monitoring plan (Plan).

Section	Worked Example — Pharmacist Medication Review
S	"I've been feeling dizzy in the mornings since my blood pressure dose was increased."
O	BP 98/62 mmHg (sitting), pulse 58 bpm; last reading 138/88 mmHg two weeks ago
A	Symptomatic hypotension likely related to recent antihypertensive dose increase
P	Recommend prescriber review dose; advise patient to rise slowly and monitor BP daily; follow up in 3 days

4.3 Writing Discharge Summaries

A discharge summary is the primary document that transfers a patient's care from a hospital or facility back to community-based care, including their regular pharmacist. It must be complete and clear enough to stand entirely on its own.



Pharmacist's Role

The medication list in a discharge summary is the single most error-prone section — discrepancies between hospital and pre-admission medications are a leading cause of post-discharge adverse events, making pharmacist review at this step especially valuable.

A well-written discharge summary avoids two common failure modes: excessive length that buries the critical information the next provider actually needs, and excessive brevity that omits the reasoning behind treatment decisions. A useful test is whether a pharmacist who has never met the patient could safely counsel them using the discharge summary alone.

Component	Sample Excerpt
Admission diagnosis	Community-acquired pneumonia, right lower lobe
Hospital course	Treated with IV antibiotics for 4 days, switched to oral on Day 5, afebrile since Day 3
Discharge diagnosis	Resolved community-acquired pneumonia
Medications	Continue amoxicillin-clavulanate 625mg twice daily for 3 more days; resume home atorvastatin
Follow-up	Review with primary physician in 1 week; return sooner if fever or breathlessness recurs

4.4 Medication Reconciliation and Pharmacist Documentation

Medication reconciliation is the formal process of creating the most accurate possible list of a patient's current medications and comparing it against admission, transfer, or discharge orders to identify and resolve discrepancies. It is one of the pharmacist's most important documented contributions to patient safety.

Medication Reconciliation at Transitions of Care



Fig 4.4 — Medication reconciliation checkpoints across a hospital stay

- Compare the pre-admission medication list against current orders at every transition of care
- Document any medication started, stopped, or changed, along with the clinical reason
- Flag discrepancies to the prescribing team promptly, and document that this was done
- Provide the patient with an updated, reconciled medication list in plain language at discharge

Common Source of Discrepancy	Example
Omission	A regular home medication is simply left off the admission orders
Duplication	A medicine is prescribed under both its brand and generic name
Dose or frequency error	A once-daily home dose is transcribed as twice-daily on admission
Incomplete OTC/herbal history	Over-the-counter or herbal products are not asked about or recorded

5. Technology and Digital Communication Tools in Healthcare

Digital tools now mediate a large share of healthcare communication — between providers, between institutions, and directly with patients. Understanding these tools and their proper use is now a core professional communication skill.

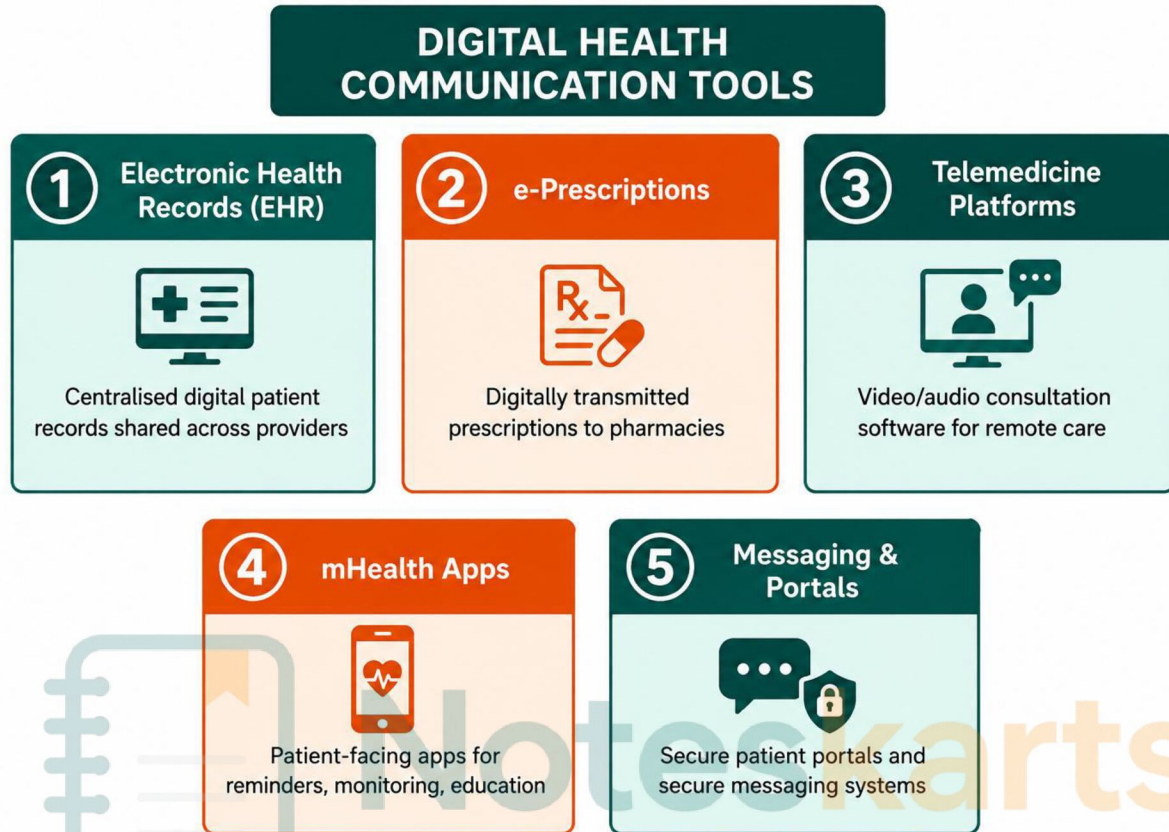


Fig 5.1 — The digital health communication landscape

5.1 Electronic Health Records (EHR)

An Electronic Health Record is a digital, centralised version of a patient's medical history, accessible (with appropriate permissions) across the providers involved in their care. EHRs reduce the communication failures caused by paper records being unavailable, illegible, or lost, but they introduce their own risks — copy-paste errors, alert fatigue, and information overload.

Benefits of EHR	Risks of EHR
Instant access across providers and locations	Copy-paste errors carry outdated information forward
Legible, searchable records reduce misreading	Alert fatigue from excessive automated warnings
Built-in checks for interactions and allergies	System downtime can halt access to critical information
Supports audit trails for accountability	Risk of unauthorised access if credentials are not secured

Pharmacist's Role

Alert fatigue is a genuine risk to patient safety, not just an inconvenience — when a system generates excessive low-value warnings, staff can become desensitised and start overriding alerts automatically, including the rare one that matters. Take time to configure and use clinical decision-support alerts thoughtfully rather than dismissing them by habit.

5.2 e-Prescriptions and Digital Pharmacy Tools

Electronic prescribing (e-prescribing) transmits a prescription digitally from prescriber to pharmacy, removing the ambiguity of handwritten orders and enabling automated checks.

The e-Prescription Workflow

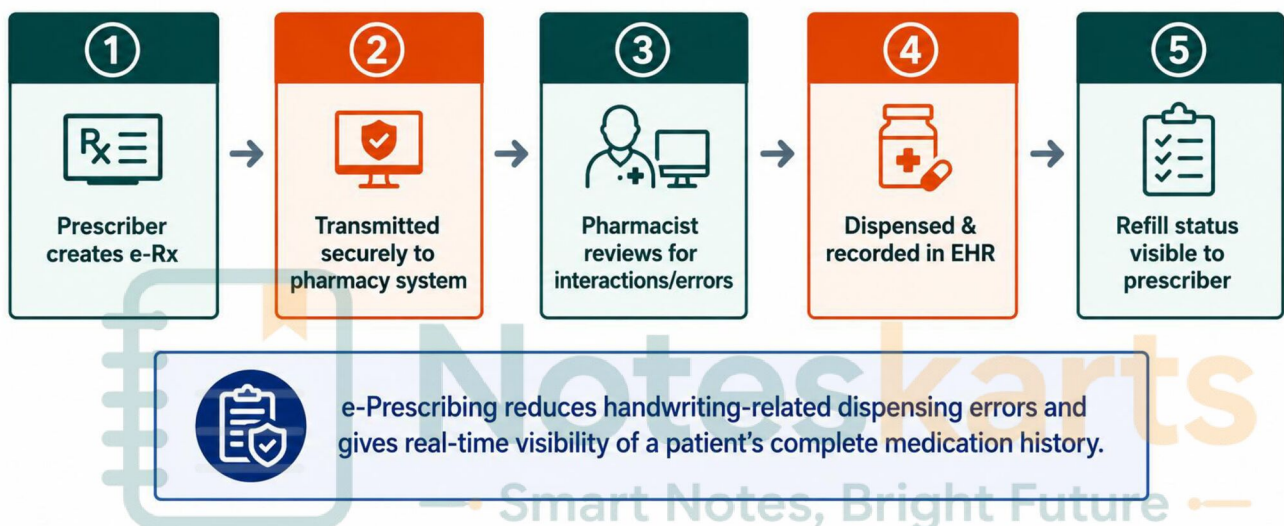


Fig 5.2 — The e-prescription workflow

5.3 Telemedicine and mHealth Applications

Telemedicine platforms and mobile health (mHealth) applications extend care beyond the physical clinic — enabling remote consultations, medication reminders, symptom trackers, and direct patient education. Their growth has been especially significant in expanding access for patients in rural or underserved areas of India, supported by frameworks such as the Telemedicine Practice Guidelines issued alongside the Indian Medical Council regulations.

- Telemedicine consultations require the same standards of privacy, consent, and documentation as in-person visits
- mHealth apps used for reminders or monitoring should be recommended based on evidence and data-privacy practices, not popularity alone
- Confirm the patient's identity and location at the start of every telemedicine encounter, since jurisdiction can affect what care may legally be provided remotely
- Have a clear escalation plan for when a condition is beyond what can be safely managed remotely

Artificial intelligence is increasingly present in this landscape too — symptom-checker chatbots, AI-assisted triage tools, and automated medication reminder systems are becoming common. These tools

can improve access and efficiency, but they do not replace professional clinical judgement, and patients should always know when they are interacting with an automated system rather than a licensed professional.

Telemedicine Modality	Best Suited For
Video consultation	Visual assessment, building rapport, most conditions needing dialogue
Audio/phone consultation	Follow-up on stable conditions, low-bandwidth settings
Asynchronous messaging	Simple queries, prescription refill requests, non-urgent updates
Remote monitoring devices	Tracking chronic conditions (blood pressure, glucose) between visits

5.4 Digital Communication Etiquette and Data Security

Digital channels are convenient but create new risks — messages can be forwarded, screenshotted, or stored indefinitely, and unsecured platforms can expose sensitive health data.

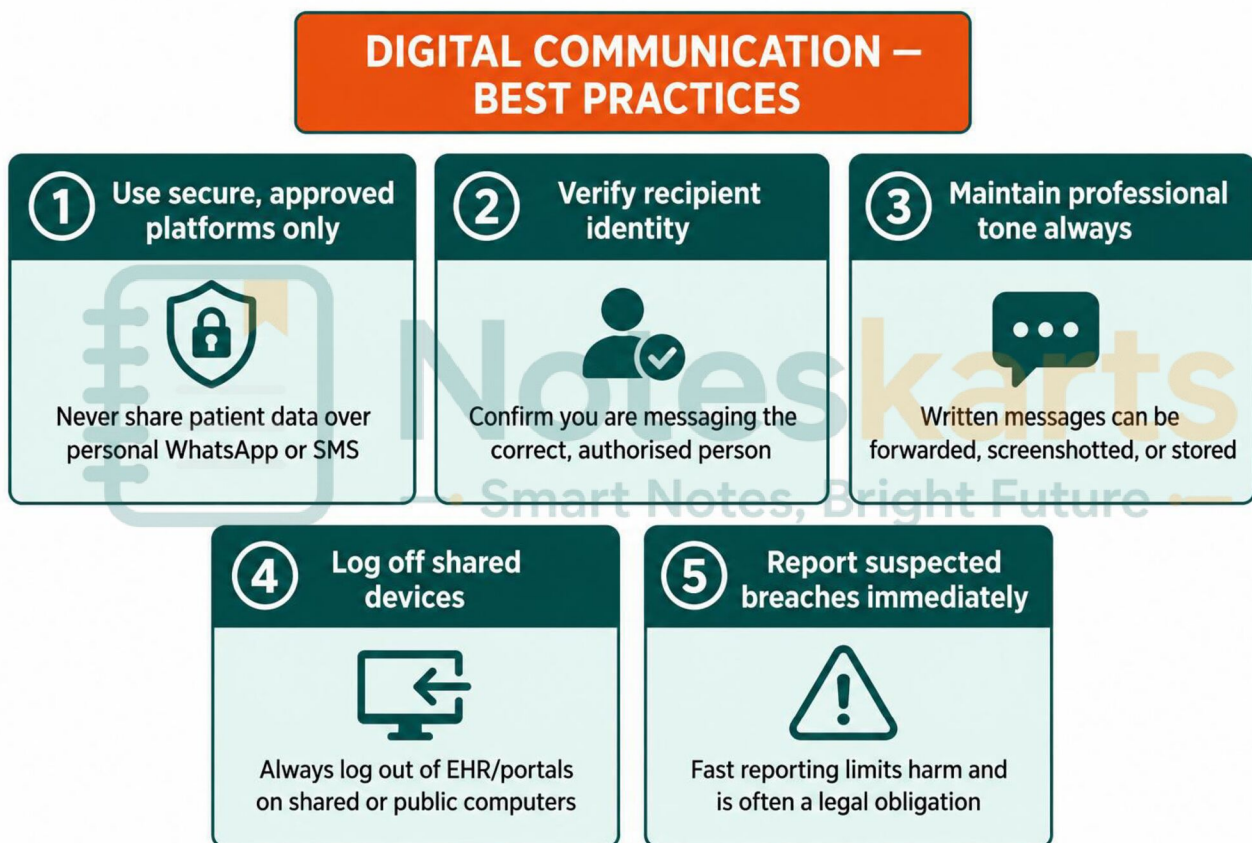


Fig 5.3 — Best practices for digital healthcare communication

Exam Focus

The same confidentiality principles that apply to spoken and written communication apply in full to digital communication — a casual WhatsApp message about a patient carries the same ethical and legal weight as a spoken disclosure in a public corridor.

Under the Digital Personal Data Protection Act, 2023, health information is treated with particular sensitivity, and patients (as 'data principals') have rights including being informed how their data is used and requesting its correction or erasure. Healthcare institutions and pharmacies handling digital patient data are expected to implement reasonable security safeguards and to notify affected patients and authorities in the event of a data breach.

Data Security Checklist for a Pharmacy

- | |
|--|
| Use unique logins for every staff member — never share passwords |
| Lock or log off any screen displaying patient data when unattended |
| Encrypt or password-protect any device storing patient information |
| Dispose of printed patient records through secure shredding, not general waste |
| Train all staff periodically on data protection obligations and breach reporting |

Responding to a Suspected Data Breach

Speed matters: the sooner a breach is contained and reported, the smaller its impact — delay in reporting is itself often a regulatory violation.

Fig 5.4 — Immediate steps after a suspected data breach



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