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COURSE BROCHURE

Advanced Art of Communication for Clinical Teams and Families Training Course

21 March – 1 April 2027
Amman

Advanced Art of Communication for Clinical Teams and Families Training Course

Ref: 748_28086 **Date:** 21 March – 1 April 2027 **Location:** Amman **Fees:** 5500 GBP

Art of Communication for Clinical Teams and Families is a 2-week advanced training course for physicians, nurses and patient-facing hospital staff who lead difficult conversations at the bedside and across disciplines, and who leave with a Ward Conversation Playbook for their unit. Families now expect a voice in care decisions while multidisciplinary rounds grow more complex. Jupiter Prime Training delivers this course on the craft of clinical conversation.

Why Art of Communication for Clinical Teams and Families Matters Now

Three pressures shape clinical conversation today. Families arrive informed, anxious and ready to challenge, so a poorly handled meeting quickly turns into a formal complaint. Care is delivered by rotating multidisciplinary teams, where a missed cue between a registrar, a charge nurse and a pharmacist can harm a patient. Incident reviews also show that silence and hierarchy, more than missing knowledge, often sit behind adverse events. Units that talk well earn trust, shorter disputes and safer transitions; units that do not face escalation, staff distress and reputational damage. The course rests on patient-centred and relationship-centred care models and on structured team-communication practice.

Who Gains Most from Art of Communication for Clinical Teams and Families

- Senior clinicians who lead family meetings about prognosis, limits of treatment and goals of care
- Nurse leaders responsible for shift transitions, ward rounds and escalation of deteriorating patients
- Patient relations and experience leads who mediate tense exchanges between relatives and clinical staff
- Intensive care, emergency and oncology practitioners who deliver serious news under time pressure
- Clinical governance staff who guide disclosure conversations after harm or near misses

Mixed groups from one ward or service line, combining medical, nursing and allied staff, gain most because they rehearse the same scripts and agree shared signals for raising concern.

Art of Communication for Clinical Teams and Families Capabilities

Participants practise each conversation with simulated relatives and colleagues, receiving structured observer feedback on wording, pacing and silence.

- Design a staged approach to serious news that checks prior understanding before sharing it — family meetings on prognosis
- Apply shared decision frameworks with option grids and teach-back — treatment choices with patients and relatives
- Build a structured bedside and shift handover with read-back checks — continuity between outgoing and incoming teams
- Communicate concern across professional hierarchy using graded assertiveness — escalation of deteriorating patients
- Calm angry or grieving relatives through de-escalation and boundary-setting — patient relations and unit safety
- Specify an honest disclosure sequence after an adverse event — clinical governance and family trust

Key Art of Communication for Clinical Teams and Families Terms

- Teach-back — asking the patient or relative to explain in their own words what was said, confirming real understanding.
- Closed-loop communication — the sender gives an instruction, the receiver repeats it, and the sender confirms it was heard correctly.
- Graded assertiveness — rising levels of voicing concern, from a question to a firm stop, used to cross professional hierarchy.
- Goals-of-care conversation — a planned discussion of what matters most to the patient, guiding treatment intensity and limits.
- Open disclosure — honest, timely explanation to a patient and family after harm, including apology and next steps.
- Psychological safety — a shared belief within a clinical unit that staff can speak up without blame or humiliation.

Art of Communication for Clinical Teams and Families Day by Day

Day 1: The Clinical Conversation Landscape

- Relationship-Centred Care Model — Where Conversation Sits in Quality
- Communication Failure in Incident Reviews — Patterns Behind Adverse Events
- Family Expectations Mapping — Rising Demand for Involvement
- Recorded Consultation Analysis — Baseline of Individual Style
- Unit Communication Audit — Priorities for Improvement

Day 2: Listening, Empathy and Nonverbal Cues

- Active Listening and Reflective Statements — Accurate Picture of Concerns
- Empathic Response Phrases — Acknowledging Emotion Before Information
- Body Language and Proximity at the Bedside — Signals of Respect
- Use of Silence — Space for Distress and Reflection
- Cultural and Faith Considerations — Tailoring Approach to Each Family

Day 3: Delivering Serious News

- Staged Disclosure Protocol — Sequence for Sharing Grave Results
- Perception Check Before Disclosure — Gauging What Is Already Known
- Warning Shot and Pacing — Controlling the Flow of Information
- Handling Denial and Collusion Requests — Truth-Telling Within Family Dynamics
- Documentation of the Conversation — Shared Record for the Care Team

Day 4: Shared Decisions and Goals of Care

- Option Grids and Decision Aids — Weighing Treatment Benefits and Burdens
- Teach-Back Technique — Confirming Understanding of Choices
- Goals-of-Care Meeting Structure — Aligning Intensity With Patient Values
- Surrogate Decision Makers — Speaking for Patients Without Capacity
- Limits of Treatment Discussions — Withholding or Withdrawing Interventions

Day 5: Structured Handover and Transitions

- Situation-Background-Assessment-Recommendation Format — Concise Clinical Briefings
- Bedside Shift Report With the Patient — Involving Families in Transitions
- Read-Back and Closed-Loop Checks — Preventing Lost Instructions
- Discharge and Transfer Conversations — Safe Moves Between Care Settings
- Telephone and Digital Messaging Etiquette — Reliable Remote Exchanges

Day 6: Interprofessional Team Communication

- Multidisciplinary Ward Round Format — Shared Plan Across Professions
- Daily Safety Huddle — Early Warning of Unit Risk
- Graded Assertiveness and Speaking Up — Crossing Professional Hierarchy
- Psychological Safety Climate Survey — Readiness of Staff to Raise Concern
- Team Debrief After Critical Events — Learning Without Blame

Day 7: Conflict and De-escalation With Families

- Early Signs of Escalation — Recognising Rising Tension
- Verbal De-escalation Sequence — Calming Angry or Grieving Relatives
- Boundary-Setting Statements — Protecting Staff and Other Patients
- Mediated Family Meeting — Resolving Disputes About Care
- Complaint Conversation Recovery — Restoring Trust After Grievance

Day 8: Communication During Incidents and Harm

- Open Disclosure Sequence — Honest Explanation After Adverse Events
- Apology Language — Expressing Regret Without Speculation
- Second Victim Support — Care for Staff Involved in Harm
- Emergency Team Communication — Clear Roles in Resuscitation
- Incident Briefing for Relatives — Updates During Investigation

Day 9: Coaching and Sustaining Communication Practice

- Peer Observation Framework — Structured Feedback on Real Conversations
- Simulation Scenario Design — Rehearsal of High-Stakes Encounters
- Patient Experience Feedback Analysis — Themes From Family Comments
- Communication Competency Rubric — Assessing Junior Staff
- Resilience and Emotional Load Management — Sustaining Compassionate Practice

Day 10: Practising the Ward Conversation Playbook

- Simulated Serious News Meeting — Applying the Staged Disclosure Protocol
- Simulated Handover Under Pressure — Applying Read-Back and Briefing Formats
- Simulated Family Dispute — Applying De-escalation and Mediation
- Observer Scoring Against the Rubric — Priorities for Personal Growth
- Ward Conversation Playbook Assembly — Scripts, Signals and Escalation Routes

Applying Art of Communication for Clinical Teams and Families After the Course

- Lead a monthly simulated family meeting on the ward, using the staged disclosure protocol and observer scoring rubric
- Introduce a daily safety huddle with read-back checks and agree graded assertiveness phrases with the unit team

Art of Communication for Clinical Teams and Families Questions FAQ

What is the art of communication for clinical teams and families, and why does it matter now?

It is the skilled practice of speaking with relatives and colleagues during serious news, decisions, handover, conflict and harm. It matters now because informed families expect involvement and multidisciplinary care multiplies the points where a missed message can hurt a patient.

Which roles gain most from art of communication for clinical teams and families training?

Senior physicians, nurse leaders, intensive care, emergency and oncology practitioners, patient relations leads and clinical governance staff gain most. Groups from one ward benefit further because they agree shared scripts and signals for escalation.

How does art of communication for clinical teams and families differ from a general healthcare communication course?

It concentrates on team dynamics and family encounters under strain rather than routine consultation skills. Participants rehearse speaking up across hierarchy, mediated family meetings and disclosure after harm, at an advanced level suited to experienced clinicians.

What do you bring back from art of communication for clinical teams and families training?

You bring back a unit playbook of tested scripts, handover formats and escalation routes. You also gain observer-scored practice in serious news, family disputes and incident disclosure, plus a rubric to coach junior colleagues.

Art of Communication for Clinical Teams and Families: The Way Forward

The Ward Conversation Playbook gives a unit agreed scripts for serious news, handover, family disputes and disclosure. Its first use is deciding how the next difficult family meeting is staffed and staged. Charge nurses, consultants and patient relations leads use it day to day, and after the first incident review the team should revisit how well speaking-up signals worked in practice.