ENGLISH
IN
NURSING
Practical English for Professional Nurses

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RCI

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Rumah Cemerlang

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Pasal 72

Barang siapa dengan sengaja melanggar dan tanpa hak melakukan perbuatan sebagaimana dimaksud dalam pasal ayat (1) atau pasal 49 ayat (1) dan ayat (2) dipidana dengan pidana penjara masing-masing paling sedikit 1 (satu) bulan dan/atau denda paling sedikit Rp.1.000.000,00 (satu juta rupiah), atau pidana penjara paling lama 7 (tujuh) tahun dan/atau denda paling banyak Rp.5.000.000.000,00 (lima miliar rupiah).

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KATA PENGANTAR

In the global era, English is a compulsory subject that must be taught to all university students. English mastery is also required for prospective medical personnel, including nurses. Nursing students need English not only for their current needs, but also for their future professional careers because it is undeniable that nurses in Indonesia often encounter obstacles when serving foreigners. It is quite difficult for them to have a dialogue with foreign patients even though nowadays our country is increasingly visited by foreigners for holidays, research, or student exchanges and it is not impossible, while here they experience health problems or need medical check-up.

This book presents four language skills (Listening, Speaking, Reading, and Writing) which include nursing terminologists, language focus, and communicative conversation with the patient, reading texts, writing activities, and some exercises. This book is certainly very helpful to facilitate nursing students in getting the ability to carry out their duties in a work environment or anywhere where English is used and needed. Hopefully this book can be studied and practiced easily to achieve Nursing English competence.

Banyuwangi, Oktober 2022

Authors

DAFTAR ISI

CHAPTER 1

PATIENT ADMISSION

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- Welcoming a New Patient
- Admission Procedure
- Checking a Patient's Identity
- ID Bracelet
- Orienting a New Patient to Health Care Facility

Exercise 1. What will the nurse do when the patient is coming to the hospital? Put the tick (√) for the nurse does, and cross (X) for the nurse does not do!

☐ Gives the patient a cup of coffee.
☐ Puts on patient's ID bracelet.
☐ Gives the patient meals.

- ☐ Shows the patient rooms around hospital.
- ☐ Checking the patient's identity.
- ☐ Helps the patient put on the gown.
- ☐ Observes the patient.
- ☐ Shows the patient how to use nurse telephone call.
- ☐ Shows the patient bathroom and other facilities.
- ☐ Informs the patient about the timing of doctor visit.

Patient admission means a process of receiving a new patient to the unit/ward of the hospital or facilitating the patients to stay in the hospital or ward for observation, investigation, care and treatment of the diseases they are suffering from.

The purposes of admission are:

- ✓ Welcoming a patient.
- ✓ Providing comfortable and safety for a patient.
- ✓ Providing immediate care.
- ✓ Receiving the patient in the ward based on his/her condition.
- ✓ Alleviating the patient's fear and worry about the hospitalization.
- ✓ Helping patient if any emergency.
- ✓ Assisting the patient in adjusting to the hospital or clinic environment.
- ✓ Facilitating recovery for patient from his/her problems.
- ✓ Acquiring vital information of patient as the basis care.
- ✓ Establishing nurse and patient relationship.
- ✓ Undergoing evaluation and treatment.

Here are the admission procedures:

A. Out Patient Department

1. Receiving patients by greeting them kindly and make them comfortable.
2. Telling the patient to do registration.
3. Recording the social data of patients: name, address, gender, age, marital status, telephone number, religion, education, and income.
4. Recording Medical Data: medical history, provisional diagnosis, diagnosis, and the duration of illness.
5. Medical Examination

B. In Patient Department

1. Taking patient into the ward.
2. Admitting patient by greeting the patient friendly and introducing himself/herself to patient and his/her family.
3. Orienting the patient to the ward, facilities like toilet and unit available for patient.
4. Explaining hospital policies and routines, doctor visiting time, and explaining for hospital payment or bill.
5. Preliminary observation of the patient.
6. Helping the patient to occupy the bed.
7. Caring for valuable and clothing.

Conversation: Welcoming a Patient

Nurse Ayu : Hello, good morning Madam.

Mrs. Shanum : Good morning nurse. I would like to check my illness.

Nurse Ayu : Okey, I am nurse Ayu who is shifted in the registration. What is your name Madam?

Mrs. Shanum : Shanum Alfia Mumtaza
Nurse Ayu : What do you feel Mom?
Mrs. Shanum : I've got stomachace and diarrhea because these 3 days I ate very much spicy food.
Nurse Ayu : Ok we will examine you but first you must complete the registration. Please fill and complete this registration form.
Mrs. Shanum : I am little bit confused. Can you help me to fill my data in this form nurse?
Nurse Ayu : Yes sure. To complete this form I should ask your personal details. Are you ready?
Mrs. Shanum : Ok certainly.
Nurse Ayu : What is your nick name?
Mrs. Shanum : Shanum.
Nurse Ayu : Where do you live?
Mrs. Shanum : I live in Glagah Banyuwangi.
Nurse Ayu : What's your date of birth?
Mrs. Shanum : 8th of October 1988
Nurse Ayu : How old are you?
Mrs. Shanum : 34 years old.
Nurse Ayu : Are you married?
Mrs. Shanum : Yes, I have a daughter and two sons.
Nurse Ayu : What is your religion?
Mrs. Shanum : Moslem
Nurse Ayu : What is your profession?
Mrs. Shanum : I am a lecturer.
Nurse Ayu : Who is your next of kin?
Mrs. Shanum : My husband Mr. Arman.
Nurse Ayu : Do you have health assurance?
Mrs. Shanum : Yes BPJS
Nurse Ayu : What's your telephone number?
Mrs. Shanum : 085748015150

Nurse Ayu : Ok Mrs. Shanum your data is complete. This is your queue number. You can wait in the waiting room until the nurse call your name.
Mrs. Shanum : Thanks nurse.
Nurse Ayu : You're welcome Mrs.Shanum. I hope you can be better soon.

Health Assessment
Nurse Ayu : How many days have you had diarrhea?
Mrs. Shanum : Two days.
Nurse Ayu : How many times do you defecate in a day?
Mrs. Shanum : 5 times.
Nurse Ayu : What was the last food you consumed?
Mrs. Shanum : I ate very much spicy food 3 days in a row.
Nurse Ayu : have you ever got diarrhea before?
Mrs. Shanum : Yes, 5 months ago I got diarrhea but this current diarrhea is worse.
Nurse Ayu : How do you feel the pain?
Mrs. Shanum : My stomach like squeezing
Nurse Ayu : Which part of the stomach hurts?
Mrs. Shanum : Lower stomach (while holding the stomach)
Nurse Ayu : If I give number from 1 to 10, what is the pain scale?
Mrs. Shanum : For about four.
Nurse Ayu : Have you taken any medication?
Mrs. Shanum : Yes I've consumed "Diapet" capsule for 2 days.
Nurse Ayu : Are you allergic to any drug or food?
Mrs. Shanum : No.
Nurse Ayu : I will check your temperature, blood pressure, pulse, respiration, height, and weight.
The doctor will come and see you in a few minutes.
Mrs. Shanum : Ok thank you nurse.

Nurse Ayu : You are welcome.

LANGUAGE FOCUS

Expressions to start communation with patient.

You must first explain what you are going to do toyou're your patient, you can use the following expressions:

No	Expressions	
1	I need to……..	Ask your personal data
2	I want to……	Check your ID bracelet
3	I would like to……	Interview you
4	It's time for me to…	Ask your condition
5	I will…..	Assess your health
6	I am going to……	Put on your ID bracelet

Some questions to ask for personal details:

- Name
- Age
- Gender
- Address
- Telephone number
- Marital Status
- Health Insurance
- Occupation
- Next of kin
- Reason for contact

Exercise 2: Interview your patient and fill his/her identity in this form!

Date & time of contact:_____

Name :_____

Age :_____

Gender :_____

Place, date of birth :_____

Religion :_____

Address :_____

Phone Number :_____

ID Bracelet

Easyid.org

Exercise 3. Match the abbreviation on an identity (ID) bracelet with their meaning!

No	Abbreviation	Meaning
1	Hosp.No.	a. The gender of patient
2	ADM	b. Doctor
3	Dr	c. Patient's room
4	MRN	d. Date of Birth
5	Ward	e. Hospital number
6	Sex	f. Admission date
7	Age	g. Medical record number
8	DOB	h. How old the patient is

Listening

Exercise 4. Listen to the conversation between Nurse Rima and Mr. Jones and answer the following questions!

1. What does Nurse Rima need to do?
2. What is Mr. Jones hospital number?
3. What is Mr. Jones allergic to?
4. What is ID bracelet colour needed by Mr.Jones?

Exercise 5. Put the following extracts from the conversation into the correct order!

- ☐ Please tell me your full name!
- ☐ Have you got your ID bracelet on?
- ☐ Do you have any allergies?
- ☐ When were you born?
- ☐ May I look at your ID bracelet?
- ☐ So that's why we have to check everything carefully.
- ☐ I will just check on your ID bracelet
- ☐ I will change it for you soon sir.

Exercise 6. Listen again the conversation between Nurse Rima and Mr.Jones. Check the information on ID bracelet below, put a tick √ to the correct information and correct any wrong information!

Easyid.org

Exercise 7. Practice the conversation in pairs about checking patient personal details. Student A is as a nurse (use the ID bracelet of patient 2 below). Student B is as a patient (use the patient information 2 in the box below). Then take turn the roles and practice again by using ID bracelet of patient 3 and patient 3 information in the box!

ID Bracelet of patient 1

Patient 1 Information:
You are Adzka Mumtaz Alfarizi. You had a Chronic Kidney Disease. You are allergic to penicillin. Your legs are swollen, difficult to urinate, and headache. Little bit Nausea and vomiting.

ID Bracelet of patient 2

Patient 2 Information:
You are Suhainah Marfu'ah. You've got Tuberculosis. No allergy. Cough for 2 weeks with a little blood, shortness of breath, fever at night.

ID Bracelet of patient 3

Patient 3 Information:
You are Fitri Lestari. You've got Appendix. You're allergic to steroid. Pain in the lower right abdomen, fever does not go down. The pain is getting worse when the leg is bent.

Here is an example of dialogue. (Based on the ID bracelet of patient 1 and patient information 1)
Nurse : Excuse me Mr. Fariz, I need to check your information on your ID bracelet.
Patient : Certainly.
Nurse : Can you tell me your full name please?
Patient : Adzka Mumtaz Alfarizi.
Nurse : Right. Can you tell me your date of birth?
Patient : It's 19th of November 1997
Nurse : Oh that's wrong. 19 10 1997. I will change then. Your hospital number is six, three, five, one, two, nine.
Patient : That's correct.
Nurse : Do you have any allergies?
Patient : Yes I am allergic to penicillin.
Nurse : Ok I will get a red ID bracelet for you, so everyone knows if you have an allergy. How's your condition right now?
Patient : My feet are swollen, I have difficulty urinating, and I got a headache.

Nurse : Do you feel nauseous?
Patient : Little bit and my appetite is reduced.
Nurse : I'll make a note of your record. Then after this we'll place a catheter to monitor input and output of fluid and give a diuretic to reduce swelling in your legs.

Share your experience!

1. Have you ever seen the ID bracelet when you are in the hospital or hospitalized?
2. Do you know what is written on the id bracelet?
3. Do you know the function of ID bracelet?
4. What colour of ID bracelet have you ever known?
5. How to distinguish ID bracelet if there is the same patient's name and identity?
6. Do you know when the hospital puts the id bracelet on the patient?
7. Do you know when the hospital released ID bracelet to

Reading

Patient Admission

Patient admission is part of the hospital service procedure system. This is where the first service a patient receives when he or she is coming to the hospital, so it really determines the good and bad impression of the hospital. There are several types of patients who come to the hospital; they are patients who can wait, outpatients who come by appointment, patients who come in a non-critical condition, patients who need immediately help (emergency patients), and inpatient. Patient arrivals in the hospital can occur for several reasons such as being sent by a practicing doctor outside the hospital,

referral from another hospital, public health center or other type of health services, or coming of their own accord.

There are three ways of receiving patient in the hospital as outpatient, a day patient, or inpatient. Outpatient is a patient who needs treatment but does not need a bed to stay in the hospital. A day patient is a patient who needs treatment and a bed for a few hours, but he/she does not need to stay in the hospital overnight. An inpatient is a patient who needs treatment and a bed at least one overnight stay in the hospital. Outpatient admission procedures are (1) a new patient is accepted at admissions. (2) A new patient is interviewed by officers to obtain identity data which will be filled in the clinical history summary form. (3) A new patient will receive a patient number which will be used as identification cards, which must be brought on each subsequent visit to the same hospital. (4) After completing the registration process, a new patient is welcome to wait at the destination polyclinic and the medical record officer prepares the medical record file then sent to the destination polyclinic patient.

After receiving sufficient service from the polyclinic, there are several possibilities for each patient: (1) the patient may go home immediately. (2) The patient is given an agreement slip by the clinic staff to come back on the day and date that has been set. (3) The patient is referred or sent to another hospital. (4) The patient must go to the treatment room (hospitalized). All medical record files of patients who have finished receiving services must return to the medical record section and for patients who must be hospitalized, their medical records must be sent to the inpatient room.

The important things and rules that must be considered by nurses in admitting inpatients are (1) the patient reception department is fully responsible for recording

all information relating to the admission of a patient in the hospital. (2) The patient reception department must immediately notify other departments, especially the direct interested parties immediately after receiving inpatient. (3) All departments must notify the reception of patients, if a patient is allowed to leave the hospital. (4) make complete records of the number of beds used and available throughout the hospital. (5). Complete and legible medical records and uniforms must be kept by all departments while the patient is hospitalized. (6) Clear instructions must be known by all officers working in the admission and discharge process of patients.

Hospitals need to plan patient admissions and predict the number of beds they need. It is also essential to keep accurate records of patient care from admission to discharge and follow-up, including personal details as well as medical history such as past illnesses, treatments, lifestyle, and also patient's test results. This is very important not only to ensure proper care, bu also medical records sometimes are used for research and court purposes.

Exercise 8. Vocabulary

Match the words to a suitable definition!

No	Word	Definition
1	Admission	a. Patient can leave the hospital
2	Hospitalized	b. The way people live or everyday behavior
3	Life Style	c. Monitoring a patient's health over time after treatment
4	Overnight stay	d. room containing licensed patient beds
5	Emergency	e. When a patient is coming to the hospital

No	Word	Definition
6	Discharge	f. A patient who receives medical treatment without being admitted to a hospital.
7	Follow up	g. Dangerous situation that requires immediate care.
8	Outpatient	h. time as an inpatient
9	Referral	i. A patient stay in a hospital for treatment because of his/her illness or injury
10	Inpatient room	j. Sent the patient from one health professional to another health service, for additional healthcare services further diagnose for a particular condition.

Exercise 9. State whether the statement is True (T) or False (F) based on the passage above!

1. The patient must register himelf/herself when coming to the hospital.
2. The patients who come to the hospital are all inpatients.
3. The first service patient receives influence the impression of the hospital.
4. Non critical patient need immediate care.
5. The patient comes to the hospital only because of referral from the independent practice doctor or public health center.
6. The patient identity and clinical history is needed when admission.
7. Personal data is a part of medical records.
8. A day patient must stay in the hospital overnight.

9. Outpatient needs a bed at least one overnight stay I the hospital.
10. Medical record can be used for research and court purposes.

Summary of an admission

Read the following example of patient admission summary!

Siti Zubaidah is an old woman aged 72 years. She is a retired civil servant. Her husband has passed away and her son is her next of kin. Mrs. Zubaidah had got a stroke and admitted to the hospital as an inpatient. She has medical history of high blood pressure, high cholesterol and high blood sugar. She really likes consuming seafood and sweet food.

Exercise 10. Write the admission summary based on the patient informations given in the box!

Patient Information 1

Forename : Wahyu Santoso

Surname : Hidayat

Age : 35 years

Gender : M

Reason for admission : Diarrhea and severe dehydration

Next of kin : Mother Emilia

Medical History : Appendectomy one year ago

Family History : Asthma

Patient 1 Admission Summary

Patient Information 2

Forename : Dewi Sulastri

Surname : Ikhsan

Age : 62

Gender : F

Reason for admission : Asphyxiate and cough with mucus

Next of kin : Her husband Mr. Gofur

Medical History : Severe asthma

Family History : Her husband is an active smoker since he was 15 years old.

Patient 2 Admission Summary

Patient Information 3

Forename : Amalia Maryam

Surname : Syafa'at

Age : 11 years

Gender : F

Reason for admission : dizzy, nausea, fever, nosebleed

Next of kin : Father Syafa'at

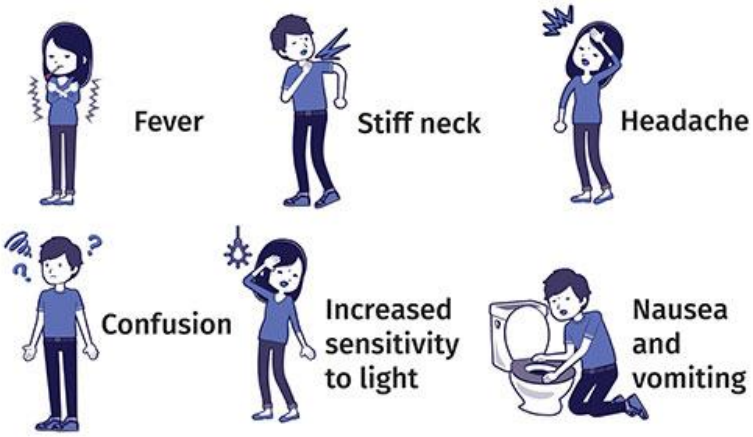
Medical History : Typhoid

Family History : Allergic

Patient 3 Admission Summary

CHAPTER 2

TALKING ABOUT PAIN, SIGNS, AND SYMPTOMS



cdc.gov

- Expressing Pain
- Identifying Pain
- Mention the Signs and Symptoms of Disease
- Exploring the Patient's Pain and Symptoms
- Pain Management

Exercise 1: Find the words related to pain!

A	N	P	U	M	K	L	I	S	O	P	M	I	V
K	T	A	N	A	J	G	M	E	T	I	L	Z	P
S	R	I	W	C	P	Q	O	Z	A	J	T	B	A
X	E	N	M	U	Z	P	D	S	E	D	B	P	I
O	H	K	E	T	K	S	E	T	I	B	U	R	N
D	T	I	R	E	Q	V	R	N	I	R	B	E	F
P	E	L	M	I	G	W	A	L	D	U	R	P	U
T	U	L	O	T	H	Q	T	K	P	I	W	A	L
J	H	E	V	M	U	L	E	A	D	S	X	V	A
C	H	R	O	N	I	C	D	L	S	E	T	G	S
R	O	G	L	M	E	M	I	G	R	A	I	N	E
A	J	S	I	B	M	I	Q	V	E	K	O	F	V
M	Z	I	G	V	A	L	O	F	M	X	W	A	S
P	R	Z	E	Q	L	D	K	Y	I	W	D	O	E
C	A	U	G	W	I	V	L	O	F	Y	R	A	V
I	G	L	O	Q	M	S	U	W	S	E	J	R	E
L	X	Y	A	M	H	S	I	G	M	U	Z	A	R
H	O	W	P	W	U	Z	I	Q	L	M	E	V	E
P	A	N	X	I	E	T	Y	S	W	E	E	R	B
D	Q	R	Y	T	V	H	G	I	J	X	R	F	A
Z	E	R	M	U	B	N	O	X	I	O	U	S	L

Exercise 2 Listening.

Listen to the conversation between Nisa and the nurse, then mention whether the statement is True (T) or False (F) based on the conversation you've heard!

1. Nisa is getting shiver, dizzy, fever, and cough.
2. Nisa is shivering since two weeks ago.
3. Nisa does not have sleep disturbances.
4. Nisa is getting cough with phlegm.

5. Nisa gets only antibiotic prescription from the doctor.
6. Nisa is getting severe disease.
7. Nisa needs to eat nutritional foods.
8. Nisa has to have less rest.
9. Nisa has to finish the medicine prescribed by the doctor.
10. Nisa can see the doctor next week if she still has any complaints in her body.

LANGUAGE FOCUS

The expressions of showing pain:

- ✓ Aw that hurts
- ✓ I feel hurt
- ✓ I feel painfull
- ✓ It is very painful
- ✓ It is very hurt
- ✓ I can't stand it, it's getting worse.
- ✓ Ouch I've got tootache.
- ✓ It's killing me.
- ✓ It hurts me so much.
- ✓ My shoulder is very hard to move.
- ✓ I cannot move my body.
- ✓ My back hurt so bad.
- ✓ I can't hold it anymore.
- ✓ This is so bad.
- ✓ My stomach is really hurt.

Nurses can explore the patient's pain and symptoms by using these questions:

1. Asking the location of pain.
   - ✓ Please describe the location of your pain.
   - ✓ Where do you feel the pain?
   - ✓ Where is the pain located?
   - ✓ Does the pain radiate?

✓ Does it feel like move around? ✓ Show me where. ✓ Does it occur in a particular place? ✓ Do you feel pain in your… (part of body)?
2. Asking the character or quality of pain. ✓ Does it feel stiff or hard? ✓ What is it like? ✓ Is it sharp/dull/squeezing/stabbing/aching? ✓ What does it look like? ✓ Describe the quality of your pain! ✓ Is it shooting/ burning/ throbbing/ crushing/ nauseating/ stretching/ twisting?
3. Asking the severity or intensity of pain. ✓ Please describe the intensity of your pain! ✓ Is it mild, moderate, severe, excruciating, or unbearable? ✓ On a scale of 0 to 10 with ten being the worst, how would you rate what you feel? ✓ Does it interfere with your daily life? In what way? ✓ How much does the pain interfere with your daily activities ✓ How bad is it? ✓ What was the worst it has been? ✓ Does it force you to slow down, lie down, sit down? ✓ How severe is the pain on a scale of 0 to 10 with zero being no pain and ten being the worst pain?
4. Asking the frequency of pain. ✓ Describe your frequency of pain please! ✓ Is it intermittentt, occasional, constant? ✓ How frequently have you experienced pain?
5. Asking the time of pain. ✓ How long does it last?