Discussing the importance of communication in nursing

To listen to another person is the most caring act of all. Listening and attending are by far the most important aspects of being a nurse (Burnard 1992). One of the basic elements of nursing is good communication skills with patients. Being unable to communicate well with a patient immediately can destroy the nurse/patient relationship and therefore the patient may not trust the nurse (Anon 2007). The purpose of this essay is to discuss the importance of communication in nursing. Without communication nurses would be unable to provide the correct care, but improving communication is a life-long developmental process (Ewles and Simnett 2005). I will draw upon my personal experience from the clinical area to show how well the theory relates to the practical side of nursing and use the process recording sheet for structure and guidance (Appendix i).

In accordance with The Nursing and Midwifery Council (2008) Code of Conduct, nurses must respect people’s right to confidentiality. Therefore for the purpose of this essay I have used a pseudonym and the patient discussed is referred to as Carol Brown and any personal or identifiable information has also been altered so as to protect her privacy and dignity which are also enshrined in the Nursing and Midwifery Council (2008) Code of Conduct. I asked Carol for explicit permission to use our interpersonal relationship in my communications essay and advised her of my obligations on my professional conduct to which I am bound by the Nursing and Midwifery Council (2008), regarding professional, moral and safe practice. Carol was in agreement to be involved with my assignment and on no account was her physical care at risk during this interaction.

I was nearing the end of my placement in a general medical ward within a large general hospital. The ward treat a variety of medical complaints including diabetes, gastrointestinal disorders, stroke and alcohol liver disease. A young 36 year old female was admitted to the ward, now known as Carol Brown with an increased weight loss due to non-intentional self-neglect probably caused by her chronic condition although could be deep rooted to family relationships (Day and Leahy-Warren 2008). Carol was awaiting heart surgery, replacement hips and replacement knees at major surgical hospital in another area of the country. Her health status was poor as she suffered from rheumatoid arthritis, psoriasis, and had a congenital heart defect. Carol was in need of pain management, and although it was currently being managed with a variety of powerful painkillers, these proved to have little relief. Carol spent the majority of time in bed due to her severe pain, and due to this she cried out a lot. I thought that communication would be difficult with Carol as she was mostly in pain but I also believed that she would like someone to talk to but that person would need to be a good listener. It is important to remember that nurses have the duty to provide care holistically, for the whole person, not just for their physical needs but their mental and social needs too (Kenworthy et al. 2002).

Carol liked to be washed in her bed every morning as movement for her was difficult. The bay that she was in was busy with little privacy and only the curtains for seclusion. I went into assist her to wash one morning and because of her psoriasis she needed special creams applied routinely. She spoke quietly about her illness and explained her difficulties to me. Her head was bowed and she had difficulty in making eye contact. She talked slowly

and quietly and sometimes mumbled, she also appeared quite melancholy at times. Talking about her family, her illness and when she was younger made her sad and she was crying. I think this was cathartic for Carol and it could be that feelings beneath the surface may need uncovered in more detail to enable her to release her emotions (Bulman and Schutz 2008). I felt that Carol's ability to communicate was linked to how she felt about herself. She was inclined to judge herself too severely and underestimated her abilities. This self-blame reflected her ability to communicate (Ewles and Simnett 2005). She was in so much pain, her head was bowed and she could not make eye contact. I was leaning in close to her bedside, touch was not good, her body was too sore. I tried to show empathy towards Carol by giving her time to talk, being patient and listening to her. This was an example of Egan's (2007) Soler theory which is a non-verbal listening method that is used commonly in communication. Was she crying because she was in so much pain or was it because she was recalling happy memories from before she fell ill? I was keen in developing the therapeutic relationship. According to Arnold and Undermann-Boggs (2003), empathy is the ability to be sensitive to and communicate understanding of the patient's feelings. Being compassionate is similar to being empathetic in a way that it is important to recognise that Carol's feelings belong to her and not to me.

I was interested in Carol's illness, to learn more about her condition and hear about her difficulties. Getting to know your patient helps to promote dignified care (Nicholson et al. 2010). She was very independent and wanted to do as much as she could by herself. Help was minimal and she only asked when she was struggling to re-position her feet. I used active listening to allow to

her speak without interrupting. Active listening is not only the act of hearing but of being able to interpretate any underlying meaning (Arnold and Undermann-Boggs (2003). I paid close attention to her facial expressions and body language and Argyle (1988 p. 57) suggests “ facial expressions provide a running commentary on emotional states”. I asked Carol open questions about her illness as I thought this would allow me to encourage her to talk and she responded to this well. “ Open ended questions are used to elicit the client’s thoughts and perspectives without influencing the direction of an acceptable response” (Arnold and Undermann-Boggs 2003 p. 241). It also allowed Carol to describe her experiences, feelings and understandings and I felt this approach was appropriate.

I wanted to try and distract her from her pain as I found it difficult to see her being so unhappy, so I commented on some magazines that were lying on her table and asked her about her taste in music. This was a good subject, her eyes lit up and she smiled. We finally made eye contact. Carol and myself were exchanging verbal and non-verbal communication in order to understand each other’s feelings. According to Kozier (2008) non-verbal communication can include the use of silence, facial expressions, touch and body posture. Carol was keen to talk about her taste in music and became very chatty, in fact, she became somewhat excited. I put some cd’s on for her to listen to and as I did this she asked me questions about my taste in music. There was now no barriers to our communication as we both shared the same taste in music. When the music was playing Carol was in a different world, she was more relaxed. Research has shown that the pain and tension of illnesses such as arthritis can be eased with music therapy (Murcott 2006).

I took her hand and held it gently, her eyes were closed, she was smiling and she appeared more content. By holding her hand, I felt as though I was comforting and reassuring her. Touch is a form of non-verbal communication and can be a powerful way of communicating (le May 2004). This was an indication that I really did care and that I wanted to help her. “ Using touch skilfully and thoughtfully can convey that you are able to ‘ be with’ your patient” (Benner 2001 p. 57). Communication can be therapeutic and the music playing was not a barrier in communications, it was in fact beneficial. Music has the power to tap into our emotions and alleviate tension (Mallon 2000). Therefore, it is argued that effective communication is more than delivering high quality patient-centred care; but it also allows patients to feel involved in their care, which can make a significant difference to their outlook on their treatment (Collins 2009).

Reflecting back I realised that I was really quite worried about the communication difficulties I was facing during my interaction. Carol was a very obstinate person who knew exactly what she needed and yet she desperately wanted to be as independent as possible. I wanted her to allow me ‘ in’ and for her to be comfortable with me. I am glad I eventually gained her trust and we both became more relaxed. Trust is an important element in the nurse/patient relationship and can in fact affect the patient care in practice (Bell and Duffy 2009). In fact, the impact that this interaction had on our relationship was that as the days went on we became very good friends and she was very special to me. Sully and Dallas (2005), suggests that to have an empathetic understanding of our patient’s needs we must recognise their need for comfort and we respond to this compassionately. It was

important to be non-judgemental, I accepted Carol for who she was no matter what her circumstances were and my main concern was to care for her in a professional and beneficial way and in a manner that she preferred. The Royal College of Nursing (2003) suggests that the personal qualities of a nurse should include compassion, respect and a non-judgemental approach. Putting the interaction into perspective, I originally found Carol very demanding, always calling out and constantly pressing the call buzzer. Some staff were very reluctant to go to her because her personal care was very time consuming. It was time consuming but it was because she was in a lot of pain. Surely this was a barrier to communication as some staff did not take the time to listen to what Carol required and as health promoters, we need to develop skills of effective listening so that we can help people to talk and express their needs and feelings (Ewles and Simnett 2005). Rogers (2004) used the term unconditional positive regard, this meaning that people can be too judgemental and it is important to disregard how much of a ‘ burden’ someone thinks a patient with complex needs might be and treat everyone equally.

From recording and analysing my interactions I have learned to accept people for who they are as each of us have had different experiences throughout life and these experiences make us who we are. It was also important to acknowledge Carol’s point of view, her emotions and thoughts without judgement as being aware of these helped to appreciate her perspective and needs (Silverman et al. 2005). I have also learned to be a good listener and an active listener. Ewles and Simnett (2005) suggest that this means taking note of the non-verbal communication as well as the

spoken words. It is important to maintain eye contact, observe the body language, listen properly and pick up on non-verbal signs as well as verbal signs. The environment is important too, along with being sensitive, honest and compassionate (Anon 2007). Collins (2007) argues that judgemental attitudes can stand in the way of getting to know your patient and that labels attached to individuals such as ‘ demented’ can act as a language barrier. Effective nursing requires us to be assertive, responsible and to help our patients achieve the best possible health status (Balzer Riley 2008).

In conclusion, the key points that have been discussed in this essay are that of the importance of communicating in nursing and how nurses can improve their communication skills and maintain their effectiveness. We must provide holistic care for our patients and the goal is to listen to the whole person and provide them with empathetic understanding. Another key point is that we must be non judgemental no matter what the patient’s circumstances are. Overall communication during this interaction was positive, therapeutic and helped to build a relationship. This essay has shown how personal experience from the clinical area relates the theory to the practical side of nursing and how it is imperative that communication is clear, understandable, appropriate and effective.

2059 words

References

ANON., 2007. Communication skills (essence of care benchmark). Nursing Times.

http://www. nursingtimes. net/whats-new-in-nursing/communication-skills-essence-of-care-benchmark/361127. article (Accessed on 21. 07. 10).

ARNOLD, E., and UNDERMANN-BOGGS, K., 2003. Interpersonal relationships: professional communication skills for nurses. 4th ed. Missouri: Saunders.

BELL, E., and DUFFY, A., 2009. A concept analysis of nurse-patient trust. British Journal of Nursing. 18(1), pp. 46-51.

BENNER, P., 2001. From novice to expert: excellence and power in clinical nursing practice. New Jersey: Prentice Hall.

BLAZER-RILEY, J., 2008. Communication in nursing. 6th ed. Missouri: Elsevier.

BULMAN, C., and SCHUTZ, S., 2008. Reflective practice in nursing. 4th ed. Sussex: Blackwell.

BURNARD, P., 1992. Counselling: a guide to practice in nursing. Oxford: Butterworth-Heinemann.

COLLINS, S., 2009. Good communication helps to build a therapeutic relationship. Nursing Times. 105(24), pp. 11-12.

DAY, M. R., LEAHY-WARREN, P., (2008). Self-neglect 1: recognising features and risk factors. Nursing Times. 104(24), pp. 26-27.

EGAN, G., 2007. The skilled helper: a problem management and opportunity development approach to helping. 8th ed. California: Thomson.

EWLES, L., and SIMNETT, I., 2005. Promoting health: a practical guide. 5th ed. Edinburgh: Bailliere Tindall.

KENWORTHY, N., et al., 2002. Common foundation studies in nursing. 3rd ed. Edinburgh: Churchill Livingstone.

KOZIER, B., et al., 2008. Fundamentals of nursing: concepts, process and practice. Essex: Pearson Education.

LE MAY, A., 2004. Building rapport through non-verbal communication. Nursing and Residental Care. 6(10), pp. 488-491.

MALLON, M., 2000. Healing Sounds. The Scotsman. 12th May, p. 9.

MURCOTT, T., 2006. Music Therapy. The Times. 18th February, p. 17.

NICHOLSON, C. et al., 2010. Everybody matters 1: how getting to know your patients helps to promote dignified care. Nursing Times. 106(20), pp. 12-14.

NURSING AND MIDWIFERY COUNCIL, 2008. The NMC code of professional conduct: standards for conduct, performance and ethics. London: NMC.

ROGERS, C., 2004. On becoming a person: a therapist’s view of psychotherapy. London: Constable.

ROYAL COLLEGE OF NURSING, 2003. Defining nursing. RCN. http://www. rcn. org. uk/__data/assets/pdf_file/0008/78569/001998. pdf (Accessed on 29. 07. 10).

SILVERMAN, J., et al., 2005. Skills for communicating with patients. 2nd ed. Oxon: Radcliffe publishing.

SULLY, P., and DALLAS, J., 2005. Essential communication skills for nursing. Edinburgh: Elsevier.