A critical analysis of the

This essay will present a reflective account of communication skills in practice whist undertaking assessment and history taking of two Intensive Care patients with a similar condition. It will endeavour to explore all aspects of non verbal and verbal communication styles and reflect upon these areas using Gibbs reflective cycle (1988).

Scenario A –

Mrs James, 34, a passenger in a road traffic collision who was not wearing a seatbelt was thrown through the windscreen resulting in multiple facial wounds with extensive facial swelling which required her to be intubated and sedated. She currently has cervical spine immobilisation and is awaiting a secondary trauma CT. Mr James was also involved in the accident.

Scenario B –

Mr James, 37, husband of Mrs James, the driver of the car, was wearing his seat belt. He had minor superficial facial wounds, fractured ribs and a fractured right arm. He is alert and orientated but currently breathless and requiring high oxygen concentrations.

Patients who are admitted to Intensive Care are typically admitted due to serious ill health or trauma that may also have a potential to develop life threatening complications (Udwadia, 2005). These patients are usually unconscious, have limited movement and have sensation deprivation due to sedation and/or disease processes. These critical conditions rely upon modern technical support and invasive procedures for the purpose of monitoring and regulation of physiological functions. Having the ability to

effectively communicate with patients, colleagues and their close relatives is a fundamental clinical skill in Intensive Care and central to a skilful nursing practice. Communication in Intensive Care is therefore of high importance (Elliot, 1999) to provide information and support to the critically ill patient in order to reduce their anxieties, stresses and preserve self identity, self esteem and reduce social isolation (João: 2009, Alasad: 2004, Newmarch: 2006). Effective communication is the key to the collection of patient information, delivering quality of care and ensuring patient safety.

Gaining a patients history is one of the most important skills in medicine and is a foundation for both the diagnosis and patient – clinician relationship, and is increasingly being undertaken by nurses (Crumbie, 2006). Commonly a patient may be critically ill and therefore the ability to perform a timely assessment whilst being prepared to administer life saving treatment is crucial (Carr, 2005). Often the patient is transferred from a ward or department within the hospital where a comprehensive history has been taken with documentation of a full examination; investigations, working diagnosis and the appropriate treatment taken. However, the patient's history may not have been collected on this admission if it was not appropriate to do so. Where available patients medical notes can provide essential information.

In relation to the scenarios where the patient is breathless or the patient had a reduced conscious level and requires sedation and intubation, effective communication is restricted and obtaining a comprehensive history would be inappropriate and almost certainly unsafe. The Nursing Midwifery Council promotes the importance of keeping clear and accurate records within the

Code: Standards of Conduct, performance and ethics for nurses and midwives (NMC, 2008). Therefore if taking a patients history is unsafe to do so, this required to be documented.

Breathing is a fundamental life process that usually occurs without conscious thought and, for the healthy person is taken for granted (Booker, 2004). In Scenario A, Mrs James's arrived on Intensive care and was intubated following her facial wounds and localised swelling. Facial trauma by its self is not a life threatening injury, although it has often been accompanied with other injuries such as traumatic brain injury and complications such as airway obstruction. This may have been caused by further swelling, bleeding or bone structure damage (Parks, 2003). Without an artificial airway and ventilatory support Mrs James would have struggled to breathe adequately and the potential to become in respiratory arrest. Within scenario B, Mr James had suffered multiple rib fractures causing difficulty in expansion of his lungs. Fractured ribs are amongst the most frequent of injuries sustained to the chest, accounting for over half of the thoracic injuries from non-penetrating trauma (Middleton, 2003). When ribs are fractured due to the nature and site of the injury there is potential for underlying organ contusions and damage. The consequence of having a flail chest is pain. Painful expansion of the chest would result in inadequate ventilation of the lungs resulting in hypoxia and retention of secretions and the inability to communicate effectively. These combined increase the risk of the patient developing a chest infection and possible respiratory failure and potential to require intubation (Middleton, 2003).

The key issue of Intensive Care is to provide patients and relatives with effective communication at all times to ensure that a holistic nursing approach is achieved.

Intensive care nurses care for patients predominantly with respiratory failure and over the years have taken on an extended role. They are expected to examine a patient and interpret their findings and results (Booker, 2004). In these situations patient requires supportive treatments as soon as possible. Intensive Care nurse should have the ability and competence to carry out a physical assessment and collect the patients' history in a systemic, professional and sensitive approach. Effective communication skills are one of the many essential skills involved in this role.

As an Intensive Care nurse, introducing yourself to the patient as soon as possible would be the first step in the history and assessment taking process (Outlined in Appendix A). Whilst introducing yourself there is also the aim to gaining consent for the assessment where possible, in accordance with the Nursing and Midwifery Council's Code of Professional Conduct (NMC, 2008). Conducting a comprehensive clinical history is usually more helpful in making a provisional diagnosis than the physical examination (Ford, 2005). Within Intensive Care the Airway, Breathing, Circulation, Disability, Exposure/Examination (ABCDE) assessment process is widely used. It is essential for survival that the oxygen is delivered to blood cells and the oxygen cannot reach the lungs without a patent airway. With poor circulation, oxygen does not get transported away from the lungs to the cells (Carr, 2005). The ABCDE approach is a simple approach that all team

members use and allows for rapid assessment, continuity of care and the reduction of errors.

Communication reflects our social world and helps us to construct it (Weinmann & Giles et al 1988). Communication of information, messages, opinions, speech and thoughts are transferred by different forms. Basic communication is achieved by speaking, sign language, body language touch and eye contact, as technology has developed communication has been achieved by media, such as emails, telephone and mobile technology (Aarti, 2010). There are two main ways of communication: Verbal and non verbal.

Verbal communication is the simplest and quickest way of transferring information and interacting when face to face. It is usually a two way process where a message is sent, understood and feedback is given (Leigh, 2001). When effective communication is given, what the sender encodes is what the receiver decodes (Zastrow, 2001). Key verbal features of communication are made up of sounds, words, and language. Mr James was alert and orientated and had some ability to communicate; he was breathless due to painful fractured ribs which hindered his verbal communication. In order to help him to breath and communicate effectively, his pain must be controlled. Breathless patients may be only able to speak two or more words at a time, inhibiting conversation. The use of closed questions can allow breathless patients to communicate without exerting themselves. Closed questions such as “ is it painful when you breathe in?” or “ is your breathing feeling worse?” can be answered with non verbal communication such as a shake or nod of the head. Taking a patients history in this way can be time consuming and it is essential that the clinician do not make assumptions on behalf of

the patient. Alternatively, encouraging patients to use other forms of communication can aid the process. Non verbal communication involves physical aspects such as written or visual of communication. Sign language and symbols are also included in non-verbal communication. Non verbal communication can be considered as gestures, body language, writing, drawing, physiological cues, using communication devices, mouthing words, head nods, and touch (Happ et al: 2000, Alasad: 2004). Body language, posture and physical contact is a form of non verbal communication. Body language can convey vast amounts of information. Slouched posture, or folded arms and crossed legs can portray negative signals. Facial gestures and expressions and eye contact are all different cues of communication. Although Mr. James could verbally communicate, being short of breath and in pain meant that he also needed to use both verbal and non verbal communication styles.

A patient’s stay in Intensive Care can vary from days to months. Although this is a temporary situation and many patients will make a good recovery, the psychological impact may be longer lasting (MacAuley, 2010). When caring for the patient who may be unconscious or sedated and does not appear to be awake, hearing may be one of the last senses to fade when they become unconscious (Leigh, 2000). Sedation is used in Intensive Care units to enable patients to be tolerable of ventilation. It aims to allow comfort and synchrony between the patient and ventilator. Poor sedation can lead to ventilator asynchrony, patient stress and anxiety, and an increased risk of self extubation and hypoxia. Over sedation can lead to ventilator associated pneumonias, cardiac instability and prolonged ventilation and Intensive Care

delirium. Delirium is found to be a predictor of death in Intensive Care patients (Page, 2008). Every day a patient spends in delirium has been associated with a 20% increase risk of intensive care bed days and a 10% increased risk of morbidity. The single most profound risk factor for delirium in Intensive Care is sedation (Page, 2008) Within this stage of sedation or delirium it is impossible to know what the patients have heard, understood or precessed. Ashworth (1980) recognised that nurses often failed to communicate with unconscious patients on the basis that they were unable to respond. Although, research (Lawrence, 1995) indicates that patients who are unconscious could hear and understand conversations around them and respond emotionally to verbal communication however could not respond physically. This emphasises the importance and the need for communication remains (Leigh, 2001). Neurological status would unavoidably have an effect on Mrs James's capacity to communicate in a usual way. It is therefore important to provide Mrs James with all information necessary to reduce her stress and anxieties via the different forms of communication. For the unconscious patient, both verbal communication and non verbal communication are of importance, verbal communication and touch being the most appropriate. There are two forms of touch (Aarti, 2010), firstly a task orientated touch – when a patient is being moved, washed or having a dressing changed and secondly a caring touch – holding Mrs James hand to explain where she was and why she was there is an example of this. This would enhance communication when informing and reassuring Mrs James that her husband was alive and doing well. Nurses may initially find the process of talking to an unconscious patient embarrassing, pointless or of low importance as it is a one way conversation (Ashworth, 1980) however as

previously mentioned researched shows patients have the ability to hear. Barriers to communication may be caused by physical inabilities from the patients however there are many types of other communication barriers. A barrier of communication is where there is a breakdown in the communication process. This could happen if the message was not encoded or decoded as it should have been. If a patient is under sedation, delirious or hard of hearing verbal communication could be misinterpreted. However there could also be barriers in the transfer of communication process as the Intensive Care environment in itself can cause communication barriers. Intensive Care can be noisy environment (Newmarch, 2006). Other barriers can simply include language barriers, fatigue, stress, distractions and jargon. Communication aids can promote effective communication between patient and clinician. Pen and paper is the simplest form of non verbal communication for those with adequate strength (Newmarch, 2006). Weakness of patients can affect the movement of hands and arms making gestures and handwriting frustration and difficult. Patients may also be attached to monitors and infusions resulting in restricted movements which can lead to patients feeling trapped and disturbed (Ashworth, 1980). MacAulay (2010) mentions that Intensive Care nurses are highly skilled at anticipating the communication needs of patients who are trying to communicate but find the interpretation of their communication time consuming and difficult. The University of Dundee (ICU-Talk, 2010) conducted a three year multi disciplinary study research project to develop and evaluate a computer based communication aid specifically designed for Intensive Care patients. The trial is currently ongoing, however this may

become a breakthrough in quick and effective patient – clinical and patient – relative communication in future care.

This assignment has explored communication within Intensive Care and reflected upon previous experiences. Communication involves both verbal and non verbal communication in order to communicate effectively in all situations. Researching this topic has highlighted areas in Intensive Care nursing which may be overlooked, for example ventilator alarms and general noise within a unit may feel like a normal environment for the clinians however for patients and relatives this may cause considerable amounts of concern. Simply giving explanations for such alarms will easily alleviate concerns and provide reassurance. From overall research (Alasad: 2004, Leigh: 2001, MacAuley, 2010: Craig, 2007) Intensive Care nurses believed communication with critically ill patients was an important part of their role however disappointedly some nurses perceived this as time consuming or of low importance when the conversation was one way (Ashworth, 1980). Further education within Intensive Care may be required to improve communication and highlight the importance of communication at all times. Communication is key to ensuring patients receive quality high standard care from a multidisciplinary team, where all members appreciate the skills and contribution that others offer to improve patients care.