Nurses role in communicating effectively in clinical practice

The purpose of this essay is to discuss and analyse the nurse's role, in relation to communicating effectively in clinical practice. To explore this area fully an example taken from a clinical practice will be outlined, in accordance to the NMC (2008) confidentiality guide lines. To follow after will be how we learn to communicate, what communication is and the potential barriers that prevent effective communication. A nursing module by the name of Egan (SOLER) that has been especially designed to help nurses develop communication skills will be discussed in relation to the clinical practice example. Another nursing module from Roper, Logan and Tierney has also been briefly examined and related back to the clinical practice example. Suitable conclusions will be drawn up to bring this topic to a closure.

In accordance to the Nursing and Midwifery Council (NMC) 2008, the patients name has been changed in order to protect their identity. Alex is a male patient, in his late forties and is currently being treated for on a mental health ward. To communicate with Alex a trusted relationship had to build up first, as he suffers from paranoia schizophrenia. His average day would consist of being huddled into a ball in a small arm chair anxiously aware of everyone and everything around him. I aimed to make sure that I approached Alex in the same manor every shift in order to build up a trust between us, so that i could offer assistance to him if needed. Over the placement period the trusted bond between Alex and I had started to form and he now trusted me enough to help assist him to the dining room to feed him, where as normally the food was brought to him because of his nervousness and anxiety around large groups .

In order to communicate effectively you need to understand the aspects involved with communication. The basics start off with oral and written communication skills taught to us from a young age, in order to achieve in life. Oral communication is a constant learning skill throughout life, by observing and practising. The same can be said for written communication. Both communication aspects should equally complement one another, as weak or poor oral/written skills can lead to disagreements between individuals, poor documentation, and waste of time for resources. Whilst mastering the art of effective oral communication other factors now come into play such as, using open and closed questions to enhance a conversation and also the facilitators/barriers to communication. As well as being able to speak and write correctly, other learning functions are also taught from a young age by observing others, and are also included in our constant learning curve through life, these include listening, understanding, becoming self aware and to the ability to maintain confidentiality . Without these important extra factors no further improvement personally or professionally would be able to happen. If unable to listen and understand oral communication/commands catastrophic consequences could occur, especially in the field of nursing.

Effective communication is needed in order to understand the individual’s viewpoint on their illness and to strive for empathy. The nurse’s job does not only involve looking after the physical demands of the patient, but also to try and build up a therapeutic relationship between them.

Oral communication consists mainly of two divisions called verbal and non verbal, from which they both strand off and explore the various different characteristics between them.

‘ Verbal communication pays close attention to the accents, pitch, tone, volume, speed and context.’ (Arnold, 2001, p. 41)

Referring back to the clinical example above, before I started to communicate with Alex I politely asked him what language he spoke or preferred to use, Alex stated that English was his only language.

The Nursing and Midwifery Council (2008) states that, ‘ You must make arrangements to meet people’s language and communication needs’. (NMC code 2008, p. 3)

Communication was one of the barriers that affected Alex so therefore effective verbal communication was extremely important to my patient in order for him to maintain his social interaction skills and memory processing (Mason and Whitehead 2003) By approaching Alex frequently throughout each shift I tried to maintain as much social interaction as possible to help him overcome his timid social skills and to keep some sort of normality to his daily living on the ward. Communicating with Alex would often be a one way conversation due to the lack of response when communicating with him; some qualified health care professionals would spend less time with him, for the feeling of being ignored. When actually socialising with the patients is a therapeutic activity and can help with the healing process.

Mason and Whitehead states that, ‘ Thus, nursing can be viewed as a social action and also as a form of therapy in itself’.

I tried to speak to Alex in a way that I hoped would reassure to him that I brought no harm, by slowing down my speech and speaking quieter and softer than normal. The purpose in doing so was that speaking in a lower tone to Alex proved to be more effective and calming for him, which overall provided a better response in conversation. If you were to suddenly ask Alex a question, without thinking about your self-awareness and interpersonal skills first, it would startle him and sometimes cause an outburst of unsettlement.

Whilst trying to keep sentences short and simple for easier understanding, to further the conversion I made a conscious effort to ask open questions that would prompt more of an answer other than yes or no. The reason in doing so was to try and assist with Alex’s social skills and build up his autonomy confidence. Questions such as ‘ what visitors have you had today’ or ‘ who got you out of bed this morning’ would help to establish a small conversion whilst trying to set up building blocks to further the conversation.

To start a conversation off with one of the following words who, what, when, where, why and how, help to approach an open ended question and to also address specific symptoms. (Sheldon L. K, 2009.)

‘ While non verbal communication looks more at the paralinguistic’s such as, body language and movements, facial expressions, proximity, eye contact and posture.’ (Arnold, 2001, p. 41)

Referring back to the clinical example above, non verbal communication needed just as much attention because Alex would sit with his knees pulled in tightly to his chest, with his arms wrapped around them and his head bowed down. By displaying these closed gestures, Alex was indicating his need for self protection, and that he was feeling vulnerable. In order to open up his body language and communicate with Alex small and gestures had to be used such as, trying to maintain eye contact throughout lets you establish a connection and initiates communication whether it be verbal or non verbal, it also helps to engage with your patient and help with attentiveness. (Gupta, 2008)

Before I sat down or made an approach, I made sure that I informed Alex what I was going to do.

Uys and Middleton suggest, ‘ When moving towards the patient, inform him/her verbally of what your actions mean’.

By pulling up a chair to sit next to Alex decreasing the proximity between us i tried to show warmth, care and understanding, by placing my arm slowly and gently on his arm of the chair, instead of standing over him and coming across as superior. (Boyer, J. M 1992)

Proximity between Alex and I would differ from day to day, sitting close to him in a chair may be ok some days and on others you would need to allow significant body space. By judging his non verbal communication such as facial expressions and eye contact, you consciously knew the distance he would appreciate. (Uys and Middleton, 2004)

To offer assistance to Alex and prepare him for moving off his security setting and into the dining room for food, I would verbally and non-verbally explain to Alex what the plan was and how we were going to get to the dining room. I would point to specific points in the day room and explain it would only take three steps or five steps to the next point, to try and encourage movement. Whilst pointing around the room I would show my palms instead of pointing my index finger. The reason for showing my palms was that pointing at something can be misinterpreted as an attack, whereas a palm is more open and patient, ready for encouraging small movement at a time. Showing points in the room to where we would walk to first, would make the journey to the dining room seem less intimidating and also not to cause any additional anxiety for him, as some restless and panicky patients need reassurance about the availability of support (Uys and Middleton, 2004)

Other day's small gestures would be all it took for Alex to open up his body language, such as keeping a happy, wide eyed expression around him, showing that i was still available if he wanted some reassurance.

The work of Egan (1986) has been drawn upon extensively by nurses as the basis for active listening, as this skill is a fundamental aspect required by nurses to provide adequate care, and by suggesting that non verbal skills can demonstrate to the patients that you are listening to what he or she is saying. The frame work is labelled by the name of SOLER, and is an acronym from the word squarely. It encourages the nurse to sit squarely facing your patient so that you may engage them fully; this was especially helpful when talking to Alex as it showed I was willing to communicate with him. It also mentions about adopting an open posture to show encouraging and

facilitates patient expression. Alex displayed closed off gestures, by implying openness I tried to facilitate effective communication whilst also being aware of my own body language, posture and movement. To lean slightly forward showing attention and interest was not always a good position to hold, as being so close to Alex would slightly unnerve him and make him feel intimidated. Soler also suggests maintaining good eye contact, which again shows interest. In relation to Alex maintaining good eye contact was vital for encouragement and progress when assisting to the dining room, by showing a wide eye, happy expression I aimed for encouragement and reassurance. The last part of Soler, Egan argues that it is imperative not to fidget and to feel at ease and relaxed (Stretch, 2007) again this part played an important factor when assisting Alex to the dining room.

There are also many barriers that prevent effective communication between the nurse and patient’s such as, stereotyping. Nurses must try and refrain from culturally stereotyping patients, and should consult patients regarding values, beliefs, preferences and cultural identification first. (Boyer. J, M, 1992)

Other barriers include perceptions, prejudgements, environmental factors and nurse’s avoiding subjects or rapidly changing the subject if the nurse feels uncomfortable within a nurse/patient situation. The reason for distancing themselves was to avoid exploring an area that could actually do more harm than good to the patient. Over time this procedure has been reviewed and communication is now seen as a vital aspect for improved better care and a more therapeutic nurse-patient relationship. (Walsh and Crumbie, 2007)

Roper, Logan and Tierney collaborated to refine the Roper models (1980) as a way of introducing beginning students to think about nursing practice. It has been used extensively within the United Kingdom as a frame work for nursing care, practice, teaching and learning.

The module is divided up into two sections, the module of living including the sixteen activities of living (ALS) and the module for nursing including twelve further activities of living that came into action after a lengthy debate in 1996.

Starting off with the module of living Roper et al categorized this section into three groups, ‘ essential’ looks at the physical demands of daily living, ‘ increase quality of living’ pays close attention to the social aspect of daily living, and ‘ mortality’ looks at the dying stage of life. The next twelve ‘ activities of living’ are related to particular human needs and have biological basis to them, whereas the sixteen activities of daily living have social and cultural determinants. (Aggleton and Chalmers, 1986) (Holland et al, 2003)

The focus of the theory model is aimed at efficient nurse/patient communication in order to achieve a positive living outcome for the patient. It shows empathy, non judgement and respect to the patients needs by recognising that, people require nursing episodically and that minimal disruption to a person’s lifestyle should be maintained.

As mentioned previously with Alex, communication with him on the ward was to try and keep some sort of normality to his daily living, whilst being looked after.

Roper, Logan and Tierney states that, ‘ Alternative strategies should be carried out on an informed basis and not simply in accordance with past precedent.’ (Aggleton and Chalmers, 1986, P. 31)

One of the new strategies tried with Alex was to assist him to the dining room for food, rather than bringing the food to him where he felt secure in his chair. The purpose in doing so was to encourage and seek responsibility for self-care, to promote dignity and to raise Alex’s self esteem.

Conclusion