

How effective communication can contribute to health



Interactions with people can be formal or informal. Formal interactions are likely to involve a social worker talking to an official capacity. Informal interactions in contrast are more themselves and relaxed the different types of interactions are verbal and non verbal. Verbal interaction occurs when the person speaks, when people talk to each other one to one or in groups. Effective verbal communication involves a two way process of speaking and listening. In St John's Palliative Care Homes all forms of communication are important for a good relationship between client and staff.

Ways to communicate verbally would include; asking questions, probing and prompting within the conversation e. g. at St John's a nurse asking the client what their granddaughter/ son is like if the client mentions that they have them, and the tone of voiced used. Verbal communication is most commonly used in communication with children, meetings, providing support and dealing with problems and complaints. Stress and being upset are barriers to good communication, as is confusion and being emotionally stressed. At St John's hospice multi skilled professionals all work together to prevent these barriers occurring when communicating with clients and clients relatives.

Non-verbal communication is using body and aspects of behaviour to convey messages. This is called body language. The main features of non-verbal behaviour that are important in human communication are; facial expression, eye contact, gesture, posture, proximity and touch, silence, warmth, mirroring and reflective listening. Staffs at the hospice need to be able to recognise different types of body language. E. g. a client may say that they are doing fine when their body language is telling the nurse they need help or want to talk to someone.

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If someone were listening effectively they would be paying attention to the speaker by showing all of the features shown above, linguistics and paralinguistics.

Interpersonal interaction is based on the effective use of communication skills. People who work in health and social care rely on the communication skills as much as their technical knowledge and practical care skills in order to be effective practitioners. St John's Hospice workers gradually develop and improve their communication skills through training, practice and experience. Acquiring an understanding of the basic elements and characteristics of human communication is an essential part of learning how to communicate with people.

As with all things in this generation, communication comes with its problems. Problems in communication will include people with special needs. E. g. deafness, blindness and psychological impairments. These problems can however be often overcome or made less disabling through the use of technical equipment and alternative communication strategies. Such equipment is hearing aids, text phone or an electronic communicator. These and many other devices can provide people with speech, hearing and complex physical disabilities with effective communication assistance.

When communicating with people with special needs the communicator should make sure they are seen clearly, face both light and person at all times, make sure mouth is visible, speak clearly and slowly, repeating and rephrasing if necessary, make sure they do not shout into the person's ear or hearing aid, minimise background noise and use good body language. All of

these factors will help communicate effectively to people with special needs. All of the St John's staff are effectively trained and know what to do automatically and so do not unnerve the client or make them feel uncomfortable by making obvious mistakes or faults if trying to communicate them.

St John's staffs also know efficient background information on each client. This is through referral forms. Referral forms are used to write down all the patients' details. Case booklets are filled in by all professionals, a detailed admission section and daily notes added from medical note to family details, patient's concerns etc. case conferences held to set up support for patients going home. All written information must be sensitive and with agreement of the patient, who can see them at any time. Comments such as 'jean is a nice lady' are not acceptable, as they are personal judgements.

At St John's Hospice communication start as soon as the possibilities of hospice care is mentioned to the patient. They are often fearful and have the wrong impression of what the hospice is like and that they go there to die. A Liaison nurse can visit them at home to allay their fears, arrange them a visit or show them photos, and portray St John's in apposite way. When bad news about illness is first given to a patient from their GP or a hospital consultant, they are often shocked and upset and can't take it all in. Having someone with them can help, or taping the consultation to listen to later and the use of information leaflets all help.

A follow up consultation may be needed, where questions can be answered. Stress and being upset are barriers to good communication, as is confusion

and being emotionally distressed. Multi skilled professionals all work together to meet the patient's needs. GP's, district nurses, voluntary organizations, social workers and St John's staff meet regularly to discuss and complete care plans and liase to best meet the needs of the patients. Everything the hospice does contributes to the health and care of the patient.

How client confidentiality can be maintained.

Most people in caring professions and roles are aware of the need for confidentiality, but we must not assume that the client will know about this, or expect it. Some clients will have heard stories of confidentiality being broken and if they are worried about this, it could prevent good communication taking place between you. However, it is important for you to explain to the client that you represent an agency. Make it clear that, as far as possible, whatever you are told will be held within the agency and perhaps will only have to be shared with your supervisor. Most people will be reassured if you make it clear you will not discuss their confidences with others outside the agency without consulting hem first.

Often, family members or others will ask you to breach this confidence. You can usually find a way of avoiding this but sometimes you will have to state clearly tat you cannot break any confidences made by the client.

Some people working in a caring capacity have to sign contracts committing them to respecting confidential information. There can be legal penalties for breaking these contracts. If a lawyer, policeman, judge or employer says you

must breach a confidence you will need to take advice from someone in a senior position in your organisation.

Boundaries of Confidentiality

It is sometimes useful, when deciding on who should be given confidential information, to separate people into the following groups:

- * Those who must know

- * Those who should know

- * Those who could know

- * Those who shouldn't know

A typical team on a medical or surgical ward would include doctors, nurses, social workers, physiotherapists, dieticians, pharmacists and others. Related to this team are secretaries, receptionists, porters and ward cleaners. These individuals are vital to the working of the team but do not always need to know everything about their client.

Confidentiality of Information

It is possible to identify a series of levels of information, which might be used to decide on whether or not the information could be shared. There are four levels of information:

- * Identification: name, address, sex, marital status and primary disease.

- * Medical information: disease, extent of disease, treatment investigation, past medical history and drug information.
- * Social information: housing, work, family and social relationships.
- * Psychological relationships: anxiety, stress, sexual problems and emotional state.

At present this information is stored, presented and shared in a variety of ways:

- * Documents, reports, case sheets, nursing Kardex ect.
- * Tutorials, or formal doctor-doctor, nurse-nurse contact
- * Ward meetings, formal or informal, where problems are shared and discussed
- * Ward rounds, with discussion between the staff
- * Letters giving information are exchanged between the staff
- * Investigation forms are completed and sent throughout the hospital, and into the wider community.
- * Computers and records: the use of computers and databases has provided a new element in the maintenance of confidentiality, and the problem of ensuring access to records by patients.

Data Protection Act

Many organisations, both public and private, hold files of information on the people they deal with. People who have never met or spoken to you may take important decisions about you on the basis of your file, often. All they know about you is what the file says.

If the information is incomplete, inaccurate or unfair, your rights may be at risk- or you could be denied a benefit or a service that you need. The best safe guard is a right to see the file for yourself. Several laws allow people to see certain files held on them, and some information can also be obtained under the non-statutory ‘ open government’ code of practice.

Data Protection Act 1984

This Act gave patients the right of access to their own medical records held on computer.

Access to Health Records Act 1990

This Act gave a similar right of access to information recorded after November 1991 on non-computerised medical records. The cut off date is likely to disappear under new legislation. There are some exceptions to rights of access, the most important being:

* Doctors may refuse the patient access too all or part of the records if it is their medical opinion that access may ‘cause serious physical or mental harm to the patient’.

* Access may be denied if this would disclose information about a third party without his or her consent. Third parties do not include doctors or others whose errors might be disclosed by a scrutiny of the records.

Access to Medical Reports Act 1989

This Act gives people the right to see medical records prepared by the doctor for employment or insurance purposes.

Maintaining client confidentiality in St John's Hospice

All nursing and other staff have to comply with the 'UKCC Guidelines for professional practice', which explain issues of confidentiality, and the 'Code of Professional Conduct UKCC'. Patients are fully involved in all written Care Plans etc and nothing is written down secretly or without their knowledge, but will be stored privately so strangers cannot access it. It is very much a policy of trust, openness and honesty. The Data Protection Act 1984 and Access to personal files Act 1987 and Access to Health records Act 1990 are all followed recording and storage of client information.

St John's confidentiality and communication can cause implications. The hospice confidentiality must be handled with care. The patient has a right to believe that any information they give will be used only for the purpose for which it was given and will not be released to others without the consent of the patient. A confidentiality form needs to be signed by the patient and nurse. Documents of patients are kept in a locked room and in 10 years after the patient has died the documents are then shredded and burnt. Codes and

locks are kept on computers and cupboards, which are changed frequently to stop people knowing the codes easily.