

Communication in nursing and a clinical example



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This assignment is a reflective account of my relationship and communication with a certain patient during my first clinical placement in a nursing home.

All names in this text have been changed, to respect the confidentiality of the patient and other healthcare professionals (NMC 2002).

Introduction

“ Most people have felt anger and helplessness at not being listened to when saying something important. Also the intense frustration of being misunderstood...” Ellis, RB. (2003). Defining Communication. In: Ellis, RB, Gates, B, Kenworthy, N Interpersonal Communication in Nursing. 2nd ed. London: Churchill Livingstone. p3.

I have recently been on 7 week placement in a nursing home for the elderly. It was a residential home but also had a small dementia unit in which patients with mental health problems were taken care of. This experience has taught me that communicating with elderly patients both with and without dementia can be extremely difficult. In certain circumstances I found it hard to understand what some residents wanted due to these communication barriers.

In my essay I will be describing to the reader, what dementia is, what communication is and how important verbal and non verbal communication is to sufferers of dementia.

What is Dementia? “ Dementia is a common condition. In England alone, there are currently 570, 000 people living with dementia. That number is

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expected to double over the next 30 years.” Dementia. Available://www. nhs. uk/conditions/dementia/Pages/Introduction. aspx. Last accessed 20 Dec 2009.

Dementia is a condition that is connected with an ongoing decline of the brain and its abilities. It is generally caused by damage to the structure of the brain and is most common in people over the age of 65. Thinking, language, memory, understanding, and judgement are all affected in someone who has Dementia. Sufferers may also have problems in controlling their emotions and behaviour when in social situations. Due to this their personalities may appear to change.

There are 4 kinds of dementia. Alzheimer’s disease, Vascular dementia, Dementia with Lewy bodies, where and Frontotemporal dementia. These 4 kinds were all present in patients in the dementia unit, where I spent 7 weeks; however I will be concentrating on Alzheimer’s.

ALZHEIMER’S IS...

What is communication? Communication is essential for human interaction; it is the process of passing on information form one person to another. Both verbal and non verbal communication is used by a healthcare worker however for a dementia sufferer non verbal communication is essential. (Argyle, 1978) believes that non verbal communication can have five times as much effect on a person’s understanding of a message compared to the verbal communication at the time.

Chomsky calls the act of speech (verbal communication) 'performance' and the knowledge of the language 'competence'. People perform the complexity of speech daily but have no real knowledge of why or how they came to be able to. Speech allows us to hold conversations, ask questions, give instructions, hide the truth, build routines and most importantly talk about interactions in which we are involved (Argyle, 1978).

Why is communication important? Communication is extremely important in the healthcare industry. In order (as a healthcare worker) to understand your patient and vice versa, there must be good, clear communication. This will help the patient receive better care. If a patient cannot be understood properly it would be very hard to give appropriate care. If there is good communication between a patient and healthcare worker, it will ease the patients' anxiety. Patients are at risk for high levels of anxiety and frustration if communicative attempts are unsuccessful. (Finkee, Erin HMS 2008).

Communication helps the carer and patient get to know each other better, it helps them to bond and learn what makes the patient happy or upset, what foods they like and more importantly when there's a problem the patient is more likely to turn to the carer if there is a good bond there. A good bond can be hard to achieve with a patient with dementia as short term memory is often lacking so previous conversations can be forgotten. Approach towards patients with dementia is very important, facial expressions, tone of voice, uniform and how we present ourselves can say a lot about us.

When communicating with the elderly residents if I were to raise my voice in an aggressive way they may feel threatened and scared by me, but if I speak to them in a pleasant tone of voice then the resident is more likely to feel

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at ease around me. I can then start gaining trust and understanding between myself and the resident. When a patient has dementia they can't speak by the final stage. Closed questions must be used by this stage. There are 2 types of questions, open and closed. Open questions leave the answer open to respond with a lot of information or a little. Closed questions are those that a patient has nod or shake their head to or use other body parts such as thumbs up or down. This style of questioning is appropriate to use on someone in the final stage of dementia. Closed questions are such like " Are you okay?", " Are you hungry?". This allows the patient to communicate with us without actually saying anything. These types of closed questions are a type of non verbal communication. As I have mentioned earlier there are two types of communication, verbal and non-verbal. Verbal Communication talking to the patient and them responding with speech. It can really be very difficult to use verbal communication with Alzheimer's patients because their short term memory is limited to they forget easily what's been said. According to Argyle (1990) in a conversation, words make up only 7% of a message; tone, tempo and syntax make up to 38% and body language makes up to 35%. Non verbal communication can be expressed by our facial movements, gaze and eye contact, gesture and body movement, body posture and body contact, use of space and time and how we dress. (Henley 1977) states that how powerful we feel in an interaction can be expressed non-verbally. Our unspoken communication can be shown through our body language. Touching patients can be an essential tool for a nurse. It can offer support and understanding, comfort and security. It adds extra meaning to the spoken word. Macleod and Clark (1991) suggest that most touch between nurses and elderly patients is related to practical procedures,

fulfilling a practical rather than an emotional purpose. Facial expressions and tone of voice can match what you're trying to say. If you're frowning or looking sad, this can cause patients to get angry and upset, but if you're smiling at patients, this can raise their mood. Listening and attending are both also very important aspects of communication. Patients who can speak freely about their ideas and feelings need a little encouragement so that they can explore these ideas a little further, such as saying " Mm" or " Aha".

In the mental health hospital that I was on placement at, most of the clients had Alzheimer's disease, so it was very difficult to communicate with all of them as the majority of them couldn't find it difficult to communicate certain issues at some times. It was hard for me to know their needs as they couldn't tell me what they wanted, the only way I could help them was if I asked them closed questions like " Do you want something to eat?", or " do you need to go to the toilet?". This gave the patients the opportunity to give me a yes or no nod or use their eyes to tell me what they wanted.

Another way I noticed if patients were agitated was if they were walking around fiddling with everything and trying to get out of the hospital , I knew something was wrong, usually it was because they were constipated or needed the toilet, other times was because they were thirsty and needed a drink. If I was feeding the patients and they wouldn't open their mouth to eat the food or push against the spoon I would know that they weren't hungry.

Sometimes patients would spit their tea out, this was usually because it was too hot. Barriers to communicating and how to overcome them the biggest barrier to communicating with a patient with Alzheimer's disease is the fact that some of them cannot speak. But when we speak to them, there can be barriers so that patients can't hear or understand us, these include: -

Background noises, e. g. the radio playing loudly, or the television too loud, people around talking as well as us, this can confuse patients even more. Turning the television down whilst having a conversation with a patient can help. - The way we speak, if we are mumbling they won't be able to understand us, or if we have an unfamiliar accent that they don't recognise or understand they won't be able to respond to us. Speaking clearly and giving simple instructions helps patients understand us better. - If we are feeding patients and talking to them at the same time, clients will get all confused and frustrated. Or if we are eating or chewing something ourselves whilst talking to a patient, this can affect our speech and make it difficult for the patient to understand what we're saying. Taking time to concentrate on one task at a time avoids confusion. Calling clients by their name can draw their attention better rather than just talking to them right away, because otherwise they might ignore us because they don't know that we're talking to them. Providing the patients with the words they might want to say can help us meet their needs because perhaps they might begin something but then start mumbling, listening carefully to them will make things much easier for us to respond and help them.

Conclusion Before going on placement, I felt very nervous and anxious on what it was going to be like working with patients who I knew couldn't communicate with me. I kept thinking about how hard it was going to be to know how to take care of them and try to reach their needs in the best possible way, the only thing that helped me through the experience was the fact that I had a great deal of empathy and patience which helped me communicate better with the patients so I didn't get frustrated or angry when they couldn't respond to me. Before I went to work on the ward, I had read up and researched <https://assignbuster.com/communication-in-nursing-and-a-clinical-example/>

Alzheimer's disease, to have a greater understanding on what to expect, and to be able to deal with the environment in a more professional manner. I used verbal and non-verbal communication and body language e. g. touching, feeling, smiling and speaking clearly. This helped me communicate much better with the patients as a majority of them couldn't reply to me verbally, so they used eye contact and touch to help me know what they wanted or needed, e. g. if a patient took my hand and lead me to the direction of the toilets, I knew they needed the toilet.

Mr. Jones was brought to the nursing home in the Flintshire area by his son. He is 88 and has suffered from dementia for a number of years but in the past year Alzheimer's has progressed fairly quickly leaving his son unable to care for him. Mr Jones's symptoms include major confusion, withdrawn from society, delusions and extreme mood swings, he often gets extremely angry. He needs carers for certain normal activities essential for daily living such as finding the toilet, helping him on with his clothes and generally watching over him throughout the day. Some of his needs may also be due to his age; he has problems with his mobility so needs a carer for that not just due to the Alzheimer's.

My mentor asked me to spend some time with Mr Jones, talk to him and build up a rapport with him. The day before my mentor had given me some leaflets on the subject of dementia and Alzheimer's to prepare me and give me a better understanding.

When I first sat down with Mr Jones he just seemed like a 'normal' elderly gentleman of fine health for his age, however as I began speaking to him I

found quickly how advanced his Alzheimer's was. It was quite upsetting for me as I had never been in that situation before. Within the first 20 minutes of speaking to Mr. Jones he had asked me the same question and we had the same conversation around 5 times. I found this rather awkward as I was unsure whether to continue with the repetitive conversation, create a new one or whether if I did so it would end in the same way. Mr Jones also mentioned to me that he was the homes Gardener. Confused by this I went to my mentor who assured me that this was a delusion he had thought was real since his son moved him into the home and to just 'leave him to it'.

I found that after the first week of me working there Mr Jones recognised my face, he still continued to ask me the same questions such as 'where do you live?', 'do you know my son?' and tell me about his gardening job but he would remember by name. So knowing my name had clearly gone into his long term memory.

The thing that worried me the most however was that Mr Jones would ask me when he was going to get his pay cheque. The other staff told me to tell him 'next week'. I found this shocking and an insufficient answer. I felt that if I did as the other staff told me this would just reinforce the delusion and so I when he asked me the next time I told him the truth. This however made him very distressed and upset. The NMC (2002) outlines that we must not add extra stress or discomfort to a patient by our actions. This has proved to be a hard role to follow as either choice would have added discomfort to him.

This experience left me feeling very uncomfortable and inadequate in my role. I tried to understand why he had manifested this delusion and came to

the answer that perhaps it was a coping technique at the thought of being put into a home. I felt anger and frustration and helplessness that there was nothing I could think to do to help this delusion fade away.

Although this experience was very frustrating for me and probably the patient, it has highlighted the need for me to improve my communication skills.

It appeared to me that Mr. Jones' delusion was not only a psychological disorder caused by his condition, but a way for him to put his mind at ease. Critical analysis of this experience has pointed to the fact that I have inadequacies in my skills; I had focussed too much on my morals and worry that I was being untruthful with him when perhaps reinforcing his view would have caused him less displeasure. I had not considered his other needs like his wishes or desires and I had not gathered enough personal information about him beforehand to know this - maybe he liked gardening.

I had been unsure about what to say or do to ease Mr. apparent anxieties and had adopted what Watson & Wilkinson (2001) describe as the blocking technique. By continuing my actions to carry on with the meal, I was cutting short the patients need to communicate a problem.

I was influenced in this decision because I felt obliged to be seen to reduce his anxieties, knowing my actions would be judged by an audience of other care workers and patients on the ward. I did not respond efficiently to reduce his distress and this pressure led me to deal with the situation inadequately and for that I felt guilty (Nichols 1993).

I should have allowed more time to understand what Mr. Jones was thinking and feeling by maybe asking him calm questions such as do you know where you are, how long have you been here? And perhaps he would have come to a gradual realisation by himself. I could have shown more empathy in the form of my own body language to promote active listening (Egan 2002) instead of just worrying about his mind wandering to an untruth.

Gould (1990) cited by Chatham & Long (2000) have suggested that $\frac{1}{2}$ many of the non verbal behaviours we use to reassure patients, such as close proximity, prolonged eye contact, clarification, validation, touch, a calm and soothing voice, the effective use of questions, paraphrasing and reflecting thoughts and feelings and summarising are all sub skills with the totality of empathy $\frac{1}{2}$.

There is an abundance of information about communication, especially for nurses because it is considered by many as the core component to all nursing actions and interventions. Lack of effective communication is a problem that still exists because the learning process that leads to a skilled level of ability may take years of experience to develop (Watson and Wilkinson 2001).

It has been quite difficult for me to admit my inadequacies in communication, but Rowe (1999) explains that a person must identify their weaknesses as an initiative for becoming self-aware. Only with acceptance of one's self, can a person begin to acknowledge another person's uniqueness and build upon this to provide holistic care.

I know the knowledge I have gained through reflection of my experience will not always ensure that I will treat patients with unconditional positive regard, simply because of the diversity in the nature of us as individual human beings and the environment surrounding us. I have gained a new perspective on my practice which is to set myself personal goals in facilitating effective communication between the patient and myself, should the situation present itself again.

BERLO'S MODEL!