Theories of communicatiion in health and social care

Introduction

In the context of health and social care settings, it is very important to have good communication between service users and staff (Gambrill, 2012). As Hepworth et al. (2010) comment, it is vital that care staff develop good communication skills so that they have effective communication with service users and can explain treatment needs to the latter. In addition, care staff must learn professional communication techniques (and know how to apply them) to create a better health care environment (Cournoyer, 2013). There are many different forms of communication, including, for instance, verbal and non-verbal forms. There are also many approaches through which good communication relationships can be fostered (or hampered) and it is imperative, therefore, that care staff learn from best practice so as to ensure that they maximise the potential for the development of a meaningful relationship (Reeves et al., 2011). Good communication and interpersonal skills are, quite simply, essential to the practice of effective health and social care (Greenhalgh, 2008).

Such skills are not merely limited to day-to-day communications with clients. In communicating with others, the practitioner needs to be able to use a variety of strategies to ensure that professional practice meets health and social care needs and facilitates a positive working relationship. Indeed, as Reeves et al. (2010) suggest, there are different approaches for communication and it is imperative that the individual practitioner tailors his or her use of these to the individual needs of the individual patient. Accordingly, expertise, or at least a sound working knowledge of all of the following approaches – humanistic, behavioural, cognitive, psychoanalytical

and social (to name but five) – is vital. These theories are, as alluded to, applicable to developing certain techniques in the sector of health and social care. For example, as Gitterman and Germain (2013) comment, humanistic theory is applicable in situations where people are involved in aspects of self-actualisation, self-conception, self-esteem, honour, and dignity. This approach reflects on the perspective that every human being has the potential to be good, to enjoy life, to contribute positively, and to be a loving and lovable member of society. Thus, as Healy (2014) suggests, this is an approach that aims to maximise critical thinking and analytical optimism. In the health and social care sector, service providers such as doctors, nurses, home care managers, and social workers are, as Ife (2012) contends, offered appropriate training in order to care for service users in the most humanistic manner by implementing or practising modes of communication relevant to the appropriate situation and/or individuals.

Theoretical foundations

Social theory, as Howe (2009) explains, is the use of theoretical frameworks to study and interpret social phenomena within a particular school of thought. It is an essential tool used by social scientists, and the theory relates to historical debates over the most valid and reliable methodologies that should be used in the analysis and evaluation of needs and how such analysis can be transformed into ' real-life' action (Parrott and Madoc-Jones, 2009). Certain social theories attempt to remain strictly scientific, descriptive, or objective, whereas, as Healy (2014) postulates, conflict theories present ostensibly normative positions, and often critique the ideological aspects inherent in conventional, traditional thought. It is

important to recognise the differences between such models so as to ensure that the right model is used with the right service user to maximise an understanding of their care needs. At all times, the needs of the client must come first (Hughes, Bamford and May, 2008).

In commenting further upon the individual theories it should be noted that, as Weitz (2009) remarks, cognitive theory is a theory which is recognised to be implemented instantly. Social cognition is, therefore, the encoding, storage, retrieval, and processing of data in the brain (Parrott and Madoc-Jones, 2008). Widely used across psychology and cognitive neuroscience, it is particularly useful when assessing various social abilities and how these can be disrupted by persons suffering from autism and other disorders. Thus, it is clear that the utilisation of this theory in treatment assessment should be tailored to those individual patients who exhibit the systems of the neurological problems noted – and not just used as a ' catch all' for all patients (Miles and Mezzich, 2011).

It is the requirement of all care settings to accept, follow and implement effective strategies to provide the right source of communication to all the staff, service users and visitors (Krauss and Fussell, 2014). The appropriate and applicable training on verbal techniques must be given to care staff and other professionals. Furthermore, all employees should be made aware of new developments and techniques through further training and educational courses during the course of their employment. This level of career professional development is important because, as Zarconi, Pethtel and Missimi (2008) comment, it is vital to modernise employees' knowledge and

skills to help them to deal with the demands of changing communication and technology, as well as the changing aspirations and demands of clients.

For the betterment of any care settings, research always plays a vital role (Bourgeault, Dingwall and de Vries, 2010). There is a number of techniques that have been followed and brought into daily-use in a health care context. These are now considered to be everyday techniques, but when they were introduced they were ground breaking and radical – which shows how keeping abreast of new developments and integrating new techniques into daily working patterns can result in longer term benefits, not just for individual benefits but also the wider profession as a whole (Greenhalgh, 2008). Some of those techniques include the special needs of communication for those with autism, dementia and all of those who have sensual impairment, and it is to such issues that this assignment now turns.

The application of relevant theories of communication to health and social care contexts

Any health and social care department consists of different types of service users. As a care provider, it is imperative that professionals implement several types of communication techniques through knowledge, experience and skills, as advised by Krauss and Fussell (2014). In accordance with the views proffered by Thompson, Parrott and Nussbaum (2011), who have advanced the cause of using multitudinous approaches to communication, the role of positivism can be seen as critically important. Indeed, many theorists such as Carl Roger, Abraham Maslow, and B. F Skinner, have made life-time studies of how this approach can be beneficial to patient care (Weitz, 2009). In a similar manner, through an evaluation of characteristics

based on a humanistic behavioural analysis of actions, people can also be monitored and their health care provision improved, as noted by Burks and Kobus (2012), by treating all people with respect through being gentle and kind. This helps to build mutually beneficial relationships between patient and carer and between different health care professionals.

To recognise and understand the behaviour of separate individuals, and to understand how care provision needs to be tailored to meet their individual needs and circumstances, a range of case studies was undertaken by the author. In so doing, cognitive behaviour theory was applied; a summary of the individuals assessed and how their treatment needs were developed is given below. So as to ensure that this assignment conforms to best practice with regards to ethical research, the names of all people have been changed so that there are no personal identifiers. As a consequence, this section of the research not only complies fully with the ethical research protocols of the university but also those advanced by Bourgeault, Dingwall and de Vries (2010).

Case Studies

Case Study One

Estrella is a lady of about 65 years of age. She has been diagnosed with dementia and has lived with this condition for a number of years. She is physically very fit and enjoys walking, making a habit of walking every afternoon after a siesta. Estrella was interviewed at home. The following is a transcription of the interview that took place. It is useful in research to take a transcription because as Speziale, Streubert and Carpenter (2011) contend,

it enables the researcher to check facts and return to the data whilst they are analysing and interpreting it.

" Hello Estrella. May I come in please?" I asked.

" Yes, dear, you can come in." The beaming smile from Estrella suggested that as soon as she saw me she felt happy and she was very welcoming. She showed me into the lounge room and I then asked her " How was your siesta, Estrella? Did you have a good sleep?"

She replied, " Yes, dear, but I had a weird dream."

Concerned, I questioned, " What kind of weird dream did you have, Estrella?"

" I just forgot it, dear!" she replied. I asked Estrella kindly and politely if she would like me to help her get changed before she embarked upon her walk. " Yes, dear, otherwise we will stay here forever," she answered, whilst looking at me with a sweet smile.

In the above situation, as a care worker, I applied humanistic theory. This is shown by my engaging with Estrella in a manner that nourished individual respect. The benefits of this approach are clearly evident through the polite and efficient conversation that took place. The needs of Estrella were quickly identified and, accordingly, a high level of care was delivered.

Case Study Two

Norah is a 75-year old widow. She has been diagnosed with dementia. If she is awake she tends to stay in her bedroom and, as soon as she is awake, she asks for her breakfast to be brought into her room. From the reading of case

notes, which is, as Beresford, Croft and Adshead (2008) suggest, a useful way to gain prior information on a new client, I realised that Norah preferred having her breakfast in her bed and that her breakfast must be warm: neither hot nor cold. I also realised that she likes to have a glass of milk with her breakfast and that she appreciates having the curtains opened so that she can enjoy the outside view. Having already let myself into Norah's house on the morning of the interview, I asked her, " May I come in, Norah?", and explained that I had brought her breakfast in the manner that she likes.

She replied, " Oh, thank you, pet; that's very kind of you. I didn't have to ask for it and you already brought it... And it is just the way I like it."

Having deposited the tray on her lap, I opened the curtains. Norah smiled and said, " Thank you very much, pet." Once she had finished her breakfast, I took away the tray and let myself out.

In this case study it can be seen that, in accordance with the approach advanced by Greenhalgh (2008), cognitive behaviour theory was applied. Norah's needs were recognised before she had given voice to them. Therefore, in my role as carer, I applied my knowledge and precipitated her needs.

Case Study Three

Aelfric, a former steelworker, is 78 years old, and has been diagnosed with dementia. He is a very shy patient and finds it very difficult to socialise with other service users. Indeed, such is his shyness that he prefers to stay in his room most of the time, as Aelfric feels that no one likes his company. This, he has suggested, in reflecting upon himself, may be due to his attitude,

behaviour and language. Mindful of this plethora of problems, I decided to integrate Aelfric in a bingo day with the rest of the service users once a week.

" Good morning, Aelfric! How was your day?" I asked.

He rarely answered, and on this occasion he did not.

" I have good news for you today; have you ever played bingo before?" I queried.

Finally Aelfric answered, " Well, I used to, but am I not the right age to play that kind of game."

I responded, " Oh! That is wonderful, because I have booked a day out for you to play bingo with the rest of the patients and you are coming as well."

At the beginning, Aelfric did not like the idea of going and being part of the team. As a result, at the start of the bingo session he did not participate and just sat in the corner. However, he later participated and even won a game. As the weeks passed, Aelfric never wanted to miss a week, and began making friends as well.

In the case of Aelfric, social theory was applied in accordance with the recommendations advanced by Healy (2014). By the end of several months, Aelfric had become positively friendly with me, which shows how analysing a person using this theory can be beneficial to treatment needs.

Case Study Four

Minka is a 30-year old lady with learning difficulties and limited speech skills. In the middle of a normal shift, whilst a colleague and I were bathing her, she suddenly started screaming and crying. We did not know what we had done wrong, so I asked her politely, " What have we done wrong?"

Minka seemed to be expressing that the shampoo we had used on her was not nice, and that it smelled bad, and that it had gone into her eyes. Conscious of the discomfort we had caused Minka, I apologised and asked her, " What shampoo would you like me to use?" Minka pointed to the other shampoo. This shampoo was then applied to her scalp and, as a result, she stopped screaming and let us do our job. When we had finished washing her hair, Minka indicated that she was very happy and asked us to smell her hair.

In this case my colleague and I had applied psychoanalytic theory in accordance with the approaches advanced by Weitz (2009). We understood Minka's needs better as a consequence of so doing.

Communication skills in health and social care contexts

The Department of Health has, as Thompson, Parrott and Nussbaum (2011) note, been updating all kinds of communication techniques in order to achieve the aims and objectives of the health care sector. Many new technologies have been gradually implemented with the aim of ensuring that the service operates in a professional and effective manner. With regards to the contribution to service users, professionals and staff have been introduced to the latest technologies and have adopted them into their daily working lives in order to ensure that they are following best practice

(Sarangi, 2010). This has been achieved through, for instance, the attendance of relevant training sessions and courses which are specifically tailored to update knowledge and skills. As Miles and Mezzich (2011) further observe in commenting more generally upon such improvements to health care, modern equipment and communication aids are being used to monitor the effectiveness of care service provision. It is within this arena that it is vital that professionals use verbal and non-verbal communication techniques to deal with service users and colleagues.

It is good practice in the health service to ensure that there is an effective handover between professionals and generally, as Thompson, Parrott and Nussbaum (2011) advise, there is a hand-over during each shift. A hand-over is essential for it updates carers on the progress of service users. A hand-over normally reviews the service user's health and emotional condition and usually the nurse in charge of the morning shift discusses with the afternoon staff the progress of a client. Training is mandatory in the National Health Service. There are many types of training and staff are encouraged to attend training opportunities as it benefits the health sector and ultimately provides a better service to the clients (Zarconi, Pethtel and Missimi, 2008). Through using such techniques, best practice is filtered down between colleagues which helps raise the overall level of professionalism within the service.

An analysis of strategies to support users of health and social care services with specific communication needs
In order to allow service users to be fully involved in the decisions made that relate to their individual health care, it follows that effective communication must be used to enable the service users to understand what is proposed for

them (Gitterman and Germain, 2013). In order to achieve this aim, and given

the comments previously made within this assignment, it is imperative that

the health and social care sector develops a range of strategies to meet this

need. Every care setting is, as Krauss and Fussell (2014) confirm, required to

adopt and implement the strategy of providing the right and proper sources

of effective communication to staff. Through the use of verbal and non-

verbal techniques, all care professionals and staff are made aware of this

and they are also provided with training related to verbal and non-verbal

techniques. There are different techniques to support vulnerable people in

the health sector, such as reading lenses and voice recognition systems, and

Braille. In addition, as Gitterman and Germain (2013) observe, the Picture

Exchange Communication System is used as an aid for individuals who suffer

from autism. This is an effective system that has now become, as Healy

(2014) comments, part of mainstream treatment.

An overview of how communication processes are influenced by values and cultural factors

As a national health service, the NHS works with a divergent set of people

across the nation as a whole. Reflecting upon modern day multicultural

Britain, the NHS accordingly needs to be aware of an array of different

cultures and sub-cultures within the UK (Greenhalgh, 2008). In addition, the

NHS and wider social and health care sectors must be aware of cultural

differences, religious tolerance, and language barriers. According to Sarangi

(2010), and in line with the values of a tolerant society, everybody should be

treated with respect and in accordance with their cultural and ethnic values.

Care workers must, therefore, keep in mind cultural, religious, and linguistic

differences so as to ensure, as Reamer (2013) notes, that service users do

not feel that they have been treated in a way that is disrespectful, for it might lead to the creation of feelings of disappointment and shame. Such emotions would be counter-productive to the establishment of a professional and meaningful client-professional working relationship. For example, a Muslim client may request a halal meal and the hospital or care facility should provide one so that it operates in a manner that is respectful of the needs of the client. Indeed, ensuring that such values are central to patient care may help patient recovery and will further show the patient that his or her individual needs are valued by the service.

Whilst, within a British context, English is the main language, there are vast swathes of the population who do not speak the language, do not understand the language, or have no knowledge of the language (Beresford, Croft and Adshead, 2008). Thus, it is essential for the wellbeing of all citizens that English is not the only language in which heath care provision and needs are discussed. There have been major moves forward in this regard over the last thirty years throughout British society, with an increasing number of publications of an official nature being available in different languages. Thus, even the cultural sensitivities of the Welsh and Scottish are now addressed with regard to the publication of information. With reference to health care, service users who either do not speak English or have very little knowledge of it, may find communicating their health care needs difficult, as Beresford, Croft and Adshead (2008) assert. In order to treat such people with respect and dignity, the health service must continue to act in a proactive way and employ translators so that those who do not speak the language can still have their health needs assessed. This is, Weitz (2009)

notes, an arena of increasing importance within the UK as the country becomes evermore multicultural.

The Department of Health ensures that when information is provided to clients and service users, leaflets are distributed in different languages. Such provision needs to be expanded so that all who use the NHS feel valued – regardless of the language in which they choose to communicate. Indeed, it has been suggested by Thompson, Parrott and Nussbaum (2011) that all hospitals and surgeries should have a range of translators on call at all times; it is evident that were this provision to be widened to every care home and local authority responsible for the wider social needs of patients, further progress would be made. If such services are not provided, those who do not communicate in English may feel like second-class citizens and this would have a drastic impact on the extent to which the health sector could build a meaningful relationship with such clients; ineffective communication would lead to poor quality services.

Policies and procedures are implemented so that different religious and cultural backgrounds, along with differences in socio-economic status, are not reacted to in a negative manner within a health and social care setting. The latter of these, socio-economic status, can often be overlooked but needs to be considered so that no member of the public feels discriminated against in the service that they receive (Weitz, 2009). Existing legislation provides fundamental guidance as to how health and care operatives should work and it is clear, from that legislation, as Ife (2012) notes, that issues of intolerance have no place in modern day social and health care. The same also applies to issues of sexual orientation – the ' respect' agenda is,

therefore, an important component of daily life in social and health care settings. Existing legislation allows all people to have the right to be offered the facilities that they need to ensure that their health and well-being is maximised by the state and, within an increasingly multicultural society, techniques and strategies of communication have been successfully established to enable all to access the services that they need (Healy, 2014). Complacency is not, however, an option for the service; needs continue to develop on a daily basis and it is imperative therefore that the service as a whole, as well as staff on an individual basis, reflect critically upon their own actions to ensure that they work in a non-discriminatory manner (Burks and Kobus, 2012).

How legislation, charters and codes of practice impact on the communication process in health and social care

Good practice with regards to communication in the work place is achieved through the adoption of various techniques and methods. As Ife (2012) opines, the Data Protection Act is an important piece of legislation in the workplace and it ensures that personal data is secured and accessed in a controlled and responsible manner. Health care records are, by definition, very personal and many patients have concerns as to how such data is stored. By enforcing rigorous protocols and ensuring, through ongoing training and assessment, that all staff understand the importance of best practice in data protection, such fears can be allayed. It is also worthy of note that clients may also now seek copies of all data held about them. Accordingly, it is vital, as Reamer (2013) maintains, that data recorded about individual patients is always done in a mature and professional manner so as to ensure that no offence is caused. Further, the information contained

within such records cannot be disclosed to a third party without the consent of the service user. The Data Protection Act can be seen, therefore, to promote good practice and, as such, helps to ensure that the health sector runs smoothly. Treating somebody as humanely as possible is therefore a fundamental aspect of health and social care and, if privacy and dignity are respected, it follows that the protection of human rights is also achieved (Ife, 2012). Allied to this are issues that relate to freedom of speech, choice and the rights of individual patients; it is clear, as noted within this essay, that by increasing the ability of patients to communicate effectively with health care professionals about their care, ' patient' voice is increased.

The effectiveness of organisational systems and policies in promoting good practices in communication

As Thompson, Parrott and Nussbaum (2011) assert, good practice in communication within health and social care contributes to the efficiency of the service and builds confidence and trust in individuals. This is shown by the fact that staff and professionals are governed by a code of conduct (Hepworth et al., 2010). In addition, the use of computers has revolutionised the National Health Service and, within the confines of this essay, an example of the effectiveness that increased computerisation has brought is described. For example, a case that was reviewed in the unit referred to a gentleman picked up by the police, as he was wandering the streets. This middle-aged man had been shouting and responding to voices in his head and it appeared that he was unwell. The police rang the Mental Health Assessment Unit and asked for more information about the patient, including whether or not he was known to the service. As a result of the computerisation of records, a simple search on the browser indicated that he

was known and provided details of previous care. This, therefore, allowed

paramedics to respond to his needs more quickly because they were aware

of his preconditions. Such efficiency within the service would not have been

possible with the computerisation of records. However, such systems do

bring into question issues of data protection and it is imperative that, as

Cournoyer (2013) states, computer records are held in a secure manner and

that information is kept confidential, so no third party can access it without

the consent of a senior manager.

Ways of improving the communication process in a health and social care setting

The National Health Service has implemented a system whereby a patient's

record and daily progress are being saved on RiO. On this system a patient's

file can be retrieved and updated. In most hospitals, RiO is used and it has

proved to be effective (Thompson, Parrott and Nussbaum, 2011). The main

drawback of this method is that all staff members – whether junior or senior –

have to have access to RiO, creating additional budgetary pressures on

training. An individual patient's health is monitored on RiO and any staff

member can delete information, such as a care plan, from the details stored.

This could cause problems if a staff member accidentally deletes something.

This again illustrates why increasing training budgets is essential to improve

communication processes (Sarangi, 2010). In addition, on some of the wards,

the verbal and written commands of staff are very poor. This can be

particularly evident where nurses do not have a very solid grasp of English

(Krauss and Fussell, 2014). Whilst it is important not to discriminate, there is

a need for a robust process of recruitment to ensure that all medical

professionals can communicate with each other in a clear manner (Reeves et

al., 2011). In order to minimise this problem, staff should only be recruited on the basis of the qualifications that they possess. Indeed, it is now widely argued by academics, including Miles and Mezzich (2011) and Greenhalgh (2008) that a minimum qualification level should apply to all health care professionals – perhaps at a level equivalent to an NVQ level 2 qualification.

The National Care Standards Act (2000) makes provisions for the standard of care to be delivered and in so doing sets out 42 standards of care that need to be implemented. Within the documentation there is not much emphasis on the implementation of modern systems of communication that can contribute in the provision of information about the care services as well as service users and staff. So far the standards of care have been monitored on a humanistic basis, but the communication systems need to be improved (Thompson, Parrott and Nussbaum, 2011). This could once again be achieved through further training. In addition the Care Quality Commission has the power to inspect and assess the performance care homes and to make recommendations in areas where an improvement in the level of services being delivered is needed

Standard ICT packages to support work in health and social care
With continuous progress in the field of information technology and the medical and healthcare sectors, the use of the software packages for dealing with reports such as writing, printing, storing, retrieving, updating, and referring have become very important. Indeed, as Reeves et al. (2011) suggest, computer literacy is a basic requirement for all health care professionals. Older staff and those who may not have benefitted from recent school-based educational opportunities may once more benefit from

the availability of tailored courses. Further, as systems develop, there is clear evidence to suggest that all staff should undertake refresher courses, especially with regards to data protection law (Thompson, Parrott and Nussbaum, 2011). Prior to recent IT developments, all patient records were recorded on paper. This was not only cumbersome but made searching for specific records more difficult. Further, the records could only be readily accessed on site. These deficiencies in the paper-based approach have been rectified by the adoption of multi-layered computer systems, which also enable remote access and the sharing of information between agencies. As Parrott and Madoc-Jones (2008) claim, critical to this revolution in the keeping, making, and recall of paperwork has been the development of both the internet and the intranet. However, this has also brought an array of potential problems, including issues relating to third party access and security. With reference to my own workplace (as a means of providing a practical example), the use of computers has developed to such an extent that it has cut down on all paper work. Daily progress notes are entered on a sophisticated package and day-to-day care of the clients is inputted on the system.

Benefits of ICT in health and social care for users of services, care workers, and care organisations

If a service user is discharged from the health services and thereafter returns to see his local general practitioner or attend an accident and emergency unit, an advantage of computer-based records is that his details can be retrieved from the system. Such information that was not readily transferrable using paper-based systems helps multi-disciplinary teams achieve continuity of care and, as a result, the client is treated better. In

addition, as Parrott and Madoc-Jones (2008) notes, social workers find it easier to go on the internet and find places for service users in different catchment areas quickly. Detailed information about the services offered is displayed and the service user is updated; processing times are quicker – and treatment is again improved. IT also helps with training – both in delivery and record keeping. Indeed, as has been evident through my own experience, most training in mental health trusts is done online.

Conclusion

This assignment has, through case studies, personal experience, and the assimilation of data from existing studies, provided a thorough overview of a range of communication techniques used in the NHS and associated social care settings. In addition, comment has been made on the individual needs of patients and how these can best be assessed using a range of different theories. Further, the role of ICT has been discussed and examples given as to how its incorporation into health and social care sectors has transformed working practices. Through addressing