Chapter 1
INTRODUCTION

“It’s phenomenal what openness and communication can produce. The possibilities of truly significant gain of significant improvement are so real that it’s worth the risk such openness entails.” – Stephen R Covey.

Appropriate communication is one of the important aspects of nursing profession and it is a most challenging task. In nursing practice, nurses often have a great deal of information to share with patients and their family members and nurses are expected to do this effectively. Informing the patient about the illness they are suffering from and the ways of treating this illness is an essential part of effective communication skills. Though it is a tool which helps to have a better understanding about the concerns of the patients, it also helps in offering appropriate emotional support. Proper communication process is important as it enables the nurses to explore the concept of interpersonal communication. It also assists the nurses to identify, practice and apply all the skills related to communication which in turn enables them to develop helpful and caring relationship with the patient (Neese, 2015). Moreover, Noguchi (2014) through his research stated that around 30% of the medical errors and patient injuries could be easily brought down through appropriate communication. Whereas, poor communication leads to potential errors which may further lead to drastic condition like death. Hence, without efficient and effective communication between the nurse and the patient, efficient health care would be difficult to be achieved.

Wide range of quality of health care sectors is engaged in increasing their improvement activities that are reliant for nurses to help address the demands in their field (National Accreditation Board for Hospitals, General Information Brochure for Nursing Excellence Certification Program, 2015). Good quality in patient-care delivery and safety of the patients are based on the quality of the nursing care provided through the knowledge, skills, competence, compassion and experience of the nursing staff. However, the current scenario highlights the increasing attritions and rapid staff turnover due to various reasons like worker’s value system and work environments (Dwivedi, 2013). Yet, the hospitals confront the challenges with regard to nursing facilities including scarcity of nursing resources and difficulty in engaging nurses at all levels.
Consequently, the hospitals are dependent on the student nurses; so that they can be prepared well to get engaged and utilized effectively in the clinical to compensate the shortage as well to provide training through a proper clinical exposure (National Accreditation Board for Hospitals, 2015). The present health care sector is widened with complicated circumstances than it used to be in the past. In this complicated circumstances the interactions made with the patient, inter-professionals are highly demanding and impose a lot of stress apart from the job responsibility (Bach, & Grant, 2009). Thus the success of the health care system relies completely on the knowledge, practice skills and attitude of the health care personnel are the sole responsibility in rendering the services (WHO, 2000).

**Definitions of Communication**

The communication has been defined in different terms by various authors based on their understanding and experience. The views about this term is widening day by day in depth. Earlier it was considered as a basic tool to fulfill the need of life. However, later it was considered to be a basic need to lead a better life.

One of the earliest definitions in the field of nursing care was provided by Hovland, Janis, and Kelley (1953). They defined communication as the process where the communicator sends stimulus with a purpose to change or to make the behavior happen by the listener. Gode (1959) defined it as a process which makes the information that belongs to one available for others.

According to Rusech (1961) ‘Communication is a universal function of man that is not fixed to any particular place, time or context’. Stainer (1964) opined communication as a process of sending information, idea, emotion, ability, etc. of one person to another by use of symbols such as words, pictures and numbers.

Further, explaining about effectiveness in communication Patton, and Giffin (1977) viewed that effective communication occurs when the receiver interprets the sender’s message in the same way as the sender intended it.
Duld, et al. (1984), viewed interpersonal communication as a dynamic process involving continual adaptation and adjustments between two or more individuals who are engaged in face to face interactions during which each person is continually aware of what the other one is trying to explain. They further elaborated that the process of communication is existential in nature and involved an exchange of facts, feelings and meanings through seeing hearing or touching one another (Petrie, 1947).

However in the context of nurse-patient relationship effective communication is defined as the successful team work where the patients and nurse exchange information, involving the patients to actively participate in their planned care from admission to discharge and ensuring that the responsibilities of both patients and providers are understood Joint Commission on Accreditation of Healthcare Organization (2010). Hence, for the communication to be truly effective, the messages are to be negotiated until the information is correctly understood by both sender and receiver as it is a two-way process (expressive and receptive). This successful communication occurs only when patients comprehend accurate, timely, complete and unambiguous message from providers in a way that enables them to participate accurately and responsibly while providing their services to the patients.

Theories of Communication
Shannon Weaver (1949) proposed the initial model of communication that consisting of three components namely Sender, Channel and Receiver. However, this model failed to explain assurance about the transmission, accuracy, and effectiveness of communication. The disadvantages related to this model were altered by another model called SMCR proposed by Berlo (1960). SMCR model comprises of four components namely into four components namely Sender, Message, Channel and Receiver.

Styles of Communication
Newton (1995) proposed five communication styles. They are as follows: Assertive Style, Aggressive Style, Passive–aggressive Style, Submissive Style and Manipulative Style. Assertive style demonstrates high self esteem of an individual. In this style, an individual firmly, respectfully and clearly state one’s ideas and needs without violating the rights of others.
Aggressive style is offensive type as it expects the individual to give importance to their self needs and requirements. Moreover, in order to achieve the needs, an individual may even violate the norms and even exploit the rights of others. Passive – aggressive style is where the individual appears to be passive by outlook but one’s internal feelings include anger and jealousy. The person with this style has low self esteem. Submissive style of communication includes pleasing and requesting others in order to prevent conflicts. People with this type of style pretend as if others are very important. Manipulative style of communication includes cunningness. Person with this style is smart enough to get the things done by others. A person with passive style remains un-reactive to any situation openly. This nature makes one to fail to assert for oneself during need and hence allow others to easily infringe one’s rights.

Kurtz and Silverman (1996), recommended Calgary Cambridge framework as a practical teaching tool to enhance communication between the doctor and patient. Though it was mainly framed for the doctors and patient communication it is even validated to use for the nurses also (Munson, & Willcox, 2007; Kaufman, 2008; Beaumont 2012). The framework proposes six components to guide the process of communication. They are Initiate the session, Gathering the information, Providing the structure, Building the relationship, Explaining and planning, and close the session. Initiating the Session includes establishing initial rapport and identifying the reasons for the consultation. Gathering information involves exploration of patient’s problems. Providing structure includes organizing the conversation and maintains the flow. Building relationship includes using appropriate verbal and non verbal behavior and involving the patient while communicating. Explanation and planning is where proper information is provided aiding in proper understanding of their condition. Closing the session involves future follow up and coping of the patient.

Further, Hamilton, and Martin (2007) have also framed a structure for effective communication skills. This component of effective communication includes five I’s namely interacting with the patient, establishing the intention of the interaction, and deciding on the intervention to be used, assessing the impact of the interventions, and evaluating the implications of the subsequent information obtained and then act accordingly.
Charlton, Dearing, Berry, and Johnson (2008) determined two communication styles namely biomedical and bio-psychosocial. The biomedical communication style is based on patient’s condition and its related information. Whereas, bio-psychosocial style involves the detailed communication including showing concern with the patient’s feelings and responses. It is more of patient centered communication.

Murphy (2015) stated that the communication styles are not inborn instead they are acquired as the needs grow. He classified four communication styles namely: 1. Analytical communicator who would have little tolerance, unemotional, and logical. 2. Intuitive communicator who would be eager and lacks patience and thus derives into conclusion without analyzing the complete situation. 3. Functional communicator, who follows a series of steps while handling people or situation and the details about the person or situation are very clear. 4. Personal communicator, who emphasizes on listening skills, emotional connection and bonding with others which helps to understand the true feelings.

**Techniques in Nurse-Patient communication**

Potter and Perry (1999) identified various aspects that have to be considered during verbal communication. These aspects include vocabulary, denotative and connotative meaning of words, intonation of voice, pacing, clarity, brevity, timing and relevance of information. In contrary, Arnold and Boggs (2003) focused on the importance of nonverbal communication. They distinguished four areas in which nonverbal behaviors would be used namely, proxemics, cultural variations, kinesics, which includes body language and facial expression and appearance.

However, Knapp and Hall (2002) viewed that nonverbal and verbal messages goes hand in hand and while communicating both should be considered and emphasized. In nonverbal communication, repeating, conflicting, complementing, substituting, regulating and accenting are the common signs to be observed.

Egan (1975) proposed SOLER, an acronym which explains about the techniques that may aid in effective use of non verbal communication. The five components involved are Sit Squarely, with an Open posture, Lean forward to listen, maintain Eye contact, and Relax while conversing.
Later, these five techniques by Egan (1975) were modified by Stickley (2011) and a new proposal replacing the SOLER to SURETY was made by adding the touch factor and emphasizing the importance of the individual intuition. The acronym SURETY includes S - "Sit at an angle"; U - "Uncross legs and arms"; R - "Relax"; E - "Eye contact"; T - "Touch"; and Y - "Your intuition".

The communication role of nurse as per Hamilton and Martin (2007) is well explained by their acronym EDUCATE. The seven letters represent each role of nurse in communication they are E – Educate and Eclecticism, where the nurses always mean to maintain a sense of connectivity and a form of psychological bonding with the patient. D - Demonstration of skills explains not only about the readiness of nurses in interpersonal relationship, but also in executing various procedures whenever needed for the patient. U – Understanding means the nurse should always try to understand and relate herself empathically with the patients before any procedures. C – Clarification, communication, collaboration and confidentiality, A – assessment and ability to adapt, the nurse should always engage herself in continuous assessment of the patient’s condition and readily react to the situation in case of any emergency. T – Teaching element, the nurse should always involve herself in educating the patient and informing them about their conditions. E – Evaluate various nursing interventions for its achievement in optimizing the patient's condition.

**NEED FOR THE STUDY**

Communication is an integral aspect of the nurse-patient relationship and is one of the six fundamental values of nursing identified by the United States government strategy to deliver high-quality, compassionate care for patients. The policy document compassion in practice states that ‘communication is central to successful caring relationships as well as for effective team working’ (U.S. Department of Health, 2012). The Nursing and Midwifery Council (2008), highlights the importance of communication in its code of conduct, stating that nurses must meet peoples’ language and communication needs and share with people the information they want or need to know about their health in a way that can be understood by patients. A report submitted by the US Joint Commission on Health in the year 2002 reported that around 55% of errors are happening in administration of medicine in US hospitals and around 65% of deaths were caused due
to ineffective communication. Hospitals, in particular, are stressful and high-pressure environments, that often lack staff. The UK Health Commission in 2012 suggested that the risk to patients from poor levels of communication was ‘less acute in the hands of nurses’. Reader, and Gillespie (2013)

Modern health care has become extremely complex and it continues to grow in complexity because of economic pressures that have resulted in increasing capabilities of modern medicine (Woods & Cook, 2001). Moreover, enhanced patient rights, autonomy and expectations are important factors especially when a student accesses a patient in order to learn. During this process of student learning the questions of patient about who examines them and their right to rest and privacy must be respected (Zeijden, 2000). Yet, the demand for patient access continues unabated across the wide range of health professionals in training. Norgaard, Ammentorp, Kyvik, and Kofoed, (2012) stated that though definite knowledge about communication and qualification is mandatory for all the health care providers still severe communication errors are felt by the patients and also the health care professionals.

Factors Leading to Poor Communication
The causal factors for poor communication or miscommunication are, growing complexity in the health sector, staff shortage, increasing work load of the health care providers, inadequate preparation of the health personnel, persisting theory and practice gap. Other reasons include fear, exhaustion or overload, a lack of quality information among the health professionals, low education level, lack of experience, and emotional stress (Nurse Theory, 2016). Furthermore, according to a recent report submitted by Fierce Health care (2016), the reasons for improper communication are due to misinformation about patient’s condition, ignoring a patient’s complaint, and not receiving adequate informed consent from the family members and accent from the patient.

Surprisingly, the statistical information provided by Controlled Risk Insurance Company in USA in the year 2016 states that around 2000 lives had been endangered due to poor communication. Among this 55% of cases were due to miscommunication, especially while transferring the patients within the hospital settings which might have led to around 80% of medical errors (Joint Commission, 2015). CRICO (2016) has found that 44% of
miscommunication happens in inpatient, 48% in outpatient, and 8% in emergency department.

The next important component in the nursing profession is clinical experience which has always been an integral part of nursing education. As the students gain experience, the nursing skills in them are sharpened and they are able to perform the clinical principles practically in them. Clinical posting has been identified as one of the most anxiety provoking components of the nursing program. Bel. et. al., (2008) opined that the lack of clinical experience, unfamiliar situations and supervision done by faculty members add up to the anxiety and stress among the nursing students. Sharif, and Masoumi (2005) identified four major themes in their study on nursing student’s experienced during clinical practice, namely initial clinical anxiety, theory practice gap, clinical supervision and professional role. Inspite of being an important factor, students felt they had an insufficiency in clinical skills upon completion of the pre registration program (Jinks & Patmon 1998). The researchers also observed that in clinical practice, the communication difficulties exist between professionals and patients. National Accreditation Board for Hospitals, General Information Brochure for Nursing Excellence Certification Program (2015), stated that the shortcomings of traditional nursing education in preparing nurses to meet the current expectations in the health sector is one of the factors that lead to failure of quality care to the patient.

Nurse patient communication skills are facilitated through a proper questioning techniques, active listening, paraphrasing ability, reflecting on the situation and summarizing the conversation with the patient. By using these communication skills a nurse can effectively gather the information of the patient, give information, responding to the patients need. (Hamilton and Martin, 2007)

Present Scenario of communication skills of Student Nurses
In an Indian study Conducted by Seth (2016), it was reported that around 28% of the nursing students in Bihar and Gujarat had stated to after finishing the course searching for the job is the biggest challenge. The student nurses about 24% from the Gujarat stated that the skills earned through their training were not enough to fulfill their expected role. Seth (2016) also had stated that, 20% of the students In Bihar felt low confidence and poor communication skills even after their completion of their graduation. The students felt that it was due to lack of proper training in the institutions. They also
have demanded for improving their training programs and to conduct soft skills like communication and personality development.

According to Imran (2013), the majority of nursing students were having good theoretical knowledge about the communication, but they lagged in effective communication skills. The need for health care providers to possess good communication abilities in addition to their knowledge and technical competences is not always met in practice. This was reiterated by Ghamari-Zare, Purfarzad and Adib-Hajbaghery (2013) who found that the nursing students have deficiencies in their communication competence such as nurse-patient communication in general and which was predominantly observed while administering medication.

In regard to the clinical posting of the student nurses, Gilmartin (2001) opined that they were rejected by the patient and their families just because of being a student. A number of students participating in the current research stated that they were afraid of communicating with patients. According to Grilo, Santos, Rita and Gomes (2013) fear of dealing with patient, lack of confidence and emotional distress are the main known causes that make the students become distant from the patients. Conversely, Suikkala and Leino-Kilpi (2005) opined that knowing the student’s personality with potentials and limitations is essential for a facilitative relationship and providing care for patients without prejudice toward different patients is one of the most important items of professional values (Parvan, Zamanzadeh & Hosseini, 2012).

Preparing students to create constructive communicative relationships is very much essential in nursing practice (Rosenberg, & Gallo-Silver, 2010) because it enables students to respect (McGilton, Irwin-Robinson, Boscart, & Spanjevic, 2006) and helps in providing safe nursing care for patients. Some studies show that nursing students do not have the necessary knowledge and skills to communicate with patients (Suikkala, & Leino-Kilpi, 2001) and one of the problems of newly graduated nurses is that they lack readiness to communicate with patients and families. This is recognized as disturbing factor for nurses' clinical performance (Fallowfield, Saul, & Gilligan, 2001). Jaffari-Golestan, Vanaki, and Memarian, (2008) conducted a review on the nursing curriculum in Iran reported that communication skills are not considered as a unique syllabus and in some courses only a few hours are dedicated to it. Therefore, it was opined that inorder
to communicate effectively after graduation, it requires both educational and clinical support for acquisition of this competence (Jaffari-Golestan, Vanaki, & Memarian, 2008).

Latham and Fahey (2006) stated that nursing students “often experience lack of self-confidence and hesitation when faced with increased responsibility and accountability for patients’ health”. Factors that influence the confidence of student nurses ranged from achieving competence in a skill or set of skills to achieving meaningful and effective communication with patients, relatives and multidisciplinary team members. The achievement of competence in a skill or skill set enables the student to develop personal and professional confidence and develop their identity as a nurse (Edwards, Smith, Courtney, Finlayson, & Chapman, 2004; Godson, Wilson, & Goodman, 2007; Lundberg, 2008).

However, it is also important to note that effective and meaningful communication plays a significant role in confidence by providing the student with information, validating self worth and integrating professional self value (Arja, Helena, & Jouko, 2008). These authors also identified that personality and a supportive clinical environment have a significant part to play in building confidence levels of nursing students.

As a student nurse has minimal experience and exposure, if one is posted without proper preparation, they may end up in reality shock and stress (Zaventrick & Huff., 2010; Liu et al., 2007). The majority of student nurses’ level of knowledge and attitude about communication were low and these remain as the major reason for most of the serious communication problems experienced by both health care professionals and patients (El-Demerdash, El-Fatah, & Gad, 2012; Nørgaard, Ammentorp, Kyvik, & Kofoed, 2012). This demands the need for training on communication skills (El-Demerdash, El-Fatah, & Gad, 2012). Health care students may benefit from training through simulation scenarios, prior to experiencing the complexity of "real" patients. Practicing communication skills in a mistake-forgiving environment allows students to understand, recognize, and correct their errors in a non-threatening and trainee-centered environment with immediate formative feedback. Most importantly, the same encounters highlight personal strengths and can help build student confidence.
The above issues and other potent drives of change require innovative, simulated teaching for the novice student and the final year students, particularly in the non-cognitive areas of communication, interpersonal development and reflective practice. This encouraged the researcher to develop the communication skill training program, for the student nurses with an aim to improve the communication skill and enhance nurse-patient relationship. The researcher also intended to evaluate the communication skill program modules using the appropriate tools and using objective methods of observation by videotaping and evaluating it by independent raters.

Unlike in developed countries, the trainee nurses do not have systematic curricula for imparting practical training for nurse-patient communication in India. Developing a standardized program will be a landmark in the training curriculum of nursing students in India.