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Communication skills required when working with older people

ABSTRACT

This project will explore the importance of communication for health and social care professionals working with older people. It is a European funded 3 year project comprising 25 countries, of which the United Kingdom (UK) is one. The aim of this project was to understand the experiences of older people of communication during interactions with health and social care professionals. This project has been funded by the European Commission with the support of the Lifelong Learning Programme of the European Union.

Semi-structured interviews were conducted with sixteen people, 60 years and above in the UK, one of the five countries in this work stream. This represents one element of the project, ELLAN (European Later Life Active Network). The interview framework was developed in Portugal, the lead country for this work stream, and used in all five participating countries. All interviews were recorded and transcribed. Thematic analysis was undertaken to identify common themes. Communication was a recurrent theme among the participants in this project, central in all interactions with older people.

The findings from this project can influence the education of health and social care professionals in the UK, as well as having the potential to impact on current practice. It can influence practice in all settings: not just those in care of the older person. Moreover, greater awareness of the importance of communication can enhance working relationships between health and social care professionals.

Key words: Communication, Qualitative, Interviews, Healthcare, Older people

INTRODUCTION

‘The single major issue which remains, and which could be traced back to the root of almost every issue raised was a lack of integrated effective institutional communication’ (Francis 2013 p 1163).

Communication both written and oral was the third highest concern for the National Health Service (NHS) representing 10% of all complaints received for 2013/14 (Health and Social Care Information Centre 2014). Effective communication is essential for nurses and midwives (NMC 2015), allied health professionals such as physiotherapists, paramedic and speech therapists in terms of the Health and Care Professionals Council (HCPC 2008) and doctors (GMC 2014). Communication is also included in the Essential Skills Clusters as a requirement for student nurses (NMC 2007).

“Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say and do and essential for ‘no decision about me without me’. Communication is the key to a good workplace with benefits for those in our care and staff alike” (DoH 2013 p 13).

Communication can be divided into three types: verbal, non-verbal and written. Verbal communication is central to the role of any health and social care professional. If verbal communication is not clear it can be difficult for a service user to comply with the plan of care (Arnett & Douglas 2007). Verbal communication includes questioning, clarifying issues, giving feedback, negotiating and delegating. Non-verbal communication can include accent, bodily contact or proximity, appearance, tone of speech, gaze and posture (Sharples 2007 in: Brooker & Waugh 2007).

Written communication can take the form of medical notes, nursing notes, observation charts and medicine administration records. While written communication is often not mentioned, it is very important as it helps professionals to communicate between each other within and across healthcare settings. Electronic communication can include any computer record that has been inputted onto a computer in relation to the service user, examples included: electronic prescriptions, electronic service user records, electronic referrals and emails.

Communication was identified as one of the 6C's by the Department of Health (DoH 2012) when it carried out its consultation exercise on the values required for nurses. The National Health Service (NHS) Constitution (DoH 2013) highlighted that better communication was needed between organisations and staff to support improvement and safety of care for all service users. However, the introduction of the Health and Social Care Act (2012) where a greater variety of organisations can provide healthcare as authorised NHS providers, as well as existing NHS services may lead to greater challenges for effective communications between health and social care professionals.

Francis (2013) in his report about Mid Staffordshire NHS Trust found repetitive concerns about communication. The need for respect between professionals and service users was a significant theme. A lack of respect can have a major impact on communication, both verbal and written. The Mid Staffordshire NHS Trust was placed in the worst 20% of acute trusts for a number of reasons, among them team working and communication, by the National NHS Health Survey 2007. Communication also emerged as an issue in the report by the Parliamentary and Health Service Ombudsman (2011). He suggested that the '...theme of poor communication and thoughtless action extends to discharge arrangements, which can be shambolic and ill-prepared, with older people being moved without their family's knowledge or consent' (p 9).

Effective communication was considered essential to ensure patient centred multi-professional working (Carter 2009 in: McCray 2009), using a range of communication skills: verbal, non-verbal and written (Egan 2010). It was suggested that non-verbal communication conveyed two thirds of the meaning of a conversation (Moss 2012), highlighting its importance. On the other hand, while there was a need for health and social care workers to be aware of their own non-verbal communication, they also needed to be aware of the non-verbal communication of service users in the course of their work. Non-verbal communication can provide a significant amount of information about how a person is feeling/thinking and can help with the overall assessment (Moss 2012).

Barriers to communication can occur including: language barriers, background noise, busy environments and hearing issues to name but a few. Effective communication is very complex and no two situations are the same therefore health and social care professionals needed to be versatile

in different situations. While many people entered helping roles in health and social care settings with a baseline set of communication skills, additional training was also considered necessary to further develop these skills (Egan 2010).

‘Helping is about constructive change that makes a substantive difference in the life of the client’ (Egan 2010 p 8). Communication is a strategy that is used by health and social care professionals to facilitate change either for the service user and their family or in the workplace.

The ELLAN project is a European project made up of 25 countries and led by Finland. There are a number of separate work streams in the project. This paper will discuss the findings of one element of the project, the importance of effective communication for health and social care professionals when working with older people.

METHODS

This was a qualitative project, involving semi-structured interviews.

Research Aims: The aim of this project was to understand the experiences of older people of communication with health and social care professionals.

Ethical Considerations: Ethical approval was given by the University for this research (14/EHC/031). The participants were recruited through a local user and carer group and their participation was voluntary where they could opt out of the project at any point. Participant information sheets and consent forms were given to the gatekeeper and all participants. All sound files and transcripts were anonymised.

Research Design and Methods: This was a qualitative project with a sample of 16 participants from one area of the United Kingdom (UK) (see table 1).

No of participants	Gender	Household Arrangement	Nationality	Age Range	Carer/ User
16	8 male 8 female	6 living alone, 10 lived with other person	15 English 1 German	60 - 89	3 user/ carer 13 user only

Table 1: Participants’ Profile

The participants had a wide variety of interactions with health and social care professionals. This added to the data collected during this project. The interview framework was developed in Portugal, the lead country for this work stream. The questions were developed in Portuguese and translated into English which led to some cultural difference in how such questions would be structured in the UK. They were agreed by all the countries in the work stream before been used. This ensured consistency across all countries in this workstream. However one of the challenges of this approach was the lack of an opportunity to pilot the interview questions in the UK before undertaking the interviews (Silverman 2010).

Interviews are useful when there is likely to be a discussion around sensitive subjects in contrast to focus groups (Coombes et al 2009). Each interview was unique in terms of the discussion about the individual experiences of each participant (Coombes et al 2009). They provided a safe environment to explore such issues in more detail in contrast to a focus group. Semi-structured interviews provided the flexibility for the interviewer to follow up the participants individual experiences of receiving services from health and social care professionals. All sound files were transcribed and thematic analysis was undertaken. The scripts were read and re-read and initial themes were identified. This iterative process helped me to identify new themes, leading to levels of analysis comparable to those described by Parahoo (2014) in terms of basic, intermediate and higher. Once the initial themes were identified, these were then grouped into categories. Once this was completed I then ranked the categories in order of importance.

RESULTS

While the sample comprised of equal numbers of males and females (Table 1) there was no specific differences in their expectations or experiences of the participants when meeting with health and social care professionals. The participants provided examples of good communication alongside experiences of poor communication.

One participant suggested that '... he explained it all to me' (participant 1, female) suggesting the sense of reassurance it engendered. Explanations were valued by other participants also suggesting 'Now if I was asked to go to a particular hospital, I'd jump at the chance because they looked after

me well, everything was explained as they went through' (participant 2, male). In this project communication both verbal and non-verbal was highlighted by 13 of the participants. However, there was limited data provided in the interviews about documentation and its role in communication. It might not always be apparent to the service user the importance of documentation in their interactions with professionals.

Figure 1 below outlines the themes that emerged from the interview transcripts. The larger circle outlining the non-verbal communication themes highlighting the importance of non-verbal communication (Moss 2012) in terms of overall communication while documentation brings all forms of communication together represented in the written form what has occurred during the interactions the service user has had with the professionals. However the limited reference to documentation in this project may suggest that what was written about individuals was not always done during their meeting with the professional.

Documentation represented the amalgamation of what happened through verbal and non-verbal communication presenting it as the 'glue' that brings both elements together (Figure 1). Despite the importance of it, the limited reference to documentation suggested that it did not represent a major part of the interactions the participants had in this project with health and social care professionals.

Verbal and non verbal communication predominated the interviews.

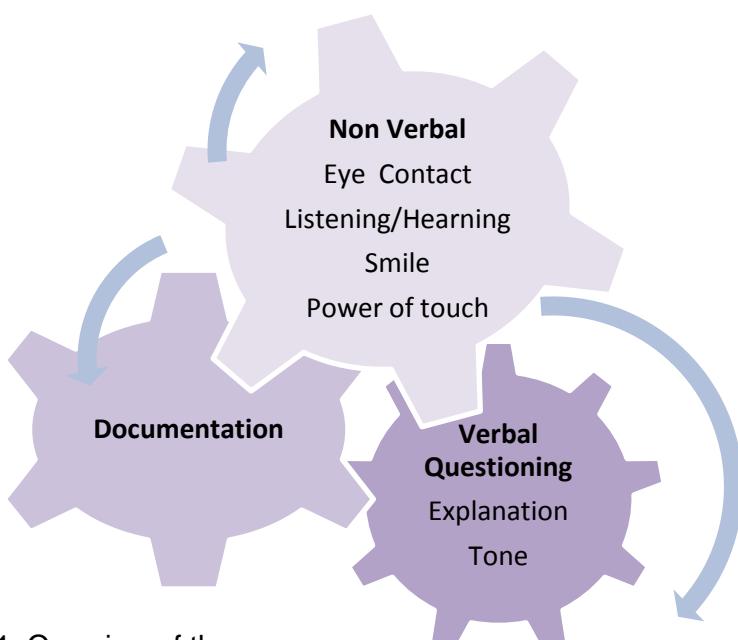


Figure 1: Overview of themes

Verbal communication: One participant felt that medical staff talked about her but not to her on some occasions, although this was not routine.

'It is a bit annoying when they stand at the foot of the bed talking amongst each other, when they should be talking to you. That is annoying. And it does happen occasionally when you might have a visit where there are two or three doctors standing at the foot, discussing you and you're sitting in bed wondering what they're talking about. And then you go away, and you'd like to go and say, come back and tell me what...' (Participant 11, female).

She felt very uncomfortable with this experience. Some participants felt there were examples of ageism when receiving services from health and social care professionals, this included change in speech tone, speech speed and patronising.

'I went for a flu jab a while ago, and this nurse gave me a form to sign. And she said, date of birth? So I said, Oh, I'll fill that form in for you, it'll be quicker. So I ended up with a wrestling match trying to get the form off her because by then, I was going to fill that form in. But, voices do change and attitudes change when people realise that you're over a certain age' (Participant 15, female).

It was felt by some of the participants that professionals made assumptions about people of a certain age. Others felt they were heard but not listened to 'You can hear and not listen, if you understand what I'm saying' (Participant 10, male). The participants in this project argued how uncomfortable these experiences were for them.

Another participant commented on the need for individuality and respect in the way that professionals communicate with the people they encounter in doing their role. This participant felt he should have been asked how he would like to be addressed rather than assumptions been made.

'I would say communication, they've got to. But how can ... and they've got to treat everybody differently. What does one person doesn't do another. I know like my mother, she always wanted to be called Mrs. Now, I don't I wanted to be called ...' (Participant 2, male).

This view was echoed by other participants who suggested the need to view the person as an individual:

'You're not just another number in a book, you know, they are ... at the time, you know you're talking to them, they are genuinely interested in you as a person, to get whatever problems there are out into the open and sorted' (Participant 4, male).

Non-verbal communication: Non-verbal communication was part of most of the interactions that the participants had with health and social care professionals. Much of the non-verbal communication can be difficult to describe and is subjective. The participants in this project were very aware of the non-verbal communication they had experienced and the impact it had on their interactions.

'It is the way they approach, because if they come with a face like thunder and lightning and you say, oh my God. And right away, you've built up a contact where you are all thinking the wrong ... it might be the wrong thing about the man' (Participant 3, female).

This participant focussed on the approach of the person and first impressions she got before even the first word is spoken. She spoke of the message that was sent to her when the professional was using the computer in the first instance rather than greeting the service user.

Listening and hearing was a recurrent theme in this project raised by many of the participants. One participant reiterated that:

'... sometimes people will have their own baggage that they've got on board and they're just ... they don't want to give you the time, you know, they won't listen to you. They're hearing but they're not listening, so they're not really understanding what's going on' (Participant 16, female).

Another participant suggested:

'But the good ones treat me as a human being and listen. And they might agree or might not agree with what I'm saying, but they're prepared to treat me as a human being and listen to me, and be honest with me' (Participant 6, male).

However, a different participant suggested that ‘...it’s to be hoped they listen to you’ (Participant 2, male).

There was a further example from a participant about the power of touch and how much better this person felt. However some professionals may feel hesitant to use touch.

‘And the male staff nurse and the first year student, it was their first placement, just came, he said, come here, he said, you need a hug, don’t you? And I’m just sobbing. And he sat on the bed next to me and he put his arm around me, and the student nurse was just stroking my back and just letting me sob. And he drew the curtains and let me get it out of my system’ (Participant 9, female).

Documentation: The limited reference to documentation in this project may suggest the lack of prominence it had, during the interactions for participants in this project. Although it was clear that documentation was central to all interactions. For the participant documentation might only become apparent if a complaint has been made. One participant reported that the surgeon was called away and the registrar ‘...came in and dealt with all the paperwork, which he didn’t really know what he was doing. He was a bit new. So I was referred to the wrong department’ (Participant 1, female).

The same participant also had an instance where a nurse came to remove a cyst and the participant said to her:

‘...have you read my notes? She said no, she said, it’s just removal of a cyst. I said well read my notes. I can remove a cyst. I said, no, no, I said, stop, read the notes. And she then was absolutely horrified that she might have gone ahead with this’ (Participant 1, female).

She believed that if she had not fully understood what was been done to her or the outcome could have been very different. Many service users place their trust in the professional and might hesitate to challenge them in such cases.

There was another example of an issue with documentation where the participant was going to receive heparin until he said ‘...no, I’m on warfarin. Well, it doesn’t say in the notes. I said, yes, it does say in the notes, I said, it’s there in red’ (Participant 2, male).

All professionals need to familiarise themselves with what is written about a service user before undertaking any procedure. In this project there was limited reference to documentation by the participants, but where it was mentioned it was clear how important it was during consultations with health and social care professionals. The examples in this project related to professionals not checking documentation as opposed to poor documentation.

DISCUSSION

'No decision about me without me' (DoH 2012, p 3). Verbal and non-verbal communication is essential for all health and social care professionals. In this project a number of the participants discussed their experiences of effective or poor communication. 'Positive communication requires positive non-verbal communication' (Russell 2007 p 438).

Effective communication is essential for all interactions in healthcare and should occur with and alongside the service user who should be at the centre of all decision making (Royal College of Physicians & Royal College of Nursing 2012). It was discussed by one participant where it was challenging to understand how decisions could be made in the absence of the service user. As was suggested by Francis (2013 p 1595) 'there needs to be good communication with and about the service user, with appropriate sharing of information with relatives and supporters'. It may be challenging to understand a service user's routine when at home, if the service user is not fully involved in the decision making process, contributing to that decision making process, and how the treatment advice will fit in with that routine.

Sharples (2007) suggested that speech and hearing can be a barrier to communication. It would appear that some professionals made an assumption that those over a certain age had hearing problems regardless, and change how they communicate with the person due to this. So it was crucial that the focus was on individuality (participant 15, female).

As professionals we may not be aware of the impact our own non-verbal communication has on the interactions with service users and how it can contribute up to two thirds of the meaning within the conversation (Moss 2012). Listening to a person is entirely different than hearing them (McCabe & Tiimmins 2006) and in this project the participants were aware that some professionals were not

always hearing what they were saying. This has highlighted the extent participants could interpret from the body language of the professionals. However for professionals it can be very challenging to document non-verbal communication due to its subjectivity. There may be cultural differences in non-verbal communication making some of it challenging to interpret correctly.

While it is essential for professionals to speak to the service user, it is equally important for them to speak to each other about the most appropriate care needed by the service user, no one professional or professional group can have all the answers on a service user's care. There was a view that multi-professional meetings were needed (participant 3, female). This concurred with the view of the Royal College of Physicians and Royal College of Nursing (2012). Although in reality examples found by Francis (2013, p 1028) included '...surgeons operating on colorectal service users in an emergency situation who had failed to liaise with or hand service users back to the colorectal team ...'.

Listening was considered essential to effective communication (Morrissey & Callaghan 2011). However due to time constraints for nurses, the opportunity for rich communication in clinical practice with service users can be compromised (Chan, Jones & Wong 2013).

All too often much has been communicated either to the service user or between professionals that has not been documented or has been documented in a way that has led to mis-interpretation. Documentation is like the 'glue' that binds verbal and non-verbal communication together in health and social care. The examples presented in this project showed how problems can occur if documentation is not checked before care delivered, or not documented correctly when care has been delivered. More serious incidents were averted by the alertness of the participants in the incidents discussed. However not all service users are as alert, (for example those with dementia) or may not feel confident to challenge the professional. Although in this project the examples related to the professionals not checking the documentation before undertaking the plan of care, there are many incidents caused by poor documentation or incomplete documentation. Whilst written documentation is recognised as essential for all health and social care professionals, it is equally important to consider the quality of such documentation. This will enable other professionals to fully understand what others have done and the plan of care for the individual.

As Flynn (2011, p 10) highlighted in her serious case review of Summer Vale Care Centre the importance of documentation, ‘... accurately recording and communicating facts are essential’. Issues with documentation were also found by the Parliamentary and Health Service Ombudsman (2011) in their report on Care and Compassion where they found problems with care plans either not completed or incomplete, absence of risk assessments and lack of incident forms in relation to falls. In light of this it would be challenging for the health and social care professionals to provide continuity of care.

Limitations of the project: The interview questions that were developed in Portugal, led to some cultural challenges following translation. This part of the project represents a small part of the overall project, and the participants for this project represent only one geographical area of the UK. The findings of this part of the project only represent the views of 16 people, although the five countries combined in this work stream will have the views of 80 participants.

RECOMMENDATIONS

Sessions on communication are more usual when professionals are in training such as students of nursing, medicine, paramedic studies or physiotherapy. Perhaps there is a need for communication to be recognised as part of routine essential learning for all health and social care professionals that are updated on a yearly basis, and not just restricted to learners. The Francis Report (2013) along with the Laming Inquiry (2003) highlighted a number of issues related to communication. Issues with communication often come to light through complaints (Health and Social Care Information Centre 2014), serious case reviews and inquiries. However limited attention is given to examples of effective communication and strategies that could be used for sharing such examples of good practice. While there are many examples of good practice happening on a daily basis, the media often sensationalise experiences service users have in the health service helping them to sell newspapers, ignoring many of the positive experiences that many have. Therefore the public get the impression of service users having very poor experience of the health service.

Clinical supervision or peer supervision can provide opportunities for professionals to discuss practice, issues including communication. This approach enables professionals to learn together as

well as individually. ‘Supervision can also provide a key process to help a living profession or organisation breathe and learn’ (Hawkins & Shohet 2012 p237).

CONCLUSION

This project recognised that effective communication as the ‘bedrock’ of any therapeutic relationship. Effective communication for health and social care professionals has been a priority for some time, but it remains a challenge to many professionals as was seen in the Francis Report (2013). The participants in this project provided numerous examples of experiences where communication could have been better alongside examples of excellent communication with healthcare staff.

Communication remains a challenge for many professionals due to its fluidity, changing based on context, individual needs and affected by the professionals own experiences, value and views. The diversity of situations encountered in the course of their professional duties required the professional to have versatility in their communication skills. It is vital the professional can acknowledge this and remain open to reflection and learning. Learning from the experiences discussed by Francis (2013) is essential to ensure that such practice is not repeated.

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