Communication is the transfer of information among people. As a registered nurse working in a hospital I am required to communicate with my patients, an interdisciplinary team of various healthcare professionals, and ancillary staff. Effective communication in the nursing practice is one of the major components in providing quality care to patients. Ineffective communication between a nurse, her patient, and other co workers can put patients in harm’s way. Andy Betts, a freelance nurse consultant and professor at the University of Nottingham in the United Kingdom, claims that "studies over the last three decades identify communication problems as persistent causes for concern in the delivery of healthcare.” Without effective communication in nursing, there can be lack of understanding, poor client care and even medical mishaps. (Papa, 2011, p.1) Effective communication skills, is therefore a valuable asset to have working in a patient care environment.

The nursing course Communication/Behavior focusing on the nurse-patient relationship and teaches techniques and theories that the healthcare professional can utilized when communicating with patients. The communication skills that were learned improve the nurse patient relationship. It allows for a true therapeutic relationship to develop between the patient and nurse. This paper discusses a patient interaction, in which I demonstrated ineffective and effective communication while working in a hospital setting in the Surgical Step-down Unit at Beth Israel Hospital- Kingsway Division.

Ineffective Communication

The Surgical Step-down Unit is a critical care unit were unstable, and critically ill pre-operative and post operative surgical patients go to receive care. It is a six bed unit, with cardiac and hemodynamic monitoring. It is staff with two registered nurses and one patient care assistance. On November 1st, I was taking care of three patients, one of my patients Mrs. T and I had a falling out. Mrs. T is a 50 year old Puerto Rican women, she is married, and has four children (three boys and one girl). Mrs. T came to the hospital for severe abdominal pain, nausea, vomiting, severe fatigue and weakness for 3 weeks. Mrs. T has a past medical history of cervical cancer, liver failure, congested heart failure, and uncontrolled type 1 diabetes with a previous hospitalization in which Mrs. T was in a coma for four months due to uncontrolled diabetes and developed a condition called diabetic ketoacidosis. The current admission she was diagnosed with multiple abdominal hernias, a possible colon-bladder fistula, DKA, and acute renal failure.

At the beginning of the shift I was given a report on the patient. I was told that the patient was not compliant with the care and the previous shift nurses communicated their frustrations with her behavior. One of the nurses stated, “She wasn’t taking care of herself at home (referring to Mrs.) with blood sugar averaging in the five hundreds, and waiting three weeks to seek care, so why would she accept care from me! She thinks she knows everything! I took this with a grain of salt because sometimes nurses expect their patient to do everything they were told to do regardless of the patient’s own personal concern. As nurses we feel like we are the experts and can become defensive when challenge by a patient and unfairly label them. Compliance is often defined as ‘the extent to which a person's behaviour (in terms of taking medication, following diet, or executing life style changes) coincides with the clinical prescription’. (L van der wal, Jaarsmal, Moser, Veeger, Gilst & Veldhuisen, 2006, pg. 434) By not conforming to clinicians' expectations, patients may be viewed as deviant and labeled non-compliant. (Snelgrove, 2006, pg. 28) This could lead me to unfairly judge Mrs. T and could hurt our chances of building a therapeutic relationship.

I introduced myself to Mrs. T, and explained that I was going to be her nurse from now to seven pm tonight. I then started to do a physical assessment on the patient. She was alert and oriented times three, had good verbal responses, and appeared upbeat. After I completed my assessment I shared my finding with my co worker. Mrs. T was very sick lady with multiple issues developing and needed to be more frequently monitored than the other patients, and maintained on strict bed rest. I then explained to the patient that she is on strict bed rest and when she needs anything to call for a staff member. Mrs. T verbalized understanding, and at this point I do not view her as non compliant with care.

Approximately about half an hour later the patient wanted to go to the bathroom. She refused the bed pan and demanded to get up. I tried to explain to the patient that it wasn’t safe, but she didn’t care. She started to raise her voice and pull the cardiac monitor off. At this point I made a judgment call not argue with the patient because I did not want her to hurt herself or increase her stress levels. I offered the patient a bedside commode, in which is like a portable toilet and would still allow for her to be on the monitor. Mrs. T refused and said, “Miss I am going to the bathroom, I am a grown woman, you can’t tell me what to do!” Mrs. T was getting off the bed and nearly collapsed on to the floor; she was too weak to stand and would have fallen if I wasn’t at her side. After placing the patient back in bed, I wasn’t sure how to interpret the situation. I knew that the patient has an extensive past medical history, currently seriously ill and seemed to be angry. I thought a psych consult might be appropriate, and that I was in for a long day.

A little bit latter the surgical intensivist came to see the patient he wanted to insert a Salem sump nasogastric tube and a Foley catheter. The staff spent an hour and half trying to convince the patient to allow this to be done. This was so frustrating, why come to the hospital if you are not gonna accept the care. I started to view Mrs. T of as being difficult, and non compliant. Negative labelling of certain types of patients is comparable to Podrasky & Sexton’s (1988) findings that nurses tend to respond to difficult patients with anger and frustration. (Smith,1994, pg. 645).

Throughout the day the patient made at least twenty attempts to get out of bed, and when she was refused she would defecate in the bed refusing to use the bed pan. Even though she was on a NPO diet( nothing by mouth) and was fully aware of that, she was demanding food, and her family was bringing her food and secretly giving it to her. Eating cause her to become nausea and vomit. The first time I caught her eating, it sadden me, because she just wouldn’t listen and was further putting her life at risk. I looked at the patient and in a disappointing tone, with my shoulders shrugged I said, “Now you know Mrs. T you are not allowed to eat anything”. Mrs. T responded, “I don’t care, I’m hungry, you people in here starving people”, I replied, “No one is starving you, you are on an NPO diet because you are very sick, and eating will worsen your condition.” The patient in hostile tone told me it was her life and she knows how sick she is, and said she wouldn’t do it again. But I caught her eating and drinking two more times. I tried to talk to her again in front of the family but as soon as I walked away they gave her something to drink. The patient also refused insulin and only allowed us to check her sugar when she felt like agreeing, and didn’t want to be attached to the cardiac monitors and intravenous tubing where she was receiving fluids and antibiotics.

By the end of the shift I was completely disconnected from the patient. Mrs. T condition was worsening, she was still not compliant with care, and we were just waiting for the “bomb” to go off. I said to my fellow nurse, “If, she doesn’t care why should I. Why should I have to constantly repeat myself to an alert, and oriented person, who clearly doesn’t care? I can only help someone that wants to be helped.” When my work day was over I was relieved; I felt like my efforts to help the patient were wasted. I was left with a resounding feeling of fatigue, confusion, and powerless. I left without telling the patient goodbye.

This was example of ineffective communication. The first thing I did wrong was labeling the patient as non–compliant and hostile. Mrs. T history of not following medical regimen and our first disagreement allowed me to blame the patient. Blaming offered a social explanation for why the event became unmanageable. (Smith, 1994, pg. 648) I allowed my personal feeling to intervene with me caring for the patient. My feelings of being powerless, and inability to change the situation caused me to emotional, and physically detach myself from the patient. I never tried to find out what were her concerns, and needs. I was dictating what I wanted her to do without involving her in the care. I didn’t think about how Mrs. was feeling about her own health and current condition. I also talked downed to the patient, and displayed my discontent with her behavior with my body language and action. I failed the patient by not listening to her and by becoming withdrawn, distant, and avoidant. I needed to put my feelings aside and focus on the patient and trying to build a trusting relationship.

Effective Communication

Effective communication with my patients is what I strive for. Effective communication is one of the most important component of the nurse-patient relationship. The nurses ability to effectively communicate with her patient can have an astounding affect on the patient. It is November 4, 2011 and I am working in the Surgical Step-down Unit again. When I entered the unit I looked to see if Mrs. T was still there. I was happy to see her, I smiled and said “Good morning”. I felt bad about our last encounter and felt like I could have handle things differently. After receiving report, I was glad to hear that the Mrs. T condition had improved but the nurses reported she was still non compliant. When I went to her bedside I introduce myself and ask the patient if she remember me. Mrs. T replied “yes”. I smiled again and ask her how she was feeling, today? Mrs. T stated “I feel okay, but I still have a lot of abdominal pain. I asked her if she in a lot of pain now and if she needed something for pain. She replied yes, and I gave her a shot of Demerol and told her that she should shortly start to feel some relief. After I gave her the pain medication I started my physical assessment. I informed the patient on my findings and let her know that her condition was improving. I asked her if she had any questions or concerns and she replied no.

As the day progressed I kept Mrs. T informed on the plan of care for the day, and allowing her to agree or disagree. I supported and understood Mrs. T need to maintain her autonomy. Instead of dictating I was encouraging Mrs. T to be an active member in her healthcare. For example, Mrs. T refused a chest x-ray because she had one several hours early and didn’t want to go to the cold basement. When I informed the doctor he didn’t know she just had one and cancelled the test. She smiling, happy and even proud of her self.

Her mood soured when the PCA, Julie try to check her blood sugar. The unit was basically quiet and then all you heard was this giant eruption. Mrs. T was yelling and telling the PCA to get away from her, she don’t need nobody telling her what to do! Immediately I jumped up and put myself between the PCA and Mrs. T. I told the PCA to go on her break. I then asked Mrs. T, “whats wrong, why are you yelling? The whole day you were in a good mood, why are you upset?” Mrs. T responded, “Why she kept bothering me, I told her no, and she should have listened.” I replied, “Mrs. T you are upset because she wanted to check your blood sugar? Mrs T replied “yes”. I asked her why don’t you want to check your blood sugar? Mrs. T replied, you guys have my sugar running low, giving me all that insulin my sugars are normally 400 to 500”. I asked Mrs. T more questions regarding her past medical care, and the last time she was seen by an endocrinologist. I realize that there was need for education and I ask the patient if she didn’t mind I would like to give some teaching on diabetes. Mrs. T, agreed, and I printed out an educational pamphlet on diabetes and insulin. I gave a copy to the patient and highlighted key points that I wanted the patient to understand. After completing the teaching and Mrs. verbalized understand, I asked Mrs. T how did she feel. I told her its okay if she feels overwhelmed. She stated that she feels confused, because she had everything backwards. She thanked me for taking the time to teach her, even though she was being nasty. I replied, “Don’t worry about that, it’s very stressful when you sick, I just wanted to help you get better”.

After fifteen minutes I went back to the patient and ask her if she gonna let us check her blood sugar. She looked at me, smiled, and said, “yes”. As I was checking her blood sugar, I asked Mrs. T if she felt any benefit from the blood sugar being better controlled. Mrs. T blood sugar were ranging between 160-250. Mrs. T stated, “I feel better, and I have more energy and not thirsty all the time.” My response to Mrs. T, “I am glad to hear that you are starting to feel the benefits of better controlled blood glucose. So what is your plan for your diabetes care when you are discharge. Are you going to check your blood sugar, give yourself insulin, and follow up care with an endocrinologist? Mrs. T stated that she was truly feeling better and would like to get ger blood sugar controlled because, she hasn’t felt this good in a long time, but from what you taught me, it is very difficult to controlled. I then told Mrs. T that both of my daughters are type 1 diabetic and I know how difficult it is to control their blood sugars. It is a life long process but as long as you are actively trying to improve it gets easier to manage with time. Mrs. T was shocked to learn that both my daughters have diabetes. I explained different options and technologies available to make diabetes management easier. She expressed interest in an insulin pump, with a blood sugar sensor. She asked me if I could teach her, I said “I would be honored to helped you, but I am not always here.” I gave her my cell phone number and told her if she had any questions or concerns she can call me. When the endocrinologist came to see Mrs. T she asked him if she could be place on an insulin pump and if she could come to her office and see her as an outpatient. Mrs. T was discharge a couple of days later, she has called me at least two times and I have called heard at least three times to check on her. She seems to be doing well, and seems truly interested in improving her health.

This was my example of good communication. I should Mrs T respect, and allowed her to maintain her autonomy. I never dictated to her and allowed her to express her concerns. Through active listening and showing empathy, I was able to get the patient to open up to me. When an individual is initially diagnosed with a chronic illness or acquires a new impairment, a number of very realistic concerns and fears may rapidly come to mind. (Taylor, pg.1) Cognitive behavior therapy is a technique that healthcare providers can used to help facilitated patient adherence to medical regimen. A growing number of research studies point to positive outcomes of cognitive behavioral approaches that involve reductions in symptom severity and improvements in self efficacy, physical functioning, and quality of life. (Taylor, pg2) I initially identify an error in Mrs. T thinking about her diabetes, and addressed it by doing teaching in a manner Mrs. T could underdstand.

The next thing I did was used motivational interviewing to get the patient o decode the need to follow up care after discharge.  Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. (Rollnick & Miller, 1995, pg. 1) After doing diabetic teaching Mrs. T and comparing her current blood sugars to those at home. Mrs.T developed an discrepscany. She realized that she felt better, and had more energy to do things she wanted to do when her blood sugars where better controlled. For example she wanted to be more active in her children lives. She didn’t like feeling weak and sluggish, she wanted to change. The patient exhibited readiness and willingness to change. Whem she should me ambivalence, I gave her treatment options that made diabetes easier to manage, along with continous support and my telephone number. Mrs. is currently on a insulin pump, and checks her blood sugar three times day. During our last telephone conversation her blood sugars where ranging from 200- 300 mg/dl. She stated she feels good and is taking better care of herself.

In conclusion, effective communication is the key to a successful patient nurse relationship. Mrs. T was a very complicated patient and required a lot of one or one time. Communication was difficult and I handle our iniattly encounter wrong. I wanted her to allow care and when she didn’t. I judged her, became confrontational, frustrated, upset, and detached when interacting with Mrs. T. Even though I wanted the best for the patient, I didn’t take her into consideration. My only concern was her physical condition and not her mental or psychological state. The next time I saw Mrs. T I was determined to get through to her using some of the techniques taught in class. I recognized that mrs.T needed to play an active role in her recovery, I kept hher aware of test results, and plan of care. Allowed Mrs. T to refused care, maintaining her autonomy. I then guided her to appropriate thinking by doing teaching. By using guided question I helped Mrs.T develop and discrespancy between her goals and past behavior. Mrs. T found a reason to want to change that was important to her. After I interaction Mrs. T has been actively involved in her care, and I have been there to give her continous support.

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