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Communication skills education and training in pre-registration BSc Nursing 🔒

Chapter:
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Introduction to communication skills education and training in pre-registration BSc Nursing ▲ ▶

Nursing degree students arrive with a variety of skills and while some students may have experience of caring, other students may have had limited exposure. Some younger students, although adept at negotiating social media, are often anxious about interacting with patients, clients, and carers for the first time particularly when dealing with sensitive issues such as end-of-life care or after a death (Poultney *et al.* 2014). All, however, need to develop their interpersonal skills to demonstrate compassion, empathy, and a person-centred approach to maintain patients' dignity alongside effective dialogue. Faculty students

specializing in the fields of adult, mental health, learning disabilities, or children's nursing undertake a core clinical skills module including four hours of communication skills teaching in the first year.

This chapter will review the development of simulated learning in communication skills education in a large Faculty of Health, Education, and Life Sciences, highlighting the approach taken including the evaluation strategies and the challenges. Educational standards in the United Kingdom (UK), as specified by the Nursing and Midwifery Council (NMC) [Box 23.1] highlight the key competencies nursing students need to demonstrate proficiency in to become a Registered Nurse (NMC 2011). Additionally, particularly within mental health and learning disability nursing where it arises frequently, nurses have to be competent and confident in assessing mental capacity, as well as ensuring reasonable adjustments are made where needed to meet legislative requirements (Equality Act 2010). Such emphasis on communication is timely with an increasing focus on delivering empathetic, compassionate, and individualized care in a multicultural society in all fields of nursing (Atherton and Kyle 2014), especially at the end of life (Shannon *et al.* 2011).

Box 23.1 Pre-registration communication competency standards

Nurses should be able to:

- ◆ Communicate safely and effectively.
- ◆ Build therapeutic relationships taking into account differences, capabilities, and needs.
- ◆ Be able to engage in, maintain, and disengage from therapeutic relationships.
- ◆ Use a range of communications skills and technologies.
- ◆ Use verbal, non-verbal, and written communication.
- ◆ Recognize the need for an interpreter.
- ◆ Address communication in diversity.
- ◆ Promote well-being and personal safety.
- ◆ Identify ways to communicate and promote healthy behaviour.
- ◆ Maintain accurate, clear, and complete written or electronic records.
- ◆ Respect and protect confidential information.

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Prior to the development of a new BSc (Hons.) Nursing programme in 2010, communications skills education was limited to lecture-style teaching. However, an opportunity arose to include high fidelity simulation (Aldridge 2012) with actors simulating patients and their carers using scenarios taken from clinical practice. After a systematic evaluation, this was supported by a Higher Education Academy Grant with local hospices as collaborators (Lewis *et al.* 2013). The BSc programme now aims to provide communication education throughout the pre-registration nursing programme alongside supported clinical experience, enabling students to develop more complex communication skills as they develop as practitioners.

Early challenges

Although there is conflicting evidence on the value of using simulated patients over other experiential learning, such as peer role play, using non-healthcare professionals enables constructive feedback for students from a lay perspective, which is recognized as invaluable (Bokken *et al.* 2009). In higher education, the realistic portrayal of a patient or carer may be undertaken by laypersons, clinical staff, lecturers, or other students as well as professional actors. In a BSc programme with over 700 new students annually however, professional actors are prohibitively expensive. Early work focused on increasing the faculty's pool of actors by training third year students from the Birmingham City University's School of Acting and clinical staff who already acted as simulated patients in the learning disability field of nursing (O'Boyle-Duggan 2010). This initial group, and later cohorts of drama students, participated in a two-day training programme to standardize practice and provide a common preparation level for all simulators. This included practising the scenarios and giving constructive feedback. The core elements of the faculty training programme are shown in Box 23.2.

> ### Box 23.2 Faculty simulator training
>
> Facilitated by a lecturer and a professional actor:
>
> ◆ Introduction: What is expected of a professional simulator?
> ◆ Communication skills: What skills do we want to promote in healthcare professionals?
> ◆ Preparing for simulation sessions.
>
> - Using pre-written scenario.
> - Giving constructive feedback.
> - The value of delivering a lay person's perspective.
> - Establishing a suitable playing level.
> - Flexibility and improvisation.
>
> ◆ Practising scenarios and giving feedback.
> ◆ Simulating sensitive issues and the need for self-care strategies.

Drama students are well-versed in aspects of communication such as observing non-verbal behaviours, listening for and delivering cues, and identifying linguistic issues related to pace, pitch, and tone—thus finding a common language to describe communication skills proved easier than anticipated (Lewis *et al.* 2013). Active feedback from lecturers who facilitate the teaching sessions is valued highly by the actors. Additional time spend on simulating learning disability scenarios helps them to portray a patient with a moderate or severe disability. Initially drama students also helped to improve the quality and depth of 12 field-specific scenarios, which are based on commonly occurring clinical situations (shown in Box 23.3).

Box 23.3 BSc (Hons) simulation scenarios

Adult nursing

◆ Responding to a cancer patient's query: 'What does palliative mean?'

◆ Responding to a shocked and distressed patient in an outpatient clinic.

◆ Responding to an irritable and aggressive older patient unable to return home.

◆ Discussing options with a relative of an extended family staying beyond normal visiting hours.

Mental health

◆ Assessing a patient after finding a half-empty whisky bottle under their bed.

◆ Helping an aggressive, bed-bound patient who has been moved from another ward and is suffering nicotine withdrawal.

◆ Dealing with a patient's approach for a night out after their discharge from the ward.

Children's nursing

◆ Discussing the care of a baby with a cold with her anxious and socially isolated mother.

◆ Establishing conversation with a withdrawn adolescent patient with cystic fibrosis after the death of their close friend.

◆ Assessing a 15-year-old patient admitted to hospital after a self-harming episode.

Learning disabilities

◆ Assessing pain in a patient with moderate learning disabilities and limited speech who wants to return home.

◆ Managing a patient in casualty with autism and limited speech who wants to remove a head dressing.

Dementia care

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◆ Settling a patient with Alzheimer's disease who is restless and distressed at evening visiting time.

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New scenarios added recently include settling a distressed patient with Alzheimer's disease and assessing a teenager after a self-harming incidence. As nurses have a statutory responsibility to meet the care needs of all people to enhance the students' exposure to all nursing fields, each teaching session must include a scenario from each field. This has been particularly helpful in exposing not only the students, but also the lecturers to the communication challenges experienced in other fields of nursing.

Implementation and evaluation

Session facilitators are provided with written guidance including a lesson plan, suggested ground rules for negotiation, and a structured feedback strategy based on Pendleton's rules (Garala *et al.* 2007) (Box 23.4), originally developed in medical education, with recommendations to discuss ground rules prior to starting the session.

Box 23.4 Pendleton's rules for feedback (adapted)

The participating student has the opportunity to talk first and is encouraged to discuss positive points:

◆ The participating student has the opportunity to suggest alternative strategies to improve their performance.

◆ The observing group are invited to provide feedback with positive points given first.

◆ The facilitator and group provide constructive feedback with care taken to ensure comments are not given in a negative manner.

◆ An actor is invited to give a lay perspective.

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Grounds rules include allowing student volunteers and facilitators to halt a simulation at any time, to leave the room if distressed (although this happens rarely), to gather ideas from the group before commencing, and to highlight confidentiality issues. Prompt feedback and debriefing after simulated learning is acknowledged as particularly valuable (Aldridge 2012) and group discussion often broadens to include the effect of communication skills in developing or eroding relationships, power imbalances, the value of silence, and the use of touch as well as ethical issues. As recommended in all simulation work (Aldridge 2012), structured feedback during and after focuses on the student's positive achievements and helps to avoid humiliation, before constructive suggestions for improvement. It is also a cornerstone of generating a supportive environment, which is needed to encourage student participation. Using ice-breaker exercises that deliberately incorporate an element of surprise have been popular and useful in gaining active participation in quieter groups. A pre-session exercise encouraging students to self-record an interview with a friend on their mobile phone to gain insight into their normal speaking voice and to consider issues such as pitch, speed, and tone had a limited response, and may be incorporated into an earlier communication skills session. Linkage of the session content by facilitators to theoretical constructs covered in an earlier lecture-style session is encouraged. As suggested by Byland *et al.* (2009), workshop style training for lecturers was offered to promote competent facilitation of each teaching session. However, due to time pressures and the long standing experience of many lecturers, this had limited success and new facilitators are encouraged to 'see one' and 'do one' under supervision before embarking on solo facilitation. This has been successful in giving new facilitators some initial support and allowed others to decline this style of teaching if it is not their preferred option.

Quantitative and qualitative data analysis

Quantitative evaluation focused on 26 two-hour sessions delivered prior to the first year BSc (Hons.) students' first clinical placement, with a systematic approach to evaluation taken to determine the sessions' effectiveness regarding students' confidence, to support future bids for funding, and to highlight any cost benefits (Lewis *et al.* 2013). Attendees voluntarily completed an anonymized pre- and post-session survey using a 10-point Likert scale measuring confidences for a range of activities such as explaining the taking of a vital sign, responding to patients' verbal and non-verbal cues, explaining professional boundaries, dealing with strong emotions, and communicating with patients regarding specific issues such as dementia and learning disability. There are no standarised values for confidence levels in clinical skills training (Sook Yoo *et al.* 2010). This

strategy was chosen however, as it is commonly used in simulation (Aldridge 2012) and communication skills training (Wlikinson *et al*. 2009).

A representative sample of 300 students, from the approximately 520 first year students who participated, completed the survey at the start and end of each session. There were 271 surveys returned with no missing data. Detailed statistical analysis has already been reported (Lewis *et al*. 2013) and will only be précised here; but of the 82 students who took part in a simulation (*participants*), 196 students observed and give feedback (*observers*) with 12 students not specifying their level of participation. Students also added their field of nursing, namely adult, mental health, learning disabilities, or children's nursing, and were given the opportunity to add free text comments. Calculation and tabulation of the response frequencies for pre- and post-session confidence scores demonstrated that students felt more confident immediately after the simulated learning. As the data was ordinal in nature, non-parametric inferential tests were used to demonstrate these differences were 'real' and unlikely to be due to mere chance, with a statistically significant increase in confidence following the teaching session for students in all nursing fields. Statistical analysis suggested all students benefited from the class. Splitting the data into the two groups of participants and observers also demonstrated that the amount of confidence improvement (the 'effect size') is unsurprisingly larger in the participant group compared to the observer group, possibly due to a greater sense of 'ownership' when students took part in the simulation. This information added to knowledge acquired in previous faculty research (O'Boyle Duggan *et al*., 2010).

Qualitative data collection in this project was limited, with students adding free text comments to the survey. Although the numbers of these were small, they were predominately positive, focusing on the value of simulated learning. As one student notes:

> 'This session taught me to concentrate solely on patients and relatives and them expressing their concerns.'

The value of structured reflection and debriefing of simulated scenarios with students may be particularly under-recognized, as reflectivity and the development of self-awareness may help to develop nurses who are emotionally-competent (Horton-Deutsch and Sherwood 2008). In post-registration degree level modules, student, peer, and facilitator feedback is enhanced by video-recording simulations (Garala *et al*. 2007), which nurses reflect on in assignment work Although initially self-conscious, this is a powerful tool for students, helping to raise self-awareness, and can be usefully employed provided the feedback is well-structured and delivered in a supportive environment. This may be particularly useful in oncology and palliative care where events are likely to have an emotional dimension, which can be a neglected area of healthcare education.

Facilitator and actor feedback

Explicating stating ground rules and a structured feedback strategy was helpful in protecting all participants, including facilitators, from unnecessary stress and emotional. A pack of written guidance was useful for facilitators. who also suggested the sessions might have improved the students' performance in a objective structured clinical examination (OSCEs) held after the sessions. This is unsurprising, as nursing practical procedures do require communication competence (Sook Yoo *et al.* 2010) and communications skills in medical education are recognized as a critical component of patient consultations.

Formal assessment of the facilitators' competence has not been undertaken, although evidence suggests this can be a key factor in ensuring effective simulated learning (Byland *et al.* 2009); regular open and honest peer review is also recommended. As noted earlier, a workshop for potential facilitators was poorly attended, but often advice is sought informally and care has been taken not to alienate colleagues. Some tasks within the session are more complex than others, such as resolving learning disability scenarios and gaining student participation in larger groups. Designing and negotiating facilitator competences and regular review by colleagues with individual feedback, perhaps as part of a faculty annual peer review process, may be a useful development for the future. The faculty also runs a Master's level module for simulated learning, which has provided a useful forum for discussing and promoting the need for effective facilitation skills.

Drama students from the School of Acting highlighted the satisfaction felt in using their expertise to help healthcare professionals develop key skills for clinical practice. It assisted their own development particularly in improvisation and other skills (Lewis *et al.* 2013). Although drama students found nursing students able and keen to learn, there are challenges. Drama students have a commitment to their own learning. Those who do participate however, are committed. They also often have experience as users of the health service which can be useful to nursing students. A University renumeration scheme and integrating the training into a BSc (Hons.) Applied Performance (Community and Education) module, has not increased the proportion of drama students able to undertake this role. Consequently, the faculty remains reliant on other actors for simulation work.

Learning disability

People with learning disabilities accessing mainstream healthcare face many challenges where health professionals continue to disregard the legal requirement to make reasonable adjustments (Equality Act 2010) for the communication difficulties experienced by many people with learning disabilities (Emerson *et al.* 2011). In general healthcare services, communication difficulties can hamper essential diagnostic and screening procedures such as taking an adequate history. Staff can lack confidence and, in busy clinical environments, consultation times are often inadequate to address concerns of the cognitively impaired. Even making an appointment can be a challenge. Education with a focus on learning disabilities including communication can improve awareness, and demonstrates that discrimination can be tackled with positive changes in attitude and interpersonal skills (Webb and Stanton 2009).

With regard to end-of-life care, Read's work (2006) highlights that those individuals with a learning disability who have a life-limiting illness find it particularly difficult to access relevant end-of-life services, while Willner *et al.* (2011) has identified gaps in knowledge and training needs of healthcare professionals in relation to consent issues. Since 2010, nursing students have been exposed to live simulation to promote a person-centred approach to communication (O'Boyle-Duggan 2010), which is recognized as an important element in palliative care for people with learning disability (Morton-Nance and Schafer 2012). Pre-registration students from all nursing fields have an opportunity to interact with a simulated patient who exhibits a variety of learning and health needs related to the students' clinical field. Simulations take place in specifically designed skills rooms replicating the relevant clinical environment, such as a ward or a home environment, with students given extra time to assess a client's clinical needs using a range of strategies and clear, unambiguous language (Tuffrey-Wijne and McEnhill 2008).

Mixed methodology research (O'Boyle-Duggan *et al.* 2012) with 173 health students was conducted over a period of 18 months and involved students from the Operating Department Practitioners programme, and adult and children's nursing students. Students completed a standardized satisfaction and confidence survey, with focus groups conducted after a clinical placement experience to evaluate the benefits to the students in their clinical practice (O'Boyle-Duggan *et al.* 2012). Evaluation of responses indicated a confidence increase with students feeling involved and able to consider, from a personal perspective, how communication and behaviour affected service users. They also reporting feeling more competent in using skills related to theory when responding in real time to emotionally distressed simulated service users. This was particularly valued as students were able to make mistakes, which could then be safely explored and rectified. Debriefing and reflecting on performance were also an important component of the live simulation, which was

highly valued by students who stated that this enhanced their learning (O'Boyle-Duggan 2010). Students felt observing simulations highlighted the issues and communication barriers that may be encountered in clinical placements as 'you saw it from the outside too', as well as learning how you would react in an unpredictable improvised situation; which as a simulation participant noted 'you can't get in a lecture'. Recommendations for practice and reflective statements from students as a result of this simulation work are shown in Box 23.5.

Box 23.5 Student reflections and recommendations for practice

Recommendations for practice

- ◆ KISS: keep it short and simple.
- ◆ Talk more slowly.
- ◆ Talk to the child rather than parents.
- ◆ Take more time.
- ◆ Think about finding out the child's interests to initiate dialogue and to gain trust.
- ◆ Distraction techniques may be useful.
- ◆ Speaking to [the] patient without [his or her] parents.

Student reflections

- ◆ 'I didn't quite understand how difficult it can be to communicate with children who have learning disabilities.'
- ◆ 'Not all children with learning disabilities have challenging behaviour.'
- ◆ 'It is surprising how instinctive I can be when put into a scenario.'
- ◆ 'Even though each patient is an individual and should be treated the same, it is alright to make allowances and to take your time.'
- ◆ 'It reiterates that hands-on practice is the best way of learning and finding mistakes in our techniques.'

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Such simulation work highlights that, when encouraged to do so, students will make reasonable adjustments in their nursing care, as per the

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Equality Act (2010), in a creative way to communicate with patients with learning disabilities—as illustrated by the following comments:

> One gentleman, he'd like—I'd throw a ball at him and he'd throw it back, and he'd sit there for hours just playing ball. Another one was a piece of music and you put that on and instantly it's like, 'Yeah, I remember this,' and it'd make him happy, and you can talk to him. And it was really rewarding. Just finding something that they enjoyed and you could use (O'Boyle-Duggan *et al.* 2012).

Some comments also hint at a change in attitude:

> I suppose it is the change in attitude, isn't it really? Instead of saying 'Oh I'm busy. I'm going to have to write all the notes up'. That really just takes two minutes, just to go and spend a bit of time with someone. And that can mean a lot to somebody (O'Boyle-Duggan *et al.* 2012).

The available literature however, suggests there is little evidence of outcome measures in terms of clinical impact when using simulation in nursing and other health education programmes. Work is developing in a variety of nursing and health and social programmes—such as social work and speech and language therapy—with a view to evaluating the clinical impact of improved communication in more depth. Live simulation, in collaboration with students, is also being developed for use in an end-of-life e-learning package for learning disability nursing.

Children's nursing

It may be under-recognized that communication dialogue in children's nursing often necessitates discussing topics of an intimate nature such as hopes and fears, developmental concerns, sexuality, drug use and abuse and, sadly, terminal illness. Communication may be very challenging, particularly within the context of oncology and palliative care (Potter *et al.* 2013). Nursing students must take account of the age, development, and any communication or learning disabilities a child may have while avoiding jargon or appearing patronizing (Chilman-Blair 2010). Qualitative research by Carson (2010) highlights the nurses' emotional insecurity in communication at the end of life, particularly with parents, coupled with feeling unsure of how much emotion to display themselves' after a death. Published work by Poultney *et al.* (2014) highlights students concerns such as 'What do I say if a patient asks am I dying?', 'How do I break news to a family?', 'What if I say the wrong thing?' (p. 347). Some of these issues are addressed in small group teaching entitled 'Perceptions of Dying', which leads on to the more detailed communication scenarios used in communication skills simulation sessions.

In addition, consultations in paediatrics are often 'triadic' with three participants involved at the same time such as a child, parent, and nurse, which presents special challenges. Parents have a key role and may act as an intermediary between the child and nurse clarifying questions and empowering the child or they may inhibit the child's role in the dialogue, answering on their behalf and disempowering the child (Lambert *et al.* 2012). In serious illness such as seen in oncology parents may attempt to block open and honest communication in the belief it will protect the child from emotional distress.

As seen in Box 23.3, three simulation scenarios have been developed for use in the first year of the BSc (Hons.) Nursing Child field, chosen for their transferability into a range of healthcare settings, their commonality, and the level of challenge for the students. They have also been filmed to allow the students access to the key communication skills via an online educational facility. These scenarios focus on reassuring an anxious parent of a one-week-old baby, taking with a distressed 15-year-old who has been self-harming, and communicating with an adolescent with cystic fibrosis, recently bereaved of a friend with the same condition. Guided by the facilitator examination of the specific skills and exploration of communication strategies encourages reflection in reluctant students. These discussions often broaden to include ethical and confidentiality issues alongside self-care and effective coping strategies. Simulations can include encouraging the students to write down information in a structured way, such as using the SBAR tool—Situation, Background, Assessment, and Recommendations—which may facilitate the safe handover of patient information between staff (Shannon *et al.* 2011). In some scenarios it is also pertinent to highlight technologies, which may be used to bridge communication gaps such as picture boards, synthesized voice recorders, and use of sign language, such as Makaton, among children with learning disabilities (Lambert *et al.* 2012). A video based around the family of a three-year-old child who has Down's syndrome has also been developed, illustrating how a family have overcome the challenges of communicating with their daughter who has little speech for her age by first using baby signing and then Signalong. Such strategies allow the whole family, including a two-year-old sibling to communicate together. Such electronic resources allow students to develop an understanding of some of the challenges faced in the communication with children with learning disabilities that will be transferable to clinical practice.

A clear barrier to communication training for children's nurses is the lack of 'children' to work as with. Within simulated communication training, it could be argued it is easier for adult, mental health, or learning disabilities nurses to accept an altered reality and 'buy in' to the simulation, because they are working with role players of a representative age and developmental level as their patients. Whenever possible, and to maximize the potential learning, actors employed in the children's nursing field are younger-looking actors able to portray an

adolescent patient with realism—although the literature surrounding this issue is scarce. The importance of family-centred care within children's nursing is paramount and communicating with the child's parents within simulation is very realistic. Unfortunately, we may miss the essence of communicating with children, as well as assessing their levels of understanding, language acquisition, and using play as the avenue through which to build therapeutic relationships. Steps for the future include investigating how to explore these skills more fully, allowing the students to begin to embed such practice throughout the nursing programme, and increasing their confidence and competence for further development with children and families in clinical practice.

Conclusion

Integrating simulation into communication skills education and training in nursing education is a developing field and, in a large faculty, demanding in terms of staff time, effort, and financial cost. Systematic evaluation is always needed. Where it exists, it suggests that students derive an immediate benefit in terms of increasing confidence and developing self-awareness. It may aid their flexibility in using a range of communication skills and strategies to support dialogue with patients and clients. Useful in many situations, simulated learning may be valuable in addressing areas of sensitivity such as death and oncology and palliative care, to promote the need to make reasonable adjustments to communicate with people with a disability. Undertaking such work inevitability raises further areas for development. These include assessing the impact of such teaching on clinical practice. It does give educators however, a creative opportunities to link classroom learning to clinical practice.

Acknowledgements

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