

TITLE

Communication Skills Training for Nurses: Is It Time For A Standardised Nursing Model?

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Communication is a core and complex skill required by all healthcare professionals (HCP), an activity that is affected by attitudes, emotions and knowledge [1]. The process of communication is central to effective, safe, patient-centred and compassionate nursing practice. Communication between nurses, patients and their families can be improved with education and training [2]. We contend that not only can it be improved, it must be improved, and that education is key. The stakes for nurses' communication are high as its effectiveness impacts patient safety and sentinel events, workplace culture and job satisfaction [3]. Globally, most patient complaints relate to communication breakdowns with HCPs [4]. For communication in nursing education to advance globally in strategic ways, an understanding of the current educational landscape is critical. The aim of this paper is to

highlight pressing international issues in relation to optimising nurses' communication practice, with a focus on identifying the gaps and challenges in educational research and practice, and suitable models for education.

Historically, the mainstay of learning to be an effective communicator has been to observe others communicate. Learners find it difficult to differentiate between effective and ineffective role models without a framework to refer to [5]. Without a framework to guide best practice, they can mimic less effective communication behaviours. Brown [5] refers to this as 'sitting by Nellie', learning by the practice of observing another. Once assumed to be an innate skill that developed with experience and time, we now know that nurses' effective communication praxis should be a skill underpinned by theoretical foundations that can be intentionally learned and developed across practice contexts [6].

Nurse-patient communication often occurs simultaneously with other nursing actions, such as medication administration. This distinguishes nurses' communication praxis from that of medical colleagues for whom communication with a patient and/or family may be the specific focus of care (e.g., delivering diagnosis). The environments in which nurses work also shape nurses' communication praxis. It is imperative to optimize nurses' abilities to communicate within the inherently unpredictable practice environments that are characterized by dynamic elements, non-linear relationships and emergent behaviour [7]. Nurses need to be excellent communicators in such complex contexts, not just co-facilitators in a linear exchange of information. In April 2021, "The Essentials: Core Competencies for Professional Nursing Education" [8] was approved as an educational framework for the preparation of nurses by the American Association of Colleges of Nursing. Eight concepts, including 'Communication', are highlighted as core components of nursing, which has significant implications for basic and continuing nursing education in communication.

To prepare nurses for communication in practice roles, some educational models have been used in communication skills training (CST), but there may have been a reliance on medical models of communication training. For example, whilst the Calgary Cambridge Guide (CCG) [1] was originally designed as a framework to guide skills-based education for

the medical consultation, it is now recommended for HCP CST [9]. The appropriateness of this model to guide educational initiatives that aim to improve nurses' communication practice has not been extensively evaluated.

Communication skills (CS) can be taught and learnt. Much like one would learn other skills, such as performing a surgical intervention, communication needs to be practiced to develop [1]. Debate problematizes the educational preparation of nurses that prioritises technical (clinical) skills over core non-technical (behavioural) skills [10]. Kroning [11] warns that classifying communication as a non-technical skill obscures its' understanding as an inherently dynamic, artistic and scientific knowledge-in-action that is essential to expert practice.

2. Communication is integral to nursing practice

Nurses account for around 59% of the health sector [12]. Concerns have been raised regarding the quality of nurses' communication with patients and their families [13-15] and lack of compassionate care [16]. In an era of a global ageing population, concern has also been raised about the quality of nurses' communication with the older population [17, 18]. Nurse graduates lack confidence with verbal interactions and their ability to meet patients' psychosocial needs [19]. These concerns suggest a lack of educational preparation to enhance nurses' communication praxis.

There is increasing expectation that all HCPs practice within a patient-centred care (PCC) framework [20]. HCPs require sophisticated CS to elicit patients' preferences and recognise and respond to their needs and concerns [21]. In the wake of dehumanising treatment of patients at the Mid Staffordshire NHS Trust, the policy document titled 'Compassion in Practice' highlighted the 6 'Cs': Care, Compassion, Courage, Communication, Commitment and Competence [22]. Communication was explained as 'central to successful caring relationships and to effective team working'.

Scholars espouse that caring is the essence of nursing and that nurses should focus on the relationship with the patient [23]. Because of increasing complexity and lack of time, nursing practice is at risk of becoming more technical and less caring. Dempsey [24]

highlighted that ideally every clinical response and interaction should be informed by compassion. Holopainen, Nystrom and Kasen [25] suggest that in a caring encounter, the competent nurse is genuinely concerned, respects the patient as a person, and emphasises openness. Professional expectations may be higher for nurses in advanced practice nursing (APN) roles.

Nurses who are credentialled or registered as APNs have similar expanded portfolios (e.g., assessment, diagnosis, prescribing medications), all which require advanced CS. In the UK, APN programmes include subject areas related to organisational, interpersonal and CS [26]. In Australia, APNs are expected to work in partnership with the patient to determine therapeutic goals and options and communicate about health assessment findings and/or diagnoses, including prognosis [27]. Canadian APNs are expected to demonstrate advanced skills in communication, negotiation, coalition building and conflict-resolution [28]. There is an absence of literature regarding how we prepare APNs to communicate at an advanced level.

3. Communication challenges for nurses

Nurses find some types of conversations difficult. They lack confidence and skill in communicating with patients and families in situations of serious illness, prognostic questioning, strong levels of emotion, and end of life care, and identifying goals of care [19, 29-32]. Oncology nurses find it difficult to demonstrate empathy arising from the burden of carrying bad news and perceived institutional barriers [33]. Refined CS are needed to empathically break bad news to patient, a difficult task for APNs in particular [34]. Intensive care nurses find it challenging to communicate with families, citing inadequate training and peer support as barriers [29]. Accordingly, this lack of confidence leads some nurses to avoid interactions with the family. Hospice nurses find it difficult to discuss symptom management and what is perceived as denial of prognosis [32].

Nurses have expressed concerns that their capacity to have meaningful conversations with patients and their families are restricted by availability of time [29, 31, 35]. Ball et al. [35] identified that nurses say they lack time to comfort and talk with patients, and

from their perspective, this affects provision of safe and quality care. Failure to create time for patients, and to listen to them, may reflect uncompassionate care [36].

It is feasible that organisations are not providing nurses with enough time to engage with patients. It is also possible that time is not the issue and nurses are failing to recognize they are communicating in every interaction. Fleeting nurse-patient exchanges are viewed as compassionate action by patients [36]. Chan [37] found that senior nursing students were unaware of opportunities they could create space to engage effectively with patients whilst maintaining their routine. This speaks to the specific issue of peri-procedural communication; skilled, meaningful conversation as nurses perform technical tasks. To be able to employ these opportunities effectively, nurses must be better at recognising CS embedded in care. To do so, awareness of a model for communication could be of help. Numerous studies have shown that patient-centred interviewing takes little extra time [1]. However, most of the evidence is based on physician studies in primary care.

There is an identified lack of research that has focused on patients' experiences of engaging with nurses at the point of care [38]. Recent evidence suggests that nurses may not be providing PCC [16, 39] and studies have identified concerns regarding the clinical competence of new nursing graduates, including communication [15]. How we are preparing nurses for compassionate, patient-centred, and supportive care, optimising the time they have, is worthy of consideration.

4. The Current Landscape of Communication in Nursing Curricula

The literature review by Bachmann et al. [9] was unable to identify consensus statements regarding teaching of CS in non-medical professions, concluding that communication training was lacking in undergraduate education, including nursing. In their view, foundations of effective communication should be the same for all HCPs, yet rigorous examination and debate about this has not occurred. The lack of focus on communication training for nursing is surprising because verbal and non-verbal communication is central to compassion and the professional requirement for nurses to practice patient-centred and compassionate care [40].

Rising discourse suggests that behavioural skills, such as communication, should be given the same priority in healthcare curriculum as psychomotor skills [41]. However, there has been prominent focus in nursing education on knowledge translation and developing technical skills in contrast to behavioural skills [42]. This may reflect the notion that nursing practice is often embedded in care activities, undertaken when nurses are performing psychomotor skills (e.g., wound dressing). It is unknown whether CS are a focus of educational activities that are aimed to develop procedural skills. Of course, they are integral to each other. Individual engagement has been suggested as “the blockbuster drug of the 21st century” [8], and the AACN purports that nurses are ideally positioned to engage individuals and their families in their care [8]. Westbrook et al. [43] estimated that nurses spend about 37% of their time with patients; professional communication consuming approximately 19% of their shift. Nursing graduates in the US are expected to engage with individuals in establishing a caring relationship and communicate effectively with individuals, both core concepts of person-centred care. The American Nurses Association (ANA) publication, ‘Nursing: Scope and Standards of Practice, Third Edition’, includes professional behavioural competencies expected of nurses such as communication (Standard 9) and collaboration (Standard 10). Nurses are expected to communicate effectively and collaborate with healthcare consumers in their practice. [44]

The authors’ experience is that communication education is often implicit, integrated and/ or theoretical, rather than a standalone curriculum item in preparatory nursing courses. Unlike the medical profession, there is no internationally established core curriculum for communication in nursing education. In 2008, a consensus statement, representing opinion from all 33 medical schools in the UK, recommended core curriculum for clinical communication in undergraduate medical education [45]. The purpose was to assist educators to design medical curricula that prepared students to effectively communicate with patients and their families. The consensus statement was updated in 2018 to include shared decision making and PCC, and reflect relational, contextual and technological developments [46]. Subsequently, Bachmann et al. [9] developed a core communication curriculum for

medicine, midwifery, nursing, pharmacy, psychology, dentistry and physiotherapy professions. To our knowledge this model has not been implemented nor evaluated in nursing curricula.

Despite the lack of consensus guidelines for nursing curricula content in CS, there is evidence of CST in undergraduate programs. In a systematic review, Gutierrez-Puertas et al. [47] explored the impact of educational interventions on the quality of nursing students' CS. Most studies focused on specific challenging conversations (e.g., mental health, end-of-life care) and were undertaken in the USA. Simulation was the most frequently used intervention. Unable to clarify which methodology was more effective, the authors emphasised that new generations of students prefer immersive experiences. In their opinion, CS in everyday conversation with patients are equally important, particularly when nurses perceive they lack time to communicate with patients. In a systematic review, Smith et al. [48] identified 22 studies that examined the effectiveness of simulation to teach nursing students (n=14), nurses (n=6) and nurses and students (n=2) about palliative and end of life communication. Significant variation in the type of interventions and range of outcome measurement tools were found. Interestingly, a systematic review of the methodological quality of teaching CS to undergraduate medical students identified similar concerns: mainly descriptive studies and lack of objective, behavioural outcome measures [49]. This emphasises the need for simplification and standardization of outcome measures in this field. In their literature review of communication education research, Grant and Jenkins [50] identified weaknesses in study design and research methodologies and highlighted excessive costs for hi-fidelity simulation and simulated patients. In their view, limited funding will continue to restrict future research to small convenience samples, further hampering the strength of evidence.

From our understandings as academic teaching staff employed in various universities in Australia, Canada, UK, Denmark and USA, formal CST in keeping with expert recommendations [9] has not routinely been incorporated in undergraduate nursing curricula. Without a consensus statement, professional guideline, or policy about communication

standards, and therefore a shared language amongst nursing professional groups, there is likely to be a variable starting point at graduation that may exacerbate the theory-practice gap. It is our hypothesis that the already crowded nursing curriculum does not have either the staffing or financial resources available to pay simulated patients or accommodate smaller class sizes which enable peer role play as standard practice. Also, a lack of experienced trainers are significant barriers to widespread implementation of experiential CST in foundation nursing programs.

5. Post-graduate education and training in communication skills

Arising from gaps in undergraduate training, nurses may seek communication education in the form of a post graduate qualification or professional development training. Several post-graduate units specifically focused on communication education have been identified. A graduate nursing course in Canada, 'Communication in Serious Illness' [51], focuses on developing understanding of communication and theories to support nursing practice when caring for patients with serious, life-limiting illness. A core unit for a Masters coursework degree at Flinders University (Australia), 'Advanced Thinking, Communicating and Problem Solving for Health Professionals' [52], aims to advance CS in a variety of practice contexts and conflict situations. The End-of-Life Nursing Education Consortium's (ELNEC) Graduate Online Curriculum in the US was designed to address concerns about the quality of communication between healthcare professionals and patients/families [53]. The online curriculum, aimed at nurses providing end of life care, includes a 1-hour module titled "Communication in Palliative Care".

Not all nurses undertake formal postgraduate qualification, estimated to be lower than 12.6% in the UK [54] and 18.2% in the USA [55]. Hence, there is a need to incorporate educational programs for nurses in a large majority of healthcare organisations to address this gap. There is limited high quality evidence regarding the effectiveness of training for the professional development of communication for qualified nurses. Kerr et al. [56] summarised findings from trials that objectively measured the effectiveness of CST interventions in nursing practice. Whilst the seven trials, undertaken in seven different countries, identified

various improvements in nurses' CS, programs varied significantly in structure and outcome measurements. Five of the seven studies were undertaken in oncology settings, limiting the scope of evidence in other care settings. Other systematic reviews that have examined the effects of CST for improving nursing communication have focused on cancer and palliative care. Moore et al. [57] assessed whether CST employed in oncology care improved patient health and satisfaction. Of the 17 identified studies, most were conducted in outpatient settings (n=11): four conducted in inpatient settings and two conducted in community settings. Almost every study used a unique outcome measurement scale. They were unable to find statistically significant benefits in the sub-group analysis of the two studies that only included nurses. One of the identified benefits of CST was the reduction in burn out of HCPs, particularly pertinent in the current COVID-19 pandemic [57]. Smith et al. [48] identified six studies that explored the effect of simulation-based learning to enhance nurse-patient interaction in end-of-life care. This evidence highlights a gap in communication education and training for nurses in acute medical and surgical settings, and other specialist areas (e.g., emergency).

Advanced Practice Nurses require additional education regarding communication to support their expanded responsibilities. Berry [59] found that only 30% of APNs were using a patient-centred communication style. Very little research has explored the quality of APN-patient communication. An APN program in the USA focused content and simulation on breaking bad news, empathetic communication, motivational interviewing, and the "angry" patient [34]. The effectiveness of CST on cancer truth-telling for APNs was tested in a pilot study in Taiwan [60]. Defenbaugh and Chikotas [61] examined the impact of standardised patient experiences on quality of communication for APNs in the USA.

Gaps in communication education in pre-registration and post-graduate nursing programs puts pressure on healthcare organisations to incorporate CST programs to address this gap. Globally, healthcare organisations have competing priorities that limit available funds for professional development. Nurses prioritise their professional development with personal and employment responsibilities. Organisations generally offer

informal training initiatives during double staffing times. This limited time is unlikely to provide adequate time for CST which is best structured as blended education incorporating theoretical preparation alongside experiential learning [1]. Training initiatives for nurses need to be designed for sustainable and accessible implementation.

6. The evidence gaps for communication skills development for nurses

There is absence of a common language for CST in nursing [9]. The CCG [1] has been incorporated in several international professional development initiatives in Australia, Ireland, and Denmark [62, 63]. The original purpose of the CCG was to guide the structure of medical consultations. Interestingly, the CCG is not outlined as a recommended structure to guide nurse-patient conversations in several communication textbooks specifically written for nurses [64-69]. The authors' experience in Australia, USA and Canada suggests that the CCG is not utilised in undergraduate nursing curricula. Conversations that nurses typically have with patients are often unplanned and spontaneous, which is different than most conversations doctors have in an organised and scheduled medical consultation.

Communication training initiatives for nurses must be relevant to the contextual realities of nurses' praxis. Whilst it could be debated that CS needed by nurses is not sufficiently different from medical doctors, there has been a lack of research exploring exactly what CS are needed by nurses, and how it is different, necessary and supportive of an integrated interprofessional approach to care, particularly in the acute hospital settings outside oncology and palliative care. We contend that while CS may be the same or similar, the enactment of those skills are indeed different because they are always dynamically adapted in a role and relational context that is determined by inherent power relations arising from existing historical, sociopolitical, organizational and gendered relational influences [70]. This is an essential issue to inform any ongoing development of CS curricula and model development. Core CS training must be guided by a dynamic adaptive communication model and beyond the merely technical and within a static, controlled environment.

Significant effort is required to convince organisational leadership to invest in CST programs that justifies the expense, including health economic outcomes (e.g., length of

stay) and patient-reported experience and outcome measures (e.g., satisfaction) [71].

Limited evidence regarding the best blend for CST between theoretical and experiential learning [47, 50] and lack of a specific outcome measure to evaluate the effectiveness of CST initiatives [72] confines the building of conclusive evidence needed to convince healthcare organisations of the need for future investment.

In the twenty-first century there is greater expectation that nurses, and APNs, engage in relational praxis to create partnerships with patients and their families to enable shared decision making and PCC [8]. Nurses require complex CS that are informed, culturally safe and adapted to social-psychological complexities such as low literacy levels. Changing clinical paradigms reflect increased challenges to nurses' communication competencies that include responding to aggression, health behaviour change for long term and complex illness including dementia, and rising incidence of mental health illness and issues. Finally, technological advances have led to new ways of communicating in providing care and teaching (e.g., telehealth) [46]. Global crises and emerging contexts, such as COVID-19, pose additional demands that have significant implications for nurses' communication expertise [73]. For example, the requirement to wear personal protective equipment is an obstacle to effective communication, and video consultations may affect the quality of consultation [74].

7. Conclusion

In summary, the importance of CST has long been overlooked for the largest profession in healthcare, nursing. Nurses are ideally positioned to engage with patients and their families; however, they find certain components of communication challenging and often avoid difficult conversations with patients and their families. It is likely that this avoidance has a significant detrimental impact on patients, carers, clinicians and the health system. The limited amount of research is concentrated in oncology, palliative care and end-of-life settings, and the evidence base is weak. This limits the applicability of education research in the clinical setting more broadly, for example, acute care nursing and chronic illness.

There is a need to explicate what has been hidden, but implicit, in nurses' communication. Essential contextually and culturally mediated CS must be made explicit, and their value made clearly evident, within organizational contexts. A reasonable starting point should be the development of a consensus statement for communication curriculum in nursing education. This statement could be developed as an international initiative, led by a sub-committee of tEACH (the teaching subcommittee of EACH), that aims to identify essential and focused CS required by nurses. We propose that the next step should be to develop (1) an approach to identify core curricular components using a Delphi approach and (2) a model in which these components exist and are situated. The model will explicate assumptions, adaptive theoretical underpinnings and reflect a nursing standpoint philosophy. How academic institutions incorporate CST in an already crowded curriculum will require careful consideration. Experienced nurses and educators are also likely to need CST so they are able to adequately supervise undergraduate and postgraduate nursing students, who should be implementing effective CS in practice. This training should extend to all clinicians beyond palliative and oncology nurses.

We need to understand in much more depth what to teach and how to teach nurses about communication. It is likely some key CS can be taught across all health disciplines, but discipline specific skills are in need of urgent consideration. Large scale intervention studies, with validated objective behavioural outcome measures, need to be undertaken to develop a strong evidence base that justifies the healthcare organisational investment for CST.

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