



1

Theories and Models of Communication

Janine Archer and Lesley Jones

University of Salford, UK

Chapter Aim

- To explore the theories and models that underpin communication relevant to the role of a nursing associate

Learning Outcomes

By the end of this chapter, the reader will be able to:

- Identify and define the components of the three models of communication
- Describe contextual factors that affect communication
- Understand the importance of effective communication within the role of a nursing associate

Test Yourself Multiple Choice Questions

1. What are the three key communication models?
 - A) Transgression, interaction and transaction
 - B) Transmission, interaction and transaction
 - C) Transport, interaction and transaction
 - D) Transmission, intervention and transaction
2. Which of the following is/are the result(s) of poor communication?
 - A) Medication error
 - B) Poor patient outcomes
 - C) Low staff morale
 - D) All of the above

The Nursing Associate's Handbook of Clinical Skills, First Edition. Edited by Ian Peate.
© 2021 John Wiley & Sons Ltd. Published 2021 by John Wiley & Sons Ltd.
Companion website: www.wiley.com/nursingassociate

3. Which of the following terms is used to describe a communication barrier?
 - A) Channel
 - B) Code
 - C) Noise
 - D) Receiver
4. Which of the following represents the contexts considered important in the Transactional Model of Communication?
 - A) Psychological, social, cultural and relational
 - B) Physical, psychological, social and cultural
 - C) Physical, psychological, social, cultural and relational
 - D) Physical, social, cultural and relational
5. In Peplau's interpersonal relations theory, which of the following indicates when the nurse and patient begin to work collaboratively to enable the patient to become an active recipient of treatment?
 - A) Orientation phase
 - B) Identification phase
 - C) Exploitation phase
 - D) Resolution phase

Introduction

Nursing associates provide safe and effective holistic patient-centred care that is underpinned by the 6Cs of caring (Department of Health 2012). Communication, one of the 6Cs, is a complex yet critical element in all areas of nursing activity. The nursing process, the assessment, diagnosing, planning, implementation and evaluation of care, is achieved only through careful attention to interpersonal relationships, the environment and the specific skills of verbal and non-verbal communication. Nursing associates are required to communicate with a wide variety of patients across their lifespan, including babies, children and young people, carers and families, and adults and older people. They are expected to provide prevention, treatment, rehabilitation and end-of-life care while working in a broad range of settings, such as at home, close to home and in hospital. They do not work in isolation and so require excellent communication skills to work effectively with not just patients and carers but also health and social care colleagues within a multidisciplinary team. Many of the people nursing associates communicate with will have communication challenges requiring them to make reasonable adjustments and adapt their style of communication.

There is a well-established link between team communication, worker morale and patient safety. Poor team communication has been directly linked to high nurse turnover rates and low morale (Brinkert 2010). Low morale contributes to high levels of stress, burnout, poor job satisfaction and an overall poor quality of life (Khamisa et al. 2015).

Supporting Evidence

The National Institute for Health and Care Excellence (2016) has provided guidance for health and social care professionals to enhance the transition between inpatient mental health settings and community or care home settings
<https://www.nice.org.uk/guidance/ng53/resources/tailored-resources-4429245855/chapter/2-Ensuring-effective-communication-between-teams-and-with-people-using-services-families-and-carers>

Poor communication is often a feature in healthcare related events (Burgener 2017) with communication issues frequently featuring in National Health Service (NHS) complaints and medication related events. Within hospital and community health services, Ombudsman data identifies communication issues as one of the five most common complaint factors in cases which were fully or partially upheld in 2018–19 (Parliamentary and Health Service Ombudsman 2019).

In recent years, a number of serious failings in healthcare provision have made national news, for example, the Francis enquiry. This public enquiry reviewed reports on poor care in the Mid Staffordshire Foundation NHS Trust between 2005 and 2009, which was believed to have contributed to the avoidable death of many patients and highlighted communication failings in sharing information and concerns (Francis 2013).

Poor communication between healthcare professionals, poor communication with patients and limited communication between primary and secondary care have all been identified as factors which influence medication errors (World Health Organization 2016). Keers et al. (2013), in a systematic review of causes of medication administration errors in hospital, also identified inadequate written communication as a factor.

Take Note



Ineffective communication among healthcare professionals is one of the leading causes of error and patient harm, as well as reducing staff morale

Good communication is essential in meeting patients' needs and providing safe, quality patient care. Improvements in communication can lessen healthcare errors and make a positive impact on patient outcomes. For the nursing associate, it is important that they develop underpinning knowledge about communication as well as the skills to deliver effective communication to provide high quality care.

Red Flag

4

Poor communication between nursing associates and those they offer care and support to can occur for a variety of reasons. The provision of health and social care can be very unpredictable, complicated and stressful. The needs of patients can arise unexpectedly, and their condition can change very rapidly; when there is a communication breakdown, this can lead to negative care outcomes.

This chapter will focus on the underpinning knowledge of communication and will be followed by a series of chapters that will examine the specific communication skills required by the nursing associate. The Nursing and Midwifery Council (NMC) (2018) standards of proficiency for nursing associates require, at the point of registration, the nursing associate to communicate effectively using a range of skills and strategies with colleagues and people at all stages of life and with a range of mental, physical, cognitive and behavioural health challenges; this is closely related to platform 1, that is, being an accountable professional.

The World Health Organisation (WHO) defines communication as ‘the transfer of information, ideas or feelings’ (World Health Organization 2009, p.16). More recently, communication has been described as ‘the exchange of information between people by sending and receiving it through speaking, writing or by using any other medium’ (Sibiya 2018, p. 20). Effective communication means that information is conveyed clearly between people. To be an excellent nursing associate requires communication skills to engage effectively with patients using two-way communication. Failure to recognise this two-way communication could lead to negative conclusions, negative attitudes and dissatisfaction. The nursing associate must, therefore, continuously try to improve their communication skills to ensure high quality patient-centred care.

Models of communication help us to consider the processes involved when communicating in several arenas with a variety of people. They provide a visual representation of the different aspects of a communication encounter, simplifying the numerous steps the nursing associate needs to consider. Having this underpinning knowledge can help the nursing associate think about their current communication encounters, plan for future communication encounters and reflect and learn from the previous ones. The three main models that will be discussed in this chapter are the transmission/linear, interaction and transaction models of communication.

Transmission Model of Communication

In 1949, Shannon and Weaver first described the transmission, or linear, model of communication which consists of a sender creating a message which they send to the receiver without any feedback (see Figure 1.1.). This model describes communication as one way, from sender to receiver, which suggested that the sender and receiver had little to do with the interpretation of the message. The model does recognise physical noise as a communication barrier.

The main issue with one-way communication is that it does not include feedback which enables the sender and receiver to ensure that the meaning within the message has been understood. Relying on one-way communication can have an impact on patient outcomes. An example of this might be where a nursing associate advises the patient how to apply a cream but does not check whether the patient has understood the information. This could lead to the cream being applied incorrectly and delaying or even worsening the patient’s condition. Communicating in this way has been described as something you do ‘to’ someone.

Communication models have evolved since the linear model was first described over 70 years ago, but the model was useful in that it established some terms which have subsequently been adopted and developed further (see Table 1.1).

The nursing associate will already have thought about the different aspects of communication. They may have realised that they communicate with colleagues differently when they are tired (sender) and that they adapt their tone of voice when talking to a young child (receiver). They may have considered the message being conveyed by avoiding medical terminology when telling patients about their treatment. They may have considered providing written and verbal instructions to convey the information (code). They will have considered the channel of communicating, for example, if a patient cannot hear, they may have written down the message or have taken the patient into a side room away from the noise of the ward environment.

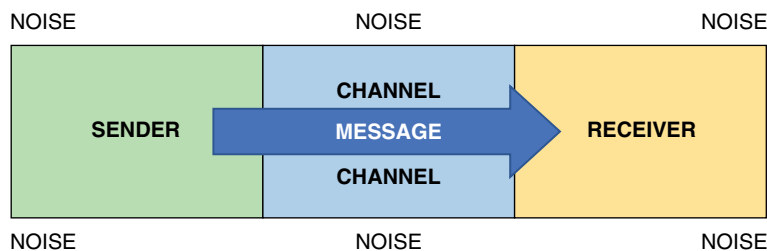


Figure 1.1 Transmission model of communication. Source: Adapted from Shannon & Weaver (1949).

Table 1.1 Common communication terms.

TERM	MEANING
Sender/receiver	The sender is the source of the communication. Anyone who is audience to the message is referred to as the receiver.
Message	The information being conveyed.
Code	Sometimes referred to as <i>encoding</i> and <i>decoding</i> . Encoding can be defined as transforming an abstract idea into a communicable message, using words, symbols, pictures, symbols and sounds. Decoding is when the receiver interprets the message and comes to an understanding about what the source is communicating.
Channel	The way the code is conveyed, for example, it may be easier to present complex information in a graph rather than written word alone.
Noise	Communication barrier.

Source: Adapted from Kiernan (2015).

The Interactive Model of Communication

The interactive or interaction model of communication relies on an exchange of communication from the sender to the receiver and back again creating two-way communication within physical and psychological contexts (Schramm 1997). The main difference between one- and two-way communication is that two-way communication provides feedback which enables the sender and receiver to ensure that the meaning within the information has been understood. It, therefore, closes the communication loop and is one way of minimising misunderstandings in the receiver's interpretation of the original meaning of the message.

This model is more interaction focused and concerned with the communication process itself. This model acknowledges that with so many messages being sent at one time, many of them may not even be received and some messages may be sent unintentionally.

The interactive model also takes into consideration the communicator's fields of experience and physical barriers. It also introduces semantic and psychological barriers. Physical barriers are vitally important as nursing associates must be able to care for people in a broad range of settings, including at home, close to home and in hospital, within a context of challenging environments. Nursing associates work with patients and their carers and families during times of heightened stress, anxiety and fear, and these emotions can affect our communication. Feedback and context help make this model of communication more useful than the transmission model for exploring individual communication encounters. The interactive model is depicted in Figure 1.2.

Orange Flag



Psychological barriers include the mental and emotional factors in a communication encounter

One of the main issues with the interactive model of communication is that it suggests communication is predictable and orderly, that is, A asks B a question and B responds. The reality of communication, especially in healthcare, is that it is much more disorganised with interruptions and people talking at the same time.

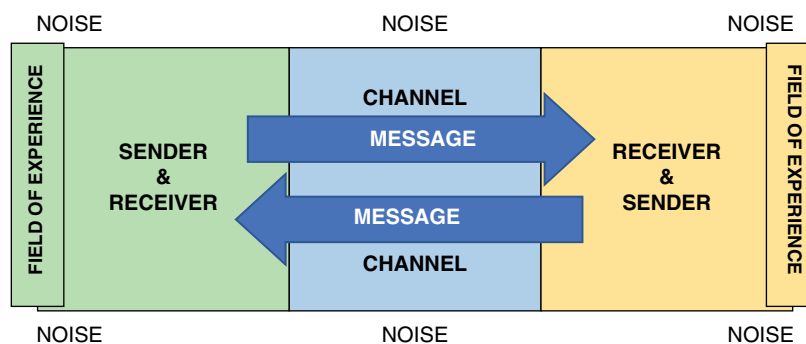


Figure 1.2 Interaction model of communication. Source: Adapted from Schramm (1997).

The Transactional Model of Communication

As the study of communication progressed, models expanded to account for more of the complex elements of the communication process. The transactional model of communication places emphasis on the concurrent and continuous nature of communication. In this model, all those involved in the communication experience are simultaneously the sender and receiver, continuously sending and receiving information and feedback from each other using verbal and non-verbal communication (Barnlund 1970).

The transactional model describes communication as a process in which communicators (can be more than two people) generate social realities within social, relational and cultural contexts. The purpose of communication is not simply to exchange messages but to also create relationships, develop intercultural relations, shape self-concepts and engage with others to create communities.

Blue Flag



The therapeutic relationship is an essential prerequisite to effective communication between health professionals and patients in order to not only transmit information but also effectively address mental processes that become activated by it. The communication between the nursing associate and the patient includes the ability to express genuine concern for the care of the patient, with the patient becoming a participant.

The transactional model also considers the context in which the communication occurs, which shapes the way you communicate; consideration is given not only to the content of the message (the what) but also to the relational dynamics (the how it is said). Like the interactional model of communication, the transactional model acknowledges the participants' field of experience but includes a more complex understanding of communication across physical, psychological, social, cultural and relational contexts. Figure 1.3 outlines the transactional model.

The transactional model agrees that physical and psychological contexts are important but in isolation are too simplistic. The transactional model argues that communication is more complex, as it shapes a person's reality before and after specific interactions occur, and, therefore, emphasis is placed on the importance of contextual influences outside of the single interaction, namely social, cultural and relational contexts.

Social context focuses on the stated rules and unstated norms that guide communication. There are many examples we can draw on from healthcare here. For example, a trainee nursing associate observes that the ward round is monopolised by the consultant and the nurse in charge and the trainee nursing associate may only realise they break this norm from the reaction of others, for example, being told not to talk again during ward round. These types of norms are traditional and have no place in the future of healthcare; the role of the nursing associate is to be resilient and advocate for best patient care.

Green Flag



The Nursing and Midwifery Council (NMC) (2018) Standards of proficiency for nursing associates

The NMC standards of proficiency require the nursing associate to understand the importance of courage and transparency and apply the duty of candour, recognising and reporting any situations, behaviours or errors that could result in poor care outcomes (Platform 1: Being an accountable professional; 1.3)

Relational context includes the historical and current relationship you have with an individual. The nursing associate will communicate differently with colleagues compared with family and friends and similarly with people they have just met versus someone they have known for

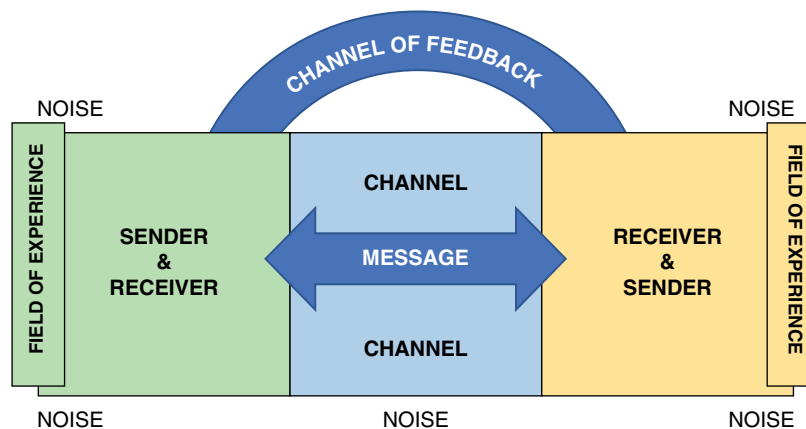


Figure 1.3 Transactional model of communication. Source: Adapted from Barnlund (1970).

some time. Early interactions are more likely to be governed by the social context of rules and norms but these may be less apparent as relationships develop. Consider the nursing associate's differing response when a patient says 'Get me a drink' compared to if a partner were to say it.

Cultural context includes, for example, ethnicity, gender, nationality, sexual orientation, class, ability and ethnicity, and we all have multiple aspects of cultural identity which influence our communication. The nursing associate needs to be aware of unconscious bias, as it harms patients and staff (Kapur 2015). Unconscious (or implicit) bias occurs when the way information is processed is influenced by stereotypes, and, therefore, those stereotypes impact actions and judgements. A stereotype is a belief that associates a group of people with certain traits or characteristics and is a prejudgement of a person based on the group they are associated with. Unconscious bias is a natural method of cognitive processing, so we all possess it. In healthcare, unconscious bias can lead to false assumptions and negative patient outcomes, especially in minority groups. An example might be that the nursing associate inadvertently spends less time with the patient with mental health issues because of the stereotype they hold that all people with mental health issues are violent. It is important for the nursing associate to be aware of unconscious bias and, while it will always exist, develop strategies to overcome it.

Yellow Flag



Health Education England have developed a Cultural Competence e-learning package to support health professionals in developing cultural competence <https://www.e-lfh.org.uk/programmes/cultural-competence/>

The three models of communication (transmission, interactive and transactional) while relevant to the role of the nursing associate, as they apply to all forms of human interaction, were developed to describe communication in general. The nurse-patient relationship is, by its very nature, embedded in interpersonal communication. There are a number of communication theories that have been developed in nursing to help explain and guide interactions between nurses and patients (Bylund et al. 2012). One such theory is Peplau's interpersonal relations theory (1997) which focuses on the nurse-patient relationship and the therapeutic process that takes place. Although the focus is on the nurse-patient relationship, it is similar to the transactional model in that communication that occurs in this context involves complex factors such as environment, attitudes and beliefs and culture. Peplau's interpersonal relations theory defines four stages of the relationship that achieve a common goal:

- Orientation phase: This is the initial stage of the relationship where the nursing associate demonstrates patient-centred care that enables the patient to ask questions and develop trust in the nursing associate. First impressions of the nursing associate and the healthcare provision begin to evolve. This phase sets the stage for a more trusting relationship and is where the nursing associate would introduce themselves (Granger 2014), collect information about the patient's needs, potential, interests and the patient's susceptibility to experience fear or anxiety (Fawcett 2010).
- Identification phase: This is when the nursing associate and patient begin to work collaboratively to enable the patient to become an active recipient of treatment. The nursing associate uses knowledge, skills, attitudes and values while consistently providing compassionate, non-judgemental care and empathy. This is an important stage during which the power shifts from the nursing associate to the patient as the patient becomes more independent. The nursing associate uses their communication skills as an educator and a leader to enable better patient outcomes.
- Exploitation phase: The patient maximises wider opportunities, exploiting the nurse-patient relationship to address treatment goals. The patient feels like an integral part of the relationship and may make requests to the nursing associate to gain a greater understanding of their own health and social care needs.
- Resolution phase: As a product of effective communication, patient issues are resolved, and they become independent. The patient no longer relies on the nursing associate's support, and the relationship ends. The skills here are for the nursing associate to enhance the patient's ability to become more self-reliant in leading a productive and healthier life (Fawcett 2010).

Conclusion

Excellent communication skills are critical in the development of effective relationships with patients, their carers and families and when working with other health and social care professionals. While it is important for nursing associates to develop the underpinning knowledge that governs communication experiences, it is equally necessary for them to develop the skills and behaviours that are prerequisite to effective communication. Chapter 2 highlights key approaches and identifies common barriers to effective communication.

References

- Barnlund, D.C. (1970) A transactional model of communication, in Sereno, K.K. & Mortenson, C.D. (eds.) *Foundations of communication theory*, New York, NY: Harper and Row, 83–92.
- Brinkert, R. (2010) A literature review of conflict communication causes, costs, benefits and interventions in nursing, *Journal of Nursing Management*, 18(2): 145–156. doi: 10.1111/j.1365-2834.2010.01061.x.

- Burgener, M. (2017) Enhancing communication to improve patient safety and to increase patient satisfaction, *Health Care Management*, 36(3): 238–243. doi: 10.1097/HCM.000000000000165.
- Bylund, C.L., Peterson, E.B. & Cameron, K.A. (2012) A practitioner's guide to interpersonal communication theory: an overview and exploration of selected theories, *Patient Education and Counseling*, 87(3): 261–267. doi: 10.1016/j.pec.2011.10.006.
- Department of Health. (2012) *Compassion in practice*. [online] Available: <https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf>. Accessed 6 September 2020.
- Fawcett, J. (2010) *Contemporary nursing knowledge: Analysis and evaluation of nursing models and theories* (2nd ed), Philadelphia: F.A. Davies.
- Francis, R. (2013) *Report of the Mid Staffordshire NHS foundation trust public inquiry*, London: The Stationery Office.
- Granger, K. (2014) *Hello my name is*. [online] Available: <http://hellomynameis.org.uk/home>. Accessed 6 September 2020.
- Kapur, N. (2015) Unconscious bias harms patients and staff, *British Medical Journal*, 351: h6347. doi: 10.1136/bmj.h6347.
- Keers, R.N., Williams, S.D., Cooke, J. & Ashcroft, D.M. (2013) Causes of medication administration errors in hospitals: a systematic review of quantitative and qualitative evidence, *Drug Safety*, 36(110): 1045–1067. doi: 10.1007/s40264-013-0090-2.
- Khamisa, N., Oldenburg, B., Peltzer, K. & Ilic, D. (2015) Work related stress, burnout, job satisfaction and general health of nurses, *International Journal of Environmental Research and Public Health*, 12(1): 652–666. doi: 10.3390/ijerph120100652.
- Kiernan, E. (2015) Communication theory and its application in nursing and healthcare, in Lawrence, J., Perrin, C. & Keirnan, E. (eds.) *Building professional nursing communication*, Melbourne: Cambridge University Press.
- NMC. (2018) *Standards of proficiency for nursing associates*, London: NMC.
- Parliamentary and Health Service Ombudsman. (2019) *Complaints about the NHS in England 2018/19*, Parliamentary and Health Service Ombudsman. [online] Available: <https://www.ombudsman.org.uk/publications/complaints-about-nhs-england-quarter-4-2018-19>. Accessed 6 September 2020.
- Peplau, H.E. (1997) Peplau's theory of interpersonal relations, *Nursing Science Quarterly*, 10(4): 162–167. doi.org/10.1177/089431849701000407.
- Schramm, W. (1997) *The beginnings of communication study in America*, Thousand Oaks, CA: Sage.
- Shannon, C. and Weaver, W. (1949) *The mathematical theory of communication*, Urbana, IL: University of Illinois Press.
- Sibiya, M.N. (2018) *Effective communication in nursing*, London: Intechopen.
- World Health Organization. (2009) *Human factors in patient safety: review of topics and tools*, Geneva: World health Organization.
- World Health Organization. (2016) *Medication errors: technical series on safer primary care*, Geneva: World Health Organization.