

ORIGINAL RESEARCH

What counts as effective communication in nursing? Evidence from nurse educators' and clinicians' feedback on nurse interactions with simulated patients

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Abstract

Aim. To examine the feedback given by nurse educators and clinicians on the quality of communication skills of nurses in interactions with simulated patients.

Background. The quality of communication in interactions between nurses and patients has a major influence on patient outcomes. To support the development of effective nursing communication in clinical practice, a good understanding of what constitutes effective communication is helpful.

Design. An exploratory design was used involving individual interviews, focus groups and written notes from participants and field notes from researchers to investigate perspectives on nurse–patient communication.

Methods. Focus groups and individual interviews were held between August 2010–September 2011 with a purposive sample of 15 nurse educators and clinicians who observed videos of interactions between nurses and simulated patients. These participants were asked to give oral feedback on the quality and content of these interactions. Verbatim transcriptions were undertaken of all data collected. All written notes and field notes were also transcribed. Thematic analysis of the data was undertaken.

Findings. Four major themes related to nurse–patient communication were derived from the educators' and clinicians' feedback: approach to patients and patient care, manner towards patients, techniques used for interacting with patients and generic aspects of communication.

Conclusion. This study has added to previous research by contributing grounded evidence from a group of nurse educators and clinicians on the aspects of communication that are relevant for effective nurse–patient interactions in clinical practice.

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Keywords: communication, education, educator, feedback, nurse–patient communication, nurse–patient interaction, nursing, supervisor

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Why is this research or review needed?

- The quality of communication in interactions between healthcare providers and patients has an important influence on outcomes for patients.
- Investigations of the patient perspective relating to communication in healthcare settings have tended to focus on interactions between doctors and patients.
- As participants in an interaction with patients, nurses involved in the interaction may not be able to report accurately on their own performance due to a lack of self-awareness.

What are the three key findings?

- The perspectives of nurse educators and clinicians were obtained as reflected in their feedback to nurses on observed clinical interactions.
- Four major themes were considered to be important by nurse educators and clinicians in what constitutes effective nurse–patient interactions in clinical practice: approach, manner, techniques in interaction and communication.
- Approach, which was concerned with involving patients and ensuring sensitivity to patient needs, functions as an overarching theme for the other themes of manner, techniques in interaction and communication.

How should the findings be used to influence policy/practice/research/education?

- The research provides comprehensive and rich data that should be used in training intervention tools for improving nurse–patient communication.
- The data should be used to orient students to what experienced peers value and improve awareness of the impact of particular approaches and techniques for effective communication with patients.

Introduction

The quality of communication in interactions between healthcare providers and patients has an important influence on patient outcomes. This influence can be pivotal in

such areas as patient health, education, adherence and satisfaction with care (Silverman *et al.* 2005). As nurses have a key role in meeting the communication needs of patients, effective nursing communication skills are a critical element of patient care (Candlin & Candlin 2003). To support the development of effective communication skills among nurses, a well-developed understanding of effective nurse–patient communication is required. This article examines what counts as effective communication from the perspectives of nurse educators and clinicians.

Background

Past research on what comprises effective communication has drawn on the perspectives of patients and nurses, as well as examining the convergence of these perspectives. Another methodological approach employed to determine effective communication has involved the use of clinical communication tools.

In past work, investigations of the patient perspective have tended to focus on interactions between doctors and patients. Jagosh *et al.* (2011) found that patients believed doctors' listening skills to be an important aspect of communication in clinical settings. In one of the few studies of patient perspectives on nurse–patient communication, McCabe (2004) found that patients' perceptions of good nurse communication correspond to experiences of patient-centred interactions with nurses.

Work has also been undertaken examining the nurse's perspective in determining what constitutes effective communication. Sheldon *et al.* (2006) investigated nurses' views on 'difficult' communication with patients and identified nurses' and patients' 'negative emotions' (p. 145) as a detrimental factor for communicative success, whereas Chan *et al.* (2011) found that, depending on their perceptions of the purpose of the communication, nurses tended to view availability of time as a key determinant of quality communication. Thus, communication perceived as primarily rapport- or relationship-building was viewed as time consuming, which was not the case for communication seen as task-oriented.

Previous communication studies have also explored the extent to which the patient and provider agree on what has been communicated as a measure of the success of an interaction. Sarkar *et al.* (2011) reported low levels of agreement between physicians and patients on information exchanged during outpatient visits at a cardiac clinic. Park and Song (2005) also found that nurses and patients did not agree on the barriers to successful communication.

Patient perspectives are a necessary component of measures of communicative effectiveness, particularly with respect to interpersonal aspects of interaction (Schirmer *et al.* 2005). Despite the importance of the patient perspective, patients can be influenced by the extent to which their treatment outcomes meet their expectations (Schirmer *et al.* 2005). Patients may be worried about their treatment outcomes and their experience of having a medical or surgical condition requiring hospitalization can mean that patients are not fully attuned to how health professionals communicate with them. The nurse perspective on effective communication has not been observed to be subject to the same kinds of limitations as the patient perspective (including the influence of patients' particular health circumstances). However, as nurse and patient perspectives on communicative effectiveness may not coincide, a difficulty in relying on either or both of these perspectives is how to reconcile any differences between them. Furthermore, as participants in an interaction, nurses may not be able to report accurately on their own performance due to a lack of self-awareness, for example (Schirmer *et al.* 2005), which suggests that an external perspective may be helpful.

Other studies have used validated instruments to evaluate the communication skills of nurses in interactions with patients. Examples include use of the Roter Interaction Analysis System (RIAS) (Roter 1991, Roter & Larson 2002) in Kruijver *et al.* (2001) and the SEGUE (Set the stage, Elicit information, Give information, Understand the patient's perspective and End the encounter) framework (Makoul 2001) in Carvalho *et al.* (2011). Using the SEGUE

framework enabled Carvalho *et al.* (2011) to find demonstrable evidence for the efficacy of communication skills training, while Kruijver *et al.* (2001) contributes to our understanding of the characteristics of provider-patient communication by showing, through the use of a standardized observational scheme, that more than half of all nurse communication with simulated people with cancer was concerned with purely practical, or instrumental, aspects of patient care. The problem with solely resorting to tools to determine what constitutes effective communication is that the complexity of the actual communication encounter and the competing practices that may impact on communication are not taken into consideration.

In summary, it is important to incorporate different perspectives in evaluating communication between nurses and patients (Carvalho *et al.* 2011). Nurse educators and clinicians external to the communication encounter may give valuable feedback without being distracted by what happens in the clinical setting, as compared with nurses interacting with patients or the patients themselves. Knowledge gained from nurses external to the communication encounter can extend the evidence base for what counts as 'effective' communication in nurse-patient communication.

The study

Aim

The aim was to identify aspects of communication that nurse educators and clinicians consider to be relevant for effective nurse-patient interactions in clinical practice.

Design

An exploratory design was used to identify the aspects of communication valued by nurse educators and clinicians according to elicited feedback commentary on observed nurse-patient interactions.

Table 1 Participant characteristics ($N = 15$).

	Number of participants	Duration of focus group/interview	Gender	Appointment/affiliation
Focus Group 1	5	70 minutes	Female: 5	Hospitals 1, 2, 3 University 1
Individual Interview	1	40 minutes	Female: 1	University 1
Focus Group 2	2	60 minutes	Female: 2	Universities 2, 3
Focus Group 3	7	60 minutes	Female: 6 Male: 1	Hospital 3 University 1

Participants

A sample of nurse educators and clinicians was recruited using a purposive sampling approach. Nurse educators and clinicians were invited to participate based on their knowledge of and experience in clinical communication practices. They were eligible to participate if they had a current educative or clinical role in nursing in a hospital or university, if they believed that they had an understanding of key issues in communication with patients and if they had an interest in improving the quality of nurse communication. Participants were recruited via an email containing an introduction to the study and an invitation to take part in a focus group or, if they were not available for a focus group, an individual interview. Emails were initially sent to nurse educators and clinicians known to the researchers and were then further distributed to individuals in the relevant expert population using a chain referral strategy (Patton 1990). Fifteen nurse educators and clinicians participated in focus groups and an individual interview, at which point data saturation had been reached.

Data collection

Data were collected in three separate focus groups and an individual interview held at an Australian university between August 2010–September 2011. The average duration of the focus groups or individual interview was 1-hour (Table 1). Data collection was scheduled according to participants' availability. Two researchers were present during data collection: one to facilitate proceedings and another to take field notes. As a stimulus for comments and discussion, participants were shown videos of nurses interacting with simulated patients and were then asked to comment on the

quality of the nurse performances in these interactions. This mode of stimulus involving simulated patients has ample precedent in healthcare communication research (see Roter *et al.* 2008, Langewitz *et al.* 2010). Simulated patients were also used for the study because in the context, where the study was carried out, approval to observe real patients (on video or live) is subject to stringent ethical restrictions and not readily obtained. Moreover, the use of videos, rather than live interactions, was an efficient way of ensuring that participant feedback commentary was generated from a common stimulus. Participants were asked to comment as if providing routine formative feedback to a nurse. Specifically, participants were asked the question: What would you focus on in giving feedback to this nurse? Participants were initially asked to document their responses before being invited to present their feedback orally. Their oral feedback was audio-recorded for transcription and analysis. Written feedback by participants and field notes of the researcher were also transcribed for analysis.

Procedures

A standard procedure was followed up for each of the focus groups and individual interview. After the researchers introduced the study, participants viewed two video stimuli (Videos A and B) and made written notes on 'effective' and 'less effective' aspects of the nurse performances on note-taking sheets provided. The videos were shown once. The facilitator elicited feedback on Video A from each participant in turn, ensuring that each participant was given enough time for their contribution. The facilitator then elicited feedback on Video B in the same way, but reversing the speaking order for participants. This individual feedback was followed by facilitated general discussion on the

Table 2 Video stimuli for focus groups and individual interview.

	Video A	Video B
Setting	General ward	Emergency department
Nurse	Nurse (female)	Nurse (female)
Patient	Patient (female): asthma; persistent coughing	Patient (male): presented with self-inflicted wounds to wrists, which have been sutured by doctor; awaiting discharge
Salient elements of scenario	Patient lying down Nurse standing next to bed Nurse performs patient assessment Nurse raises bed to bring patient to sitting position Discharge plan discussed	Nurse does not inform patient that doctor has ordered a referral for psychiatric assessment Availability of psychiatric assessment team delays patient discharge by over 1 hour Nurse gives no explanation of delay Patient grows increasingly anxious waiting to be discharged and confronts nurse
Duration of video	5.5 minutes	3.5 minutes

nurse performances. Field notes were taken by the second researcher throughout each focus group and interview to support the data provided by the audio-recordings and to note any aspects of the feedback needing clarification at a suitable break in the discussion or subsequently. Participants' written notes were collected at the end of each focus group and individual interview.

Materials

The video recordings used in the study were produced for the purposes of communication skills training for student nurses and beginning level practitioners entering areas of clinical specialization (Table 2). They were loosely scripted based on authentic interactions and had been previously vetted by practitioners who deemed the interactions to closely resemble authentic nurse-patient interactions. Video A showed a patient interaction scenario in a general ward and featured a nurse carrying out an assessment of a simulated patient experiencing asthma symptoms (duration: 5.5 minutes). Video B, set in an emergency department, dealt with patient aggression and featured a nurse with a simulated patient who was required to wait in the department before he could be discharged (duration: 3.5 minutes).

Ethical considerations

Ethics approval was obtained from the relevant University ethics committee. Written informed consent was obtained from all participants. Participants were assured that privacy and confidentiality of collected information would be maintained at all times.

Data analysis

Data from focus groups and the individual interview were audio-recorded. Information obtained from focus groups, the individual interview, written notes and field notes was transcribed verbatim for analysis. A thematic analysis (Forman & Damschroder 2008) of the transcripts was undertaken to identify themes in the participants' feedback that related to the quality of nurse performances in interactions with patients. Taking a grounded theory approach (Strauss & Corbin 1990), the process of identifying themes was data driven. Initially, three coders (members of the research team) worked independently to identify emergent themes in the data. The coders then met to compare first round findings and to prepare a tentative protocol for identifying and labelling themes, or coding the data. This process was followed by a cycle of coding meetings, re-examinations of the data, successive refinements of the coding protocol and

presentations of the coding scheme to the whole research team. Once the coding scheme was confirmed, one of the coders completed the final coding of the data.

Rigour

Rigour of study was addressed by employing several mechanisms to ensure credibility and dependability (Lincoln & Guba 1985). Instrumental in establishing credibility were the multidisciplinary nature of the research team and the provision for peer scrutiny of the study. This multidisciplinary nature allowed for a triangulated perspective on the professional culture of the participants. A reference group was established, which provided periodic external scrutiny of the study. Members of the reference group, all experts in clinical education and practice, were also consulted specifically for feedback on the study results. As a further credibility check, the reference group was invited to gauge how well the results of the thematic analysis reflected professional values in relation to effective communication with patients.

To help maximize the accuracy of the data, member checking was used at the end of each focus group or interview when participants were asked to explain any comments that were unclear to the researchers and which had not been elucidated during the discussion. Such comments entailed the use of technical language, or vagueness or ambiguity in expression. The researcher field notes were helpful in identifying comments needing clarification. Where required, the researchers also sought confirmation or explanation from participants by email shortly after the focus group or interview.

Rigour of the study was also established by examining inter-coder reliability among the three coders. The level of agreement was generally high. Some inter-coder disagreements were settled through discussion and re-examination of the data. In other cases, disagreements were resolved through collaborative refinement of the coding protocol to remove inconsistent or imprecise instructions.

Findings

Demographics

The 15 study participants were drawn from three hospitals (Hospital 1, 2 or 3) and three universities (University 1, 2 or 3). Fourteen participants were female. Participant experience in the nursing profession ranged from 10 years to more than 30 years in a diverse range of specializations and settings including midwifery, acute care, general, sur-

gical, mental health and paediatric nursing. All participants had either a current or previous role in nurse education, whether in a clinical environment as a supervisor of nurses or as an academic in a hospital-affiliated university; some had joint clinical appointments at a hospital and university.

Themes of the study

Participants had shared concepts in their feedback on the nurses' performances in the stimulus videos. Overall, this feedback concerned the quality of the nurse's clinical knowledge and the quality of nurse-patient communication. Feedback on communication skills and feedback on clinical expertise was noted to co-occur in the data and indeed, the interdependence of these two dimensions of performance was noted explicitly by participants. Feedback on the nurse's clinical knowledge related to the display of procedural knowledge, understanding of clinical issues and soundness of clinical reasoning. Participants referred to clinical knowledge using terms such as 'aptitude' and 'judgment':

But just like I said, that sort of lack of clinical um, aptitude really which she just didn't seem to be able to make those contextual judgments.

(Focus Group 2: lines 20–23)

Participants also evaluated quality of clinical knowledge in giving feedback on particular behaviours (or absence of behaviours) that were seen as instantiating the nurse's

expertise. Such behaviours related to patient monitoring, physical assessment of patients, therapeutic interventions and patient referral to other services. For Video A (Table 2), where the patient is coughing persistently, feedback was given on the therapeutic intervention by the nurse, i.e. the steps taken to make the patient more comfortable before taking patient observations:

Well she knew what she was there for. She um, was there to do the obs and she did the right thing, ah the patient was lying down, the patient was coughing so she sat the patient up.

(Individual Interview: lines 73–75)

With respect to communication, four major themes were identified in the data related to what was perceived to be relevant to effective nurse-patient interactions in a clinical setting: approach, manner, techniques in interaction and communication as a generic concept.

Approach

Feedback in this theme addressed the nurse's overall approach to the patient and patient care and was frequently conceptualized in the educators' and clinicians' feedback in terms of the degree of patient-centredness in the nurse's approach. The theme includes feedback on the extent of patient involvement in the nurse's approach to practice. It also comprises feedback on the nurse's awareness of and sensitivity to the patient's needs and concerns as far as these were apparent to the study participants. Factors related to these needs and concerns included the patient's emotional state, needs and readiness for receiving informa-

Table 3 Feedback on the theme of approach.

Extract	Source
1 <i>You have to pick up on the cue. You know, [the patient] commented at least once or twice about going home. So...You had a great big open door there for an important conversation.</i>	Focus Group 3: lines 346–350
2 <i>There are different triggers for aggression and um a well-trained nurse would assess those triggers. She couldn't.</i>	Individual Interview: lines 133–135
3 <i>I think she picked up on the patient's prior experiences and obviously this patient's probably been in with asthma before and so used words like 'sputum' that other patients may not understand.</i>	Focus Group 1: lines 199–202
4 <i>I think we teach nurses sometimes to explain all these procedures. Ah, most of the time [patients] don't actually want to know that. So it's about just being silent, working out when they need this information.</i>	Focus Group 1: lines 407–409
5 <i>At no time was the patient given the opportunity [for] involvement in the clinical decision-making. He really was just a bystander that they happened to be treating.</i>	Focus Group 3: lines 73–75
6 <i>I just felt that she had a little bit of a tick a check box approach sort of thing, 'Okay I've got three new things to do, I've done this and done that', which doesn't lead to any really inducive conversation about if [the patient] did really have some needs at home.</i>	Focus Group 1: lines 294–297
7 <i>I said 'routine', very routinised which is the nature of nursing practice and that can give a patient a sense of security cause you know you're safe, the routine's going on. But for some people they might feel their individuality is being compromised as they're treated more like a patient.</i>	Individual Interview: lines 19–23

tion from the nurse and discharge planning. In relation to patient discharge, the nurse in Video B (Table 2) was given negative feedback on what was perceived as her failure to respond to patient cues of feelings of anxiety about the delay in his discharge, as shown in extract 1, Table 3. Similarly, negative feedback was given on the nurse's inability to notice or understand cues for patient aggression (extract 2, Table 3).

The nurse's ability to provide information and explanations tailored to individual patients' needs was also perceived to be an indicator of sensitivity to patients' needs. This feedback concerned the quantity, the level of detail and the manner information and explanation was given to patients. In response to Video A, feedback was given on the nurse's choice of technical rather than lay terms in giving an explanation to the patient with asthma. As it is evident in the video that this patient has had previous hospital treatment for asthma, the use of specialist terminology was viewed positively as a marker of the nurse's ability to give an appropriately tailored explanation (extract 3, Table 3).

It was noted by participants that the nurse in Video A provides an ongoing procedural description as she takes patient observations, prompting feedback to be given on the tendency of nurses to over-explain in some situations. This was viewed conversely as a marker of a lack of sensitivity to patients. The importance of being able to gauge patient readiness for information was noted (extract 4, Table 3).

The theme of 'approach' included feedback on the extent to which the nurse included the patient in discussion and decision-making around his/her care. In Video B, featuring the patient who has presented with self-inflicted wounds, the nurse discusses the patient's chart and treatment plan with a doctor. The conversation takes place in front of the

patient without any acknowledgement of the patient's presence. The doctor then leaves and the nurse does not communicate to the patient what was discussed. Participants gave negative feedback on these behaviours that excluded or failed to involve the patient (extract 5, Table 3).

In contrast with patient-centredness, a 'routine', or 'task-oriented' approach to nursing practice was also identified in the feedback. A task-oriented approach was typically viewed negatively and positioned as conflicting with a patient-centred approach; in other words, a focus on 'tasks' was perceived to be at the expense of a focus on patients and their needs. This focus on tasks tended to be regarded as a means of disregarding the individualized needs of patients, for example, what they may require following their discharge home (extract 6, Table 3). On the other hand, one participant noted that the 'routine' associated with a task-oriented approach could have a positive impact on patients where this reflected patient expectations of nursing care. Ultimately, a qualified view was given by this participant with her observation that an approach based around the routines of practice could diminish the patient's sense of individuality (extract 7, Table 3).

Manner

Feedback in this theme concerned aspects of nurse behaviour that the educators and clinicians viewed as indicators of the level and quality of the nurse's engagement with the patient. Thus, in giving feedback on various nurse behaviours, terms such as 'engaged', 'distant', 'withdrawn', 'friendly' and 'respectful' were used. In Video B, the patient is trying to get the nurse's attention, but the nurse walks past without acknowledging him. This behaviour, construed as 'ignoring' the patient, was implicated in

Table 4 Feedback on the theme of manner.

Extract	Source
1 <i>She made a very flippant comment but she's talking as she's walking. So again, it's like, 'I'm so busy I can't stop but here's a little flick of information'. So in a way, again, it was disrespectful.</i>	Focus Group 3: lines 390–392
2 <i>Everyone is busy. It's to be un-busy and to look at that patient and go, 'What is it that that patient really needs?' and make them feel like at that moment they are the most important person when you're talking to them.</i>	Focus Group 3: lines 353–355
3 <i>'Do you know what's going on?' 'Do you have any questions for me?' There's a sort of tone in that that doesn't allow a lot of space for people to raise questions.</i>	Focus Group 1: lines 284–287
4 <i>Certainly toning down the tone of the voice. Um the thing is with people generally in an accident and emergency department, they're hyper anxious anyway regardless of why they're there...so a conversational tone, a less authoritarian approach...is much much better.</i>	Focus Group 2: lines 293–297
5 <i>As an experienced nurse there are a lot of things you pick up from that in terms of the body temperature.</i>	Focus Group 2: lines 104–105

participants' feedback on the nurse's manner (extract 1, Table 4).

The concepts of 'empathy' and 'rapport' also featured in feedback in this theme. In response to Video B, where the patient experiences feelings of agitation and aggression, participants commented on the absence of nurse behaviours deemed to be empathetic or rapport-building, such as spending time with patients despite a busy schedule and establishing a quiet space where to sit with a distressed patient. Characterized by an absence of such behaviours, the nurse's manner towards the patient was described as 'un-empathetic', failing to cultivate or demonstrate 'rapport' with the patient and giving the impression of being 'too busy' to engage with the patient (extract 2, Table 4).

Tone of voice was also invoked in the feedback on this theme in terms of impatience in providing time for the patient to speak. The nurse in Video A, who is assessing the patient with asthma, asks several questions to check the patient's understanding and to provide an opportunity for the patient to seek further information. Such questions were viewed positively by participants; however, the nurse's tone was not evaluated favourably, as it gave the impression that the nurse was not prepared to attend to the patient's responses (extract 3, Table 4).

The nurse's tone of voice in dealing with the patient in the emergency department in Video B also prompted negative feedback. As the scenario advances, the patient becomes increasingly agitated and eventually behaves aggressively towards the nurse. The nurse's tone of voice in responding to the patient was viewed as inappropriate for the situation (extract 4, Table 4).

A further aspect of the nurse's manner towards patients, 'being nice' in the sense of being friendly, pleasant or kind, was noted by participants. The behaviours observed to be associated with a 'nice' manner included smiling, engaging the patient in small talk and using touch to comfort or reassure a patient. 'Being nice' was conceptualized as having underpinnings in the nurse's overall approach to nursing practice in so far as having a pleasant manner was seen to indicate a concern for the patient's feelings and their needs and therefore to be a marker of patient-centredness. The feedback on 'being nice' was also linked explicitly to clinical skills by noting the clinical functions of adopting a 'nice manner' with patients, such as using 'ordinary conversation' to build rapport and trust which, in turn, facilitates information gathering. The clinical function of the use of touch was also mentioned. It was noted that the nurse in Video A did not touch the patient. A 'touch on the arm' may be a token of comfort but it is

also, as noted in extract 5 in Table 4, integral to a thorough patient assessment.

Techniques in interaction

'Techniques in interaction' refers to feedback on a range of interactional tools used by the nurse. Interactional tools included question types used by the nurse to elicit information (open/closed, leading and compound question forms) and terms of address used with patients. Other tools included the lexical choices made when providing information to patients, including the nurse's choice to use lay or technical terms.

This theme also encompassed feedback on a range of functions employed (or not employed) by the nurse during the interaction, including introducing one's self, informing the patient, explaining/paraphrasing, checking patient understanding, providing opportunities for patient talk/questions, listening and checking/clarifying information elicited from the patient. Positive feedback was given where these functions were observed and negative feedback where their absence was noted. For example, not providing explanations of treatments to patients prompted negative feedback (extract 1, Table 5), as did not seeking to clarify patients' understandings of decisions around their care (extract 2, Table 5).

The nurse's techniques for managing interactions with patients were sometimes explicitly conceptualized in the feedback as realizations of the nurse's underlying beliefs and attitudes about nursing practice. For example, it was noted that the nurse's questioning technique allowed the patient time to respond. This was seen to reveal something of the nurse's overarching approach to their professional role which, in this case, can be broadly termed patient-centred (extract 3, Table 5).

Communication

Feedback coded as communication included comments where participants referred explicitly to both verbal and non-verbal communication in various ways. Where this theme was associated with non-verbal communication, the features mentioned were eye contact, stance, touch and the management of space, including physical proximity between nurse and patient. This communication could be either unintentional or strategic and was seen by participants as having an impact on the effectiveness of the interaction. Extract 1 in Table 6 refers to the nurse's stance in Video A (standing at the foot of the bed) in relation to the patient who is lying down in bed. In reference to Video B, the nurse's physical proximity to the patient was commented on regarding the patient's need for personal space (extract 2, Table 6).

Table 5 Feedback on theme of techniques in interaction.

Extract	Source
1 <i>She didn't explain anything about the antibiotic or the steroid she just said 'Oh look you got this (in you) and I'll be giving it to you'.</i>	Focus Group 1: lines 331–335
2 <i>I thought not clarifying the plan with the patient probably fed into what happened. So he didn't know that [the Crisis Assessment Team] had been called, um and that sort of lack of honesty and disclosure probably precipitated the issue.</i>	Focus Group 3: lines 4–7
3 <i>'Do you have any questions?' and then allowing her the time to actually answer those questions...So it wasn't rushed and she really made it a point that the patient was very much the focus of her attention when she's dealing with her.</i>	Focus Group 3: lines 146–150

Table 6 Feedback on theme of communication.

Extract	Source
1 <i>You become conscious of how big someone is when they're standing up...and I just wondered how much easier it would have been if she could have pulled up a chair and just had a little bit of a chat before she did the obs and so forth.</i>	Individual Interview: lines 11–15
2 <i>I didn't mention the distance. It really should be at least a meter between you and the patient and in the [video], you would know that some of it was too close which may have made the patient a bit more uptight than they would have been.</i>	Focus Group 3: lines 279–283
3 <i>[The nurse] was standing up so it wasn't again not really conducive to if the [patient] wanted to bring something up, um the nurse wasn't really indicating she had time to stay and talk to her about it at that time.</i>	Focus Group 1: lines 302–305
4 <i>In terms of ah communication there was good eye contact ah I thought.</i>	Focus Group 2: lines 99–100
5 <i>She was pretty comprehensive in the information that was given...and I think when that sort of communication occurs the patient actually feels very comfortable about offering or asking questions.</i>	Focus Group 3: lines 155–157
6 <i>It was quite an effective communication in that she got what she wanted out of it, which was finding out basically her assessment of her obs and things like that and where her coughing was so I guess um yeah it was effective for that in that respect.</i>	Focus Group 1: lines 318–321

Non-verbal communication was commented on regarding its role in both creating and embodying 'distance' between nurse and patient. In extract 3 in Table 6, the physical distance created by the nurse's stance (standing up) was perceived to affect the processes of giving or receiving information. Furthermore, the psychosocial distance embodied in the nurse's stance, through what this communicates non-verbally (i.e. that the nurse did not have 'time' for the patient), indicates a lack of patient-centredness in the nurse's attitude.

Participants also employed the specific terms 'communication' or 'communication skills' to refer to different aspects of verbal and non-verbal communication. In some cases, this feedback consisted of unelaborated references to quality of 'communication' (e.g. 'Poor communication skills', Individual Interview: line 202). Typically, participants' elaborations provided a definition of 'communication' as it was used in a given context. In such instances, 'communication' referred to features of non-verbal communication, to the provision of information to the patient and

to the effectiveness of the interaction from a clinical perspective. In extract 4 in Table 6, the 'eye contact' that the nurse makes with the patient is referred to as if synonymous with 'communication'. Similarly, in extract 5 in Table 6, the provision of information by the nurse is characterized as tantamount to 'communication'.

'Communication' was also invoked in relation to the nurse's clinical goals with patients. This clinical perspective is illustrated in extract 6 in Table 6. Here, the nurse's success in taking patient observations was perceived as evidence for the effectiveness of the 'communication' between the nurse and patient.

Discussion

The findings of this study offer new insights into nurse-patient communication because they contribute empirically based evidence grounded specifically in the values of nursing professionals, rather than extrapolated from other fields of health care. Furthermore, the approach of collecting

feedback on videoed interactions, rather than on live interactions or from nurse participants in an interaction, was effective for eliciting nurses' views: firstly, the video medium afforded nurses time to reflect on the feedback they gave; and secondly, in being external to the communication encounter, nurses were free from the distractions of involvement in an interaction and were therefore in a position to provide comprehensive and critically reflective feedback. The results indicate four major aspects of communication that nurse educators and clinicians consider relevant in what constitutes effective nurse–patient interactions in clinical practice. These aspects have been categorized under the themes of approach, manner, techniques in interaction and communication.

Importantly, these themes are not always discrete but instead often co-occur and interact with one another. It appears from the data that approach, concerned with involving the patient and ensuring sensitivity to patient needs, functions as a super-ordinate theme encompassing feedback on all the other themes. For example, feedback from educators and clinicians demonstrates how a lack of patient-centredness in approach underpins an absence of rapport-building and other behaviours associated with a positive 'manner' towards patients.

The overarching nature of the theme of approach indicates the importance of patient-centredness in the nurse–patient interactions. This finding on the central relevance of patient-centredness concurs with patient perspectives on effective communication (McCabe 2004) and also with widely espoused conceptions that skilful and effective nursing communication is patient-centred and entails strategies for engagement and relationship-building with patients (Kruijver *et al.* 2001, McCabe 2004, Lein & Wills 2007, Fleischer *et al.* 2009, Langewitz *et al.* 2010).

Feedback specifically on non-verbal communication (themed 'communication') highlighted its importance in nurse–patient interactions. Notably, the significance of non-verbal communication in interactions between healthcare providers and patients is stressed in the teaching and learning literature (e.g. Silverman *et al.* 2005). However, it is rarely addressed in nursing communication research (Kruijver *et al.* 2001).

Moreover, in relation to the generically themed 'communication' feedback, it was noted that the term 'communication' was used often and variously to refer to different aspects of the interaction including eliciting and offering information, achieving clinical goals, and eliciting non-verbal communication such as engaging with the patient directly through eye contact. The broad scope of this concept indicates its centrality in the nurse–patient encounter, as widely reported in the

literature (Bowles *et al.* 2001, Wilkinson *et al.* 2002). Nevertheless, as also noted in the nursing literature, the concept has thus far been ill-defined. The term 'communication' has been used to refer to a range of processes and behaviours including information exchange, listening, demonstrations of empathy, interviewing techniques and therapeutic interactions (Chant *et al.* 2002, Fleischer *et al.* 2009). This study offers further clarification of the multidimensional concept of communication by offering examples of how it is enacted in interaction with the patient and an evaluative perspective on what makes particular instances of communication effective or otherwise.

Limitations

This study has several limitations. A small number of video stimuli were used in focus groups. As these stimuli provided scenarios in only two settings (a general hospital ward and an emergency department), the feedback elicited in response could not represent the full range of communication skills and behaviours that occur in nurse–patient encounters. The findings therefore may not be directly applicable to other healthcare settings. Additional data using different stimuli and more informants should be gathered to deepen understanding of other clinical settings.

Conclusion

The study findings serve as a starting point in informing understandings of the aspects of communication that nurse educators and clinicians consider relevant for effective nurse–patient interactions in clinical practice. This knowledge could be used in the context of training to complement training intervention tools currently available. Further research could be conducted canvassing nursing students' views on the video stimuli and comparing their comments with those offered by more experienced participants. This information might help to orient students to what is valued by their experienced peers and encourage greater awareness of the impact of particular approaches and techniques for effective communication with patients. The themes identified in this study also have potential as the basis for developing or refining current observation tools used for assessment purposes. As many of the analytical tools and feedback frameworks that are applied to nursing assessment and training (e.g. the RIAS and SEGUE) were developed in disciplines outside nursing, it would be beneficial to include evidence from within the nursing profession to reflect on how closely these tools relate to the construct of effectiveness in nurse–patient communication.

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Conflict of interest

No conflict of interest has been declared by the authors.

Author contributions

All authors have agreed on the final version and meet at least one of the following criteria [recommended by the ICMJE (http://www.icmje.org/ethical_1author.html)]:

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
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