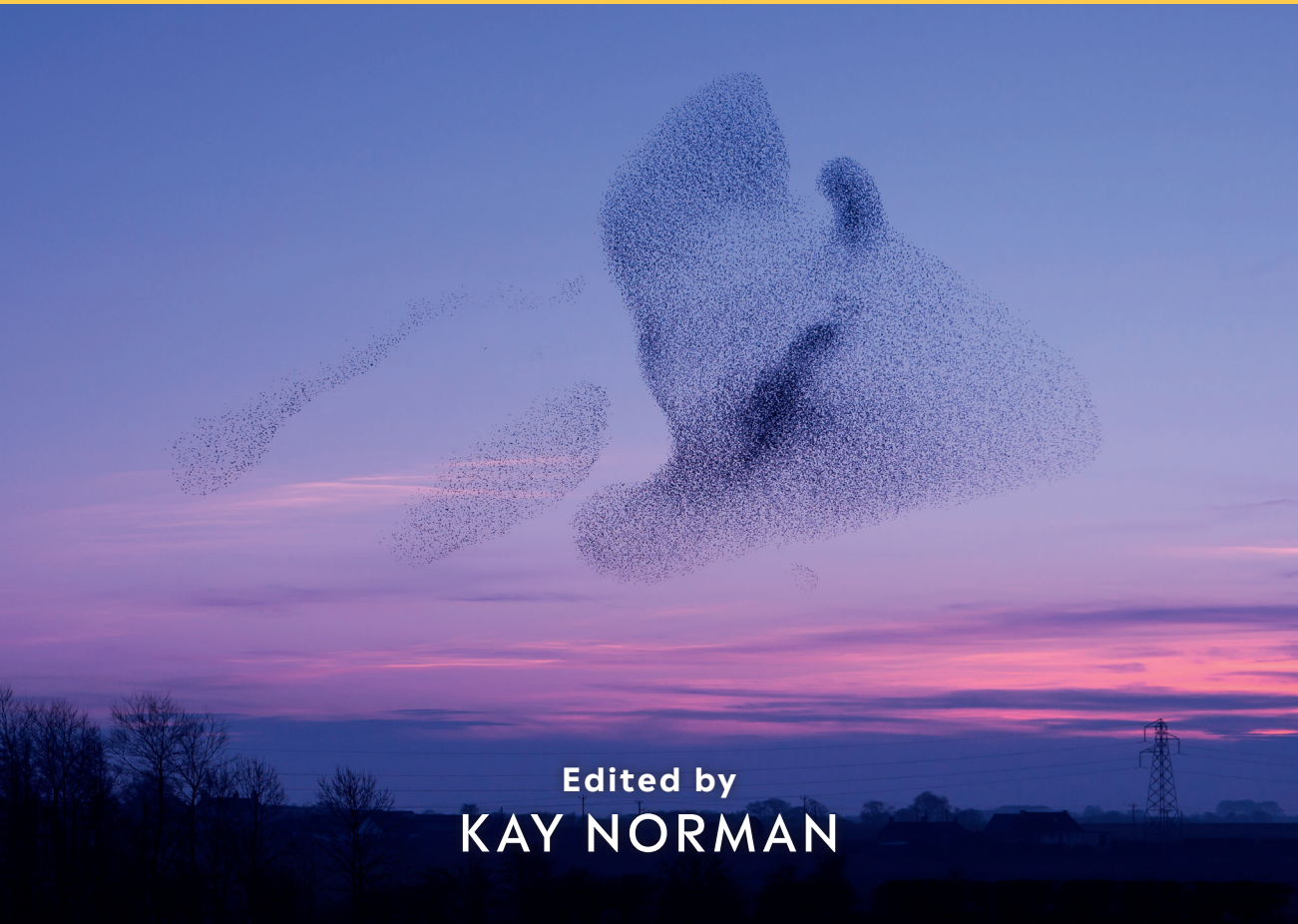
ESSENTIALS

COMMUNICATION SKILLS

For Nursing and Healthcare Students



Edited by
KAY NORMAN

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Introduction

This book is designed primarily for student nurses who care for adult patients, and will help you to appreciate the many facets of communication in your role. You are obviously interested in progressing your understanding of communication skills by reading this book, so hopefully the various chapters will encourage you to question your own communication practices, as well as those of others, to learn and improve together. This reading will require you to take time to think critically, challenge you to question your own viewpoints and approaches, and to reflect on past and current situations where communication encounters may have gone well or not so well. Reflective activities are included in each chapter to help you apply your learning to practice situations.

Ultimately you are responsible for upholding the professional standards within the Nursing and Midwifery Council (NMC) *Code*. The four areas – prioritise people, practise effectively, preserve safety, and promote professionalism and trust – all have communication at the heart of their section statements, and are evidenced throughout all chapters of this book. As a student nurse in 1986 I remember the first quote I had to memorise: "Communication is the essence of nursing", which still holds true today. Communication as a concept is fundamental to the nursing profession and must be nurtured and practised.

Communication methods are many and varied, with additional texts available on specific areas, such as social media and technological aspects. This book will focus on the themes included in the NMC (2018) *Standards for Pre-registration Nursing* (Annexe A). Each chapter will provide you with some detailed information and activities to develop your learning and understanding. Key learning points and further reading resources are highlighted at the end of each chapter. Many chapters also include websites and video clips that support the reading material. Case studies draw together the main concepts and themes discussed in each chapter, providing reflective questions to evaluate your learning.

All chapter authors have a wealth of practice and educational experience and are passionate about sharing their communication expertise with you. We do hope you enjoy your reading and learning journey.

Kay Norman, Editor

Chapter 3

Communication skills in promoting health

Alison Lewis

LEARNING OUTCOMES

By the end of this chapter you should be able to:

3.1 Understand the impact of effective health promotion communication strategies

3.2 Recognise the importance of motivation and behaviour change

3.3 Appreciate the need for an evidence-based approach to promoting health

3.4 Describe communication approaches that could be used to address common health risk behaviours seen in various patient/client groups.

3.1 Introduction

The communication skills required to undertake health promotion stem from the Ottawa Charter for Health Promotion (World Health Organization, 1986) definition, which states that: "Health promotion is the process of enabling people to increase control over the determinants of health."

This definition implies that there are two strands to health promotion – the process to improving health **and** empowering people to take control over their health. Whilst recognising the social determinants of health are often out of an individual's control, empowering a patient/client to take control over an aspect of their health creates a positive experience for that individual. Communication becomes the pivotal tool that health promoters must apply in order to meet these two components. Health promoters need multiple skills to undertake this work, ranging from one-to-one communication skills to more facilitative skills for group sessions. There is also an emphasis on listening and understanding how people receive and interpret information, as well as being able to assess motivation for a change in health behaviour.

This chapter will discuss some of the communication skills you can employ with your clients and patients to achieve the health promotion aspects of the Ottawa Charter, to help reinforce health messages in a positive way for the people and communities you care for.

3.2 Assessing motivation for change

As nurses, it is important we understand how motivated our patient or client is to make a health behaviour change, before offering health promotion information. The days of the healthcare professional 'telling' patients how to be healthier should now be disappearing from current healthcare communications. We now know this approach is not effective, as some of the health issues we currently see increasing have demonstrated, for example obesity or type 2 diabetes.

There are a number of models and theories we can use to ensure a robust assessment is made prior to any health promotion intervention. If you would like further information on these, you can access additional reading materials in the Further reading section of this chapter. The model we will discuss in this chapter is the 'transtheoretical model', as described by Prochaska and DiClemente in 1983 and deemed to be a seminal piece of work within this area of health promotion (see *Figure 3.1*).

The model is based on five phases of change, through which a person will move in a cyclical manner from precontemplation to maintenance, whilst recognising at all points that relapse may be inevitable through this process. It is widely agreed that relapse is part of making long-term health behaviour changes, and this model

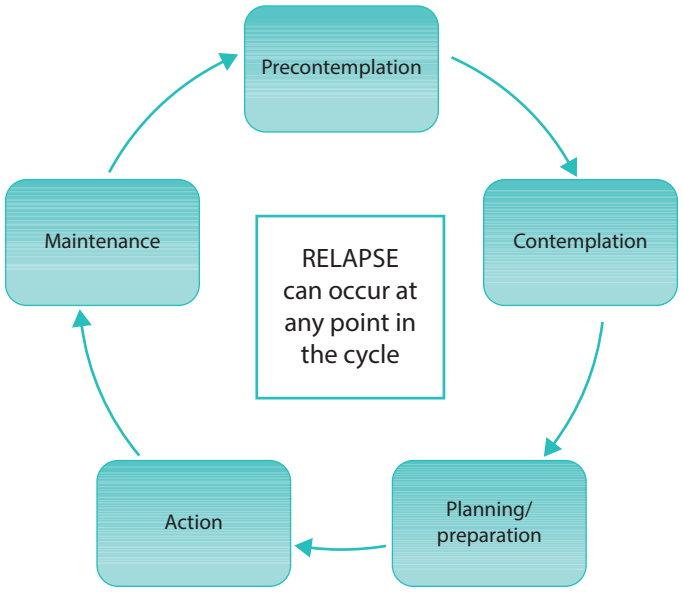

Figure 3.1 *Adapted from the transtheoretical model of behaviour change (Prochaska and DiClemente, 1983).*

encourages the nurse to help people at all stages of motivation and readiness to change, rather than just focusing on the few who are at the action phase. By listening to our patients, we can identify where they are within this model and subsequently offer appropriate guidance and discussion to help them move to the next phase.

At the precontemplation phase, an individual who smokes is not thinking about stopping smoking, whereas someone at the preparation phase is making active plans and setting a quit date. Between these two phases is contemplation, where the individual is thinking about stopping smoking and wants to make the change, but is unable to do so. It is within this phase that an individual can be helped to identify their motivation for change, as it is dependent on how important the change feels to that individual and how confident they are of achieving it. This discussion around importance and confidence is based on Bandura's (1977) theory of self-efficacy, where self-efficacy refers to an individual's belief in his or her capacity to execute behaviours necessary to produce specific performance attainments. Self-efficacy reflects a confidence in the ability to exert control over one's own motivation, behaviour and social environment. It is most useful to reflect upon in situations which trigger relapse.

During the precontemplation and contemplation phases, an individual's self-efficacy to make a change or abstain from a behaviour (i.e. how important the change in behaviour is deemed to be and level of confidence to make the change) is lower than the temptation to continue with the unhealthy behaviour. An example of this may be the patient who is within these phases and asked to discuss the benefits and drawbacks of smoking, and the benefits significantly outweigh the drawbacks.

Within the preparation and action phases, self-efficacy has increased to a point where the gap between wanting to make a change and temptation to continue with unhealthy behaviour has narrowed and the patient is able to make a healthy change.

Finally, when relapse occurs, temptation has overpowered an individual's self-efficacy, and they thus adopt the unhealthy behaviour once more. This stage is very important in the model of change, as in the case of smoking, it is recognised that an individual will relapse on average three times before they are able to stop smoking permanently (*Table 3.1*).

Another factor to consider when assessing motivation for change in our patients is how health literate the individual is. The World Health Organization, at their 9th Global Conference on Health Promotion in Shanghai (WHO, 2017), defined health literacy as: "the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways that promote and maintain good health".

In order to move from the precontemplative to the contemplative phase of the transtheoretical model, a patient requires some degree of health knowledge and understanding. As a nurse working with an individual in this phase, a discussion around what information they would like and what they already know is vital.

Table 3.1 *Summary of the stages of behaviour change*

Precontemplation	The individual is not actively thinking about changing their behaviour but may become aware that change is desirable. The nurse may be able to help move an individual to the contemplation stage by asking open questions such as "How are you feeling about your health?"
Contemplation	The individual becomes clear that change is needed and may start to research possible means to achieve the desired change. The nurse will be able to help identify their motivation for change and may enhance their confidence and self-efficacy. A discussion of the benefits and drawbacks of making the change may be helpful.
Planning	The individual is actively developing a plan of how they will implement the change. The nurse can support this stage by providing information requested by the individual (see below).
Action	The individual's desire to make the change is now stronger than the temptation to continue as they are and they take action such as actively accessing health services, joining a support group, etc.
Maintenance	The individual takes steps to ensure that the change is lasting.
Relapse	This can occur at any stage in the change process – for example an individual trying to quit smoking will relapse on average three times before stopping permanently. At this stage a discussion of the individual's self-efficacy may support them to attempt to change again.

The 'Elicit–Provide–Elicit' technique from motivational interviewing (Miller and Rollnick, 2012) is an appropriate approach to use. This requires the health professional to ask:

- what the individual already knows about the issue
- how they feel about making a change
- what information they would like from the nurse to help them move into the planning phase.

(See *Chapter 4* for more information about motivational interviewing.)

The nurse can then provide the individual with the information requested (and in the format requested by the person) in a non-judgemental and supportive manner. This will ultimately increase the individual's health literacy regarding the behaviour change they wish to make and help them to feel in control of their own health and lifestyle. The nurse then ensures that the patient has all the information they need and can assess how ready they are to change.

It is also important when assessing motivation for change that there is 'congruence' between nurse and patient. Congruence occurs when the conversation that you are having with your patient is aligned to their thoughts and feelings about the desire to make health behavioural changes. If it is not, you may face resistance from your patient and possible return to a previous phase of the model.

The following scenario illustrates what can happen when congruence between the nurse and patient is lacking.

SCENARIO 3.1

Katie is 17 weeks pregnant and smokes 15 cigarettes per day. During a discussion with the nurse, Katie is able to articulate some of the reasons why she should give up smoking during pregnancy, indicating some health literacy about her behaviour. However, her nurse incorrectly identifies her as being in the contemplation phase, moving towards preparation, without checking and agreeing this with Katie. The nurse's conversation focuses on making a plan for behaviour change before fully exploring Katie's motivation to make this change. There is no congruence between patient and nurse and in turn, Katie shows resistance by becoming withdrawn and showing a lack of interest in the conversation.

When assessing motivation for change it is necessary to explore with your patient how important they feel this behaviour change is to them and how confident they feel to undertake the change. In the example in *Scenario 3.1*, Katie was indicating that she felt it was important to stop smoking but was not feeling confident to make this change at present. Her nurse needed to discuss how confident Katie was feeling about giving up smoking and what strategies would help her to improve her confidence and belief she could make this change.

Thinking carefully about our own skills in communicating with our patients at each step of the health promotion process, the OARS acronym in *Figure 3.2* is most effective in helping our patients to explore their motivation to change health behaviours.

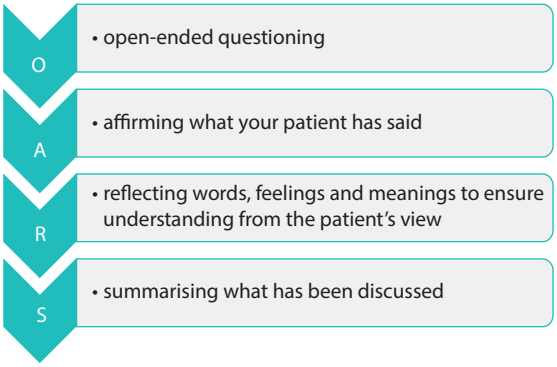

Figure 3.2 *The OARS acronym.*

These are the skills required to help move around the model of behaviour change and towards the planning and action stage and are discussed in depth in *Chapter 4*. Using open-ended questioning at the start of a conversation, such as 'How are you feeling about your health?' gives an individual choice to discuss a health issue or not, which in turn reveals what is important to your patient about their health choices. This style of listening will also help when a relapse has occurred. As already stated,

relapse is an integral part of this behaviour change cycle and each time it occurs, the individual has an opportunity to reflect on why they relapsed. Discussing this with their nurse will help them to understand further the issues that caused them to relapse and enable a conversation about how to prevent this from happening next time they are trying to change their behaviour.

ACTIVITY 3.1

Consider a patient who is obese and is at risk of developing health complications because of this. How do you feel about instigating a conversation to assess the stage of motivation to change? Drawing on previous reading from this book, what styles of communication would be appropriate in this situation? What questions would you ask?

If the patient appears to be at the contemplation stage, how would you discuss and encourage the move to the next phase of planning for change? What resources are available in your area to support a plan of action?

You can also consider this model for your own health behaviours to consider a particular health issue. Which phase from the transtheoretical model do you think you are in?

How ready or motivated to change this behaviour are you? Remember to think about how important the change is to you and how confident you feel to make a change.

What would help you to move into the next phase of the model and how would you like this to be delivered?

3.3 Explaining an evidence-based approach to health

In order to explain an evidence-based approach to health to patients/clients, we first need to understand ourselves what this is and how it can best be employed within the role of the nurse. The NMC *Code* (Nursing and Midwifery Council, 2018) section 6 states: 'Always practise in line with the best available evidence'. To achieve this the nurse can:

- make sure any information or advice given is evidence-based, including information relating to using any healthcare products or services, and
- maintain the knowledge and skills you need for safe and effective practice.

An evidence-based approach to health can best be defined as: "the integration of the best research evidence with clinical expertise and the patient's preferences and values" (Sackett *et al*., 2000).

This definition, although first published in 2000, remains relevant today. It suggests there are three components to evidence-based healthcare that can be viewed as a collaboration between research evidence, professional expertise, and patient values and understanding (*Figure 3.3*).

Our patients expect that all nurses understand the care they are delivering and are able to discuss and explain why this care or intervention is suitable for an individual. We need to be able to provide a thorough rationale about the care we are giving, based on the best available evidence, so a patient can be helped to make an

Figure 3.3 *The interdependence between the three key features described to aid decision-making.*

informed decision about their health. It is also necessary to base care on the most reliable and current evidence that is available, to ensure we remain 'accountable' for our practice. The NMC *Code* (Nursing and Midwifery Council, 2018) declares that 'nurses and midwives are accountable for the care that they deliver' so being able to justify your intervention based on the most relevant and current evidence will ensure that this element of the *Code* is adhered to.

As discussed above, Sackett *et al*. (2000) described how clinical decisions are also reliant on a professional's clinical judgement. This can be used to decide whether the best evidence can and should be applied to the individual patient/client, given each patient is an individual and in unique circumstances. Professional 'intuition' or 'gut feeling' was first described by Benner (1984) as being in a close relationship with experience. He claimed that intuition is grounded in both knowledge and experience and that in the absence of reliable research, professional judgement is the best available evidence on which to promote health and care. In a recent review conducted by Melin-Johansson *et al*. (2017), nursing intuition was found to be part of a process that is based on knowledge and experience and they suggested that it has a place alongside research-based evidence.

Finally, in Sackett's model, he describes the importance of listening to a patient/client's preferences, values and understanding about the care they could receive. Some clients wish to be fully involved in the decisions relating to the care they receive and for these patients, tools such as the NHS 111 website (https://111.nhs.uk) can be invaluable to support their understanding before or after we as nurses have discussed the care options. For all patients, it is vital that we gain their informed consent prior to an intervention or health promotion activity. Even with the most reliable research evidence available and discussed together with the nurse's professional judgement, if the patient/client chooses not to consent then this care/information cannot be given.

There are a few caveats to this, for example within the safeguarding arena of both children and vulnerable adults. Referral to statutory services for protection must take place to offer safety for the child or adult. It also applies where a patient has either temporarily or permanently lost the ability to consent, due to a learning disability, mental health illness, brain injury or dementia and the Mental Capacity Act (2005) is invoked. This Act allows for decisions to be made on behalf of such a patient by the providers of their care and is always based on the most current evidence available.

So how do nurses find valid reliable and current evidence to impart to their patients?

Within the field of healthcare, there is a significant debate about evidence and what type of study constitutes the best possible evidence of an intervention. Many authors use a pyramid to illustrate the hierarchy of evidence, as illustrated in *Figure 3.4*.

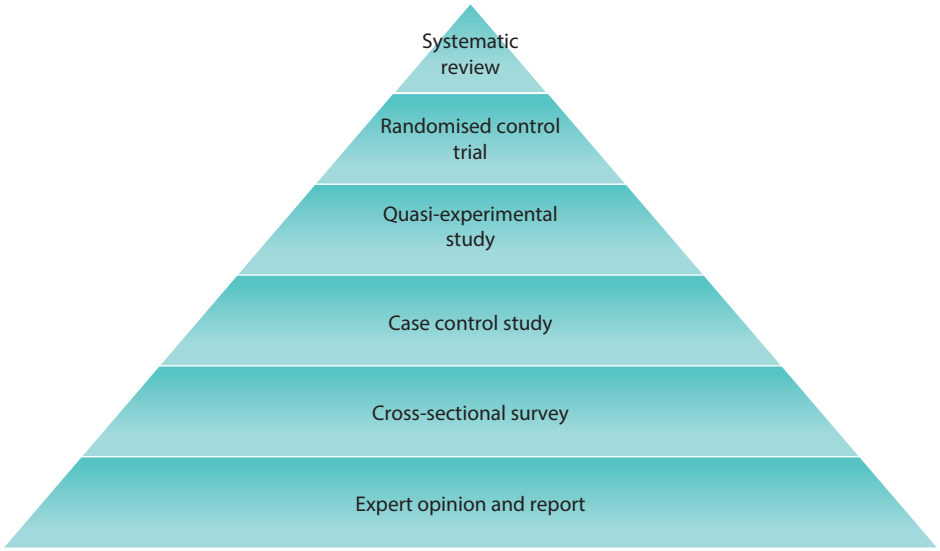

Figure 3.4 *The hierarchy of evidence.*

Within health and nursing research, systematic reviews are deemed to provide the gold standard of research. These are reviews of all the primary research available in a subject area, and the reviewers form a recommendation based on the findings from them all. The Cochrane Collaboration, which is a non-profit organisation with contributors worldwide, produces reviews that summarise the best available evidence generated through research to inform decisions about health. However, evidence-based programmes of health promotion tend to be of a quasi-experimental and cross-sectional study type where there is no comparison group of patients and the results are often interpreted with multiple caveats. Whichever evidence source we use, nurses need to be able to critically analyse the findings to decide whether the evidence is valid and reliable. There are many publications available that can help to support this analysis and nurses need to ensure they feel competent to undertake this with their patients.

Strategies for disseminating information are detailed in *Section 3.4*. However, it is important to consider how evidence-based practice is communicated verbally to patients in a clear, consistent way. You may have heard patients justifying a health activity or approach based on information gained from a friend or family member. They may also refer to a magazine or newspaper article they have read or web sources. It is important to acknowledge their understanding based on the information they have received and not dismiss this as trivial material. Building a trusting, respectful relationship will help to encourage dialogue about the types of evidence available and the trustworthiness of information relating to a patient's health needs. Some key points to consider in these situations are listed below. You may choose to use some or all of these, depending on the situation presented:

- Show an interest in the type of information drawn upon by the patient to help understand their viewpoint.
- Do not be dismissive of non-evidence-based information the patient believes to be true.
- Take time to explain the variety of information available and how robust research studies help to ensure a consensus of opinion based on the best possible evidence.
- Use clear, simple language that can be understood.
- Explain that you aim to provide the best care possible based on clinically researched evidence.
- Compare the information in a magazine to a clinically based research study to demonstrate differences.
- Discuss the history of ritual, tradition and personal choice in care and how this has progressed to evidence-based practice.
- Show how the advice or care you are giving relates to evidence-based practice.

ACTIVITY 3.2

Reflect on an episode of care where a patient needed to receive some information regarding a health-promoting activity. How was this undertaken? Was the information shared based on the most current evidence? How do you know this?

List four key points you would follow to ensure you impart current evidence-based healthcare.

3.4 Strategies for disseminating information (population and individual)

Since the rapid introduction of the internet and social media, the way health professionals, individuals and populations receive health information has changed radically. Prior to the proliferation of the worldwide web, most health staff received information from key health information sources such as government departments, research journals and the printed press. The information disseminated was one-directional and relied upon the professional sharing it with their patients/clients and local population in a timely manner (see *Figure 3.5*).

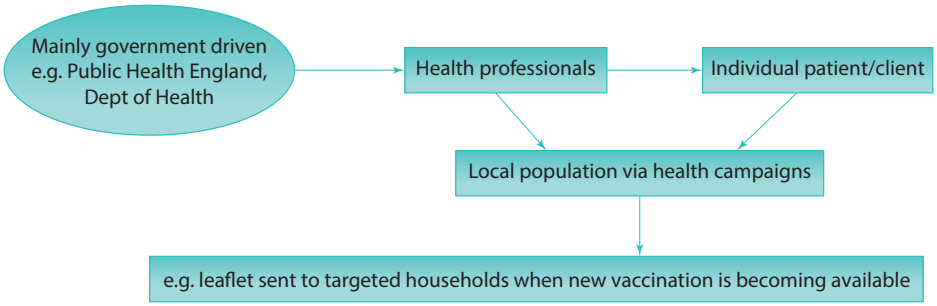

Figure 3.5 *Health information sources.*

This strategy of disseminating health information offered very little choice in the information shared to both an individual and at population level but was reliable and evidence-based. This was similarly seen by the adoption of mass media campaigns from the mid 1980s. These were often seen to present information in an alarmist way, an example being the 1986 'AIDS – Don't Die of Ignorance' TV campaign (www.youtube.com/watch?v=TMnb536WuC0). Again, the use of mass media as a strategy for sharing health information offered very little choice to the individual, although it was relatively successful in reaching the population as a whole.

We now need to find strategies that embrace the proliferation of new sources of information. Individuals can now obtain the information that they require from a wide range of sources and can also disseminate it to other interested parties, as described by Dumbrell and Steele (2013). This means that health information can be shared in a more dynamic manner and this is illustrated in *Figure 3.6*.

As social media is playing more of a role in informing and engaging our patients in their healthcare decision-making, nurses should question the reliability of the

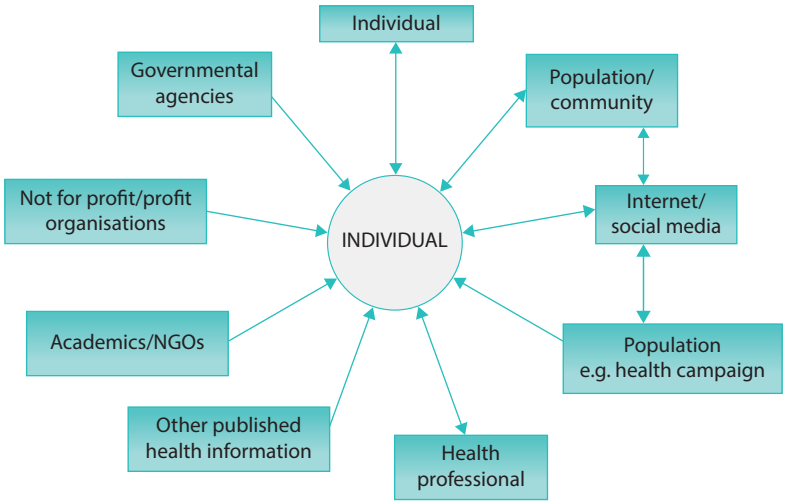

Figure 3.6 *The sharing of health information, offering choice to both individual and population.*

information that is being shared and whether individuals have the critical appraisal skills required to make sense of the vast amounts of information available.

A study of primary care nurses by Bekkum and Hilton (2013) found that media influence can have a detrimental effect on an individual's decision-making as there is not always sufficient unbiased information presented. Nurses need to use their knowledge to help their patients/clients to understand what the research behind the headlines is actually saying. One example is a recent cohort study by Sabia *et al*. (2018) which looked at alcohol consumption and the risk of a dementia diagnosis. The headline in the press and on various social media platforms was: "Middle-aged non-drinkers may have 'higher risk' of dementia", whereas the actual study published in the *British Medical Journal* was entitled "Alcohol consumption and risk of dementia: 23 year follow-up of Whitehall II cohort study".

In order to help a patient/client have a full understanding of this piece of research, the nurse needs to draw upon her critical appraisal skills and a range of communication strategies to ensure that the individual does not see this as a reason to start drinking alcohol, for example.

As we know that people are increasingly using social networks to exchange and search for health information, our strategy for promoting health needs to engage with this medium. Health organisations, professionals and academics can use these platforms to promote the correct information when mass media is covering an area in a more biased way. By regular dissemination of information regarding promoting healthy behaviours, a wide array of individuals and local populations can be reached.

Another strategy that could be employed to communicate reliable health information to the wider population is to use social media platforms in a more rapid and coordinated manner. Recently Twitter has become a popular source of health information (Hughes, 2016). Hughes suggested that recognised healthcare organisations such as Public Health England and academics can share current reliable information in a very timely manner, which would help our patients/clients to have more of the facts when the headlines hit!

However, we do need to be aware of the level of literacy required by the audience when sharing information in this form, and organisations and professionals sharing health information need to be clear in their profile that their information is evidence-based and of a robust nature, to help patients/clients/nurses identify the highest-quality information.

Health professionals such as nurses need to be aware of the varying quality of information available through Twitter and other social media platforms and be prepared to discuss this information with their patients, who may have accessed information and need help to interpret and understand what the information means for their own health decisions.

A further consideration of relying on social media for health information dissemination is that some groups of patients may not be able to access this technology. These groups may in fact be the target audience. The elderly and those with poor literacy skills or English as a second language may still need to be offered health promotion in a more traditional form as discussed earlier in this chapter, such as a face-to-face consultation with a health professional, with some information given in printed form and translated as required. This can enable them to make a more informed decision about their health at their own pace.

Younger members of the population are very quick to adopt the latest and differing social media platforms, compared to their parents and so only using one form of social media could exclude groups. Therefore organisations must offer multiple ways to disseminate and communicate key health promotion messages to be understood by both the individual and population concerned.

ACTIVITY 3.3

Make a list of the social media platforms you know and also ask colleagues. Now look at health-related posts and blogs within these platforms. How accessible is the platform to navigate and how did you appraise the quality of the information presented? How is the information communicated to the audience? Would you consider using any of these to help communicate or reinforce health messages with your patients?

What skills do you feel are required by the nurse to ensure patients can interpret, understand and make an informed decision regarding their healthcare?

3.5 Addressing common health risk behaviours

Life expectancy is rising within the UK. Men can now expect to live until 79.5 years of age and women to 83.1 years. That is the good news. Unfortunately, due to our health behaviours the population as a whole is spending more of this extra life unwell, with as much as 16 years of ill health for men and 19 years for women (Public Health England, 2019). What we are dying from is changing too. Whilst heart disease and stroke remain common causes of death, the number of patients dying with dementia and Alzheimer's disease has increased by 50–60%. We have an ageing population and this is putting a strain on all our health and social care services. Therefore we need to help our patients and clients to address their health risk behaviours and start making more healthy choices and adopting a healthier lifestyle.

The common health risk behaviours are well recognised and discussed frequently by the media, health professionals and governmental agencies. The key areas that contribute to the highest proportion of ill health are:

- consuming a diet high in calories, fat and sodium, and low in nutrients
- low levels of physical activity and high levels of sedentary behaviour
- smoking cigarettes
- abusing substances including alcohol, and prescription and illicit drugs

An individual and in turn the population could reduce these health behaviours. Statistics suggest that heart disease, stroke and type 2 diabetes could be prevented by up to 80% and cancers by 40%. The Global Burden of Disease report, based on findings from 1990 to 2016, highlighted the incidence of poor health and older age occurring within the various regions of the UK (Steel *et al*., 2018). They provide some evidence to suggest that smoking in women is the number one risk factor for ill health for this half of the population and that poor diet coupled with smoking were the largest contributors to the number of deaths globally.

3.5.1 Making Every Contact Count (MECC)

One public health approach to trying to address these common health risk behaviours is Making Every Contact Count (MECC). This approach is supported by Public Health England (PHE) and Health Education England (HEE) and focuses on the lifestyle issues that can make the greatest positive change to an individual's health in a non-directive way.

> *'Making Every Contact Count (MECC) is an approach to behaviour change that uses the millions of day-to-day interactions that organisations and people have with other people to support them in making positive changes to their physical and mental health and wellbeing.'*
>
> (Public Health England, NHS England and Health Education England, 2016)

MECC aligns well with many of PHE's priorities – stopping smoking, drinking alcohol within the recommended limits (14 units per week for men and women with some days of no alcohol each week), eating more healthily (reducing sugar, eating five or more portions of fruit and vegetables a day), being more physically active (10 minutes of brisk exercise per day), keeping to a healthy weight and improving mental health and wellbeing. It can also help with achieving the *Five Year Forward View* (NHS, 2014) principle of keeping the ageing population healthier and independent for longer.

Figure 3.7 is a diagrammatic representation of MECC and behaviour change interventions. It is envisaged that all health and social care staff will be trained and able to offer very brief and brief interventions to the patients and clients they see every day and that from signposting them on to more specialist professionals, we can start to make some difference to our nation's health.

What does a brief intervention look like?

A brief intervention, as discussed in *Chapter 2*, can happen anywhere and at any time. It aims to raise awareness, stimulate thinking and signpost to other information or agencies. Using the OARS acronym in a brief intervention could be the start of a patient thinking about making a move towards a healthier behaviour.

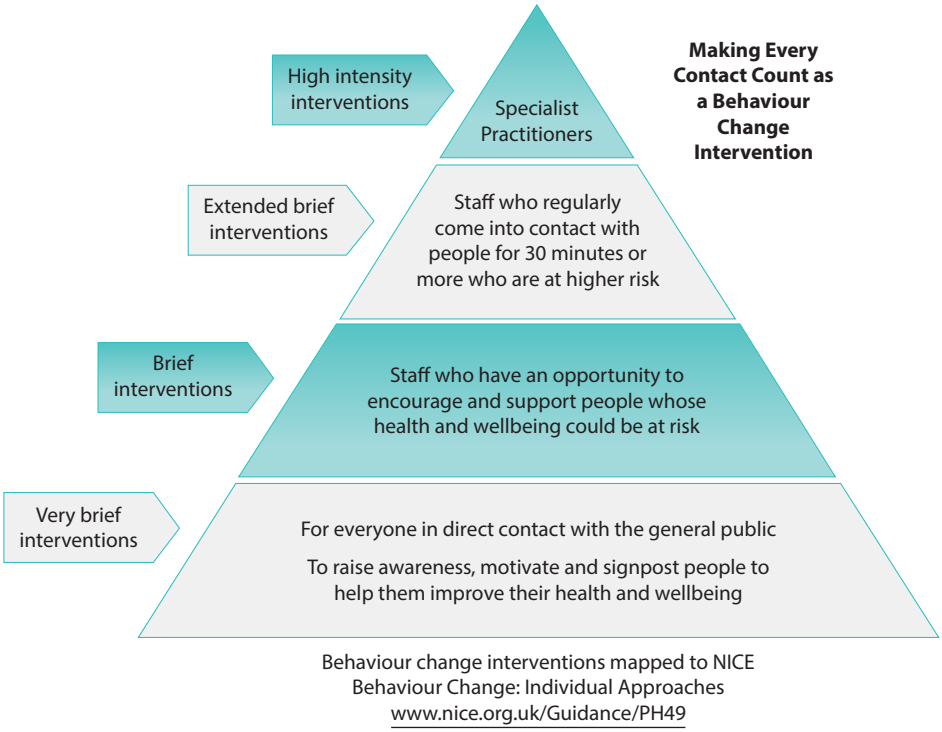

Figure 3.7 *Representation of Making Every Contact Count and behaviour change interventions.*

SCENARIO 3.2: A BRIEF INTERVENTION

A student nurse, James, is working within a GP practice nurse placement. He notices a patient who attended the diabetes clinic with the practice nurse and himself the week before. The patient is reading a leaflet on healthy eating.

James: open-ended question: Hello Mrs Jones. I see you've been looking at one of our leaflets about healthy eating. I remember we were discussing this with you last week. How have you been getting on with the diet sheet we gave you?

Patient: Not very well actually. It doesn't have any of the foods that I like and it's very confusing.

James: *affirming and reflecting*: Oh, I see. It sounds like you're not finding the information helpful and are looking for something that is more relevant to you.

Patient: Yes, that's right. I want something that helps me with foods that I like to eat.

James: Summarising and signposting: OK, shall we see what information we have here and whether any of it is more helpful? We could also look at the Change4Life and Diabetes UK websites for more information.

Patient: That would be great. I've been worrying about coming back to see the nurse today as I haven't been getting on at all well with it.

ACTIVITY 3.4

Can you think of a time in practice where you could have used the MECC approach to discuss a patient/client's health behaviour as a brief intervention?

If you were in a similar situation again, how might you start a conversation with the patient/client, and could you follow the OARS acronym to complete the brief intervention?

Make an aide memoire card with OARS written on it to keep in your pocket until this conversation becomes more familiar to you. You could have some agencies/information sources on the back for the most common health behaviours discussed earlier. Remember the more you practise this type of conversation, the easier it will become.

CASE STUDY

You and a family nurse are visiting a young client, who we will call Jody, as part of the Family Nurse Partnership programme (FNP, 2018). Jody commenced weaning of her baby at 11 weeks. The Department of Health guidelines (2018) state that exclusive breastfeeding until 6 months is best for baby. There is some evidence that has shown that the early introduction of solid food has long-term consequences for the health of that individual, with a higher incidence of gut allergies and obesity (World Health Organization, 2002). The Department of Health's guidelines are based on this WHO research.

Up until this stage Jody had exclusively breastfed her baby, but he had started waking at night and she had read in one of the daily newspapers that commencing solid food might help her baby to sleep better. She had also discussed the issue with her mum, who had reinforced this decision as she herself had introduced solids at around 3 months with each of her children. At a regular home visit at 12 weeks, Jody tells you and the nurse about the decision she has made and explained her reasons.

What would you and the nurse do in this instance? What initial conversations could be had and what approach could be taken?

What stage of the transtheoretical change model do you think Jody could be at this point? How could you ensure congruency with Jody to build a trusting relationship?

Thinking about what this meant for Jody, you and the nurse decide to ask Jody whether she would like to look at some reliable evidence around introducing solid food. Jody gives her consent so you are able to share the current weaning guidelines and further explore what Jody's baby might be telling her regarding the breastfeeding and sleeping. At around 3 months of age, her nurse knows from professional expertise and evidence that the baby is possibly in a growth period and may be asking for more frequent feeds to stimulate Jody's breast to increase the supply of milk to match this growth. This is discussed in the material produced by the Department of Health and so aids the nurse's sharing of this knowledge in a way acceptable to Jody. Using the technique of 'Elicit–Provide–Elicit' (described earlier in this chapter), Jody is able to understand the supply and demand feature of breastfeeding and accept that this is normal for her baby at this age.

CASE STUDY (*continued*)

At the end of this discussion, Jody informs you and the nurse that she thought her baby was not yet developmentally ready for solid food and that she was going to concentrate on her breastfeeding and wait until he showed signs of needing more before commencing weaning again. However, she felt pressured by family and friends as they had always done things that way with their babies.

What information would you leave with Jody to support her decision? Think about the types and format of information she would be able to access, such as websites, written articles, leaflets. Are they evidence-based? How would you explain the differences between an evidence-based approach and a custom and practice approach?

At the next visit two weeks later, Jody reported that she had stopped offering solid food to her baby and he had settled back into a more normal routine of feeding 2–3 hourly during the day and 3–4 hourly at night. The nurse felt that this was a positive reinforcement of Jody's healthcare decision and the fact that they were both much less tired and distressed, was a good evaluation of the discussion two weeks previously.

Jody did not introduce solid food to her baby's diet until he was 25 weeks old after reading the guidelines left by her nurse and using government social media platforms for information. She told her family and friends about this in order to share and justify her approach. Jody had also found information about baby-led weaning on the internet and wanted to discuss this with you and her nurse to understand whether this was reliable information and relevant for her and her baby.

This case study illustrates how important it is to assess an individual's motivation for change prior to offering health information, influencing factors which could affect decision-making such as family and friends in this instance, and then to use communication techniques to help understand the situation from the client's perspective. Using the most reliable and up to date evidence-based information, alongside professional expertise and client knowledge and understanding, allowed this mother to make an informed decision about the health of her baby. This in turn may reduce poor health outcomes for this child in later life and will ensure subsequent children that this mother has will be offered the same health decision regarding feeding.

Summary

This chapter has discussed some of the communication skills that a nurse might use to aid health promotion with their patients. It is important to remember that health values and beliefs are individual and as nurses, we must recognise that not everyone will want or believe they need to change unhealthy behaviours, despite overwhelming evidence. An honest, trusting relationship is fundamental to encourage a partnership approach in health promotion activities, but it is also important to realise that brief interventions can be as powerful as sustained health behaviour strategies.

KEY LEARNING POINTS

Four key points to take away from *Chapter 3*:

- Models of health promotion can help to structure health promotion activity with your patients, in particular the transtheoretical cycle of change.
- Always use the most current evidence base, but be mindful that new research is frequent.
- Communication of information must be adapted to the needs of the individual or group to ensure it is meaningful and understood.
- MECC can be a useful approach to draw on in any setting to focus on lifestyle issues.

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