Communicating with nurses: patients’ views on effective support while on haemodialysis

Nurses were found to concentrate on technical aspects of care which prevented the development of the supportive relationship that patients on dialysis wanted.

Haemodialysis involves continuous filtration of a high volume of blood through a dialyser (artificial kidney), where the blood is purified before being returned to the patient. Those with ESRD and on hospital-based haemodialysis have to adhere to a strict regimen of dialysis, dietary and fluid restrictions, and medications. They have to accept dependency on the technology of dialysis and the healthcare team for survival.

**Losses and lifestyle disruptions**

Various studies highlight how the loss of energy and fatigue associated with ESRD and dialysis hinders a person’s ability to perform normal everyday activities such as working, socialising and travelling (Al-Arabi, 2006; Heiwe et al, 2003).

According to Kimmel and Levy (2001), about two-thirds of patients on dialysis are unable to return to employment because the physical complications of the illness and treatment are too demanding for those in a strenuous job. Inability to work also causes financial difficulties for patients with ESRD (Kaba et al, 2007).

The restrictive nature of dialysis causes significant lifestyle disruptions. Several studies report how the intrusiveness of dialysis affects patients’ ability to perform normal everyday activities (Faber et al, 2003; Curtin et al, 2002).

The time-consuming nature of dialysis seems particularly difficult for many. A large proportion of time is spent attending therapy, travelling to and from the dialysis unit, waiting to be attached to the machine, and waiting for needle sites to stop bleeding at the end of treatment (Walton, 2007; Hagren et al, 2005).

The restrictive treatment regimen of dialysis causes some patients to miss out on family, community and social events (Kaba et al, 2007; King et al, 2002; Martin-McDonald, 2002).

In addition, ESRD and dialysis therapy can change a person’s body image, making them feel different and unattractive (Auer, 2002).

Skin discolouration associated with uraemia, premature ageing and musculoskeletal deterioration all contribute to an altered body image in patients with ESRD (Nagle, 1998).

Other negative factors include scarring from repeated surgery, the appearance of a dialysis catheter or fistula, weight gain from excess fluid, and being connected to a dialysis machine (Curtin et al, 2004).

This negative body image can affect sexual functioning in intimate relationships (Shirani and Finkelstein, 2004; Auer, 2002).

The qualitative literature gave valuable and interesting insights into patients’ perceptions and experiences of ESRD and dialysis.

However, only a small number of studies (Sloan, 1996; Rittman et al, 1993) used a Heideggerian phenomenological research design, so it seemed appropriate to address this.

Heideggerian phenomenology is a qualitative research design used to explore and interpret the experiences of people in their everyday
lives. It provides a way to create an understanding of people’s experiences within the context of their whole life, incorporating their past, present and future (Leonard, 1994).

**AIM**
This study was set up to provide a detailed and in-depth description of the experiences of 16 people undergoing haemodialysis therapy in the Republic of Ireland.

**METHOD**

**Data collection**
The study was carried out using Heideggerian phenomenology.

Patients were enrolled from a haemodialysis unit in a large teaching hospital in the Republic of Ireland. The hospital research ethics committee gave approval.

Participants were provided with information about the study and assured of privacy and confidentiality. Full written consent was given.

Each participant was assigned a pseudonym. They were told they had the right to refuse to participate or withdraw at any time.

A purposive sample of 16 patients was used. Purposive sampling enables a researcher to select participants who are most likely to increase understanding of the phenomena being studied (Holloway and Wheeler, 1997).

The sample consisted of seven women and nine men who were aged 18 or over, spoke English and were on hospital-based haemodialysis therapy for ESRD.

Data was collected using conversation-style qualitative interviews, which were audiotaped and transcribed verbatim.

**ANALYSIS**
Data was analysed using a qualitative interpretive approach. Interview transcripts were read several times and a list of categories was created. Similar or shared categories within transcripts were developed into themes.

Continual reading, writing, thinking and dialogue took place during analysis. Interpretations were repeatedly discussed with other researchers involved in the study. This ensured that interpretations were challenged, questioned and confirmed, enhancing rigour.

**RESULTS**
Several participants described their inability to communicate with nurses during treatment.

They indicated that nurses were persistently busy, putting patients on and taking them off dialysis machines, and rarely spent time talking or listening to them during treatment. Nurses seemed to interact with patients only when managing technical and physical aspects of care.

**Communicating with nurses: reality versus myth**
Participants indicated that the level of nurse-patient communication on the unit rarely progressed beyond a superficial or clinical level.

They highlighted their dissatisfaction with this shallow level of communication. Feelings of disappointment, frustration and anger were expressed both implicitly and explicitly.

For example, Ali indicated that nurses were too busy to communicate with him during haemodialysis. He implied the only time they approached him was to respond to alarms.

They [the nurses] would come to you [during dialysis], but only if you wanted them… or they might pass by and they’d say ‘Are you OK?’ but they wouldn’t have time to stop and chat to you… they might for a minute or two…. If the machine is beeping, they’ll have to come then, but they just correct the machine and go again.

Alex, too, illustrated the lack of nurse-patient communication. Nurses were too busy to talk to him during treatment and seldom approached him, unless a technical or physiological complication occurred.

‘They [nurses] usually seem to be busy enough… and they’re usually putting someone on, or taking them off, or else they’re doing reports… You could have several dialysis sessions and they wouldn’t really come to you and sit down and have a chat… that wouldn’t really happen… the odd one might… if you felt weak or sick or if the machine started beeping.’

Like Alex, Jeff also discussed his inability to communicate with nurses on the unit.

‘If the machine doesn’t beep, there is no reason for a nurse to be coming up to take your blood pressure… where if there is something wrong with you, there is always someone around… it would usually be a problem with the machine, it would be beeping, but the machine hasn’t beeped at all now, it mightn’t beep at all for the night, so there would be no one coming near you.’

Jeff’s account conveyed his disappointment with the levels of engagement and interaction with nurses.

Danny also highlighted his dissatisfaction and disappointment with the degree of nurse-patient communication. He expressed a need to talk to nurses and share his concerns about his illness and treatment. However, since the nurses rarely spoke to him during dialysis, his concerns were not acknowledged.

I accept there are staff issues, you can’t expect people to sit down and spend half an hour chatting every day, but it would be nice to be asked how you are getting on, and if you had any problems… you do feel a bit isolated at times… very few of them [nurses] have any comprehension of what it is like to be here on dialysis… the restrictions and the limitations… you really do need somebody you could tell your problems to.

Elena was asked if she had the opportunity to talk with nurses during treatment. She replied:

No… they [nurses] seem to be so intent on pressing the buttons on the machine, reading what it says… and talking to somebody at the same time as they’re doing something isn’t a good idea either… because if they’re [nurses] doing things and then they suddenly say ‘Oh dear’, and you think, ‘What have they done now?’… You know they’ve lost their concentration… so therefore you tend not to worry them too much about trivia until they’ve got it [machine] more or less set up.

As with other participants, Elena’s account exemplified how the technological aspects of therapy took up nurses’ time and attention. Although Nancy had spent over four years on haemodialysis therapy, her conversation on haemodialysis therapy, her conversation with nurses did not seem to have progressed beyond a clinical level.

Indeed, Nancy’s account illustrated that the nurses rarely focused on anything beyond the technical and physical aspects of her care. By structuring conversations around these issues, it seemed nurses essentially disregarded Nancy’s distinctive concerns about her illness.

You don’t get a chance [to talk to the nurses], they’re so busy… they put you on the machine, but it’s a basic ‘How are you
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today’ and I say ‘I’m fine’, just very shallow conversation... you can’t say ‘Well, I really don’t feel good’, they haven’t time... if I was very sick, I’d say ‘Oh God! I’m not well, I’ve been vomiting’, and they’d say ‘We’ll get the doctor over to you’, and they would... that’s it basically.... It is always about your needles, or about the blood pressure, or about your medication... to do with your illness to a certain extent.

**DISCUSSION**

The findings suggest that the participants on haemodialysis rarely have the opportunity to communicate with nurses during treatment.

Yet, considering patients attend dialysis three times a week, it seems reasonable to suggest that nurses working in this area should be able to spend some time communicating with them.

Communication is a fundamental part of nursing, and is essential in developing an effective nurse-patient relationship (McCabe, 2004; Attree, 2001). In addition, a positive nurse-patient relationship is necessary for high-quality, person-centred care.

We suggest that the lack of nurse-patient communication, as described by participants, hindered the development of a connected relationship between nurses and patients.

Morse (1991) provided a model for understanding nurse-patient relationships. These range from a superficial clinical type to a more involved type, mutually agreed by the nurse and patient over time (see Box 1).

This model will be used to illustrate how the lack of nurse-patient communication on the unit prevented nurses and patients from developing a connected relationship.

**Different relationships**

According to Morse (1991), the ‘clinical’ relationship begins when patients are treated for a minor issue. The time the nurse and patient spend together is brief and superficial, with the nurse making an assessment and applying treatment. This level of involvement is satisfactory to patients because they have no expectation of nurses beyond the care needed.

The ‘therapeutic’ relationship is also short term and patients’ needs are not extensive. The nurse can provide care quickly and effectively because the condition is not serious or life threatening. It might simply involve nurses providing information and reassurance before minor procedures. In both clinical and therapeutic relationships, the nurse views the patient first as a patient and second as a person.

Conversely, in ‘connected’ and ‘over-involved’ relationships, the nurse views the patient first as a person and second as a patient.

In the connected relationship, the patient and the nurse spend a lot of time together and the relationship has evolved beyond a clinical and a therapeutic level. The patient’s extensive needs particularly speed up this process and they decide to trust the nurse, and the nurse decides to meet the patient’s needs. The nurse acts as the patient’s advocate, protecting them and mediating on their behalf with family and medical staff.

**BOX 1. DEFINITIONS OF MUTUAL NURSE-PATIENT RELATIONSHIPS**

- **Clinical relationship** - The patient is being treated for a minor issue. The nurse spends a short time with the patient. The nurse makes an assessment and applies a treatment. The patient is satisfied with this level of involvement. The nurse’s communication and interaction is superficial and requires little emotional involvement with the patient.

- **Therapeutic relationship** - This relationship is also short term and the patient’s needs are not extensive. The nurse is able to provide care quickly and effectively because the condition is not serious or life threatening. The nurse meets the patient’s psychosocial needs, such as offering information and reassurance before minor procedures/surgery.

- **Connected relationship** - The patient and nurse have spent enough time together for the relationship to have developed beyond a clinical and a therapeutic level. The needs of the patient mean they need a more mutually connected relationship with the nurse. The patient decides to trust the nurse and the nurse decides to meet the patient’s needs. The nurse acts as the patient’s advocate, protecting them and mediating on their behalf with family and medical staff.

- **Over-involved relationship** - The nurse and patient have spent a long time together and the patient has extensive needs. They develop mutual respect and trust, and care for each other. The nurse is so involved with the patient that they fail to maintain a professional perspective.

Source: Morse (1991)

An over-involved relationship happens when the patient and the nurse spend an extensive length of time together and develop mutual respect and trust, and care for each other. The patient has extensive needs. The nurse is so committed to meeting the patient’s needs that they can overlook the treatment regimen, the consultant, the institution and responsibilities towards other patients.

**Study relationships**

Drawing on Morse’s (1991) model, it seems reasonable to suggest that the relationship between nurses and participants on the haemodialysis unit should have developed to the ‘connected’ level or could have even reached the ‘over-involved’ type.

The sheer length of time patients spend on therapy, combined with their extensive needs, demand a connected nurse-patient relationship.

The intense care and commitment needed when nursing patients who are chronically ill suggests that the relationship could potentially progress to the over-involved type.

But participants’ accounts of communicating with nurses showed that the relationship seemed to be at the clinical level. Nurses merely performed physical assessments of patients before the treatment – weight, blood pressure – and began treatment. The interaction between nurse and patient was superficial, with minimal personal involvement.

However, unlike in Morse’s (1991) description of the clinical relationship, participants on dialysis were not satisfied with the level of interaction they had with nurses.

They had expectations of nurses beyond the care needed and received. They clearly wanted more personal involvement from nurses.

These findings indicate that the nurse-patient relationship was unilateral rather than mutual.

Involvement and interaction require mutual connection. However, when one person decides not to develop a connected relationship with the other, a mutual relationship cannot be achieved. In a unilateral relationship, one person is unwilling or unable to develop the relationship to the level desired by the other (Morse, 1991).

It seemed that nurses were either unwilling or unable to develop the relationship desired by participants.

The extensive length of time nurses spent with patients each week suggests their relationship should have been more connected.

Yet this was not the case. It seemed that nurses were using strategies to inhibit interaction, which hindered the development of a positive nurse-patient relationship.

According to Morse (1991), nurses tend to use blocking strategies if they are not committed to the patient as a person, or are
‘burnt out’ and do not have the energy to invest in the relationship.

Various strategies can inhibit a connected relationship. The deliberate depersonalisation of a patient occurs when the nurse refuses to talk or chat to them and avoids eye contact.

Another strategy involves nurses maintaining an efficient attitude, giving patients the impression of busyness. This allows nurses to focus on physical tasks and avoid the more humanistic elements of care, such as providing counsel and information to patients.

These blocking strategies identified by Morse (1991) were highlighted within participants’ accounts of communicating with nurses.

For example, they indicated that the nurses appeared to be excessively busy all the time. They rarely spoke to them during therapy and seemed to be excessively busy all the time. The nurses’ failure to communicate and engage with patients prevented a connected relationship from developing. As a result, participants’ concerns and anxieties about their illness were neither acknowledged nor addressed.

CONCLUSION

Effective communication did not occur between nurses and patients on the unit. Participants indicated that nurses rarely communicated with them during dialysis, concentrating instead predominantly on the technical and physical acts of care.

The absence of effective communication has been shown to hinder the development of a connected nurse-patient relationship.

Morse’s (1991) work provides a framework to illustrate how the nurse-patient relationship had failed to reach the connected type.

We suggest that the nurses were unable or unwilling to develop a connected relationship with patients. They used strategies to inhibit their communication and interaction with clients, which prevented the development of a mutually connected nurse-patient relationship.

The literature emphasises that people with ESRD on dialysis experience many losses and lifestyle disruptions. For that reason, there is a need for nurses to provide supportive care to these patients to enable them to come to terms with their illness and treatment.

Supportive care involves the provision of holistic care to patients with renal disease from diagnosis to death (Noble et al, 2007; Reiter and Chambers, 2004). Through supportive care and disease control, patients’ quality of life can be maximised at all stages of renal disease.

Effective, open and clear communication is a key characteristic of supportive renal care throughout all stages of the illness trajectory (Noble et al, 2007). It ensures that care is focused on the desires and goals of the person. In addition, it facilitates shared decision-making between healthcare staff, patients, family and carers (Reiter and Chambers, 2004).

RECOMMENDATIONS

If patients on haemodialysis are to receive supportive care, communication and interaction with patients should be recognised as a fundamental aspect of renal nurses’ role.

A programme of clinical supervision should be set up to help nurses on the haemodialysis unit at the study hospital to enhance their ability to communicate and relate with patients.

Clinical supervision would enable the nurses to reflect on their communication and interaction with patients. Through critical reflection, they should be able to recognise the positive and negative effects of their communication patterns on patient comfort and well-being.

They would be able to identify their use of blocking strategies and seek ways in which to prevent these strategies from hindering their ability to communicate and relate with patients.

A further study should explore nurses’ perspectives of communicating and interacting with patients on haemodialysis therapy.

REFERENCES


