

# HIV and communication skills for practice

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## Abstract

The quality of communication in interactions between HIV specialist nurses and patients has a major influence on patient outcomes. As nurses, we have a responsibility to continuously strive to improve our communication skills as poor communication can be damaging and lead to confusion and poorer patient outcomes. Where communication is poor, patient care and outcomes suffer. As HIV specialist nurses, communication is an integral part of our role and could be argued to be the most important skill.

**Keywords:** HIV, communication skills, barriers to communication, conflict resolution, emotional intelligence, self-awareness, motivational interviewing, advanced communication skills, confidentiality, language

## A. Revalidation

This article has been prepared with continuing professional development (CPD) in mind and can be used to support your revalidation. It is estimated that 2.5 hours of CPD activity will be required for completion of the reading, 'time out' activities, the quiz and writing a brief reflective account in relation to your learning and its applicability to your practice. There is a self-assessment quiz at the end of this article for you to assess what you have learnt.

## B. Aims and intended learning outcomes

After reading this article, undertaking the activities and completing the self-assessment quiz you should be able to:

- understand the importance of good communication skills in the workplace with colleagues, patients and carers;
- identify the key components of good communication;
- identify barriers or blocks to communication;
- have a clearer understanding of conflict resolution, emotional intelligence, motivational interviewing and advanced communication skills;
- reflect on your emotional intelligence and current practice identifying several ways in which your own personal communication skills could be developed; and
- identify examples of multidisciplinary team (MDT) communication in your current working environment or clinical area.

## C. Introduction

The quality of communication in interactions between HIV specialist nurses and patients has a major influence on patient outcomes. As nurses, we have a responsibility to continuously strive to improve our

communication skills as poor communication can be damaging and lead to confusion and poorer patient outcomes. Where communication is poor, patient care and outcomes suffer. In the investigation of care in the Mid Staffordshire NHS Foundation Trust, poor communication played a part in almost every aspect of systemic failure [1].

As HIV specialist nurses, communication is an integral part of our role. We could argue that it is the most important skill we use in our role.

*'Patient care is the ultimate function of clinical nursing and communication is the foundation of the nurse–patient relationship and should be "open, honest and transparent" and suited to the needs and abilities of the patient or client with whom the nurse interacts.'* [2].

Riley defines communication as *'a reciprocal process ... between two or more people'* [3] which is a shared exchange between two or more people. Communication should not be one sided.

We use communication skills throughout the patient's journey. This can include: pre-diagnosis discussions and support, post diagnosis discussions and support, throughout the patient's treatment journey as they face challenges with adherence, side effects and treatment switches; patient expectations realistic or otherwise; comorbidities; breaking bad news; and finally in palliative care. HIV specialist nurses are also integral in being a patient's advocate and liaising with members of the wider multidisciplinary team. This will involve liaising with consultants, GPs, social workers, support workers and palliative care teams amongst many others. The HIV specialist nurse will also be involved in using their communication skills with family members, partners and significant others.

HIV specialist nurses often find themselves in the role of care coordinator, facilitator of multidisciplinary team meetings and case conferences. Such situations are arenas where there may be conflicting ideas, differences of opinion or professional bias. In such scenarios, where

patients and carers are present, it is important that they are treated with unconditional positive regard, feel heard and are part of any decision-making process.

Understanding both the language of HIV and a patient's degree of health literacy are major factors in engaging in meaningful and often difficult conversations. The National HIV Nurses Association (NHVNA) have produced best practice guidance (BPG) on the language of HIV which is a guide for nurses. The BPG advises to keep the language we use kind and simple, use easy to understand medically correct language, be mindful of jargon, use people-first language, educate and challenge misinformation, challenge language that stigmatises and use empathy [4].

*'Some of the terminology we hear and use is medically inaccurate, and adds to myths and stereotypes surrounding HIV. Negative terms can further add to the self-stigma for people living with HIV.'* [4].

Good communication helps patients feel at ease, feel in control and feel valued. One of the most precious things we can give to patients is our time. When we demonstrate that we are prepared to spend time with someone, to listen to them, get to know them and understand how they are feeling, we're showing that we value that person. Being able to communicate well helps us achieve this with patients [2]. It is important for us as nurses to reflect on our communication with patients and understand the importance of emotional intelligence. Emotional intelligence refers to a person's ability to discern, evaluate, control and handle his/her own emotions and that of others in a positive manner. Nurses constantly interact with many different patients and colleagues in a variety of situations; therefore, emotional intelligence is particularly important in our profession and we will discuss this in greater detail later on in the article.

## D. Modes of communication

As specialist nurses, we use many modes of communication, see Figure 1.

Understanding how patients prefer to communicate is important. Some patients prefer to communicate via text or email whilst others value and appreciate face-to-face contact. Written communication via letter or email needs to be accurate, clear and non-judgemental. Remember that patients will be sent copies of all letters if requested and need to be able to understand what is written and agree with the content. Understanding confidentiality is crucial to our role, it reassures patients and develops trust, it gives us professional credibility and integrity; it affords patients protection and facilitates good patient experience and outcome. All NHS trusts have a responsibility in law to protect personal information. Information governance training is part of mandatory training for all NHS staff, both clinical and non-clinical. When sharing, or storing any patient information several important points need to be considered:

- Who needs to know?
- Who has our patient given us permission to share with?

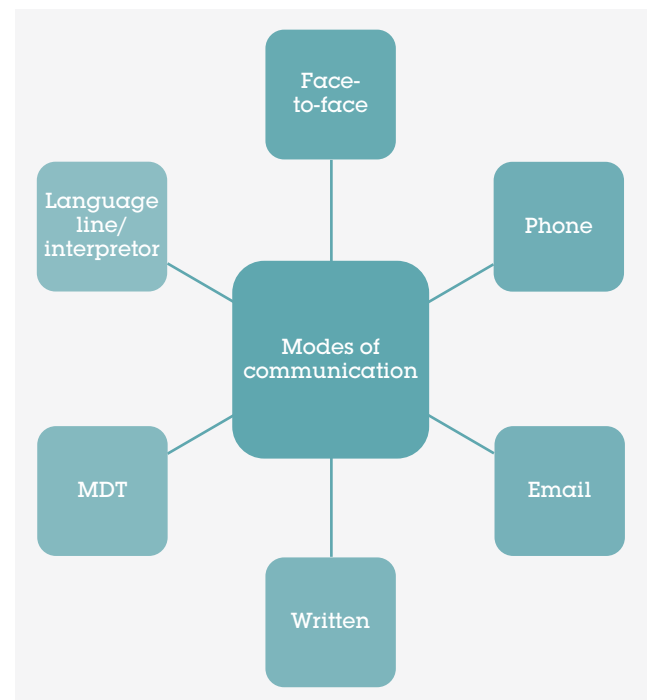


Figure 1: Modes of communication. MDT: multidisciplinary team

- Is it documented and where?
- Are sharing agreements in place?
- Are we communicating sensitive information on email addresses that are safe and secure?
- Have we fulfilled the information governance requirements for our organisation?

Face-to-face communication undertaken as a one-to-one consultation is our most common form of communication mode, however where that consultation takes place will dictate what is discussed and how it is communicated. The power balance in the nurse–patient relationship within the context of communication can shift on the basis of where a consultation takes place. Hospital based face-to-face consultations firmly put the nurse in the driving seat in terms of the environment setting, the nurse can control all the external factors or blocks to effective communication. Ideally all clinical conversations with patients should always be in a confidential setting as the norm, but there may be times when this may not be the case. Community HIV nurses' contacts with patients are, in the vast majority of cases, in the patient's own home environment where the nurse has no control over the environment, and may have little control over the external factors or blocks to effective communication. Community nurses' face-to-face-contact with patients is often controlled by the patient's personal circumstances, lifestyle or home environment. Face-to-face contact with patients can pose a potential personal safety risk.

All NHS staff should access NHS trust training on managing personal safety in the workplace, which is often linked with assertiveness and conflict resolution training.

**Time out activity 1**

Reflect on the language, and modes of communication you use with patients.

What is the mode of communication you feel most comfortable with? Look at your own communication style. What works? What doesn't work? What mode of communication challenges you?

## E. Types of communication

The aims of communication skills are to: inspire trust, build relationships, show compassion, educate patients and be culturally aware and non-judgemental. Figure 2 shows some communication methods.

### Listening

Communication can involve being quiet. Listening is vital to good communication. Really hearing what patients are saying and attending to what they say is a key skill. Remain quiet, but encourage the patient to speak with gentle head nodding as acknowledgement. When the patient has finished speaking, reflect back your understanding of what has been said for clarity [5].

### Verbal

Make sure what you say is clear, accurate, honest and appropriate (to the person's age, language/culture and level of understanding). Always be respectful and encouraging. Be aware of the tone of your voice.

### Non-verbal

Our body language says a lot about our interest in our patient, or significant other, and engagement in the communication we're having. It is important that our posture, eye contact, facial expression and touch

all match the words we are saying. Even when we say the right things, the message can be lost if our body language suggests we're thinking something different [5].

### Questioning

There are two types of questions. These are closed and open questions. To enable communication to be a reciprocal process use open questions to allow patients to talk. Open questions in turn help patients feel we are giving them time and allows them to feel valued.

### Written

Write as near as possible to the time you've delivered the care. Write simply and clearly. Write legibly (if hand-written) and as error-free as possible if keyed into a computer. Insert dates and times as accurately as possible to when specific events and circumstances occurred. Avoid giving personal opinions. Avoid writing anything judgemental or which may seem personally abusive or insulting. Report factually on what you have observed [5]. An important part of written communication and information for patients are patient information leaflets, which can be from an extensive range of providers: pharmaceutical companies with drug information, NHS advice leaflets, national HIV organisations and local service providers. It is important to ensure any written information provided to patients from a third party is patient appropriate to every individual case.

Some elements of good communication are shown in Box 1.



Figure 2: Communication methods

#### Box 1. Elements of good communication, effective listening and responding skills

- Listen without interrupting.
- Show empathy and try to understand from patient's point of view.
- Use body language that indicates you are interested and concerned; adopt a relaxed and open body posture to initiate a 'mirroring posture' by the patient or others involved to promote an atmosphere conducive to good communication.
- Gently touch the patient if it seems appropriate. Lean forward, listen intently and maintain eye contact if it is culturally acceptable.
- Do not interrupt until the patient has finished talking.
- Assure the patient that you have professional discretion.
- Avoid unclear or misleading messages.
- Avoid giving long explanations.
- Ask questions to clarify unclear messages.
- Use reflection at regular intervals during the conversation to ensure clarity and understanding, it also ensures patients feel listened to and that any concerns are heard. When possible reflect verbatim.
- Offer information that is transparent, this relieves anxiety. Do not offer your personal opinion.
- Provide a private quiet, well-lit environment without distractions.
- Stay focused on the conversation.

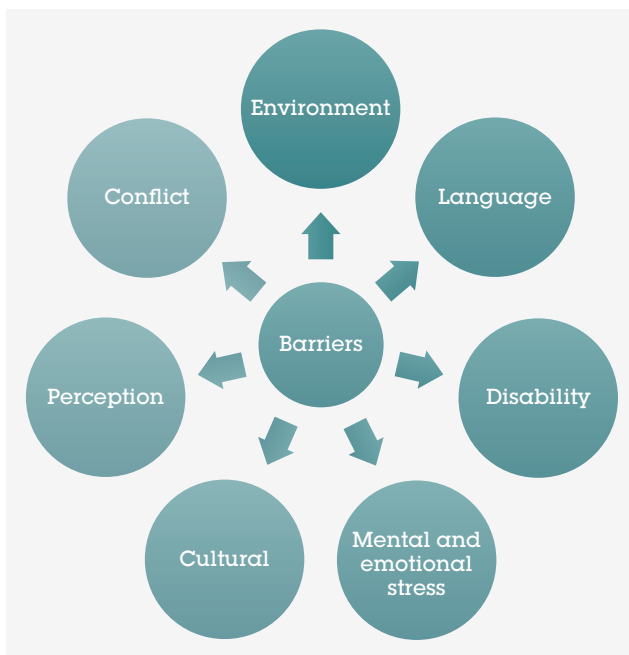


Figure 3: Barriers to communication

## F. Barriers or blocks to effective communication

The occasions when we experience aggressive behaviour are few, however good communication skills can be used to diffuse volatile situations and reduce the risk to staff safety. Barriers to effective communication can bring about a gradual breakdown in relationships, see Figure 3. The need for nurses to understand potential barriers cannot be overstated. Blocks to listening may be external or internal.

### Environmental or external blocks to effective listening

- Noisy environment
- Lack of privacy and confidentiality
- Visual distractions in a cluttered environment
- Poor preparation of the subject matter or a lack of background knowledge
- Lack of silence or pauses in the consultation
- Poor timing of appointment
- Feeling rushed, either the patient or the nurse

Be aware of the environment in which care is provided. Busy clinics, increased workload and time constraints can cause a task-orientated culture. Nurses can be more concentrated on a task than listening and communicating with their patient [2].

### Language barriers: internal or person-centred blocks to effective communication

- Is there a telephone interpreting service available if required?
- Do we have interpreters present who are gender and culturally appropriate?
- Are we simplifying the language we use or are we using jargon that the patient does not understand? [4]
- Is the language we use stigmatising? [4]

### Disability or learning difficulty

- Difficulty with speech or hearing loss restricting dialogue
- Discomfort with visible disability preventing eye contact
- Visual impairment reducing options when providing relevant literature
- Attention deficit hyperactivity disorder (ADHD)/autistic spectrum disorder (ASD) causing lack of concentration or loss of focus
- Lack of understanding owing to language barriers or poor health literacy

### Mental health diagnosis and emotional distress

As HIV nurses, the majority of us will be qualified general nurses, few of us will be registered mental health nurses. What both strands of registered nursing share is the Rogerian person-centred approach to providing care, and whilst most HIV nurses are not mental health nurses, they should have an understanding of the main principles that lie behind a mental illness diagnosis in addition to knowledge of the main features of more common diagnoses, e.g. anxiety disorders and mood disorders. This can help provide insight and understanding to a patient's experience. It is well documented that the life expectancy of those with enduring mental illness is as much as 20 years less than that of the general population and as nurses we have a professional obligation to reverse such statistics. We need to ask ourselves some simple questions:

- Are we able to recognise and respond appropriately to severe anxiety states?
- Do we allocate more time to patients with a mental health diagnosis to allow time for reassurance and reinforcement?
- Do we provide continuity of care ensuring the patient is seen by the same person whenever possible whilst being mindful of creating a dependency?
- What is our knowledge of local mental health services? Is there a crisis team locally?

### Cultural barriers

- Be aware of the language being used
- Gender issues. For example, a female patient may need to see a female nurse/doctor
- Be aware of people's spiritual needs e.g. fasting periods/prayer times coinciding with clinic times
- Be respectful to patient's religious beliefs

### Self-perception

- Sometimes our preconceived attitudes can affect our ability to listen [2]
- Our lack of awareness of LGBTQ+ appropriate language and use of correct pronouns with patient's who identify as non-binary
- Prejudice of personal appearance e.g. body art or piercings, gender, race, lifestyle, religion or LGBTQ+
- Our internal, person-centred blocks to effective listening



## Conflict

- Personality clashes
- Frustration and anger, feeling unheard, trivialising or minimising issues
- Disinterest owing to having different goals or agendas, for example patient may choose not to take treatment – respecting their choice
- Personal limits of an inexperienced staff member in a challenging situation
- Preoccupation with other problems

### Time out activity 2

Reflect on barriers you have personally experienced to communication.

What have you put in place to overcome them?

Reflect on your own self-perceptions that can be a barrier to effective communication.

## G. Communication techniques, skills and styles

Specialist nurses will acquire and learn new techniques through experience, reflection and taught courses. We will discuss communication techniques such as: conflict resolution; emotional intelligence; motivational interviewing; and advanced communication skills.

### Conflict resolution

*'Conflict is a common effect of two or more parties not sharing common ground. Conflict can be healthy in that it offers alternative views and values. However, it becomes a barrier to communication when the emotional 'noise' detracts from the task or purpose. Nurses aim for collaborative relationships with patients, families and colleagues.'* [2]

Conflict can occur at any time and in any place, between two individuals or groups when there is a disagreement or difference in their values, attitudes, needs, or expectations [7]. Good communication and conflict resolution skills can decrease the risk of conflict between us as nurses and our patients. Individuals respond in five different ways to conflict. These are: avoidance, competition, accommodation, compromise and collaboration [8]. Collaboration is the most desirable approach in resolving a conflict. It is an assertive and cooperative approach that allows individuals to be creative and find a solution that satisfies both parties' concerns and where positive patient outcomes can be achieved [9].

There are many strategies to resolve conflict. See Box 2, Johansen's (2012) ways to deal with conflict [10].

Being aware, as nurses, of our own part in creating conflict is very important. If you've done something wrong be willing to acknowledge it and say you're sorry, even if the conflict is not entirely a result of your actions. The importance of 'duty of candour' cannot be overstated. Every nurse must be open and honest with patients when something goes wrong with their treatment or care, has the potential to cause harm or

### Box 2. Johansen's ways to deal with conflict [10]

- **Recognising** early warning signs of conflict is the first step toward resolution. Paying attention to body language and being aware of the mood of our patient.
- **Be proactive** and address the issue of concern at an early stage. Avoiding the conflict may cause frustration and escalate the problem.
- **Actively listen** and focus your attention on your patient. Try to understand, interpret, and evaluate what's being said.
- **Remain calm.** Don't respond too quickly and keep your own emotions under control. Don't react to volatile comments. Do not take what is being said personally. Remaining calm will help the patient feel calmer.
- **Clearly identify** the problem. A clear understanding of the issues will help reduce miscommunication and start the process of seeking a solution and being collaborative.
- **Manage the conflict** in a way that successfully seeks to reach an acceptable solution for the patient.

distress [11]. This means that nurses must tell the patient when something has gone wrong and apologise to the patient, offer an appropriate remedy or support to put matters right and explain fully to the patient what has happened.

### Emotional intelligence

*'Emotional intelligence is a concept that may be central to nursing practice as it has the potential to impact the quality of patient care and outcomes, decision-making, critical thinking and the overall well-being of practicing nurses.'* [12]

Emotional intelligence refers to a person's ability to discern, evaluate, control and handle his/her own emotions and that of others in a positive manner. Nurses constantly interact with many different patients and colleagues in a variety of situations; therefore, emotional intelligence is particularly important in our profession. Emotional intelligence involves recognising feelings, self-monitoring or awareness, how emotions impact relationships and how they can be managed. Motivation, empathy and social skills can all be impacted by emotional intelligence [13].

Emotional intelligence includes:

- the ability to correctly identify emotions, both in self and in others;
- using these emotions to assist reasoning;
- having the capability to understand feelings;
- managing our own emotions; and
- controlling emotional situations.

Emotional intelligence helps us to become more self-aware and recognise emotions, to self-regulate and control our emotions and think before acting and finally to empathise, build and manage relationships with our patients. Emotional intelligence is especially useful in conflict resolution.

### Motivational interviewing

Motivational interviewing (MI) is an empathetic and supportive counselling style that encourages and strengthens a patient's motivation for change. As nurses,

we can all learn and acquire MI skills. The skills that MI practitioners need are those that also are needed for enabling communication in healthcare: reflection, active listening and open-ended questioning. MI is being increasingly used in the areas of health promotion, public health and primary care to support lifestyle/behaviour change [14]. MI relies on identifying patient's core values and goals and using them as a basis to stimulate behaviour change [15]. This particular style of communication is particularly useful with patients who may struggle with adherence, accepting their diagnosis, or those patients who may have decided they do not want to be on treatment. The aim of MI is to enable the patient to come to a point where they feel empowered to make a choice to change, and are not coerced by healthcare professionals to change.

### Advanced communication skills and advanced care planning

Advanced communication skills training requires highly-skilled facilitation because it challenges nurses to reflect on their current practice and explore new skills and strategies for handling complex situations. The aims of advanced communication skills are to improve patient experience through enhancing skills for communicating effectively with patients and their families with compassion, dignity and respect. Advanced communication can be used at any point during our patient's journey, however it is especially of value when a patient becomes palliative and is nearing the end of their life. Nurses are often in positions where they have to have difficult conversations with both their patients and significant others. Effective and robust MDT working is crucial at this point and making strong links with palliative care teams is invaluable.

The Preferred Priorities for Care (PPC) document is for anyone who wishes to plan for their future end-of-life-care. The PPC gives patients a chance to think about, talk about and write down what they would like to happen with the care they want at the end of their life [16]. This is not a legal document, however, patients should be encouraged to share it with significant others and those involved in their health care. As specialist nurses, we often know our patients best and are therefore best placed to help then fill in this document even though it may be uncomfortable and difficult.

Everyone has the right to refuse cardiopulmonary resuscitation (CPR) if they wish. Patients can make it clear to their medical team that they don't want to have CPR if they stop breathing or their heart stops beating. This is known as a do not attempt cardiopulmonary resuscitation (DNACPR) decision, or DNACPR order [17]. Again, as specialist nurses we are best placed to have these difficult and sensitive conversations with our patients sometimes being the only ones who broach the subject. Once a DNACPR decision is made, it's put in the patient's medical record, usually on a special form that health professionals will recognise. A DNACPR order isn't permanent, and

patients can change their mind at any time. Always ensure that patients have the mental capacity to make these decisions including refusing treatment [18].

Managing silences can be difficult; however they can be very productive. It can take some time to be comfortable with silences. Allowing silences gives the patient space to reflect. Sometimes patients are very nervous, especially if they are relatively new to us, are recently diagnosed or are facing great difficulty, and protracted silence may be excruciatingly uncomfortable for them. Patients can often get lost in their own thoughts and feelings or feel overawed by them. If this becomes apparent it's advisable to acknowledge their discomfort and saying something like, '*I imagine it's very difficult for you*' or '*Are you feeling uncomfortable?*' Such a response will break an uncomfortable silence and likely lead to a continuation with the conversation. Silence may also be a sign that the patient is hoping for something to come from the nurse; this might be reassurance or confirmation that the nurse has been listening or has understood what has been said. This would present an opportunity for you to summarise what has been said.

Challenging patients and others as an advanced communication skill can be used to help patients explore inconsistencies in how they communicate or express themselves. We must remember that it's the behaviour that is challenging rather than the patient. Challenging or confronting patients works best when a good nurse–patient relationship has been established, this is because the patient is less likely to experience the challenge as a criticism or feel threatened. When used in this way, challenging or confronting patients can ensure the patients make good use of it, which can facilitate more meaningful communication or disclosure. Being challenged can be therapeutic because it provides an opportunity for nurses and patients to explore areas where they feel 'stuck'. When we are constructively challenged, it invites us to own our behaviour and to accept responsibility for it.

The term 'immediacy' relates to communicating with patients in the 'here and now'. The skill of using immediacy appropriately can be used to:

- bring patients back into the present when conversations are directionless;
- change the dynamic of the conversation to be more meaningful during difficult conversations or where there is tension and anger;
- challenge the nurse–patient relationship by looking at the 'here and now', this is especially relevant when there is a deep level of trust on behalf of the patient and they feel a sense of congruence;
- help the patient see more clearly and take ownership of what is happening;
- give the patient an opportunity to air any anxieties, doubts or challenges they may feel; and
- deflect transference, when the nurse feels personally affected by what has been said by the patient, this could be the disclosure of a traumatic event or comments of a more personal nature. It may also

be owing to communicating with a patient with severe depressive illness, leaving the nurse feeling emotionally exhausted afterwards.

If we look at self-disclosure, nurses occasionally feel it's appropriate to share some personal experience or details about themselves with patients. It is important that this should not be done to meet the needs of the nurse. The purpose of self-disclosure on the part of the nurse is to model non-defensive self-disclosure, to enter into a fuller congruent person-centred relationship with the patient.

### Time out activity 3

Reflect on your own emotional intelligence.

What do you understand by the term emotional intelligence? Are you comfortable with silences? Has there been an appropriate time where you challenged a patient? What was the outcome? Have you ever used self-disclosure? If so what made you choose to do so?

## H. Internal constructs and communication: nursing perspective

### Equality and diversity

The Equality Act 2010 has relevance to how we communicate with patients, in its broadest sense through legislation stating that services must be inclusive to everyone in our society regardless of gender, age, race, disability, religion or sexual orientation.

This is of particular importance with patients who have additional communication needs as previously highlighted. However, how we communicate with patients on a personal level because of own belief systems and values can often be called into question, do we provide:

- empathy – the ability to communicate understanding of a patient's experience from the patient's perspective;
- integrity – by committing to being professional including communicating openness, straightforwardness, honesty and transparency;
- respect – showing appropriate esteem for patients and their understanding of themselves and communicate this in our actions;
- care – are we benevolent, competent, and are we addressing every patient's communication needs and facilitating personal agency; and
- diligence – do we deploy our skills and knowledge to communicate in a way that achieves a beneficial outcome and a good patient experience?

### Self-awareness and personal development

Our own personal beliefs and values can have an effect on how we treat and communicate with others and this can sometimes be true when dealing with patients. It is important that we have an understanding of both our own 'self' in relationship to others and our personal belief systems to ensure that we treat patients with

equity and ensure that they feel treated with unconditional positive regard.

Our personal and professional moral qualities are our own internalised values that shape how we relate to our environment and communicate with our patients. High levels of compatibility between personal and professional moral qualities will enhance professional integrity and personal resilience. Humility or the ability to assess accurately and acknowledge our own strengths and areas for personal development will facilitate better relationships both in the workplace with colleagues and patients, and in our own personal lives. By adopting qualities such as positive regard, acceptance and empathy we can be closer to yet at the same time more detached from the patient we want to help, and provide an objective communication style rather than an emotive or subjective one.

### Clinical supervision

Clinical supervision is a professional practice requirement for all registered nurses, it is also mandatory in a great many other 'helping professions'. Supervision is often confused as a form of counselling, which it clearly is not meant to be. Supervision demonstrates professional accountability and candour by reviewing our work with patients and colleagues. This is important because it ensures regular contact with other peer professionals, it is supportive, constructive and exploratory, it encourages the examination and review of professional practice.

Clinical supervision in the context of communicating with patients can be the appropriate forum to reflect on difficult conversations, on how things may have been done differently, or situations where there is an opportunity to have a positive influence on future practice. Supervision can be used to highlight a way forward in difficult situations or when working with patients who present with challenging circumstances or clinical complexity. Clinical supervision is also a vehicle with which serious concerns can be escalated to the appropriate level, this can be of relevance when caring for vulnerable patients when a potential safeguarding issue may be communicated to a nurse during a consultation.

### Time out activity 4

Reflect on your political and spiritual beliefs and how you communicate with patients.

What political beliefs do you hold? What spiritual beliefs do you hold? How did you come to have these beliefs system?

How do you think these beliefs affect your views on supporting and communicating with patients?

How would you act as a nurse if you fully acted out your political and spiritual belief?

Is caring and communication for all patients equally in harmony with your political and spiritual beliefs?

Make a note of your responses.

What feelings came up for you when reading through each of the points?

## I. Conclusion

How we communicate with patients will often dictate a clinical outcome. Good communication skills are essential tools that enable us to provide person-centred care. Every patient differs in the way they react emotionally and psychologically to an HIV diagnosis and coping with the subsequent life adjustment that is needed to optimise their physical and mental health. As experienced HIV nurses we are experts at managing the condition process that is HIV, however for that expertise to follow through with excellent nursing care we should ensure that we possess the level of communication skills required to help patients interact with us and encourage them to identify and articulate their needs, fears, anxieties and a desire for advice, guidance and support. Nurses' communication skills must also facilitate relational depth where there is an enduring sense of contact and interconnection between us as providers of HIV care and our patients.

*'Communication is at the heart of everything we do in our society. It's central to our learning, our work and our leisure interests. But it's particularly important in health care, where patients can feel vulnerable, alone and frightened, and where you'll be working with colleagues in the health care team who rely on good communication to help them deliver safe, coordinated and effective care.'* [6]

## J. Useful resources

Preferred Priorities of Care document <https://www.ntw.nhs.uk/content/uploads/2019/05/NTWC49-App01-Prefd-PrioritiedPPC-Care-V02.pdf>

Do not resuscitate (DNR) <https://www.nhs.uk/conditions/end-of-life-care/advance-decision-to-refuse-treatment/>

Mental capacity act. <https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/>

## K. Acknowledgements

We would like to acknowledge our patients and all they have taught us over our careers and the importance of effective communication. We would also like to thank our colleagues in the wider HIV team in Liverpool.

## Funding

This article has been supported by an educational grant from MAC AIDS Fund. The company has had no editorial input to the article.

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