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What does this paper contribute to the wider global clinical community?

This article presents a new therapeutic communication model to support nurses to engage with patients suspected of or confirmed with COVID-19

We highlight and draw from nursing and psychological literature to devise a user friendly TAGEET model that provides practical guidance for nursing clinicians

We address the emotional impact of COVID-19 on nurses and provide some guidance for nurses on self-regulation, self-management, and self-care at a difficult time for nurses

Aim
To design and present a new communication model "TAGEET" to help nurses engage therapeutically with patients suspected of or confirmed with COVID-19.

Background
COVID-19 is a highly contagious disease that brings with it fear and anxiety for all involved inclusive of nurses and patients. New guidelines for nurses to follow such as attention to physical distance coupled with the wearing of defined personal protective equipment, gloves, long-sleeved disposable gown, FFP2 face mask, and eye protection places additional strain on nurses to engage therapeutically with patients. Evidence suggests that the wearing of face masks and personal protective equipment act as barriers to effective therapeutic engagement with patients. We found an absence of communication models to help nurses engage therapeutically with patients.

Design
This is a position paper that draws on previous research to inform the design of a new model for nurses to engage therapeutically with patients suspected of or confirmed with COVID-19.

Method
We reviewed the literature on caring for patients in isolation, the barriers to therapeutic communication and the psychological impact of infectious diseases on nurses and patients.

Conclusion
Remaining emotionally present to self, whilst being present to others can be challenging for nurses in a pandemic environment. We believe that the "TAGEET" model (**T-** Tune-in, **A -** Approach and introduce, **G -** Ground self, **E -** Engage and respond, **E -** End encounter, **T -** Tune-out), although devised for nurses to engage therapeutically with patients suspected of or confirmed with COVID-19 could be used by all healthcare professionals in any challenging clinical environment.

Relevance to clinical practice
This new therapeutic communication model will provide support for nurses with how to manage self in the context of caring for others in a COVID-19 environment

Keywords: communication model, communication skills, COVID-19, emotional regulation, interpersonal, nurses, pandemic, therapeutic engagement.

1.0 INTRODUCTION

With the arrival of the COVID-19 virus, healthcare workers (HCWs) have had to modify the way they engage and communicate with patients/clients to meet stipulated healthcare guidelines. Hence, nurses' therapeutic engagement with patients may now be different to the evidence-based methods taught heretofore in healthcare education. The lack of scientific

evidence about COVID-19 has contributed to much fear, anxiety, uncertainty, and a heightened fear of contagion for all involved (HCWs, patients and their families). Evidence of high mortality rates from Covid-19, at time of writing this article known to be 870, 286 globally (World Health Organisation **[**WHO**],** 2020a) coupled with the knowledge that over 230,000 HCWs have contracted the disease, more than 600 nurses have died (International Council of Nurses **[**ICN**],** 2020), and over 3,000 HCWs have died from the virus (Hilliard, 2020), has put an additional unprecedented strain not only on nurses but on all frontline staff.

When caring for patients suspected of or confirmed with COVID -19, HCWs must adhere to new and strict healthcare guidelines. For example, HCWs must maintain a physical distance (where possible) and wear appropriate personal protective equipment (PPE) when attending to patients suspected of or confirmed with COVID-19. Whilst experienced HCWs may have some experience caring for and communicating with patients with a highly contagious disease/illness, most however will not, or at least not during a pandemic, and consequently this experience will be entirely new. Therefore, there is a need to revisit nurses' therapeutic engagement and communication skills in the context of caring for patients suspected of or confirmed with COVID-19.

1.1 Aim

The aim of this position paper is to present a new therapeutic communication-model that uses a mnemonic to provide an easy to recall and practical step-by-step guide for nurses to engage therapeutically with patients suspected of or confirmed with COVID-19 in the clinical environment.

2.0 DESIGN AND METHOD

This is a position paper that draws on previous research literature. This literature deals with caring for patients in isolation, barriers to therapeutic communication, and the psychological

impact of infectious diseases on nurses. This is undertaken to inform the design of a new model for nurses to engage therapeutically with patients.

3.0 BACKGROUND

COVID-19 is a highly contagious disease with the added risk of severe acute respiratory infection and serious threat to life. Healthcare authorities in each country have issued their own guidelines for healthcare staff in the nursing care and management of patients with COVID-19. For example, in Ireland the Health Service Executive (HSE, 2020) has stipulated that concurrent with standard infection control and isolation precautions, healthcare professionals (HCPs) must where possible maintain a physical distance of at least 1 metre, but ideally 2 metres, from individuals with respiratory symptoms. In addition, HCPs must use defined PPE when caring for suspected or confirmed COVID-19 persons. This includes the wearing of gloves, long-sleeved disposable gown, FFP2 respirator face mask, and eye protection (goggles or face shield), as outlined by the WHO (2020b) and the European Centre for Disease Prevention and Control (2020).

Evidence suggests that the wearing of PPE by HCPs is a physical barrier to effective communication with patients who are in isolation (Wong et al., 2013). One of the main problems reported by patients is their difficulty in distinguishing a nurse from other HCWs (Clavelle et al., 2013). Roderick et al. (2017) explored hospitalised patients' (n=50) preferences regarding their ability to identify the types of HCWs wearing isolation gowns. Most patients in this study (n=28, 56%) reported that all HCWs should wear a pre-printed large font adhesive sticker badge on the outside of the isolation gown stating who they are e.g. Registered Nurse (RN) or other. Qualitative analysis of patients' comments in this study highlighted the need for all HCWs to introduce themselves with their name and HCW type

every time they enter the patient's room (Roderick et al., 2017). Hence the importance of introductions and the wearing of a name badge by nurses, or other HCWs, is critical to patient care.

Face masks have also been identified as a barrier to effective communication**,** with many patients reporting that they prevent them from identifying facial features and expressions of HCWs (Padhy et al., 2020; Wong et al., 2013). Wong et al. (2013) explored the effect of doctors wearing face masks on patients' (n=1,030) perception of doctors' empathy, patient enablement, and patient satisfaction in Primary Care clinics in Hong Kong. Using a randomised controlled trial (RCT) and two groups of patients (n= 514 doctor-mask consultations and n = 516 non-mask consultations) Wong et al. concluded that the wearing of a face mask during consultations had a significant negative impact on the patient's perceived empathy and also diminished the positive effects of relational continuity. It is important therefore, for nurses to be aware of the impact that wearing a face mask and PPE can have on empathic communication, and this is critical for effective therapeutic engagement.

Isolation precautions are considered an essential public health measure for infection control, nonetheless, there is considerable evidence of adverse effects of isolation in hospitalised patients (Sharma et al., 2020; Tran et al., 2017; Vottero, & Rittenmeyer, 2012). These precautions are generally used for hospitalised patients with known or suspected colonization with pathogens transmitted in hospitals. Isolation precautions encompass a single room, restriction of the patient's movement, and the wearing of PPE by healthcare staff and visitors (Siegal et al., 2007). Indeed, there is strong evidence to suggest that the use of these precautions can have a positive impact in preventing the transmission of pathogens such as Methicillin-resistant staphylococcus aureus (MRSA; Loveday et al., 2006) and Severe Acute

Respiratory Syndrome (SARS; Seto et al., 2003). These precautions are known to have a negative psychological impact on patients. A systematic review conducted by Abdad et al. (2010) concluded that isolation had a negative impact on the mental health of hospitalised patients, as was reflected in higher scores obtained for depression, anger, and anxiety. Tarzi, et al. (2001) also reported significantly higher levels of depression and anxiety in isolated MRSA-positive older adults (n=22) than those found in the MRSA-negative cohort (n=20). In a recent meta-analysis conducted by Sharma et al. (2020) high levels of anxiety and depression were also identified as evident amongst isolated hospitalised patients. Arguably, some of the negative effects may be due to the fear and uncertainty surrounding isolation, the severity of symptoms, the lack of knowledge and/or understanding of isolation precautions or indeed the disease itself, particularly if little is known about the illness trajectory. Preparing patients psychologically and emotionally prior to isolation coupled with regular good communication with HCPs may reduce some of this fear, uncertainty, anxiety, and depression experienced by patients.

Numerous studies have reported on the adverse psychological effects of the 2003 SARS outbreak on HCWs (Bai et al., 2004; Chua et al., 2004; Maunder et al., 2003; Shih et al., 2007; Tam et al., 2004). Some of these negative sequelae include fears of contagion, anxiety, anger, conflict between roles as HCW and role as parent (Maunder et al., 2003), tiredness, worry about health, fear around social contact (Chua et al., 2004), financial worries, as well as high mortality risk to self, family and others (Shih et al., 2007). Thus, we argue that caring for patients suspected of or confirmed with COVID-19, coupled with the fear and anxiety that surrounds COVID-19 for all stakeholders, puts additional strain on nurses to be and/or remain emotionally present during therapeutic communication encounters with patients. Indeed, we contend that nurses' therapeutic communication, and presence, is even more critical given

that in the current pandemic climate patients are not or may not be allowed any family members and/or visitors whilst in hospital/nursing home and/or in isolation. Remaining emotionally present and being able to engage therapeutically with patients is difficult given the fear, uncertainty, and threat to life on the nurse as well as on her/his own family/friends/colleagues.

4.0 THERAPEUTIC COMMUNICATION AND ENGAGEMENT

Therapeutic communication (TC), a term first coined by Jurgen Ruesch in 1961, refers to an interactive process between nurse and client to achieve health-related goal(s). It encompasses both verbal and nonverbal communication in the context of a healing conversation with a specific health-related purpose. Therapeutic conversations are designed to offer a safe, empathic way for patients/clients to explore the meaning of their illness experience and to learn the best ways of dealing and/or coping with the situation (Arnold & Boggs, 2019). Over the years, several theories and viewpoints of therapeutic communication have been proposed e.g. by Peplau (1991), Northouse and Northouse (1992), Knapp and Hall (2013), Potter et al. (2017), and De Vito (2019). Nonetheless the basis of effective therapeutic communication involves good professional interpersonal communication between patient and nurse. Here we argue that the skills required by nurses to engage therapeutically with patients suspected of or confirmed with COVID-19 require a high-level of emotional awareness, flexibility, and sensitivity in order to sustain emotional presence.

Engaging therapeutically puts specific challenging demands on nurses to be emotionally present and empathic with patients amidst the anxiety and fear generated by COVID-19. Evidence suggests that emotional sharing with poor self-regulation can lead to personal distress, thereby decreasing HCPs' capacity to show empathic concern (Decety & Lamm, 2009; Figley, 2012). A study conducted by Gleichgerrcht and Decety (2013) reported that

empathic HCPs, especially those who experience intense and prolonged exposure to patients, develop burnout and/or compassion fatigue. Hence, we contend that nurses engaged in therapeutic communication with patients in a COVID-19 healthcare environment must strive to achieve a balance between being emotionally present and empathic whilst at the same time maintaining the required physical distance to protect self. The challenge for nurses is to manage their own feelings and emotional expression while caring for patients, a process known as emotional labour (Hochschild, 1983). It is suggested that where there is heightened anxiety, intense fear and/or uncertainty in a clinical environment nurses may surface act by hiding feelings or faking emotions as a strategy, rather than engaging in deeper acting and displaying genuine emotions (Diefendorff et al., 2011**).** An additional challenge and pressure for nurses arises from the belief that they should only express positive emotions and suppress those considered to be negative (Brotheridge & Grandey, 2002).

As nurses adjust to a new clinical pandemic environment, they must also adjust and adapt their communication skills to meet the needs of their patients. Communication frameworks and models can provide the scaffolding to guide and support nurses' communication skills with patients. Indeed, several models and frameworks have been proposed and used by nurses. One such framework is Heron's six category intervention framework (Heron, 1989), but as pointed out by Tennant and Butler (2007), this framework does not take into consideration the healthcare practitioner's context, self-awareness, and emotional competence. Other beneficial educational models developed include SOLER (Egan, 2010) and more recently SURETY (Stickley, 2011), both focusing on non-verbal communication skills only.

5.0 "TAGEET" THERAPEUTIC COMMUNICATION MODEL

In the absence of a comprehensive, user-friendly model or framework to guide nurses to engage therapeutically with patients in stressful and challenging situations such as COVID-19, we developed the "TAGEET" model of therapeutic engagement. We believe this model will be particularly helpful to nurses who may be feeling overwhelmed or anxious, or who are experiencing role conflict whether as nurse or parent, or who may be under time pressure, or may be juggling many caring activities, and/or maybe unfamiliar with such a stressful clinical environment. The TAGEET model is an action-focused process model in that it "provides practical guidance in the planning and execution of endeavours/strategies" (Nilsen, 2015. p.3).

TAGEET MODEL

T- Tune-in

A - Approach and introduce

G - Ground self

E - Engage and respond

E - End encounter

T - Tune-out

Each of the above six points will now be presented and explained in more detail.

5.1 Tune-in

For the nurse, to tune-in involves becoming aware of and balancing the needs of self, others, and the situation (that of working in a specialist area such as a COVID-19 ward/unit, hospital or other healthcare environment). Self-awareness involves that the nurse check-in initially on their own thoughts, feelings, and behaviours, while reminding themselves of their previous experiences, confidence, and competence (also known as self-efficacy; Bandura, 2004) acquired to cope in stressful situations. This knowledge and belief will help nurses when stepping into the current clinical situation. The nurse's feelings about the clinical situation

could influence his/her actions. For example, feelings of fear, anxiety, and/or discomfort when dealing with patients suspected of or confirmed with COVID-19 could lead to the nurse minimising or even avoiding contact with those patients. By being self-aware and confident the nurse is more likely to be able to manage his/her own feelings and emotions and stay in charge, rather than becoming overwhelmed by them (Goleman, 2011). In addition, for the nurse to remain present, and connect therapeutically, it is important that the s/he feels safe in their working environment i.e. an awareness, knowledge, education, and implementation of any up-to-date safety clinical procedures and/or protocols.

5.2 Approach and introduce

Approach and introduce self to patient giving your name and professional role e.g. staff nurse/other while using a clear visual aid (a label with your name and role and why you are present). It is important that the patient knows who you are behind the PPE and why you are present so that s/he can give consent for any caring task/procedure. This should give the patient more clarity and some control which may help to alleviate their anxieties and fear**s**. Check the patient's communication ability, sight, hearing ability**,** and any tailored communication techniques. Check for safety of self and patient. Good introductions help to connect and humanise contact with patient, whilst also supporting the development of a therapeutic nurse-patient relationship (Guest, 2016). Some patients with COVID-19 may have breathing difficulties or may have an oxygen mask in situ and struggle to communicate verbally, but may still want to communicate with HCPs, hence nurses need to have access to pen and paper or a communication board.

5.3 Ground self

Grounding self helps the nurse to calm, relieve stress, anxiety, or tension so that s/he may be more present and connected with self and patient. There are several techniques that nurses may use to ground themselves, but here we introduce two - so nurses may choose one or the other. 1) Take a deep breath and ensure your feet are positioned firmly on the ground, whether standing or sitting, so that you feel rooted like a tree as opposed to feeling unanchored as you would be when caught up with negative thoughts and/or feelings. Next, do a quick self 'body scan' to help you become more aware/mindful and less tense (Call et al., 2014; Dreeben et al., 2013). Start at the top of your head and move down along your body to check where you might be feeling tension. If, or when, you sense tension, direct your natural breath to relax that part. Alternatively, if you have trouble relaxing then try tensing that part of the body and hold tightly for a few seconds, then let go and feel yourself ease down slowly. 2) Another quick exercise that some nurses may prefer is to 'count to 10 and breathe'. For 10 breaths focus on breathing out, counting how long it takes you to exhale (usually 4-10 seconds), pause for a count of 2-4 seconds, and then inhale for a count of 4-8 seconds. By focusing on breathing slowly you are distracting your mind from negative or anxious thoughts. In a few minutes after this simple grounding technique, you should feel your body at ease or less tense and be able to think more clearly. To get the most benefit from these mindful/grounding exercises it may be helpful for nurses to practise engaging in these more frequently, and for a longer period of time, perhaps with the support of an audio, script, or class to help deepen and familiarise oneself with this practice.

5.4 Engage and respond

Engage with patient, attend to your non-verbal communication, for example, posture, eye contact, hand gestures and any other signals that might put the patient at ease. Try to adhere to distance guidelines to keep safe but maintain a position that enables communication at eye level, if possible. Ensure that your gestures are conducive to conveying therapeutic

engagement and are relevant to the patient's situation. Speak loudly, slowly, clearly, sensitively, thoughtfully, and courteously. Ensure that your tone of voice expresses interest, respect, and empathy, and is congruent with the message you are conveying. Tone of voice is critical to convey understanding and needs to be slow and steady yet loud enough to be heard through the face mask/visor. Speaking through a face mask and visor is difficult not only for the nurse but also for the patient who, in the absence of not seeing the nurse's lips to confirm content, may find this method of communication difficult to comprehend and/or difficult to hear. Ensure that the patient can see your eyes so as to make a humane connection. Use open/closed questions as appropriate and encourage the patient to ask questions during your time together. Ask only one question at a time and be mindful that you may need to repeat it.

Listen attentively, especially for feeling words which may indicate fear, anxiety, sadness, loneliness, grief, depression, or indeed issues to do with mortality. Do not interrupt or rush a patient who has breathing difficulties. Listen for concerns relating to self/family/others or the patient's need for information or education about illness/ isolation/other. Briefly check in with yourself, or as Egan (2010) suggests, keep an ear lightly tuned to self, so that you can regulate your own emotional state whilst staying present to the patient. This includes compassionately (as opposed to critically) checking in and identifying any internal negative emotions, such as helplessness, hopelessness, fear and/or sadness, whilst pausing and internally acknowledging to yourself that these are common, human emotions (Neff, 2003). Also, remind yourself of any supports/resources that may be drawn on at a later point. Respond appropriately, thoughtfully, therapeutically, and empathically while tuning in to own feelings and emotions. Demonstrate empathy and sensitivity by acknowledging and validating the patient's feelings. Check how much the patient wishes to know so they are not overwhelmed. You may need to get consent from the patient to discuss their health issues

with an appropriate chosen family member or significant other. Respect the patient's wishes about not disclosing sensitive issues. Responses that indicate skilled therapeutic listening include clarification, restatement, paraphrasing, reflection, and summarisation (Arnold & Boggs, 2019). Be sensitive and allow the patient time to breath, time to cry, and periods of silence where relevant. It is important that the patient feels they were listened to with respect, and that the nurse show empathy, genuineness, and unconditional positive regard in her/his responses (Rogers, 1957). Answer the patient's questions and queries openly and honestly, within the confines of your role, or where necessary inform the patient that you will refer their queries to appropriate personnel.

Therapeutic engagement although contingent on the needs of the patient demands that the nurse can deal with her/his own and the patient's emotions in what is known as emotional regulation (Gross, 2014). It is important to recognise that engaging in a difficult healthcare conversation may deeply touch the nurse's own experiences and emotions. Arising from their own personal experiences, a nurse may feel anger, fear, sadness, complicated by issues of mortality. Furthermore, a nurse may have conflicting emotions such as honest despair contrasting with hope (Sheldon et al., 2006). A nurse may dismiss some questions for fear of becoming overwhelmed or, use blocking behaviours **(**Chan et al., 2019; Chinweuba et al., 2013) to avoid discussing patient's psychological issues. Hence the feelings about the content of the interaction must be balanced with feelings about what is happening to self or other in the situation (Hargie, 2006). The nurse must listen not just to the patient but also keep an ear lightly tuned into self (Egan, 2010) so she or he can listen effectively to the other person.

5.5 End the therapeutic encounter

End the therapeutic encounter by checking with the patient for understanding of content, information and/or education provided, clarify any misunderstandings, summarise conversation, and indicate next link and/or how-to further access healthcare staff, if needed (Arnold & Boggs, 2019). Inform the patient if you are referring to another HCP. Assure the patient of confidentiality if you are engaged in a sensitive, personal, and/or difficult therapeutic encounter. Building trust in the therapeutic encounter may take time (Egan, 2010). If you have built a relationship with the patient, they may now feel able to ask a question that they were too vulnerable to ask earlier on in the encounter. Prior to leaving, remind the patient to write down any questions they may have between your or other nurse visits as this will help with later engagement.

5.6 Tune-out

Take time to tune-out and let go of feelings that are damaging to yourself or likely to restrict your adjustment to new clinical situations. Take a minute to "**PAUSE**" and reflect on the encounter or event. Check back in on yourself, check for feelings of being overwhelmed, anxiousness, worried, defeated, exhausted, fatigued, helplessness, numb, grief stricken and/or sadness. Most importantly, check for and savour any positive feelings that arise, such as feelings of satisfaction, purpose, affection, gratitude, appreciation and/or self-worth. According to Bartels (2014) the pause helps to "slow our racing minds, offering space so we are not drawn into the vortex of failure versus success" (p.75). It is important to draw on any familiar resources or coping mechanisms to bracket or start to let go of difficult, disturbing, or challenging encounters or issues so as to continue caring for other patients. Some examples of coping mechanisms include mindfulness, breathing techniques, drinking a cup of tea/coffee, a walk to a window or other strategy chosen by the nurse. Check also if you require external support from peers/therapist/counsellor/other to help reduce anxiety, to enhance peace of mind, and/or to feel connected to others (not so alone). Taking time to tune-

out and debrief is known to enhance nurse's ability to deal with critical events and/or manage stressful work environments (Royal College of Nurses [RCN], 2019). Talking about what happened, sharing thoughts, feelings, and experiences with peers/other may help to reduce **the** psychological impact. It is important to acknowledge the need for advice/help/support and/or self-care if feeling challenged or struggling with a difficult therapeutic encounter(s). Not acknowledging need for emotional support may lead to disconnection and burnout. All nurses need to engage in self-care activities outside of work such as participating in leisure, social, or any fun activities. These may help with reducing tension, angst, pressure, or guilt. Self-care strategies may help with stepping back mentally and/or physically from stresses or strains experienced, and thus help to rejuvenate and restore the nurses' energy and vitality.

6.0 CONCLUSION

Therapeutic engagement is essential in all areas of healthcare, but is even more critical in very challenging clinical environments, for example, in the environment where there are patients suspected or confirmed with COVID-19. This is a highly contagious disease that brings with it not only fear, worry, and anxiety about contracting the virus, but also a fear of serious illness and death. The need to share these feelings and anxieties with others is important for both nurses and patients alike. Hence, remaining emotionally present to self, whilst being present to others can be extremely challenging for nurses in this environment. The therapeutic engagement model "TAGEET" introduced here although devised for nurses caring for patients suspected of or confirmed with COVID-19 could be used by all HCPs (doctors, physiotherapists, social workers and others) in any challenging clinical care environment. Indeed, the authors believe that this new model, once learned, could be transferred to any clinical care situation involving challenging therapeutic encounters inclusive of palliative and End-of-Life healthcare. We also suggest that academic and clinical nurse/midwifery educators draw on the TAGEET model to educate students at

undergraduate and postgraduate levels to enhance their therapeutic engagement with patients or clients or women.

7.0 RELEVANCE TO CLINICAL PRACTICE

This new therapeutic communication model will provide guidance and support for nurses with how to manage and regulate their own emotions in the context of caring for others in a COVID-19 or any other challenging clinical environment.

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