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Emotional intelligence – essential for trauma nursing

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ABSTRACT

Patients and their relatives are increasingly considered partners in health and social care decision-making. Numerous political drivers in the UK reflect a commitment to this partnership and to improving the experience of patients and relatives in emergency care environments. As a Lecturer/Practitioner in Emergency Care I recently experienced the London Trauma System as a relative. My dual perspective, as nurse and relative, allowed me to identify a gap in the quality of care akin to emotional intelligence. This paper aims to raise awareness of emotional intelligence (EI), highlight its importance in trauma care and contribute to the development of this concept in trauma nursing and education across the globe.

1. My story: one patient – two perspectives.

The phone rings to alert the arrival of another trauma patient. The team members gather, prepare their equipment, confirm their roles and take their positions.

My phone rings to alert me of a trauma patient. I need to attend.

The patient arrives. The team members busy themselves with the primary survey. Efficiently moving around the patient, the team assesses the airway, protects the cervical spine, delivers oxygen, inserts lines, performs a CT: all within 30 minutes.

Meanwhile, I'm waiting for information about the trauma patient. What's the diagnosis? What condition is he in?

The patient returns from CT – confirmed flail chest, pulmonary contusions, fractured T5, multiple rib and transverse process fractures. Monitoring continues, alarms beep, analgesia is administered. The team disperses.

Finally I arrive to see the patient. But this is no ordinary patient and I am no longer a nurse. This is my husband. Lying in a gown he appears vulnerable, the pain etched on his face. My children ask, "What's wrong with Daddy?"

This is my story, not as an emergency nurse but as a relative experiencing the London Trauma System. Whilst I prepare dinner one evening my husband lay injured on a wet road, more than 30 miles from home. Amnesic but conscious, he asked a bystander to call me. I heard how my husband was in severe pain and found it difficult to breathe. The sirens were the last thing I heard.

Like a priority call I was given a 'heads up' but rather than methodically preparing equipment and calmly greeting the trauma team, I was panicking. Feelings of anxiety, distress, uncertainty and anger shook my foundations. The next few hours proved to be the most distressing of my life. Still at home and with no further information, my mind was racing. Would I receive that dreaded knock on the door? I finally got a call from an ED nurse 3 hours later.

As an emergency nurse the worst case scenarios are ingrained in me but at that moment I wasn't a nurse. I was firmly placed on the 'other side' as a relative. It was in this state and carrying these emotions that I finally arrived at the hospital with my two children.

What struck me when I first saw my husband was his vulnerability. The gown did little to secure his dignity or identify him as an individual and his pain was tangible. The trauma team had dispersed; a doctor remained to suture his leg. There was an air of efficiency in the department and staff went about their business calmly yet little time was spent engaging with either myself or my husband. Engagement can be described as 'being there', yet I felt that the staff were somewhat detached, focusing only on the technical aspects of care. Contact moments with staff were dominated by clinical skills such as providing analgesia, suturing and recording vital signs. Although staff members were not unkind, friendly

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Table 1
Three types of intelligence required for excellent emergency nursing care.

Abstract	Concrete	Emotional
Calculating drug doses	Proficient and safe use of medical devices/equipment	Interpersonal skills
Calculating EWS	Clinical skills (for example)	Active listening
Calculating burns	IV administration	Eye contact
SBAR communication	Venepuncture	Caring touch
ECG interpretation	Cannulation	Engagement; 'being there'
Information giving and advice	Performing, interpreting and recording vital signs	Body language (use and reading)
Pattern recognition (triage, decision-making)	Chest drain set-up and monitoring	Friendly tone of voice
Problem solving (using cognitive ability)	ECG recording	Respect for differing opinions
	Documentation	Sitting with the patient
		Problem solving (using emotions)
		Empathy
		Understanding others
		Responsive to needs
		Sensitivity
		Self-awareness
		Managing emotions (own and others)
		Holistic care
		Physical and emotional comfort
		Attention to environment in line with patient needs (privacy, safety)
		Family centred care

conversation in an attempt to get to know my husband as an individual was lacking. No one approached me to explain what had happened or to outline the plan. In the ward my husband felt like a CT report and a cut leg. Standing at the end of the bed the following morning, the ward team spoke about him, not to him. Satisfied that the CT report confirmed a diagnosis, the team left without further clinical or psychosocial assessment. Caring touch and holistic concern was distinctly lacking.

I was the relative we see every day, anxious to see their loved one, focussed only on one person. My husband was a relatively 'run of the mill' trauma patient yet my experience shows that no matter how routine a trauma patient seems to us, relatives can experience a whirl of emotions akin to the worst case scenario. These emotions were neither recognised nor acknowledged by the ED or ward staff. Care was mechanistic and protocol driven; the focus was purely clinical with little recognition or consideration of my husband as an individual or his family. I realised something was missing – something I have identified as emotional intelligence.

A story more well-known than mine is that of James Styner. His tragic experience identified significant gaps in trauma care that saw the development of the Advanced Trauma Life Support (ATLS) model. More than 30 years later, ATLS is now internationally recognised as a minimum standard for the care of trauma patients. However, my experience has led me to question whether such protocols have inhibited the development of empathy, self-awareness and managing emotions; the key tenets of emotional intelligence.

Holistic care, empathy and compassion are central to the nursing profession. The nurse–patient relationship and family-centred care are key to patient experience and excellent care (Bulmer Smith et al., 2009). Central to this is the nurses' ability to understand, detect and manage emotions; both their own and those in their care. Emergency nursing is fast-paced and highly emotive. Whilst ED patients value proficient clinical care, patient satisfaction improves when ED nurses show compassion, caring attitudes and an ability to understand the patient and their problems (Nairn et al., 2004). Emergency nurses need to be equipped with skills and intelligence relevant to the diverse nature of our work.

When one speaks of intelligence it is perhaps cognitive, or academic intelligence, that comes to mind. However, intelligence more widely encompasses abstract, concrete and social intelligence (McQueen, 2004). Abstract intelligence entails verbal and mathematical skills; concrete intelligence involves technical and physical skills and social intelligence relates to understanding and interacting with people (McQueen, 2004). Stemming from social intelligence, EI is a concept that has gained much weight in the fields of nursing, leadership and business. I believe that excellent emergency and trauma nursing require abstract, concrete and emotional intelligence (Table 1).

Despite the vast amount of literature related to EI, not one definition exists. The presence of various theoretical models may explain this lack of consensus. Salovey and Mayer (1990) proposed the 'ability model', viewing EI as purely related to cognitive ability. That is, emotions are a source of information that we use to make decisions about the social world. Conversely, Bar-On (1997, as cited in Ingram, 2013) presents a 'trait model', suggesting that EI is related to personality and separate from cognitive intelligence. Daniel Goleman popularised EI in 1995 with claims that EI can matter more than IQ. Goleman proposed a 'mixed ability' model, claiming that EI relates to both personality and cognitive ability. He believes EI can be learned and developed and achieved success in the business world stating that EI increases sales, productivity and popularity.

For the purpose of this paper, Salovey and Mayer's (1990) definition will be used; EI is "a form of social intelligence that involves the ability to monitor one's own and others' feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and action" (p. 189). Self-awareness, self-regulation, motivation, empathy and social skills are key characteristics of EI (Goleman, 1995).

The last decade has seen an abundance of literature exploring EI as a concept in nursing. Codier et al. (2008) showed that EI is associated with clinical performance. That is, nurses who demonstrated higher levels of EI were working at higher levels of practice. These findings are supported by Codier et al. (2010) who found that nurses with higher levels of EI were less likely to focus purely on technical skills and instead showed greater consideration for holistic care and wider organisational factors. They also showed that EI is associated with expert practice.

Adams and Iseler (2014) explored the relationship between EI and quality of care. They identified various patient outcome measures such as MRSA and *C. difficile* rates, falls, hand hygiene compliance and medication errors. They found that nurses' EI was associated with reduced infection rates and patient falls but did not influence other outcomes.

Although much of the literature on EI and teamwork relates to student teams with longer contact time than the trauma team, there appears to be a correlation between EI and team performance. Teams