

# Reflective assessment on communicative nursing



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**Explain why communication is important in nursing and using a reflective framework, describe how communication skills were used in practice specifically related to the use of the nursing process.**

In this essay communication will be defined from a general and a clinical point of view in order to point the differences, if this is the case. The aspects and channels involved in the communication process will be briefly explored in order to show their influence, studied by Kenworthy et al (2001). With all this points considered the importance of communication in nursing will be portrayed. Following this first part, the reflective cycle developed by Gibbs (1988) (see appendix 1) will be used to evaluate and analyze a nurse to client interaction during in one of the stages of the nursing process, in order to describe how communication skills were applied in practice. Furthermore, these skills will be related to the importance of a nursing practice framework and its relevance to the current nursing standards and policies.

Watzlawick et al (1968) cited by Kenworthy et al (2001) has argued that individuals have the need to interact with each other and communication is the tool to achieve. Communication defined by Collins School Dictionary (2005). "Communication is the process by which people or animals exchange information", this definition is a very general, it does not explain the process, aim or influences that communication carries. Instead Sheldon (2005) explains it as sharing health-related data, a process where nurse and client are sources and receivers of information. Sheldon (2005) remarks different ways to communicate such as: verbal and non-verbal or written and spoken. Finally, Sheldon (2005) suggests that nurse-client communication is not only sharing information but also building a relationship. Both definitions describe the process of passing information, although the second one

analyzes more in depth about how messages can be transmitted and imply that information-exchange varies in different ambits. Sheldon (2005) adds that the communication which builds relationship is an important factor in healthcare. This point raises questions about how and what factors influence a communication process.

There are 6 aspects of communication presented by White (2000): sender, receiver, message, channel, feedback and influences. The sender is the nurse and the receiver could be a client (or a colleague). The message is the information being sent. This message is dispatched through different channels, such as verbal, visual or kinaesthetic. The feedback is the reaction of the receiver to the sent message. This helps the sender to identify whether the message is being understood properly or it has to be resend. Finally, the influences are culture, education, emotion and expectations from the interaction.

This aspects can be included in 4 types of communication as explored by Craven and Hirnle (2006). The first is written. It is based on recording or informing others about a situation or an incident occurred during a workday. This is a nurse's key role and it is very important for the patient's care. The second type is verbal. This is sometimes a h3 alliance and other times a weapon that might cause long-lasting misjudgement regarding the health workers presented by Stulhmilller (2000) cited by Craven and Hirnle (2006). The third is non-verbal: gestures, facial expression, space, voice tone and volume play a very important role in communication. Craven and Hirnle (2006) argues that this type is as important as the verbal. Contradictorily Druckman et al (1982) found that non-verbal communication carries more

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weight and has a deeper influence than verbal statements. The last type of communication described by Craven and Hirnle (2006) is meta-communication. It involves everything that is happening while the communication process is taking part. It ranges from the nurse as a worker to the hospital as a building and passing through other issues such as privacy or past experiences.

While caring for a client a nurse takes up several responsibilities and roles. There are six roles that usually can be found, studied by Peplau (1952) cited by Sheldon (2005) (see appendix 2). All these roles involve working towards a patient centred philosophy, defined by the NMC code of practice (2008). Nearly every type and channel of communication is referred throughout the entire document. A nurse looks after patients' rights and needs, making sure all information is provided before undertaking a treatment or when working in the primary care field.

A nurse belongs to a team (the healthcare workers) therefore findings should be recorded and transmitted accurately to ensure that colleagues or services are aware of any changes on the client's situation, as reflected on the NMC code of practice (2008). All these aspects involve communication, therefore a nurse is a communicator, sometimes a sender and sometimes a receiver of the information, viewed Craven and Hirnle (2006). All the aspects of communication should be practiced during every minute of a shift, highlighted by Thomas (2004). However, Thomas (2004) points out that there is good and also bad communication. For example bad communication is when a client is given too much or misleading information or private and confidential data is shared with people not involved in the client's care needs

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(in this case the client's consent is needed before giving information to non-care professionals). This practice violates the clients' rights. Although it is still communication, these actions break the NMC code of practice (2008) and the Fundamentals of Care (2003). For example, the client is given too much information or misleading information.

Following this explanation about the importance of communication in nursing, I will use the Gibbs reflective cycle (1988) (see appendix 1) in order to identify communication skills and their importance in practice.

**Description: Focused on the admission process.**

Mrs. V. arrived to the ward on Thursday morning. She was confused and a bit agitated as she believed she was going shopping and never expected to be in hospital. However, her son had brought her to the ward for a 3 weeks respite while he was on holidays.

Firstly the qualified nurse in charge introduced himself politely, extending his hand and asking: " Welcome the ward I am M., your named nurse, how would you like to be called?" Mrs. V. answered: " Everybody calls me Mrs. V.." Afterwards the nurse invited her into the office, where he was going to carry out the admission process. The nurse introduced me as a student and asked Mrs. V. whether she minded my presence during the admission. Mrs. V. did not mind and did not look unoccupied about me. The nurse closed the office door and transferred the calls to the other office making sure no one was going to interrupt the admission process. The nurse sat next to Mrs. V., kept relaxed and opened body position and showed a friendly attitude. This was achieved by smiling, making her comfortable by offering a chair, also by

respecting the spacing boundaries and by showing interest. The nurse explained what was going to happen during the assessment, the importance of it and reasons why it was done. The nurse made sure that Mrs. V. was aware that if she did not feel confident answering any questions, that was not going to be a problem and it was her choice and right not to answer. Once Mrs. V. understood and agreed with the way the assessment was going to be done, the nurse started to ask question regarding her daily living activities and lifestyle. Although, the nurse had read her notes beforehand, he wanted to gain further information about Mrs. V's physical health, past treatments or any difficulties when walking or standing up and to get a general picture of her. Mrs. V. was hesitant about many answers and was unsure about some past events. During this first encounter she had said several times she thought she was going shopping. The nurse patiently rephrased the same idea (" your son brought you here, where you will stay the next 3 weeks for a respite ...") and she kept agreeing, however she would again ask about shopping. Along the assessment the nurse had been taking some notes, he always kept eye contact and formulated open questions as well as closed ones. The nurse agreed verbally and non-verbally by nodding with the head, rephrasing what it was being said and showing interest in what Mrs. V. was saying and the way she expressed it.

Following this interaction, the nurse invited Mrs. V. to come out of the office to be introduced to the staff on-duty and to show the bedroom where she was going to spend the following 3 weeks. Once Mrs. V. was familiarized with the ward layout, the nursing staff helped her to put her cloths away and put

her toiletries in a named box. Mrs. V., afterwards she happily sat in the living room and started to interact with the staff and other patients.

**Feelings:**

When Mrs. V. was admitted I felt that the nurse was very welcoming, respectful and thoughtful when interacting with the client. Moreover, the nurse had introduced all the ward staff on-duty by their names and I was introduced as a student, and consequently Mrs. V. was asked to give her consent for me to be in the admission process.

I thought this was a homely and natural way of starting Mrs. V's stay and she seemed less tense about the situation and settled into the ward routine quicker as she could recognize all the staff.

I was amazed to see the nurse's good communications skills and the way they were used. The nurse, via verbal and non-verbal communication, helped Mrs. V. to feel like at home and built trust in a very short period of time.

**Evaluation:**

The nurse demonstrated his knowledge of the client rights, the Fundamentals of Care (2003) and the NMC code of practice (2008). This was shown by treating Mrs. V. as an individual, asking her how she wishes to be address, requesting her consent for others to participate during the first stage of her stay (myself in this case), ensuring that information was given at all the time, respecting privacy and confidentiality, being patient with her feelings and assessing her situation as a whole.

During the intervention the nurse interacted with the client using genuineness and unconditional positive regard, developed by Roger (1961) <https://assignbuster.com/reflective-assessment-on-communicative-nursing/>

cites by Sheldon (2005). These were mostly applied along the admission assessment in the office, although genuineness was a part of the whole process of the admission. This could be found in the behaviour of the staff towards the first encounter with the client. Here the nurse acts with honesty and respect towards Mrs. V., building confidence and clarifying his willing to help and understand the client's needs and feelings.

The nurse also compiled all information of the admission process in the appropriated manner, so other members of the service or external agencies involved in Mrs. V.'s care can access accurately when preparing further interventions, such as physiotherapist appointment or O. T. team visits. Furthermore, all the members of the staff on-duty and the ones coming onto the next shift were appropriately informed about the admission, following the NMC code of practice (2008) by record keeping and sharing information procedures. Consequently, Mrs. V. care could be kept save and carried out as planned by other members of the team.

I could not see any weaknesses through this intervention. I believe there were many positives aspects, as I tried to evaluate them above. Overall, I think communication skills were used appropriately to ensure the comfort of the client and to undertake the nurse's duty of care.

**Analysis:**

Firstly, I understand the need to apply the nursing process in the caring set in order to recognize individual needs and capabilities. This was described by Arets and Morle (1995) cited by Holland et al (2003) as a systematic problem solving method (see appendix 3).



Despite that assessing is a constant activity that a nurse should undertake on daily basis as needs or strengths of a client might change, exposed by Roper et al (2000), I will focus this analysis on assessment as a single action during the nursing process. Here the nurse is responsible to recognize and identify the patient's problems, needs and capacities through observation and verbal communication. This stage involves data collection. This was done by using Roper et al (1996) Daily Activities of Living assessing tool (See appendix 4).

For the purpose of this analysis the next daily activities of living (dying, breathing and circulation, expressing sexuality and controlling body temperature) will not be included as they were not discussed during the admission assessment. However, body temperature was taken as a routine check in conjunction with other body indicators measurements.

In order to assess verbally Mrs. V's capacity, the nurse asked closed and opened questions. The advantages of these types of questions as suggested by Sheldon (2005) are data is easily gathered, assessment of information is more complete, acknowledge of the client's experience and also summarizing the assessment feedback is more explicit (See appendix 5).

Regarding the observational data collection Holland et al (2003) give some questions that can be asked to one self for the daily activities of living assessment of Roper et al (1996) (See appendix 6). Also here it is highlighted the need to use a framework to systematically gather information in order to find or foresee possible problems.

Secondly, the nurse maintained a consistent approach when talking with Mrs. V. or asking for feedback about the information that was being given. White (2000) describes 6 aspects of communication. These are part of the whole interaction. Sometimes communication is influenced by falling into elderly people stereotypes, which may make them feel treated as simpleton or as child. Ellis et al (2003) explains this as the tendency to modify the language when speaking. It can be done by using 'baby talk', raising the voice when an elderly is hearing impaired or by using invalidating statements. From the way the nurse assessed Mrs. V., I did not notice any commentary or behaviour that involved a misconception of the client's intellectual capability. This is reflected on the description part when the nurse reinforces to Mrs. V. that she can take all the time she needs and also when explaining to her things in different ways. These 2 behaviours are a sign of good nursing practice when collaborating with the people in a nurse care, described in the NMC code of practice (2008).

Thirdly, the nurse applied a holistic model of nursing when assessing Mrs. V. In this case the nurse used the Roper et al (1996) assessing tool, as mentioned above. The nurse treated the assessment as a very important part of Mrs. V.'s respite. The nurse allowed time for Mrs. V. to express her thoughts and worries freely, privately and without interruptions. The nurse had prepared the admission assessment prior to Mrs. V.'s arrival, this helped to exclude note reading during the assessment and to allow more time for the nurse-client relationship building. During the assessment the nurse applied the nursing literature and used a framework to gather information, and took some notes but this did not take over the communication process.

But this is not always possible, as Jones (2007) found out the admission process is likely to differ from the standards and policies in nursing literature. However, the nurse was able to conduct the admission assessment with enough time, as Mrs. V. was the only admission for that day, so the nurse has no timing pressure. This was very adequate because Mrs. V. was taking out of her daily routine for a long time of period therefore she had to be assessed conscientiously.

All the techniques and models the nurse was using during the assessment highlight the importance to keep up to date knowledge and skills. This is reflected in the NMC code of practice (2008) in order to work towards delivering high standard personalized care.

**Conclusion:**

The admission assessment was carried out following the procedures laid by the NMC. The nurse showed acknowledgement of his role and responsibilities as a professional, as well as a broad usage of interviewing and counselling techniques. Furthermore, the nurse applied a holistic nursing model theory to practice. Each of these points illustrated how the first stage of the nursing process was handled and also the importance of communication skills in the nursing profession.

**Action Plan:**

At this stage of the nursing course, I realize the importance of the nursing process and how nursing literature is related to practice.

In the future admission process where I will be involved in, whether as an observer or assessor, I will try to bring forward the relevant literature and

theories studied, in order to improve my practice and enhance the client's care.

In conclusion, communication is a process of transmitting and receiving information. This process involves several aspects, one of them are the channels. These are widely used in nursing and are key points for the nursing process. As a nurse engages in its roles the honesty and reliability in communication grows and is achieved with a client. Consequently, the care is delivered as individualized as possible and the client's needs are identified and met.

Communication in nursing is important in order to listen, understand, inform, explain, feedback and update a client, therefore the rights, ideologies, choices and backgrounds of the individuals and their families should be prioritized, always complying with the statutory legislation and guidelines.

For future improvement of the communication, and the clinical practice, acknowledgement of properly communication methods are essential. In addition to this, professional development and self-awareness should be reached through life long education programs.

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## **Appendixes**

### **Appendix 1**

<http://www.nursesnetwork.co.uk/images/reflectivecycle.gif>

Accessed on 13/01/09

### **Appendix 2**

Peplau's 6 nurses' roles cited by Sheldon (2005):

1. Stranger: The nurse receives the client the as a stranger providing a climate that promotes trust.
2. Resource: The nurse gives information, answers questions and interprets clinical information.
3. Teaching: The nurse serves as a teacher to the learner/patient, giving instructions and providing training.
4. Counseling: The nurse provides guidance and encouragement to help the patient integrate his or her current life experience.
5. Surrogate: The nurse works on the patient's behalf and helps the patient clarify domains of independence, dependence, and interdependence.
6. Active leadership: The nurse assists the patient in achieving responsibility for treatment goals in mutually satisfying way.

### **Appendix 3**

The 4 stages of the nursing process described by Arets and Morle (1995) cited by Holland et al (2003):

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1. Assessment
2. Planning
3. Implementation
4. Evaluation

#### **Appendix 4**

Roper et al (1996) tool which is composed of 12 daily activities of living:

- Maintaining a safe environment
- Communication
- Breathing and Circulation
- Eating and drinking
- Elimination
- Personal hygiene and dressing
- Controlling body temperature
- Mobilising
- Expressing sexuality
- Social care/family involvement
- Sleeping
- Dying

#### **Appendix 5**

Nurse direct questions:

- Do you know where you are? / How are you feeling? / Do you know why you are here?
- Do you cook your own meals? / Have you got a varied diet? / Do you do your own shopping? / Do you have any religious preference?
- How is your sleeping pattern? / Do you wake up during the night?

- Do you live on your own? / Do you live in a house or a bungalow? / Does anybody visit you? / Does your son live near you?
- How do you manage with your daily personal care? / Do you have difficulties on dressing?

## **Appendix 6**

Questions suggested by Holland et al (2003)

- Does the client use a walking aid or wheel chair?
- How far can the client walk?
- Has the client the capacity to use both hands?
- Does the client appear to be reluctant to talk?
- Is the client able to swallow effectively?
- Does the client have bones/joints illness?
- Does the client smoke?
- How many and how long has the client smoked?
- Are the cloths clean or dirty?
- Does the client have a smell?
- Does the client have skin problems?

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