

Therapeutic
engagement is a
basic tool for nurses



**ASSIGN
BUSTER**

\n[[toc title="Table of Contents"](#)]\n

\n \t

1. [Description](#) \n \t
2. [Feelings](#) \n \t
3. [Evaluation](#) \n \t
4. [Analysis](#) \n \t
5. [Conclusion](#) \n \t
6. [Action plan](#) \n

\n[/toc]\n \n

My rationale for choosing communication and therapeutic engagement is that it occupies a central position in my experience and transition and from student nurse to an accountable practitioner. Through communication the nurse gets to know the patient and is able to form a therapeutic relationship. It is the foundation and a basic tool of the nurse -patient relationship.

Without clear communication it is impossible to give care, effectively make decisions, protect clients from threats to well being and ensure their safety on the ward, co ordinate and manage client's care and offer comfort. The relevance of communication and therapeutic engagement in mental health is emphasised in the summary of the Chief Nursing Officer's review of mental health nursing (DH, 2006). One of the key recommendations in improving outcome for service users is developing and sustaining positive therapeutic relationship with service users, their families and/or carers and should form the basis of all care. The NMC (2008) Code of Professional Conduct similarly emphasise that nurses must work with other members of the team and patients to promote healthcare environment that are conducive to safe,

<https://assignbuster.com/therapeutic-engagement-is-a-basic-tool-for-nurses/>

therapeutic and ethical practice. The SLAM NHS Foundation Trust document 'Engagement and Formal Observation Policy' (SLAM, 2008) also highlight the importance of communication and engagement with patients under observation. Many patients and their family members often experience difficulty in communicating with healthcare professionals. The Audit Commission (1993) has stated that poor communication between patients and healthcare professionals is one of the main reasons for complaint and litigation in the healthcare service. The NHS Plan (DH, 2000) emphasised the importance 'getting the basics right' by improving the quality of care and the experience of patients. One of the ways of achieving this is through effective communication between patients, carers and healthcare personnel. This is highlighted in the Department of Health document, Essence of Care (2003) (www.dh.gov.uk): Patient focused benchmark for clinical governance. In this document is a new benchmark focusing on communication between patients and/or carers and healthcare personnel which compliments that of record keeping and privacy and dignity benchmarks. The NHS Knowledge and Skills Framework (KSF) (DH, 2004) lists communication as a core dimension which is a key aspect of all jobs in the NHS and underpins all other dimension in the KSF. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) now Nursing and Midwifery Council (NMC) stated that 'communication is an essential part of good practice in nursing and it is the basis for building a trusting relationship that will greatly improve care and help reduce anxiety and stress for patients/ clients, their families and their carers (UKCC, 1996).

My ward is a Patient Intensive Care Unit (PICU) of a forensic setting. It has thirteen in-patients and a staff strength of twenty three nurses both qualified and unqualified. Agency staffs are frequently engaged to make up the number of staff necessary to care for patients on a particular shift. On the average there are between seven and eleven nursing staff per shift depending on the prevailing situation on the ward. It has two supervised confinements and two intensive care areas. Admissions are planned and it is based on a set of assessment criteria. Only acutely unwell patients are admitted. This essay will draw on my first working experience as a primary nurse of an acutely unwell psychiatric patient to illustrate my development with regards to communication and therapeutic engagement. Gibbs (1988) reflective cycle will be used to reflect this experience.

Description

I had just started work as a newly employed member of staff and was assigned primary nurse to a thirty year old patient of Afro-Caribbean origin who was transferred from another ward following a relapse in his mental state. He was under section 3 of the Mental Health Act (1983). This patient is named A for confidentiality purposes (NMC, 2008) had diagnosis of paranoid schizophrenia and had no insight into his mental illness. His carer was his mother with whom he had a luke-warm relationship. He was very suspicious of staff interventions and would not engage. Routine blood tests had revealed that he had elevated creatine kinase (CK) levels (Creatine Kinase enzyme, high levels of which cause severe muscle damage, neuroleptic malignant syndrome, myocardial infarction etc). Following this finding, his antipsychotic medication was withdrawn pending further blood tests. He

refused to have a blood sample taken for further tests; he believed staff would 'drink' his blood. As his primary nurse, I made several attempts to encourage him to have the blood tests, but he would not be persuaded.

He was also diagnosed with type II diabetes and was dependent of insulin. He self managed his physical illness by carrying out blood glucose level monitoring and self administering insulin under staff supervision. Patient A fed only on pre-packed barbeque chicken purchased from the supermarket and would not eat food served on the ward. I had one to one engagement with him to discuss his dietary intake and also formulate a physical and mental healthcare plan. He was not interested and made no contributions to the discussions. I gave him copies of the care plans which he declined. He said 'you can keep those care plans I don't need them and I am able to take care of myself'. By the end of the second week, his mental state had deteriorated so much that he was very paranoid, irritable and getting into arguments with fellow patients and staff. He was involved in incidents both verbal and physical aggression and became increasingly difficult to manage on the ward. For his safety and that of others the team made a decision to nurse Mr. A in supervised confinement based on rationalist -analytical approach, having carried out risk assessment and looked at his history as well as the trust policy. As part of this risk management plan he was transferred to the intensive care area (ICA) and nursed under enhanced observation by two nursing staff. I requested to be allocated to nurse him in the ICA as often as the trust and unity policy would allow, in order to assess his mental state and attempt to build a rapport with him. Mr. A would not talk but I persisted. He noticed that I was frequently allocated to observe him

and gradually opened up. I explained to him the team's decision to nurse him in the supervised confinement and the ICA. We talked about politics, football, music etc and our relationship developed and continued till he was transferred to a rehabilitation ward.

Feelings

I felt very frustrated and inadequate and was very much under stress. It was obvious from his reaction that he had no confidence nor trust in me and saw me just like any other healthcare professional. Woods (2004) highlights the complex problems and needs of patients who find themselves in forensic settings and maintain that it is a common occurrence that some patients can not engage in treatment while others simply refuse to do so. Arnold and Underman-Boggs (1999) maintain that any meaningful relationship begins with trust. Trusting a nurse is particularly difficult for the mentally ill, for whom the idea of having a caring relationship is incomprehensible. As his primary nurse I saw myself as the advocate ready to work with him and seek his interest at all times. As nurses, we are called upon to play our roles as advocates, supervising and protecting client's rights and empowering them to take charge of their lives. Ironbar et al (2003) stresses that, therapeutic relationships can be stressful. Working closely with people who are mentally unwell and under stress can be very demanding and emotionally draining experience. Consequently, nurses need to be aware of the effect that such relationships can have on them. This requires insight, self awareness and ability to cope effectively with stress. My initial perception was that Mr A was a difficult patient and considered withdrawing as his primary nurse but I felt emotionally attached. I understood that I owed Mr A. a duty of care (NMC,

2008) and simply withdrawing was not professional in my view. O'Carroll et al (2007) contended that in our professional roles, nurses do not have the same option as we do in our personal life by withdrawing from difficult relationships. Rather it requires exploring the situation which may help recognise ways in which the nurse is influenced by his emotions. The authors caution that nurses must learn to manage their own emotions. Furthermore, they need to communicate their emotional reactions to the patient, albeit in a modified form. I empathised with Mr A and it drew me closer to him, revealing to me the depth of his mental illness. I wished I could do something 'here and now' to help alleviate the state of confusion, anxiety and helplessness in which he found himself. Barker (2003) reports of how in recent times empathy has been shown to enable nurses to investigate and understand the experience of persons experiencing a state of chaos as a consequence of psychiatric order. I felt uncomfortable when Mr A had to be physically restrained (PSTS techniques) and nursed in supervisory confinement, I felt that this procedure was not justifiable because the privacy, dignity and respect of this client had been compromised. As nurses we are to demonstrate respect for patients by promoting their privacy and dignity (NMC, 2008) (Essence of Care, 2003). On the other hand, I thought that his safety and that of others was paramount and this could be achieved only by nursing him separately from the rest. The NMC (2008: para 8: 4) Code of Professional Conduct clearly states that when facing a professional dilemma, the first consideration must be the safety of patients. The collaborative team decision to nurse him in the supervised confinement area made me feel valued as a team member. I was actively involved in the decision making process and carried out risk assessments. I felt that I was

<https://assignbuster.com/therapeutic-engagement-is-a-basic-tool-for-nurses/>

insensitive with my sustained persistence to get him to talk. I should have understood that his moments of silence were necessary to help him calm down (SLAM, 2008). I also felt unsupported and struggled to cope with the management and care of Mr A. I was unable to access clinical supervision because my supervisor was away on holiday.

Evaluation

Although it seemed difficult at the beginning, but by the time Mr A was out of the ICA we had developed a good working relationship. I did not show my disappointment at his reluctance to engage when he was acutely unwell and stayed positive. Engaging with him while nursing him in the ICA offered me the opportunity to explain to him the teams' decision to place him under enhanced observation. Actively listening to him and discussing with him his thoughts and feelings have helped lessen his distress. It also enabled me to give a comprehensive feedback to the team regarding his mental state.

We met in one to one engagements and discussed his concerns and needs. A good and well ventilated environment was always made for our meetings. Following assessments, we discussed his care plans, participation in group activities, crisis management and other forms of therapies. He felt very much in charge, highlighting his most pressing needs. Whenever we met, there was a demonstration of mutual respect and desire for working together in a partnership. Together we identified and prioritised his goals for recovery based on his strengths and what he believes is achievable. Faulkner (1998) asserts that goals must be clearly defined so that both the professional and the patient are going in the same direction in terms of what they wish to achieve by a certain time. During our interactions, clear boundaries were set

<https://assignbuster.com/therapeutic-engagement-is-a-basic-tool-for-nurses/>

and clarified for Mr A what were acceptable behaviours. Boundaries were set as to what he was allowed to do without supervision, how he engaged with others and appropriate ways of addressing issues he felt unhappy or uncomfortable with. The plan of care was therefore service-user centred and recovery orientated approach. The recovery model has been incorporated into the principles of care delivery in the trust (SLAM, 2007). It aims to help service-users to move beyond mere survival and existence, encouraging them to move forward and carry out activities and develop relationships that give their lives meanings. Wood (2004) indicated that nursing forensic patients is not easy and requires complex treatment plans that focus fundamentally on reducing risk of harm to others.

As part of his recovery, he was encouraged to self manage his diabetes under supervision. Giving his understanding of his physical illness information was provided to enable him to make informed decisions about his lifestyle. Mr A consented to giving regular blood samples. His CK level fell to normal levels and was restarted on anti psychotic medication. However, it took time for Mr A to adequately understand the situation that he was in and the effect of his illness on his lifestyles. It must also be stated that it was not always possible to meet with Mr A as planned. Scheduled meetings had to be cancelled due to being engaged with very pressing ward issues.

Analysis

The use of therapeutic communications in nursing, particularly empathy, is what enables therapeutic change and should not be underestimated (Norman and Ryrie, 2004). Egan (2002) argues that empathy is not just the ability to enter into and understand the world of another person but also be

able to communicate this understanding to him/her. The relevance of empathetic relationships to the goals of health services are suggested by the increase in focus on patient centred care and the growth of consumerism. The client-centred focus is illustrated by the NHS patient charter which emphasises that clinicians need to collaborate with users of the health services in the prioritising of clinical needs and the setting of treatment goals (Barker, 2003). Nurses should be aware that patients who are paranoid and suspicious of staff interventions as was the case of Mr A, might not readily accept support from staff. This implies that working with such patients can be very challenging and difficult. It therefore calls for the nurse to remain impatient, calm and focused. The need to build therapeutic relationship with the patient is paramount in gaining trust and respect (Rigby and Alexander, 2008). Caring, empathy and good communication skills are needed to help patients through their illness. Therefore the use of effective interpersonal skills facilitates the development of a positive nurse-patient relationship. McCabe (2004) argues that the use of effective interpersonal skills, a basic component of nursing, must be patient centred.

Nursing Mr A in supervised confinement and subsequently in the ICA was in accordance to SLAM (2008) Engagement and Formal Observation Policy. Despite the frequent occurrence of this nursing intervention in mental health settings, for the whole of the UK there are no national standards or guidelines for practice of observation. The current situation in England and Wales is that policies are developed and implemented at a local level using SNMAC (1999) practice guidance for observation of patients at risk as a template (Harrison et al, 2006). Nursing patients in supervised confinement,

though a common practice in the PICU raises a number of ethical, professional and legal issues about the role of the nurse, whether he/she is a custodian or therapist and a friend is debateable. Alland et al (2003) noted that patients view enhanced observation as uncomfortable at best, custodial and dehumanising at worst. Mr A felt that his pride and dignity had been taken away from him he was at risk and therefore an immediate and effective risk management plan had to be implemented. This was necessary to ensure his safety and that of others even though he expressed unhappiness with this intervention. By engaging him and encouraging him to share his thoughts and feelings his anger appeared to have lessened as he joined in the discussions of politics, music, football etc. Thurgood (2004) empathised that showing your human side to clients is very important. Engaging meaningfully with patients and helping them talk about their feelings is the first step to alleviating some of their distress. The NMC (2008) Code of Professional Conduct clearly points to the rights of patients in relation to autonomy. There appeared to have been a reach to Mr A's rights. The difficulty we faced as a team was finding the balance between allowing some privacy and dignity versus persevering his safety and security. Consequently, a dilemma arose for me as his primary nurse in relation to his rights, obligations and duties. In fact Article 5(1) e of the Human Rights Act (1998) specifies the right of the state to lawfully detain the ' person of unsound mind'. Within the UK, that framework is provides by the Mental Health Act 1983 (DOH, 1998). One may argue then that there is no fundamental incompatibility between the Mental Health Act and the Human Rights Act.

There were times that scheduled meetings with Mr A had to be cancelled because of urgent administrative duties. It meant that he lost the opportunity to meet up with me to discuss his concerns and needs. The concept of Patient Protected Time (PPT) in inpatient units is therefore valid. It allows patients to meet with a healthcare provider on one to one for a specified time when the ward is closed to administrative duties to discuss care plans, social activities, therapies and others. Such interaction according to Song and Soobratty (2007) promotes feelings of self confidence, esteem and recovery. It can also aid the patient therapeutic progress as it can help with social interaction and building relationships. However, nurses complain they already have plenty to do without an added pressure of PPT to contend with. Nurses frequently complaining of being too busy to develop therapeutic rapport with patients (Mental Health Act Commission 2008). Yawar (2008) reported that only 16% of patients' time was spent in ' what can loosely be termed as therapeutic interaction'. The remaining of the 84% was spent aimlessly either pacing p and down the ward or doing nothing. Nurses recognise their responsibilities to engage with patients and welcome the opportunity to do this without other demands (Edward, 2008). The Department of Health (2002) called for improvements to ensure adequate clinical support inputs to inpatient wards and to maximise the time spent by staff therapeutically engaged with patients. Therapeutic engagement, therefore involves spending quality time with patients with the aim to empower them to actively participate in their care.

Conclusion

Communication is without doubt the medium through which the nurse-patient relationship takes place. The skills of active listening and reflection promote better communication and encourage empathy building. My first role as a primary nurse as a good learning experience. My conduct throughout the whole experience earned me a favourable feedback from my team leader. Caring for acutely mentally unwell patients requires of the nurse sensitivity, conveying warmth and empathy. Engaging meaningfully and actively listening to patients under enhanced observation makes them perceive the practice as valuing rather than punishing, therapeutic rather than custodial. Feeling safe and secured provides a platform which can assist patients to begin to resolve some of the difficulties they may be facing in their lives. It is imperative that nurses involve patients in all aspects of their care, empowering and making decisions in partnership with the team. By developing collaborative relationship with patients, nurses can provide prompt and focused interventions which can limit illness damage, assist in the process of symptoms management and help the process of recovery.

Action plan

My aim is to be proactive in the future by promptly seeking support from senior colleagues and requesting for clinical supervision. I aim to develop the skill of emotional resilience and intelligence to be able to deliver care that will promote patient welfare and aid recovery. The preceptorship experience has been a breath of fresh air. A time to look back and take stock of the transition from student nurse to an accountable practitioner. Listening and sharing in the experiences of fellow nurses was a good learning experience.

The preceptors were fantastic master clinicians who were receptive to our contributions as they explored our experiences at the beginning of each teaching session. This experience has undoubtedly enhanced my critical thinking as a nurse and prepared me to move forward in my development and practice as a caring and competent nurse. I see myself as being in the right job which offers many opportunities for development and to improve upon my knowledge and skills.