Reflection of clinical practice nursing essay

The purpose of this essay is to demonstrate application of core components of the NMC Code of Professional Conduct (2008) using reflective practice. The NMC Code of Professional Conduct (2008) states that nurses should act in accordance with the code, using an ethical and legal framework to ensure patient wellbeing and respect confidentiality. Nurses must act in a fair, non-discriminatory way which respects customs, values and beliefs of an individual, providing care which demonstrates sensitivity (NMC 2008, p2). Reflective practice is described by Duffy (2008, p. 1405) as an active and deliberate process to critically examine practice, where an individual is challenged to undertake the process of self-enquiry. Refection allows us to look at an experience and how it makes us feel and react, asking what is good and bad, and what can be learnt (Sellman & Snelling 2010). Gibb's reflective cycle (1988) allows a systematic and structured analysis and reflection of an event.

Description.

On my second day of placement in Theatres, I was in the recovery room where a 3 year old boy was being recovered following surgery. The next patient admitted was a Polish lady, who I will call Joanna, in order to maintain confidentiality. She was admitted following an elective termination of pregnancy. Pre operatively she had an interpreter present, but she had returned to the ward and was not present in recovery. When she woke up, Joanna turned to her right and saw the 3 year old boy next to her. She became distressed and started to cry. Joanna appeared to understand no English at all, I tried to calm her down and reassure her, but she did not seem to comprehend. The staff nurse thought that she was upset at seeing

the boy after her procedure and went to get a mobile screen to separate the patients. Joanna then became more upset. I called the ward and asked the interpreter to come back to recovery, as the patient was getting more distressed and we were not able to reassure her due to a communication barrier. The 3 year old boy was also becoming upset. When the interpreter arrived Joanna was able to verbalise that it was the presence of the child that caused her upset and anxiety, as it was the last thing she expected to see when she woke up from anaesthesia.

Feelings.

I felt helpless as I could not fully understand why she was upset, and I was unable to reassure her or calm her down. I also felt sad and concerned for the 3 year old boy who was obviously distressed by the circumstances. I was concerned that Joanna may have felt more isolated by putting the screen there, and maybe felt judged because of her procedure. I felt the staff nurse assumed the presence of the boy was causing Joanna’s upset, but that we could not be absolutely sure.

Evaluation.

Joanna was in a vulnerable position during her post- operative period, and we were unable to help her immediately due to communication barriers. We attempted to resolve what we thought might be the problem by placing the screen, but this appeared to worsen levels of distress for Joanna. Alongside this we were unable to assess her pain, nausea levels and fully explain what we were doing. Positively, we called the interpreter to return as soon as possible to attempt to resolve the situation. I also feel that I was able to look

inside myself to challenge my Muslim religious beliefs, which are fundamentally against abortion, putting these aside to treat Joanna in a fair non-discriminatory way. I was able to act in a sensitive and compassionate manner, affirming my belief that I am able to adhere to the Code of Professional Conduct (2008) and its core components.

Analysis.

The Abortion Act (1967) allows termination of pregnancy up to 24 weeks if continuance of the pregnancy would involve risk to the physical and mental health of the mother. Abortion is one area where health professionals may raise a conscientious objection. Nurses may avoid taking part in the procedure, but must continue to care for the patient, before and after the procedure, despite personal opinions and moral concerns (Royal College of Midwives 1997, NMC 2006). Kane (2009) states in accordance with the NMC nurses must give appropriate and comprehensive care to all patients, regardless of their reason for being in hospital. The Code of Conduct states “ you must act as an advocate for those in your care” (2008, p2), nurses also have a legal obligation to care. I feel I gave appropriate care, regardless of Joanna’s reason for admission, and did not treat her any differently because of this.

The Royal College of Nursing (2012) state that nurses must be culturally competent, caring for the needs of people with differences in beliefs, values and cultures, to provide meaningful, beneficial health care. Health care is compromised when the patient does not understand what is being said to them (Anderson et al. 2003). Communication is seen as a fundamental

component in cross cultural care and language difficulties can lead to insufficient care and poor quality nursing (Jirwe et al. 2010, Jacobs et al. 2006). I do feel although we attempted to resolve the situation, our ability to care for Joanna was compromised by not being able to communicate verbally. Jirwe et al. (2010) found in their study that nurses who experienced difficulties in talking to their patients led to care being mechanical and impersonal, as they were fearful of making mistakes. Jirwe et al. (2010) suggest that nursing programs need to address this deficit to ensure nurses are skilled to deal with cross cultural differences, such as using translators, nonverbal communication etc. This is supported by Jacobs et al. (2006) who state that people with limited English are less likely to receive the care they need and are less satisfied with health care. The only factor that can improve this is the use of someone who speaks their language, i. e. an interpreter. Carnevale et al. (2009) state that linguistic barriers can cause discrimination and compromise nursing care. They apply ethical theory in that the patient should be respected as a unique person, their right to self-determination upheld, respect for privacy and the nurse’s responsibility for one’s competence and judgement. Veiga et al. (2011) found in their research that the presence of a support person in the recovery room post termination was perceived by the women in a positive manner and also reduced anxiety levels.

Termination of pregnancy is associated with pain, which can be exacerbated by anxiety and psychological factors (Pud et al. 2005). It is estimated 10-20% of women following terminations suffer from serious negative psychological complications such as anxiety, depression and sleep

disturbances (Coleman et al 2005). I am concerned that Joanna's level of anxiety, may have caused her increased pain, and may also have affected her recovery in the longer term. I was unable to find any research that suggested that adults and children should not be recovered together. However there is a drive in the UK to provide same sex accommodation where possible in order to promote dignity and privacy (NHS Institute for Innovation & Improvement 2010). A privacy and dignity report by the Chief Nursing Officer stated that screens if used should be high enough to feel like they are in a separate room.

Conclusion.

Based upon the literature reviewed during the analysis, it is evident that an interpreter should have been available to reduce Joanna's stress, anxiety and even pain response. We do not always know how a patient will recover in the immediate postoperative period and patients can often be disorientated. This was made worse for Joanna as she did not understand what was happening. We could not effectively give reassurance, or fully assess the situation due to the language barrier. The only way in which this could have been resolved was to have the interpreter present when she came round from her anaesthetic. In reflection, the screen should have been in place before Joanna came round from theatre to protect both her, and the 3 year old boy's dignity and privacy. If the screen had been in place, then this incident would not have occurred. It I difficult to say whether placing the screen was the right action after Joanna became upset, as it seemed to cause Joanna more distress. However, we also had to take into consideration the 3 year old boy, who was frightened, scared and also becoming upset. It is my opinion

that this was in both patient’s best interests to place the screen after the fact, although it would have been a better situation if the interpreter had been present. It must however be said, that it is not always possible to have an interpreter due to scarce resources, but as the patient’s advocate, we should do all we can to protect their best interests.

Action Plan.

In future, regardless of my location, I will endeavour to be aware of potential problems that may arise due to the patient’s circumstance or environment. I will be more focused on making sure that all resources are in place, such as anticipating when an interpreter may be necessary, and also ensuring dignity and privacy are maintained. I feel this reflective essay has been invaluable, and I am able to demonstrate ethical practice, acting in a non-discriminatory and fair manner, within a legal framework , despite my own personal beliefs.

References.

Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E. et al. 2003. Culturally competent health care systems. American Journal of Preventative Medicine. 24 (3), pp. 68-79.

Carnevale, F. A., Vissandjee, B., Nyland, A., and Vinet-Bonin, A. 2009. Ethical considerations in cross linguistic nursing. Nursing Ethics. 16 (6), pp. 813-26.

Coleman, P. K., Reardon, D. C., Strahan, T., and Cougle, J. R. 2005. The psychology of abortion: a review and suggestions for future research. Psychology & Health. 20 (2), pp. 237-271.

Duffy, A. 2008. A concept analysis of reflective practice. Determining its value to nurses. British Journal of Nursing. 16 (9), pp. 1400-1407.

Gibbs, G. 1988. Learning by doing: A guide to teaching and learning methods. Oxford: Further Education Unit, Oxford.

Jacobs, E., Chen, A. H. M., Kaliner, L. S., Agger- Gupta, N. et al. 2006. The need for more research on language barriers in health care: A proposed study research agenda. Millbank Quaterly. 84 (1), pp. 111-133.

Jirwe, M., Gerrish, K., and Ermami, A. 2010. Student nurse’s experiences of communication in cross cultural care encounters. Journal of Caring Sciences. 24 (3), pp. 436-444.

Kane, R. 2009. Conscientious objection to termination of pregnancy: the competing rights of patients and nurses. Journal of Nursing Management. 17, pp. 907-912.

NHS Institute for Innovation & Improvement. 2010. Delivering same sex accommodation. www. institue. nhs. uk/delivering_same_sex_accomodation

Nursing and Midwifery Council, 2008. The NMC Code of Professional Conduct: Standards for Conduct, Performance and Ethics. London: Nursing and Midwifery Council.

Nursing and Midwifery Council, 2006. Conscientious objection A-Z Policy sheet. www. nmc-uk. org/aframedisplay. aspxx? documentID-1562. (accessed 18th Sept 2012)

Pud, D., and Amit, A. 2005. Anxiety as a predictor of pain management following termination of first trimester pregnancy. Pain Medicine. 6 (2), pp. 143-148.

Royal College of Midwives (1997). Conscientious objections position paper 17. www. rcm. org. uk (accessed 18th Sept 2012)

Royal College of Nursing. Transcultural care of adults. www. rcn. org. uk/developmental/learning/transcultural/adulthealth/sectionone (accessed 18th Sept 2012).

Sellman, D., and Snelling, P. 2010. Becoming a nurse: a textbook for professional practice. Pearson Education Ltd: China.

Veiga, M. B, Lamm Gemeinharat, C., Houlihan, E., Fitzsimmons, B. P., et al. 2011. Social support in the post abortion recovery room: evidence from patients, support persons and nurses in a Vancouver clinic. Contraception. 83(3), pp. 268-73.