

Initiating compassionate and person-centred care essay sample



Compassion is a complex notion thought to have powerful influences on therapeutic relationships. The concept of measuring compassion in nursing has catalysed research into quantifying this otherwise invisible act of humanity (Sturgeon 2008). Person-centred care; attuning your kindness and competence to meet the unique needs of another person, is accepted as a true example of compassion (Sharp, McAllister and Broadbent, 2015).

Moreover, being a reflective practitioner and having an awareness of ourselves in others' wellbeing encourages person-centred care (Roberts and Machon 2015). I will reflect on an episode of self-initiated compassionate care; capturing the patient at the centre of my approach. In accordance with NMC (2015, pp. 6) framework I will ensure confidentiality by referring to the subject as ' Patient B'.

Patient B is a 24 year old male with post-traumatic stress disorder (PTSD) situated on a medium secure ward in hospital under section 3 of the Mental Health Act (2007) due to risks of physical aggression. At this time he was exhibiting increased agitation due to anticipation of a move to another unit. The healthcare assistants observing the patient called my mentor from the enhanced care suite to inform her that his mood was deteriorating and he had begun to self-harm. As we entered the suite he was visibly frustrated; making verbally aggressive remarks to staff present. I had some background knowledge of his position as anxieties had surfaced on previous shifts therefore I decided to ask him if he was worrying about his move.

This distracted him from self-harming and my mentor gave me a visual nod to continue. Rather than asking more questions I made a suggestion to help

him write a letter to his new hospital; communicating his uncertainty around the changes that were about to happen. He agreed therefore I went to retrieve a pen and paper, sat down with him and wrote down his description of feelings towards the move. The patient handed over the broken CD he had self-harmed with afterwards and thanked me.

Thoughts

Initially, when I learned of Patient B's distress and self-harm this provoked thoughts of his current difficulties with managing his feelings towards his move. As we entered the room, my agenda was to help relieve his pain by informing him I understood why he was in crisis and that this needed to be escalated further than simply providing him reassurance; in order to fully address the issue.

Feelings

I had reservations around being overzealous in awareness of my student status. This was however counteracted by a moral obligation I felt towards the patient and my colleagues to apply knowledge of his circumstances and the background I'd managed to derive from experience where similar events had unfolded. Being so direct in identifying the problem was a risk I took in order to grant patient B some optimism that his worries weren't unusual and that ultimately the people around him cared enough to know what was wrong.

Evaluation

My conviction and creativity appeared to be well-received by both my colleagues and the patient. Riley and Matheson (2010) assert that creativity is the ability to read between the lines; seeing beyond the immediate circumstances and applying yourself analytically. My mentor and the healthcare workers' allowed me to pursue my suggestion without challenge which motivated my confidence to continue. This enabled me to experience an increased level of autonomy; argued to be a significant contributor in creating a healthy work environment by enhancing nurse satisfaction and patient safety (Lake and Friese, 2006).

There was a supportive element in this approach, to involve the patient in decisions made around his care, which reinforces the person-centred thesis outlined by The Health Foundation (2014). The outcome of my intervention was successful in both discontinuing the self-harm and unearthing the cause of patient B's distress to establish a specific need for extra-care amongst the team.

Analysis

Knowledge of Patient B's decline due to an upcoming transfer was reinforced by documented historical problems with transitioning between placements, which I had previously read in his file. This was attributed to poor relationships with guardians in childhood and difficulties with managing emotions surrounding separation. A psychoanalytic-based explanation would put forward attachment theory (Ainsworth & Bowlby, 1991) as the rationale behind his difficulty with emotional regulation when faced with disruption in a tie with the primary caregiver. This is supported by Hirschi (1969) who

highlights attachment as a driving force for internalising societal norms within children and Hoeve et al. (2012) who demonstrate the link between poor attachment in childhood and anti-social behaviour.

Although the patient's presentation appeared anti-social; the self-harm aspect exposed his vulnerabilities.

"...Those who self-harm may do so to communicate, to secure help and care or to obtain relief from an overwhelming situation" (NICE guidelines, 2011).

Research suggests that self-harm is often linked to acute life events in combination with long-term personal and social difficulties, repetition is high and 80% of individuals presenting to hospital suffer from some form of mental disorder (Saunders and Smith 2016). Evidenced-based methods of reducing self-harm typically take a Cognitive-Behavioural Therapy (CBT) approach (Hawton et al. 2016) however the understanding within practice is that due its complexity there is no 'one-size fits all' intervention and a key aim in treatment is understanding the specific contributing factors in each individual (National Collaborating Centre for Mental Health UK, 2012).

Person-centred care according to Kenneth and McEwen (2000) is based upon empowering service users to direct their care thus promoting collaborative decision-making. In my opinion, this had broken down and patient B's anxieties partially reflected a lack of control and understanding towards the decisions being made about his future. The suggestion of communication with the receiving unit signified a need for clarity from those responsible in the decision-making process to enhance the patient-healthcare professional relationship paramount to person-centred care (Kitson et al. 2013) and

assert the patient's feelings to develop an appropriate solution to care-planning (The Health Foundation 2016).

One barrier to person-centred care for decision-making in this instance is the application of the Mental Capacity Act (2005) to patient B. This legislation provides guidance for the provision of care to those who lack capacity to make decisions because of an impairment or disturbance in the functioning of the mind (Department for Constitutional affairs, 2007). When a person is deemed to lack capacity following assessment, specific decisions can be taken for them but it must be in their best interests (NHS. uk, 2017).

My wish to help was accompanied with apprehension of undermining those present due to my inexperience. Literature suggests this is common and reinforced by a 'culture shock' students experience when transitioning from academe to practice (Strouse and Nickerson 2016). A lack of confidence within practical settings is found to be a frequent inhibitor to student nurse retention (Last & Fulbrook 2003) as students felt there was a disproportionate emphasis on theoretical underpinnings over clinical skills within their studies. Further evidence suggests that the supernumerary status imposed on a student can influence different views on what they need to learn and is expected of them (Allan and Smith 2009). The Nursing and Midwifery Council (NMC 2010) outlines essential skill clusters for pre-registration which assert that students must uphold values of the code whilst working within the limitations of the role and recognising their own level of competence.

Reframe

Retrospectively, there are elements which could have been addressed alternatively. Firstly, the patient's tendency to self-harm is a larger issue beyond the crisis he was experiencing in this instance. The wider implications of self-harm as a coping strategy (Doyle, Sheridan & Treacy, 2017) indicate that patient B may be a risk to himself and requires a specific crisis plan outlining management strategies (NICE guidelines, 2011). There is evidence that nurses' attitudes towards self-harm can commonly be negative (Karman et al. 2015) therefore an awareness of this is essential and how positive attitudes and training may signify propensity to help within an in-patient setting (Wheatley & Austin-payne, 2009).

Furthermore, Patient B's needs may have been more imminently met had there been clear information about his transfer vulnerabilities to all healthcare professionals involved in his care. Although noted in his electronic patient record following previous crisis episodes; this information had been diluted down and subsequently missed in the shift-handover. Good interpersonal communication is considered essential in healthcare; encouraging shared-decision making (Beaulieu, Haggerty and Santor 2011). If a proactive rather than reactive approach (Osborne & Williams 2012) was taken; support could have been more readily available to the patient before his mental state deteriorated.

My insecurities around being over-ambitious in intervention could have been highlighted in a debrief afterwards so I could share my dilemma with the team. The importance of processing your own thoughts and feelings with colleagues in clinical supervisions has been linked to quality of care (White 2010)

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Future Action

This example of compassionate, person-centred care has induced recommendations for future practice.

First of all, I have a responsibility for my own learning in placements therefore aim to be more candid when expressing uncertainty in preparation for registration when hesitance is less likely to be met with understanding. In future placements, I will identify my confidence in care-initiation as an aspect for development; incorporating this into an action plan in 'Pebblepad' and making adjustments where appropriate (NMC 2015).

The significance of communication when building strategies for crisis intervention is another area I wish to champion. I plan to maximise opportunities for sharing experiences in group clinical supervisions, so that teams avoid being reliant on shift handovers and electronic records to fully inform them of patients' progress and mental-state.

Self-harm is a contemporary issue that emerges complimentary to mental health, affecting many of those in our care. It has encouraged me to research and train further around this topic; investigating the evidence-base for best practice management.

References

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