Nursing: single sex wards

The introduction of single sexed wards was aimed at creating a safer environment for the female patient. Yet, the following paper will illustrate, that although the female patient is now at a much reduced risk of abuse or assault from fellow male patients, they are still at risk of abuse from male nurses, involved in the, sometimes intimate interactions required when caring for this type of patient. This has an inevitable impact on the male nurse when considering how he cares for a patient.

How he can protect himself if accusations of abuse or assault being aimed at him. To answer this, the paper will first discuss the nature of mental health nursing, the relationships that are formed with patients and the therapeutic aspect of them. It will analyse the image of the male nurse, examining conflicts between the effect of socialisation and the pressure to be caring professional. The paper will utilise a critical incident, which occurred while on placement, to demonstrate the problems faced by the male nurse, raising important issues and consequent dilemmas.

It will make reference to literature that suggests appropriate ways to create a therapeutic relationship, examining how it works, while recognising the important aspects of communication, dynamics, power, choice and professional boundaries. It will examine user perspectives, while exemplifying the growing body of evidence available, which indicates, that some female patients are still being abused or assaulted by nursing staff, particularly male nurses. It will reveal what the users of mental health services recommend, comparing that with what professional evidence suggests.

Finally the paper will, through reflection and newly acquired knowledge, suggest how a male nurse cares for a female patient effectively and professionally and how through this, the nurse can protect both the patient and themselves. The nature of nursing The nature of nursing involves physical and emotional intimacy, making demands on both the nurse and the patient (Savage 1987). Due to the nature of the problems in mental health, it can be difficult for the patient to give information, sometimes of a deeply personal in nature, if the environment is not right.

Therefore, it is the responsibility of the nurse to ensure that the patient is content with their key worker, that they are allowed privacy, allowing them to disclose this deeply personal information about themselves and to feel comfortable in doing that. A philosophy shared by Edwards (1998) who states that the patient must feel comfortable at all times and not embarrassed by any encounter. The nurse must see the patient as an individual not an illness. A statement repeated throughout training.

Does this suggest that the professional image of the nurse has become less well defended and more emotionally involved? This along with the fact that the use of the nursing process has encouraged a more intimate relationship between the nurse and patient (Savage 1987) adds to the confusion surrounding nurse identity/role especially for men. The relationships formed between the nurse and patient must be carefully scrutinised, as they are paramount to how well the patients' care is delivered.

These relationships allow the nurse to effectively assess the needs of the patient and thus deliver care to patients more accurately. If the nurse can

deliver this to the patient then all approaches to psychiatry agree that it will allow the nurse to explore better the nature of the individual’s illness (Heron 1993). Mental health nursing involves not just planned therapeutic interventions but also brief supportive discussions between nurse and patient that require little or no specialist training. These interactions have one thing in common.

They involve the passing of verbal/nonverbal information between two or more individuals (Rogers, Pilgrim, and Lacey 1993). It requires the nurse to have the ability to communicate effectively with patients. Communication is vitally important when considering the protection of both nurse and patient an issue to be discussed later in more detail. These supportive interventions usually take the form of expressing genuine concern for a patients well being. This can be done through verbal means, “ I want to help, I understand” or through non-verbal means e. . holding a patients hand.

The image of the male nurse After examining the nature of nursing, the author identifies the need for the male nurse to be acutely aware of how he is viewed by the patient in order to protect the patient and thus himself. To do this, the concept of socialisation must be discussed. The Socialisation process encountered by every man and women as they develop seems to programme them with the belief that the role of a female is to nurture and care, whereas the male role is that of protector (Edwards 1998).

Possibly indicating, that the male nurse’s role has changed from that of an acceptable social role to an unacceptable professional role. Upon consideration, I agree with the comments made, as I had to challenge my

own beliefs about the image of the male nurse. In the author’s opinion what we are taught by society and personal experience shapes our beliefs some of which we may not be fully aware. I now identify the need to recognise this, and challenge it appropriately. If, I as a student nurse have rooted beliefs about the image of the male nurse, then what do the general patient population think?

To confuse the male nurse further he then encounters professional socialisation. This teaches the nurse to distance them-selves in order to be objective and carry out the care effectively, thus leaving the nurse in conflict as it can be viewed as reinforcing this less nurturing more protective approach by male nurses. This would be the easier option, as it would fit in with social values. Yet, such things as hand holding during invasive procedures are encouraged in training. So if a male nurse shows a caring compassionate side to his nature at work, then how does the patient perceive this?

Is it in a sexual or negative nature, as it deviates from society’s normal view of the man as the protector, or do they accept that expression of kindness the same way as they would a female nurse, as a genuine regard for their well-being? It is something I struggled with. How do you get the balance right? Firstly the nurse must reflect on his or her own practice. Critical Incident The following incident occurred during my first branch placement on a ward catering for women with acute mental health problems.

I was approached by a 63 year old lady who was complaining of “ noises and voices” in her head. I was asked to explore the problem further with her and

arranged to do this in 10 minutes time. Meanwhile I advised her to try to relax. I approached the patient in her room. She was crying and in a state of distress. She asked me to sit with her, as she was frightened. I saw this as a reasonable request and did so. After approximately 5 minutes a staff nurse came to the door, and requested my presence urgently. The staff nurse explained to me that I had put myself at risk.

If an accusation of abuse had been aimed at me then how would I have explained my actions? This incident left me confused regarding the way in which I should have handled it. What should I have done? Why was I not aware of this issue? What should I do the next time? These questions and many others were paramount to me at that time and I had difficulty in finding answers to them from fellow staff and trust policy. The male nurse and female patient relationship The issues raised through this incident were plenty.

Harrison (1992) suggests that an effective Nurse-Patient relationship is characterised by trust and confidence in the nurse, the nurse has a responsibility to be sensitive to patients' feelings, care, and support, while displaying respect for privacy, dignity, and choice. Such qualities are not discretionary (Bignall 1999). For example, if I had offered a chaperone in this case, the patient may have replied " Why do you want a chaperone in here don't you trust me", possibly making the patient uncomfortable and unable to share their true feelings.

Even if she accepted the presence of a chaperone then would she still have felt uncomfortable and embarrassed about sharing information in front of a

third party? Literature shows that patients appreciate a nurse who shows respect and concern for their well- being (Rogers, Pilgrim, & Lacey 1993). So, maybe the nurse should approach the issue with the patients' safety being central. For example, I could have said " Would you like somebody to sit in with us" shifting the emphasis from my protection to hers. If the answer is yes then the issue is resolved and can be explored at a later date.

If the answer is no, then it is the duty of the nurse to record this and inform other staff of the patients decision. Therefore suggesting the nurse should always offer, not need a chaperone. You could argue that the presence of a third person may unbalance the 1: 1 interaction or offend patients. Bignall (1999) states that women would like the offer of a chaperone but feel uncomfortable asking for one. Also stating that wherever an interaction takes place there is a fundamental right for all patients to maintain their autonomy by making informed decisions for themselves.

This should extend to the offer of a chaperone, with an equal importance on the sex of the chaperone. Therefore suggesting that if possible one should always be offered as part of good practice. This was argued by staff on the ward to be impractical as there were not enough nurses to do this. To overcome this simple documentation of this will go a long way to protecting you in a court of law. The use of touch Within this relationship the nurse and patient communicate, both verbally and non verbally. This communication should be skilled in its use.

For example, If a patient is displaying behaviour which is of concern to you then the nurse must qualify this behaviour by restricting, touch, unnecessary

eye contact and altering the tone of voice accordingly. In other words become neutral (Edwards 1998). Non-verbal signals are difficult to control. They give a great deal of information to the other person, therefore the nurse must learn to be aware of them and, if control over them is not possible, then withdrawing from the situation may be the best course of action.

This self-awareness is vital if the nurse is to be effective. Touch is a powerful non-verbal means of communication at the nurses' disposal. It should be an emotional response to a patients circumstances arising from empathy and genuine regard for them as a person (Savage 1987). Expressive touch is not required as part of a task. Mental health nurses use this more than any other kind of touch (Edwards 1998). As I am a tactile person by nature, I had problems with this aspect of communication. I needed to know the boundaries involved when communicating this way.

Savage (1987) suggests who's being touched, the type of touched used and that the overall contexts are important factors. She also states that the nature of the patient's illness dictates whether or not it is safe to touch. It posed questions about the care of patients with a history of sexual abuse. With people who have been sexually abused, touch could be easily misconstrued (Webb 1994). Suggesting the male nurse must be more aware of the importance of getting touch right. One way of helping the nurse do this is to listen to what patients say about the problems encountered within the nurse patient relationship.

Listening to service users There is mounting evidence of the prevalence of sexual abuse in mental health nursing. Nibert et al (1989) found that 38% of in patients had been sexually assaulted. With women being more likely to experience such harassment. This could lead the nurse to question how effective when compared to a female nurse the male nurse can be and whether they should be employed on all female environments. More recently, Feinemann (1998) indicated that sexual assaults were on the increase yet the issues have not been addressed across the board.

The American Psychiatric association (2001) states that it expels on average 12 members a year for various forms of patient abuse – most of them sexual. Other aspects include, Bakers (2000) report on behalf of ‘ Mind’ finding that when sexual harassment occurs the patient is not likely to be believed. That staff in some incidences suggested that due to a patient being attractive then she needed to be more careful. Surely it is our responsibility to protect these patients? Therefore, how can a male nurse protect the female patient from abuse?

Even though our awareness of the problem may be more evident, with the introduction of single sexed wards, the problem still exists within the nurse patient relationship. As explained earlier mental health nursing is that of a deeply personal and sometimes intimate nature. This can sometimes lead to sexual attraction between nurse and patient. Therefore the male nurse should be aware of these natural and common feelings that occur between two individuals in this setting. They must address these ‘ taboo’ aspects of the nurse-patient relationship.

Recognising the imbalance of power that is evident within the Nurse-patient relationship giving the nurse the opportunity to exploit the patient sexually, emotionally and financially. It is therefore in the interest of the patient for the nurse to have an awareness of how he is viewed by the patient and act accordingly. This is a subject, which appears to be avoided in training. We receive sessions regarding a patients need to express sexuality yet no training on how to deal with it when it is aimed at vice-versa or us.

This is not a new problem it has been known for a considerable amount of time. Freud (1914) cited in (Corby 1998) suggests that an erotic element can enter the nurse -patient relationship through transference and counter transference. He emphasises that the attraction is not for the professional but for what the professional represents. Why then are we left to resolve this issue ourselves? Nurses frequently use innuendo and the pretence of sexual attraction to get patients to conform (Webb 1994). For example, the nurse may say “ come on do it just for me”.

As a male nurse this is completely unacceptable practice as it could easily be confused as genuine sexual attraction and can be considered as an abuse of power. Webb (1994) also suggests that conflict around these issues can interfere with the therapeutic relationship. Adding importance to communicating effectively with the patient and other staff. Savage (1987) suggests that sexual attraction can and will enter into the nurse patient relationship. This can be a mutual feeling. This becomes a problem when carrying out simple tasks such as taking a pulse. These situations could now be highly charged with sexual content.

If a patient is seen to be attracted to a nurse or vice-versa then this is viewed as deviant or not normal thus affecting the care delivered. Nurses often deal with the problem of sexual attraction through avoiding the patient as much as possible or by being offhand (Savage 1987). To protect the patient and myself this issue of sexual attraction must be discussed and treated as a nursing issue and not a personal one. The nurse must reaffirm that these 1: 1 sessions are of a clinical nature and not the potential for a sexual encounter. A philosophy supported by Whitley (1978).

Yet, without support from other staff and an open attitude to what can be described as human nature these issues will always be personal. So it is important for the male nurse to be able to admit this to themselves and other staff. Unfortunately, nurses will not do this as it is seen as a breech of their ‘ professional behaviour’. If nurses acknowledged this, then the issue could be discussed within the team and the problem tackled more effectively. Professional/User recommendations Users of the services recommended that to address safety, dignity and privacy there must be provision for women only space (Baker 2000).

This has already begun to happen in the form of single sexed wards, yet as discussed earlier that does not tackle the problem of male staff abusers. Perkins & Repper (1998) identify the need to consider differences in race, ethnicity, age and class. They express the need for a culturally sensitive mental health services with separate areas for women who would normally experience some separation from men. As the ward frequently had patients of Asian origin, the male nurse must observe that cultures rules regarding the male-female relationship.

Whether touch should be used, whether a male should be key-worker in this instance etc. The RCN (1994) recommend that ‘ Nurses should listen to and accept as legitimate the experiences and needs of women who use the services. If the nurse can do this, then it will make them more empathic. A concept that is at the heart of nursing. The patient has the right to every consideration of privacy during their stay. The nurse must ensure confidentiality. This offers a dilemma. How can you when the advice being given is to ensure you talk in a more public place or have a chaperone?

Privacy allows the patient or nurse to be sexually expressive therefore questioning whether the nurse should offer privacy at all for 1: 1 interactions. Privacy allows conversations with the named nurse to occur of which others cannot hear the content. This has obvious benefits when working with patients with mental health problems. It appears that it is not in the nurse’s interest to press for increased patient privacy.

Recommendations for practice There are several ways of assuring protection for both nurse and patient: 1. Knowing your job description. This includes limitations and expectations of you in the job. . Remain alert and focused at all times. 3. Record observations objectively, timely, accurately and completely. This is important, as documenting any concerns regarding a patient’s behaviour will help protect you if an accusation is made. 4. Inform colleagues of these concerns and discuss ways of dealing with them. 5. Maintain a professional rapport with the patient throughout your relationship. 6. Assessment should include key issues such as whether or not there is a history of abuse, needs in terms of relationships, and personal choice as whether to have a male or female key worker.

7. The needs of and risk to vulnerable women are recognised and addressed.

8. Identify the agreed policy and protocols in place for staff that work with patients who are vulnerable and of the opposite sex. The trust-wide policy includes these issues listed above. It states that any staff carrying out physical examinations must be either the same sex or have a chaperone. This, in practice is not always adhered to and the question must be why? Does the nurse/doctor who does not offer a chaperone have ulterior motives? Why didn’t you tell anyone where you were going?

Why did you choose to sit in the room without a window? These are questions a tribunal or court of law may ask and it is up to the nurse to answer them using evidence. The main findings of this paper are primarily, that there is a need for better education regarding the issue of sexual attraction between nurses and patient surely this can be discussed within an academic environment, if not in a professional one. There must be an acute awareness of self on behalf of the male nurse as there must be more emphasis put on the correct use of non-verbal communication, especially touch.

Trust policies need to be made clearer and identify the problems discussed with sexual attraction or abuse, maybe if the profession refuses to acknowledge the need for a more open attitude towards the issue of sexual attraction then the individual trusts should provide a councillor within the hospital who nurses can go and discuss this specific issue with, as it would be unlikely to be picked up during supervision. It recommends the need for offers of chaperones to be common place within practice but more

importantly whatever practice a ward decides to adopt then it should be consistent in its use.

This includes the male nurse recognising and challenging the deep-rooted values which society has installed during our developing years with the effect of making him a more professional, more competent, protected individual. I have learned that initially it was easy to feel like the victim in all of this yet the real victims are those clients who have endured abuse. It is therefore important to stop this practice through a greater awareness of the problem and a more realistic view of the nurse not just being a professional but also a human being.