

Applying ksf six core dimensions to clinical practice



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This assignment will discuss the Department of Health (DoH) Knowledge and Skills Framework (KSF) Six Core Dimensions and how they apply to clinical practice.

For the purpose of this assignment, one core dimension will be chosen to explore further. Using the process of reflection, an area of clinical practice will be critically analysed using the evidence base and current best practice to provide examples of application.

The DoH KSF was developed as part of Agenda for Change. It describes the knowledge and skills that National Health Service (NHS) employees are required to apply in their role to deliver a quality service (2005, Royal College of Nurses (RCN)).

It is essential for career progression and applies to all nurses who are employed under Agenda for Change terms and conditions.

The KSF aim is to enable the development of services to better meet the needs of users and the public. Its purpose is to be used as a tool to support the development and learning of staff in their posts, and also aid diversity and equality.

The key objectives of KSF are; to identify skills and knowledge staff need within their post, to assist in the guidance of individual development, to base review and development of staff on a fair and objective framework, the KSF also provides the foundation for NHS pay progression. It does this through incremental pay points, the main ones being two 'gateways' within each pay band. The foundation gateway checks that the required knowledge and skills

for the post are being met. The foundation gateway takes place within the 12 months since you have joined a pay band.

The second gateway is a formal review of the individual's development against the KSF for their post, and takes place at the top of the pay band at a fixed point. This verifies that individuals have applied skills and knowledge so that the full outline of the post is being met

The KSF is made up of ' dimensions' which describe different aspects of work of all NHS posts. There are six dimensions core to the working of every NHS job, these are: " Communication, Personal and people development, Health, safety and security, Service development, Quality, and equality, Diversity and rights" (2005 RCN). There are twenty four further ' specific dimensions' which are applied to define parts of different job roles but for the purpose of this essay only the six core dimensions will be discussed.

The KSF sets out a ' post outline' for every NHS job. This ' post outline' sets out the requirements of a post by providing a framework for development and assessment. This outline also states the knowledge and skills that are needed so that the post is being undertaken effectively.

Yearly, the individual and their manager will review how their knowledge and skills are being applied against the KSF outline. A Personal Development Plan

will then be formulated and agreed upon in order to guide learning and development

for the year ahead.

Every posts outline includes six ' core dimensions', each of these dimensions having four levels, or ' indicators' within it. The higher the indicator specified, (4 being the highest), the greater the expectation of knowledge and skills necessary for the post.

As a staff nurse who has been in post for 10 months, my role is defined by the ' foundation' gateway, this ensures that as new to the role I can apply the basic knowledge and skills required and build on them to meet the full KSF post outline.

The core dimension I have chosen to explore within the rest of this assignment is communication.

The level expected within the Communication dimension at the foundation gateway for a Band 5 Staff Nurse is level 3. This level is defined as being able to " develop & maintain communication with people about difficult matters and/or in difficult situation" (2007 Allied Health Professionals, Centre for Professional Development, Working Group, [www. dvh. nhs. uk](http://www.dvh.nhs.uk)). The area of clinical practice I shall explore within this context is providing reassurance to anxious patients awaiting major surgery.

It is widely accepted that undergoing anaesthesia and surgery is a common cause of anxiety in many patients, (Leach et al 2000, Lee and Gin 2005, Mitchell 2008)). These anxieties can include how much pain they will experience after surgery and if they will suffer nausea and vomiting. Carr et

al (2005) argues that for many patients, it is the general anaesthetic creates the greatest apprehension.

Physiological responses to anxiety include; sweating, nausea, hypertension, tachycardia, and heightened senses to smell, hearing and touch (Pritchard 2009). Psychological responses to anxiety include; nervousness,, aggression, and tension (Markland and Hardy 1993). Broadbent et al (2003) examined the negative effects of increased pre-operative stress on wound healing in hernia patients, and found that patients who had reported the highest levels of pre-operative stress had delayed wound repair.

These normal responses to anxiety require the nurse to acknowledge the existence of these responses, to develop strategies to reassure the patient, to enable them to cope with forthcoming surgery.

Lack et al (2003) and Kindler et al (2005) states that empowering patients and addressing their psychological needs can reduce the risk of complications, improve post operative health outcomes and be cost effective.

The patient who shall be called Mrs Hill to maintain confidentiality (Nursing and Midwifery Council, 2008), was admitted to hospital, prior to surgery the next morning. Mrs Hill was 42 years old and lived at home with her husband and 2 children. She had recently been diagnosed with breast cancer and was to undergo a mastectomy with reconstruction of a transverse rectus myocutaneous flap (TRAM) to the left breast. This is major surgery requiring up to 10 days in hospital and carries with it several risks, including failure of the flap and infection.

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I met Mrs Hill when I was carrying out her hospital admission. It became clear from her verbal and non verbal communication that Mrs Hill was very anxious about the forthcoming surgery. Mrs Hill was talking quickly, not stopping to think about answers to my questions, avoiding eye contact, and adjusting her suitcase on the bed. It was felt that the giving of reassurance was important and necessary at this stage.

Purtilo and Haddad (2007) argue that when used correctly the skill of reassurance can have significant benefit to patient wellbeing.

When attempting to reassure a patient it is important to make them feel at ease. Williams (1997) highlights the importance of correctly greeting the patient, as impressions are made within moments of meeting. Williams (1997) says nurses should introduce themselves, and use the patient's full name until a preferred form of address is established. I attempted to make Mrs Hill feel at ease by introducing myself by my first name, I then asked her name, and if she was fine with me addressing her as such.

Walsh and Crumbie (2007), state that when nurses reassure, they need a positive attitude towards the patient, and must perceive patients as valuable people. I believe I achieved this by asking Mrs Hill about her family and her job. Walsh and Crumbie (2007) also say that nurses must also exhibit positive communication skills and possess knowledge related to the cause of anxiety.

To convey reassurance many communication skills need to be applied. These include verbal and non verbal skills. Verbal skills include the speed and tone of voice. An anxious patient needing a soft tone of voice, prioritising the <https://assignbuster.com/applying-ksf-six-core-dimensions-to-clinical-practice/>

order of the information you give, allowing time for questions and thought.

Non verbal skills include body language, appearance, and facial expressions, for example using eye contact whilst appearing relaxed and confident.

Mysercough and Ford (1996) argue the importance of the nurse appearing unhurried and willing to listen. A patient who feels the nurse is short of time and will be less likely to discuss feelings and anxieties they are experiencing (Hurley 2005).

Workman and Bennett (2002) stipulate the need for an unrushed, calm and non-judgemental atmosphere. Most patients are more willing to discuss feelings if they feel in an environment that gives them time to respond, therefore encouraging honesty and trust.

While completing the hospital admission I observed Mrs Hill often talked in a hurried way and was not making eye contact. The door to her side room was open and the ward was busy with the rush of the morning routine, the assessment was often interrupted by colleagues asking if I “ had the keys”, and making the bed while the admission was being carried out. I closed the door, shut the blinds facing the ward and sat down on a chair next to the patient, thus showing Mrs Hill that I had time and respect for her.

These actions appeared to put the patient at ease, as we laughed about the busy ward and my intrusive colleagues. When the assessment was recommenced Mrs Hill was making eye contact, and appeared less rushed with her responses time. Through these small actions Mrs Hill could see that I had time to both listen to her fears and answer any questions she may have.

Krohne and Slangen (2005) have shown how the presence of a nurse for <https://assignbuster.com/applying-ksf-six-core-dimensions-to-clinical-practice/>

support during the pre-operative period can be very beneficial; they compare this presence to the reassuring safety that occurs when a partner or parent is close. Krohne and Slangen (2005) believe that by the nurse being close by and communicating freely with the patient, it offers the patient and increased sense of security.

To be able to communicate effectively requires the nurse must have empathy for the patient. Williams (1997) describes this as “ being able to take the patient’s perspective and understand how they might be feeling” (Williams, 1997, pg90). Patients come from differing backgrounds and cultures, therefore nursing should be non-biased and must give everyone the same care and opportunities.

Anxiety management has traditionally been associated with the provision of information pre operatively, and Ivarsson et al (2005) found that most patients were satisfied with information they were given.

The view that provision of information prior to surgery alleviates anxiety has been challenged by some (Kiyohara et al 2004, Ivarsson et al 2005).

Kiyohara et al (2004) also argue that increasing a patient’s knowledge of surgery may reduce anxiety levels in some, but not all patients respond positively to this information and may provide no benefit.

Mitchell, (2002) also argues that information may be of no benefit to anxiety management at this late stage. I was aware that Mrs Hill had the procedure explained in advance at admission in clinic and information leaflets were given, but her questioning made me feel that the provision of more detailed

information would be of benefit, for example choices of pain relief, amount of drains and how long they are to stay in.

The giving of reassurance requires the nurse to stay within safe boundaries. According to Purtilo and Haddad, (2007) the aim is to provide as much information as possible, whilst not to giving false hope. If there are risks, the patient should not be given false information and told everything will be alright. Mrs Hill was seeking reassurance that after surgery the flap would not fail, I was very conscious about how I approached this and resisted telling her everything will be fine, instead relating facts and information whilst maintaining empathy. Experience makes the giving of this type of information easier, but care must be taken as there could be serious consequences if information is wrongly given.

Nurse must be flexible when giving information, different strategies need to be employed with different patients. For example Williams (1997) highlights how it is best to avoid using medical terminology. When offering reassurance, differing strategies also need to be used, for example, whether to give information in the form of leaflets, to offer kind words, or to just listen. Mrs Hill was an intelligent woman and felt comfortable enough to discuss and work through her anxiety by talking about the procedure she was due to have done, and about how she would feel post-surgery. Again, consideration was given to not 'glossing over' the fact that it was a major operation and offering false reassurances. When I had finished the pre-operative assessment Mrs Hill appeared to be less anxious and much calmer regarding her surgery.

The aim of reassurance was reduce anxiety by creating trust and showing empathy. It remained respectful, privacy was maintained and competent care given at all times. “ Patients are reassured if they feel happy with their predicament, more secure, less worried, less anxious and at ease with their situations and surroundings” Hinchliff et al. (2003).

Through my use of communication skills I believe I achieved these aims with Mrs Hill.

As nurses, we are sometimes unsure about what to say to our patients and fail to realise that listening is often the best way to help. The experience I had with Mrs Hill has made me appreciate how important the skill of listening is, it is often beneficial not to speak but just to listen, with the correct non verbal techniques being utilised, for example, eye contact.

All the communication skills discussed need consideration when attempting to reassure a patient having surgery. This assignment has been beneficial and has aided my professional progression. An understanding has now been gained that communication skills we, as nurses can take for granted, are actually very important

When giving reassurance to patients.

By being able to provide evidence based best practice regarding reassuring an anxious patient, I have through my role as a staff nurse provided examples of application and I have been able to provide evidence that I have met, through my role, particular indicators set out in KSF Core Dimension 1, Communication, Level 3. One example being Indicator C, which states that “

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one must recognise and reflect on barriers to effective communication and the context in which it is taking place” (2007, Allied Health Professionals, Centre for Professional Development, Working Group. www.dvh.nhs.uk/downloads). This was achieved by identifying Mrs Hill’s anxiety, why she was anxious and adjusting the way I interacted with her according

As I progress along a nursing career pathway and gain increased job responsibility the number of core dimension will increase, particularly when undertaking a managerial or specialist nurse role. The levels required for the core dimensions also increases, thus requiring more detailed and in depth examples of application.