Communication and interpersonal skills reflection

The aim of this report is to look at a critical incident that occurred in placement and relate this to the theory and knowledge regarding communication and interpersonal skills, so as to demonstrate an understanding of my views on the art and science of reflection and the issues surrounding reflective practice Reflection is part of reflective practice and a skill that is developed. It can be seen as a way of adjusting to life as a qualified healthcare professional and enhancing the development of a professional identity (Atwal & Jones, 2009).

Reflection is defined as a process of reviewing an experience which involves description, analysis and evaluation to enhance learning in practice (Rolfe et al 2001). This is supported by Fleming (2006), who described it as a process of reasoned thought. It enables the practitioner to critically assess self and their approach to practice.

Reflective practice is advocated in healthcare as a learning process that encourages self-evaluation with subsequent professional development planning (Zuzelo, 2010). Reflective practice has been identified as one of the key ways in which we can learn from our experiences.

The incident that was chosen was so for the reasons that the situation made the student aware of inadequacies on his own part and those of the staff on the team, which made him reflect upon the situation and how this could be learned from, so as not to make the same mistake again.

Before the critical incident is examined it is important to look at what a critical incident is and why it is important to nursing practice. Girot (1997), cited in Maslin-Prothero, (1997) states that critical incidents are a means of

exploring a certain situation in practice and recognising what has been learned from the situation. Benner (1984, cited by Kacperek, 1997) argues that nurses cannot increase or develop their knowledge to its full potential unless they examine their own practice.

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MODELS

In order to provide a framework for methods, practices and processes for building knowledge from practice, there are several models of reflection available. All can help to direct individual reflection. Reflective models, however, are not meant to be used as a rigid set of questions to be answered but to give some structure and encourage making a record of the activity.

John’s (2004) model reflects on uncovering the knowledge behind the incident and the actions of others present. It is a good tool for thinking, exploring ideas, clarifying opinions and supports learning.

Another model, Schon (1987), however, identifies two types of reflection that can be applied in healthcare, ‘ Reflection-in-action’ and ‘ Reflection-on-action’. Reflection-in-action can also be described as thinking whilst doing. Reflection-on-action involves revisiting experiences and further analysing them to improve skills and enhance future practice.

Terry Borton’s (1970) 3 stem questions: ‘ What?’, ‘ So What?’ and ‘ Now What?’ were developed by John Driscoll in 1994, 2000 and 2007. Driscoll

matched the 3 questions to the stages of an experiential learning cycle, and added trigger questions that can be used to complete the cycle. However, Driscoll (2006) notes that reflective practice is often represented as a choice for health professionals, whether to be reflective or not to be, about their clinical practice.

Finally, Gibbs (1988) reflective cycle is fairly straightforward and encourages a clear description of the situation, analysis of feelings, evaluation of the experience, analysis to make sense of the experience, conclusion where other options are considered and reflection upon experience to examine what one would do if the situation arose again.

In spite of all these models' advantages, there are known barriers which prevent practitioners being able to reflect effectively and time plays a huge role. Smyth (2004) questions whether there is any time to think and be reflective because of the busy work environment that practitioners are involved in.

CHOSEN MODEL

In this report, I have chosen to use Gibb's Reflective Cycle (1988) as a framework, because it focuses on different aspects of an experience and allows the learner to revisit the event fully. Gibbs (1988) will help me to explore the experience further, using a staged framework as guidance and I feel that this is a simple model, which is well structured and easy to use at this early stage in my course. This model comprises of a process that helps the individual look at a situation and think about their thoughts and feelings at the time of the incident; and consists of six stages to complete one cycle.

Its cyclical nature starts with a description of the situation. This includes e. g. where were you; who else was there; why were you there; what were you doing; what were other people doing. Next is to analysis of the feelings that is, trying to recall and explore those things that were going on inside your head?

The third stage is an evaluation of the experience; making a judgement regarding the reasons behind the event and its possible consequences.

The fourth stage is an analysis to make sense of the experience. At this stage the event is broken down into its component parts so they can be explored separately. The fifth stage is a conclusion of what else could I have done; the creation of insight through the reflective process towards individual roles within the event being considered. And final stage is an action plan to prepare if the situation arose again. That is, recognitions leading towards behavioural adjustments where faced with similar events in the future (NHS, 2006). The use of this model represents a fundamental shift from the ideas of Kolb in that Gibbs' model specifically refers to the key processes within reflection itself, rather than as reflection as a process within general learning.

Reflective practice can mean taking our experiences as an initial point for our learning and developing practice (Jasper, 2003). Many literatures have been written in the past that suggest the use of reflective assignments and journaling as tools to improve reflection and thinking skills in healthcare (Chapman et al, 2008). Reflective journals are an ideal way to be actively involved in learning (Millinkovic & Field, 2005) and can be implemented to

allow practitioners to record events and document their thoughts and actions on daily situations, and how this may affect their future practice (Williams & Wessel, 2004). The experience gained in this can then be used to deal with other situations in a professional manner.

By contemplating it thus, I am able to appreciate it and guided to where future development work is required.

Context of incident

In the scenario the patient’s name will be given as Xst. The consequences of my actions for the client will be explained and how they might have been improved, including what I learned from the experience. My feelings about the clinical skills used to manage the client’s care will be established and my new understanding of the situation especially in relation to evidence based practice will be considered. I will finally reflect on what actions I will take in order to ensure my continued professional development and learning.

Xst is 55 year old woman who has a 10 year old daughter. She suffers from psychiatric problems, lack of motivation and has difficulties in maintaining her personal hygiene and the cleanliness of her flat. She was one of my mentor’s clients to whom I had been assigned to coordinate and oversee her care under supervision. Nurses owe their patients a duty of care and are expected to offer a high standard of care based on current best practise, (NMC 2008).

Description

Xst had been prescribed Risperidone Consta 37. 5mg fortnightly, which is a moderate medication. Risperidone belongs to a group of medicines called antipsychotic, which are usually used to help treat people with schizophrenia and similar condition such as psychosis. Xst did not like attending depot clinic and she missed three consecutive appointments. My mentor decided after the third non-attendance to raise the issue in the handover meeting where it was decided to see Xst in the morning but when we arrived she was not there. We left a note for her to call the office. We did not hear from her and a further home visit was carried out to arrange for her next depot clinic appointment. I was asked to call a meeting of the multi-disciplinary team (MDT) who, at the meeting agreed that there would be a problem if the next injections were missed.

At the next clinic, we waited for about an hour but she failed to attend. At a subsequent meeting with the patient, she agreed a joint visit with the CPN, my mentor and me to re-assess her condition and consider if it was necessary to refer her case to the Consultant.

I was given the opportunity to participate in the assessment, which showed that her behaviour was very unpredictable and very forgetful. Her inability to take her medication and to manage her personal hygiene clearly demonstrated that she was not well and indeed, had no insight into her illness and was in denial (Barker, 2004). However, the patient had been very upset because of the lack of communication and interpersonal skills that the staff and the student had displayed.

I talked to Xst about her non-concordance with her medication, whilst stroking her hand but she persisted in saying she was well. I reminded her that continuous use of the medication would benefit her mental health and protect her against relapse. We agreed that she could discuss this with the doctor on her next outpatient appointment, with the option of reviewing or reducing her medication. I stressed the importance of her communicating any side effects or reservations she may have about the medication to doctor. She appeared to understand this and following the discussion, she finally complied with her depot injection.

Feeling

During the handover, I was nervous as I felt uncomfortable about giving feedback to the whole team. I was worried about making mistakes during my handover that could lead to inappropriate care being given to Xst or could cause her readmission to hospital. As a student nurse I felt I lacked the necessary experience to be passing information to a group of qualified staff members. However, I dealt with the situation with outward calm and in a professional manner. I was very pleased that my mentor was available during the handover to offer me support and this increased my confidence.

Evaluation

What was good about the experience was that I was able to carry out the initial assessment and identify what caused Xst failure to comply with the treatment regime. From my assessment I documented the outcome and related what had happened to the MDT with minimal assistance. Accurate documentation of patient’s care and treatment should communicate to other

members of the team in order to provide continuity of care (NMC, 2008). The experience has improved my communication skills immensely, I felt supported throughout the handover by my mentor who was constantly involved when I missed out any information. Thomas et al, (1997) explains that supervision is an important development tool for all learners. The team were very supportive throughout the process as they took my information without doubt.

What was not good about the experience was the fact that my mentor had not informed me that I was going to handover the information; as a result I had not mentally prepared myself for it. I also felt that I needed more time to observe other professionals in the team carrying out their handovers before I attempted to carry out mine. During the first MDT meeting, I felt that we did not provide enough time to freely interact with Xst to identify other psychosocial needs that could impact on her health. However, in any event, she was unable to fully engage because of her mental state. Turley (2000) suggests that nursing staff should include their interaction with the patient when recording assessment details, which can be used to provide evidence for future planning and delivery of care. Dougherty and Lister (2004) have suggested that healthcare professionals should use listening as part of assessing patient problems, needs and resources.

Analysis

The literature regarding communication and interpersonal skills is vast and extensive. Upon reading a small amount of the vast literature available, the author was able to analyse the incident, and look at how badly this situation

was handled. I realised communication is the main key in the nursing profession as suggested by Long (1999) who states that interpersonal skills are a form of tool that is necessary for effective communication. The behaviour of the person listening to the person who is talking is important during the interpersonal process (Burnard, 1992). The author used touch to convey support, genuineness and empathy, which is essential for the helping relationship (Betts, 2002, cited in Kenworthy et al, 2002). Carl Rogers (1967, cited by Betts, 2002, in Kenworthy et al, 2002) recommended three principal conditions necessary for effective counseling: empathic understanding, congruence or genuineness and unconditional positive regard. The terms genuineness and congruence are used interchangeably and used to describe the helper always being real in the helping relationship (Betts, 2002, cited in Kenworthy et al, 2002).

I found it difficult to communicate with the patient initially because I did not understand her condition (Adams, 2008). It was also difficult for me not to take her behaviour to heart and show emotion at the time and thought this to be a failure. Even though the NMC (2008) maintains that nurses have a responsibility to empower patient in their care and to identify and minimise risk to patient, the principle of beneficence (to do well) must be balanced against no maleficence (doing no harm) (Beauchamp and Childress, 2001). All these transactions were recorded in Xst’s care plan file and on computer. Good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow NMC (2009). The consequences of my actions for the patient and her daughter were that she

attended to her daughter’s needs and to her personal hygiene, and made regular fortnightly visits to the clinic. Her mental condition was improved. She was allowed to continue on her moderate medication and she did not have to be readmitted in the hospital.

However, Bulman & Schutz (2008) argue that this failure is to educate and for us to learn from practice and develop thinking skills. I would agree with them, as I learn best from practical experience, and build on it to improve my skills. With this is mind, I am now going to focus on my weaknesses, in both theory and practice, and state how, when and why I plan to improve on these.

Through effective communication I was able to convince Xst of the need to take her medication. I was able to pass on the information to the MDT for continuity of care. Roger et al (2003) concluded that communication is an on-going process but can be a difficult process when dealing with mental health problems. Whilst talking I attempted to use Egan’s SOLER (Egan, 1990, cited in Burnard, 1992). The SOLER acronym is an aid to identifying and remembering the behaviours that should be implemented in order to promote effective listening (Burnard, 1992). I Sat facing Xst; assumed an Open posture; Leaned towards Xst slightly (in order to express interest); maintained Eye contact and attempted to appear Relaxed, as advised by Egan. During the handover I was pleased that the MDT members were supportive and interested in what I was saying and they asked questions.

My mentor explained that a patient with schizophrenia can often behave like this as they develop dementia, which Noble (2007) also confirms. Since the

incident I have read about schizophrenia and I am now aware that the patient’s expressionless face Netdoctor (2008), also made her comments appear more confusing and aggressive.

Conclusion

In conclusion, I have learnt that through effective communication, any problem can be solved regardless of the environment, circumstances or its complexity. Therefore, nurses must ensure they are effective communicators. I have identified the weaknesses that should be turned to strengths. I am now working on strengthening my assertiveness, confidence and communication skills. Participating in the care of Xst I have realised that a good background information and feedback about mental health problems before providing care to clients can assist in accurate diagnosis and progress monitoring. A good relationship between client and staff nurse is therapeutic and help in building trust. This can be achieved by a free communication that allows the client to express their feelings and concern without the fear of intimidation. From the experience, I feel the knowledge I have acquired will aid me in future practice should such situation arise again.

Action Plan

So that I could identify my strengths and weaknesses in both theory and practice easily, I found that the use of a SWOT analysis provided a good framework to follow. I have then built on this by producing a development plan that focuses on my weaknesses and how, when and why I plan to improve on them. I will now begin to work on these, the main reason being of course, that I am determined to be a competent, professional nurse in the

future. I am now more prepared for any future patients with this disease as I have researched it. I will take the time to talk to them, to make sure they are at ease with me, before providing any care. If they appear distressed I would get another member of staff to help me to reassure them.

Learning Need

To improve my knowledge about patients' illnesses and the risks of relapse associated with not taking medication.

To identify and have good background information and feedback about patients' mental health problems before providing care to them.

To ensure a good rapport exist between my patient and I, in order to build up a therapeutic relationship with them and to gain their trust.

To have effective communication with the patients and other members of the multidisciplinary team and being prepared.

Planned action to meet these learning needs

I aim to read books about different illnesses and causes of relapse and to read my patient's notes.

I will be talking with senior members of staff and allocating time to talk to patients and their relatives and participating in the ward round. Finally, I will have regular meetings with my clients.

Target time to meet the learning needs

I hope by the end of third year and some will be on-going skills to develop throughout the training.

CONCLUSION

I have clearly demonstrated that by using a reflective model as a guide, I have been able to break down, make sense of, and learn from my experience during my placement. At the time of the incident I felt very inadequate

It was also difficult for me not to take her behaviour to heart and show emotion at the time, it is clear that this is an area I need to build on for the future. Nursing requires effective preparation so that we can care competently, with knowledge and professional skills being developed over a professional lifetime. One way this can be achieved is through what some writers refers to as technical rationality, where professionals are problem solvers that select technical means best suited to particular purposes. Problems are solved by applying theory and technique.

The invaluable use of non-verbal communication has now become clearer to the author. The author believes he has become more self-aware regarding his own non-verbal communication and hopes that in the future he will use his communication skills to become a better advocate for the patient in his care.

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