Health visitor reflective essay

I attended a core group meeting for a family with complex needs. Parents Poppy and Richard had struggled to overcome a class A drug addiction and that there were grave concerns about the wellbeing of the 4 children in the family home. I sat opposite Poppy across a small table as this was the last available seat in the room. Richard was unable to attend but it had a very positive start for Poppy who discussed some of the improvements since the last official meeting. She appeared content and motivated to ensure things continued to improve. I was aware that an important discussion was going to take place about a serious incident which had occurred within the family and had been observed by a health visitor visiting the family next door. The purpose of the discussion was to support Poppy to understand the risks of leaving children unattended in the car and readdress the on-going issue of smoking around the children in confined spaces. The issue was broached by the social worker and Poppy immediately expressed unease. She denied having been involved until Poppy was informed it had been witnessed by another health visitor. Poppy became very angry, very quickly and made reference to the name the health visitor (her name had not been disclosed in the meeting). Her anger was then directed at my community practice teacher and me as the health visitor/student in the room. Poppy maintained intense eye contact with me and when I glanced away she noticed and it escalated her anger. Amongst the shouting and swearing Poppy was asking why Health visitors always interfere with her family and she was expressing that there was nothing wrong with what she was alleged to have done. As the main receiver of Poppy’s upset I tried to put active listening skills in to practice.

Chosen Reflective Model and Rationale:

Reflection is described by Boud et al (1985 p43) as ” a generic term for those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to a new understanding and appreciation” . It is deemed a particularly valuable tool within the health profession for many reasons. Reflection is a tool which can be used at all levels within the health care setting and is arguably imperative within practice (Ralphe et al 2011). It facilitates critical thinking (Cotton 2011) and by scrutinizing experiences professionals are then able to decipher the evidence within their own practice.

Moreover it supports practitioners to make more sense of difficult and complex situations (Driscoll and Teh 2001). The collection of knowledge of individuals and groups through the form of refelction helps people to look not only at the situation but at how to understand it enough to be able to commit to improve similar situations which may arise again. Thus leading to improved practice (Ghaye and Lillyman 2010)

Examples of reflective models include Gibbs (1988), Johns (2004) and Driscol (2000). Johns’ model is recommended for more complex reflection and decision making (REF). On one hand this would work well as a basis for this assignment however the model looks at the situation which has been resolved and it could be argued that it does not consider how the situation can be taken forward (Rolfe 2001). Although this could be adapted the Gibbs model of reflection (Gibbs 1988) has been chosen as a guide for this assignment. Despite being a fairly straight forward model, it is favourable because it aids a clear description of the scenario, analysis of feelings,

evaluation of the experience, analysis to make sense of the experience and conclusion for each point that will be reflected upon. This enables careful consideration on what I would do if the situation occurs again.

Communicating in Difficult Circumstances and Relevance to Health Visiting:

According to the Department of Health (2007) one of the key elements to health visiting practice is to deliver the healthy child programme (Department of health 2009). This outlines the role of the health visitor and this includes the need for the health visitor to reduce health inequalities and protect children at risk (Department of Health 2009). The distressing conversation for Poppy was aimed to protect the children from potential harm caused by cigarette smoke and also to protect the children from the harm of being left unattended in a smoky car. It was acknowledged that smoking cessation had been suggested to Poppy but denied with such ferocity that the idea was to put things in place to protect the children from being harmed as a result of her smoking. After all as professionals we have to remind ourselves that Poppy has a right to smoke if she chooses to. The safeguarding of the children is paramount and therefore despite it being a tricky issue to address, it was an issue which was vital to work with in order to safeguard the children.

It is important to recognise that delivering these messages set out in the healthy child programme (2009) are not always straight forward. The people at highest risk of poor health are often those who have a lesser understanding of the consequences of their actions on the health of themselves and their families. They are perhaps less likely to comprehend

the information which is delivered to them and the fact that this information is often changing (Knai 2009). Good communication is therefore crucial. Communication is defined by Porche (2004 pp266) as

The transfer of Information and the understanding of the information from one individual another. It is the process through which individuals share thoughts, ideas, facts, beliefs, values and traditions.

The department of health (2012) recently published Developing the Culture of Compassionate Care, which highlights Communication as one of the 6 C's (Care, Compassion, Competence, Communication, Courage, Commitment) required to maximise compassionate care. It acknowledges that good communication skills contributes to better listening which results in people receiving care feeling valued and therefore happier with the service they receive (Department of Health 2012).

Focusing on communication in difficult situations is very relevant to Health visiting practice as there are frequent barriers which can effect delivering the public health messages. In this case the barrier was Poppy's resistance as a loving Mother to acknowledge the risks which her actions may have on her children and the emotions this consequently provoked creating a difficult situation in which to communicate not just the public health messages but to support Poppy in de-escalation. Resistance to accept information and support from health visitors is an on-going issue (REF) so having the opportunity to critically reflect on the situation will support me to ensure better practice in futur

Eye Contact

Initially Poppy seemed calm and positive about the progress she had made with her children avoided eye contact. However when angry, Poppy maintained strong eye contact with me in particular. I was surprised at how intimidated I felt, not by the shouting and verbal abuse but by the intense way in which Poppy was looking at me. I glanced away and looked towards my community practice teacher. This move that for me seemed quick and subtle had a profound effect on Poppy and she demanded I look at her when she is talking to me and this was followed with a threat.

As specialist community public health nurses it is important to recognise that communication goes way beyond the verbal conversations that we have with people. Nonverbal communication plays a very strong role in the impressions that we give to people therefore having an understanding of what happened with Poppy is key to furthering my communication skills and awareness in future.

Non-verbal communication is profound. Eyes and eye contact are a major part of non-verbal communication and many messages are consequently sent and received by the eyes (Sieh and Brentin 1997). The person who is listening holds eye contact with the speaker in order to express that they are listening and taking on board what the speaker is saying. The speaker holds eye contact with the listener so that they will know that the conversation is being directed at them (Lerner 2002).

It is a real challenge to define normal eye contact as it differs from person to person depending on personal preference and aspects such as culture. (REF

something on culture). It is not possible to create a text book advising when to look and how long for (Rungapadiachy 1999). Therefore responses to eye contact are open to interpretation and could lead to confusion within communicative situations (Sieh and Brentin 1997).

Eye contact can have a positive impact on people. A good level of eye contact from the listener can make the person speaking feel as if they are being listened to and listener is interested and focused (Rungapadiachy, 1999). Alternatively, any form of eye contact can cause some people to feel uncomfortable, self-conscious and threatened (Rungapadiachy, 1999). Minimal eye contact may indicate lack of interest (Sieh and Brentin 1997) but it is important to acknowledge that eye contact may be less prominent when engaging in difficult or intimate topics (Rungapadiachy, 1999). Knapp (1978, cited in Rungapadiachy, 1999, pp206) recognises that when a person is disapproving of something it can be displayed in aggressive and intimidating eye contact. Furthermore early signs of anger can be shown via intense and threatening eye contact (Neild-Anderson et al 1999).

Poppy initially avoided eye contact. She may have felt self-conscious being surrounded by professionals and despite the discussion being originally very positive, the subject matter was also intimate and personal. Similarly possible that she was able to anticipate what was about to be said.

As Health visitors the heart of what we do is safeguard children physically and emotionally. The information discussed was vital within our role but it was not easy for her to deliberate and acknowledge. The intimidating eye contact displayed could have been because she was feeling intimidated or

she was not accepting of the information being given to her. Moreover, I broke the eye contact momentarily and this may have upset the foundation of the conversation. For Poppy this could very easily be construed as non-compliance to listen on my part (Kidwell 2006).

If we feel that something is unacceptable then it is likely that our eye contact will decrease (Rungapadiachy 1999). I acknowledge that I looked away from Poppy whilst she was communicating with me. Consciously I feel this is because I felt intimidated. However perhaps subconsciously I was not accepting of what she was saying.

I attempted to communicate to Poppy through non-verbal communication that I do care and I appreciate that the situation was not an easy one for her. This is much like the view of Chambers and Ryder (2012 p106) who acknowledge that " many nurses have become very skilled at communicating messages and meaning without words". However in this case, either I was not portraying myself in the manner that I intended, or it went un noticed as a result of Poppy's heightened state of anxiety and upset.

At the time I did not consider that Poppy could have misinterpreted my eye contact for staring. Poppy's behaviour was intimidating but this did not exempt her from feeling intimidated herself. It is possible she felt under attack as a result of the raised concerns and prolonged eye contact on my part could have been threatening (Duxbury, 2000). Moreover, averting my gaze suddenly, may also have signalled fear in me which could also have distracted Poppy from getting her point across (Manos and Braun 2006). Alternatively I acknowledge that eye contact is also natural process and the

anger which Poppy displayed did frighten me thus triggering a fight or flight reaction (Manos and Braun 2006). I did not escape physically but there was a shift in my gaze in order to avoid a threatening glare and it could be argued that this does not assist good listening.

Although it was not possible in this situation because of the room space, I understand the importance of positioning within a meeting. I was positioned directly opposite Poppy which meant that I was the centre of her vision and she of mine. This meant that where less intrusive peripheral eye contact may have worked better, I was holding what could have been construed intimidating contact (Duxbury, 2000).

My Community Practice teacher fed back that my expressions and levels of eye contact were acceptable and skilled. She viewed the reaction as unavoidable because of Poppy's nature and the topic of the conversation. I acknowledge that there were a number of factors which triggered Poppy's anger and it is because I deem eye contact so important that I have prioritised it. It is very difficult to know whether it directly correlated with the escalation of her emotions and if it did which of the above discussions applied to her. However as a result I am more aware of different personalities and how communication methods can be interpreted and it is this which is so vital for future practice.

Seih and Brentin (1997 p5) reinforce this by stating " Being sensitive to your own eye contact patterns and the patterns of those with whom you communicate will help you be more perceptive of what is occurring in the communication process",

Active Listening

I was aware that Poppy needed support to deescalate. I was not confident addressing this myself despite having had years of experience deescalating distressed people who displayed challenging behaviour. This was different. There was pressure on me as Poppy had targeted me and I was feeling increasingly intimidated by what was happening. Whilst Poppy was shouting I nodded a few times so she would feel listened to. She made some unpleasant threats to my community practice teacher and me and was suggesting that there was no problem with leaving children unattended in a smoky car or in smoking with them on her lap. I was equally careful as I did not want to give the impression that I was condoning what was being said. When active listening was used Poppy did respond calmly on occasion. Verbal contributions which I made in response to Poppy included:

“ Am I right in thinking that you feel that your privacy has not been respected?”

“ Are you saying you feel health visitors don’t think you are a good mother?”

Active listening is central to good interpersonal skills (Wondrak 1998). Where listening may be deemed passive when a person is talking and another listening it is in fact very active. Active listening is defined by Arnold and Boggs (2007 pp201) as “ a dynamic, interactive process in which a nurse hears a client’s message, decodes it’s meaning, and provides feedback to the client based on their understanding of what has been said”. It is deemed an empathetic means of communication where the listener understands and

shares the feelings of the person talking whilst recognising they are not their own feelings and opinions (Balzer-Riley 2008.)

A significant advantage of active listening is that it prevents misunderstanding. By relaying back to the person what they say they are feeling it ensures that there is no guess work and thus confusion over what is being said (Balzer-Riley 2008). Active listening is therefore a useful tool in attempting to defuse situations involving conflict (Reznic et al 2012). It allows the individual to communicate and get a response when conversation is not appropriate. In these instances the use of active listening enables the person talking to feel like they are being engaged with but without bombarding them with information they are not in a position to receive (McBride and Maitland 2002).

Actively listening gave me the opportunity to be proactive. I was embarrassed and threatened and felt that it was my fault that Poppy was upset (as a result of me diverting eye contact). I had a personal battle because on one hand I felt sad for Poppy as she was clearly distressed and I understand that she has a lot of difficulties in her life. On the other hand I was shocked that she said that she did not care about the issues in hand. It could be argued that she was being defensive because she felt uncomfortable in the situation; however the issued in hand were very real and reflected what she was saying.

As theory suggests, active listening in this instance was useful. It enabled Poppy to feel that she was being listened to and perhaps even understood. Although Poppy appeared fraught, the fact that I was relaying to her what

she had just told us seemed to gradually calm the situation. It was my hope that by actively listening we would eventually get to a point where Poppy was ready to talk and receive advice and information. I acknowledge this was perhaps naÃ¨ve but Poppy was empowered enough to make the decision to walk away to calm down. Despite the challenging situation there was no obvious misunderstanding to be resolved, more a serious issue which needed to be addressed.

I would like to have been able to offer Poppy some space to calm down but this would not have fitted in with the core group. I was very conscious that there were a room full of people watching and that this would not have supported Poppy to deescalate. It was a relief that by actively listening to Poppy, my CPT was able to encourage her to make the decision.

In contrast to the recommendation I made for future practice regarding eye contact, it is recommended that the listener sits squarely in front of the person talking and maintains good eye contact when engaging in active listening (Duxbury 2000). I would agree that this is the case when the conversation is calmer however I learnt that in this scenario this was not appropriate as I was sitting directly in front of Poppy. The verbal communication I contributed through the active listening process had a more positive impact than the way in which I was sitting. Linking in with the above reflection about eye contact, it is recommended to maintain good eye contact with the person talking if it is within their cultural boundaries (McBride and Mailtland 2002).

Active listening will be a dynamic part of my communication methods in future and I aim to learn more about the effects of active listening on people who receive care. I would like to attend further training in this area as I now see it as a vital aspect of communication and I acknowledge that active listening skills can be improved. As an active listener, sensitivity is a key concept and I believe it is a method which could be particularly beneficial when communicating with women who are suffering with post natal depression.

The concept of active listening is consistent however the ease in which we do it will vary from case to case as will the outcome. The situation described above was tense and it took self-discipline for all those involved not to engage in a conversation which could have caused the incident to worsen further and the non-verbal communication methods varied from what is recommended. In future I will be aware of adaptations which may be required rather than solely facing them at the time. Ultimately active listening will be valued as much as any other forms of communication.

Leadership

As previously established, communicating in difficult circumstances and communicating information which may be difficult for families to acknowledge is not unique in health visiting. As health visitors embrace new leadership challenges it is important to acknowledge the above reflection and consider how what has been learnt can be disseminated through teams. Throughout the SCPHN course communication skills such as active listening are taught and these skills are useful not only in communicating with families but also with teams. Building relationships and having the ability to

communicate and negotiate successfully are key skills in leadership and being able to gage appropriate eye contact and active listening both come under the umbrella of communication (Adams 2010). Effective communication is a core competence in good leaders (Sobieraj 2012) and this is demonstrated in the NHS Leadership Framework (REF) which prioritizes communication as a key component.

Recommendations for future Practice as a leader:

- Further training in non-verbal communication skills needs to be available to teams as this will benefit communication used with families and further professional relationships.
- Non-verbal communication skills should be discussed with all of the team regularly for example in team meeting s or supervision and used as a measure for understanding and success.
- Critical reflection on various scenarios should be carried out in order to further understanding in these areas and support the application of evidence based practice.
- Empower team members to communicate effectively and understand the importance of non-verbal communication strategies
- As a leader I will take what I have learnt with regards to this reflection and use the skills in communicating with both families and team members.

When making recommendations be sure it doesn’t start to sound like a shopping list – balance this with the demands and pressures of the real

world. Maybe find examples of where these suggestions have been put into practice…this helps to justify your recommendations etc.

The above recommendations support the notion of leading with compassion. Offering team members with the compassion we want them to provide enables each individual to feel empowered to give effective and compassionate care of which non-verbal communication is so important (Sobieraj, 2012).