Analyse contribution of engagement in biopsychosocial assessment client nursing e...

In this essay the process of building a therapeutic relationship and assessing clients' own circumstances within the inpatient admission and the framework found in practice will be uses analysed and criticized by using Johns (1994) model of reflection.

The framework that has been used in mental health services is the Care Program Approach (CPA), which it has been profoundly criticised since it was introduced. Therefore the reflection will look into other model of nursing, Tidal Model, which offers a different philosophy of care. The reflection will also explore the interpersonal interactions theories which the nursed used during the assessment and how these aided to engage the client in the biopsychosocial assessing process. It also will be discussed other intervention models and the possible usage in similar situations.

In order to begin the analysis of the above points, engagement needs to be defined. Thurgood (cited by Norman and Ryrie (2004) p. 650) described it as: ' can be broadly defined as providing a service that is experienced by service users (including carers) as acceptable, accessible, positive and empowering'. Although this definition gives an idea of the concept, it lacks to define the key elements of engagement, which Cutcliffe and Barker (2002) identified as forming a human to human relationship, expressing tolerance and acceptance, and hearing and understanding. Both definitions gather the professional values of the service and the interaction itself. Yet, Cutcliffe and Barker (2002) definition can be considered more practical when holistically assessing clients. However, these definitions do not acknowledge factors of engagement that are behind the interpersonal relationship, such as personal or organizational perspectives of engagement. The personal perspective for

the nurses practice is underpinned by poor structural organization, occupational cultures and stress, bureaucratic constrains, lack of time and nursing culture driven by measurable targets (Hosany et al (2007) and Addis and Gamble (2004)). On the other hand, clients and their families are conditioned by the mental illness, their past experiences with other services, the trust in the service and the relevance of it. Additionally, the organizational issues effect upon engagement and care by reducing services budgets, by not providing resources and also by politics.

Engagement has been recognized as an important part of mental health services users' care. The National Service Framework (NSF), the National Institute for Clinical Excellence (NICE) and the Department of Health (DoH) appoint that users under CPA should be provided with resources to build a therapeutic relationship, optimise engagement and reduce risks. These documents also highlight the need to provide a therapeutic environment in order to provide best care and to engage the clients and their families with the service.

Taking into account all the above information a reflective account will be taking place in the following pages by using Johns' model of reflection (1994).

1. Description of the experience

The clinical environment where this assessment took place was in an acute adult ward. The ward is based in an old mental health hospital, which has old and pilling off wooden windows, untidy roofs and old fashioned flooring. The ward had untidy carpets, the curtains did not draw appropriately and the

painting on the walls was peeling off. These are the organisational barriers affecting engagement.

This particular client was known by the service already, to protect his right to confidentiality he will be referred as John (NMC code of practice 2008). John had been stable for 10 years, but in the past few months his mental state had worsened. His psychosis and levels of anxiety increased; he distrusted neighbours and other acquaintances as well as strangers. Consequently, he stopped going out of his house and began to self medicate with over the counter sedatives. Crisis and Resolution Home Treatment Team (CRHTT) was involved and as they felt that John was not able to cope at home, they decided that an inpatient admission would be beneficial.

Before the admission the CRHTT forwarded the CPA form 1A, which updated the ward staff about the latest assessment of the client's biopsychosocial needs. Once John arrived to the ward, he fully understood the situation where he was in. He was able to consent and had capacity to agree with treatment and, thus, he was admitted as an informal client. This facilitated the initial interaction and the initial grounding for the nurse/client relationship. Before the beginning of the assessment Tom (John's named nurse) introduced everyone to John, roles were explained, a welcome pack with the ward information and a CPA booklet were given and Tom provided all the information in an oral and written manner.

The nurse started the assessment by formulating open questions. However John gave single direct answers (yes, not, not sure …). Consequently, the nurse decided to change to more direct questioning. After that the client was

very co-operative and was answering all the questions. He reported to be very anxious, which also was noticeable by looking to his body language (he was sweaty, clenching his fingers, rubbing his hands on the chair's arms and removing his spectacles several times during the interview). At this stage the nurse decided to undertake an anxiety assessment by using the scales tools available on the ward – the Beck's Anxiety Inventory (BAI, see Appendix 1).

Following this assessment, John began to answer the questions more in depth and he appeared more eased, stating several times that he was in hospital for help and was going to do everything that was available for his recovery. Following the local trust policies and NICE guidelines, the CPA 1A assessment was concluded (as it must to be completed within 72 hours of the admission); the Integrated Care Pathway for Inpatient Safety and the Patient Property Liability Disclaimer were filled in and signed by nurse and client.

2. Reflection

The whole assessment was intended to gather as much information as possible about John in order to understand the client's actual biopsychosocial situation (holistic assessment) and the context that led to the admission, which would highlight the needs and strengths of the client. However, inpatient admissions are more likely to focus on a more medical approach to health, mainly because social interventions cannot be implemented until the client's mental state has stabilized and he is ready to move on to community settings. Along this process the multi-disciplinary team organizes care to build up the grounds to enable recovery (Simpson 2009). This particular

ward was focus on treatment and stabilizing, working on one to one interventions (nurse-client), building a therapeutic relationship through structured and unstructured interventions, and used CPA as a nursing intervention framework. Alongside these individual interactions, the activity nurses and the occupational therapist offered daily social and leisure activities. These groups provided skills and entertainment to the clients on the ward, but did not follow a particular model of nursing, such as the Tidal Model, and they offered activities to spare the free time on the ward without promoting recovery.

The Tidal Model provides structured group-work centred on recovery (Barker and Buchanan-Barker 2005). This model centres its assessment on a holistic approach for the short and long term needs, viewing the mental illness as a unique experience of each individual, their families and social environment. It looks into the lowest point of the illness (such as an inpatient admission like John's) as the point where the recovery begins with a positive approach to the illness.

There are three working groups recommended in this model: discovery, solutions and information (see appendix 3), where therapeutic relationship is built and issues common to the individual and others are discussed and explored. As mentioned above, the ward nurses had more structured interventions with clients, and the issues discussed in these interviews were correlated to the Tidal's Model theme groups. In these interviews the clients engage with their primary nurses and they discuss their concerns in relation to their care or other personal matters. These interventions or interviews were intended to happen at least twice weekly for at least an hour. However,

for organizational issues (usually low number of staffing) not all the clients had the opportunity to benefit from these one to one interventions on a regular basis.

Initially, the Tidal Model research was criticised for being bias, for lacking to fully describe clients' pre and post intervention with the model, not taking into account ' Hawthorne effect' and most of physiological factors and by not reasoning the need for a new model in mental health care (Noak 2001). However, further research and analysis showed that the Tidal Model provides tools and structure to improve care in acute ward admissions filling the gaps in care pointed in the NSF and The Sainsbury Centre for Mental Health (Gordon et al 2005). One could say that this model has been shown to improve mental health services, fulfil the historical gaps within nursing practice and to be grounded on evidence-based practice. However, the author of this essay believes, after reading the relevant literature, that for the implementation of the Tidal Model the levels of staffing (and therefore the service budget) should be increased and nursing practice cultures must be changed by re-educating the workforce. Arguably both implementations are very difficult to achieve as the health service has seen budgets cut downs in the recent years and nurses' practiced has been subject to negative ward cultures towards nursing models.

On the other hand CPA, which is the framework used on the ward, was first designed after a series of fatal incidents which involved mentally ill people. It was aimed to be introduced in Wales by 2004 (in England was done by 1991). CPA is person centred focus which promotes social inclusion and recovery, through assessment and planning of individualized needs and

strengths, working with the clients and their families or carers (Care Programme Approach Association (CPAA) 2008). Despite the initial intention that the CPA was brought to improve service users' quality of care, to increase inter agencies communication and to be a case management tool, some critiques appeared. Simpson et al (2003a) researched showed CPA was thought to be an over-bureaucratic duty within the professionals. The author of this paper has observed in practice, not in this particular assessment, that some professional do not reassess clients' when they are admitted. Instead the latest CPA 1A form (usually filled in by the CRHTT) is photocopied or copied-pasted and re-used to speed up the process. This would be acceptable if the client was assessed the day or night before the admission, because the social, psychological or biological needs would have not changed in that period of time. When older assessments are used, changes in circumstances might have not been updated. In the worst case scenario a health professional could have misunderstood the client's needs and have documented them wrongly. This misunderstanding could be carried over, therefore care would be affected. This hypothetical scenario shows that CPA assessments should be done every time when needed.

CPA as a case management tool fails to compile the most important features which promote therapeutic relationship. In contrast with other case managements models the role of the care co-ordinator is more of an administrative and as an alternative service prescriber (Simpson et al 2003a). This means that there is no need for a specific training or skills related to therapeutic relationship, partly because other services (or service providers) will engage with the client, and the care co-ordinator just

oversees the process of care. Moreover, CPA also lacks a nursing model background and fails to define specific roles within the multi-disciplinary team. These factors reduce the teamness feeling between the health professional (Simpson et al 2003b). Although, it could be argued that the reason, why CPA is lacking nursing background, is that it was not designed as a mental health nursing framework but for the use of mental health services. In this particular reflexion the care co-ordinator was not present in the admission and never mention during the assessment. Whether it was a usual situation or not it is something that never was discussed, but it shows Simpson et al (2003a and 2003b) critiques of CPA as a case management were factual.

CPA and Tidal Model are intended to provide holistic care for clients and their families. However, the Tidal Model is more client's centred than CPA, and it also looks into the more positive side of the clients' situation, foreseen the now and future as a whole. It explains the illness as an accumulation of life factors. The Tidal Model complements other health and social care professionals, as well as it searches to nurse by building a special relationship between health practitioner and client. Moreover, CPA always looks for risk signs in the short-term and from a psychiatric approach. As this assessment took place in an inpatient admission it is important to bear in mind that in this particular environment CPA forms (1A, 2, 2A and 4) were used for assessment, planning, implementing and evaluation of inpatient care and for the liaison with other health professional in tertiary care (such as physiotherapist, dietician or occupational therapist). Perhaps CPA would benefit from sharing some principles of a nursing model (like the Tidal

Model), by using it as a tool more than as a paperwork and from a better staff training and promoting adherence to nursing models (Barker 2001).

Whether the ward uses Tidal Model or CPA to structure care, an inpatient admission is always stressful and uncomfortable experience for clients and their families. John saw the nurse as a stranger in an unfamiliar place, however, Tom was there to guide the client throughout his care, to provide information and to be somebody he could relay on. This first encounter related to the orientation phase described by Peplau (1952) (cited by Sheldon (2005), see Appendix 2). In this phase John's past experiences, expectancies, culture and believes were to condition the initial interaction. Following this phase John went into the identification stage, where he sought assistance for anxiety relief techniques, shared needs and strengths when and co-designed care plans and began to have feelings of belonging and capability, therefore decreasing negative feelings. This exchange of feelings is going to lead to exploitation and resolution phases, where John will engaged with treatment (medical, physical and social), having different needs at different times, starting to be informed about all the help available towards the final stage, feeling as an important part of the whole nursing process and finally ending the professional relationship when discharged. The exploitation and resolution phases were not observe as at the time of writing John was still an inpatient.

John had had previously one bad inpatient admission. He reported that he was very unhappy when he was in the other hospital 10 years ago. He explained that the bad experience was related to the other clients and organizational issues rather than staff. John stated that he was feeling

anxious but happy that he was getting help. His positive attitude helped to engage him in the assessment process and on the ward activities, which were the first steps towards the identification phase. Therefore, John could begin to have professional input from other members of the multi-disciplinary team.

Tom interacted in a way that John felt understood, respected and individualized. Tom did not appear to have preconceived ideas of the client after reading the CPA forma 1A. And certainly, Tom treated John respectfully and as an equal human being. He followed the NMC code of practice 2008, which states that: ' you must treat people as individuals' and ' not to discriminate in any way those in your care'. Tom tried to adapt the pace of the questioning to the client's needs, involving him and asking in a respectful manner. Tom also acknowledged John's anxiety feelings, and showed it when taking further (BAI see appendix 1) assessments to empathize more with John's situation. This reinforced the approachability and genuineness of the nurse and led John to open and engage with the assessment process and the health professional.

3. Influencing factors

John scored 45 points in the BAI (see appendix 1), which is a high scoring. This could have been influenced by the hospital admission and the assessment process. Despite these factors and John's actual mental state he engaged in the assessment actively. The BAI scales consist of 21 observable and self-rating symptoms of anxiety, rated from 0 to 3 (0 being the lowest score), which can also be easily transformed in direct questions or self

rating. At the end of the assessment the scores are added up and compared against the scales.

There are several assessment tools available such as Hospital Anxiety and Depression Scales (HADS) or Hamilton Anxiety Scales (a collection of them can be found in the Appendix 1 reference). The BAI is shown to be a quick and reliable when measuring clients' anxiety levels and it also differentiates General Anxiety Depression and depression (Fydrich et al 1992). Although, these characteristics appear to be positive, it could be argued that BAI is just a merely adaptation of the DSM-IV panic symptoms and therefore it could also be said that measures panic attacks rather than anxiety levels (Cox et al 1996 and de Beurs et al 1997). On the other hand, HADS which achieves good levels of anxiety and depression screening could have been more appropriate for hospital settings and more accurate (Bjelland et al 2002).

It is important to point out that NICE clinical guideline for management of Anxiety (2004) does not recommend a specific tool for assessment of anxiety, which gives to the professional practitioner choice on the usage of available tools. This affects practice as these scales are not used as often as they should be. Most practitioners relay on their observations and experience to perform informal assessments, rather than using research based scales. It is perhaps understandable when dealing with clients unable to fully understand these assessments. But in practice it can be noticed that nurses do not tend to use anxiety inventory even with clients that could engage with the process.

Tom designed care plans in partnership with John and made him realise which were more realistic goals in the short and long term. Tom had shown knowledge and understanding of the professional capabilities that the NSF defined in the documents " The Ten Essential Shared Capabilities" (2004) and " The Capable Practitioner" (2001). These documents set basic principles that underpin positive mental health practice as well as providing the basic grounding for service workers to continue developing and learning skills. Therefore, it was observed during the placement that along the whole admission the nursing team also guided care and practice as appointed by these documents. They provided patient-centred care, which is accountable for each client and respecting the individual. The team also had a broad knowledge of national legislations as well as local policies and services, and worked under the same professional and ethical principles recognizing the rights of the clients and their families. They promoted recovery and self-realisation by identifying people needs/strengths and empowering the individuals. Most of the team members were undertaking further training, to keep their skills up-to-date or be able to transfer their existing skills to new environments. They also worked in partnership with family, carers, lay people and external agencies, such as community care services, voluntary associations and vocational services.

4. Evaluation

In the interview Tom used a Rogerian approach (Roger (1961) cited by Sheldon (2005)). He also showed knowledge of Peplau's interpersonal theories and applied them in practice by creating a shared experience of care. However, it also would be appropriate to use the Heron's six-category

intervention framework (Heron 1989). This framework was designed to enable a practitioner (nurse) taking the lead to facilitate the clients' specific needs or arising issues. Therefore this intervention could have been used in the admission's assessment and the following one to one sessions, which have been described in this essay. The framework is made off two categories, which are subdivided in three more. The first category is authoritative which it can be prescriptive, in which the nurse influences and directs behaviour, gives advice and prescribe goals. It also can be informative providing information or giving feedback for the client's behaviour. The third subcategory is confronting, in which the practitioner challenges the client's beliefs or actions. The second category is the facilitative which is divided into cathartic, in which the nurse tries to release the clients' painful feelings and talks about or express them with actions (tears, anger or shouts). Next subcategory is catalytic, where the nurse tries to help the client and encourage self-discovery and learning. Finally, supportive is the category where the client is supported in an unqualified manner.

The facilitative stage of the framework would have been the most appropriate to use in the first assessment. John's mental state would not have benefit from an authoritative approach as he might have felt threatened by the staff, therefore his willingness to engage with the service could have reduced greatly. This approach shares the same goals as the one that Tom used. The outcome would have been the same, which was the beginning to build a relationship towards recovery. However, it is important to know different ways to practice and to interact in order to provide an

individualised care. This principle is shared by the models discussed in the essay (CPA and Tidal Model) and also by the nursing professional code (NMC code of practice 2008).

5. Learning

Although, it was difficult to deal with John's anxiety levels and his initial unwillingness to engage with the assessment, it was possible to create a therapeutic relationship between nurse and client. After this reflexion it was learnt that nurses' knowledge and usage of the right nursing models, strategies and tools can be adapted to individual situations and their own circumstances. It is also important to share principles of care and to change some nurses' cultures regarding models of care.

It was positive to reflect upon this experience and, therefore, to realise how the theory learnt was applied in practice. Since nursing studies and practice are moved towards research based knowledge it seems that the human connection and relationship building have lost their place in the nursing profession. As a student it is good to see that values based nursing promoted safe, trustful and supporting environment, which led to a healthy therapeutic relationship (Hewitt 2009).

In conclusion, the reflection and analysis of engagement through a biopsychosocial assessment illustrated how personal and organizational factors effect on clients care. It was found out that applying specific intervention techniques, mental health screening tools and the adequate adaptation to the individual and the situation promote engagement and build a healthy therapeutic relationship. Furthermore, the research showed that

the relevant mental health regulations and nursing professional code recognise the need to keep up-to-dated knowledge and skills in order to provide the best care.

All the above techniques and tools were found to be used in a very individual way between the nursing professionals. In addition to this, it was found that theses personal adaptations to practice and clients' care were beneficial when reducing barriers for engagement and personalising the care.

The positive and negative characteristics of the actual mental health framework CPA were brought forward and it was found that it lacks a nursing model background. CPA and Tidal Model when compared and contrasted, showed that both mental health frameworks differ gratefully from each other but at the same time they could benefit from each other.

Despite the ward worked under CPA and used a more medical approach to nursing, the nursing team shared the same professional capabilities and worked towards holistic goals and recovery.

Over all, in order to engage and to provide relevant services for clients and cares' biopsychosocial needs there should be a continues connection between practice and theory in nursing.

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Appendixes

Appendix 1

Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

Not At All

Mildly but it didn't bother me much.

Moderately – it wasn't pleasant at times

Severely – it bothered me a lot

Numbness or tingling

0

1

2

3

Feeling hot

0

1

2

3

Wobbliness in legs

0

1

2

3

Unable to relax

0

1

2

3

Fear of worst happening

0

1

2

3

Dizzy or lightheaded

0

1

2

3

Heart pounding/racing

0

1

2

3

Unsteady

0

1

2

3

Terrified or afraid

0

1

2

3

Nervous

0

1

2

3

Feeling of choking

0

1

2

3

Hands trembling

0

1

2

3

Shaky / unsteady

0

1

2

3

Fear of losing control

0

1

2

3

Difficulty in breathing

0

1

2

3

Fear of dying

0

1

2

3

Scared

0

1

2

3

Indigestion

0

1

2

3

Faint / lightheaded

0

1

2

3

Face flushed

0

1

2

3

Hot/cold sweats

0

1

2

3

Column Sum

Scoring – Sum each column. Then sum the column totals to achieve a grand score. Write that score here _____ .

Interpretation

A grand sum between 0 – 21 indicates very low anxiety. That is usually a

good thing. However, it is possible that you might be unrealistic in either

your assessment which would be denial or that you have learned to " mask"

the symptoms commonly associated with anxiety. Too little " anxiety" could

indicate that you are detached from yourself, others, or your environment.

A grand sum between 22 – 35 indicates moderate anxiety. Your bod