Reflection on interpersonal skills in clinical practice

This is a reflective essay based on my experiences whilst on my five week surgical placement in a local hospital. The aim of this essay is to explore the use of communication and interpersonal skills in clinical practice. I have chosen this particular incident as I spent a considerable amount of time communicating verbally and non verbally with this particular patient. To protect the identity and maintain confidentiality of the patient I have chosen to discuss they shall be known as ‘ John’, this is accordance with the NMC code of professional conduct (2008). To assist me in the process of reflection I will be using Gibbs (1988) reflective model. The structure of this framework allows the reflection to be written in a clear way, which provides opportunities to look at the incident from a number of perspectives; this will help to highlight areas of practice which could be changed in the future (Jasper, 2003). There are numerous reasons why reflection is important to nurses. Through reflection we can get to know more about what we do and what limits our abilities and this gives the opportunity to improve the way we care (Ghaye and Lillyman, 2001).

Description

John was a 74 year old man admitted onto the ward from the emergency department 2 days previous to me starting my first late shift of that week. He had been suffering from retention of urine, and was in considerable pain. My mentor and I were informed during handover that we would be looking after John on this particular shift and could we change the dressing on his right leg as he had an ulcerated leg due to suffering from a condition known as Peripheral Vascular Disease (Alexander el al, 2004). As a consequence of this disease he also had his left leg amputated below the knee some years

ago and mobilised using a wheelchair. It became clear during the handover that John had been very difficult the last couple of days. The nurse in charge went on to say that he had thrown items across his room and was constantly pressing his nurse call button and shouting all day, he had also refused to have a wash and change his pyjamas. As we left the room where the handover had taken place, my mentor said she thought that we should change John's dressing now but first we should get him washed and changed and could I assist her. We gathered all the equipment we needed from the treatment room and made our way to John's room. I knocked on his door and introduced myself as a student nurse, I then asked John for his consent for me to assist him in having a wash and change of clothing (NMC, 2008). John was sat on his bed, he appeared to be quite tense, he looked up at me and shouted ' no, I want to see a doctor and I haven't had a cigarette for 2 days'. I explained that I was here to assist in changing the dressing on his leg and to help him to have a wash and change. I moved closer towards his bed and lowered myself to his eye level. I then began to engage in conversation with him by maintaining a soft tone of voice and asking him if he would like a cup of tea after we had finished. His body language softened and he looked up and smiled, he said ' I would love one'. I smiled back at John, I then repeated the question of assisting him with having a wash and change, whilst maintaining a relaxed posture and eye contact with him. John gave me his consent and I proceeded to assist him in maintaining his personal hygiene with respect and dignity (NMC, 2008). With John's co operation my mentor and I were then able to go on and change his dressing on his leg.

Feelings

Through this learning experience I encountered different feelings towards the situation. From the initial handover, the staff nurse in charge did not paint a positive picture of John. I wondered why this particular patient was so aggressive and demanding and the staff described him as being ‘ difficult’. I felt anxious, as this was my first placement as a first year student and I did not feel experienced enough to deal with the situation. During my encounter with John it became clear why he would feel so angry and frustrated. I noticed he didn’t have a wheelchair in his room, and it became apparent that he was a smoker. He also hadn’t been given any nicotine replacement therapy to help him cope with his withdrawal symptoms. When the full extent of John’s situation became clear to me, I felt immense frustration for him. According to the NMC Code of Professional Conduct (2008), nurses should treat patients with respect and maintain their dignity. With John not having a wheelchair, he was confined to his bed and therefore had lost his autonomy. The situation also made me very angry, reflecting back I feel I should have been more assertive and maybe questioned why John’s requests had been ignored by the staff.

Evaluation

It was a shame that the professional staff acted the way that they did, ignoring how angry and frustrated John had become and not acting upon it. The nurse’s compassion and communication skills seemed to be very much lacking, not listening to his requests and showing no feeling towards him. This breakdown in communication in the nurse – patient – relationship with john, left him feeling frustrated and not in control of his own wellbeing (Garnham, 2001).

At first, I could not see any good points in this situation; however looking back I can see that it did have its positive side, in as much as allowing me to examine myself and to search for my short fallings in relation to the incident. The incident has also given me the opportunity to link theory to practice. The way I communicated with John had a positive outcome for both of us in that his personal hygiene needs were met, and I learnt that effective communication is essential in building a trusting bond between the patient and the nurse (Almond & Yardley, 2009). The bad points of this experience were that I judged John based on the information I received during handover without meeting him first. This could have created a barrier between myself and the patient. Accepting a patient as a unique individual and without judgment is very important in the communication process. I have learnt from this experience that as nurses we should respect a patient's beliefs and values, and we should not let our own beliefs and values affect our decision making in patient care (Rogers, 1957). I also feel I should have been more assertive when it came to the way John was being treated by the staff. As a first year student I did not feel comfortable questioning the way a professional staff nurse carried out her nursing care. However, from this experience I will question bad practice in future, as the NMC (2008) states that I am personally accountable for my actions and omissions in my practice and I must always be able to justify my decisions.

Analysis

According to Briggs (2006) as cited in compendium of clinical skills ' Communication is the process of conveying information between two or people'. Communication is essential in building relationships with patients

and gaining trust. In the NHS the majority of the complaints brought against them were for poor communication from healthcare staff (Pincock 2004). To highlight how important communication is in the nursing profession, the NMC identified it as being an essential skill and only if a student is competent in this skill can they then go on and register as a nurse (NMC 2007b).

In order to communicate with John the situation required the use of interpersonal skills, known as non verbal and verbal communication. Non verbal communication is described by lister and dogherty p62 as being information transmitted without speaking. John's body language indicated that he was tense and anxious therefore approaching him with empathy ensured that he is being understood and that his participation in communication was valued (Peate 2006)nurs 21st. Given the history of John's aggressive outbursts it was necessary to consider the proxemics in the situation. It is recommended that keeping within a distance of 4 to 12 feet away from a person is less intimidating for them (Egan 2002). In order to engage in conversation with John, Egan's (2002) acronym SOLER was used. This is a process of using body language to actively listen to a person. By sitting squarely towards John, having an open posture, leaning in towards him, maintaining eye contact and maintaining a relaxed posture, encouraged him to relax and feel less intimidated and therefore talk more openly (Lister and Dougherty).

Verbal communication with John was enhanced by the use of facial expression and paraverbal communication. (Fund Nursing p195) states that ' Facial expressions give clues that support, contradict or disguise the verbal message', therefore the use of a smile when approaching John indicated

warmth and friendliness. This was assisted further by the use of para communication; these are the cues that accompany verbal language. These include tone, pitch, speed and volume of the person speaking, therefore by communicating with John with a soft tone of voice added further meaning to the spoken words (fund nurs).

The barriers in communication during this incident were John's aggressiveness. This could have been due to the withdrawal from cigarettes, as according to Bruce (2008) irritability is a symptom of nicotine withdrawal. If a patient is unable to smoke in hospital then nicotine replacement therapy should be introduced and the patient treated like any other dependant. Bruce (2008) suggests that ' Withdrawal from nicotine needs to be recognised and treated appropriately in the acute hospital and it will often be the ward nurses who are relied on to recognise the symptoms'. These symptoms were overlooked by the staff and to add to his frustration he had no means of mobility to be able to leave the ward for a cigarette. This may account for his outbursts of anger. Peplau (2004) suggests that when there is an obstacle or obstruction preventing a person from achieving their goals this may lead to frustration which in turn often leads to anger.

Action Plan

Using Gibbs's reflective cycle has assisted me in making sense of the situation and to put things into perspective, recognising how I can put this learning experience to positive use in my future practice as a Nursing professional. If this situation were to arise again I know I would now have the courage to question the nurse's attitude at an earlier stage pointing out that

‘ bad practice’ by anyone is not acceptable. From this experience I have learnt that I need to be more assertive and if I feel the needs of a patient are not being met, my first consideration should be to protect the interests and safety of patients, in line with the NMC (2002) Code of Professional Conduct, (clause 8). This reflection has highlighted the need to increase my knowledge and understanding of the process of communicating with patients from different cultural backgrounds, I will address these issues by, listening and learning from the qualified staff and by reading relevant literature.

Conclusion

In conclusion it can be seen that the nurse has a very important role in communicating with patients through their treatment. When a patient is admitted to hospital, assessments should be made based on the activities of daily living, Roper, Logan & Tierney (2000). John’s assessment not only should have identified the level of care needed, it should also have established his normal routine, and the fact that he was a smoker and required a wheelchair for mobility. If John’s needs had been assessed correctly the breakdown in the relationship between John and the professional staff could have been prevented. Overall, through this reflection I have learnt that communication is an essential skill that requires as much practice and consideration as any other aspect of nursing.