TABLE OF CONTENTS

3 • PREFACE BVNA, Stacey Bullock

5 • INTRODUCTION Helen Ballantyne

10 • 1. NURSING CARE PLANS AND THE PATIENT by Helen Ballantyne from Veterinary Nursing Care Plans: Theory and Practice

26 • 2. COMMUNICATION AND INTERPERSONAL SKILLS by Victoria Lavender from Becoming a Nurse: Fundamentals of Professional Practice for Nursing

58 • 3. EFFECTIVE LEADERSHIP OF TEAMS by Sue Mellor from Practical Leadership in Nursing and Health Care: A Multi-Professional Approach

74 • 4. ADVANCING PRACTICE THROUGH RESEARCH by Andree le May and Susan Holmes from Introduction To Nursing Research: Developing Research Awareness

89 • 5. PROMOTING BEST PRACTICE AND CONTINUING PROFESSIONAL DEVELOPMENT by Lesley Baillie and Sharon Black from Professional Values in Nursing
What a year to be proud of here at the British Veterinary Nursing Association (BVNA)! We have been busy on the Council and so has the profession...

Firstly, we were absolutely blown away by the response of the largest social media campaign to date for the BVNA Veterinary Nurse Awareness Month (VNAM). We had veterinary nurses across the nation signing up to showcase the amazing roles we play every day. VNAM and the tag #whatvnsdo went global, with practices sharing their profiles, snaps and videos, and some outstanding creations evidencing the truly wonderful human beings that we are. We will run this each year; however, we must continue to promote our identity to protect the title of the ‘Veterinary Nurse’ in industry and educate our clients to aid their understanding of the importance of our training and the registration of veterinary nurses. We strongly believe that by standing together, we can project a true reflection of our profession.

BVNA have stood shoulder to shoulder with some of the worlds’ largest animal welfare organisations to enable the voice of veterinary nurses to be heard and raise awareness of the issues that are affecting us today - or that may affect us tomorrow. BVNA have forged strong relationships with other representative organisations to encourage our combined members to unite in highlighting the key elements of the profession as a whole, helping to contribute to both its recognition and sustainability.

The politics of such a profession relies upon a strong foundation of representatives from all areas of industry and we encourage our members to be part of that, with projects like our VN Voice polls and other surveys, and joint campaigns such as the schedule 3 reform. Make sure you have your say on the future of veterinary nursing; you speak, we listen!

We are confident that the BVNA Council contains a diverse number of impartial members, all holding the profession in high regard. With that in mind, the council maintains an inclusive selection process whereby skills are matched to the variety of roles necessary for the BVNA to function and make decisions. This year has seen an overwhelming response to those standing for council through its nomination and voting process, and we have been impressed with the personal statements of the candidates which reflect the passionate work that we do as veterinary nurses. Presidents, council members and its associates, past and present, have made the BVNA what it is today. It is their work that allows us to continually work toward strengthening those fundamental qualities that see our organisation at the forefront for veterinary nursing voice. The Council has a succession plan for future presidential candidates, aligned to match the skills required for such a role.
This book has been lovingly drawn together to reflect some of our profession’s fine, modern-day attributes: we aren’t just ‘veterinary nurses’; we are advocates for animal health and wellbeing. We are professional practitioners who choose a career, not just a job; one that demands long hours and difficult situations. However, it is also one that promotes personal satisfaction of a job well done. We plan our patient’s care and adapt to their needs by encouraging involvement from the whole veterinary team and by reflecting on our practice to gain insight into potential improvements. We demonstrate fine leadership skills between interpersonal teams to facilitate a good example of in-patient care and customer service, whether we take this further into management or not. We are involved in the implementation of researched, proven and often innovative medical options and nursing care, to provide an unrivalled professional service to our clients and their loved ones.

BVNA plans a lifetime commitment to its members. Our newly fledged student association, The British Association of Veterinary Nursing Students (BAVNS), can support you on your training journey, to become the registered veterinary nurse that you have always longed to be. The association then endeavours to support you through your professional career by offering ongoing, valuable CPD options and providing employment, legal or financial advice. We aim to promote your mental and physical wellbeing through health or times of illness, and are always here to help.

We think that veterinary nurses are pretty amazing. We hope that you enjoy BVNA Congress 2017 and that you will come with us into the future of veterinary nursing.

– Stacey Bullock, BVNA Council Member
This FreeBook is for all veterinary nurses: newly qualified, experienced, and all of those in between. It is for veterinary nurses who are looking for something more: a greater depth of understanding, more skills, or a little more knowledge; skills, knowledge and understanding that will help them become the very best veterinary nurse they can be.

Primarily the function of this book is to open up a world of new educational resources for the veterinary nursing profession as many of the chapters are taken from human centred nursing textbooks that might not have been considered before.

Historically, veterinary nursing has had little to do with human centred nursing. The veterinary and medical professions may have acknowledged similarities anecdotally and socially, but seldom worked together to exploit those similarities. This is changing, the concept of One Health encompasses the development of a collaborative strategy between human centred health care professionals and veterinary professionals on a wide range of subjects. It is difficult to open any veterinary publication without there being some reference to One Health be it explicitly, for example a report on the work of a One Health committee consulting on zoonosis, or implicitly through an observation on the benefit of animals in combatting the UK’s well documented obesity epidemic. As well as working collaboratively, One Health also supports the idea of sharing resources. As veterinary nursing establishes itself as a profession it is important that veterinary nurses look wider for their ongoing education and explore human centred resources to address their developmental needs. In doing so veterinary nursing will be able to adapt and use existing resources as well as share its own knowledge and expertise with the human centred nursing team.

As many of the chapters of this FreeBook are aimed at the human centred nursing profession, some adaptation and imagination is required. As an example communication skills in human-centred nursing are taught so that nurses may build a therapeutic relationship with the patient. In veterinary nursing, it may be argued that such a relationship is just as essential, although it is likely to be with the owner of a patient rather than directly with the patient.

As an introduction the concept of using human centred nursing resources, the first chapter of this free book is taken from a veterinary nursing textbook about nursing care plans. A much used tool, care plans have been borrowed and adapted from human centred nursing. The chapter describes how nursing care plans may be used practically for veterinary patients, to support holistic care and continuity of care in the
veterinary environment. It also outlines the potential benefits of adapting self care plans used in human centred nursing to support ongoing veterinary care in the home environment. It explains that effective communication skills, both with colleagues and owners of animals, are essential to ensure continuity of care and animal welfare.

It is widely acknowledged that effective communication is essential to patient care, no matter the species of the patient. What is sometimes more surprising to professionals is that communication skills can be taught. Like the placement of an intra venous cannula, there is theory, an explanation, and practice. As with all areas of work, there will be some who find it easier than others, but all can benefit from learning some of the basic components of effective communication as outlined by Victoria Lavender in Chapter Two.

Effective leadership, like effective communication, improves team work, helps get the job done, and enables us to work safely and efficiently. Many veterinary nurses take on the role of head nurse within their practice. This role is may be given to them based on their experience: the number of years they have been at the practice, their academic qualifications, or even just because it is ‘their turn’.

How many of those VNs feel prepared when they take on that role? How many ask for specific management and leadership training? How many seek out guidance on how best to motivate and unite a new team, or how to manage conflict? Many VNs simply muddle along, as best they can, coping through a combination of instinct, experience and occasionally luck.

Chapter Three is taken from a textbook called Practical Leadership in Nursing and Healthcare, edited by radiographer Suzanne Henwood, and draws on the work of a wide multi-disciplinary team to provide useful and relevant information on how to lead a healthcare team.

The chapter selected is about teamwork and will be relevant to veterinary nurses who are leading a team but perhaps feel that things could be better, or that something is missing. The chapter highlights the need for a team identity, guides leaders through the concept of team building exercises and explains how to facilitate team communication. As this chapter introduces detailed information on concepts rarely emphasised in veterinary nursing training, it may also open the door to a happier work life; there is nothing more stressful at work than feeling unprepared to face the challenge of the day.
A relatively new but developing area of veterinary nursing is research. Every profession has a specific body of knowledge, unique to it: knowledge that is continually being added to by experience and research. Increasingly, in the UK more veterinary nurses are coming into practice at graduate level. There is a greater awareness of research throughout the profession as more VNs are exposed to frontline research and are keen to support the profession and their patients by developing research projects to establish evidence for practice.

Chapter Four originates from an easy to read resource primarily designed for human-centred nurses, but readily adaptable to the veterinary nursing profession. In this, the first chapter of their excellent textbook, Le May and Holmes explain the need for research and research awareness within nursing, and address the concept of evidence-based practice. It provides a strong foundation on the subject for any veterinary nurse who is curious about developing research in practice.

Curiosity about nursing is an attitude to be whole heartedly supported in both newly qualified and experienced veterinary nurses. As a professional, asking ‘why’? is an essential part of developing, learning why things are done the way they are, and ensuring that standards of practice are kept high. Asking why is a form of critical thinking, of dynamic development. Instead of passively agreeing, or simply following instructions, veterinary nurses should be understanding deeper concepts and making independent decisions based on their knowledge and understanding.

Continuing professional development (CPD) is the key to getting the answers to ‘why?’ Under the Royal College of Veterinary Surgeons Veterinary Nursing Code of Conduct, CPD is mandated. Chapter Five provides an overview of the commitment to human centred nursing CPD, why it is necessary, and how it may be carried out. It stimulates contemplation of the CPD mandate as an opportunity rather than an obligation: an opportunity to share good practice to the benefit of the individual, the profession and, most importantly, the patient.

Sources of CPD are increasingly varied within human centred nursing, and for CPD to count towards the mandated number of hours, it must be accompanied by a reflection on how the information might be used in practice, and how it links to the nursing code of conduct. It is wise for veterinary nurses to consider the same principles as they partake in CPD. Long gone are the days of sitting passively, hoping to learn through osmosis. Active learning stimulates debate and interest, and self-assessment of knowledge is the ongoing responsibility of a professional.
In essence this FreeBook is designed to be a key to open up a world of resources, that although not always specifically designed for veterinary nurses are nonetheless highly useful and relevant when approached critically and questioningly.

It is a key to develop new skills, improve established ones, and see subjects from a different point of view. There really is a world of information out there, so go and get it!

– Helen Ballantyne, author of *Veterinary Nursing Care Plans: Theory and Practice*
CHAPTER 1

NURSING CARE PLANS AND THE PATIENT

This chapter is excerpted from
Veterinary Nursing Care Plans: Theory and Practice
By Helen Ballantyne
© 2017 Taylor & Francis Group. All rights reserved.

LEARN MORE >
BY THE END OF THIS CHAPTER YOU WILL BE ABLE TO:

1. Explain how a nursing care plan may stimulate holistic, patient centred care within the veterinary environment
2. Recognise the potential benefits of using nursing care plans to promote continuity of care
3. Outline the benefits of an effective therapeutic relationship
4. Explain the communication skills required to support a therapeutic relationship
5. Describe the application of nursing care plans to the care of chronically ill patients

Nursing care plans can benefit animals being cared for in veterinary practice in two ways. Firstly, the use of a nursing care plan will facilitate an individualised and thorough assessment which will ensure all the needs of the patient are taken into account. Secondly, the use of a nursing care plan promotes continuity of care.

HOLISTIC CARE

The UK RCVS code of conduct for veterinary nurses is clear in its assertion that all practicing veterinary nurses are required to put the needs of their patients first, ensuring their priority is always the health and welfare of the animals committed to their care.

By participating in the care planning process, nurses are taking significant steps to fulfil this requirement. A nursing care plan should ensure that all the needs of the patient, their health and their welfare are taken into account. There is evidence that the use of nursing care plans can promote effective patient care. In Brown's (2012) case study of an eleven month old cat who had been involved in a road traffic accident there was the opportunity to directly compare and contrast care provided without and with a care plan. Brown is clear in her conclusion that comparing the patients' records prior to and following the introduction of a nursing care plan, a more holistic approach was made when a care plan was used. Cited care needs that were addressed after a nursing care plan was put in place included accurate management of calorific requirement through calculation of the recommended energy requirements and the use of gentle massage and grooming to stimulate and soothe the patient. In addition, it was noted that when the nursing care plan was in place, care was spread over the day rather than being bunched up to particular parts of the day which may have left the cat stressed and over stimulated.
Wager and Welsh reinforced these findings in 2013. They observed positive outcomes of using a care model and associated care plan in veterinary nursing, explaining that it supported individualised and patient specific care. They cite the work of Wager and Lock as additional examples of previous published positive experiences associated with the use of nursing care plans in frontline clinical practice. The evidence is that use of a nursing care plan, implemented as a result of using a structured model of care can improve care for veterinary patients.

CONTINUITY OF CARE

Alongside the direct benefit of improving patient care, nursing care plans also facilitate continuity of care. A detailed, accurate and contemporary nursing care plan is an invaluable record of the care a patient has received and is due to receive. There are many situations when information about the care of a patient will need to be passed on to a colleague. Patients receiving round the clock care will be cared for by different nurses on different shift patterns. Potentially, the need for specialist care may require the transfer of a patient to a new veterinary hospital. At each of these points a comprehensive transfer of information about the patient must be passed to the new staff. Known colloquially in the medical profession as ‘handover’, it has long been known in that this passing on of the care of a patient to another colleague is a vulnerable time in terms of patient safety.

If handovers are ineffective, clinically relevant information may be omitted, or miscommunicated which in turn may lead to delays in treatments and diagnosis, inappropriate treatment or even omission of care. The use of a written nursing care plan is an excellent adjuvant to a verbal handover and description of care. In human centred nursing, community nurses will leave nursing care plans in the homes of their patients, knowing that different nurses may attend and therefore need up to date and clear instructions as to the care required.

DEVELOPING A THERAPEUTIC RELATIONSHIP

Alongside the explicit benefits of improving patient care and facilitating continuity of care, the use of nursing models and associated nursing care plans have implicit benefits as their use supports the therapeutic relationship between nurse and owner of the animal. Within the context of veterinary nursing, a therapeutic relationship may be defined as a series of interactions between a nurse and the owner of an animal that supports effective patient care.
The use of the Orpet and Jeffrey Ability model of care draws the nurse’s attention to the importance of the relationship between the owner of the animal and the care that animal needs and receives. There are two stages to this, firstly there is the emphasis that the model places on obtaining a comprehensive health history from the carer of the animal which marks the beginning of what hopefully should be a therapeutic relationship between owner and nurse. Secondly, there is documented emphasis on ensuring that owner compliance is taken into account when planning care.

While comprehensive documentation using a nursing care plan may help multi-disciplinary working through improved communication, it is important that in the case of veterinary nursing (much like paediatric human centred nursing) a family centred approach is applied. The owner of the animal should be considered an extended member of the multi-disciplinary team. There are numerous examples of how a lack of owner adherence to care requirements can directly impact on a patient’s care so it is important that a therapeutic relationship is maintained. The clear and concise information found on a nursing care plan may support clear communication and subsequently support the therapeutic relationship between nurse and owner.

A key advantage of developing a therapeutic relationship with an owner or carer of an animal is that the veterinary nurse may get to know the owner better and design a care plan that takes into account the owner’s needs. There is no point in writing out clear discharge instructions for an owner who struggles to read. While illiteracy is rarely something that people admit openly, there may be tell-tale signs noticed as a veterinary nurse spends time with an owner. This may lead to a modification of the approach to an owner, so less reliance on written materials and more on diagrams or practical demonstrations. A further example is when veterinary nurses are caring for animals owned by healthcare professionals, discharging a newly diabetic cat to a diabetic nurse specialist will likely need a different approach to discharging to someone who doesn’t know what diabetes is. Assumptions of their knowledge should never be made, but it is likely they will have a higher level of understanding generally.

A therapeutic relationship will allow a nurse to openly consider the other factors advocated for consideration within Orpet and Jeffrey’s Ability model including the culture of the owner and the financial situation of the owner. Being able to have open and frank conversations about such things should enable the team to make adaptations to care to support the owner and therefore provide better care to the animal. Through such relationships patient centred plans of care may be made. With diligent owner education and support, care that has traditionally been reserved to
a veterinary hospital environment may be moved in the home. There are multiple benefits to being able to facilitate this, the animal is likely to suffer less stress, feeling more comfortable in their own environment. The owner may reduce both their trips to the vets and the financial impact of the animal’s treatment by providing care at home. A prime example is addressing nutritional needs when owners of animals may be taught to administer enteral nutrition, just as human centred nurses will teach their patients to manage their own feeding regimen through gastrostomy tubes.

COMMUNICATION AND THE THERAPEUTIC RELATIONSHIP

Empathy and compassion are a key characteristics of a positive therapeutic relationship. To communicate effectively, nurses must demonstrate empathy and compassion. Difficult to define due to the subjective nature of both and potentially more difficult to identify, empathy is considered the ability to consider the situation or circumstances of another person without acknowledging personal feelings on the matter. Compassion is a reflection of the relationship between the nurse and patient, or in the case of veterinary nursing, also between the nurse and animals owner. It should incorporate kindness and the recognition of suffering and vulnerability. Being able to demonstrate compassion and empathy are the foundations of a therapeutic relationship, if both are present owners are more likely to trust nurses, confide in them and therefore work with them to promote the health of their animal. Nurses should concentrate on developing skills to listen actively, to ensure that they understand and clarify what owners may be saying to them. They should also ensure they work collaboratively, with both the owner and their colleagues to ensure that information provided is accurate and relevant.

One of the key barriers to a therapeutic relationship is when healthcare teams make assumptions. A nurse may write the most detailed home-care plan, full of useful hints and tips for caring for the pet with advice and guidance. However, if initial conversations have not been had and the veterinary team have simply assumed that the owner will be able to manage, afford and facilitate the required care, when in fact the owner cannot, it is likely to mark a negative start to the long term care of the animal.

When trying to develop effective relationships with owners, nurses need to be mindful of their own thoughts, emotions and feelings. Emotional intelligence is often discussed in the context of those working in the caring professions. It is associated with an ability to recognise, express and possibly most importantly control one’s own
emotions. Nursing patients with long term conditions can be difficult emotionally. Owners are ultimately the decision makers and it might be hard for nurses to facilitate decisions that they perceive to be wrong or misguided. Nurses need to pay attention to their emotional intelligence and take steps to promote it through consideration of coping strategies such as establishing a sensible work-life balance, taking regular time off, spending time with family and friends, and potentially using reflective practice to address any concerns and move forward.

Furthermore, it can be very difficult to display compassion for others when nurses are not working within a compassionate environment and not being treated with compassion themselves. A mutual respect for colleagues despite personal differences may be difficult to sustain, but will contribute towards better outcomes for patients and their owners.

**SELF-CARE PLANS IN HUMAN CENTRED NURSING**

There are several areas of care within human centred nursing where patients are encouraged to think ahead and make their own care plans in discussion with their friends and family.

If patients are to be encouraged to read and agree to plans of care, conversation must be open so that the patient understands their own medical situation. It is the patient’s right to know what their care plan entails. It is likely that in knowing and understanding what the plan is, they are far more likely to comply and achieve the goal associated with the planned intervention.

Patients with chronic disease may well become experts in managing their symptoms. They will use the relevant drugs appropriately and liaise with various members of their multi-disciplinary team as required. Self-care plans will often lay out strategies for step up therapies for exacerbations of their condition alongside instructions for daily care and medication.

A nursing care plan written with the patient that the patient can take home with them can guide the patient’s self-care when staying at home. Managing and treating early symptoms may well be safer than leaving them until the patient is weak, unwell, admitted to hospital and consequently more at risk from infection through being recumbent with a compromised immune status.
A excellent example of a patient’s self-care plan that is used regularly is the lung self-care plan used in the author’s workplace, Papworth Hospital NHS Foundation Trust. The Lung Defence Unit is a team of healthcare professionals who look after patients with difficult lung infections. The case mix includes patients suffering from primary and secondary immunodeficiency syndromes, aspergillus related lung disease, rheumatoid arthritis, serious childhood infection and chronic aspiration. The self-care plan provides a comprehensive resource for patients to use to manage their condition in partnership with the multi-disciplinary team.

**My rescue treatments**

- Antibiotics
- Steroids

Discuss keeping a rescue pack at home with your GP!
Other advice for exacerbations.

You should contact the Lung Defence Telephone Support Service on if:
- your symptoms worsen despite taking your rescue treatments
- you need your rescue treatments more than 3 times a year

**My follow up**

My follow up will be by telephone in clinic

You should have a list of your current medications, a record of any chest infections since your last review and any questions you may want to ask to hand.

**Useful Resources**

- www.bronchiectasishelp.org.uk
- www.bronchiectasis.info/
- online bronchiectasis community
Palliative care within the NHS is used in chronic disease. Palliative care teams are experts at controlling the symptoms that accompany the end stages of chronic disease. They develop care plans that view the patient as a whole, administering synergistic medication that can provide relief of a variety of symptoms. Furthermore they will plan those interventions with the patient. Different people will prioritise different symptoms to deal with and only the patient can decide how they want their symptoms managed. A medication review might be indicated and yet again, patient involvement is key. Patients may potentially opt to discontinue some of their treatment medication to eliminate unpleasant side effects.
NURSING CARE PLANS
AND THE PATIENT

Helen Ballantyne

Some people wish to spend their last weeks and months at home, some feel more comfortable in hospital. These discussions are had in advance and plans put in place with the agreement of the patient, these plans are then documented and shared with the multi-disciplinary team and family members.

Patients holding their own care plans is not particularly novel. Care plans for the under-fives have been held their home with their parents for many years. The ‘red book’ has documented nursing care, provided healthcare goals, guidelines and care notes and is often a regularly used document of care. People are familiar with this model and it is a huge source of information and a useful tool for continuity of care.

Currently, it may be assumed that most veterinary treatment of animals in the UK occurs within a veterinary environment. Even though nursing care plans are more likely to be used in the veterinary environment, is there any reason why their use cannot be extended to the home environment as well? Owners very often extend veterinary care through the administration of regular medication, monitoring and specific feeding after education and training from the veterinary team.

A prime example of the extension of the veterinary care of animals is the care owners provide after a patient has undergone and routine elective procedure. These procedures, such as neutering are completed as day cases, under general anaesthesia. When owners arrive to collect their animal and take them home, they are often given very specific instructions regarding home care, including management of medication, diet and exercise. Knowing that when owners collect their animal they are very often distracted and unable to concentrate on the information from the vet or nurse, written instructions are often provided. These support the verbal information exchange and many veterinary teams have been providing such information sheets for years. These standardised care sheets, are, essentially nursing care plans, specific instructions designed to facilitate care of the animal at home.
NURSING CARE PLANS
AND THE PATIENT
Helen Ballantyne

Excerpted from Veterinary Nursing Care Plans: Theory and Practice

CHAPTER 1

NURSING CARE PLANS
AND THE PATIENT
Helen Ballantyne

Figure 2.2 • Post operative care sheet example
CARE PLANNING AND CHRONIC ILLNESS

The care planning process is very often applied to animals who are acutely ill inpatients at the veterinary hospital. However if the evidence demonstrates that using the care planning process and the associated care plans may improve the care of veterinary patients, might the same process equally be applied to outpatients who are chronically ill?

A chronic condition of ill health may be defined as one that continues for a long period, or recurs regularly over time. In the context of veterinary nursing, chronic health conditions in animals also have the added characteristic that they require care input from their owners.

Consideration of chronic ill health in animals must go hand in hand with consideration of quality of life. Quality of life is a complex subject, and the subject of much debate within human centred nursing. Numerous definitions and tools are available to try and measure quality of life. Ultimately many of them are designed so that the impact of the care of chronic health conditions might be measured. Assessing quality of life is equally complex in animals, and often relies on a subjective assessment between the veterinary team and the owner, taking into consideration factors such as ability to exercise, pain levels, perceived enjoyment of activities and ability to perform normal bodily functions such as toileting, eating and drinking.

Owners who are caring for animals who are chronically ill benefit from a therapeutic relationship with veterinary nurses. Many veterinary nurses have evolved their role to include the assessment, monitoring and support of chronically ill outpatients. The development of such a role may be due to a combination of logistics and communication skills. Some veterinary nurses simply have more flexibility in planning their day to facilitate accessible clinical appointments to discuss chronic health conditions in detail and assist owners to understand the care their pet needs. Some veterinary nurses may possess better communication skills than their veterinary surgeon colleagues and consequently owners may prefer speaking with a veterinary nurse and may confide more to a nurse than a vet allowing the nurse to develop a more specific care plan.

Chronically ill animals require regular assessment, in combination with discussions surrounding quality of life. Through these regular assessments and therapeutic interactions with the veterinary team, therapy may be optimised, often through a combination of nursing interventions. The support of these owners and their animals
also requires a forward thinking approach so that future appointments may be booked and new interventions followed up to ensure that owners are happy and able to administrate the care required.

### THE AIMS OF SUPPORTING AN OWNER TO CARE FOR A CHRONICALLY ILL ANIMAL AT HOME

1. Optimise the health and welfare of the animal
2. Provide the best possible patient experience for animal and owner

There are two aims of supporting an owner to care for their chronically ill animal at home. The primary aim must always be to promote the health of the animal and achieve positive clinical outcomes, the relief of pain for example, or optimal blood glucose control. A secondary aim is to provide a better patient experience, for both owner and animal. Therapeutic relationships built up over time facilitate care of both owner and animal that is specific to them. It allows the veterinary nurse to think laterally and provide care that might not be routine, but suits a particular set of circumstances. Follow up appointments might be booked several weeks or months ahead to fit into work patterns. Advice and support might be provided by phone and email, rather than relying exclusively on face to face consultations. Home visits might suit other owners and allow assistance to be provided with medication or monitoring of a patient’s condition.

### HOME CARE PLANS

In her 2016 article, Belinda Marchbank discussed the idea of extending the use of nursing theory, the nursing process, nursing models and nursing care plans to chronically ill patients living at home. One of the biggest challenges in supporting owners to care for chronically ill animals is knowing what information is relevant and what the best possible way of giving that information to an owner might be. The use of the veterinary nursing process, in combination with a model of care may produce a care plan which a nurse and owner may use together to facilitate home care.

Marchbank’s chronic illness management plan (CHIMP) was designed to use the same parameters as that of the Ability model from Orpet and Jeffrey. Similar to the self-care plans used in human centred nursing, it provides a template whereby the veterinary nurse may assess the needs of the patient and create a written record of the nursing interventions the owner can carry out at home to support the health and wellbeing of their animal. Perhaps, given the reliance most animals have on their owners, adapting
the title used most often in human centred nursing, ‘self-care plan’ to ‘home-care plan’ is more appropriate for the veterinary nursing profession. Using the CHIMP model, a home-care plan may provide details of the medication the patient requires, with space to include the particulars of future planned appointments, explanation of the diagnosis and details of any potential complications of the diagnosis.

Education

<table>
<thead>
<tr>
<th>Patient name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client name:</td>
<td></td>
</tr>
</tbody>
</table>

Diagnosis: The client will need to know the name of the disease their pet has been diagnosed with. They will also need an explanation of the disease process and how the disease will affect their pet.

Explanations of disease:

<table>
<thead>
<tr>
<th>Medications:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Duration</th>
<th>Special instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Each medication that the pet requires should be listed out here. Special instructions could include use gloves, store in fridge, give 1 hour before food, etc.

Ongoing monitoring and care

Revisit schedule

<table>
<thead>
<tr>
<th>Date</th>
<th>Length</th>
<th>Purpose</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It is important to set the clients up for success. Giving them the details of the needs such as how often, what will be done at each revisit and the approximate cost will allow them to plan for these and increase compliance which will ultimately result in better outcomes for the animal.

| Diet: | Prescription diets can form part of the management and/or treatment of many diseases. It is important that the clients are clear about the diet required, how it benefits and how to transition this diet from the pet’s current diet. |
| Water: | The water requirements or thirst of the patient can be impacted significantly by either the disease itself or by the medication required to treat the disease. Clients will need clear advice about whether to provide extra water dishes or how to monitor the water intake of their pet. |
| Toileting: | The water and food intake can in turn influence the toileting behaviour of the animal. Clients need clear advice about this; they may need to increase the frequency of toilet stops for their pet. |
| Mobility: | Mobility and hence the activity and rest requirements of the patient can be impacted by either the disease itself or by the treatment. |
| Activity and rest: | Clients will need advice about whether to: increase/decrease activity, provide physiotherapy, change the type of exercise the animal is doing, etc. |
| Behaviour: | Disease often has a significant impact on an animal’s behaviour. |
| Potential complications: | The client will need to know what changes to expect from the disease or from the treatment. |
| Notec: | Symptoms can change and new ones can develop as a disease progresses. |

If you are ever concerned about your pet please call the clinic immediately.

Figure 2.3 • The Chronic Illness Management Plan
Borrowing from and adapting the self-care plans from human centred nursing, veterinary home-care plans may also include details of resources owners can use to further their understanding of the condition of their animal. As previously discussed, health literacy in the UK is rising, the general public are much more likely to know and understand their own health condition having used resources from the internet. This may account for the rising number of animal owners keen to learn more about their pet’s health and welfare from internet sites or other owners in the same situation. Taking the time to construct a list of useful, relevant resources that owners might use to further their understanding may prevent confusion and worry that can be caused by undirected web browsing. Common misconceptions include the direct application of human centred medicine to veterinary patients, or confusion surrounding the use of human drugs for animal patients, so particular instructions might be provided e.g do not use paracetamol. Additionally as with human centred self-care plans, the inclusion of the contact details of who should be called should the animals condition deteriorate is useful.

**THINGS TO INCLUDE IN A HOME-CARE PLAN FOR CHRONICALLY ILL ANIMALS**

- Patient identification details of the patient the care plan relates to
- Diagnosis
- Explanation of diagnosis
- Medications – including dose, duration of use and any specific instructions for use
- Details of follow up appointments, at the practice, via email or telephone
- Contact details of veterinary team caring for the animal
- Nursing interventions according to the CHIMP model (diet, water, toileting, mobility, activity and rest and behaviour)
- Details of any potential complications and their associated signs and symptoms
- Details of useful resources for further reading and comprehension of the condition
- Space for notes so owners may jot down comments or questions

Such home-care plans are useful tools in supporting patient care in the home environment. The advantages of using such a care plan in chronic illness echo the advantages of using a nursing care plan in practice for inpatients. There are advantages to both the patients and the nursing team responsible for the animals care.
The home-care plan will facilitate holistic, individualised care, it will ensure that all the needs of the patient are addressed. It provides a record of the nursing care and the information given to the owner, so fulfilling professional requirements surrounding record keeping. Additionally, copies of the home-care plan may be made so that any other people who will be responsible for the animal will have clear and concise instructions. This is useful for animals that may need to go into a kennels or cattery, or spend time in “doggy day-care” or with pet sitters when owners are away or at work.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Lionel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name</td>
<td>Ballantyne-Lane</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Feline lower urinary tract disease (FLUTD)</td>
</tr>
<tr>
<td>Explanation</td>
<td>FLUTD is not a specific disease but actually a term that covers the symptoms Lionel has experienced, straining to urinate, pain on urination and urinary blockage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Buprenorphine</td>
</tr>
<tr>
<td>Meloxicam</td>
</tr>
<tr>
<td>Prazosin</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Veterinary appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
<tr>
<td>No further check ups planned unless you are concerned that Lionel is having problems urinating.</td>
</tr>
</tbody>
</table>

**Diet**
- Please feed a wet diet twice daily this will up Lionel’s water intake.

**Water**
- Encourage Lionel to drink regularly, consider use of cat fountain or added water to his meals

**Toileting**
- Monitor Lionel’s urinating closely, contact us if you have any concerns

**Mobility**
- Lionel can have free access to house and garden as before his illness

**Activity and Rest**
- Lionel is unrestricted in activity and rest

**Behaviour**
- Please monitor Lionel’s behaviour, changes to his usual behaviour or routine such as urinating in inappropriate places may indicate he has cystitis again.

**Potential complications**
- Thank you for the insurance claim form will submit it on your behalf in next 14 days. If you would like to read more about Lionel’s condition details can be found at www.goodinfoaboutyourpet.com

Figure 2.4 • example home care plan using CHIMP model for a cat following urethral obstruction
Discussing complex chronic conditions can be challenging, the aim is to support the owner to comprehend and ultimately manage their animal’s health in conjunction with the veterinary team. Yet again, the owner becomes part of the multi-disciplinary team. The home-care plan may be used as a communication tool for the veterinary team, providing a structure to the nurse – owner interaction, as it is filled in, step by step. Clear and concise communication is the cornerstone of all therapeutic relationships. While the written home-care plan may support and reinforce the process, it shouldn’t be used as a complete substitute for discussion and explanation.

**REVIEW**

- Nursing care plans can improve patient care for animals admitted to veterinary care, additionally, nursing care plans support individualised care which can promote patient health and wellbeing
- Therapeutic relationships with the owners of patients rely on the demonstration of empathy, compassion and emotional intelligence
- Continuity of care is an important factor in keeping patients safe, nursing care plans are a valuable tool to support continuity of care
- Nursing care plans may also be applied to chronically ill patients living at home, supporting their health and providing a more positive patient experience with the veterinary team.

**CRITICAL THINKING EXERCISE**

Consider some of the surgical and medical interventions that are frequently carried out within your practice. Do you provide home care plans for the owners of patients who have undergone those procedures? Now consider the procedures that are less frequently carried out. Does your practice also have home care plans for those patients having those procedures too? If not consider designing and writing some. Do you think it is more important to have home care plans for patients undergoing routine elective surgery, or for patients that are undergoing surgical or medical interventions that are not carried out frequently at your practice? Why might the owners of animals who are undergoing more unusual treatments benefit more from detailed home care plans?
This chapter is excerpted from
Becoming a Nurse: Fundamentals of Professional Practice for Nursing
By Derek Sellman, Paul Snelling
© 2016 Taylor & Francis Group. All rights reserved.

LEARN MORE
COMMUNICATION AND INTERPERSONAL SKILLS

Victoria Lavender

Excerpted from Becoming a Nurse: Fundamentals of Professional Practice for Nursing

CHAPTER 2

LEARNING OUTCOMES

After reading and reflecting on this chapter, you should be able to:
• explain the basic components of communication;
• outline a range of communication and engagement skills that can be employed within a caring relationship with a client;
• describe the skills involved in initiating, maintaining and disengaging from the therapeutic relationship;
• discuss the importance of the development of emotional intelligence in interpersonal skills working.

INTRODUCTION

The fundamental importance of effective communication in nursing practice is acknowledged repeatedly and has long been regarded as integral to the provision of high-quality patient-focused care. There is evidence that effective communication prior to and during physical procedures reduces anxiety, enhances coping and increases treatment concordance. For Faulkner the ability ‘to communicate effectively ... is at the heart of all patient care’. The nurse’s competence in communicating will determine whether, and to what degree, the client’s nursing needs will be appropriately assessed and met.

Central to the healing process is the professional caring relationship (often called the therapeutic relationship) between the nurse and the client. This chapter explores some essential building blocks for creating and sustaining as well as disengaging from therapeutic relationships.

The chapter is divided into three parts. In Part 1 an outline is offered of the importance of effective communication and interpersonal skills in relation to nursing practice. This is accompanied by a brief overview of the scope of the subject area.

Part 2 provides a fuller explanation of the importance of nurses being effective in communication and interpersonal skills. A brief review of verbal and para-verbal aspects of communication is offered before explaining two aspects of building and maintaining the therapeutic relationship: (i) building and maintaining trust; and (ii) demonstrating respect, empathy and genuineness.

In Part 3, a deeper exploration of communication and interpersonal skills is provided with an emphasis on some more advanced and complex aspects of developing and
maintaining a therapeutic relationship. Some information relating to barriers to and disengaging from therapeutic relationships concludes the chapter.

PART 1: OUTLINING COMMUNICATION AND INTERPERSONAL SKILLS

CASE 1.1

Almira is a third-year student nurse working on a general medical ward in a small local hospital. Suzanne (Almira’s mentor) is a larger than life personality who was born and brought up in the local community. Almira finds Suzanne loud and a little overbearing with her unrestrained jollity, her tendency to stand a bit too close, and her (over) use of physical contact. Almira notices that Suzanne tends to call everyone (staff and patients) ‘pet’ and is surprised that no one seems to mind. Almira is not sure she likes being called pet, but she does not voice her objections because it seems to be accepted as part of the ward culture and, anyway, she is intimidated by Suzanne.

THE IMPORTANCE OF DEVELOPING COMMUNICATION SKILLS

Stickley and Freshwater argue that ‘nursing involves the formation of a meaningful relationship through the development of an effective interpersonal process’. They point out that a need for improvement remains despite emphasis placed on the importance of effective interpersonal and communication skills in nursing.

Peplau’s theory of nursing helped turn attention away from internal patient pathology towards therapeutic processes between nurse and patient. Peplau recognised the therapeutic opportunity for patients to understand the circumstances of their health along with the potential to make beneficial health-related changes. At the heart of the interpersonal process lies a requirement for nurses to develop effective and caring communication skills.

RESEARCH FOCUS 1.1

Mallett and Dougherty report in their study of patient satisfaction of care that the quality of nurse’s communication was recorded as the least satisfying aspect. They go on to suggest that complacency or indifference to the goal of improving communication and interpersonal skills has no place in the preparation for becoming a registered nurse.
ACTIVITY 1.1

Think about someone you recognise as a good communicator:

- List the top 10 skills/qualities you think make that person an effective communicator.
- Explain why you think the top 5 skills/qualities on your list are the most important.

COMMUNICATION AND NURSING

Communication can be defined as a reciprocal process of sending and receiving messages. Thoughts, feelings and information are sent as encoded messages and may be conveyed verbally via pitch, tone, inflection and speed of speech. Equally important messages are conveyed non-verbally via facial expression, eye contact, body posture, body position, movement and gestures. The receiver decodes the message to make sense of the sender’s thoughts, feelings or information and generally returns messages in response to what they have understood. Consisting of a sender, a message and a receiver, this model of communication is described as linear.

Figure 1.1 illustrates the reciprocal nature of interpersonal communication. Both sender and receiver are likely to receive simultaneous transmissions from each other requiring amendments to both coding and decoding processes. The transmission process will also be influenced by, for example, environmental factors (such as external noise levels), the degree of privacy, or the presence of others. Encoding and decoding messages is fraught with potential for misinterpretation and/or misunderstanding, and with additional barriers such as the specialised language of health care or differing attitudes, values or beliefs of the participants, this makes the communication process complex and highly individualistic.

Contemporary models of communication try to capture this complexity. In a circular transactional model, such as the one in Figure 1.2, communication is viewed as a...
circular process with communication as ‘a reciprocal interaction in which sender and receiver influence each other as they converse’. The emphasis here is placed on the contexts of communication within a relationship and, in contrast to the linear model, holds that feedback and validation are interdependent and dynamic elements. Feedback as the response from the receiver to the original message will affect future communication. In this model feedback is conveyed even in the absence of a response, and validation is understood as a form of feedback that confirms participants hold similar understandings of the message and the feedback.

![Diagram of a circular transactional model of communication.](image)

Nelson-Jones categorises the basic means by which we send messages to one another as:

- **verbal messages** (via words and language);
- **para-verbal or vocal messages** (via volume, articulation, pitch, tone and speech rate);
- **non-verbal or body messages** (via facial expression, eye contact and gaze, gesture, posture, physical proximity, touch, clothing and grooming); and
- **action-taking messages** (via letters, reports and e-mails when sender and receiver are not face-to-face).

Nurses are most involved with face-to-face interactions with patients, their relatives and carers, and other health care professionals so this chapter focuses primarily on verbal, para-verbal and non-verbal communication and interpersonal skills.
**PART 2: EXPLAINING COMMUNICATION AND INTERPERSONAL SKILLS**

**THE COMPONENTS OF COMMUNICATION**

The complexity of the communication process requires nurses to ensure proficiency and effectiveness in clarity as senders of messages and in sensitivity of understanding as receivers. Being aware of the complexities, subtleties and dynamics of individual components of communication enables the nurse to use a range of effective and appropriate communication skills.

**Verbal communication**

Language may be formal (e.g., government reports, university regulations) or informal (e.g., everyday conversations). Nurses need to be aware of the possible distancing effect that professional language may have with clients struggling to understand and translate what is being said. Cultural differences in language affect the nurse–patient relationship and can easily get in the way of mutual understanding. For example, Almira (Case 1.1) comes from a different background to most of the staff and patients and dislikes being called pet. The recognition that even simple everyday conversations between nurses and patients have the potential to cause offence is an important part of understanding the need for sensitivity and respect in communication; and arguably Suzanne and her colleagues do not show sufficient sensitivity for Almira’s language traditions. Thus part of developing effective interpersonal skills for nursing practice is an awareness of a need to adopt clear, precise and unambiguous words appropriate to and respectful of others in professional relationships.

**Para-verbal communication**

Para-verbal (or vocal) communication includes vocalisations (parts of speech that accompany words) that add to what is being said in important ways. Vocalisations can be interpreted as conveying information about the sender’s message and include: volume, articulation, pitch, tone and speed of delivery. Each has the potential to be interpreted (or misinterpreted) by the listener regardless of the intention of the speaker.

Volume refers to loudness or softness of speech and should be appropriate to a client’s hearing capacity and environmental conditions. Overly loud delivery of speech may be interpreted as conveying anger or hostility, or may simply make others feel uncomfortable (Almira wonders if some patients find Suzanne’s loudness uncomfortable); undue softness may convey uncertainty, shyness or deference.
Articulation refers to clarity of words spoken and can be related to volume. For example, a nurse who mumbles will compound communication problems for someone with difficulty hearing in noisy environments (and hospital wards are often noisy environments).

Pitch refers to the height or depth of the voice and tone refers to the manner of delivery. Both can be interpreted as conveying (regardless of the intention of the speaker) the underlying thoughts, feelings and attitudes of the speaker.

The rate of speech includes the number of words spoken each minute as well as the frequency and the duration of pauses between words. A rapid speech rate may convey speaker anxiety, excitement or degree of happiness. A slow speech rate may convey ponderous thinking, pomposity or condescension.

Each para-verbal aspect of speech can obstruct clear and effective communication. When everyone understands the culturally and socially specific speech conventions, the potential for misunderstandings is minimal. So in a small, localised community with few ‘outsiders’, ways of communicating (including the nuances of, for example, irony, dialects and accents) will be understood by all participants. Until recently, this has been the situation on the ward where Almira is a student. Such communities are becoming rare with increasing multiculturalism and increasing diversification of language development in different communities. As populations of nurses and patients diversify so the potential for misunderstandings or offence increases. In professional life the onus is on the nurse (rather than the patient) to enable rather than hinder effective communication. So Suzanne seems to be relying on forms of communication no longer appropriate to her situation. Providing safe and effective care requires nurses to recognise responsibility for developing effective interpersonal skills as part of maintaining methods of communication that contribute to the well-being of patients, and this includes ensuring respectful communication between health and social care individuals.

Non-verbal or bodily communication

Perhaps the main vehicle for sending non-verbal messages is through facial expressions. According to Ekman ‘seven categories of emotion [mediated by facial expression] have been found ... happiness, surprise, fear, anger, sadness, disgust/contempt and interest’.

The eyes, the eyebrows and the mouth shape are particularly effective in conveying expressed or unexpressed emotion. Eye contact both sends and collects information
and helps to regulate turn-taking during conversations. Nelson-Jones suggests that during conversations, listeners look at speakers more often than speakers look at listeners (approximately 70–75 per cent for the former, 40 per cent for the latter). Speakers tend to look at listeners just before they intend to pause or stop speaking to collect feedback about the listener’s reactions and to invite the listener to take a turn at speaking. However, eye contact conventions vary. Hogg and Holland note that Western understandings of eye contact as signaling honesty is understood as rudeness or challenging in some cultures. In Arabic cultures, prolonged eye contact denotes respect, whereas in South Asian cultures it is regarded as aggressive or confrontational.

Gestures are physical movements that accompany speech and demonstrate, illustrate or emphasise particular aspects of verbal communication; sometimes replacing words, for example, nodding or shaking the head indicating agreement or disagreement respectively. Gestures too are culturally specific, so a gesture in one part of the world may mean something altogether different in another. The classic example offered by Liberman et al. is the hand gesture made by the thumb and first finger meeting to form a circle in the familiar ‘OK’ sign in many parts of the world. For Hispanic Americans, however, this signals an invitation to perform a sexual act.

Posture encompasses both the relative heights of speaker and listener and whether the body is turned toward or away from the other person. Unequal height can cause feelings of unease; for example, a nurse standing might seem to tower over a client who is lying or sitting. Turning the body or part of the body towards the other person conveys interest. Turning the body away or crossing the arms or legs (often referred to as a closed posture) may be interpreted as lack of interest, indifference or defensiveness. An open posture with arms and legs uncrossed, relaxed and reasonably still indicates acceptance, interest and a willingness to continue communication.

Physical closeness is an important non-verbal component. Hall suggests zones of comfort in Western cultures as intimate (between 15 and 46 centimetres) for spouses, lovers, close friends and relatives; personal (46 to 122 centimetres) for acquaintances at social gatherings; social (1.22 to 3.6 metres) for people unknown to each other; and public (over 3.6 metres) for impersonal public gatherings. Some individuals do not observe these proximity zones and the zones may be different in different cultures: ignoring the social norms of any one group by positioning the body too closely may give rise to feelings of unease or even threat. This helps to explain why Almira feels uncomfortable in Suzanne’s presence.
The therapeutic relationship is initiated, promoted, managed and sustained by the nurse for the express purpose of helping the client meet their treatment goals.

The intimacy of nursing requires nurses to be sensitive to these zones and to ensure physical proximity does not raise patient feelings of violation or distress. This can be a difficult area to negotiate as touch is such a powerful conveyer of warmth, comfort and acceptance, so an awareness of how patients might show non-verbal signs of discomfort (e.g., slight facial grimacing or physical movement away from the nurse) is important.

**ACTIVITY 1.2**

Face-to-face communication includes:
- *verbal components* (words and language);
- *para-verbal components* (volume, articulation, pitch, tone, rate of speech);
- *non-verbal components* (facial expression, eye contact and gaze, gestures, posture, proximity and touch, clothing and grooming).

Try to identify each of these components while you are engaged in conversation with another student. Use the questions below to help you think about how these components facilitate or hinder the communication process.

- Do you use all components in all conversations?
- In what ways do the different components interact?
- Which (if any) components dominate?
- Which (if any) components hinder communication?
- Which (if any) components enable effective communication?

**THE THERAPEUTIC RELATIONSHIP**

The idea of therapeutic relationships between nurses and clients builds on the work of humanist psychologist Carl Rogers. The therapeutic relationship is initiated, promoted, managed and sustained by a nurse so as to help clients meet their treatment goals. It is defined as a helping relationship ‘established for the benefit of the client, whereas kinship and friendship relationships are designed to meet mutual needs’. Arnold and Underman Boggs suggest that social relationships are distinguished from therapeutic ones that aim to:

- enhance well-being;
- promote recovery; and
- support self-care.
In the therapeutic relationship communication is directed towards the needs of the client although the patient is not merely a passive recipient, for inherent in the therapeutic relationship is a sense of affiliation or working in partnership. Gallant and colleagues trace the idea of client as equal partner as consistent with contemporary emphasis on the importance of basic human rights.

Timmins and Price suggest that partnership working acknowledges and values the patient’s knowledge and skills in managing their ill-health, particularly for long-term conditions. If communication is unidirectional from nurse to patient, then essential information is likely to be omitted from the assessment, planning and evaluation of client care. In the absence of partnership, giving clients information follows a pattern of ‘I talk/you listen’, reinforcing notions of professional dominance.

The most frequently cited benefit of partnership working is empowerment understood as enhancing the ability of a client to act in their own interest, leading to improved self-esteem and confidence. Arnold and Underman Boggs describe empowerment as preparing patients to cope with difficult life situations resulting from alterations in health and well-being.

**Developing and maintaining therapeutic relationships**

Some of the essential skills necessary for building and maintaining a nurse–patient therapeutic relationship can be summarised as:

- building and maintaining trust;
- demonstrating respect, empathy and genuineness;
- active listening;
- listening to self and developing self-awareness;
- setting and maintaining professional boundaries.

The first two act as building blocks for the more advanced and complex skills needed for the other three. Building and maintaining trust together with demonstrating respect, empathy and genuineness will be the focus of the remainder of this part of the chapter. Active listening, listening to self and developing self-awareness, and setting and maintaining professional boundaries are considered in Part 3.

**Building and maintaining trust**

Trust can be defined as the firm belief in the honesty, integrity and reliability of another person. A therapeutic relationship always begins with trust. Trust is part of
the psychological contract between nurse and patient. It is difficult to define but if a therapeutic relationship is to develop, the patient must be able to feel the nurse is trustworthy.

Earning a patient’s trust is a lengthy process and a warm, friendly and respectful greeting is likely to start the process well. Ensuring the client’s preferred form of address is used, correctly pronounced and that friends or family members are welcomed will help begin building an early rapport essential for the formation of trust. An introduction, a brief explanation of one’s role in the patient’s care, maintaining eye contact, an open body posture, appropriate proximity and equal height with the patient may all serve to strengthen the patient’s willingness to trust the nurse.

However, these simple techniques should reflect the intentions of the nurse. If the verbal message (i.e., what the nurse is saying) does not match the nurse’s facial expression, posture, or tone of voice the disparity between words and manner will create a sense of unease or even distrust. Knapp notes that we may be able to match our facial expressions and posture with what we are saying but we often fail to control the movements of our hands, legs or feet. So we can very easily ‘give away’ feelings of, say, anxiety, irritation or boredom, by, for example, clenching our hands, swinging our legs or tapping our feet.

**ACTIVITY 1.3**

Have a go at saying the sentences below to a partner or while looking in a mirror. Try to match your non-verbal and spoken messages.

- No, you’re not disturbing me. It’s lovely to see you, please come in.
- I feel very upset at your news, it’s so sad this has happened.
- Please don’t worry, it was only an old vase – I’m sure I can get another one.

Now repeat the sentences while deliberately mismatching your non-verbal behaviour with the words and the way you deliver them. For example, if the last statement is accompanied by an angry facial expression, a rigidly held posture and clenched hands, the reassuring verbal message will be lost giving the receiver the impression of the sender’s anger despite the words used. Try to work out why the non-verbal message is likely to dominate and undermine the sender’s verbal message.

**Empathy** is the ability to ‘step into’ the inner world of another person in order to understand their thoughts, feelings, behaviours and meanings.
Trust is reinforced by behaviour. The nurse who promises to pass on a message or perform a task and fails to do so without apology or explanation will quickly lose a client’s trust. The nurse who breaks a patient’s trust damages the nurse–patient relationship, their own professional standing and the reputation of nursing.

Demonstrating respect, empathy and genuineness

Rogers claims that respect, empathy and genuineness are the core conditions for building and maintaining therapeutic relationships, demonstrating warmth and respect with unconditional positive regard: that is, accepting others for what they are, not on condition they behave in certain ways or exhibit particular characteristics.

Respect

Treating people with respect is fundamental to nursing. The way a nurse introduces themself to, and how a nurse addresses, a patient will convey an attitude of respect (or otherwise) to that patient. So the nurse who routinely addresses all older patients by first name or as ‘pet’ or ‘dear’ (even where that is local convention) is failing to respect those who prefer formal forms of address. The routine of asking patients how they would like to be addressed and then making that preference known to other health care professionals is one way to show respect. Valuing and acting in accord with patient preferences demonstrates respectful communication.

Being respectful entails paying close attention to what the client says, ensuring the client understands all aspects of their care, seeking permission or consent and protecting and actively promoting the client’s privacy. Being respectful also includes maintaining client confidentiality, promoting choice and accepting different cultural behavior.

CASE 1.2

Shirley, aged 57, has a history of mental health problems. She is currently experiencing periods of low mood, with a loss of appetite and insomnia. She tries to describe her thoughts and feelings to Marty, her named nurse. Shirley speaks hesitantly and in little more than a whisper. Marty finds it increasingly difficult to focus on what Shirley is saying and allows himself to lose concentration. His eye contact with Shirley becomes fleeting and he begins to gaze out of the window. He tries to stifle a yawn and once or twice interrupts Shirley by asking inconsequential details.
ACTIVITY 1.4

Read Case 1.2 before answering the following questions:

- How is Marty’s behaviour likely to affect Shirley’s expression of her thoughts and feelings?
- What might she interpret from his behaviour?
- What effect could this have upon the relationship between them?

Being respectful requires assertiveness. To be assertive involves clear and direct communication of individual needs and acknowledgement of the needs of others. When we show respect we are heeding another’s right to be treated with dignity and consideration without ignoring or undermining our own needs.

Respect does not mean merely agreeing with the client’s perspective, for respectful disagreement involves stating your point of view, explaining the reasons for it and acknowledging others may have a different perspective. Respect entails listening attentively, acknowledging differences and not succumbing to a need to be always right. The nurse who apologises for mistakes, misunderstandings, individual shortcomings and/or unforeseen changes to plans, demonstrates professional accountability and respect for the injured party.

Arnold and Underman Boggs describe empathy as ‘the connective caring bridge between health providers and clients’. When we mentally put ourselves in the shoes of others and verbally convey what it might be like to wear those shoes, we are being empathic. Empathy aids in establishing therapeutic relationships by conveying a sense of being cared for. Balzer Riley suggests that it is not just empathy that is beneficial, but the intention of the giver and the perception of the receiver. To experience an empathic response from a nurse is to experience feelings of connectedness, of being cared for, understood and accepted. For the nurse, empathy can help establish and maintain a caring relationship with, and demonstrate respect for and acceptance of the client’s internal world.

Responding empathically can be broken down into a number of steps:

1. Focusing on the speaker by filtering out distractions, paying attention to verbal and non-verbal messages, and recognising expressions of feelings.
2. Being aware of one’s non-verbal responses, including facial expression, eye contact and gaze, gestures, posture, proximity and touch.
3. Being aware of one’s verbal responses, choice of words, tone of voice, volume, articulation, pitch and rate of speech as well as congruence between verbal and non-verbal communication.

4. Identifying dominant feelings expressed by the speaker.

5. Verbally reflecting back, the feelings you think you have heard. For example, ‘It sounds as if you feel really disappointed that you won’t be able to go home today as planned’.

6. Checking to see if your interpretation of the speaker’s feeling is accurate. For example, ‘Have I got that right?’ or ‘Is that how you are feeling?’ Checking allows for feelings to be clarified. If your interpretation is correct the client will feel you understand them and this may further encourage them. If your interpretation is incorrect the speaker has the opportunity to clarify what they mean; ‘No, it’s not that I’m disappointed I’m not going home yet, it’s more that I’m anxious about coping once I’m home’.

Failing to check your interpretation of the client’s feelings may result in the client experiencing a sense of being told what they are feeling. Far from being understood and accepted, the client is then likely to feel alienated. Empathic responses, in reflecting back the feelings the client expresses, can serve as permission for the patient to voice what they might otherwise regard as unacceptable.

**ACTIVITY 1.5**

Consider the interaction between Julia, a 49-year-old patient recovering from a partial mastectomy and Lucy, a second-year nursing student.

*Julia:* I know I shouldn’t be thinking like this. Perhaps I shouldn’t even be saying this. I know I’ve got a lovely family. I just feel at times that I haven’t got the energy to carry on. Sometimes, I just wish that I could go to sleep forever and not wake up again.

*Lucy:* Now cheer up, surely it’s not as bad as all that!

*Julia:* I know you think I’m being silly.

*Lucy:* As you said, you have got a lovely family, very supportive. You are very lucky; you should count your blessings.

- What feelings might lie behind Julia’s words?
- How might Julia feel after hearing Lucy’s response?
- Is Julia likely to feel able to discuss her feelings further?
- What might lie behind Lucy’s attempt to cheer Julia up?
COMMUNICATION AND INTERPERSONAL SKILLS

Victoria Lavender

Excerpted from Becoming a Nurse: Fundamentals of Professional Practice for Nursing

CHAPTER 2

Try to write out a response that Lucy might give, which conveys a more empathic response to Julia’s first statement.

Congruence between non-verbal and verbal communication will help to convey to the client a sense that the nurse is being genuine. The absence of genuineness is said to lead to sterile application of communication techniques. Being authentic requires the nurse to be clear about their own beliefs, attitudes, thoughts and feelings. This in turn relates to the need for assertiveness skills, self-awareness and in particular, awareness of personal limitations and some of the difficulties in managing a professional image.

Although much of current nursing literature exhorts the need for genuineness, little attention has been paid to the difficulties associated with being authentic in clinical settings. The reality of busy clinical areas often means that nurses feel they have neither the time, opportunity or energy to apply Rogerian principles of empathic understanding, respect and genuineness in their hurried and often fragmented client contact. Nelson-Jones acknowledges that inexperience or under-confidence may lead to the presentation of an inauthentic but desperately held professional façade, particularly if the client appears to question the knowledge, authority and previous experience of the professional carer. Perhaps a response that honestly acknowledges areas of inexperience, particularly in not having experienced the same emotions as the client, will be both a genuine response and one that conveys a truthful validation of the uniqueness of the client’s emotional experience: a response of *I know exactly how you feel* is likely to be the point at which clients will question, albeit silently, the genuineness of the nurse.

PART 3: EXPLORING COMMUNICATION AND INTERPERSONAL SKILLS

You may have heard it said that it is unprofessional to express your personal feelings, particularly if you feel critical of the client. This suggests a need for a degree of professional detachment seemingly at odds with the requirement to be genuine within emphatic responses.
RESEARCH FOCUS 1.2

Aranda and Street explored nurses’ concepts of being authentic and the need for flexibility in presenting aspects of themselves in order to respond to clients’ particular needs, for example, to gain access to the details of the patient’s life or seek concordance with treatments. The nurses in the study termed this being a chameleon. They expressed discomfort at changing styles of interaction with clients with its implication of being manipulative and inauthentic (even when the overall goal remained improvement of patient outcomes).

Aranda and Street propose that reconciliation of these tensions is possible through the concept of a nurse–patient relationship governed by intersubjectivity. Intersubjectivity suggests that all human relationships are co-constructed by the participants, that our reactions to others are shaped and formed by their interpretation of us. The circular transactional model of communication (Figure 1.2) illustrates the fluid nature of this process. Shifts in presentation of self are not necessarily inauthentic or manipulative; they merely represent individuals’ responses to each other as each contributes to the development of the relationship.

ADVANCED AND COMPLEX COMMUNICATION SKILLS

Active listening

Many people mistakenly believe that good talkers will be good listeners. Stickley and Freshwater note there is no guarantee that a fluent conversationalist will make a good listener. Here it is useful to distinguish between hearing and listening. Hearing involves the capacity to be aware of and receive sounds. Listening involves both hearing the sounds and interpreting their meaning. According to Gordon, active listening involves trying to accurately understand a speaker’s messages and to demonstrate understanding by carefully chosen responses. Requiring the exercise of both receiving and sending skills, active listening is considered an essential skill in creating and maintaining the therapeutic relationship.

Burnard suggests that while social (or phatic) communication can aid in establishing rapport with patients, effective therapeutic communication requires the listener to move on from the phatic stage to what Wright terms ‘deep listening’. For Wright, deep listening necessarily involves setting aside one’s own thoughts, listening without
judging and attending closely to what is being said. In this sense the effectiveness of the therapeutic conversation depends on the nurse’s ability to listen and detect clues that might entail the need for sensitive responses; responses that aim to help the client explore and express their feelings. Active listening requires:

- presence or attending skills;
- asking questions;
- clarifying, restating and paraphrasing;
- using silence;
- reflecting feelings.

**Presence or attending skills**

Gardener identifies presence as a therapeutic gift of self and as ‘the embodiment of caring in nursing’. **Presence or attending skills** convey an unselfish interest in the client where the focus remains on the speaker. Presence refers to the ability of the nurse to remain physically, spiritually and emotionally attuned to the client’s communication. Attending calls for the listener to concentrate and focus on what the speaker is saying by trying to suspend any personal thoughts or ideas in order to interpret and understand the other person’s perspective.

To be effective, this intentional focus must be congruent with non-verbal messages of interest. A still and open posture, a slight lean of the upper body towards the speaker, and direct eye contact will convey the listener’s focus and interest. Appropriate facial expressions such as a smile or a frown or a nodding of the head may encourage the speaker to continue. Periodically verbal encouragements such as: go on or please take your time or short vocalisations, for example, mm or uh-huh can be given. Attending skills may sound relatively straightforward, even simplistic. However, practice, concentration and a genuine desire to understand the patient are needed to ensure active listening is not ‘acting’ listening. Over time practice will enable these skills to be incorporated into the nurse’s personal communication style and thus become both genuine and subtle.

**Asking questions**

Asking questions enables the nurse to find out about the patient. **Open questions** are useful in eliciting clients’ thoughts or feelings. Perhaps the most common exception to this is the everyday *how are you?* which, although an open question, is commonly understood as a greeting rather than an enquiry: thus tends to be met with a *fine* or an *OK*-type response. However, it can be easily adapted to become a more open question, as it would be, for example, in the enquiry *how do you feel about*
having surgery tomorrow? If the invitation to expand is rebuffed by a simple OK thanks, it is appropriate to remember that therapeutic questioning is not interrogation. Therapeutic questioning requires a sensitive and accurate reading of the verbal and non-verbal messages from the client and a willingness to adopt flexible communication strategies based on responses received.

Closed questions are appropriate when information is needed quickly or in a structured format. Examples of closed questions might be when did you have your last insulin injection? or does the pain get worse on exertion? A variation of the open question is the focused question, which is useful when seeking specific information about a particular subject or issue, for example, can you tell me more about the pain in your shoulder? or can you describe your pain?

Circular questions focus on the interpersonal context in which an illness occurs and are designed to identify family relationships as well as the impact illness might have on individual family members. Questions of this kind can help illuminate the patient within the contexts of family or others involved in their care. An example might be, who in your family is likely to be most affected by your father’s illness? or how is your younger sister coping with your mother’s diagnosis?

ACTIVITY 1.6

Can you identify which of the following are open questions, which are closed questions, and which are circular questions?

- How do you feel about being discharged from hospital?
- Have you lost weight recently?
- Do you feel overwhelmed by all your visitors?
- How will your partner manage the house and the business without you?
- Do you have any pain?
- Can you tell me if your child lost consciousness?
- What do you feel is the best course of treatment for you right now?
- Can you squeeze my hand?
- Ten milligrams a day – is that your normal dose?
- How will your father view his son’s refusal to visit?
- How do you feel about having a different community nurse?
While most of these questions clearly fall in one or other category, others incorporate elements of more than one type. For example, the question, do you feel overwhelmed by all your visitors? can be answered as both an open and a closed question. You might find it useful to discuss your ideas about which are open, closed or circular questions with other students.

Clarifying, restating and paraphrasing
Seeking clarification is sometimes necessary if the nurse is to understand the client’s message. Using a neutral tone to ask the client to elaborate or explain helps ensure that they do not feel they have to justify or defend their thoughts and feelings. A simple question that asks for clarification, such as, can you explain that to me? demonstrates interest in the client, checks the accuracy of interpretation and allows the client to feel heard.

Restating is the repetition of a small section of the sender’s message, often in the form of a query, using the sender’s own words. This allows the sender to hear for themselves what they have said and provides the opportunity for them to clarify, amend or be more specific. For example, a client might say: since my heart attack I just can’t get on with the things I want to do. I feel I’m no use to anyone any more. In restating the fragment … no use to anyone? as an enquiry, the nurse provides the patient with an opportunity to expand on what could be a significant point. Restating is a useful technique but it needs to be used sparingly or it can hinder effective communication by interrupting the flow of a client’s thoughts.

Both clarification and restatement can be counterproductive if the listener’s tone of voice is accusatory or demanding. However, restating can be used as a positive affirmation of the client. For example, in response to a client who says, I think I’ve done quite well with my exercises, the nurse might restate the fragment … only quite well? in a warm tone of voice and thus convey to the client a sense of achievement.

To paraphrase is to attempt to put into different words the core elements of another person’s message. Paraphrasing a client’s thoughts and feelings should always be done tentatively so that the client can correct any misinterpretations or confirm correct understanding. Accurately paraphrasing can mirror the speaker’s material but offers the possibility of being clearer and more succinct than the original messages. There is no single correct way of paraphrasing and much will depend on the listener’s own choice of words, but if the message has been accurately heard the client is likely to confirm it, for example, yes, that’s right or you’ve got it exactly.
Using silence

Using silence as an active listening skill offers the patient time to think, and as Arnold and Underman Boggs note, allows the nurse to step back momentarily and process what they have heard before responding. A natural anxiety on the part of the nurse concerning how to respond or whether the response is appropriate and helpful to the client may lead to filling silences with unnecessary comments. The length of a silence needs to be carefully judged and much will depend on the client’s ability to process information and respond to the nurse.

Ending a silence too quickly may not only give the client insufficient time to formulate their thoughts and responses but may convey to the client the nurse’s anxiety or discomfort with the topic. Sharing a silence can convey the nurse is willing to ‘be with’ the client in the sense of attending or presence. Silence may occur for many reasons and might mean that something has touched the client deeply; respecting the client’s silence and sitting without breaking the mood can demonstrate an empathic understanding and acceptance of the client’s feelings.

ACTIVITY 1.7

When you talk with patients be aware of silences as they arise.

- Ask yourself why did the silence occur?
- Look for non-verbal clues that may help you to form an answer.
- Be aware of how silences make you feel.
- Do you try to break a silence as quickly as you can, and if you do, why?
- Is it easier to let the silence continue with some patients and not with others?
- How do you break silences?
- If you cannot break a silence with words (and most of us are often not as articulate as we would like to be) what non-verbal means of communication might be appropriate?

Reflecting feelings

Reflecting feelings can involve paraphrasing but the focus is more on the client’s expression of feeling rather than their words. Nelson-Jones defines the skill of reflection as ‘empathising with a client’s flow of emotion and communicating this back’. Reflection involves the skilled interpretation of verbal and non-verbal clues. Emotions are not always verbalised but may be observed as incongruence between
the patient’s verbal and non-verbal messages. *I’m fine* might be a verbal response to the question of how the person is feeling but the non-verbal clues of a sad facial expression or tearfulness will undermine the verbal message. Reflection tries to capture the overt and covert messages to reflect them back in an empathetic manner.

**ACTIVITY 1.8**

In the following piece of dialogue, a third-year student nurse, Simon, uses reflection in a sensitive and effective way, enabling Clyde, a 17-year-old patient, to express his feelings.

*Clyde:* I can’t bear all the noise in here.

*Simon:* You are finding the noise upsetting?

*Clyde:* It’s just that there are so many people around all the time. I can’t explain it; somehow it makes me feel alone.

*Simon:* It sounds like you are feeling lonely. Is that how you feel?

*Clyde:* I guess so. I feel a bit silly really.

*Simon:* It doesn’t sound silly to me at all. Feeling lonely is very upsetting.

Review the skills discussed so far in this chapter and try to identify other elements of therapeutic communication involved in this exchange. You may find this more productive if you undertake this part of the exercise with another student.

Patients may resist revealing their underlying feelings, but gentle and sensitive use of reflection may help the patient to articulate and understand their emotional responses to health-related issues. Egan suggests the following questions may help students to clarify the reflective process at a more advanced level:

- What is this person only half saying?
- What is this person hinting at?
- What is this person saying in a confused way?
- What covert message is behind the explicit message?

**LISTENING TO SELF AND DEVELOPING SELF-AWARENESS**

Stickley and Freshwater assert that before we can listen successfully to others it is important to develop the art of listening to ourselves. This involves becoming conscious of the thoughts, feelings, attitudes, beliefs, prejudices and values likely
COMMUNICATION AND INTERPERSONAL SKILLS
Victoria Lavender

Excerpted from Becoming a Nurse: Fundamentals of Professional Practice for Nursing

CHAPTER 2

...to affect our interactions with others. Nurses are expected to protect the interests and dignity of patients and clients, and ‘avoid making assumptions and recognise diversity’. Arnold and Underman Boggs indicate that self-awareness helps us to connect emotionally with others. Nurses can learn about themselves through reflecting upon their motives, feelings, responses and behaviours in relation to others. A specific incident, perhaps initially regarded as negative, for example, an unsuccessful confrontation, or an interaction that could be felt to be more positive, such as a warm and caring interpersonal exchange, can be useful in providing a focus for the nurse to reflect critically upon and record both their strengths and the areas in need of further development.

ACTIVITY 1.9

The five questions below are adapted from Carl Rogers. They are designed to encourage self-awareness in nurse–patient relationships. Think of a client with whom you feel you have a therapeutic relationship. Work through the questions, applying each to your relationship. You might be tempted to simply answer ‘yes’ and move on but try to think about each question carefully. You could make short notes exploring how you can demonstrate that you are able to answer ‘yes’. What areas might still be in need of further development? What steps could you take to start to achieve this?

1. Can I be in some way that will be perceived by the other person as trustworthy, dependable, or consistent in some deep sense?
2. Can I let myself experience positive attitudes toward this other person – attitudes of warmth, caring, liking, interest and respect?
3. Can I let myself fully enter into the world of their feelings and personal meanings and see these as they do?
4. Can I accept this person as they are? Can I communicate this attitude?
5. Can I maintain separateness from this person and foster separateness in them?

Burnard suggests a positive correlation between a nurse’s understanding of self and their openness and honesty in interactions with others. By knowing personal prejudices, motivations and current abilities, the nurse can increase their capacity for being empathic with clients.
**COMMUNICATION AND INTERPERSONAL SKILLS**

Victoria Lavender

Excerpted from *Becoming a Nurse: Fundamentals of Professional Practice for Nursing*

CHAPTER 2

**SETTING AND MAINTAINING PERSONAL BOUNDARIES IN THE THERAPEUTIC RELATIONSHIP**

One consequence of becoming self-aware is noticing when aspects of the therapeutic relationship serve the nurse’s rather than the client’s needs. Question 5 above refers to maintaining a sense of separateness from the client. This may seem to contradict the call for ‘being with’ in attending skills of active listening to build an empathetic understanding of the client. However, a sense of separateness is essential in the therapeutic relationship and maintained through appropriate emotional distancing or emotional boundary keeping.

**CASE 1.3**

Jan is a mature student nurse and has formed a close relationship with Georgie, aged 11, who has been a patient on the children’s unit for several months. Georgie is aware of his poor prognosis but remains cheerful. From time to time he talks optimistically about his future hopes of being a professional footballer.

Jan has two children, one of whom is the same age as Georgie, and finds it difficult to cope with the knowledge that Georgie is likely to die soon. She feels that she needs to spend as much time with Georgie as she possibly can when she is on duty and is aware that she often thinks about him when she is with her own family. Jan has a strong sense of frustration that little can be done for Georgie. She spends extra time with him before and after each shift. As Georgie becomes increasingly frail Jan finds it almost impossible to hide her distress when he talks about which football club he would like to play for.

Jan’s mentor is concerned about the amount of time she is spending with Georgie and has noticed that she seems to resent other nurses being involved in his care. She gently voices her concerns and listens empathically as Jan acknowledges her distress and anxiety about not being able to cope with Georgie’s death. She is also able to acknowledge that her emotional involvement with Georgie and his family has led her to think that she has the most important role of all the care team members in being responsible for his care. Her mentor discloses her own similar experience earlier in her career and explains how supportive the care team were in helping each other come to terms with the death of a young patient. Jan and her mentor discuss the nature of empathy and the importance for professional staff of maintaining a sense of separateness or objectivity with a client.

**Therapeutic boundaries** are appropriate emotional distances between the nurse and client that help to preserve a sense of separateness and thus allow for safe interactions between the client and the health care professional.
COMMUNICATION AND INTERPERSONAL SKILLS

Victoria Lavender

Excerpted from Becoming a Nurse: Fundamentals of Professional Practice for Nursing

CHAPTER 2

After talking with her mentor Jan was able to relinquish her sense of being solely responsible for Georgie’s care and in consequence felt a sense of relief that she was part of a team of professional staff, able to draw on the support and supervision of experienced colleagues.

Therapeutic boundaries are behavioural limits that allow for the safe interaction between client and health care professional. According to Malone et al. these limits define and protect the space between a health care professional’s power and the client’s vulnerability. It is the nurse’s responsibility (not the patient’s) to set and maintain professional boundaries. The nurse should set clear boundaries when the relationship is first established and must remain consistent in maintaining those boundaries.

A nurse who is emotionally over-involved with the patient is likely to be meeting their own needs rather than the needs of the client. Over-involvement is likely to show itself with the nurse coming to believe that only they are able to fully understand and care for the client, losing the necessary detachment and objectivity needed in accurate assessment and delivery of care. The over-involved nurse may give more time and attention to one particular client, coming to see them in off-duty hours, discounting the efforts of other health care professionals and performing tasks for the client that they could, and probably should, perform for themselves. The over-involved nurse may agree to keep the client’s secrets or may not pass on information that should be shared with other members of the health care team. They may also disclose intimate information about themselves and about their experiences in the mistaken belief that they are being empathic or seeking reciprocity with clients.

The NMC requires that nurses maintain appropriate professional boundaries in relationships with patients and clients, ensuring that all aspects of the care focus on the needs of the patient. However, it may be others, particularly more experienced staff, who first become aware of the over-involvement of the nurse. Dowling notes that despite a theoretical understanding of the importance of maintaining a therapeutic emotional distance, inexperienced nurses are likely to be less able to maintain an expectation of equal partnership when working with patients, especially patients whose ill-health renders them vulnerable and those who seek dependency upon nursing staff.

Professional boundaries are limits that demarcate the edges of the relationship between the nurse and the client. The parameters of therapeutic boundaries must be
embedded in the core conditions of respect, warmth and authentic concern for the client. The development of self-awareness is pivotal in being able to recognise where professional relationship boundaries have become unclear. However, self-monitoring behaviour is an advanced reflective skill that demands honest and unflinching examination of one’s motives and behaviours.

Mentor and supervision support is invaluable in helping the nurse discuss and explore the nature of their relationships with clients. Most nurses will be able to recognise the difficulties faced from their own experiences and will be in a position to offer suggestions and support in managing the situation. Hawes suggests that a culture of nursing colleagues sharing their experiences of the difficulties of managing boundaries needs to be encouraged if junior nursing staff are to feel able to seek advice and support. Gallop suggests a simple reflective question can help to initiate the process of self-monitoring; for example, *would other nurses or health care professionals think my behaviour with this client appropriate?*

Dowling suggests that in certain circumstances self-disclosure may be appropriate but requires an acute sense of self-awareness. A parent of a sick child who asks if the nurse has children of their own may be seeking reassurance that someone who understands the needs of both the child and the parent is nursing their child. When a distressed client probes the nurse with a question to ascertain the nurse’s personal experiences of coping with stressful events, the nurse needs to measure self-disclosure carefully as the outcome of sharing may have a positive or a negative effect. Before self-disclosure, a useful technique might be to pause and think: in revealing this information, whose need is being met? If the answer appears to favour the nurse’s needs, then the level of disclosure is likely to be inappropriate.

Relationship boundaries may be tested by patients and might take the form of making unreasonable demands of time and attention, or by indicating that they would like a personal, social or sexual relationship with the nurse. Testing boundaries can also include using behaviours that the patient thinks will provoke a particular response from the nurse, for example, asking for confidential information about fellow patients, making crude sexual innuendoes or telling risqué jokes.

The nurse who deals clearly and directly with boundary testing reasserts the professional parameters of the relationship, allowing both the client and the nurse to refocus on goals that relate to the client’s health care. A clear statement from the nurse of what is considered acceptable behaviour, far from damaging the therapeutic relationship, serves to strengthen and underpin future interactions in a constructive
and positive manner. Indistinct, ambiguous or violated boundaries undermine the trust necessary for the development of therapeutic relationships.

BARRIERS TO THE THERAPEUTIC RELATIONSHIP

Factors that can raise difficulties in the nurse–patient relationship, include:
• nurse or patient anxiety;
• specific communication difficulties;
• low emotional intelligence.

Client or nurse anxiety can be a threat to the therapeutic relationship. Common causes of stress for patients are apprehension about their health status or about their current and future treatment options. Anxiety might also relate to uncertainty about future coping and the effects of their ill-health on others, including family members. Nurses may be anxious if they feel under-confident, unsupported by colleagues, inexperienced, or insufficiently competent. Student nurses have the additional pressure of placement assessment.

Anxiety can disrupt and seriously detract from the quality of the therapeutic relationship. Nurse–patient communication is likely to be stilted, superficial and hurried. Concentration is more difficult and active listening and attending are problematic for the anxious nurse. Anxiety will undoubtedly inhibit the degree of warmth and level of genuineness shown to the client.

Patient anxiety may result in a need for repeated reassurance from the nurse. When such reassurance is given but fails to provide the comfort sought, the nurse may feel increasingly unable to meet the client’s needs and may begin to avoid further contact.

RESEARCH FOCUS 1.3

Geanellos found that nurse unfriendliness, characterised by patients as frostiness, officiousness and apathy gave rise to patients feeling unsafe, unwelcome, anxious and unprotected.

In this situation, decreasing patient anxiety is essential if the therapeutic relationship is to flourish, and for patients with severe anxiety, psychiatric and medical interventions may be necessary. Arnold and Underman Boggs recommend that in mild to moderate levels the nurse can adopt a number of strategies to assist the client. These include:
• active listening to show acceptance;
• honesty – answering all questions at the client’s level of understanding;
• clearly explaining procedures, surgery and policies and providing reassurance based on evidence
• acting in a calm, unhurried manner
• speaking clearly and firmly (but not loudly)
• encouraging clients to explore their reasons for anxiety
• using play therapy with dolls, puppets, games and drawing for young clients
• using therapeutic touch, giving warm baths, relaxing music
• teaching breathing and relaxation exercises.

Anxiety levels for the nurse may be reduced by seeking support from mentors, other staff, course and personal tutors, peers and friends. Perhaps the most effective intervention is the one in which the nurse realises that support networks are readily available. Smith noted that when nurses feel appreciated and supported emotionally by senior staff not only do they have a role model for sensitive and empathic patient care but they also feel able to care for patients in the same way. Chant and colleagues agree, and suggest that poor support systems and an occupational or ward culture of task-orientated dominance that excludes or diminishes the importance of individualised support for nursing staff has a direct and negative correlation on the quality and standards of care for patients.

Specific communication difficulties can arise with different client groups with different needs and abilities. A detailed exploration of the needs of all client groups cannot be undertaken here but some general comments are offered.

For clients with limited cognitive ability and/or impaired communication the nurse must strive to deliver verbal messages using uncomplicated language in short sentences, containing a single subject or topic in each sentence. Ample time needs to be given and open questions, repeated and rephrased if necessary, will allow the client an opportunity to understand interactions and formulate a response. Frequently checking the client’s level of understanding by using clarification through repeating, restating and asking for further explanation, is also likely to be effective.

It may be appropriate for nurses to talk with carers or advocates, particularly if the client’s ability to communicate is severely limited; however, the individual client should not be ignored or excluded and must be addressed directly during conversation and discussion. For clients with sensory impairments, face- to-face
COMMUNICATION AND INTERPERSONAL SKILLS

Victoria Lavender

Excerpted from Becoming a Nurse: Fundamentals of Professional Practice for Nursing

CHAPTER 2

Communication where the nurse’s face can be clearly seen is likely to maximise the client’s understanding of what is being said. Increasing the speech volume may be necessary but clear articulation and unhurried speech will be equally or more effective. Para-verbal and non-verbal means of communication can enhance or, if necessary, replace limited verbal exchanges. Touch, body positioning and proximity together with explicit attending skills will help to convey the qualities of genuine interest, warmth and respect for the client.

Pictures, photographs and sign language, known as augmentative and alternative communication systems (AACs), can be used to enhance or supplement verbal communication. Picture boards, simple line drawings or objects can provide easy yet effective methods of communication. Other resources such as leaflets and books with symbols, signs and pictures to explain medical procedures are becoming increasingly available in clinical areas.

EMOTIONAL INTELLIGENCE

Defined as ‘a core aptitude related to one’s ability and capacity to reason with one’s emotions, especially in relation to others’, emotional intelligence plays an important role in effective nurse–patient communication. Being self-aware is part of emotional intelligence, although it encompasses other complex human skills of relationships including empathy, motivation, self-control and adeptness. It is argued that emotional intelligence can be extended and developed through training and that it should be at the heart of education for nursing.

Goleman suggests it is emotional intelligence that determines an individual’s capacity to develop the skills or competencies related to the following five elements of effective communication:

1. **Self-awareness** (emotional awareness, the ability to self-assess with accuracy, high self-esteem).
2. **Self-regulation** (the ability to control emotion and impulse, flexibility in handling change, the ability to innovate).
3. **Motivation** (the need to achieve, need to initiate, optimism).
4. **Empathy** (understanding and developing others, a willingness to meet others’ needs, the ability to ‘tune into’ individuals’ or groups’ emotional states).
5. **Social skills** (persuasiveness, conflict management, leadership skills).

*Emotional intelligence* requires an advanced level of self-awareness; emotional intelligence includes the wider and complex human skills of empathy, motivation, self-control and adeptness in relationships.
HOW DOES EMOTIONAL INTELLIGENCE RELATE TO NURSING?

Freshwater and Stickley claim that emotional intelligence is necessary for effective nursing because nurses work with human emotions such as fear, anxiety, sadness, hope, joy, relief and anger. Cadman and Brewer hold that the ability to manage one’s emotional life while interpreting other people’s is a prerequisite skill for any caring professional. In addition to empathy, emotional intelligence includes the ability to manage the emotions we experience as a result of nursing others.

Although it is now acceptable for nurses to show their feelings as they empathise with patients, there is a need to control and manage these emotions if the patient is not to be overwhelmed. Omdahl and O’Donnell differentiate between acceptable controlled empathic concern and unacceptable overwhelming emotion (or ‘emotional contagion’). Thus the type and degree of emotion shown requires self-regulation. This need for self-regulation is particularly important in relation to negative emotional response to, for example, irritation, anger, frustration, or disgust rather than to the many pleasurable emotions associated with nursing practice. A nurse who is unable to exert some control over their negative emotions may damage the therapeutic relationship and the wider professional image of nursing.

Henderson suggests that emotional involvement is a requirement for nursing excellence, contributing to quality care and the emotional well-being of patients and nurses. However, continuous and intense emotional work can be stressful, demanding and exhausting. Benner and Wrubel suggest that unrelenting work of this nature can adversely affect the physical and psychological health of the nurse, with the potential to lead to burnout. A balance is needed between providing intimate personal attention to patients and recognising personal limitations. Self-regulation and the adoption of coping techniques such as seeking support and supervision as well as a willingness to accept alternative nurse–patient allocation can be beneficial for both the nurse and the patient.

The complexities of health care provision across hospitals, primary care and the voluntary and independent agencies demand trust, understanding and cooperation. Motivational, social and collaborative working skills are all part of emotional intelligence. The therapeutic relationship is not an isolated entity and directly benefits from the input of all professionals associated with the care of the client. The nurse unable or unwilling to develop and extend their emotional intelligence capabilities threatens to nurse at a mechanistic or task-orientated level and this can be a significant barrier to the richness of the therapeutic relationship.
DISENGAGING FROM THE THERAPEUTIC RELATIONSHIP

By their very nature, therapeutic relationships are time limited; they have a beginning and an end. There are no set time limits for therapeutic relationships; some can last for just a few hours; others may continue for months or even years. Regardless of the length of the therapeutic relationship the same basic principles of disengagement are as follows:

- **Informing**: letting the patient know that the nurse–patient relationship is coming to an end allows an opportunity for the client to acknowledge their feelings on ending the relationship.
- **Maintaining authenticity and boundaries**: it may be necessary for the nurse to restate the professional boundaries required in the nurse–patient relationship, including the need to not make promises to keep in touch or accept invitations for meeting clients once the professional relationship is ended.
- **Acknowledging**: valuing the patient’s contribution to meeting their health care goals as well as to the professional development of the nurse.

Some patients develop a close relationship with a particular nurse: when that relationship ends they may experience feelings that lie anywhere in a spectrum ranging from mild disappointment to intense sadness or loss. Arnold and Underman Boggs draw an analogy between the psychological responses of bereavement and the termination of the therapeutic relationship for both nurse and client. Part of the therapeutic relationship should include the process of preparing the client for ending the relationship by stating when the nurse or patient will need to say goodbye. It may be appropriate from time to time to remind the client of the temporary nature of the relationship, particularly if there is a sense that the patient may have started to become over-reliant on their contact with the nurse. The first principle of disengagement is that the nurse should ensure that patients are made aware of the approaching end of the working relationship and, if appropriate, provide the time and opportunity for the patient to acknowledge their feelings.

Many student nurses will be familiar with the experience of feeling tempted to make promises of keeping in touch with clients once they have finished their clinical secondment, possibly prompted by the patient’s responses to saying goodbye. However tempting, making such promises is often unwise. It is likely to be impractical and making a promise to keep in touch would therefore be inauthentic. It is also likely to be contrary to the maintenance of professional relationship boundaries, as it could herald the change from professional to social relationship parameters. The second principle is that, if necessary, nurses must politely but
assertively restate that the nature of the professional relationship is such that it must remain focused on the client’s health care needs.

It may also be appropriate for the student nurse to express appreciation of having worked closely with the patient and to thank them for their contribution to the nurse’s preparation towards becoming a registered nurse. Partnership is a collaborative process, but patients may be unaware of their contribution to the nurse’s professional development and unaware of the contribution they have made to meet their own health care goals. It might therefore be appropriate for the nurse to acknowledge how far the goals have been met in the form of a short summary to capture these points. Other resources and future plans for meeting health care needs or the maintenance of health gains can also be discussed, for example, future follow-up care arrangements or referrals to other organisations, agencies and health care teams.

**ACTIVITY 1.10**

Review the basic principles of disengaging from the nurse–patient relationship and write a short response to the scenarios below.

- You have been working with Ian for a number of weeks and feel that you have established a close nurse–patient relationship. He is aware that today is your last working day on the unit. You have come to say goodbye when Ian says, ‘I’d really like to keep in touch. Perhaps you could come round for a drink or a meal? I know that my family would love to see you and I’d like to know how you do on your course’.

- Molly has made little eye contact with you and seems distant in her manner since you talked about the transfer of her care to the community team. You open the subject of her future plans but she interrupts with ‘I expect you find it hard to remember anyone, you must see so many different patients all the time. This time next week you won’t even remember my name’.

**CONCLUSION**

There is substantial evidence that effective communication plays a pivotal role in successful health outcomes in modern health care provision. At the heart of effective nursing care lies the professional relationship between nurse and patient, a relationship that is founded on the development and practice of the interpersonal and communication skills of each nurse. The therapeutic relationship is vitally important
to the effectiveness and quality of care and offers possibilities of deep personal satisfaction and involvement for the nurse in the care of clients.

Reading this chapter has provided the opportunity to explore some of the basic components of communication and interpersonal skills that you can now employ within caring relationships with clients. In acknowledging the importance of communication you can contribute to effective patient care by demonstrating a willingness to enhance your communication and interpersonal skills. Harnessing your skills of listening to the self, developing self-awareness, and enhancing your ability to set and maintain therapeutic boundaries can help you to overcome barriers to effective therapeutic relationships.
CHAPTER 3

EFFECTIVE LEADERSHIP OF TEAMS

This chapter is excerpted from
Practical Leadership in Nursing and Health Care: A Multi-Professional Approach
Edited by Suzanne Henwood
© 2014 Taylor & Francis Group. All rights reserved.
INTRODUCTION

This chapter endeavours to reignite and stimulate your excellence and encourages you to draw on your experiences with teams. It addresses some basic concepts, offers ideas for your consideration and provides practical tools to support continuous team development.

Leading teams through the complexity of modern healthcare systems can be challenging and requires authentic leadership. Team membership may change on a daily basis, but your compassion, integrity and the other elements of your leadership, which remain constant, can make a better team than you may have ever thought possible.

Trust your inner leader and be brave!

Let’s start with you.

REFLECTION

• Do you consider yourself to be a team player?
• What are the implications of your answer to the previous question?
• What are the challenges you face as a team leader?
• Do you trust your team to achieve?

Effective teams interact together—with synergy, trust and respect being amongst the foundations of their life force—to outperform teams who do not invest in these qualities. A team is something that is put together, but it is how a team works together that will define their effectiveness.

There are some pre-requisites for optimal team performance; agreeing on the team’s purpose, clarifying roles and responsibilities and defining values, goals and strategy are of major importance, but the group effort can be scuppered if the team does not exhibit professional values and behaviours. The complexity for the team leader is that we all have slightly different interpretations of behavioural norms. It may be acceptable to swear on some building sites but not so in a hospital clinic.

Not everyone is a natural team player, and that is OK. They can still offer a valuable contribution when they feel respected and appreciated, so long as they exhibit acceptable professional behaviour and are clear on the role expected of them. Have you ever agreed what are considered acceptable behaviours?
TEAM-BUILDING EVENTS

Development of teams rarely just happens. Taking time out of the workplace to talk and listen to each other beyond basic work exchanges is benefit to building team relationships. Hawkins notes that team development is often initially focussed on the team’s ‘boundaries, membership and rules’.

Team building appears to be metamorphosing from a bonding event—often for a newly formed team, designed to draw the members together—to more recently including some of the features outlined in the following discussion. Often it’s only an annual event, facilitated by an external consultant, which may incur a cost, so team members are required to learn from that expertise and integrate that learning into their everyday working. They are expected to develop a natural, dynamic and ongoing process, often without appropriate follow-up support.

The common ambitions of a team-building event clarify:

- What is the core business of your team?
- What are the team’s goals?
- When measured against team goals, how well do individuals perform?
- What are the challenges being faced and how can they be overcome?
- How can the team work even more efficiently and effectively?
- What do we expect from each other, often from the perspective of support, trust, and loyalty?

Common issues raised include:

- The need for better communication
- A lack of clarity regarding values, goals, priorities and who is responsible for what
- A request for more resources (Sometimes they do need more, and sometimes there are opportunities for working smarter.)
- The need for support to manage conflict

REFLECTION

- If you were to prepare a team-building day for your team, what would your ideal list of topics include?
- What would having input on each of those topics give the team?

Whilst having an annual event with a good facilitator can provide years of stories, the impact on performance unfortunately can be short term. Consider the last
team-building event you attended: What was discussed and agreed, and is that still progressing? What support could have been provided that might have extended that ongoing learning?

Utilising an expert team-building facilitator can provide great benefits. However, many teams can make incremental steps on a regular basis by deliberately focusing on and developing the team, alongside the day-to-day provision of services, and by having clear outcomes in mind and an action plan the whole team “owns”.

**SHORT STORY**

A team exercise on the first floor of a venue: two teams had to get their team members from one side of the room to the other across obstacles. We later debriefed. During debrief the participants were asked if anyone had cheated in any way. All denied cheating; they even became agitated they were being questioned. Two “mature” ladies did eventually admit that they had actually left the room, gone down one set of stairs, across the ground floor and back up another set of stairs to enter the room at the task end. We had an interesting conversation about creativity and rule bending.

**REFLECTION**

- What learning can be taken from this story?
- What thoughts arise about your (and individual members’), values/rules/policies/flexibility?
- How might that differ between colleagues?

**SIMPLE IDEAS TO DEVELOP TEAMS IN-HOUSE**

1. **Using a quiz to develop knowledge**: Develop a 5-minute quiz for the next team meeting that includes questions relevant to the team’s learning needs. It’s a good way of developing knowledge in a non-threatening manner and a fun team tool.

   Remember that such a quiz is a shared exercise to enhance the team and that no individual should ever feel exposed.
EFFECTIVE LEADERSHIP OF TEAMS

Sue Mellor

CHAPTER 3

Excerpted from Practical Leadership in Nursing and Health Care: A Multi-Professional Approach

ACTIVITY

Know your organization

Create two teams: how is not important; it is just fun.

With a pen and paper, ask them 10 questions that are relevant and that they should perhaps know. In this example related to knowing your organisation, you could be creative with the topics you choose.

Examples

- What is the name of the CEO/chief nurse?
- What is the name of the medical director?
- Name one award recently won by a team in the hospital.
- What is our team’s annual stationery/pharmacy/investigations budget?
- What are the top three compliments we receive from patient feedback?
- When are the policies due for review?
- How long is our patient waiting list?
- How many people are in the team (did you include the cleaner, night staff, etc?)
- Who in the team:
  - Is related to someone famous?
  - Has an interesting or unusual skill/hobby?

2. Social events: This could be anything that appeals to your team, for example: attending a health spa together, a pub quiz, tai chi or bringing in cakes for birthdays.

   Be sensitive that not all members may want to take part—and that is OK! Consider how to make those not involved still feel included. Try to pick something that appeals to them next time. Also be sensitive to personal circumstances, such as caring responsibilities or possible financial constraints that may restrict participation.

3. Fundraising: A great way to bring people together is to support a cause with some link or importance to the team. This could be championing the hospital or possibly to raise funds for your own patients. Again, remember that not everyone may want to take part, so be respectful to their decision, but do ensure that everyone is invited and welcome. Fundraising can have the added benefit of developing wider networks and opportunities for shared projects in the future.
4. *Taking a team from average to excellence*: Teams who have annual team-building events may consider developing an annual team ‘appraisal’ into the process. This can be achieved using the principles of staff appraisal, even using a similar formula so that members are familiar with the format. Ensure the team reviews their values, goals and purpose, how they work well together, and, importantly, how that rapport could be further improved. Ask them about their individual strengths that contribute to and develop the team whilst identifying training needs.

By reviewing accomplishment for the previous year, they can agree on the strategy for the forthcoming year, celebrate team achievements, and acknowledge success, in addition to ensuring their accomplishments.

**TEAM FEEDBACK FOR THE BRAVE**

Teams in health care are interdependent on each other to provide a complex array of services that contribute to patient outcomes.

Extra-brave leaders could ask other departments with whom they regularly interact to provide constructive feedback regarding what their team does well and identify improvement opportunities to enhance synergy in the patient pathway. As the team leader, you need to analyse the feedback to ensure that it is valid, constructive and helpful to improving your team’s performance.

This can improve relationships with other teams, as they may feel that their opinion is valued and well regarded.

**THE PERSONAL SPECIFICATION EXERCISE**

When we advertise a job, we review the competencies required and personal attributes desired (for example, team worker/good communicator).
ACTIVITY

Assume that a post in your team is to be advertised.

Ask the team to agree about the personal qualities required to become a member of the team (ensure that they are specific).

Generate a team list.

Ask each member to silently reflect the score they attribute to themselves for each of the qualities.

The characteristics they have identified will give you insight as to what they deem important and provide an indication of their team values. You can explore with the team how those attributes are currently demonstrated and where they could be further enhanced.

LEARNING TOGETHER

Learning together can be a great way to develop deeper team rapport. We often don’t get a chance to talk about things that matter to us at work.

You may have noticed that those who get on well together are often seen together at breaks, etc. You can provide that opportunity to enhance team rapport by inviting guest speakers into team training, or sending team members together on mandatory training sessions, where possible, and asking them to feedback top tips to the team on their return. This may also provide enhanced application of their learning when they return to the clinical environment, giving even greater return on investment.

SUMMARY

Remember, as a leader you cannot cover everything on this list (at least not all in one year!). Select the activities that appeal to your team and that you believe will most effectively meet their needs. After any activity, take time to reflect on what was effective and what value each element had, so you know if they are worth using again in the future. Your role as a leader is to look at ways you can build, grow, empower and engage your team on an ongoing basis. You are building your team’s identity (see the following section). Do it deliberately and with respect for each person who plays a part. Involve your team in deciding what activities they would like to see supported.
SO WHAT IS TEAM IDENTITY?

Think about sporting teams: they tend to wear specific colours or a sports kit; think of the armed forces, who pride themselves on the uniforms that identify the service they belong to. Many teams have a song uniting the supporters; others demonstrate rituals, like the All Blacks rugby team doing the Haka prior to each game. There are numerous indications of healthcare team identity from professional badges, uniforms, team languages, abbreviations and symbols.

REFLECTION

- What identifies you as part of your team?
- Is that what you want to be identified by?
- If not, how would you prefer to be identified and what can you do about that?

In health care, staff often belong to professional bodies and even introduce themselves through their professional discipline. We are now seeing the benefits of developing multi-professional teams, especially regarding disease-specific teams, managing care across care pathways. Members often belong to more than one team: their professional body and their clinical team. These relationships become fluid over time, with individuals moving between teams regularly and boundaries between disciplines blurring as professionals work together to ensure excellence in patient care. It is worth considering how both teams and individuals retain an identity and the possible effect of those changing dynamics.

REFLECTION

- List the different teams you are a member of.
- How would you describe the identity of each of those teams?
- How would others describe the team? What positive [or even negative] things would they note?
- How does your behaviour change in different teams/roles within a team?
- What could you do to build team identity further? Indeed, do you consider team identity to be a valuable entity?

LET’S EXPLORE WHY TEAM IDENTITY IS IMPORTANT

People take pride in belonging to something they value and have loyalty to their colleagues and team. It is even suggested that human beings have a need to belong. They enjoy being a part of something that contributes either to their own lives like...
EFFECTIVE LEADERSHIP OF TEAMS
Sue Mellor

Excerpted from Practical Leadership in Nursing and Health Care: A Multi-Professional Approach

a family or to a team that makes a difference. We naturally enjoy being a part of something we believe in and perceive to be performing well.

This is particularly common for those in health care, who recognise that their performance impacts directly or indirectly on the patient experience. We believe that membership in a team that works well together can provide satisfaction and a sense of well-being and belonging. Team identity can promote team cohesiveness and interdependence. Katzenbach and Smith discuss the importance of developing trust within a team to support the journey from individual to mutual accountability, as only then do we see a really cohesive team.

If we explore feedback to teams, it is important for positive progress to be reflected to the team. Feedback is an opportunity to understand what we do well but also to further develop our identity. Developing a history together helps a team to develop its identity.

REFLECTION
• When your team is at their very best, how would you describe it?
• What are they doing that creates excellence?
• How do others describe the team when it’s most effective and harmonious?

HIGHLY EFFECTIVE TEAMS

We work in teams because we cannot expect an individual to have all the required attributes, competencies and skills and because we can achieve more together than we can as individuals. That can be translated into solid returns that can be measured. West notes that effective teams are not only more productive, but have personal benefits for the team members too, including lower stress levels.

Leading teams through change and ambiguity requires leaders to be flexible and reflexive to the needs of the situation and of those involved. However, it is worth the effort because, as Katzenbach and Smith note, ‘teams and performance are an unbeatable combination’.

REFLECTION
Consider the most effective team you have ever been a member of.
• What was it about that team that made it so effective? Capture the key words that embody the team’s characteristics.
• How can you begin to introduce even more of that into your current team?
There are many seminal texts that offer guidance to leaders about the fundamentals of effective teams, yet with a little reflective time, you will realise how much you already know intuitively.

Effective teams usually have some core characteristics. Often, phrases such as ‘We knew what we were there to do’; ‘We supported each other’; ‘Everyone knew what was expected of them’; and ‘We communicated’. (How many of those appeared on your list when reflecting on when your team was working well?)

It could be easily argued that within health care we have not just effective teams, but teams who work effectively across professional boundaries. Think about the journey the average patient takes through health care and the range of healthcare professionals the patient comes into contact with. Each individual and team is dependent on those who came into contact with the patient before and after them; how they interrelate supports a patient’s seamless care pathway.

The inspirational, collaborative, authentic leader with natural insight is instrumental to a team’s success, and well-defined goals that are challenging yet realistic are a prerequisite for an effective team. You can only measure your success if you know what it is going to look, feel and sound like.

Let’s explore some of the basic concepts of effective teams a little further:

**THE PURPOSE OF A HIGHLY EFFECTIVE TEAM**

Team members need to understand where they fit in the organisational jigsaw and, importantly, what their purpose is as a team and how that impacts on the bigger picture. Within health care, that is often an easy task at a local level, as most of us recognise that our team plays one part in an elaborate labyrinth of a patients pathway. For many, this will be linked to their personal values and beliefs and therefore has their commitment. But, in addition, it requires members to take wider responsibility for their role to represent their team to ensure that their team performance contributes to the wider healthcare service delivery. It is sometimes this extra step that can be forgotten, which may impact on the whole patient experience.

**COMMUNICATION TIPS**

Beyond any doubt, one of the most common elements flagged by teams in trouble includes communication. It would seem that no matter in how many different ways and however many times information is relayed, clear concise communication is
beneficial. People have different ways of communicating and different needs; it is worth asking them to summarise back what you have said in order to ensure that the message sent was the same as the message received (we call this ‘checking it out’). The art is to deliver the information in a manner that it is heard, understood and accepted even if not agreed with.

**REFLECTION**

Use a grid similar to **Table 6.1** to make a list of your team members. Next to each one, consider the following heading for each:

**How does each individual like to be rewarded?**

Do they like to be thanked for their contribution in front of others so that their accomplishments are openly acknowledged, or do they prefer to see their name in a newsletter, or would they prefer a quiet coffee with the leader to discuss their achievements? Different people prefer different rewards; do not assume everyone is motivated by what motives you.

Remember, a kind word generates feelings of value, which lead to increased satisfaction, good will and engagement, a core aim for all teams. As the team leader, you may not need external validation, but your members might. Are you giving the right messages about being valued in a way they relate to? (And if you are not sure, just ask them. It shows how serious you are about wanting to recognise and value their preferences and contributions. It demonstrates a genuine interest in your colleagues.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Strengths</th>
<th>Motivated by</th>
<th>Likes to be rewarded by</th>
<th>Learning needs</th>
<th>Responds to type of leadership style</th>
<th>Preferred learning style</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liz</td>
<td>Good communicator</td>
<td>Challenging targets</td>
<td>Verbal praise</td>
<td>Understanding Human Factors</td>
<td>Directive</td>
<td>Activist</td>
</tr>
</tbody>
</table>

The leader who is aware of and flexible to the needs of individuals will inspire members, encouraging each to give their utmost for the team.
MANAGING MEMBERSHIP CHANGES

It is a natural dynamic for team members to leave and new members to join. This can be challenging to the team synergy for all involved, and can even be disruptive at times as we develop new relationships and sometimes mourn the leaving of a teammate. It can also be a huge opportunity to build an even better team.

Introducing a new team member with a valuable contribution can provide new opportunities as the team reforms and evolves. Remember, a new team member will bring two things: previous experience that can offer some learning and ‘fresh eyes’. Embraced as an opportunity whilst acknowledging that some may initially see it as a threat, both elements from the new member are useful to a team that wants to enhance their performance.

TEAM MEETINGS TO SUPPORT TEAM COMMUNICATION

Ask a team what they need to improve; communication is always near the top of the list. Regular team meetings often go by the wayside as things get busier. Actually, that is when you need them the most. Team meetings offer the opportunity to build relationships, confirm team direction, reevaluate immediate team goals, prioritise actions and clarify who is responsible for what, and evaluate and celebrate progress. That can include developing opportunities for creativity. Get into the habit of asking team members big, open questions: ‘What can we improve even further?’ and ‘What are we doing well?’ and ‘What problems are we still tackling?’

These questions may at first seem to elicit few responses. However, as the leader evidences his or her commitment to improvement through listening and possibly piloting some of the ideas, members will become more courageous in engaging in the ongoing conversation, and innovative opportunities can follow. A 5-minute briefing at shift change for the sake of wider situational awareness can also enhance communication and safety.

ROLES AND RESPONSIBILITIES

Clarifying roles and responsibilities is fundamental for effective teams, without which elements of confusion and duplication of roles can lead to conflict.

Asking members to share changes in their responsibilities at the team meeting can ensure that team members are aware of new perspectives. It also provides a platform
for others to offer assistance so that relevant information may be shared, affording wider team ownership.

CONFLICT IN TEAMS: ‘A CONFLICT SPLINTER’

It is worth saying that some conflict is normal. It can range from a small transient disagreement to a full-blown angry fallout with long-term ramifications. The art is for the leader to identify whether it is simply a small ‘splinter’ that will naturally heal and relates to healthy discussions, which may even strengthen relationships, or if it may be a ‘splinter’ that might become infected if not dealt with, potentially infecting the whole team over time.

Early support is key to combating destructive conflict. If you are concerned, checking your options is a wise thing to do; even if you then decide to do nothing, at least you will have made an informed choice. Often it is better to tackle an issue when it is a splinter that can be easily resolved, not waiting for it to become a fully grown infection. Executive coaching can help you work through the issues to identify your options in a safe ‘test’ environment and help you define the skills to handle the conflict effectively back in the team context.

Alternatively, your supervisor, mentor, manager, human resource team or an organisational improvement team can help you explore the dynamics of the conflict and offer appropriate support, ensuring that you work within any workplace policy and procedures.

The skilled leader ensures that each perspective is valued, and members feel that their views are respected.

COMMUNICATING AND SHARING THE VISION

We can work in teams for years and not reflect again on the basics of why we are there, together, as a team. It is often assumed that we all had (and have) the same vision and sense of responsibility towards organisational goals. Verbalising the vision, at least on an annual basis, ensures that everyone is going in the same direction and reminds individuals of their overall purpose in the team.
EFFECTIVE LEADERSHIP OF TEAMS

Sue Mellor

ACTIVITY

Ask each member of your team to write in no more than three sentences the vision for the team and separately the purpose of the team. Ask them to read them out without questions from colleagues other than those for clarification.

Use this as an opportunity to clarify the direction of the team and to develop a joint understanding whilst recognising we all see things slightly differently and have different ways of communicating our messages.

Taking the time to confirm a clear vision in everyone’s mind, as well as how they contribute to the overall outcome, should provide a sense of interdependence, belonging and respect for different perspectives. There is usually some clear common ground, and in health care it often links to making a difference to the patient experience.

A written team pledge is often a good visual reminder.

PRIORITISE

Clarifying roles and responsibilities together with the team’s overall priorities facilitates effective management of team workloads. Understanding individual members’ priorities and how their progress contributes to the wider team is also valuable to understand. It provides the opportunity to support each other, either by sharing information that is pertinent or through redistribution of work if required to enable the team goals to be met. A simple urgent/soon or routine label attributed to each task can be constructive and prevent the team from feeling overwhelmed.

ON THE ROAD TO EXCELLENCE

At your team meetings, remember the importance of sharing what is expected of all the team and its members. This can be anything from implementing a new process, reviewing a new system, celebrating success or ensuring that the whole team is trained on a new piece of equipment.
ACTIVITY

Ask each member to:

- Identify their top three priorities for the week/month ahead
- Clarify how they are progressing and what is going well
- Identify any challenges or barriers they are facing
- Identify areas where they need help or support (as well as where such support could come from)
- Generate new ideas around what may improve the patient experience

It is amazing how team members will pull together if they recognise the impact on the team of not reaching their goals/objectives. They will often help each other, which builds good will in the team’s ‘bank of support’.

TEAM RESILIENCE

The pace of change is phenomenal in health care; as science progresses, technology follows, and the quest to be cost effective is becoming a team responsibility (while still ensuring excellent high quality patient care). Like a tree that can bend in the wind, the team that can respond to the changing healthcare landscape—indeed, the team that expects a constantly changing landscape—is more likely to deal effectively with the challenges they face.

The needs of individuals in the team will differ, and the team needs to be reflexive in the support it provides each member and be honest regarding their needs of each other. The best leaders flex to the needs of the individuals whilst remaining vigilant to the team purpose and keeping the goal in sight.

EXPECTATIONS OF EACH OTHER IN THE TEAM

Managing expectations of each other is a helpful way of ensuring that team members have an agreement of what is expected of them. We all have behaviours identified that we consider acceptable when working together, yet we have all seen and possibly even displayed [if we are honest] behaviours that are not optimal. Developing the rules within the team so that people know when they are stepping over the line helps towards building trust. Trust is built and based often on experience, and once broken, it can be extremely difficult to rebuild. Therefore, taking the time to identify
what the team considers acceptable and unacceptable (and how that can be handled) will help to build trust.

REFLECTION

For evidence of this, think of a time when someone has behaved in an unacceptable manner and the impact it has had on the team. What was handled well? What could have been handled even better (and how)?

WHATEVER THE FUNCTION OF YOUR TEAM: A LAST THOUGHT

As a team leader, your focus is on delivering or supporting the delivery of excellence in patient care, and your role is to facilitate that through your team. You may not be hands-on with a patient directly, but you can always be supporting someone who is. You have a dual role: to do your own role excellently, ensuring self-leadership and effectiveness, and in addition, you have a key role in empowering each individual in your team to reach their potential so that they can contribute fully to team goals. It is a huge responsibility, but also an incredible privilege. We hope this chapter helps you to be even more effective at it in the future.
This chapter is excerpted from
Introduction To Nursing Research: Developing Research Awareness
By Andree le May and Susan Holmes
© 2012 Taylor & Francis Group. All rights reserved.
INTRODUCTION

This chapter discusses the drive for advancing practice using evidence and how research can help us to achieve this. We discuss why we need evidence-based care and what it means to provide it. We ask where evidence comes from and how we know which the best forms of evidence are before considering the need for research/research awareness, how to access research-based information and how to implement it into practice where appropriate.

We start from the premise that, as practitioners, we provide care for individual patients based on our knowledge and experience, modifying that care as our knowledge increases. While this undoubtedly enhances patient care it also raises questions about how we decide what care to provide or why we deliver different care to patients who experience similar symptoms or have the same illness. This is particularly important in healthcare today, with its relentless emphasis on ‘evidence’ and ‘outcomes’.

THE EVIDENCE-BASED CULTURE

Government expectations, the emphasis on clinical effectiveness and the increased scrutiny of healthcare mean that we must provide evidence-based care to help us justify not only what we do but also how and why we do it, and to account for our actions in terms of their efficacy, effectiveness and, increasingly, cost, demonstrating this using evidence-based clinical and patient-reported outcome measures.

EXERCISE 4.1 DEMAND DRIVERS

Try to identify the drivers of the demand for evidence-based care and think about why this is central to healthcare practice. What are the benefits to patient care?

It would be easy to believe that this is ‘new’ – it is not! The idea of research-based practice was first introduced by the Briggs Committee on Nursing and reinforced by McFarlane, who emphasized the need to increase the science base of nursing because, historically, many aspects of care had little scientific basis but were based on tradition or anecdote; we rarely questioned practices, passed from nurse to nurse, and the quality of patient care varied considerably. This, combined with the inevitable variability in effectiveness, underlies the move towards evidence-based practice (EBP).
However, political, professional and societal pressures also drive the demand for EBP. Politically, it offers opportunities to save time and money, improve patient outcomes, reduce costs and standardize care; implicit in the NHS Plan, it is strongly linked to clinical governance and quality improvement. McKenna et al believe it is ‘one of the most important underlying principles in modern health care’.

It is a professional obligation because our Code of Conduct, Performance and Ethics states that nurses must ‘deliver care based on the best available evidence’ ensuring that ‘any advice ... is evidence based if you are suggesting healthcare products or services’ as ‘you are personally accountable for actions and omission in your practice and must always be able to justify your decisions’ (author’s emphasis) [see Table 4.1].

Table 4.1 • Excerpt: Code of Conduct, Performance and Ethics

<table>
<thead>
<tr>
<th>Provide a high standard or practice and care at all times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use the best available evidence</td>
</tr>
<tr>
<td>• You must deliver care based on the best available evidence of best practice.</td>
</tr>
<tr>
<td>• You must ensure any advice you</td>
</tr>
<tr>
<td>• You must ensure that the use of complementary or alternative therapies is safe and in the best interests of those in your care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Keep your skills and knowledge up to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>• You must have the knowledge and skills for safe and effective practice when working without direct supervision.</td>
</tr>
<tr>
<td>• You must recognize and work within the limits of your competence.</td>
</tr>
<tr>
<td>• You must keep your knowledge and skills up to date throughout your working life.</td>
</tr>
</tbody>
</table>

Societal factors also increase the need for EBP. Patients both receive care and consume a service and, lying at the heart of healthcare, must have access to the information they need to make choices about their care. This increased awareness of health and illness and the levels of care and support they should expect means that patients now expect the most appropriate and best treatment and the right to choose the care they receive. Indeed, giving people more choice is an NHS priority. Patients are increasingly well informed and willing to challenge professionals; nurses must be able to explain their actions.

This means that we must examine anecdotal and unsupported practices to develop our profession and protect patients from inappropriate and, occasionally, unsafe care. We must use evidence to substantiate our interventions and professional judgements; EBP is not an ‘optional extra’ but central to everyday practice.
EXERCISE 4.2 EVIDENCE-BASED PRACTICE

Write down your understanding of EBP and compare it with the material below.

WHAT IS EVIDENCE-BASED PRACTICE?

Evidence-based practice is a systematic approach that emphasizes the use of best evidence, clinical experience and patient preferences to make decisions about the care and treatment that will obtain the best patient outcomes by selecting interventions that have the greatest chance of success. It can be simply defined as ‘the integration of best research evidence with clinical expertise, and patient values’. It has many benefits (see Table 4.2), promoting a systematic search for, and critical appraisal of, relevant evidence to answer clinical questions and guide decisions about whether particular interventions are useful, based on evidence about what does and does not work. It is conscientious (deliberate, careful), explicit (clear that it is used) and judicious (well thought through), highlighting the importance of clinical expertise because ‘without clinical expertise, practice risks becoming tyrannized by evidence but without best available evidence practice risks becoming rapidly out of date’.

Table 4.2 • Benefits of evidence-based practice

| For Patients | Improved care and reduced time wasted on inappropriate treatments  
|             | Enhances consistency in care  
|             | Increases understanding of investigations and treatment  
|             | Increases confidence in practitioners and the NHS |
| For clinical practitioners | Actively involves them in determining the appropriateness and effectiveness of care  
| | Helps in redefining and/or changing practice where necessary  
| | Enhances quality of care  
| | Presents evidence of the benefits of practice to patients and carers  
| | Increases accountability for care provision |
| For the NHS | Enables consistent decision making  
| | Reduces variation in services  
| | Promotes cost-effectiveness  
| | Promotes integration of activities (e.g. research and development, clinical audit, continuing professional development)  
| | Increases accountability to the public for the service provided |
This means that EBP, like nursing, promotes holistic care, taking account of patients’ medical conditions and individual needs and acknowledging that evidence changes constantly as new knowledge becomes available. It offers a framework for care that relies on research and other evidence rather than only on nursing theory, experience or intuition. It may reduce the research–practice gap and improve the quality of professional decisions, showing that good clinical practice is based on using evidence that intervention is helpful for treating condition B in patient C. It involves a mixture of skills, such as critical thinking, to identify clinical questions and evaluate the findings, and ‘technical’ skills, like searching online resources and interpreting the material. Thus it combines our nursing knowledge with literature, research and technology to improve patient care and advance practice.

EBP comprises five steps (see Figure 4.1): asking questions, finding and evaluating evidence, determining the intervention and evaluation. It is not, therefore, unlike the nursing process with which you are familiar. The skill lies in asking the right question(s), generating relevant evidence and using it appropriately to provide effective care.

Figure 4.1 Implementing evidence-based practice

However, because EBP means acknowledging that clinical decisions are often associated with uncertainty, nurses can find it difficult even though ‘perhaps the most
important skill for any healthcare professional to master ... is the ability to recognise and handle clinical uncertainty ... presented by our patients in wards, outpatients, and in the consulting room, but also about one’s own skill, expertise and knowledge base’. But it is only by acknowledging uncertainty, asking questions and balancing different sources of evidence to inform decision making that we can advance practice.

WHERE DOES EVIDENCE COME FROM?

Evidence is simply a piece of information that supports a conclusion; in healthcare, this typically refers to the effectiveness of interventions in achieving specific outcomes. However, although choosing the right evidence is important, this can be difficult as there are so many potential sources [see Table 4.3]. We need to know what is meant by ‘evidence’, which form of evidence is ‘best’ and how we reach conclusions about its quality.

Table 4.3 • Sources of evidence for nursing practice

<table>
<thead>
<tr>
<th>Sources of evidence</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research</td>
<td>Search published and unpublished literature - original research (primary sources), reviews (secondary sources), clinical guidelines (e.g. NICE), published research-based standards of care Generate own evidence through research</td>
</tr>
<tr>
<td>Experience (professional or general)</td>
<td>Reflect on practice: articulate reflections, facilitate discussion, search literature</td>
</tr>
<tr>
<td>Theoretical experience (not research-based)</td>
<td>Search the literature (published or unpublished), learn from others, facilitate discussions</td>
</tr>
<tr>
<td>Evidence gathered from patients and or their carers</td>
<td>Search the literature for experiential writings and/or research findings, use audit data, levels of satisfaction and/or complaint, facilitate discussion and collaborative decision making</td>
</tr>
<tr>
<td>Evidence passed on from role models and/or experts</td>
<td>Facilitate discussion and observation, consult with experts. Search the literature for findings from consensus-reaching techniques (focus groups, Delphi surveys, nominal groups technique and consensus conferences)</td>
</tr>
<tr>
<td>Evidence derived from policy documents</td>
<td>Scrutinize documentation, facilitate discussion</td>
</tr>
</tbody>
</table>

WHICH EVIDENCE IS ‘BEST’?

There is little agreement in nursing about what ‘good’ evidence, perhaps because the questions we ask relate not only to intervention[s] but also, for example, to how patients experience care, or nurse–patient relationships. ‘Best evidence’ refers to research based on a design most relevant to the question asked, likely to lead to reliable and valid findings and reduce the uncertainties that first led to the need for information.
These ‘best’ designs are sometimes considered using hierarchies of evidence, which offer a way of evaluating the reliability (or lack of potential bias) of research findings, giving insight into the perceived value of different research approaches [see Table 4.4]. There are a number of such hierarchies focusing primarily on the effectiveness of interventions; they provide a simple way of estimating the trust we can place in research findings and/or recommendations.

Table 4.4 • An example of a hierarchy of evidence

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>Strong evidence from at least one systematic review or meta-analysis of well-designed randomized controlled trials (RCTs)</td>
</tr>
<tr>
<td></td>
<td>Multi-centre studies</td>
</tr>
<tr>
<td>Two</td>
<td>Evidence from at least one RCT of appropriate size</td>
</tr>
<tr>
<td>Three</td>
<td>Evidence from well-designed trials without randomization: cohort, time series or matched case-controlled studies</td>
</tr>
<tr>
<td>Four</td>
<td>Evidence from well-designed non-experimental studies from more than one centre or research group</td>
</tr>
<tr>
<td>Five</td>
<td>Opinions from respected authorities, based on clinical evidence, descriptive studies or reports from committees</td>
</tr>
<tr>
<td>Six</td>
<td>Professional opinions from colleagues or peers</td>
</tr>
</tbody>
</table>

**Systematic reviews**

When clinical decisions involve selecting a treatment/intervention from a range of choices, systematic reviews of good-quality randomized controlled trials are considered the most valid and reliable research evidence. These comprehensive literature reviews ‘sum up’ the evidence by synthesizing the results of relevant clinical research. Studies are screened for quality and the data synthesized so that the findings of many studies can be combined to make recommendations for care. Equally useful are meta-analyses, which pool the data from studies with related hypotheses; you can find these by doing a literature search.

Such reviews are valuable and present the current state of science, often resolving conflicting reports of the evidence. You can access them through databases such as the Cochrane Database of Systematic Reviews. Systematic reviews of qualitative studies [meta-syntheses] are increasingly available.
Randomized controlled trials

When we cannot find a review on a specific topic, we need to search for papers reporting independent randomized controlled trials (RCTs) using databases such as MEDLINE, the Cumulative Index of Nursing and Allied Health Literature (CINAHL), the National Guideline Clearinghouse or the Joanna Briggs Institute. RCTs are quantitative, comparative, controlled studies where people are randomly allocated to receive one of several clinical interventions, usually including the standard treatment (control).

However, though RCTs are highly regarded, they also have limitations. A single study, no matter how rigorous, relates to a single population under specific conditions so we cannot generalize it to the breadth and scope underlying nursing practice; neither will it explain why beneficial outcomes are achieved. RCTs tell us little about how patients feel about the intervention or its effects, or explore/explain factors important to nursing: how patients feel or experience treatment, whether it is acceptable to them or its impact on their quality of life; individual needs, clinical aims and goals are unique. This means that the findings are rarely directly transferable to nursing; RCTs consider the science without the art. EBP tries to balance the science and the art of nursing, combining them with patient preferences and clinical judgement. This balance is essential to define the best practice for nursing.

OTHER SOURCES OF EVIDENCE

Less well-regarded as sources of evidence are trials that don’t include randomization and which may not be controlled (e.g. cohort, time series or case-controlled studies), while the least reliable and valid forms are professional opinions, descriptive studies or committee reports. Though expert opinion is the lowest level of acceptable evidence, nurses place higher value on it for decision making than any other source of information, but if it is the best evidence available, it may still meet the criteria for EBP.

CRITERIA FOR BEST EVIDENCE

Though hierarchies of evidence have been developed to enable different research approaches to be ranked according to the validity of their findings, considering the effectiveness, appropriateness and feasibility of interventions, they also have limitations as they focus on evaluating the effectiveness of interventions and overlook qualitative studies, policies/guidance and clinical experience; they do not indicate how to manage individual patients or address specific clinical questions. Thus,
existing hierarchies may not help us to determine the applicability of evidence to specific clinical circumstances. In any case, qualitative approaches may provide the best answer to some clinical questions, and so offer the best evidence.

The criteria for best evidence, therefore, include not only its scientific rigour but also its relevance and applicability to individual patients and clinical settings. Once evidence is identified, it must be evaluated, focusing particularly on its validity, findings and application. This means that evidence for nursing stretches beyond particular types of research; all research designs have their purpose and associated strengths, weaknesses and limitations. The important thing is that the right research design has been used to answer the question asked. It is only when clinically relevant research, clinical expertise and patient choice are considered together that the best evidence is produced, leading to effective, individualized patient care.

THE NEED FOR RESEARCH AND RESEARCH AWARENESS

EBP in nursing has been defined as ‘a problem-solving approach to clinical practice that integrates a systematic search for, and critical appraisal of, the most relevant evidence to answer a burning clinical question, one’s own clinical expertise, patient preferences and values’; it might also include generating our own evidence through research and, indeed, nurses are increasingly doing this – it is not new! Nursing has been a research-focused profession for more than 40 years and nurses’ education fosters a belief in practices that are research-based. Nurses constantly seek answers to important questions that can lead to healthier, more effective and safer experiences for patients and their families; they have made, and will continue to make, a huge contribution to patient outcomes by engaging in research and, through this, advancing practice.

This is implicit in our Code of Professional Conduct; we not only have a professional obligation to EBP but also to develop our knowledge (see Table 4.1); research helps us to fulfil both these objectives. This does not mean that we should all conduct research, but we must be research aware, able to access information about service developments, innovations and research findings, and able to interpret and critically appraise this information so as to implement and evaluate practice based on the best available evidence. This helps us to subject the ‘art’ of nursing to scientific scrutiny and substantiate claims of effective practice. Unless we integrate research with practice we will be unable to build a meaningful knowledge base to enable the delivery of truly evidence-based care.
WHAT IS NURSING RESEARCH?

EXERCISE 4.3 PURPOSES OF NURSING RESEARCH

Before reading further, consider what the purposes of nursing research might be and how using research could help your practice.

Nursing research is practice or discipline-orientated, focusing primarily on clinical care or patients’ responses to actual or potential health problems. Its purposes are to:

- promote the development of nursing knowledge;
- generate information which helps to define the unique role of nursing;
- help us to demonstrate professional accountability;
- enable us to make more informed decisions, facilitate evaluation of practice and articulate our role in care delivery;
- support evidence-based practice;
- improve/advance patient care.

Nursing research is a general term used to describe studies designed to find answers to nursing questions, solve a problem or validate nursing knowledge using an objective and systematic search for understanding. It is directed towards establishing the effectiveness of interventions, gaining knowledge that directly or indirectly influences nursing practice, or analysing phenomena [things] of importance to nursing or patients. It complements practice by combining art and science; identifying appropriate questions, which can be answered by research, relies on both creativity and curiosity.

Research begins with a clearly defined goal or aim, usually in the form of a hypothesis or question, which helps us to decide the best way to address the problem. Examples include trials to investigate the safety or effectiveness of new interventions or compare two treatments or methods of care, studies designed to investigate how a procedure or intervention could be improved, to explain how patients cope with illness or understand particular procedures or conditions.

This range of possible studies arises because nursing involves many different aspects, illustrated by this definition of nursing: ‘diagnosis and treatment of human responses to actual or potential health problems’. Since such responses may be physical, biological, emotional or social we may need to study complex situations or consider multiple factors and use a variety of approaches; there is no single way to
‘do’ nursing research. The important things are that the science of nursing evolves from, and responds to, the needs of practice, and research priorities emerge from nurses who are caring for patients.

That said, nursing must take a broad approach to generating and finding evidence, sometimes ‘borrowing’ evidence from other disciplines while maintaining a nursing focus. Though other disciplines may provide useful evidence, they rarely look at the problem or findings in the same way, thus offering only limited solutions to nursing questions. Patients are more than a collection of signs and symptoms or diseases; nurses provide care that takes individuals and their needs into account. This holistic perspective necessitates a broader approach considering potential relationships between individuals and their disease or illness. What is important is that the research designs adopted reflect the diversity of practice and incorporate scientific, social and behavioural science as appropriate. The outcomes of nursing research may, therefore, lie in a number of areas: clinical, functional, satisfaction and/or cost.

Clinical outcomes include disease-specific indicators, such as wound healing, pain, or nutritional markers (e.g. weight gain/loss), level of complications or other factors related specifically to the patient’s condition. These can be systematically measured to provide useful information about interventions or approaches to care.

Functional outcomes include such issues as the patient’s physical and psychological condition in terms of, for example, ability to take part in activities of daily living, exercise capacity, well-being or quality of life. Many nursing interventions can affect such factors; selecting between them can be achieved using indicators like these.

Patient satisfaction is an important outcome, particularly as they are consumers of services as well as recipients of care. Satisfaction can be measured, using surveys or interviews, providing valuable information about nursing interventions and care. As key stakeholders in healthcare, patients’ views are crucial to gaining understanding of anything from the quality of service provision to the effectiveness of treatment. Patient-reported outcomes offer a way of gathering their views.

Cost of care is an increasingly important consideration. Measurement includes issues such as length of stay, readmission rates and costs of equipment and/or resources. This enables us to distinguish between interventions which are equally effective in, for example, preventing infection or promoting wound healing, enabling the cost–benefit to be analysed; this should include consideration of the human costs.
Taken together, these outcomes provide us with information about different approaches to care or alternative interventions and, with patient preferences/choices, enable us to select the most appropriate care for individuals. Using the same approaches to measurement across many studies allows us to compare the findings across different settings and patient samples, thus strengthening the evidence.

DIFFICULTIES AND BARRIERS TO NURSING RESEARCH

Nurses often see research as irrelevant to their daily work, perhaps because searching for and evaluating evidence reduces the time available for patient care. But EBP is now embedded in healthcare and is not going to go away. In fact, research and EBP offer us opportunities to demonstrate our contribution to clinical effectiveness. ‘Research is not a luxury for the academic, but a tool for developing the quality of nursing decisions, prescriptions and actions. Whether as clinicians, educators, managers or researchers, we have a research responsibility; neglect of that responsibility should be classified as professional negligence’.

That said, there are barriers to research in practice, including time constraints and lack of managerial support and encouragement, together with low staffing levels and negative attitudes to research. The way research is presented can also limit its accessibility to practitioners; it can be difficult to interpret the academic style used in many research papers, not surprising when we remember that most researchers write for other researchers, not for practitioners. Thus much research is never seen by the nurses who could use it and researchers are frustrated that their valuable work is not widely circulated. Researchers could help by publishing in the journals that clinicians read and emphasizing their relevance for practice.

ACCESSING RESEARCH-BASED INFORMATION

We can obtain information in many ways, including through computer searching or journals focusing on evidence to guide practice (e.g. Evidence-Based Nursing), supported by national initiatives, such as the Cochrane Collaboration, NHS Evidence and Clinical Knowledge Summaries and the NHS Centre for Reviews and Dissemination, which produce and maintain systematic reviews and/or a core database of up-to-date evidence of the effects of healthcare.

Research clearly has the potential to inform us not only about nursing but also about relevant physical and scientific issues, increasing ‘available knowledge by the discovery of new factors or relationships’, ‘generate[ing] and refine[ing] clinical
nursing interventions’ and so advancing practice. It therefore enables us to subject the art of nursing to scientific scrutiny and substantiate claims to provide effective and efficient practice. This is essential if we are to develop a body of knowledge and generate theories to underpin and advance practice – we must identify areas of concern and design our own research to investigate them. Without this, nursing will not evolve and practice will remain unchanged.

OVERVIEW: IMPLEMENTING EVIDENCE AND RESEARCH INTO PRACTICE
(FIGURE 4.2)

The government is committed to the promotion and conduct of research as a core NHS activity, seeing it as vital in providing the new knowledge needed to improve health outcomes, reduce inequalities and identify new ways of preventing, diagnosing and treating disease. Despite this, it is increasingly recognized that the full potential of research to improve healthcare practice has not yet been realized and its benefits have been slow to become part of routine practice.

Lack of research awareness has, traditionally, been a barrier to utilization, yet this is the first step in translating it into practice. Important also is individual motivation towards implementing change together with practitioners’ belief in themselves and their ability to implement it. Balancing the benefits of change against the costs, both financial and personal, is one step towards the likelihood of change. Research and evidence are essential in attempts to achieve this.
Figure 4.2 • Implementing evidence and research into practice

EXERCISE 4.4 RESEARCH IN PRACTICE

Think about how you might be able to use research in your practice and what the benefits of doing so could be.
Using research and evidence in practice requires us to:
• find relevant research/evidence by searching the literature and/or asking experts;
• assess the quality of that research/evidence;
• determine which evidence provides the best approach to care, is appropriate to the situation and the patient, and can be provided by the organization;
• make necessary changes to practice to incorporate the evidence;
• evaluate the impact of that evidence on the care being provided;
• keep up to date and change practice accordingly.

As a cornerstone of healthcare, nurses are driven by compassion and personal commitment to ensure that patients and their families receive the highest quality of care. Asking the ‘what’, ‘how’ and ‘why’ questions, and answering these by engaging in research and implementing EBP, are ways through which we can contribute to innovation and excellence in patient care and advance practice.
CHAPTER 5

PROMOTING BEST PRACTICE AND CONTINUING PROFESSIONAL DEVELOPMENT

This chapter is excerpted from
Professional Values in Nursing
By Lesley Baillie and Sharon Black
© 2012 Taylor & Francis Group. All rights reserved.

LEARN MORE >
INTRODUCTION

This chapter focusses on the professional requirement to engage in continuing professional development and lifelong learning in order to deliver and promote care that is based on the best available evidence. Recent reports have highlighted the accountability of nurses and other healthcare professionals for the quality of care provided to patients, so it is essential that nurses continue to develop their practice and apply best evidence in care delivery, underpinned by their professional values. The nature of best evidence is discussed as well as how to access and apply best evidence in practice. The chapter explores ways of developing and improving your own practice as a professional nurse, from the point of registration onwards. A culture in which curiosity is encouraged for nurses is important, and as a registered nurse you will be able to contribute to developing a culture of learning and professional development.

LEARNING OUTCOMES

By the end of this chapter, you will be able to

- Discuss the professional requirement to engage in lifelong learning and deliver and promote care that is based on the best available evidence;
- Recognise the need to access, appraise and implement best evidence for practice;
- Appreciate and engage with opportunities to develop as a professional nurse to continually improve your own practice.

MAINTAINING AND DEVELOPING PROFESSIONAL KNOWLEDGE

The Nursing and Midwifery Council (NMC) requires that nurses must deliver care that is based on the best available evidence or best practice. The NMC also expects nurses to keep their knowledge and skills up to date throughout their working lives, participating in appropriate learning activities to develop competence and performance. The NMC guidance for post-registration education and practice (Prep) aims to help registrants provide a high standard of practice and care, keep up to date with new developments in practice, and think and reflect and demonstrate that they are keeping up to date and developing their practice.
ACTIVITY

Consider: What could happen if a registered nurse does not engage in continuing professional development?

The evidence base for practice is constantly developing, and registered nurses must base their practice on current, up-to-date evidence to ensure that people receive the best possible care. There is a public expectation that individual nurses and midwives are up to date and fit to practise at all times, so a failure to be so will diminish public confidence in these professions. A desire to incorporate the newest evidence into nursing practice is a component of lifelong learning. Courey et al. argued that the evolution of nursing as a profession requires the development of evidence-based practice linked to outcomes; therefore, nurses must be able to access and evaluate professional literature. The context for nursing practice is also continually changing; for example, legislation, health policy and professional guidance affect the way that nurses practise and deliver care. Chapter 10 illustrates this point well, as policy and legislation relevant to the safeguarding of children and adults is continually developed and revised, often as a result of public inquiries.

The overall aim of a lifelong learning approach is to ensure that clinical practice is evidence based, skilled, and led appropriately. As a registered nurse, your lifelong learning will be supported through continuous professional development (CPD) activities. Gopee’s literature review highlighted key reasons that lifelong learning is an important aspect of professional practice:

- the need for practitioners to be self-directed so that they can access the required knowledge for their practice as and when it is needed;
- the mandatory requirement for continuing professional education;
- the evolving nature of health care and practice (for example, relating to technological advancements) with the associated need for professional development;
- the relationship between professional development and the shift along the continuum of novice to expert for the enhancement of clinical practice.

In addition, Eason asserted that lifelong learning supports critical thinking, can enhance nurses’ satisfaction with their professional role and supports the desire to apply the newest evidence into nursing practice. She further asserted that a culture in which educational growth is supported and promoted is vital for advancing nursing
as a profession. How nurses and midwives interact with the concept of lifelong learning is varied, and requirements from the NMC are flexible.

**ACTIVITY**

List all the ways through which you could continue your learning and keep yourself up to date as a registered nurse.

When next in practice, ask some registered nurses questions related to the following:

- How they continue their learning and keep themselves up to date
- Tips they can give you for keeping up to date and carrying on your learning after registration

A few ways you might have thought of include

- **Work-based learning** (e.g. reflective practice, reviewing clinical audit results and incident reports, feedback from patients/families).
- **Reading professional bulletins** (e.g. from the Royal College of Nursing [RCN] and the NMC).
- **Attending seminars, journal clubs, training, post-registration courses, lectures or conferences.** These may be organised internally in your organisation, in partner universities or in other forums; look for posters, set up alerts or join e-mail circulation lists for organisations that interest you.
- **Maintaining a continually inquiring mind and thirst for knowing more.** When you encounter anything in practice that you are unsure of, access available resources (e.g. colleagues, your organisation’s intranet, the National Institute for Health and Clinical Excellence [NICE] website, the RCN website, journal articles [using an electronic database], specialist websites).
- **Talking to experts.** These experts could be colleagues (e.g. nurses in your own team, specialist nurses, multi-disciplinary team members) or experts by experience (service users or carers).
- **Taking on a link nurse role.** You may have the chance to be a link nurse or champion (e.g. for infection control, tissue viability, dementia, dignity). This will give you the chance to talk regularly with experts (e.g. lead nurse for dementia) and to meet with other staff across the organisation who are interested in this topic.
REFLECTIVE PRACTICE

Developing your reflective skills will help you to learn and develop your practice so that you optimise your learning. Dewey, an educational theorist, argued that we do not ‘learn by doing’ but by ‘doing and realizing what came of what we. Dewey’s theories were developed further by Kolb and Fry and then more fully by Kolb. The theory of how we learn from experience is often referred to as ‘experiential learning’ and is portrayed as a cycle. The process starts at the point of a concrete experience or event, after which observations and reflections occur, followed by abstract conceptualisation, where new ideas are developed, linked to other knowledge and experience, and then the new knowledge arising from the experience is tested in a new situation. This new experience then starts the experiential learning cycle once again.

Reflection enables you to consider what you did and why and provides opportunities to develop knowledge from experience and link theory and practice. Knowledge gained from reflection on practice has been termed ‘practical knowledge’, and reflection can enable the uncovering of knowledge embedded in practice. Reflecting on your practice helps you to examine your experience and consider other explanations for what happened and alternative ways of doing things. Reflection may occur during the experience (‘reflection-in-action’) or following the experience (‘reflection-on-action’). Reflection is particularly relevant to professional growth in a practice-based discipline such as nursing, as nursing knowledge is embedded in experience, and learning through experience is essential to the practice of professional nursing.

There are various models of reflective practice that have been developed to give structure and focus. For example, the Gibbs reflective cycle includes the components shown in Figure 5.1, which you work through in a cyclical manner to reflect on a particular experience.
Other reflective models include those of Palmer, who suggested a series of cue questions, and Borton’s developmental framework, which comprises three areas of focus:

- **What?** (description of what happened);
- **So what?** (the context—theory and knowledge building);
- **Now what?** (action—what to do next).

Driscoll developed Borton’s model in a nursing context and linked it to an experiential learning cycle. Johns has developed a model for structured reflection that has been refined over many years. The model aims to assist practitioners to ‘access the depth and breadth of reflection to facilitate learning through experience’; see Johns for his current version and underpinning theories. Wigens and Heathershaw considered that it is important not to use reflective models as checklists and to avoid ritualization in their use.

There are many texts focussed on reflective practice available, so do access these for further reading on this topic.

**BEST EVIDENCE FOR PRACTICE**

Nurses must deliver and promote care that is based on the best available evidence. It is therefore essential to be able to identify gaps in knowledge about evidence and know how to address these on an ongoing basis, as evidence is continually updating.
Read Box 5.1 and consider the questions posed.

BOX 5.1 • PRACTICE SCENARIO: IDENTIFYING AND ADDRESSING KNOWLEDGE GAPS

Carl is a third-year mental health student who is in his first week of a placement in a community mental health team. With his mentor, he visits a woman, Mary, who has a long history of depression and has been referred for a reassessment. She also has a long-standing pituitary disorder. Mary expresses concern that the medication she is taking for her depression and her pituitary condition have side effects and are doing her ‘more harm than good’. During the assessment, Carl records Mary’s blood pressure, which is 150/90 mm Hg; she has no history of hypertension. Carl’s mentor suggests that Mary needs to make an appointment with the practice nurse to have further blood pressure monitoring as her blood pressure is ‘higher than it should be’.

After the visit, Carl’s mentor asks him questions about Mary concerning the medication she is taking and the side effects, how a pituitary condition might affect mental health, and the normal blood pressure range. Carl finds that he is struggling to answer some of these questions. His mentor advises him that an important part of being a safe professional is to acknowledge gaps in his knowledge so that he can address these. He suggests Carl write an action plan for what he needs to learn and how he will go about this.

Questions

1. Why is it important for safety that a nurse acknowledges gaps in knowledge or skills?
2. If a service user asks a question that you cannot answer, what would you say as a student and as a registered nurse?
3. What resources could Carl access to address the gaps in his knowledge?
4. What might constitute best evidence?

Although the scenario in Box 5.1 is based on a third-year student, remember that you could encounter such situations as a registered nurse. There are many resources available to healthcare professionals to develop and update their knowledge. Here are examples of resources that Carl could access for information:
PROMOTING BEST PRACTICE AND CONTINUING PROFESSIONAL DEVELOPMENT
Lesley Baillie and Sharon Black

Excerpted from Professional Values in Nursing
CHAPTER 5

- The British Hypertension Society website
- The Pituitary Foundation website
- The British National Formulary website
- Expert practitioners (e.g. pharmacists have expert knowledge about side effects of medication and drug interactions)
- Textbooks: to look up information on pharmacology, pituitary disorders, depression
- The National Institute for Health and Clinical Excellence (NICE) evidence-based guidelines and quality standards
- The Cochrane Library: online resource that provides systematic reviews of research on different topics

NICE and the Cochrane Library systematic reviews are regularly updated, so always access the most up-to-date versions. An excellent source of information is the Evidence Search Health and Social Care website, which includes access to resources for evidence-based practice and a facility to search for evidence. Often, National Health Service (NHS) trusts and other healthcare organisations have their own clinical guidelines, based on best evidence, to assist nurses and other healthcare professionals to implement evidence-based practice in the local context.

ACTIVITY
- Find out about how evidence-based clinical guidelines and policies are developed in your organisation. Is there a committee? Who are the members?
- Where are the policies and guidelines kept?
- Access one of these documents (ask your mentor’s assistance) and examine it for its evidence base and currency (date published and review date).

No one can know everything, and the knowledge base for nursing practice and healthcare is continually developing and expanding. Therefore, it is essential to be able to know how to find information and to have the motivation and commitment to address your knowledge and skills deficits. Not being aware of or acknowledging the gaps in your knowledge and skills could endanger patients as you will not be able to provide them with safe and best-quality care. Your professional values that underpin your practice should guide you in such situations: Honesty and a real commitment to do what is best for people in your care must take priority over any personal feelings of disappointment or embarrassment associated with admitting that you do not know something. So, as a student and as a registered nurse, it is really important to
• acknowledge the limitations of your knowledge and skill;
• have the skills, motivation and commitment to rectify deficits in your knowledge and skills;
• seek expert guidance to ensure that your patients have the best possible care.

If a service user asks you a question that you cannot answer, it is better to be honest about the limits of your knowledge, but importantly you then need to explain how you will help the patient, for example, by consulting with an expert or accessing a reliable information source.

Care should be based on best available evidence, which may be derived from research, but it may also be based on experience and through reflection on practice (as discussed previously). Benner identified that practice is always more complex and presents many more realities than theory ever can, and she highlighted the value of theory derived from practice. Nurses are accountable for their actions, so they must be able to explain the knowledge base underpinning their practice. Benner explored how expert nurses develop knowledge from their practice, learning to recognise, for example, subtle changes in people’s conditions.

EVIDENCE-BASED PRACTICE

This next activity prompts you to reflect on the evidence underpinning your nursing practice.

ACTIVITY

Reflect on one intervention that you have recently used in nursing practice. Consider:

• What evidence informed this intervention?
• Where did this evidence come from?
• How did you judge the quality of the evidence that you used in practice?

Cullum defined evidence-based nursing as ‘the application of valid, relevant, research-based information in nurse decision-making’. Barker reviewed various definitions and identified four types of evidence for nursing practice: research, clinical experience, service user/ carer perspectives and the local context of care.

The evidence-based practice literature refers to a hierarchy of evidence:
1. High quality meta-analyses/systematic reviews of randomized controlled trials (RCTs);
2. Well-designed RCTs;
3. Other types of experimental studies (e.g. pre-test, post-test);
4. Non-experimental studies;
5. Descriptive studies, expert reports.

NICE guidelines, and other clinical guidelines, use meta-analyses/systematic reviews whenever possible as the basis for their evidence-based guidelines. An RCT uses an experimental approach to determine the effectiveness of an intervention (e.g. a medicine, a wound dressing, a method of giving patient information). Key features of an RCT are randomization and control. Therefore, the people taking part in the RCT are randomly allocated to either the group of individuals who receive the intervention (the independent variable) or to a control group of people who do not receive the intervention (e.g. in the case of a medicine trial, they would be given a placebo). The results of the trial derive from measuring the effect of the independent variable on one or more dependent variables, for example, the expected effect of the drug in the case of a drug trial or wound-healing measures in a trial of a wound dressing. The trial is set up to control as much as possibly any factors that might confound the results, so the sample will meet specific criteria and thus reduce the effect of additional factors that might affect the effect of the independent variable. In the case of wound dressing trials, people with diabetes are often excluded from taking part as their diabetes is an additional factor (‘extraneous variable’) that could affect their wound healing. Unfortunately, this has led to many types of wound dressing not having been tested adequately on people with diabetes. Exclusion of individuals to achieve control has led to certain groups of people being excluded from opportunities to participate in research, which has ethical implications. Nevertheless, the RCT is considered a particularly reliable form of evidence, and a systematic review uses a prescribed method to identify and critically appraise RCTs on a particular topic.

The Cochrane Library aims to provide high-quality, independent evidence to inform healthcare decision-making. The library contains databases of systematic reviews on an increasing number of topics.

While traditionally the Cochrane Library’s systematic reviews appraised only RCTs, recently Gülmezoglu et al. reported on an ‘important milestone’ for the Cochrane Library, which published, for the first time, a review of qualitative studies. The topic was a review of the barriers and facilitators to the implementation of lay health worker programmes. Gülmezoglu et al. argued that the synthesis of
qualitative evidence makes an important contribution to the knowledge available to organisations such as the World Health Organisation that are developing international recommendations on public health topics. In particular, qualitative evidence may give insights into patient experience and likely acceptability of a particular intervention.

**ACTIVITY**

Go to the Cochrane Library website and search for systematic reviews on topics relevant to the scenario in Box 5.1:

1. Hypertension management
2. Pituitary disorder
3. Depression

Access one review on each topic and read the abstract, taking note of how many studies were selected for review and the final conclusion of this evidence.

In nursing practice, the notion that systematic reviews and RCTs should always be at the top of the hierarchy of evidence has attracted some criticism, as nursing practice requires multiple ways of knowing. There are many nursing topics for which there is no conclusive evidence based on systematic reviews of RCTs. Furthermore, the application of the results of a systematic review must take into account the individual and the context of care. For example, a particular pressure-relieving mattress might have been shown to be effective in preventing pressure ulcers and be recommended in evidence-based guidelines, but the use of the mattress in practice must take into account patient preference and effect on their comfort and overall care (e.g. mobilisation goals). Barker also reported that critics of evidence-based practice argue that generalised evidence-based guidelines detract from a person-centred approach (see Chapter 7), hence that is why it is important to review evidence in the light of the individual and the individual’s situation. A collaborative group that supports evidence-based practice and has a stronger nursing focus is the Joanna Briggs Institute (JBI), which was established in Australia. The JBI takes a broader approach to consideration of evidence to underpin practice.

Barker presented various models for applying evidence-based practice and she identified the following skills and components:

- The ability to identify what counts as appropriate evidence is required.
- Formulation of the search topic into an answerable question to focus the evidence gathering is the key to a good literature search; using the PICO format (population, intervention, comparison, outcome) can help to focus the evidence search.
• Development of a strategy for searching for evidence and familiarisation with search engines and databases that will assist with the search for evidence, for example, CINAHL (Cumulative Index to Nursing and Allied Health Literature), MEDLINE, PschINFO, BNI (British Nurse Index) and SCOPUS are commonly used when searching for evidence for nursing practice.

• Critical appraisal of the evidence is an essential step in order to make a judgement regarding the quality of the evidence. There are many useful appraisal guidelines available; see the UK Critical Appraisal Skills Programme (CASP), which includes checklists for appraising different types of research.

• Clinical expertise will help to contextualise the evidence.

• Consideration of patient preferences

• Application of the evidence to the context of care delivery.

• Implementation of the evidence in practice.

Many articles have debated the difficulties associated with implementation of evidence in practice; the embedding of changes in staff behaviour are always challenging. What appear to be small changes in practice can involve many different disciplines and changes to whole systems. Service improvement methodology has been used successfully to map current processes and try out and refine changes on a small scale using repeated Plan-Do-Study-Act cycles.

One method of applying EBP is the use of care bundles. A care bundle is a set of evidence-based interventions that, used together, improve patient outcomes. As an example, the NHS Institute for Innovation and Improvement identified four key elements for a care bundle to prevent pressure ulcers, which used the acronym SKIN: surface, keep moving, incontinence and nutrition. Other examples of care bundles used in practice relate to pre-operative care, prevention of falls, dementia care, ventilator care, discharge of patients and catheter care.

**ACTIVITY**

When next in practice, investigate what, if any, care bundles are being used. Find out what their elements are and what their evidence base is. Through observing in practice and asking your mentor, respond to the following questions:

• How well has the care bundle been embedded into everyday practice?

• What have been the facilitators to implementing the care bundle?

• What have been the barriers to implementing the care bundle?
DEVELOPING AS A PROFESSIONAL NURSE

Nurses, midwives and other health professionals are, from the point of registration, autonomous and accountable, but there has been increasing recognition of the benefits of supporting newly registered staff and assisting them in consolidating their learning. Harrison-White and Simons reported on the experiences of newly qualified children’s nurses who found that the role change had been fraught, particularly the increased responsibilities and dealing with the expectations of more experienced staff. The ‘reality shock’ for newly qualified nurses is well documented, and support in the first year can assist the transition.

Read Nabila’s scenario in Box 5.2 and consider the questions posed. Preceptorship, clinical supervision and appraisal are explored in the next sections; as you read this material, consider how these might support Nabila as a registered nurse and think about yourself and your future development following registration.

Box 5.2 • PRACTICE SCENARIO: PROFESSIONAL DEVELOPMENT AND SUPPORT

Nabila is a newly qualified children’s nurse, and she has just started in a post on a children’s ward. She is excited about her job but is also feeling anxious. She will be starting on the trust’s inter-professional preceptorship course in a month’s time, and she is looking forward to the course. The ward sister tells Nabila that they are going to be introducing clinical supervision on the ward in the near future. Nabila also learns that all staff on the ward have an annual appraisal at which their performance and development are reviewed.

Questions

1. What is preceptorship, and how might this benefit Nabila?
2. What is ‘clinical supervision’? How might clinical supervision support staff development and safe professional practice?
3. What is the purpose of appraisal? How does appraisal link to professional development?

PRECEPTORSHIP

Staff working in the NHS are entitled to 12 months of preceptorship following registration. In 2010, the DH published the Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals, in which preceptorship is defined as
‘a period of structured transition for the newly registered practitioner during which time he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours to continue on their journey of lifelong learning.’

A preceptor is defined in the framework as:

‘a registered practitioner who has been given a formal responsibility to support a newly registered practitioner through preceptorship.’

Be aware that in the international literature, the term preceptor is sometimes used more broadly to include registered nurses who support nursing students, referred to as ‘mentors’ in the United Kingdom. The DH’s framework emphasises the need for all newly registered practitioners to experience a structured and supportive preceptorship period, acknowledging that the immediate period following registration can be a challenging time and that good support and guidance are essential. The overall aim is for the registered practitioner to become

‘an effective, confident and fully autonomous registered individual, who is able to deliver high quality care for patients, clients and service users.’

The DH identified that preceptorship can reap benefits for both individuals and organisations because if the transition to being a registered professional is managed successfully, staff will provide effective care more quickly and retention within the professions will be increased, leading to a greater contribution to patient care. Preceptorship supports well the concept of lifelong learning, as it sets the scene for the continuing of learning and development following registration. Following a review with stakeholders, the DH identified elements of preceptorship for newly qualified practitioners (see Box 5.3) and outlined the attributes for an effective preceptor, highlighting that these are likely to take up to 2 years to develop post-registration. Ford et al. found that preceptors recognised their professional responsibility to those entering the profession and were committed to the development of these learners. The preceptor will know the organisation and can offer invaluable support during adjustment to being a registered professional. Wigens and Heathershaw identified that newly qualified nurses need to review their achievements to date; understand expectations of them; adapt to their new role and develop new skills; continue to learn and develop their practice; effectively deliver patient care and feel valued as part of the team.
There are a number of examples of preceptorship programmes that have been reported in journal articles, and some of these include evaluation.

**BOX 5.3 • ELEMENTS OF PRECEPTORSHIP FOR NEWLY QUALIFIED PRACTITIONERS**

- Opportunity to apply and develop the knowledge, skills and values already learned.
- Develop specific competences that relate to the preceptee’s role.
- Access support in embedding the values and expectations of the profession.
- Personalised programme of development that includes post-registration learning, e.g. leadership, management and effectively working within a multi-disciplinary team.
- Opportunity to reflect on practice and receive constructive feedback.
- Take responsibility for individual learning and development by learning how to ‘manage self’.
- Continuation of life-long learning.
- Enables the embracement of the principles of the NHS Constitution.

For example, Leigh et al.’s preceptorship programme for newly qualified nurses apparently led to increased recruitment and retention of newly qualified nurses, who self-reported increased levels of confidence. Daylan provided a first-hand account of the daunting experience of being a newly qualified nurse but how her trust’s preceptorship programme supported her as she gained confidence in her new role. Harrison-White and Simons also argued that the transition from student to staff nurse can be achieved more smoothly with the support of a preceptorship programme.

A range of methods exists through which preceptorship programmes could be delivered, but core elements should be theoretical learning and supervision/guided reflection. Many NHS trusts organise preceptorship from a multi-professional perspective as it is benefit for staff who work inter-professionally to also learn together. Typically, as well as allocating a preceptor to each newly qualified practitioner, a preceptorship programme will comprise some set study days, which offer peer support, and there may be workbooks or other distance learning materials, with competencies to be achieved. As an example, Chapman reported
on a flexible ‘roll-on, roll-off’ preceptorship pathway for all new nursing and allied health professional registrants. Staff stay on the pathway for 6–12 months, depending on their personal development needs, achievement of competencies and appraisal outcomes. In another published example, Morgan et al. (2012) reported on a structured preceptorship programme that is linked to the core dimensions in the Knowledge and Skills Framework (KSF; see the section on appraisal) and includes the allocation of a preceptor, classroom-based learning, group work, self-directed learning, portfolio development and regular review meetings. Some preceptorship programmes will expect preceptees to carry out a project, for example, a service improvement project, possibly in a group.

**ACTIVITY**

Talk to a nurse who qualified in the past year and ask them:

- What were their experiences of preceptorship, and how did preceptorship help their transition?
- Do they have any tips for you to help ease your transition from student to registered nurse status?

**CLINICAL SUPERVISION**

Clinical supervision is mandatory in many professions (e.g. midwifery, counselling), but within the nursing profession, its implementation has been varied. Brunero and Stein-Parbury found evidence that clinical supervision has been established in some areas of nursing practice for some time (e.g. mental health nursing, end-of-life care), but that it is gradually being applied to other clinical contexts. There has often been misinterpretation of what clinical supervision means, with the assumption that it is about monitoring or overseeing performance rather than development of individuals. The Care Quality Commission (CQC) acknowledged that different terms may be used (e.g. ‘professional supervision’, ‘peer supervision’, ‘developmental supervision’, ‘reflective supervision’ or just ‘supervision) but emphasised that the process is separate from managerial supervision through performance monitoring and appraisal (see next section).

Proctor identified three functions of clinical supervision:

- **Formative**: an educative activity aimed at increasing knowledge, self-awareness, creativity and innovation;
PROMOTING BEST PRACTICE AND CONTINUING PROFESSIONAL DEVELOPMENT

Lesley Baillie and Sharon Black

Excerpted from Professional Values in Nursing

CHAPTER 5

• **Normative**: enables the development of consistency in approaches to patient care (i.e. ‘norms’ or standards of practice) and assists the development of strategies to manage the professional accountability and quality issues in nursing;

• **Restorative**: promotes validation and support for colleagues through peer feedback and manages the emotional response to patient care.

Using Proctor’s framework in their analysis, Brunero and Stein-Parbury identified that clinical supervision provided peer support and stress relief for nurses (restorative function), promoted professional accountability (normative function) and supported skills and knowledge development (formative function). Brunero and Stein-Parbury identified that reflection is the primary cognitive process during clinical supervision as nurses can think back on clinical experiences so that they can deepen their understanding or identify areas for further improvement.

As regards the evidence base for clinical supervision, from a review of the literature, Brunero and Stein-Parbury asserted that there is sufficient evidence for clinical supervision to be implemented in nursing. However, Buus and Gonge’s systematic review of clinical supervision in mental health nursing concluded there was insufficient evidence as studies were often too small scale and there were varied models in place. Bégat and Severinsson’s synthesis of three studies of clinical supervision led to the conclusion that clinical supervision had a positive influence on nurses’ experiences of well-being and that nurses attending clinical supervision reported increased satisfaction with their psychosocial work environment. In a study of nurses working in a dementia unit, clinical supervision was found to address support in professional and personal growth, ethical issues, clinical practice and education.

Bishop identified that the key aspect of clinical supervision that is not present in other support systems is the element of peer review and supportive challenge. She argued that clinical supervision can bring out the ‘sharpness in clinical practice—that extra awareness which derives from shared learning with colleagues’. Bishop also highlighted that clinical supervision can offer a framework to support nurses with their professional accountability, although it is important to emphasise that nurses remain accountable for their own practice.

There has been increasing acknowledgement that the well-being of healthcare professionals has a positive impact on the quality of care delivered. Accordingly, ways of supporting staff, including clinical supervision, are attracting more attention. The CQC explained that clinical supervision provides an opportunity for professionals to
PROMOTING BEST PRACTICE AND CONTINUING PROFESSIONAL DEVELOPMENT

Lesley Baillie and Sharon Black

Excerpted from Professional Values in Nursing

CHAPTER 5

• Reflect on and review their practice;
• Discuss individual cases in depth;
• Change or modify their practice and identify training and continuing development needs.

The CQC set out the purpose of clinical supervision as provision of a safe and confidential environment for staff to reflect on and discuss their practice and their personal and professional responses to their work, thus supporting staff in their development. The potential benefits of clinical supervision are summarised in Table 5.1. The CQC asserted that clinical supervision might particularly benefit staff who work with people with complex and challenging needs, for example, people with a learning disability and challenging behaviour or mental health needs, supporting them in maintaining good relationships with service users and carers.

Table 5.1 • Benefits of Clinical Supervision

<table>
<thead>
<tr>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff</strong></td>
</tr>
<tr>
<td>• Can help staff to manage the work-related personal and professional demands through providing an environment in which they can explore their own personal and emotional reactions to their work.</td>
</tr>
<tr>
<td>• Can allow staff to reflect on and challenge their own practice in a safe and confidential environment and receive feedback on their skills (separately from managerial considerations).</td>
</tr>
<tr>
<td>• Can form part of staff professional development and help to identify developmental needs.</td>
</tr>
<tr>
<td>• Can contribute towards meeting professional body requirements for continuing professional development.</td>
</tr>
<tr>
<td><strong>Service users</strong></td>
</tr>
<tr>
<td>• Helps to ensure that people who use services and their carers receive high-quality care at all times from staff who can manage the personal and emotional impact of their practice.</td>
</tr>
<tr>
<td><strong>Providers</strong></td>
</tr>
<tr>
<td>• Can support the culture of the organisation, which sets the tone, values and behaviours expected of individuals.</td>
</tr>
<tr>
<td>• Along with good practices in recruitment, induction and training, helps ensure that staff have the right skills, attitudes and support to provide high-quality services.</td>
</tr>
<tr>
<td>• Associated with higher levels of job satisfaction, improved retention, reduced turnover and staff effectiveness.</td>
</tr>
<tr>
<td>• May increase employees’ perceptions of organisational support and improve their commitment to an organisation’s vision and goals.</td>
</tr>
<tr>
<td>• A way for providers to fulfil their duty of care to staff.</td>
</tr>
<tr>
<td>• Linked to good clinical governance by helping to support quality improvement, managing risks, and increasing accountability.</td>
</tr>
<tr>
<td>• Supports CPD, which is a requirement for registration in many professions and therefore ensures the workforce remains registered.</td>
</tr>
</tbody>
</table>
Supervision may be carried out on a one-to-one basis or in a group and should be carried out on a regular basis. Supervisors should have the skills, qualifications, experience and knowledge of the area of practice required to undertake their role effectively. Effective supervision relies on trust; therefore, normally the content of the session should be confidential, but if concerns arise in the course of supervision about a staff member’s conduct, competence or physical or mental health, the supervisor may need to disclose information from a supervision session to an appropriate person, such as the staff member’s line manager.

Brunero and Stein-Parbury emphasised the peer-educative function of clinical supervision and that, through their participation, nurses can provide feedback and input to their colleagues to assist them to increase their understanding about clinical issues. They further explained that clinical supervision provides nurses with an opportunity to improve patient care in particular for specific individuals but also in relation to maintaining overall standards of care. Clinical supervision also provides an opportunity for nurses to demonstrate active support for each other as professional colleagues and that through sharing experiences they realise that they are ‘not alone’ in their feelings and perceptions of practice, thus providing them with reassurance and validation.

**APPRAISAL**

The NHS Constitution sets out that employees can expect to be provided with ‘personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential’. One structure that supports staff development is an annual appraisal with their line manager, which provides an important opportunity to review both current performance and professional development. All NHS employees are entitled to an annual appraisal. If you are employed outside the NHS (e.g. social care, voluntary or private sector), you should check what the organisation will offer you to support your development. Good employment practices would be that you have opportunities for professional development and have at least an annual review.

To obtain the most from appraisal, you need to invest some time and ensure that you prepare adequately. The NHS Employers’ website provides information for appraisees as well as appraisers, including tips about preparation through reflecting on your performance, development and achievement over the past year. You and your manager will, following the review of your work, set SMART [specific, measurable, achievable, relevant, time bound] objectives for you to work towards.
The Knowledge and Skills Framework (KSF) was established when the NHS Agenda for Change Bands 1–9 pay scale was implemented in 2004. The KSF set out core dimensions for every job in the NHS:

1. Communication
2. Personal and people development
3. Health, safety and security
4. Service improvement
5. Quality
6. Equality and diversity

There are further specific dimensions that relate to parts of particular posts. The KSF remains part of the Agenda for Change national terms and conditions and is a development tool for healthcare workers that contributes to decisions about pay progression and provides a structure to help staff develop their careers. Your appraisal is likely to focus on your performance in the KSF in relation to your job role. Individual NHS trusts will also incorporate other factors; for example, the trust’s values (discussed in Chapter 1) might be incorporated into your appraisal. Good practice is that you should have an interim/midyear review with ongoing discussion about your progress against the objectives, your performance and your development.

CHAPTER SUMMARY

Important values for professional nursing practice include a commitment to lifelong learning and to ensuring that practice is up to date and based on the best available evidence. As a registered nurse, you must be aware of your limitations and any gaps in your knowledge and skills so that you can take steps to address these through accessing, appraising and applying best evidence in your practice. The transition from student status to confident registered nurse can be daunting. You need to ensure that you engage with the support processes that are available, such as preceptorship, and use the appraisal process as a structure to plan your development. You should appreciate and reflect on ways of developing as a professional nurse so that you continually improve your own practice. Above all, ensure that you make a real commitment to continual learning; listen to and learn from patients, carers and colleagues and use the many resources available to keep yourself up to date.