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Subject Area - Nursing

Therapeutic Relationship With Patients

This piece of reflection will focus on my experiences whilst on practice placement; I will be using the (Gibbs 1988, cited in Jasper 2003, p.77) model of reflection. Gibbs cycle is set out in order of categories made up of different headings. (See appendix 1). By using this cycle it allows me to reflect in structured and effective way. The subject of this final piece of reflection will cover the development and utilisation of interpersonal skills in order to establish and maintain therapeutic relationships.

Neal (2003, p100) states a therapeutic relationship can be described as being between nurse and patient and is based on patients needs for care assistance and guidance. It is a relationship that is established solely to meet the patient's needs and therefore, is therapeutic in nature.

Chambers et al (2005, p303) suggest interpersonal and therapeutic relationships are at the centre of nursing work, the relationship that exists between nurse and patient can often provide the energy and be the catalyst, the motivation and the source of strength to continue with treatment or face difficult sometimes life threatening situations.

I felt the need to develop therapeutic relationships with the patient's so that they could feel they could put their trust in me, also that I was there to listen and talk to them not just care for them. There is also a need of good interpersonal skills when forming a therapeutic relationship. Cutcliff (2005, p57) states that you can gain comfort from drawing on your interpersonal skills are having strength and endurance, feeling self confident and brave, having sufficient competence, feeling independent, being at peace and ease with oneself and also having a sense of being valued and useful.

My final placement was an elderly rehabilitation ward which help the patient's to adapt to changes in their life circumstances. The ultimate goal is to maximise the social well being of the individual and enabling them to regain their maximum quality of life and the rehabilitation involved all the individuals' daily activities. I was not sure what to expect from this placement as it was my first experience of working on an elderly rehabilitation ward, as my first placement before was on a surgical ward. During my first days on the ward I found it very different as the patients needed more assistance with their activities of living, such as mobility when transferring and their hygiene needs.

However the ward did use the same model of care on the ward as my last placement which was the Roper, Logan and Tierney activities of living model. This helped as the purpose of this model of nursing is to provide a framework mainly for nurses to plan and individualize nursing for those interventions which are related to the patient's activities of daily living. Roper et al (2002, p434) states that living could be described as an amalgam within the activities of daily living and the way in which the activities are carried out by each person contributes to individuality in living.

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In both of these placements I have interacted with a large number of patients, all of whom have been admitted for a variety of difference reasons. This involves me admitting these patients, their overall care during their time either in hospital or in other care centres right up to their discharge.

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When I first started on the ward I was a little bit concerned when meeting patients when other staff were present as I thought that I was in the way and I would be unprepared when asked to do anything or answer any questions that the patient may ask, as the other staff seemed so professional. Prior to starting each of my placements I attended classes which involved how to act appropriately around the patient's and other members of the team in which I was working and it was to prepare us for our practice placement, but when you get out in practice and are faced with the real thing it is much different.

I knew this was something I needed to overcome and as I started to settle in and understand the routine of the ward the easier it became. Freshwater et al (2005, p101) suggests the nurse patient relationship can be viewed as a major therapeutic tool of effective patient care. McHugh Schuster (200, p7) states that communication plays an important role in the therapeutic relationship.

Clark & Bridge (1998, p2) suggest that forms of communication such as asking questions, allowing patients to express their feelings, or reassuring patients by means of touch will also result in important patient care, and increase patient satisfaction and well being. Nichols (cited in McQueen 2000, p723-731) also suggests that the nurse is the central figure in the patient care and is best placed to provide much of the psychological care and this demands good interpersonal skills to form a therapeutic relationship with patients and to communicate more effectively with relatives and other health professionals.

Communication covers a wide range of things including touch, play, and enthusiasm. Touch is important as it showed that I was listening to the patient's, touch can mean different things, and it is a silent language of non verbal behaviour. Touch is an affectionate way of transmitting warmth. Whilst I was on the ward an example of touch would be when patients are upset or anxious I would maybe hold their hand or give them a comforting hug. Not all patients are comfortable with using touch but I knew the boundaries with each individual patient.

Another non verbal communication skill could be silence giving both the patient and the nurse time to reflect upon prior or future events in the patient's care. Although it is important that the patient's needs are still met and that the focus is still on them. Therefore it is important that the nurse involves the patient through other means of communication which again could be through touch or play.

There are many ways of forming a relationship and gaining the trust and respect of the patient and I had to work out the different things that make a good therapeutic relationship. Hinchliff et al (2003, p102) states there are a number of important elements that make a good therapeutic relationship, but it is important to make clear that a therapeutic relationship is a formal relationship between a medical professional and patient. The Nursing and Midwifery Council (2004) maintains that at all times nursing staff must maintain appropriate professional boundaries in the relationships they have with patients and clients.

The NMC (2004) states that the nurse must recognise and respect the role of the patient/client as partners in their care and the contribution they can make to it. This would be the phase of identification in Peplau's (1988) model of the nurse patient relationship. Peplau (cited in Hinchliff et al 2003, p130) views the nurse patient relationship as passing through four phases orientation, identification, exploitation and resolution, with identification being when the patient finding out more about the reason for health care and the people who can be relied upon for help and advice and how the patient

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can become more involved in their own care.

In this piece of reflection I did not have to obtain consent from patients as I generalised and have not discussed individual cases. However confidentiality is of major importance whilst confirming a patient and it is essential that informed consent is valid as each patient has the right to keep their caring need private. Riley (cited in Cutcliffe et al 2005, p304) suggests that therapeutic relationships are about patient's disclosure of personal and occasionally painful feelings with the nurse at a calculated emotional distance near enough to be involved but objective enough to be of help. Neal (cited in Hinchliffe et al 2003, p102) states that confidentiality and trust are two sides to the same coin and trust is another important attribute to the therapeutic relationship as the patient will place their trust in the nurse.

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This element is important as in the nurse patient relationship the patient is in a vulnerable position. People become vulnerable whenever their health or usual function is compromised. This vulnerability increases when they enter unfamiliar surroundings, situations or relationships.

Older patients and those with dementia are especially vulnerable. I felt on the placement the patient's could put their trust in me as when taking personal information from patients I would ensure to the patient in the early stages of the relationship that information provided is treated as confidential, but will be shared on a need to know basis, with others involved in the delivery of their care.

Even something as simple as when I put a patient on the commode and I inform them I will be back to check on them in five minutes I always return straight away as I told them and if I was tied up I would ask one of my colleagues to check on them this helps to maintain their trust in me.

Chambers (cited in Cutcliffe et al 2005, p308) states that empathy is also an important feature to the therapeutic relationship and suggests empathy is the ability to recognise and understand the patient's feelings and point of view objectively. According to Riley (cited in Cutcliffe 2003, p93) empathy expressed verbally conveys caring, compassion and concern for patient's but never implies that the nurse can fully experience patients feelings, also listening is an important element as it is critical to hear what the patient is saying, verbally and non verbally. Smyth (cited in McQueen 2000, p723-731) suggests that our personal experiences can make a contribution to their emotional work and ability to empathise and by reflecting on personal experiences nurses may be better able to identify with patients.

Whilst I was on placement and listening to the patients concerns and worries, using qualities mentioned by Hinchliff el at (1998, p225) of care, concern, compassion and respect I explained that it was a natural reaction to feel nervous and unsettled and this helped to lesson their underlying anxieties. In order to be genuine it was necessary to be honest and put some of my own feelings into the situation like getting into their shoes and trying to see things like emotions and experiences from their perspective where possible.

Chambers (cited in Cutcliffe 2005, p308) states that therapeutic relationship differs in terms of focus, length, depth and degree of closeness, regardless of this; they need to be grounded in respect for the patient. Getting the message of respect to the patient can be done in a number of ways as part of the therapeutic relationship like making sure that all conversations take place in private, whilst the doctors are doing ward rounds being present, listening and validating

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material that is disclosed. Honesty and genuineness play a key role in conveying respect, even when the information shared may be difficult for the patient. The NMC (2004) states that respect in the general sense recognises the worth of a patient irrespective of gender, age, race, disability, sexuality, culture, religion, economic status or personal beliefs.

Whilst on placement I had to be aware of the aspects of treatment in respect of race and religion. This can be seen through communication, religious beliefs and special dietary needs. Each person has a right to be treated in a way their religion dictates. An example of this is through the dietary need for Muslims in the halal way of preparing meat for hospital meals. Other patients may also have special dietary needs such as patients with diabetes.

Much of nursing is on a one to one basis and is intimate of nature. Dignity is a major issue to many patients and should be respected at all times when working on a ward or other health care situation. Windang & Fridlund (2003 cited in Cutcliff et al 2005, p81) states that dignity mainly comprises as seeing the whole person, being respected and being seen as trustworthy. I have respected the dignity of others by understanding the need for respect and privacy due to the patient's personal feeling and religious beliefs. In building a therapeutic relationship I had not really considered the environment for doing so. Birrell et al (2006, p43) state how important it is that sensitive issues are discussed in side rooms or an area with an element of privacy and not just at the patient's bedside.

Although when talking to patient's privately I drew the curtains around the bed I still had to lower my voice so that other patients could not hear our conversation which was particularly difficult if the patient had hearing difficulties. On reflection I now realise that I should have found a quite room in which to discuss private matters with patients or waited until the bay was quieter or when the other patients were busy or out of the room.

The main purpose to this reflection has been to show the difference between a normal everyday relationship and a relationship between a medical professional and a patient. In a nurse – patient relationship as the NMC (2004) states there is a duty of care. This expresses itself, especially in a hospital setting. One of the important elements of nursing is establishing a therapeutic relationship. Until I had considered Gibb's cycle I had not really thought about the elements that make up a therapeutic relationship. These I now appreciate include verbal and non verbal communication, such as touch, humour, compassion and listening appropriately to the patient and it is further shaped by the concepts of power, trust, respect and intimacy.

Professional interpersonal skills arise from a variety of experiences whilst engaging with patients, relatives, colleagues and other health welfare practitioners. Egan et al (1995, p1) suggests that interpersonal skills refer to those interpersonal aspects of communication and social skills that professionals use in direct person to person contact. In looking back I feel as though I have developed my interpersonal from a normal everyday relationship to that in a medical setting.

I have learnt how to listen and talk to patients, staff and family members for me as a first year student this was a daunting task at the beginning but I felt I developed this and my confidence come from personal experience. I would hope in the future to develop further interpersonal skills and help patients in what ever setting I find them. I need to make all patients feel equal and attend to all their needs in privacy and with dignity and cooperate with their individual needs separately.

In the future and having the knowledge gained through this piece of reflection I will approach the therapeutic relationship

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much more carefully than I have up to now. I can now visualise very many more situations in which I might find myself and have a better chance of being professional in them. I have gained a huge insight into one of the most important aspects of nursing.

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