Handout 2.1: Personal and professional values

Personal

- What values are important to you?
- Think of something in life that you feel happy about; something you have done that makes you feel good.
- Think of something in life that you are not that happy about; that you regret.

Professional

- What are the reasons you came into healthcare?
- What are the values that keep you in healthcare?
- Are these the same as when you first started working in healthcare?
- What do you enjoy about healthcare?
- What makes a 'good' day?
- What makes a 'not so good' day?
- What are your professional values? Consider codes, ethical standards and practice standards.
- What do you think are the shared values of mental health clinicians?

Handout 2.2: Experience of hospitalisation

Redefining self

'Almost everything you do gets understood in reference to your illness. You used to have days when you had "ants in your pants" but now they say you are agitated. You used to feel sad sometimes but now you are said to be depressed. You used to disagree sometimes but now you are told you lack insight. You used to act independently but now you are told that your independence means you are uncooperative, non-compliant, and treatment-resistant. You used to take risks. You learned from your failures as you were growing and learning. But now that you have been labelled with a mental illness the dignity of risk and the right to failure have been taken from you. No wonder you get angry. Normal people get to make many stupid choices over and over again in their lives. Nobody tells them that they need a case manager. How many times has Elizabeth Taylor been married? At last count it was seven or eight times, I think. The poor woman lacks insight! She exercises poor judgment! She is failing to learn from past experiences! She is making the same dumb choice again! How come they don't get her a case manager?'

(Deegan, 1993)

Medication

'We were told to take medications that made us slur and shake, that robbed our youthful bodies of energy and made us walk stiff like zombies. We were told that if we stayed on these medications for the rest of our lives we could perhaps maintain some semblance of a life. They kept telling us that these medications were good for us and yet we could feel the high dose neuroleptics transforming us into empty vessels. We felt like will-less souls or the walking dead as the numbing indifference and drug-induced apathy took hold. At such high dosages, neuroleptics radically diminished our personhood and sense of self.'

(Deegan, 1996)

Handout 2.3: Social perspectives that devalue people with mental illness

Comment one

'*From a moral–practical standpoint, I am treating a human being as a mere thing if I do not take him as a person…likewise I am not treating a human being as a subject of rights if I do not take him as a member of a community founded on law, to which we both belong.*'

(Husserls, 1989)

Comment two

Wolfensberger (1980) drew a relationship between what society deems as normal and mental illness. The following highlights this:

'*Devalued people will be badly treated. They will usually be accorded less esteem and status than that given to non-devalued citizens. They are apt to being rejected, even persecuted and treated in ways that tend to diminish their dignity, adjustment, growth, competence, health, wealth, lifespan etc.*

The treatment accorded to devalued people will take forms that express social perception of the devalued person or group. For instance, people who may be perceived as risky or dangerous (perhaps for no realistic reason) may reside in settings that are prison-like.

How a person is treated will, in turn, strongly influence how that person subsequently behaves. Negative expectations are more likely to lead to negative behaviour. On the other hand, the more social value is accorded to the person, the more he/she will usually be encouraged to assume roles and behaviours which are appropriate and desirable and more will be expected of him/her and the more he/she is apt to achieve.'

(Wolfensberger, 1980)

Handout 2.4: Two accounts of mental distress

The note in the hospital file on Mary O'Hagan's chart entry said:

'*Flat. Lacking in motivation. Sleep and appetite good. Discussed aetiology. Cont. Li Carb 250 mg qld levels next time.*'

Mary wrote in her diary:

'*Today I wanted to die. Everything was hurting. My body was screaming. I saw the doctor. I said nothing. Now I feel terrible. Nothing seems good and nothing good seems possible. I am such in this twilight mood.*

Where I go down,

Like the setting sun,

Into a lonely black hole,

Where there is room for only one.'

(O'Hagan, 1990)

Handout 2.5: An experiment in social interpretation

This experiment involved eight 'sane' people (a psychology graduate student in his 20s, three psychologists, a paediatrician, a psychiatrist, a painter, and a 'housewife') who gained admission to 12 different hospitals, in five different states across the USA. There were three women and five men.

These pseudo-patients asked the hospital for an appointment, saying that they were hearing voices. They were not able to identify the voice as being related to anyone in particular and used terms such as 'empty', 'hollow' and it being like a 'thud'. Bearing in mind there was little literature about voice hearing at the time Rosenhan and his team chose terms that reflected a de-personalised voice hearing experience that reflected the understanding at the time.

The pseudo-patients gave a false name and job (to protect their future health and employment records), but all other details they gave were true, including general ups and downs of life, relationships, events of life history and so on.

Once admitted to the psychiatric ward, they stopped simulating symptoms of voice hearing and abnormalities associated with mental illness. However, Rosenhan did note that the pseudo-patients were nervous, possibly because of fear of being exposed as a fraud, and the novelty of the situation.

They joined in activities in the ward and engaged with other patients and staff in a manner that reflected their normal ordinary interactions. When asked how they were feeling by staff, they said they were fine, and no longer experienced symptoms. Each pseudo-patient had been told they would have to get out by their own devices by convincing staff they were sane.

The pseudo-patients spent time writing notes about their observations. Initially, this was done secretly, although as it became clear that no one was bothered, the note taking was done more openly.

Results

None of the pseudo-patients was detected and all but one were admitted with a diagnosis of schizophrenia and were eventually discharged with a diagnosis of 'schizophrenia in remission'.

(Rosenhan, 1973)

Handout 2.6: A reason to connect

The verbal report reads: '34-year-old female diagnosed with schizo affective disorder elevated persecutory delusions suicidal ideations, hasn't been engaged with the treating team for last 4 days.'

What are your thoughts about this person?

What picture are you getting of this person clinically?

What decisions and actions are you considering?

The nurse reported that she had been 'Dismissive to the staff and agitated after seeing the treating team'.

What comes to mind about the patient?

What is the picture you have of this person?

How do you see this person clinically, personally and professionally?

What are your ideas and beliefs around the person?

What would you consider is the level of engagement?

How would this report affect your role and interaction with the person?

Another version

The morning report read: 'Jane says she wants to leave the HDU (High Dependency Unit); that she is annoyed with being in a place which she cannot exit. She says she feels like a trapped rat. She doesn't understand why she is here.'

You are hearing this in the team meeting.

Compare the two versions.

What action has taken place for this interaction to occur?

What are some things that come to mind about Jane?

Handout 2.7: Validating the person – Helen's narrative

In this scenario, the nurse knocked on Helen's bedroom door doing 15 minute observations.

'Are you OK Helen?' the nurse asked.

Helen is 34-year-old Fijian lady with a diagnosis of schizophrenia. She has been in the ward for two weeks. She spends a lot of time in her bed, coming out only for meals.

When she talks to nurses it is usually about when she can be discharged and leave the unit (she is in the locked unit).

Traditionally the response has been to say that she is unwell at the moment and that the doctor will have to decide when she can leave the unit, at which point Helen will ask when she can see the doctor and the nurse will say the doctor will be around at some time today, however she cannot say when.

The scenario plays out day after day, leading Helen to say she is feeling depressed.

'It is boring in here. Why are you asking how I am? I feel depressed, please leave me alone' she says.

Helen is disengaged from the activities. She spends her time in her room.

The chart read: 'Isolative and not willing to engage. Spent time in her room. Only came out during meal times. Dismissive.'

Handout 2.8: Communicating meaningfully

Helen asks when she can be discharged and leave the unit. The nurse replies:

'It sounds really frustrating for you Helen. This isn't a prison Helen, this is a hospital and I am a nurse.

Sometimes, Helen, life takes us on a journey that we do not understand. Things happen in our life that we are unsure about and we may find ourselves in an unfamiliar place that may feel dark and confusing.

Life is a journey and sometimes things happen on that journey that may leave us unclear. It is a time when we have to surrender ourselves, a time to appreciate the sunshine and the trees, to take time to breath and to connect with the earth whilst others look after us. You are in that time. It will pass and you will come out of this. You are a good person Helen. This is not a prison; it is a moment in your life.'

Helen said she felt comforted by what was said to her. She expressed a sigh of relief and smiled and thanked the nurse for explaining this to her.

What has changed?

Handout 2.9: Values conflict between clinicians

Kate is a 26-year-old social worker who has worked on the unit for six months as part of the allied health team. Kate lives at home (temporarily) with her parents in the suburbs, not far from work. She would love to move out but can't afford it as she is still paying off her university fees and has just bought her first car. She goes out whenever she can and has a large circle of friends and an active social life. She says music and gardening are her main interests and she loves going to tend to her community plot at the city gardens. When she has Saturdays free she sells her organic vegetables at the market.

Jayne is a 50-year-old nurse who has worked on the unit for eight years. Jayne lives with her husband in a suburban house not far from work. Jayne moved into mental health eight years ago having worked a long time in the spinal injuries unit. She chose mental health because it didn't involve heavy lifting and was something she had done and liked years ago when she first qualified back in 1984. Her family live nearby and she enjoyed seeing them, particularly her two grandchildren.

Paul is a 26-year-old man who has recently been admitted to the mental health unit. He lives with friends and couch surfs wherever he can. Since admission he has been settled on the unit, enjoying being part of the ward activities i.e. playing pool, exercising and listening to music. Music is a large part of Paul's life. He plays guitar and writes songs. Since his admission he has lost his accommodation and has brought all that he owns on to the unit. This is not a lot: one laundry bag of clothes and one guitar. Paul spends all the day playing his guitar.

Kate often talks to Paul about his music and shares in his enthusiasm. She lets the music therapist know that there is a keen guitar player on the ward and that they would like to meet up. They are due to meet on Thursday.

When that day arrives, Jayne is looking after Paul. Paul lets Jayne know that he will be playing with the music therapist and Jayne acknowledges this. The doctor arrives on the ward at the time that Paul is to meet with the music therapy group. Jayne lets Paul know that he will not be able to go to the music session until after he has seen the doctor. Paul is annoyed about this and says he doesn't want to see the doctor.

Jayne informs him that the doctor is a busy man and that he should come immediately, that seeing the doctor is important part of his treatment and that he will have to make another time to see the music therapist. Paul becomes angry and starts abusing her, 'I cannot do anything in this place, all you want to do is control me. I've planned to have my music session today. The doctor can get lost.'

Paul is given medication to help him settle down. Jayne takes his guitar away and puts it in the store cupboard for safe keeping.

The next day Kate is working in the unit. She gets his guitar out of the cupboard for him.

Are all parties concerned with what's best for Paul?

What do you think is driving Jayne's decision?

What do you think is driving the doctor's decision?

What do you think is driving Kate's decision?

Clearly Paul's interest becomes known when he gets angry. When would have been a good time to connect with Paul's values before it got to this stage? When Paul's values are known, what processes support the transfer of this information between clinicians?

Handout 3.1: Insight

'The feeling that the diagnosed mentally ill don't know what they are talking about limits the scope of our lives. The concept of insight – perhaps lack of insight would be more accurate from the psychiatric perspective – is one of the most powerful and insidious forces eroding our position as competent creative individuals. If I am to be consigned to a category of person whose experience is devalued, status diminished and rational evidence dismissed simply because at certain times or time, I lost contact with the consensus view of reality agreed on by my peers then it is scarcely possible to expect that my control over my life will ever be more than severely circumscribed.

If my experience is not valued, I cannot be whole. It is particularly discouraging to speak to some psychiatric professionals and have my experience validated only as a particular and very sad blemish in an otherwise benign concept. This is no validation whatsoever. I am not the one regrettable bacillus in the otherwise sterile supplies room. My experience is shared and is relevant.'

(Campbell, 2000)

What is Peter Campbell highlighting?

From a values perspective, what effect does the term insight have for Peter Campbell?

What may be some of the risks for the person associated with the term 'lacking insight?'

What alternative words could be used other than 'lacking insight'?

What is the contemporary thinking around insight?

Handout 3.2: Inter-subjective nature of experience (1)

'The best thing though in that museum was that everything always stayed right where it was. Nobody'd move. You could go there a hundred thousand times and that Eskimo would still be just finishing catching those two fish, the birds would still be on their way south, the deer would still be drinking out of that water hole with their pretty antlers and their pretty skinny legs and that squaw with the naked bosom would still be weaving that same blanket. Nobody'd be different. The only thing that would be different would be you. Not that you'd be so much older or anything. It wouldn't be that exactly. You'd just be different that's all; you'd have an overcoat on this time. Or the kid that was your partner in line the last time had got scarlet fever and you'd have a new partner. Or you'd heard your mother and father having terrible fights in the bathroom. Or you'd just passed by one of those puddles in the street with gasoline rainbows in them. I mean you'd be different in some way.'

(Salinger, 1951)

Handout 3.3: Inter-subjective nature of experience (2)

'The role of the person in mental disorder is not peripheral merely as a passive victim of a disease to be fixed by medicine …what we are dealing with is not some rather stereotyped disease process stamped onto some shadowy "every person", but processes of disorder that interact with a very important and differentiated person – a person who is goal directed, a person whose feelings and interpretations influence actions that in turn affect phases of disorder or recovery, and a person who uses regulatory mechanisms … as ways of making both continuity and change possible.'

(Strauss, 1989)

Handout 3.4: Inter-subjective nature of experience (3)

'*Put simply we do not experience ourselves solely as physical objects being buffeted about by other physical objects that cause our actions and behaviour to take the forms that they do … we experience ourselves as social agents relating to others, making decisions, acting and behaving in accord with plans we have made based on reasons, that is, on motivation that involves our being directed toward goals*.'

(Davidson & Strauss, 1995)

Handout 3.5: Meaningful communication

1. *'Patient polite and pleasant on approach. Interacting appropriately with nursing staff and co-patients. Denies having any suicidal ideation or any self-harm thoughts. Mood stated as great. Affect restricted. Settled in behaviour; thoughts disorganised at times. Continues to be delusional, remains insightless re: mental state. Physical obs' within normal range for consumer accepting of medication.'*

2. *'Patient presented settled in behaviour in the beginning shift. Consumer not sure who he is. Thought inserted and disorganised, got agitated at morning tea time. Took his belongings from his room to front office saying, "Check that that's someone else's." Given PRN Olanzapine and 10 mg Valium with good effect.'*

Handout 3.6: Therapeutic engagement

First, take time to think about:

- What is my attitude towards this person?
- What am I communicating to this person? What attitude am I expressing?
- To what degree is this person seeing me as willing to listen and understand?
- What are the core messages the person is sending?
- What is stopping me listening to this person?
- How aware am I of what is going on inside myself when I am listening to this person?

Then:

- Acknowledge that differences of view are normal and can be useful.
- Set aside judgments and biases for a moment and walk in the shoes of the person.
- Respond to the person's core messages.
- Employ the person in helping you understand.
- Accept the person and work with them.
- Check yourself for any reluctance or barriers to communication.
- Don't lose focus from trying to understand the person by trying to prove they are wrong.

(Adapted from Egan, 1994)

Handout 3.7: Communicating with acutely psychotic individuals

The dos:

- Ask open ended question for which you do not know the answer ahead of time.
- Ask questions beginning with 'How…' or 'In what ways…'
- Ask specific detailed questions and couch them as much as possible in the participant's own language.
- Only ask one question at a time.
- Ask questions that imply a temporal framework of before, during and after, rather than a static state.
- Communicate respect by following the person's lead and not pursuing any areas in which a participant clearly communicates discomfort.
- Demonstrate comfort with the person's story by having a relaxed posture and not displaying extreme reaction to any particular details.

The don'ts:

- Avoid asking closed-ended questions that can be answered by 'yes', 'no' or one or two word answers.
- Avoid asking questions that begin with 'Why…' as they tend to put people on the defensive, feeling that they are being asked to explain rather than describe.
- Avoid asking value general or abstract questions that require the person to answer more than one thing at a time.
- Avoid asking interrogative type questions similar to ones used in an assessment, and avoid saying, 'Can you tell me …', as all of these tend to introduce distance between the participant and his or her own experience (as well as between the participant and the interviewer).
- Avoid interrupting the person or showing any other signs of impatience with their efforts to respond to your questions.

(Adapted from Bowers *et al*, 2009)

Handout 4.1: Reflective template

	Comments
Awareness	
Reasoning	
Communication	
Knowledge	
User-centred	
Multidisciplinary	
The 'two feet' principle	
The 'squeaky wheel' principle	
Science and values	
Partnership	

Handout 4.2: Values-based practice principles

Practice skills

1. AWARENESS: of the values present in a given situation. Careful attention to language is one way of raising awareness of values.
2. REASONING: using a clear reasoning process to explore the values present when making decisions.
3. KNOWLEDGE: of the values and facts relevant to the specific situation.
4. COMMUNICATION: combined with the previous three skills, this is central to the resolution of conflicts and the decision making process.

Models of service delivery

5. USER-CENTRED: the first source of information on values in any situation is the perspective of the service user concerned.
6. MULTIDISCIPLINARY: conflicts of values are not resolved in values-based practice by applying a 'pre-prescribed rule', but by working towards a balance of different perspectives e.g. multidisciplinary team working together.

Values-based practice and evidence-based practice

7. THE 'TWO FEET' PRINCIPLE: all decisions are based on facts and values (values base and evidence base work together).
8. THE 'SQUEAKY WHEEL' PRINCIPLE: we only notice values when there is a problem.
9. SCIENCE AND VALUES: increasing scientific knowledge creates choice in health care, which introduces wide differences in values.

Partnership

10. PARTNERSHIP: in values-based practice decisions are taken by service users and the providers of care working in partnership.

(Woodbridge & Fulford, 2004)

Handout 4.3: Pre-admission scenario

You are the admitting nurse on the acute inpatient unit. You receive a phone call from the case manager called Ian, who is working in the community, about one of his patients called John.

John is a 35-year-old man living with schizophrenia who was last admitted to the inpatient unit four months ago. You remember John from his last admission. You receive the following information from the case manager.

The neighbours phoned Ian up that morning in the health centre and said John had been knocking on their door accusing them of listening in to his conversations and poisoning his cat. They were quite distraught about this, saying they were scared he was going to do something and really people like him should be locked up, not living in their street where there are families and children. The case manager reassured them that he would look into it straight away. Later that morning he went around to John's house. He could see John was in the living room but John did not open the door. He informed John that he would like him to see the psychiatrist for an assessment. John refused to talk to him, shouting abuse and accusations about him being in allegiance with the neighbours. He proceeded to call the police who are now escorting John to the unit under the Mental Health Act. John is not resisting this show of force.

It is not an uncommon occurrence that people are admitted to the unit under highly charged, stressful conditions. You are aware that John is going to be admitted.

How do you see John?

What picture do you have of John from this information?

What is informing your picture of John?

Personal reflection

What are your assumptions?

Have you looked after John or someone like John before?

Think about the accumulated personal and professional information.
How is this influencing your thoughts?

Different perspectives
What do you think John's values may be?

Handout 4.4: John's perspective

'I am scared. The voices are full on. "You filthy person." "You don't talk to anyone." "You are a filthy, disgusting person." My voices are getting worse. I can't concentrate anymore; they have been waking me up at night. I haven't slept for two weeks. I know the neighbours have been watching me. They have been knocking on my door asking if I am OK but I don't want to talk to them. They were the ones that called the police last time I was admitted. My case manager came snooping around banging on the door wanting to take me away. I am not letting him in. I have no one to talk to. I haven't been to Stepping Stones [drop in centre] for a week. I haven't seen my cat for three days; they must have poisoned her.'

Does this change your picture?

Complete a reflective template.

What other information do you now need?

Handout 4.5: John's admission

John is admitted to the ward. The nurse who conducts the admission is David. David is a 42-year-old nurse who has worked in the inpatient unit for two years. David has two teenage children from his second marriage. He used to work as a manager in a correctional facility, but left to work in mainstream acute psychiatry because he wanted to work closer to home.

David has nursed John before and has seen John when he is well. John remembers David and is pleased to see him. David is nearly at the end of his shift. He offers John a cup of tea shows him to his room and says, 'OK, let's get down to it'.

'*It's good to see you John; I'm sorry that you have been admitted again. It sounds like you have been having some trouble with the neighbours? Everywhere is the same as before. Do you remember where the bathroom is? OK. Now I need to do a quick risk assessment for our record and ask you a few questions and then I'll leave you to it.*'

David conducts the risk assessment.

'*Do you hear voices? Are you feeling suicidal?*'

At this point John stands up and starts yelling. David quickly intervenes. The conversation alternates between the two:

'*Now calm down mate!*'

'*I do not want to be here. I am not unwell. I need to leave.*'

'*Look, you'll be OK. The doctor will see you soon. I just need to fill in these forms and then I'll be finished.*'

John is getting increasingly angry.

David is surprised by John's reaction.

What is causing John's anger?

What is causing David's surprise?

What is the risk for John?

Is there anything in the process that could be done differently?

Do you think David's familiarity with John could have contributed?

Do you think David had a different idea about their relationship?

Consider: empathy, communication, risk.

Self-awareness tips for David:

What are my thoughts and feelings about John?

What organisational priorities are getting in the way of engaging with John?

What is important for John at this time?

Practice skill: using the reflective template as a prompt, write down an alternative script.

Handout 4.6: Dining room

It is a Tuesday morning and you are the nurse in charge of a busy shift at the hospital. You have five nurses working on the shift: one is an agency nurse, while the others are regular staff. There are ward rounds, ECT, escorts to x-ray, and discharges to be arranged. The ward is full to capacity, and there is a couple of people waiting in the emergency department to be admitted. You are aware that the busyness of the ward and the tasks that need to be completed can often overtake engagement work.

It is 8am in the morning: time for breakfast and medications. It is practice for staff to be in the dining room. Today there are four staff in the dining room talking about their day ahead and observing patients' interactions.

Awareness

Whilst walking through the dining room you overhear Sue – one of the nurses – telling another nurse that the patient John has been observed responding to voices, jumping up and down in his seat, and going to other patients and shouting. She is concerned about him disrupting the others. She asks the nurse to keep a watch on him while she goes to get some extra medication.

What may be the reasons Sue makes this decision?

What might be the organisational, professional and personal values that drive the nurse to make this decision?

Handout 4.7: Sue's perspective

Use the reflective template to decide what questions you would ask Sue about her decision. Here are some areas you may consider:

Principle 7: The 'two feet' principle EBP + VBP

You are concerned about a balanced approach, 'EBP + VBP' and ask Sue about the reason for her decision.

She says her reason for giving John medication is because he is decompensating in his mental state, that she is concerned that he will disturb the other patients, and that he is escalating and needs to take medication to calm down.

What 'scientific' knowledge of psychosis is driving Sue's thoughts at this time?

Consider this through how John's behaviour is viewed.

What has led to this view?

Principle 4: Knowledge

How informed is Sue about her decision? Is there other knowledge about the situation or from John that could help her form her decision?

Principle 2: Reasoning

What do you consider are the ethical reasons behind the decision?

Consider the following ethical principles:

- Beneficence: doing good.
- Maleficence: minimising or preventing harm.
- Autonomy: respect for individual self-determination.
- Justice: fairness and equal access to care.

What is Sue basing her reasoning on?

If Sue was more informed about the reason for John's behaviour, would her decision have been different?

How does this fit with a recovery approach?

What is the evidence around medication with the person who is psychotic?

In between Sue getting the medication, John walks over to a table away from the window and sits down on his own. Another nurse brings his breakfast over. He continues to talk to himself; however, he is focused on eating his breakfast rather than shouting at others.

John's behaviour has changed and he is now settled.

Do you think this change in behaviour should be considered?

Why would it not be considered?

What was the consequence of this?

John's behaviour has changed and he is now settled. Acting retrospectively and giving John medication may not be necessary. Fixed beliefs either through principles of ethics or medical causation may sit behind an idea that the right action to take is the action that was decided previously. Being flexible and responsive is necessary to adapt to changing situations and to promote a sense of trust and therapeutic risk management.

Handout 4.8: Choosing not to take medication

The nurse approaches John with the medication.

The conversation flips between the two:

'*Here John, take this. It will make you more settled.*'

'*I don't want that. I am fine. Take it away.*'

'*No John, you are unsettled and you need to take this. It will help you to settle. Please take your medication, John it will help you.*'

'*No. I don't want to take it. I am fine.*'

The nurse continues to stand at John's breakfast table. John's response is to start to shout at the nurse that he is not going to take that, that he needs to speak to someone in higher authority. He is sick and tired of being pulled and pushed from pillar to post in this place whilst all the nurses do is to control and talk about him.

'*You take it if you need it, I am not having it.*'

Concerned that he is becoming more agitated and disturbing to the other patients, the nurse says that he needs to take this to calm down, and if he doesn't take this medication, she will have to call security and give him an injection.

When questioned about the situation Sue responded by saying she was having a busy day, he was disturbing the others and she needed to sort this out before it got out of hand. She needed to make sure John felt alright. Particularly in light of the morning handover when she was told that John had been unsettled since waking and needed to get his medication reviewed. She believed she was acting in the best interests of John and the other patients in the dining room.

Scenario analysis:

What is your response to Sue's justification? Analyse the situation using the reflective template. At what point could the path have been different?

Here are some further questions to assist your analysis:

What was the nurse's communication style?

What were the barriers to finding shared understanding?

Why has communication broken down?

What could the nurse have said?

A shared team approach

What support would you require from your colleagues to implement a VBP approach in this situation?

Handout 4.9: Values-based practice – bringing it all together

It is a Tuesday morning and you are the nurse in charge of a busy shift at the hospital. You have five nurses working on the shift, one of whom is from the agency and all the others are regular staff.

There are ward rounds, ECT, escorts to x-ray and discharges to be arranged. The ward is full to capacity however there are a couple of patients waiting in the emergency department to be admitted.

You are aware that the business of the ward and the tasks that need to be completed often take priority over spending time talking with patients.

You look for engagement opportunities wherever you can. Time in the dining room is one of those opportunities.

It is 8am in the morning time for breakfast and medications. It is practice for staff to be in the dining room to engage and support patients during meal times. Today there are four nurses in the dining room.

The value of the relationship reflects a shared understanding amongst all the staff within the unit. Taking time to engage with patients in what may be considered the ordinary interactions is considered an important aspect of nursing (Barker, 2008).

During breakfast time you take a cup of tea and ask the patient if it's OK if you join them at breakfast. You relish this time to talk to patients outside the constraints of administrative tasks.

John stands up and shouts at other patients. You are sat at the table opposite John's; you move to the adjacent table and pull up a chair. You invite John to sit next to you.

John declines your offer and continues to shout.

Practice skills: a VBP script – continue to write the story.