Assessment and communication (general principles)

Introduction

There is wide recognition that patient assessment by community nurses is central to the provision of high-quality care and that assessment in the home care setting is a complex process requiring a wide range of knowledge and skills (McIntosh 2006). The nursing process was the forerunner of modern day care management; however, as patient care becomes more complex, its continued use as a problem-solving approach has been questioned (Crow et al. 1995; Lawton et al. 2000).

This chapter explores the assessment process carried out by community nurses to help them plan patient care, the importance of communication in relation to assessment and the issue of consent in community nursing.

Background evidence

Assessment

Assessment is a patient-focused, interactive process that enables the nurse to gain knowledge about a patient in order to identify problems and plan the care interventions that are best suited to meet the patient’s needs (Walsh 1998; Aggleton & Chalmers 2000). It is fundamental to individualised patient care, and therefore how that knowledge is gained, and what objective and subjective knowledge is sought to inform care decisions, is essential (Walsh 1998).

A comprehensive nursing assessment contains multi-faceted dimensions:

- physical
- emotional
- spiritual
- psychological
- cultural
- social.

To complete the four-stage cyclical process requires:

- assessment of patient needs
- planning care that meets the patient’s identified needs
- the implementation of planned nursing interventions
- the evaluation of the nursing interventions.

It is essential for the community nurse to expand their knowledge and understanding of the patient’s, and where relevant carer’s, perspective of their own needs so that they can plan care that maintains and promotes patient independence (Alfaro-Lefevre 2002).

Assessment can be divided into two stages:

1. gathering the information and knowledge about the patient
2. using this information to make decisions about potential patient problems (Barrows & Feltovich 1987; Carnevali & Thomas 1993; Walsh 1998).

The type of information that the nurse collects from the patient can be divided into two main categories (Walsh 1998).

1. Qualitative information – information based on the individual’s and the nurse’s feelings, thoughts and experiences. This information explores the interpretations and meanings that individuals place on events. For example, how a patient feels about a recent diagnosis of cancer.
2. Quantitative information – information based on tested scientific methods, objective facts and observations. For example, blood results.
Both types of information are required to gain a full picture of the individual's health and social care needs. Consequently, assessments often involve nurses measuring and recording facts about patient's vital signs, weight and medical history, as well as asking more subjective questions, such as how they feel about having a particular disease or living alone.

Assessing a patient to ascertain needs involves an inductive and deductive approach (Crow et al. 1995). The inductive approach involves information being gathered and general conclusions being drawn from this information about needs. The deductive approach entails the nurse making inferences about the information given and then working backwards to gather more information to support or reject the idea.

Factors affecting nursing assessment

As already indicated, in order to plan care delivery the patient's needs must be identified; however, this identification cannot occur between the nurse and patient in isolation. The nursing assessment carried out and the needs ascertained are influenced by external factors, for example:

- type of need
- health need versus healthcare need
- health policy
- nursing versus social care
- professional accountability
- resource issues.

(Walsh 1998)

Identifying patient need

Type of need

Bradshaw's taxonomy of needs (1972) describes four different types of need, as follows.

- Felt need – need that a person feels that they have. This need may not always be expressed.
- Comparative need – a need that is only realised through comparing with other people or groups.
- Normative need – need that a healthcare professional determines an individual to have.
- Expressed need – a need that an individual expresses in some way.

It is important that community nurses recognise the different types of need when carrying out a patient assessment as this will help them assess the patient accurately.

Health needs versus healthcare needs

There is a subtle difference between an individual's health needs and an individual's healthcare needs. Health needs includes those factors that may influence the individual's health, such as housing, socioeconomic status and education. Healthcare needs are those needs that would benefit from the provision of healthcare, such as treatment, rehabilitation or health education (Steven & Raftery 1997). The ideal situation would be for every patient to be able to have all their needs assessed and for care to be available to meet all of these needs. The reality, however, is that limited availability of resources in the area can restrict the care available and the care that is offered to the patient. This can influence the information gathered about a patient. Prior knowledge about the services available allows nurses to explore some needs in depth, as they know that the supply is available to meet that demand. For example, if the community nurse knows that there is a bed free at the local hospice they may be more willing to discuss the possibility of imminent respite/inpatient symptom management (Bryans & McIntosh 1996).

Nursing versus social care

Since the introduction of the Community Care Act in 1993, social services have become responsible for meeting the 'social needs' of people in the community and community nursing has become responsible for meeting the 'nursing needs'. Such an artificial definition has proved problematic and confusion still exists among nurses over how to differentiate between these two needs (Wright 2003). With the Community Care Act, responsibility for the placement of individuals' long-term care in the community moved from the NHS to social services. This meant that clients who had stayed permanently in long-stay wards in hospitals under NHS responsibility began to be moved to nursing homes under social service responsibility (Wright 2002a). Despite this change, the NHS is still responsible for the nursing care element of long-term placements and for assessing every individual entering a nursing home under social service responsibility. However, the local authority and social services do not have the responsibility for all nursing home and residential residents.

The Single Assessment Process (SAP)

The Single Assessment Process (SAP) was introduced in 2001 as a key part of the National Service Framework (NSF) for Older People (DH 2000c) with a requirement
for it to be implemented by April 2004. The NSF identified the single assessment as a key way to meet the aim of ‘ensuring that older people are treated as individuals and receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social services boundaries’ (DH 2000c: 23).

The fundamental principle of the SAP is that there is an individualised person-centred assessment to which different health and social care professions contribute. The process requires partnership, collaboration and shared communication between all those involved in the assessment, planning and delivery of care to the patient. The intention is for care needs to be assessed thoroughly and accurately without patients needing to discuss their needs with a range of different professionals and without procedures being unnecessarily duplicated by different agencies involved in the delivery of care. To achieve this, the SAP assessment of the patient (Box 1.1) is carried out by one frontline professional, for example a district nurse. If other professionals need to be involved in the package of care, a referral, e.g. for specialist assessment, is made by the initial assessor to ensure that the patient receives a seamless service.

Although originally designed for the assessment of older people, the SAP is increasingly being used by health and social care agencies as a framework for assessing need and delivering services to other adults requiring care.

Some of the benefits of the SAP include:

- increased patient involvement in decision making
- improved use of specialist time
- reduced duplication in the gathering of assessment information
- reduced repetition of information giving by the patient
- improved co-ordination of care to offer a seamless service
- improved outcomes for patients and linking of outcomes to assessment information.

**Assessment for end of life care**

It is suggested that approximately half a million people die in England each year; however, people find it difficult to discuss this aspect of life openly. Of the total number of deaths it is estimated that:

- 58% occur in hospital
- 18% at home
- 17% in care homes
- 4% in hospices
- 3% elsewhere.

(DH 2008a)
For the community nursing team, 18% of deaths at home is equivalent to 8% of their total caseload; however, in reality, 40% of actual community nursing time is spent on face-to-face contact with those requiring palliative and end of life care (DH 2008a).

Communication, assessment, care planning and symptom management are the fundamental basis for achieving high-quality end of life care (Mahmood-Yousuf et al. 2008; NHS National End of Life Care Programme 2009). To support practitioners and enable them to do this successfully, a number of initiatives and tools have been developed and these are now seen as an integral part of many community nurses’ clinical practice. For example:

- the Gold Standards Framework (GSF) (King et al. 2005; Mahmood-Yousuf et al. 2008)
- the Liverpool Care Pathway (LCP) (Taylor 2005; DH 2008a)
- prognostic indicators (Thomas & Free 2008)
- advance care planning (National End of Life Care Programme 2011)
- national guidelines for continuing healthcare (DoH 2009a, 2009b, 2010).

**Gold Standards Framework (GSF)**
The GSF has been introduced as a National Framework that is aimed at facilitating a consistently high-quality approach within palliative care. The framework focuses on an anticipatory approach to care needs based on three steps for good practice (King et al. 2005).

1. Practitioners, e.g. community nurses and GPs, work in partnership to identify palliative care patients and place them on a GSF register. The register should then be used during multiprofessional GSF meetings to guide discussion and planning for individual patients’ current and future needs.
2. Assessment of the patient and, where appropriate, carer’s needs.
3. The planning of care and, where necessary, additional support to meet identified needs.

The GSF contains seven key areas known as the ‘7 Cs’:

- Communication
- Co-ordination
- Control of symptoms
- Continuity
- Continued learning
- Carer support
- Care of the dying.

(King et al. 2005; DH 2008a)

To ensure that holistic care is provided, all seven domains must be considered during the initial patient assessment and reassessment stages, and all care needs identified must be met.

**The Liverpool Care Pathway (LCP)**
The Liverpool Care Pathway for the dying adult patient contains three elements: initial assessment, ongoing assessment and care after death, and is a crucial component of the GSF (Taylor 2005). It is an evidence-based approach to assessment and care that places multiprofessional working, communication, needs identification of both the patient and carer, and clinical decision making at the centre of care (Taylor 2005; Ellershaw 2007; Marie Curie 2009).

Once a multiprofessional diagnosis of the last hours or days of life has been reached and where, for example, two or more of the following symptoms are present, the LCP should be initiated (Taylor 2005).

- The patient is semi or fully comatose.
- The patient is bedbound.
- The patient is able to take only sips of fluid.
- The patient is unable to take oral tablets.

**Prognostic indicators**
Developed in line with the GSF, prognostic indicators provide clinicians with an insight into the potential prognosis and care needs of patients in advanced disease or those predicted to be in the last six to 12 months of life (Thomas & Free 2008). They include those people who are living with a long-term condition or life-limiting illness such as:

- renal disease
- dementia
- Parkinson’s disease
- heart disease
- chronic obstructive pulmonary disease (COPD)
- cancer
- motor neurone disease
- co-morbidities.

(DH 2008a; Thomas & Free 2008)

Prognostic indicators may be used as a predictive guide during relevant patient assessment to help identify current care needs and anticipate others. By using the tool in this way it is suggested that the patient will receive the correct care and support at the right time in a proactive manner (Thomas & Free 2008). They may also be used as a trigger to initiate discussion with the patient, and where relevant significant other(s) regarding their wishes during the final stages of their illness; for example preferred place of care, resuscitation status...
The effectiveness of a community nurse’s decision making will therefore depend on a number of factors.

- knowledge base
- ability to use different methods to collect new information
- ability to extract the new information – those elements that are relevant to solving the problem
- ability to integrate that information with existing knowledge
- ability to generate hypotheses that will carry forward the decision-making process.

(Junnola et al. 2002)

**Decision making**

Using the information gathered about a patient during an assessment, nurses are required to plan care. To do this, they first need to establish what the patient’s problems or needs are. The process of examining the information and identifying problems requires nurses to make decisions, therefore decision making is a key element of the community nurse’s assessment practice and decision-making theory can provide a useful conceptual framework.

**Information-processing theory**

The inductive/deductive approach is similar to the information-processing theory (Junnola et al. 2002). This theory attempts to explain how nurses make decisions about patient problems on the basis of the information presented to them (Carnevali & Thomas 1993). The information-processing theory has the following stages (Figure 1.1).

- Observation of signs and cues.
- Generation of alternative explanations.
- Activating an hypothesis.
- Ascertaining and testing the hypothesis in relation to previous knowledge.
- Defining problems.

The thinking process of problem solving, when there is no single solution, is known as critical thinking. Critical thinking is therefore an essential component of decision making for nurses. Kataoka-Yahiro and Saylor (1994: 352) have devised a model of critical thinking for nurses and describe critical thinking as:

Reflective and reasonable thinking about nursing problems without a single solution and is focused on deciding what to believe and do.

Among other things, critical thinking involves recognizing that assumptions exist, making these assumptions explicit and assessing their accuracy. The process of critical thinking enables the nurse to do the following.
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- Raise vital questions and problems, formulating them clearly and precisely.
- Gather and assess relevant information, interpreting it effectively, arriving at well-reasoned conclusions and testing them against relevant criteria and standards.
- Think with an open mind using alternative systems of thought and recognising their assumptions, implications and practical consequences.
- Communicate effectively with others in figuring out solutions to complex problems.

(Paul & Elder 2004)

Patient assessment is a dynamic decision-making process that seeks to establish an accurate picture of an individual’s condition and through critical thinking enables the community nurse to make decisions about the care the patient requires (Figure 1.1). Possessing key information is a crucial component of any decision making and in order to gather the appropriate information required to accurately assess a patient’s condition the community nurse needs to have well-developed communication skills. Careful observation of verbal and non-verbal cues is also required (Hedberg & Larsson 2003).

**Communication**

There are two main types of communication relevant to assessment.

- Therapeutic communication – seen as communication with patients and families.
- Inter- and intra-professional communication – occurs between other professionals and nurses involved in the assessment process.

(Barr 2001).

**Therapeutic communication**

For an assessment to be accurate, and the most appropriate needs identified, the nurse must ensure that assessments are individualised (Aggleton & Chalmers 2000). Individualised care means that the patient’s personal-subjective dimension is taken into account in the decision-making and information-gathering processes (Jenny & Logan 1992). The interaction between the patient and nurse is seen to be at the heart of nursing and is the vehicle through which nursing care can be delivered (Luker et al. 2000; Wright 2002a). This interaction is commonly known as the nurse–patient relationship. The development of a nurse–patient relationship includes the following stages:

- involvement
- knowing the patient
- nurse–patient relationship.

(May 1991; Radwin 1996; Luker et al. 2000; Wright 2002b)

**Involvement**

May (1991) suggests that becoming involved with patients is part of the process of getting to know patients. Involvement in this sense is seen as the result of encounters between the nurse and the patient in which the nurse obtains knowledge about the patient. During these encounters nurses view patients not simply as objects of clinical attention, but also as individuals who place their own interpretation and meanings on events. Becoming involved with patients is therefore a process that leads towards a greater understanding of the patient as an individual. Involvement has been shown to have other fundamental features relating to the interaction that occurs between a patient and a nurse.

- **Knowledge** – gaining knowledge about patients, understanding their personality, their lives and their potential needs.
- **Reciprocity** – while nurses gain information about the patient they also respond by giving information about themselves. This is thought to allow patients to see that the nurse is actually a person with a life, too. This exchange is thought to offer a ‘connection between the nurse and the patient that is both particular and meaningful’ (May 1991: 554). The degree of reciprocity is bound by the norms of appropriate behaviour in the course of a nurse–patient relationship (NMC 2008a).
- **Investment** – the knowledge and exchange of information between the nurse and patient is constituted through a particular investment of nursing skills to meet clinical and social objectives. For example, getting to know the patient and becoming involved has a purpose of meeting nursing care needs.

The degree of involvement between the patient and community nurse needs to be balanced. An over-focus on reciprocity by the nurse can cause stress and unsatisfying care for the patient. Whereas an under-focus can lead to less satisfying care for both patient and nurse. As nurses begin to become involved with their patients they must therefore balance the degree of reciprocity and exchange that takes place between them.
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Knowing the patient

Knowing the patient is described as a process of understanding and treating the patient as a unique individual (Radwin 1995). The nurse is thought to use their knowledge of the patient to make care choices (Hedberg & Larsson 2003). When the nurse knows the patient, interventions are chosen so that the patient is treated as a unique individual. Knowing the patient is said to have three main concepts:

- the nurse’s experience with caring for patients
- chronological time
- a sense of closeness between the patient and the nurse.

(Radwin 1996)

Knowing the patient is thought not only to benefit the decision-making process, but also the achievement of positive patient outcomes (May 1993). Care based on knowing allows that care to be personalised, comforting, supporting and healing (Swanson-Kauffman 1986). Patients also feel cared for when nurses provide individualised care, begin to do more things for themselves and are more willing to accept help when needed (Lamb & Stempel 1994). Getting to know the patient is therefore an important concept for nursing assessment and a precursor to developing a professional relationship (Hedberg & Larsson, 2003).

Nurse–patient relationship

The interactions between a nurse and a patient should be based on accepting the individuality and uniqueness of the patient. Once established a nurse–patient relationship becomes the vehicle through which all other therapeutic care is delivered (Luker 1997; Wright 2002b). Within the community setting, where nurses visit patients in their own homes, the development of a nurse–patient relationship can become more complicated (Luker et al. 2000). When visiting patients at home, community nurses often become involved with the patient’s relatives and/or carers and this involvement creates another dimension to the relationship developed. Therefore community nurses must be aware of the relationships between the patient and carer/relatives as well as developing and being aware of their own relationships with the patient and carer/relative (Luker et al. 2000; Wright 2002b).

The nurse–patient or family relationship is described as a partnership (Munro et al. 2000). In this conceptualisation the nurse moves from being an expert provider of care to a patient and family, to being a partner with the patient and family. In a partnership relationship the patient and family participate as much as they are able in the planning and delivery of care. Working in partnership with patients and their families has been found to offer benefits to both the patient and the care they receive. These include the following.

- **Empowerment** – the ability of the patient or family to act on their own through increased control, confidence and competence.
- **Emotional support** – as the nurse works with the patient and family and assists them in implementing the goals required of the partnership, both the patient and family have more opportunities to be supported emotionally. Working in partnership allows the nurse to show acceptance and understanding of the patient and family and can lead to further support through caring.

(Gallant et al. 2002)

Partnerships develop from the nurse–patient relationship and the interactions that take place between the nurse and the patient. Two main attributes are required within the nurse–patient relationship for a partnership to develop (Gallant et al. 2000):

- power sharing
- negotiation.

**Therapeutic communication skills**

Effective communication is beneficial for patient care and has been found to increase the rate of patient recovery, reduce pain and increase the concordance with treatment regimens (Stewart 1996; Fallowfield & Jenkins 1999).

Communication skills have been identified as a core skill in nursing (DoH 2000b) and have been described by Wallace (2001: 86) as the ‘primary medium of care’.

Egan (1994) identified three core components that he felt needed to be conveyed within a therapeutic relationship.

- **Genuineness or congruence** – being genuine refers to nurses being themselves in the relationship, being authentic and sincere.
- **Warmth** – this has also been described as unconditional positive regard. Being warm towards a patient is showing acceptance and respect for them as a unique individual and being non-judgemental.
- **Empathy** – empathy is seen as being able to perceive accurately the feelings of another person and to communicate this understanding to them.

These core components can be conveyed through both non-verbal and verbal behaviours.
Non-verbal communication

Information and messages can be conveyed to other people either consciously or unconsciously through the use of body language. Non-verbal behaviour has a number of different functions.

- Supporting or complementing the verbal meaning of speech, for example pointing directions at the same time as verbally explaining.
- Regulating the flow of the interaction, for example touching someone to get their attention or backing away to end a conversation.
- Signalling specific meanings that are understood by members of one’s own culture, for example hand signals.
- Conveying idiosyncratic habits, for example fidgeting with a paperclip when talking or touching one’s hair.
- Expressing emotion. This is usually through facial expressions, but can also be conveyed through body posture and distance.

Non-verbal communication is dependent on a number of different variables, for example the context in which it occurs, the individual’s personal style and preference, and the personality of the person involved (Burnard 1997; Wallace 2001). For example, an individual may always run their fingers through their hair before speaking. This may be a personal habit of the person and not, for example, an indication of anxiety. Non-verbal communication cannot therefore be used to ‘read’ what a person is saying, but should be used as clues to what the person may be ‘saying’. Any interpretation taken from a patient’s non-verbal actions should always be clarified with the patient (Burnard 1997).

Non-verbal behaviour can also be used to convey to a patient that you are listening to what they are saying, for example nodding of the head or using verbal sounds, such as ‘Hmm’ or ‘Yes’. These behaviours are used as minimal prompts to convey to the patient that you are listening and attentive in order to encourage them to continue (Hough 1998).

Questions

Questions can be used for a number of reasons, for example:

- to explore an issue
- to gain further information
- to clarify information and meanings
- to encourage patients to talk.

(Hough 1998)

However, asking too many questions can reduce the amount of active listening that takes place (Hough 1998). Questions can be asked for the nurse’s benefit in order to get the facts straight in their own mind and also to understand the patient’s subjective experience. There are several types of questions that can be asked, such as closed, open, leading, confronting or funnelling (Burnard 1997; Hough 1998).

Reflection

This is a process of reflecting back or paraphrasing the last few words that the patient has used to encourage them to say more; it is also a way of conveying to the patient that the nurse has actively been listening to what they have said. Skilful reflective responses are those that stay within the patient’s internal frame of reference. This means listening to and understanding the issues from their viewpoint (Benner & Wrubel 1989).

Selective reflection

Selective reflection is similar to reflection, except that a specific aspect of what the patient has said or indicated through their non-verbal behaviours is picked up and reflected on. The nurse’s reflective response can then include something the patient said from anywhere in the patient’s response and not just from the end. Selectively reflecting responses back to patients allows throwaway comments that patients make to be explored (Burnard 1997). Often these remarks contain the real feelings and issues that patients have and require the nurse to acknowledge them and focus in on this issue. The nurse needs to be attentive to what the patient is saying using free-floating attention to be able to pick up on these casual comments and know when to intervene to focus in on these points.

Verbal communication skills

Verbal communication is thought to be the most common communication method between patients and nurses (Wallace 2001). The skills required for effective verbal communication can assist the nurse in gaining information from the patient as well as communicating and clarifying understanding back to the patient. According to Hough (1998) verbal skills can be categorised as follows:
**Empathy building**

This involves the nurse making statements to the patient to convey that they acknowledge the patient's feelings and that what they are experiencing has been understood. Such feelings may not necessarily be expressed overtly by the patient, but are being implied. This process often involves the nurse listening to the meaning of what the patient is saying and not just to what is being said. Sometimes the interpretation by the nurse of the message being conveyed can be wrong and the patient rejects the empathy-building statement. If this happens, it is suggested that the nurse stops this approach and pays more attention to listening (Burnard 1997).

**Clarifying**

This can involve checking for understanding by asking the patient or by summarising the conversation to clarify understanding of what has been said so far (Hough 1998). This method can be useful to focus the discussion on particular topics especially if the patient has identified a number of different topics in a short space of time. Clarifying enables the nurse to stay with what the patient is saying and also to ensure effective interpretation of what the patient has said.

**Silence**

Silence can be a difficult skill to develop and involves more than being quiet. Silence requires nurses to be physically and emotionally present with the patient attending to everything they 'say'. Silence allows patients time to collect their thoughts or to experience a strong emotion or feeling. Breaking the silence inappropriately can intrude on this process. A great deal can be communicated through silence, although it can be uncomfortable at first and requires practice and a conscious effort on the part of the nurse to stay with the patient throughout this period.

Verbal communication refers not just to the words that people say and the meanings these have (linguistics), but also to the way that the words have been said. The way in which words are communicated is referred to as paralinguistic communication (Burnard 1997) and includes elements such as:

- timing
- volume
- pitch
- accent.

Like non-verbal behaviours, paralinguistic aspects of communication could serve as indicators as to how the patient is feeling, but has not expressed in words (Burnard 1997). However, again such indicators should only be used as clues to what the patient is saying and must be validated with the patient. Therefore, nurses can pick up communication clues from non-verbal and paralinguistic communications as well as from the words that the patient uses.

To communicate effectively nurses need to ‘hear’ what is being communicated by the patient and be able to communicate this understanding back (Kruijver et al. 2000). ‘Hearing’ involves:

- listening to what is said by patients and families
- observing and listening to what is not said through interpreting skills
- communicating understanding of what is said
- responding to the patient’s communication.

**Barriers to communication**

There are a number of ways that communication can be impeded, for example:

- not listening
- blocking
- cultural differences
- disability.

(Barr 2001)

**Not listening**

Listening can be impeded by the following distracting factors.

- External factors such as noise, interruption and physical discomfort.
- Response rehearsal when the nurse becomes preoccupied with what will be said in reply.
- Fact finding, when too many questions are asked in search of details and facts, instead of listening to the overall message.
- Being judgemental and making mental judgements about the speaker’s behaviour.
- Problem solving. Concentrating on trying to solve the patient’s problems in your head will prevent listening.
- Tiredness and stress.
- Illness and pain.
- The nurse having had similar experiences to those described by the patient.

(Barr 2001)

**Blocking**

Nurses can prevent patients from sharing their experiences or how they are feeling by using blocking behaviours. Blocking is when a nurse actively moves the topic
of conversation away from a patient’s disclosures or expressed feelings (Booth et al. 1996). Blocking behaviours can be either conscious or unconscious. Conscious blocking can occur for a number of reasons such as stress, inability to deal with the patient’s issues at that present time and not knowing what to say to the patient. Unconscious blocking is normally through a nurse not having the communication skills needed to allow the patient to express their feelings (Kruijver et al. 2001; Wilkinson et al. 2002).

Cultural differences

The meanings of unspoken and spoken language are learnt through a process of socialisation (Barr 2001). This process of socialisation varies in different countries, geographical locations and communities. There are also differences between social classes and ages (Wallace 2001). Therefore different body language and words may have different meanings depending on the patient’s and nurse’s experience of socialisation. For this reason it is vital that meanings are clarified with patients during assessment to ensure that a shared understanding of the issues under discussion are defined (Kruijver et al. 2001).

The spoken word is the communication tool most often used by nurses within nurse–patient interaction. Different spoken languages between the nurse and the patient can cause difficulties in communicating, assessing needs and in the development of a relationship (Kruijver et al. 2001; Wallace 2001). Nurses can use channels other than the spoken word, for example using body language and gestures. However, to be able to assess the patient’s needs accurately an interpreter will be needed (Barr 2001). An interpreter could be from a central translating service or a member of the family. However, it is important to recognise that the latter may have implications on how freely the patient will communicate. For example, if a young son is the interpreter, a mother may feel inhibited in disclosing her true feelings and issues to her son as well as the nurse.

Disabilities

Certain disabilities can prevent a patient from using all aspects of communication. For example, aphasic patients who are unable to communicate verbally may rely on non-verbal and written communication to express themselves. Similarly, a patient may be able to verbalise, but due to a neuromuscular condition may not be able to convey effective non-verbal behaviours. Nurses need to be aware of how certain conditions could affect a patient’s communication, for example:

- developmental immaturity such as a patient with a learning disability
- sensory loss such as hearing or visual impairments
- neuromuscular difficulties affecting mobility and speech such as multiple sclerosis (MS) or motor neurone disease (MND)
- cerebral trauma, infection or disease, such as cerebral tumours, dementia or Alzheimer’s disease
- emotional difficulties or mental health problems, such as clinical depression, stress or anxiety.

Inter- and intra-professional communication

Inter- and intra-professional communication involves conveying messages across different organisations and professions for the benefit of patient care. Such communication within the community occurs within teams and between, for example, community nurses, GPs and practice staff, therapists, hospital, hospice and local authority staff and the voluntary sector. Good communication is an essential component of effective teamwork, which in turn contributes to the quality of care delivered to patients.

The community nurse and patient alone cannot always achieve the assessment and planning of care to meet identified needs. Community nurses may need to refer a patient to other disciplines or organisations in order to meet the needs determined at assessment. The community nurse, with the patient’s consent, may also need to discuss issues that have been raised through the assessment process with other specialist community practitioners, for example continence, tissue viability or diabetic specialist nurses. Therefore relationships that the community nurse has with other members of the primary care team and with members of other agencies becomes an important component in the assessment process.

Written communication and record keeping

Effective written communication involves any communication that is expressed in words, either on paper or electronically. This can include:

- paper healthcare records
- electronic health/nursing records
- nursing documentation
- drug administration charts
- referrals
- faxes
- electronic mail.

Like verbal and non-verbal communication, written communication aims to convey a message from a person or group of people to a targeted audience. The written communication documented in the patient’s
nursing records conveys information to other community nurses and healthcare professionals involved in the patient’s care and to the patient and their family.

The NMC (2007, 2009) states that record keeping is an essential part of patient care; it is a tool of professional practice which should assist the care process and not an optional extra. Good records help to protect the welfare of patients by promoting:

- high standards of clinical care
- continuity of care
- better communication and dissemination of information between members of the inter-professional care team
- an accurate account of treatment, care planning and delivery
- the ability to detect problems, such as changes in the patient’s condition, at an early stage.

NMC (2009: 6)

Good record keeping is a significant element in ensuring that colleagues have the information they need to provide the necessary and appropriate care for the patient, and the importance of keeping accurate, up-to-date and comprehensive records can never be overstated (Dimond 2005). Failure to maintain such documentation could lead to potential failures in care delivery, which could in turn result in harm being caused to the patient.

Doenges et al. (1995) described the goals of documentation as:

- facilitating the delivery of quality patient care
- ensuring documentation of progress with regard to patient-focused outcomes
- facilitating interdisciplinary consistency and the communication of treatment goals and progress.

Therefore when communicating in writing it is important that certain principles are adhered to and the NMC (2007, 2009) advises nurses that patient and client records should:

- be factual, consistent and accurate
- be written as soon as possible after the event, providing current information on the care and condition of the patient
- be written clearly and in such a way that the text cannot be erased
- be written in a way that alterations and additions are dated, timed and signed with the original entry still being clearly visible
- be accurately dated, timed and signed with the signature being clearly identifiable

- not include abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive subject statements
- be readable on any photocopies
- be written wherever possible with the involvement of the patient and their carer
- be written in a way that the patient can understand
- be consecutive
- identify problems that have occurred and the action taken to address them
- provide clear evidence of the care that has been planned, the decisions made, the care delivered and the information shared.

Further advice and guidance on standards for record keeping have been prepared by the Department of Health (1999c) and the Clinical Negligence Scheme for Trusts (CNST) (2005).

Barriers to written communication

There are several barriers to written communication. These barriers can affect both the way that information is presented and the way it is interpreted (Castledine 1998). Barriers can involve the following.

- Lack of time by the nurse writing the information will result in badly thought out, unclear and insufficient information being communicated.
- Jargon and abbreviations can be misconstrued or not understood by other people reading the information.
- Written and reading skills can hinder the clarity of written information given and the ability of individuals, including patients, to read this information. For example, literacy issues.

Data Protection Act 1998

The Data Protection Act 1998 came into force in March 2000 (DH 1998) to protect both the movement and the processing of personal information about individuals. The Act applies to all organisations that collect personal information about individuals but has particular significance for the NHS, which is the largest holder of individuals’ most personal information. The Act replaces the previous Data Protection Act (1984), which was devised in response to the large amount of data being held electronically about individuals. The main difference is that the 1998 Act, as well as covering data held on electronic systems, also covers personal data held on other media, including paper. This means that all hand-written information held about patients is now covered within the Act. As community nurses often process large amounts of personal information about
patients from various sources, either electronically or manually, it is especially important that they consider whether the way that they are processing this information is in accordance with the principles laid out within the Act (DH 1998). According to Dimond (2005), these principles are designed to ensure that personal data is:

- accurate
- relevant
- held only for the specific designed purposes for which the user has been registered
- not kept for any longer than is necessary
- not disclosed to any unauthorised persons.

There is also a right of subject access whereby the individual should be able, on request and payment of a fee, see what is contained in their records and have it corrected if it is not accurate.

**Freedom of Information Act 2000**

The Freedom of Information Act grants anyone wide-ranging rights to see all kinds of information held by the government and public authorities that is not governed by the Data Protection Act. It gives the individual the right to ask any public body for all the information they have on a particular subject of choice, and unless there are very good reasons not to, then this information must be provided. Personal information where the applicant is the subject of the information is exempt from the Freedom of Information Act and any individual who wants access to their personal information would need to use the Data Protection Act 1998 as the means of obtaining it (Dimond 2005).

**Consent**

A patient has a fundamental legal and ethical right to autonomy and self-determination. Ensuring that patients are given this right requires healthcare professionals to obtain agreement from a patient before starting any treatment, physical investigation or providing care for that patient (DCA 2005).

As set out in the Professional Code of Conduct (NMC 2010), nurses have an ethical, legal and professional duty to gain patient consent prior to carrying out any form of patient care. Failure to gain consent could lead to:

- charges of battery in the civil or criminal courts
- claims of negligence if a patient is harmed during a procedure where consent was not gained
- complaints through NHS complaints procedures
- charges of misconduct through the NMC.

Consent must also be obtained from the patient before disclosing confidential information in verbal, written or electronic form, although there are certain exceptions to this rule, for example:

- the patient has given their consent
- disclosure is necessary in the best interest of e.g. the patient or general public
- if not shared with another professional the patient might suffer
- court orders
- statutory duty to disclose information
- public interest
- police
- Data Protection Act 1998 provision.

(Dimond 2005)

By law, the consent obtained from the patient must be valid. There is a fundamental difference between gaining consent from a patient for treatment and gaining valid consent. For consent to be valid:

It must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question. Acquiescence where the person does not know what the intervention entails is not ‘consent’

(DH 2001e: 4)

Therefore, for consent to be valid a patient must:

- be mentally competent to make the particular decision
- have received sufficient information to enable them to make the decision
- be acting voluntarily and not under duress.

**Capacity**

In order to decide whether a patient has the capacity to give valid consent the following principles apply (DH 2001e).

- The patient must be able to understand and retain information relating to the decision, in particular the consequences of having or not having the intervention in question.
- The patient must be able to use and weigh up this information in the decision-making process.

**Adults with capacity**

Capacity is related to the retention and understanding of information relating to a particular procedure or planned intervention. An adult over the age of 16 should be assumed to have capacity unless it can be established through appropriate assessment that they lack it (DH 2001e; DCA 2005).
A patient's capacity could differ depending on, for example:

- the intervention being discussed
- the complexity of the decision required
- their health status at the time consent is requested
- fatigue
- shock
- pain
- medication
- anxiety.

For these reasons a patient’s capacity to consent must be assessed for each planned intervention. It should not be assumed that a patient incapable of consenting to one procedure is automatically incapable of consenting to another.

**Adults without capacity**

According to the Mental Capacity Act (DCA 2005), a person lacks capacity if they are unable to make a decision because of an impairment or disturbance in the function of the mind or brain. The individual would be assumed to be incapable of making a decision if they were unable to:

- understand information relevant to the decision
- retain the information
- use and weigh the information as part of the decision-making process
- communicate their decision.

Adults may be permanently or temporarily unable to give valid consent. This could be due to a mental health difficulty, learning difficulty or impaired consciousness. However, people must be given all appropriate help before anyone concludes that they cannot make their own decisions (DCA 2005).

In English law no one is able to give consent to the treatment or examination of an adult patient on his or her behalf (Mental Capacity Act 2007). Therefore parents, relatives or members of the healthcare team cannot consent on behalf of an adult. The principle that must govern the decision about treatment for adults incapable of giving valid consent is whether it is in the 'best interests' of the patient. The decision as to whether or not a procedure or intervention is in the 'best interests' of the patient should be decided by the healthcare professional responsible for carrying out the care intervention or procedure. In making this decision other factors must be taken into consideration:

- the patient's values and preferences when competent
- their psychological health, wellbeing and quality of life
- relationships with family or other carers
- spiritual and religious welfare
- own financial interests.

It is seen as good practice to involve those close to the patient to find out about the patient’s views and values before they lost their capacity (DH 2001f). The exception to this is if the patient has previously said that they do not want certain individuals involved.

**Young people aged 16–17**

For people aged 16 or 17 years the principles for consent remain the same as for adults. Consent must be given voluntarily and must be informed. If the individual is incapable of giving consent then a person with parental responsibility can give consent on their behalf or can override the young person’s refusal to give consent. Establishing capacity to consent for 16- or 17-year-olds should follow the same criteria as for adults.

Although legally it is not a requirement for nurses to obtain parental consent in addition to consent from the 16- or 17-year-old, it is seen as good practice to involve those that have parental responsibility in the decision-making process. The exception to this is if the young person has specifically requested that they do not want to involve their parents (DH 2001e).

**Sufficient information**

Consent is only valid if the patient understands the nature and purpose of the procedure (DH 2001e). However, this information alone is not sufficient to fulfil the practitioner’s legal duty of care to the patient. If a practitioner does not give a patient information about the risks of the procedure, such as side effects and potential complications, along with the potential risks of not having the procedure, then the practitioner could be charged with negligence should a patient experience subsequent complications. For example, the patient could claim that the nurse was negligent in not giving certain information about potential complications and had they known about them they would not have consented to the procedure (Sidaway vs Bethlem Royal Hospital Governors and Others 1985).

**Voluntary consent**

For consent to be valid it must be given voluntarily and freely without pressure or undue influence being placed on the patient to accept or refuse treatment. Pressure may come from family, relatives and healthcare professionals. Community nurses need to be aware of this possibility and, if it is suspected, arrangements need to be made to discuss the proposed care or treatment with the patient individually.
Therefore to ensure that a patient is able to make a balanced judgement on whether to give or withhold their consent, community nurses should inform the patient of:

- any material or significant risks in the proposed treatments
- any alternatives to the treatment
- the risks incurred by not receiving any treatment.

(DOH 2001e)

Some patients may want very detailed information about every possible risk and others may want only the significant risks outlined. Therefore if a patient asks specific questions about their treatment and the risks this should be answered truthfully.

**Forms of consent**

Valid consent can be implied or given verbally or in writing (DH 2001e).

**Implied**

Examples of this form of consent are if, having received appropriate information, a patient rolled up their sleeve and proffered their arm to receive a flu vaccination. The inference here being that if the patient was not happy with the amount of information given, or unclear, they would not have voluntarily offered the nurse their arm.

**Verbal**

A patient can give valid consent verbally (DH 2001f). The patient’s records should be used to document the discussion, information given and decisions made (NMC 2008b).

**Written**

Written consent is often thought to be a more valid form of consent than verbal or implied consent, because it provides physical evidence that a patient has given consent (DH 2001e). Written consent, however, is not proof of valid consent, as it cannot prove that the patient received and understood the information given or that consent was given voluntarily. It is therefore not a legal requirement to gain written consent. Written consent is recommended in the following situations:

- The treatment is complex and risky with the potential for adverse effects.
- Treatment requires a general or local anaesthetic.
- Providing clinical care is not the main purpose.
- The treatment could have significant consequences on the patient’s social, employment or personal life.
- Research studies.

- If it is believed that the patient may dispute the care given or they have done in a similar case before.

(DH 2001e, 2001f)

The government has devised a number of standardised consent forms to be used across the country (DH 2001f). These should be available within local work areas. The forms also include a new consent form for when a patient has been assessed to be incapable of giving valid consent. The consent form has a section for recording the rationale for the nurse’s decision in terms of capacity and why performing or not performing the procedure is in the patient’s best interests.

**Refusing and withdrawing consent**

Just as a patient has the right to consent to treatment, they also have the right to refuse or withdraw their consent ‘for a good reason, a bad reason or no reason at all’ (Dimond 2005: 142). The same principles of gaining consent apply to refusing or withdrawing consent. A nurse must establish the patient’s capacity to understand the consequences of refusing consent or discontinuing with a treatment. In particular, nurses should bear in mind that factors such as pain, shock and panic may reduce the validity of refusing or withdrawing consent (DH 2001e).

**Responsibility for consent**

The responsibility for gaining valid consent lies with the practitioner who will be carrying out the nursing intervention (DH 2001f).

**Duration of consent**

The consent given for a particular intervention remains valid indefinitely unless consent is withdrawn (DH 2001f). Community nurses must ensure that there have not been any changes that could affect the decision made, these could include for example:

- new information about the risks of the intervention
- new treatments that could offer alternatives
- changes to the patient’s condition that could affect the likely benefits and risks discussed.

When consent has been gained a long time before the intervention is due to take place, it is seen as good practice to confirm that the patient still wishes to have the intervention performed. This is the case even if there are no changes in the patient’s condition or new information to discuss.
Conclusion

The assessment of a patient is a complex process involving a range of nursing knowledge and skills to formulate and plan a patient’s care. Assessment involves the community nurse obtaining consent and working in partnership with the patient and other professionals to gather and synthesise information that will enable clinical decisions to be made about the most appropriate care interventions. The SAP has been explored as a means of gathering such information from the patient to decide on their needs and plan care.

The accuracy and effectiveness of a community nursing assessment is reliant on the communication skills of the nurse, the external factors that influence the context in which the assessment is taking place, and the relationship that is developed between the nurse and the patient. This, combined with the multidisciplinary nature of assessment and patient care needs requiring more complex problem solving, means that community nurses must work in partnership with other health and social care professionals (Fonteyn & Cooper 1994).

References and further reading


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