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Assertiveness in nursing practice: An action research and reflection project

This article describes an action research project that highlighted reflective processes, so hospital nurses could work systematically through problem solving processes to uncover constraints against effective nursing care; and to improve the quality of their care in light of the identified constraints and possibilities. Four Registered Nurses (RNs) co-researched their practice with the facilitator and over the research period identified the thematic concern of the need for assertiveness in their work. The RNs planned, implemented and evaluated an action plan and, as a direct result of their reflections and collaborative action, they improved their nursing practice in relation to becoming more effective in assertiveness in work situations.

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INTRODUCTION

Nursing in hospitals involves negotiating complex interpersonal relationships and working in a social and political context within economic constraints, while balancing a multiplicity of tasks and roles. Nurses are busy clinicians who need to have a broad range of clinical knowledge and skills, and they are accountable to many people (Benner 1984; Benner and Wrubel 1989; Taylor 1997, 2000). Hospital nurses are caught up in the complexity and busyness of daily work, but these constraints can be managed effectively by reflective processes (Freshwater 2002; Taylor 2000).

This article describes an action research project that emphasised the value of reflective practice through which nurses identified the thematic concern of assertiveness at work. This article describes the project in terms of its background, methodology, methods, processes and insights. The action plan the nurses generated and instituted for practising assertively is also described.

AIM, OBJECTIVES, SIGNIFICANCE AND BACKGROUND

This project aimed to facilitate action research and reflective practice processes in experienced Registered Nurses in order to:

• raise critical awareness of practice problems they face everyday;
• work systematically through problem solving processes to uncover constraints against effective nursing care; and
• improve the quality of care given by hospital nurses in light of the identified constraints and possibilities.

The significance of the project was in improving nursing care and in educating nurses in a research process they can use for clinical problems that emerge daily in their practice. The project originated through collaboration between a School of Nursing and practice-based nurses.

LITERATURE REVIEW

Assertiveness is an important issue in nursing practice. After a period of reflective practice, when the nurses in this project identified their need for assertiveness at work, the literature was explored with the intention of assisting in the creation of the action plan. Nursing literature repeats the call for nurses to become more assertive (Gaddis 2004; Levesque 2003; Madden 1996; McNally 2002; Milstead 1996; Morris 2004; Kupperschmid 1994; Larson 1997; Pacquiao 2000; Pauly-O’Neill 1997; Smith 1997). Education programs in assertiveness knowledge and skills have been in vogue for some time in nursing because nurses have recognised the need for assertiveness in quality nursing care (Benton 1999; Cardillo 2003; Class 2001; Crouch 2003; Floyd 1999, 2001; Habel 2004; Lyttle 2001; McCabe & Timmins 2003; Milstead 1996; Pearce 2004; Percival 2005, 2001, 2000; Stein-Parbury 2005; Woods 2003). All of these authors agree that assertiveness is important in nursing practice, but that it is complex and requires time and practice to make it effective.

This review describes some recent nursing research into assertiveness (Addis & Gamble 2004; Jaime et al. 1998; McCartan & Hargie 2004a,b; Timmins & McCabe 2005). Timmins and McCabe (2005) undertook a preliminary pilot study to assess how assertive nurses are in the workplace, in order to develop an instrument and report on the results. The researchers distributed the 44-item questionnaire to 27 registered nurses and the results showed that nurses in the study responded strongly to items allowing others to express opinions, complimenting others and saying no’ (Timmins and McCabe 2005:61). The researchers concluded that the nurses behave in a passive, nice way and were ‘less adept at disagreeing with others’ opinions and providing constructive criticism’ (Timmins and McCabe 2005:61). Even though this project has been reported as a preliminary pilot study, the results should be viewed cau-
tiously because of low sample numbers and the tendency for questionnaire respondents to indicate 'nice' or self-fulfilling behaviours, even if they practice in a contrary way, by using active assertion in their workplace.

Addis and Gamble (2004:452) aimed to understand what nurses had learned from an assertive outreach (AO) experience. The project was informed by the phenomenological concepts of Heidegger and data were collected through the use of semi-structured interviews of five rural AO nurses working in one county in England. The thematic analysis revealed that nurses understood their experience of assertive engagement as involving: having time; anticipatory persistence and tired dejection; pressure, relief and satisfaction; being the human professional confluence; accepting anxiety and fear; working and learning together; and bringing the caring attitude. Thus it was shown that being a rural AO nurse involves contradictory yet rewarding experiences in practising assertive behaviours with clients.

McCartan and Hargie (2004a:707) administered The Caring Assessment Instrument and the Assertion Inventory to a convenience sample of 94 nurses to find answers to their research question, 'Assertiveness and caring: are they compatible?' The background to their project was that 'numerous assertion studies suggest that nurses are generally non-assertive', so they wanted to 'determine whether positive and negative assertion behaviours were related to caring skills'. The researchers defined positive assertion as:

\textit{other-centred} caring type behaviours such as expressing positive feelings, initiating and maintaining interactions, giving and receiving compliments, and conveying empathy.

(McCartan & Hargie 2004a: 707–708)

Negative (standard conflict) responses 'are often viewed as self-centred skills' and may be considered 'undesirable attributes in nursing' (McCartan & Hargie 2004a:708). After analysis of the nurses' responses, they concluded that:

Overall the findings of the study suggest that positive and negative assertive behaviours are not related to caring skills ... The current findings suggest that the presence of caring attributes cannot be offered as a possible reason for non-assertion in nurses.

(McCartan & Hargie 2004a:707)

McCartan and Hargie (2004b) distributed the Bem Sex-Role Inventory and the Assertion Inventory to a convenience sample of 94 subjects, to determine the effects of nurses' sex role orientation on positive and negative assertion. The researchers reported that 'contrary to earlier studies, the findings of the investigation indicated that there was no significant relationship between assertion measurements and sex-role orientation' (McCartan & Hargie 2004b: 45). The findings of the research projects by McCartan & Hargie (2004a,b) demonstrate difficulties in making exact statements about assertiveness and suggest that its success is relative to the contexts in which nurses enact it.

The research question posed by Jaime et al. (1998:98) was whether assertiveness is a characteristic of the nursing profession. Their descriptive study aimed to determine the degree of assertiveness in nurses and to assess the influence of personal characteristics, such as age, sex, marital status, work experience and place of employment. A questionnaire measuring the degree of assertiveness in professional environments was distributed to 75 nurses working in acute care settings in three Spanish hospitals. The results showed qualitative differences according to personal characteristics although these were not statistically significant, and 'a high percentage of nursing professionals showed low degrees of assertiveness' (Jaime et al. 1998:98). The researchers concluded that given the low degree of assertiveness in the research sample, assertiveness training was necessary to improve the quality of health care.
Their conclusions assume that caring and assertiveness are linked and that assertiveness is essential in the provision of quality nursing care.

In summary, nursing research literature emphasises the need for nurses to become more assertive and to acquire the necessary knowledge and skills to make nurses' assertiveness more apparent in their workplaces.

**METHODOLOGY**

In qualitative research, methodology usually means the theoretical assumptions of how knowledge is generated and validated, which underlie the choice of methods. Given the collaborative nature of the project, a qualitative approach was chosen, informed by reflective practitioner concepts and action research.

**Reflective practice**

Taylor (2000: 3) defines reflection as 'the throwing back of thoughts and memories, in cognitive acts such as thinking, contemplation, meditation and any other form of attentive consideration, in order to make sense of them and to make contextually appropriate changes if they are required'. Schön (1983) emphasised the idea that reflection is a way in which professionals can bridge the theory–practice gap, based on the potential of reflection to uncover knowledge in and on action. He referred to tacit knowledge, or knowing in action, as the kind of knowledge of which practitioners may not be entirely aware. When practitioners/clinicians, such as nurses, are coached to make explicit their knowing-in-action, they can inevitably use this awareness to enliven and change their practice (Schön 1987).

Nursing has applied reflective practice ideas to many of its disciplinary areas. In particular, nursing has used reflective processes for some time, for example, to improve practice and practice development (Johns 2003; Stickley & Freshwater 2002; Thorpe & Barsky 2001; Taylor 2000, 2002a, b), clinical supervision (Gilbert 2001; Heath & Freshwater 2000; Todd & Freshwater 1999), and education (Anderson & Branch 2000; Clegg 2000; Cruickshank 1996; Freshwater 1999; Kim 1999; Plazter et al. 2000). Much of the literature focuses on the work of nursing as practised in clinical contexts (e.g., Freshwater 1998, 2002; Glaze 1999; Heath 1998a, b; Johns 2000, 2003; Taylor 2004, 2003, 2002a, b; Wilkin 2002).

**Action research**

Action research involves four stages of collectively planning, acting, observing and reflecting (Dick 1995; Stringer 1996). This phase leads to another cycle of action in which the plan is revised, and further acting, observing and reflecting is undertaken systematically to work towards solutions to problems of a technical, practical or emancipatory nature (Kemmis & McTaggart 1988; Taylor 2000).

Nurses have been using action research successfully in a variety of settings focusing on differing thematic concerns (e.g., Keatinge et al. 2000; Koch, Kralik & Kelly 2000; Chenoweth & Kilstoff 1998). Action research and reflective processes combine well methodologically because of their common interest in making sense of experiences, in order to progress to deeper insights and personal and professional changes. Research using action research and reflection has been successful in giving nurses contextual answers to practice issues such as dysfunctional nurse–nurse relationships (Taylor 2001b) and nurses' tendencies towards idealism in palliative care (Taylor et al. 2002).

**ACCESSING PARTICIPANTS**

**Ethical implications**

Full ethical clearance from the University and the Health Campus Research Committee preceded the commencement of the project. As this research encouraged nurses to share their practice stories, likely risks were that the privacy and confidentiality of patients may have been...
breached and that nurses may have felt vulnera­
ble in sharing their experiences, leading to
embarrassment or possible emotional catharsis,
such as tearfulness or anger. No group member
became emotionally upset beyond the ability of
the group to support them and, although the
project provided professional counselling at no
cost to self, no participant required this service.

Nurses are educated in the need for patient
confidentiality and they practice it daily in their
work. Even so, the researcher ensured that pri­
vacy and confidentiality measures were institut­
ed and maintained. Stories written in journals
and shared in group meetings were devoid of
information which could identify patients, rela­
tives and staff. Pseudonyms were used and iden­
tifying material was omitted or renamed to
protect the identities of people within the writ­
ten transcripts of the stories. Reflective journals
remained the personal property of participants
and they were not be read or sighted by the
researcher unless it was a participant’s expressed
wish that this occurred. Reports and published
material describe the participants’ stories and
interpretations, according to the issues they
raised and the practice improvements they
caused, rather than to identify specific people,
places and situations.

Participant recruitment
A verbal and written explanation of the project
was given by the researcher at a regular meeting
of the Registered Nurses (RNs) working at the
hospital. Convenience sampling was used to tar­
get intentionally RNs interested in reflecting on
their practice in order to improve it. Four RNs
agreed to participate: three females and one
male, from 30 to 45 years of age, with from 10
to 15 years of clinical nursing experience.

Data collection and analysis
Over a 17-week period, the four RNs met
weekly with the researcher/facilitator for one
hour to discuss clinical problems raised by them
in their journal writing and group discussion.

The sequence of research activities was based
on previous projects (Taylor 2001a,b). The data
collection activities were embedded in the
group processes and they were that:
• RNs were given opportunities to write jour­
nal reflections of practice experiences, by
using participant observation during the nor­
mal course of their work in ward areas. As
with all nursing care, the details of patients’
care were completely confidential.
• the reflections were shared in the group
meetings.
• the individual and the group critically
analysed the content of all the shared practice
stories and identified common themes and
issues in nursing practice (Taylor 2000). This
means that the participants collectively dis­
cussed issues raised in the stories, decided on
the specific nature of issues and named those
issues as research themes.
• a theme common to all of the reflections was
identified as the thematic concern (issue) as a
focus for the group. The thematic concern
was the need for assertion in workplace com­
munication.
• an action cycle of planning, assessing, observ­
ing and reflecting generated an action plan
for addressing and amending the identified
thematic concern.
• the action plan was instituted in nursing
practice and the results of the changed
approach to the thematic concern were
noted, through continued planning, acting,
observing and reflecting.
• the action plan underwent revision until it
achieved positive changes in successfully
managing the identified thematic concern of
assertion in nursing practice.

RESEARCH PHASES
The research period occurred in five main
phases:
• introductory processes;
• reflections on practice stories;
• locating a thematic concern;
• generating, applying and revising the action plan; and
• improving assertion through reflective practice.

Phase One: Introductory processes
The introductory processes were from the first to third meeting inclusive. In the first meeting, each participant received a folder containing documents relating to the research. Participants read the Plain Language Statement about the research and signed the Consent Form. Participants began talking about themselves, especially where they work and what they hoped to achieve from the research. The researcher/facilitator gave a brief introduction to the main ideas within action research and reflective practice and how the two combine well for research into nursing practice. Participants discussed the group processes and agreed that they would like to be uninterrupted when telling a story, and expressed the wish for confidentiality in the group to be maintained to develop trust in the group and to encourage disclosure. Participants decided to meet weekly at the same day and time and to use videoconferencing sometimes, to reduce the researcher/facilitator’s road travel.

The second meeting was by videoconferencing and each participant spoke informally about their week and how they were feeling generally. This became an informal check-in 'icebreaker' each week. Participants were concerned about having relatively little knowledge of research so they were assured that the process would be instructive in collaborative research processes. Participants were asked to reflect on the following questions: Who influenced my childhood (people, organisations, etc)? What rules for living did I learn? How have these rules for living influenced my nursing practice? Participants responded spontaneously to these questions and they agreed to reflect on these questions during the week.

In the third meeting, it was reiterated that no person’s name would appear in research reports of publications and that the use of a ‘split pronoun’ approach (s/he) to writing would hide the identity of the only male in the group. Participants read the Agendas and Minutes of the previous meetings and noted handouts on ‘Some Background on Research and Reflection’, and the first reflective task of reflecting on childhood influences. Participants shared some of their thoughts on the introductory reflecting task. For example: A participant recognised personal difficulty in facing anger, relating to a work situation in which confrontation of an aggressive colleague was needed. The participant tried to secure a ‘win-win situation’ and remarked that it was important to be assertive in the situation, especially in light of how nurses might be perceived by other members of the multidisciplinary team. It was noted that ‘disciplines have different ways of communicating’ and that it is far easier to talk with nurse colleagues than it is with other professionals, such as teachers.

Phase Two: Reflections on practice stories
The second phase of reflecting on practice stories was from the fourth to seventh meeting inclusive. In the fourth meeting, participants began sharing their practice stories. For example, a participant shared a story of being called urgently to a medical ward by some nurses and s/he did not know why, but guessed it related to a clinical situation. When s/he arrived, there was a young male patient in distress, 'in a dreadful situation'. He was 'clammy, pale' and had a tracheostomy. S/he assessed that the mucous coming copiously through his mouth and tracheostomy tube was indicative of pulmonary oedema. At first s/he thought: ‘What am I doing here? I don’t know what to do’, but the ‘old ICU nurse kicked in’ and s/he took control of the situation and organised the emergency care and medical assistance. Since that time, s/he has used that scenario to ‘highlight the case’ in the hospital, but s/he has felt powerless...
to cause changes as 'some people have a strangle hold on the decisions'. S/he also commented that s/he was careful not to blame the nurses in the situation, but wondered why they were 'trying to hide' their lack of knowledge of what to do and whether they were 'scared of getting into trouble for doing something wrong, even though they had done nothing wrong'.

This led to a conversation of how nurses are in life/death situations with so much to know in order to act quickly to be effective clinically. The researcher/facilitator suggested that the participant who shared the story raise as many questions as s/he can about the situation and personal responses to it, but to leave the questions open-ended and unanswered. Another participant commented that, especially at acute ward level, nurses are quick to notice other nurses' mistakes but do not tend to give praise to one another.

In the fifth meeting, participants spoke briefly about some reflections on the story of the acutely ill male patient with pulmonary oedema and other questions that might be asked about the story. Participants continued sharing their practice stories. A practice story related to a busy shift in ICLI, when a child with acute leukaemia was admitted. The participant told of the 'terror' that s/he feels when a sick child comes in, relating the sense of responsibility it creates. The participant was relieved when the child's care was allocated to a senior nurse who s/he felt could 'handle it' when the child needed a platelet transfusion. The participant expressed the need s/he felt to check on the infusion procedure for platelets, sensing that the nurse may not have been aware of how to do the task properly. The information was not in the ward so s/he went to locate it elsewhere. The platelets had come from hundreds of kilometres away, the 'child's parents were there', the ICU was fairly silent, 'the platelets were not going through' and the participant feared the platelets would soon be coagulating. As the nurse in charge of that shift, the participant took control of the situation by quietly suggesting to the nurse that s/he get another filter, while the participant gently moved the platelets in the transfusion bag to minimise coagulation. The participant expressed feelings of increasing stress, especially as the parents asked if anything was wrong, and s/he 'covered up' by replying that it was a faulty filter. The after hours NUM was contacted by phone and s/he 'was not impressed' having to find another filter and asked why it was necessary. The participant could not speak out loud on the phone as the ward was quiet and the parents were listening. The participant thought: 'Why couldn't she (the nurse caring for the child) admit she didn't know (how to prepare the filter)? What do the parents think?' After the story the participant asked herself: 'Why do I take so much responsibility for others?' The participant felt so annoyed at the nurse for not speaking up and admitting that she did not know how to prepare the filter, as it would have saved so much time, energy and worry.

A participant commented that nursing is a job in which nurses are 'under scrutiny and pressure'. The researcher/facilitator guided the storytelling participant through questions as prompts to get to a deeper level of reflection on the incident. Where do my ideas come from historically? In other words, what are the values you hold about nursing practice and from where do your values come? The participant expressed a belief in the need for quality care, and for maintaining a professional image of nursing. In the past, s/he has 'seen things done badly,' 'incorrectly' and s/he imagined what it might be like to be 'in the same predicament'. What do I continue to use these values in my work? 'It's just me - I just want a good outcome'. Whose interests do these values serve? In other words, who benefits? 'Me and the broader image of nursing - I guess I'm modelling the image (I want for nursing)'. What power relations were involved in the story? 'This nurse is close to (someone in authority)'. The participant realised s/he stayed quiet in not asking the
nurse in the story if she knew the correct procedure for the filter, because of implicit power relations, even though the participant was in charge of the shift and s/he felt 'it reflected badly' on her/his ability to 'handle the shift'.

In the sixth and seventh meetings, participants continued to share practice stories and to work through deeper levels of reflection and meaning by posing questions to themselves about their personal and professional values and interests.

Phase Three: Locating a thematic concern
Phase Three lasted from meetings eight to 11 inclusive. After many practice stories were shared in the second phase, it was time to locate a common interest on which all of the participants could reflect and use an action research approach to explore more deeply. In the eight and ninth meeting, participants examined a Table of practice stories to locate issues and themes within them. Participants discussed issues and interests that arose: for example, their reactions to suicide of clients and acquaintances, the relative usefulness of being under scrutiny and pressure in nursing work, the inexplicability of nurses' intuition, and the role of consumer representatives in bringing about policy changes.

In the tenth meeting, participants listed the issues/themes generated in the group as: assertiveness/confusion/conformity; bullying and horizontal violence; Aboriginal issues; professional protection of self and others; professional competency of self and others; slow change; having a sense of belonging; being under scrutiny and pressure, documentation issues; self blame and perfection; autonomy versus duty of care; and role clarification/role valuing.

In the next meeting (11), participants agreed that they would work as a whole group and needed to find a thematic concern that was sufficiently generic to their practice so that they could all see improvements in that area. After much fruitful discussion, the group decided that the area most common to them all, with the best chance of creating practice improvements, was the thematic concern of assertiveness/confusion/conf ormity. As participants had not checked their understanding of what each person meant by assertion, they defined it individually so that the group had a working definition. The responses were that assertion is about:

Participant 1: 'valuing others' opinions' while 'giving one's own opinion', and 'not being scared' to do so.

Participant 2: 'not being passive' but 'not being aggressive', so there is 'balance and a middle ground'. It is 'me challenging myself'. I prepare myself emotionally and usually say: 'I feel that ...', 'I would prefer that ...'.

Participant 3: being at a similar level to make eye contact, not towering over or being towered over; with attention to appropriate use of personal space. It involves having an 'internal conversation' to 'make sense' of the concern and 'to get it out in the right way'. It involves honesty in what I am saying and feeling, and having self respect and self esteem, to 'not let people tread all over me'.

Participant 4: an issue of equality, of feeling valued and of feeling I have an opinion worth telling others, and having them listen. It reflects confidence, and the need to let go of emotions, to find a common ground.

In discussion, participants noted that assertion is context-specific, in that it depends on the situation as to how nurses react and 'find voice' at that time. Participants spoke of trying to learn to listen, taking extra breaths before speaking and not making preconceived conclusions to assist assertive communication. We needed to take a two-week break from meetings so participants agreed to do some 'homework' reflecting
on what is useful and not useful about assertion, and on practice scenarios when they were assertive and it went well, and when assertive attempts did not go well.

**Phase Four: Generating, applying and revising an action plan**

Phase Four lasted from meeting 12 to 14 inclusive. In meeting 12, the group noted that they often have opportunities in their work to assert themselves by confronting issues as they occur, thereby choosing to avoid conformity and not speaking up. They discussed their reflections about what is useful and not so useful about assertion by reflecting on practice situations. As each person spoke, other participants responded and encouraged openness in a trusting group process.

For example, a participant said that s/he has been giving the matter a lot of thought and had realised that assertion is the 'initiation tool to get things started' as 'it is the starting point of collaboration' within the multidisciplinary team. If the timing is not right, assertion loses its impact. If the timing of assertion is wrong, the assertive attempt 'comes off the wrong way'. Courage and timing are needed to get assertive attempts just right so they have maximal impact. This point led to further comments by other group members, such as: 'In the consultation role, timing is important ... it is important not to patronise'. 'Experienced health care staff already have considerable communicative skills, and poorly timed or initiated attempts to assert may be interpreted as patronising'.

The group then moved onto the next part of the process which was to brainstorm ideas for strategies for making assertion more effective. Given that brainstorming allows all ideas to be heard and noted, the original list was unedited and it contained some accompanying discussion that arose at the time the ideas were shared.

In meeting 13, discussion continued about the 'pros and cons' of assertion and whether the action plan had been helpful to participants during the previous week at work. For example, a participant said that s/he experienced an effective assertive episode when s/he confronted a staff member who 'used to undermine' her. S/he 'pulled her aside quietly' and 'privately told her how s/he felt. The person hearing the message received it well and expressed surprise that she had that effect on the participant. 'Things have been great since'. The participant reflected that s/he had 'rehearsed' the scenario and that s/he was pleased it went well. This discussion led to the insight that nurses need not only to maintain basic courtesies in assertive attempts, they must also maintain their self respect and to remind themselves that they are worthy as nurses and people. Following discussion, the action plan was amended to the second and final version.

**ACTION PLAN: Strategies for improving assertion at work**

1. Ask: 'What are the real issues? What do I need to communicate effectively?'
2. Bring energy to the job. Don't go to work tired, or sick, or with personal issues getting in the way — that is, be feeling OK when you go to work, to give it your full attention.
3. Get your emotions under control — that is, be aware of your bodily responses to assertive opportunities, such as to note your heart rate is telling you it is important to speak, wait your turn, and then speak.
4. Get the facts ready — don’t go off ‘half-cocked’.
5. Find a good place to talk if possible, for example, not on the move and walking in a busy and noisy setting. Suggest a time to talk and go aside into a quiet environment.
6. If an ideal time and place is not possible for effective communication, gauge the responsiveness of the other person and decide whether to speak up at that time, or to wait until a more conducive moment.
7. Timing is important, so it may be better to
wait to communicate an assertive position. For example, in professional group meetings when issues arise, it may be better to wait, recognising the limitations of the context.

8. Effective assertion requires a listener. The person to whom you are communicating needs to know who you are and why they should listen to you. Introduce yourself and make sure the person knows who you are, how you fit into the scheme of things, and how you have the capacity to represent clients’ needs and issues.

9. Recognise the communication style of the other person, as little may be achieved if there is aggression and firmly held misconceptions.

10. When meeting with other people who are not in your immediate disciplinary group, to minimise misinterpretations based on lack of understanding of roles and intentions, sit down and begin by asking people about their priorities, specifically what they hope to achieve in the meeting – that is, their objectives – before conveying your own. In this way, it is possible to clarify intentions and expectations, and to see if objectives match, and thereby ascertain ‘the angle people are coming from’.

11. Be prepared to ‘go it alone’ without backup and support, when asserting a position.

12. Maintain basic courtesies, such as conveying respect, by addressing the person by name and title.

13. Maintain your self-respect and remind yourself that you are worthy as a nurse and person.

14. Remember that communication has many modes such as face-to-face, emails, letters, phone calls, etc, and that all of these communication modes are important opportunities for assertion.

15. Use ongoing reflection and educational opportunities to further develop knowledge and skills in assertion.

By meeting 14, participants were well into the action research part of the project because they were actively enlisting the action plan and refining it through practice reflections. For example, a participant told of a situation involving a student who had been at the hospital for 10 days of clinical placement and wanted the participant to write a report on her abilities. The student was ‘looking pleadingly’ at the participant. In this case, the participant asserted that s/he could not in all fairness write a report based on one day of observation of her practice, so s/he referred her to another staff member in a better position to comment. The participant said that, at work, s/he was aware of the group’s research discussions and the action plan, and s/he kept thinking: ‘Assertion!’

Phase Five: Improving assertion through reflective practice

In the last phase from meetings 15 to 17 inclusive, participants continued to share practice stories and insights related to assertiveness. For example, a participant shared a practice story of how s/he applied some principles learned in a Tai Chi workshop to a clinical situation, specifically to become ready for assertiveness. For example, a young female patient was in need of a stay in a clinical support unit before being allocated support accommodation. Frequent previous attempts to secure the admission to the clinical unit had been unsuccessful because of ‘a huge waiting list’. The participant phoned the doctor and, in a ‘relaxed’ manner, laid out the situation and ‘put it in terms of pressure of beds, and as advantages for the young female and also for the unit’. S/he emphasised improved outcomes and was successful in securing short-term admission that day, to her/his ‘amazement’. When the group discussed the story, they focussed on tone of voice on the phone when transmitting an assertive message. The ‘relaxed’ tone was because the participant thought the situation was hopeless so ‘there was nothing to lose by another plea’. Participants
agreed that if they are too earnest in their requests, the voice can become crackly and does not sound assertive. In addition, a participant noted that if s/he is out of breath, confidence decreases.

The last meeting (17) was by teleconference and the group shared practice stories and insights. Finally, the participants shared their experiences of being involved in the action research and reflection project, and their responses were:

I found the process interesting … especially in how to go about research … the steps involved. I found that I have a lot of stuff buried inside … I remembered practice stories from long ago and they are still stirring up so much, that is surprising … I need to deal with it (the practice experiences) … I enjoyed talking at a deep level. I can see my work experiences are full of opportunities for research. I enjoyed the team work and the friendship, trust and disclosure. (The participant talks regularly with a critical friend, to aid reflections on his/her practice.)

I really enjoyed the process. I was surprised by how I got into the reflection and I continued writing personal reflections. I did a lot of personal journaling at home and (a family member) enjoyed the insights into my life s/he did not know before. When I put pen to paper I was amazed at how the details came flooding back – the smells, emotions, feelings. It made me sit back and reflect about work … being (myself) I put my head down and got on with things. I tend to be a happy person and to dwell on things … being reflective is a positive way of dwelling on things … I enjoyed researching with three other experienced nurses and fitting in … with the others (participants) and areas of conversations.

I am very practically minded and value commonsense … I am not academic and could see no benefit from doing research … I did not have the experience or maybe I was too lazy … It was so timely … when I heard it was action research – action and research! – I thought: ‘That sounds good! I have had experiences and I have something to say.’ The meetings have all been valuable … I now have a different spin on research and academic. This research can help my practice. I can see what I have learned here and I have put it into practice. I had only known about medical model research and it seemed too long. This action research is perfect for me, because of doing it (researching) in a group.

The most valuable aspects of the research for me has been the focus on practice reflection. I have used reflective journaling previously and always found it a useful tool, but in the day-to-day business I have been forgetting to incorporate reflection into my self-care. My wish is for all nurses to give reflective journaling a go at least once, particularly the analysis of the reflections. The research has reminded me to reintroduce reflection more regularly into my practice. The cohesive group we formed during the research process has been a highlight for me. At all times I felt safe to disclose my thoughts and the member’s discussion and comments have been both insightful and comforting. I believe the project has fostered the formation of new nursing bonds that can only be good for our profession.

The researcher/facilitator thanked the group for their comments and suggested that they now had the knowledge and skills to undertake action research themselves, whenever they had practice issues that need deeper attention.

**IMPLICATIONS AND CONCLUSION**

The implications of the research are that action research and reflection are practical research processes for nurses to examine their practice issues and to improve nursing care. The action
research and reflective practice approach can be used in a variety of ways to assist nurses to reflect on practice issues and care improvements. This project shed light on the need for assertiveness and ways in which to improve assertiveness at work.

The nurses in this research generated an action plan with practical strategies for improving assertiveness at work. The action plan is available to other nurses who may find it useful in improving their assertiveness at work. The implications of this research for nurse teachers are that assertiveness continues to be a difficult skill to enact in the immediacy of the workplace. The communication skills within the action plan from this research can be explored in experiential teaching sessions.

In conclusion, the nurses in this research realised that assertiveness is difficult, but that it is possible when a reflective approach is taken to practice. The implication of this research for other nurses with whom it resonates is that they too can make positive changes to their assertiveness, by paying focused attention to their daily work practices.

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ANNOUNCING

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