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L'analyse de la médiocrité des soins infirmiers dans les hôpitaux en Angleterre : une question politique

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Analysing poor nursing care in hospitals in England: The policy challenge

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ABSTRACT: There have been several high profile reports of poor nursing care in hospitals in England of late. Criticism of nursing has also featured prominently in the popular media. This paper examines the complex mix of contributory factors that have created this situation, and identifies the issues that need to be addressed if policy making in this area is to improve the situation. Action is required in a number of areas, including: strengthening ward leadership, introducing measures such as "intentional rounding", and acknowledging the "emotional labour" of caring, however many recommendations have centred on the education of nurses and seemingly overlooked these other crucial issues.

KEYWORDS: health care, organisation, health service staff

Introduction

We're looking here at nothing less than the crumbling of a sense of common humanity. And that is because nursing has been all but engulfed by a fundamental moral crisis Phillips (2011).

This is characteristic of a number of observations that have been made about the state of nursing care in hospitals in England of in the last few years, and reflects concerns about a decline in the quality of care. Much of the discussion has centred on identifying the causes of the fall in standards. However although the strident tenor of the debate, conducted largely through popular media outlets, has highlighted the issue, it has done little to explain the underlying causes or indeed signal a realistic solution. The purpose of this paper is to examine some of the factors that have contributed to nursing care becoming an issue of national attention; to summarise some of the explanations of this turn of events; and then to analyse a number of key issues which have been overlooked. The measures that

will be needed if a genuine solution is to be found are identified and presented in the discussion section to indicate the policy development needed in this area.

1. Background

There have been several high profile reports recording episodes of poor nursing care in England (Francis Inquiry 2013; The Health Service Ombudsman's report [Abraham 2011]; Maidstone and Tunbridge Wells [Healthcare Commission 2007]; and the Care Quality Commission report [Care Quality Commission 2011]. They catalogue a series of failures in patient care including inadequate pain relief, people not being helped with eating, drinking and toileting, dismissive attitudes from staff, and lack of dignity in care (Abraham 2011; CQC 2011). These "official" accounts of poor care have been accompanied by extensive commentary and condemnation in the wider media which attribute these failures to nurses being too educated to care (Marrin 2009), as part of a broader and deeper spiritual malaise whereby duty to others and respect for the innate humanity of people has been eroded by the "me society" of ruthless, self-centred individualism (Phillips 2011).

Although such concern is understandable, its focus on individual "uncaring" nurses (Odone 2011; Marrin 2009), and nursing, for pursuing a misguided feminist project (Phillips 2011a), has prevented detailed and constructive consideration of the issues. Even though it is conceded in a more measured recent campaign that "nobody is going to solve the crisis in 1000 words" (Patterson 2012), the tendency has been to sensationalise, rather than to analyse the "problem(s)". This paper examines six key issues which have received less attention, in order to identify the actions that need to be taken if care in hospitals in England is to be improved. The aim is to analyse the contributory factors and argue that it is important to make sense of the complex mix of issues that need to be addressed if policy making in this area is to improve the situation.

2. Critical Review

A critical review approach is taken combining the flexibility and rigour of a discursive analysis, in order that the breadth of relevant contributory material can be considered (McSherry et al 2012). Here the principles applied by McSherry et al (2012) provide a broad framework for analysing a number of key issues which are important in the debate about standards of nursing care in acute hospitals in England. Narrative synthesis, is widely used in nursing to examine issues where the relevant literature is made up of a range of different types of studies (Roberts and Bailey 2011; Vallido et al. 2010; Rattray and Hull 2008; Wiles et al. 2008). It brings together important issues or themes arising from that literature (Mays et al. 2005). This approach was taken in the analysis reported here. Literature located to inform a key policy paper (Sawbridge and Hewison 2011) was summarised and presented to a reference group of senior nurses (Sawbridge and Hewison 2011) to inform a

critical appraisal and thematic grouping of the key findings/perspectives reported in the papers (Price 2009, Hardy et al 2009). The three broad themes identified, were subsequently developed further to the six discussed below.

2.1. Hospital design-ward layouts.

There have been several major hospital building projects in England in recent years, which have directed attention to design (Gesler et al. 2004). The traditional design for hospitals was a number of single-sex, multi-bedded “Nightingale wards”, which usually had a nursing station at the end or middle of the ward. A benefit of this design was that the nurses could see, and be seen by, all the patients. However the requirement now is for multiple single-bedded rooms which help reduce hospital acquired infections, improve patient confidentiality and privacy, and lower noise levels (Ulrich et al 2004). However this has implications for practice. The lack of visibility of nurses resulting from this configuration has led to a need to modify practice so that purposeful, regular contact with patients is planned, rather than naturally occurring as in the past, to prevent patients feeling isolated and neglected. This has taken the form of “Intentional Rounding”, which originated in the USA where it had a positive impact on patients and staff (Meade *et al.* 2006), and has been adopted in a number of hospitals in the UK as “care rounds” and “comfort” rounds (NNRU 2012; Studer Group 2006).

Another consequence of the new designs was that patients were cared for in mixed sexed wards-a grouping of four bedded bays some containing men and some containing women-and patients sharing the same facilities. Patient concerns about this situation eventually led to a policy directive being issued to reduce mixed sex accommodation, reinforced in the Operating Framework which set targets to eliminate mixed sex accommodation in Trusts (DH 2010). This target would not have been necessary in the days of thirty bedded, single sex Nightingale wards, and serves to illustrate how hospital design (as with other management and policy decisions) can have unintended and unwelcome consequences.

2.2. The Ward Sister as a Clinical Leader

The role of the Ward Sister/Charge Nurse is acknowledged as “the linchpin of healthcare services” (Cole 2010, 6). There are three main components of the role (RCN 2009) being- a clinical nursing expert, a manager and leader of the ward team, and an educator (of nurses, other health care professionals, patients and carers). However the role is poorly defined, lacks support and post holders experience tensions being perceived as the clinical expert by nurses and doctors, and ward managers by the hospital executive (RCN 2009, 6).

Ward managers experience isolation and loneliness in balancing two competing paradigms of health care (one dominated by concerns about patient care, the other by management/economic priorities) (Westmoreland 1993). These pressures are played out at ward level where organisational factors such as the imposition of

unrealistic targets can impair the ability of staff to care (Thomas 2006). The change of title from Ward Sister/Charge Nurse to “Ward Manager” adds further dissonance concerning whether the main purpose of the role is leading clinical practice or ward leadership/management (RCN2009). Ward sisters/charge nurses rejected the title of “ward manager” because they wanted to “…manage their ward and ward team by a passion for nursing, rather than an aspiration or desire to be a manager per se”(6).

The international evidence confirms the centrality of the nurse leadership role. Relationship, or people focussed leadership improves the health and well-being of the nurses and outcomes for patients (Cummings et al. 2010). Positive relationships between nurses and their leaders result in empowerment, job satisfaction and improved patient care (Laschinger et al 2011; Salmela et al. 2012). This confirms that nursing leadership at ward and board level are full time occupations in their own right, which may not be apparent to policy makers and the public. The extensive evidence demonstrating the positive impact of transformational leadership in nursing on the quality of care, further emphaises its importance in this respect (see for example Cowden et al 2011, Nielson et al 2008, Duygulu. and Kublay 2010, Zydzlunaite and Lepainte 2013, Lievens and Vlerick 2014).

Ward Managers in the English NHS have many responsibilities which can divert their focus from professional practice, standards and the development of nursing. For example they have reported frustration that they have to deal with staff management issues, manage budgets and provide a constant stream of management information which limits their capacity to find time to be the clinical leader. They were also often held accountable for decisions which they did not have the authority to make (RCN2009). This makes the role unattractive with only 10 per cent of junior nurses interested in aspiring to be a Ward Manager because of the lack of direct patient contact; significant workload pressures; long hours, and poor pay (Wise 2007). In addition many ward sisters/charges nurses are paid at a rate equivalent to roles with much lower levels of responsibility (RCN 2009). This all serves to demonstrate how the role that is the most important in hospital nursing care (RCN 2009; Ogier 1982; Orton 2001; Pembrey 1980) is not adequately supported by the system to enable post-holders to focus on clinical care, nor is it sufficiently remunerated or rewarded at a level which encourages others to take it on.

2.3. Targets

Another factor affecting care is the proliferation of targets. The Health and Safety Executive (2001) noted the importance of measurement in developing a safe environment for care, citing Drucker (1993) who maintained you cannot manage what you cannot measure. The King’s Fund (2010) conducted an evaluation of NHS performance judged against a number of measures and concluded it had been largely successful in achieving the Government’s targets. Reducing waiting times from 18 months to 18 weeks for critical operations such as coronary artery

bypass surgery, for example. However it also identified “problems” with targets, particularly how they can affect behaviour and divert attention from clinical concerns. These included rushing to admit patients to in-patient beds to ensure that the maximum four hour wait target was met. This distorted practice with 66% of patients admitted from Accident and Emergency (A & E) in the last ten minutes prior to the expiry of the maximum four hour wait period (King’s Fund 2010). With regard to the general waiting time target a survey of consultants in eight NHS trusts a “significant minority” of those who responded felt attempts to meet maximum waiting time targets clashed with their own clinical judgments of when to admit patients from waiting lists (Kings Fund 2010). This can have serious consequences such as at the Mid Staffordshire NHS Foundation Trust where it was found that over-reliance on process measures and targets adversely affected the quality of patient services (Colin-Thomé 2009; Francis 2013). Thus a focus on targets can have an undesirable effect on behaviour (Bevan and Hood 2006; King’s Fund 2010). When simple quantitative targets dominate, it creates difficulties for nurses as their prime function is to deliver compassionate care, which can be difficult to describe and measure in quantitative terms. While performance targets can help improve services, particularly in relation to waiting times, they can also lead to unintended consequences including the distortion of clinical priorities and the neglect of other non-targeted activities. This is perhaps more an outcome of how the targets were implemented and enforced, rather than problems with targets more generally (Francis 2013; King’s Fund 2010).

2.4. Organisational culture

Targets are part of the wider culture, and its importance in determining the way organisations function is a central concern in management (Collins 1998). It has been the focus of extensive empirical study in the English NHS and although it is complex and defies simple categorization it can contribute to the development of means of measuring the quality of care provided (Mannion et al. 2010). For example, the value given to patient safety and staff well-being by senior staff - and particularly by the Chief Executive - is reflected throughout the culture of the organisation (McKee et al. 2010). It is beyond the scope of this review to examine the vast amount of literature which addresses organisational culture in health care (see Mannion et al 2005;Scott et al 2003; Konteh, Dixon-Woods et al 2013 for helpful reviews). However it is important to note its influence on the way nurses deliver care as this is a crucial determinant of quality. For example the “Magnet Accreditation” approach which assigns a rating to hospitals, mainly in the United States, which have an identified set of measures in place to support staff in the delivery of quality care, demonstrates how the right culture can be developed and measured (see for example Aiken et al 2008, Drenkard 2010, Spence-Laschinger et al 2003, Kelly et al 2011). Similarly the Boorman review (DH 2009), calculated the economic costs of staff stress and called on Trusts to implement staff well-being strategies, and

West and Dawson concluded "When we care for staff, they can fulfil their calling of providing outstanding professional care for patients" (West and Dawson 2011, 7).

2.5. Pre-registration Nurse Education

There has been considerable debate in the medical (Delamonthe 2011) and popular press (Templeton 2004) about pre-registration nurse education and its failure to produce nurses able to deliver compassionate care, much of it condemning the reforms of the education system of the 1980s and 1990s (Patterson 2012 Marrin, 2009). The history of formal and regulated nurse training began with the Nightingale Model (Baly 1997) with nurse training schools housed in individual hospitals. Students were apprentices, and worked on the wards and departments as part of the staffing establishment (Moores and Moult 1979). It was criticized for exploiting students as low paid workers, and there was a need for change as the traditional pool of entrants for nurse training, young women, could find many more appealing employment and education opportunities as society progressed. This resulted in a fall in student nurse recruitment (Menzies 1960, United Kingdom Central Council for Nursing, Midwifery and Health Visiting [UKCC] 1986). In response Project 2000 introduced major changes in student nurse training (UKCC 1986). The aim of the reforms was to produce "knowledgeable doers" with the confidence and motivation to practice in a changing environment (UKCC 1985). A Diploma qualification, studied at universities, supplanted the certificate awarded by the nursing schools. Nursing students became "supernumerary" during practice placements (often misconstrued as "observation only"). So rather than being in "school" for 30 weeks out of the total 156 of their training, nurses now spent 40% of their time at University and 60% in practice (Smith 2012). This was later adjusted to a 50/50 ratio equating to 2300 hours theory and 2300 hours practice (NMC 2004; UKCC 1999).

Although concerns have been expressed about nurse education (Marrin 2009) and that it contributes to poor care, there is evidence which links higher education with improved outcomes for patients (McKenna et al 2006). Similarly Maben and Griffiths (2008) found there is no evidence to support the anecdotal view that educating nurses is linked to the "loss" of caring. They found degree educated nurses are competent and caring. Although data on nurses" qualifications are not held centrally, around 30 per cent of nurses in the UK are estimated to have a degree (Gough and Masterson 2010). In October 2008 the Nursing and Midwifery Council ruled that England be brought in line with the rest of the UK nurse education system and the minimum academic level for pre-registration nursing education would be a degree. Consequently, since September 2013, only degree level pre-registration nursing programmes have been approved (NMC 2011). This development has been greeted with admiration in the USA by campaigners seeking to increase the number of nurses trained at Baccalaureate level from the current level of 50 per cent to 80 per cent of the workforce by 2020, in order to meet the healthcare needs of an ageing population (IoM 2010). Moreover a recent review concluded there were no

major shortcomings in nursing education that could be held directly responsible for poor practice or the perceived decline in standards of care. Nor did it find any evidence that degree-level registration was damaging to patient care. Indeed, it stated that graduate nurses have played a key role in driving up standards (RCN 2012), and so singling out of pre-registration education as a "cause" of poor care is misconceived.

2.6. Emotional labour of care

The role of nurses in supporting people at vulnerable times in their life is another important issue in this discussion. Their "work involves carrying out tasks which, by ordinary standards, are distasteful, disgusting and frightening" (Menzies 1960, p97), and they provide continuous care for patients, day and night, all the year round, bearing the full, immediate, and concentrated impact of stresses arising from care (Menzies 1960).

Work exploring the reality of caring used the concept of Emotional Labour, to explain student nurses" experience (Smith 1992). It is "the induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial safe place" (Hochschild 1983, 7). As a conceptual device linking caring and learning, Smith (2012) contends it is as relevant today as when it was first proposed. It has been applied by James (1989), for example, who refined it to incorporate carework emphasizing the "labour" element of the emotional component of care, finding it was greater than hard physical work (James 1989). It has also been found that emotion in nursing is rendered invisible, is not managed and the dissonance caused by the constant suppression of powerful emotions can lead to burnout (Gray and Smith 2009), and result in nurses changing from being positive and caring to becoming negative and uncaring (Vaughan and Pilmoor 1989).

This problem has been exacerbated by the removal of organizational measures that once served to help nurses manage their emotional labour. "Task allocation" as a means of organising care work into discrete activities, enabled nurses to maintain a level of emotional detachment and protection (Menzies 1960). The introduction of the nursing process and its emphasis on individualized care (Smith 1992 p39), meant nurses were required to care "holistically" and build personal relationships with patients. Similarly changes to shift handover arrangements, with many now taking place at the bed-side rather than in an office, removed an opportunity for nurses to alleviate stress through sharing "vocabularies of complaint" (Turner 1987) about their work in private. There is a strong emotional cost to caring, which is rarely discussed. This, and the other areas identified in the review are now discussed in order to identify potential policy solutions.

3. Discussion

The review indicates that poor care is the result of a combination of factors. Attributing it to a single cause such as “uncaring nurses” or “the education system” is simplistic and unhelpful. If the complex mix of issues that contribute to poor care is to be addressed, then action is required in a number of areas. The changes to the physical environment of the acute ward which have had a negative impact on caring in some settings, may be ameliorated by the introduction of “Intentional Rounding” which has the potential to overcome the constraints of the new environments and enable nurses to improve the care they provide for patients (NNRU 2012). However, it is vital the focus is on the relational aspects of care and do not become a superficial tick box exercise to simply record that patients have been observed.

Central to this is the role of the ward sister/leader. The erosion of the clinical and ward leadership role of the ward sister/charge nurse (RCN 2009) has resulted in the leadership of care becoming diffuse (Hewison 2013). Policy reviews (DH 2011, 2010a) have recommended that ward leadership be strengthened and that ward managers be given time to lead and bureaucratic tasks reduced so they can supervise staff and the delivery of care (DH 2011). Furthermore leaders focused on organising and co-ordinating the ward, supporting staff, talking to patients and their families, will build good team dynamics and improve care outcomes (DH 2012a). Recommendations are also made that leaders be “supernumerary”, and have the time to lead their authority over all matters of ward organization be reinstated, and have leadership development support to enable them to lead care (DH 2012a). There has been some progress in this respect with the establishment of the NHS Leadership Academy (Dawson et al 2009) and the evidence for the impact of this investment in leadership will emerge in due course.

These measures need to be underpinned by a fundamental change in culture so that as well as ensuring government targets are achieved, a focus is maintained on the importance of care (Francis 2013; Berwick 2013). Action at Board level is required (Burdett Trust for Nursing 2006a, 2006b). In the early days of targets and the developing performance regime in the NHS, there was little that related to outcomes for patients, or focused on nursing care specifically. To redress this and ensure that nursing can be measured, managed and improved, the development of “clinical dashboards”, informed by national metrics which capture a range of nursing measures including falls rates, nutrition and patient experience measures (Griffiths et al. 2008), should be developed further and used more widely. This can help build a culture in which nursing care is seen as central and equally important as economic and other numerical targets. In addition the Chief Nurse for England has developed the 6Cs (DH 2012b) of care, compassion, commitment, courage, communication and competence to guide the organisation and delivery of care and recommended that they are embedded in all nursing and midwifery university education and training.

Finally recognition of the emotional content of care would contribute to this change in culture. A range of support systems for staff including the Schwartz Center Rounds, which involve facilitated multidisciplinary discussion about the impact patient care has on healthcare professionals, have had a positive effect with staff feeling more supported and less isolated (Goodrich 2011). Another approach is restorative supervision, which has been introduced in health visiting, and reduced "Burnout" by 36% and stress by 59% (Wallbank and Preece 2010). If similar results could be achieved throughout nursing, then the capacity to care can be enhanced.

4. Conclusion

This critical review has demonstrated that the delivery of poor nursing occurs as a result of a combination of factors, and that if genuine solutions are to be found then seeking a "quick" or indeed single fix is misguided. Changes in the way care is organised in response to new challenges are required, such as re-introducing care rounds. In addition action to strengthen the role of the ward sister/charge nurses as the leader of care is needed. However changing the culture of nursing to rediscover the importance of care will take time and sustained action on the part of all health care staff and indeed the government. This needs to be underpinned by systems of support for nurses, embedded in organizations, so that they are able to care for others. Action is needed on all these fronts if the policy and professional challenge of eliminating poor care is to be met.

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Résumé • Mots-clés

L'analyse de la médiocrité des soins infirmiers dans les hôpitaux en Angleterre : une question politique

RÉSUMÉ : Plusieurs rapports de haut niveau ont relevé la médiocrité des soins infirmiers dans les hôpitaux en Angleterre. La critique des soins infirmiers a également figuré en bonne place dans les médias populaires. Cet article examine l'ensemble complexe de facteurs contributifs qui ont créé cette situation, et identifie les questions qui doivent être abordées si l'élaboration des politiques dans

ce domaine est d'améliorer la situation. Des mesures s'imposent sur un certain nombre de plans, notamment : le renforcement du leadership dans les services, l'introduction de mesures de rondes auprès des équipes soignantes, et une reconnaissance de la dimension émotionnelle du travail de care. Cependant, de nombreuses recommandations ont porté sur la formation infirmière tout en négligeant visiblement ces autres aspects cruciaux des questions soulevées.

MOTS-CLÉS : soins de santé, organisation, personnel médical