

LEARNING TO EMBODY PROFESSIONAL VALUES AMONG UK NURSING ASSOCIATES

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Abstract

The Nursing Associate is a new role within UK healthcare that entails a two year vocational undergraduate education pathway integrated with extensive front line clinical practice. The curriculum mirrors aspects of existing preregistration nursing programmes of which common features are regulation and development of professional attributes. Curriculum content includes teaching about such values with the intention of developing the students' knowledge and translating this until it becomes embodied in their practice.

A mixed methods survey study was designed to evaluate the extent to which this curriculum aim was being achieved to inform subsequent related teaching and learning interventions. The aim was to describe students' perceptions of developing as an honest, caring, compassionate, conscientious and competent nursing associate. Enquiry also included exploring students' perceptions of how this development is likely to impact on patient care as well as enablers and barriers to achieving fitness for practise in these 5 domains. Ethical approval was granted by the University of Bolton Faculty Research Ethics chairperson. Students from the first cohort of this new programme were invited to participate and complete the survey (n=68 with 57 participants). They were working in 4 different National Health Service Trusts. The survey had 4 dimensions – a self-rating scale of 5 professional domains and a free text counterpart in which respondents could explain why they had chosen that rating. A final section of the survey invited any further free text comment about factors enabling or posing a barrier to developing professional attributes.

Thematic analysis of qualitative comments was undertaken to generate findings. These showed that students expressed these attributes as a sense of being (already embodied) and also development (becoming) in so far as they had learnt more about what each attribute was and could recognise steps they had taken to move towards embodying the attribute. Some respondents also identified praxis – where real world practice fell short of their expectations, and a positive aspect was that they reported being courageous enough to challenge such mismatches.

Overall the findings suggest that the pedagogic design linking propositional knowledge to students' clinical work promoted reflection on real world practice experience was moving students towards developing professional attributes. It also highlighted differences in the degree of reflective insights students demonstrated about their own values, thus directing attention towards how this could be promoted as an essential skill within the curriculum. These findings provide the basis for informing tripartite (university student and service) working relationships, especially around challenging areas of concern to students and also how to draw role models from current practice into shared classroom teaching. Additionally it identified some factors that could be used to inform students' decision making to overcome barriers to developing these professional attributes.

Keywords: Nursing Associate, professional values, curriculum development.

1 INTRODUCTION

One of the fundamental aspects of effective health care provision is the recognition of the need for responsive change [1]. Epidemiological factors, demographics, political stance, technological advances, social mobility and economic variants within society exert a rapidly changing environment which subsequently challenges health care delivery and, innately, current educational systems for health care [2] [3]. Recent reports of failings within health care provision, particularly in relation to the nursing role, have provided a catalyst for the revision of educational programmes and development of new roles in practice [4]. Accordingly various reviews have been undertaken which explore the feasibility of, and conclude that, a second line nursing role would support and enable existing registered nurses to deliver high quality patient centred care [5].

Half of the 1.4 million people employees in the National Health Service (NHS) are in health care professional roles (2012) [6]. According to the NHS Confederation (2016) [7] between 2009 and 2015 there was a 0.7% annual rise in registered nursing staff (currently 314,966) and more people (348,999) employed in clinical support roles - such as health care support workers (HCSW). Their numbers were projected to increase 0.6% annually [7]. This sizeable unregistered nursing staff contribution to the NHS nursing workforce also extends into other allied sectors. Cavendish [8] identified that within health and social care there are approximately 1.3 million unregistered, frontline nursing staff delivering the bulk of patient care within the primary, secondary and independent sectors. Notably, evidence suggests that in many cases these unregistered staff are undertaking increasingly complex procedures, often without the level of knowledge and training required for safe and effective practice [9] [10]. This is evident in cases of deficient care previously highlighted in government led inquiries that drew attention to a definitive overall lack of education and training for unregistered staff [8] [11] [12].

The Francis Report (2013) [11] publicised serious care failings at a UK NHS hospital where several patients had died owing to substandard care [13]. The key findings recounted a catalogue of errors impacting patient care and safety and extended into allegations of abuse [11]. Primarily it was clear that the growing numbers of unregistered nurses and an increased demand on services from patients presenting with multiple complex illnesses had led to care being undertaken by unregistered staff [14], [15]. Conversely supervision from registered practitioners was erroneous, compounded by a lack of education and training being delivered from the employing organisation [16] [8]. Francis [11] further identified the development of an '*unacceptable culture*' whereby staff development and education was replaced in favour of organisations evidencing perceived acceptable staffing levels in the practice areas.

It is widely recognised by the World Health Organisation and the RCN that safe staffing levels have become a key focus across many organisations as a pre requisite to reducing patient harm [17] [18]. Furthermore it is no secret that measures to address a projected £22 billion saving across UK healthcare provision has been placed at the forefront of the political agenda [19] [20]. Anecdotal evidence suggests that unregistered staff have seemingly been placed at the forefront of care provision in a bid to alleviate the pressure on the staffing budgets [21]. However this concept has been viewed as a cost cutting exercise affording a false economy with evidence to suggest that it leads to a reduction in overall quality of care and increase in patient harm [10] [21]. Furthermore there is a plethora of research which compounds the concepts that high quality, cost effective care requires high quality, relevant education and training programmes for health care workers [12] [8] [5] [22].

In 2013 Professor Don Berwick, Professor Sir Bruce Keogh, Camilla Cavendish, Rt Hon Ann Clwyd MP and Professor Tricia Hart and the NHS Confederation were commissioned by the UK government to conduct further independent reviews into the findings of the Francis Report [11]. Berwick [23] concluded that the mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives. The NHS should become a learning organisation and its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS.

Despite growing evidence to support the need for a radical overview of the education and supervision of unregistered staff in practice a fragmented approach to educational programmes has been identified [24]. Furthermore a lack of education, training and development opportunities has been a key contributor to consistently poor quality of care [25].

A new Nursing Associate (NA) role has been developed for these reasons discussed above (failing care, fewer front line nurses and an inability to fill vacant posts). The University of Bolton is at the vanguard of educating the first cohort of NAs nationally and has programme aims of producing 'graduates' who embody the necessary professional values that were clearly demanded in the Francis and subsequent reports. These values are not a 'given' and professional behaviour needs to be articulated and demonstrated so students can demonstrate required values and behaviors based on thoughtful application of a defined knowledge and experience base.

The curriculum included education about professional values through patient-centered integrated learning, where students would think about recent practice and examine experience before being introduced to practice examples through a variety of means (Case studies, Problem based learning, Action learning sets, Group work- peer learning, group feedback and in-class discussion). This helped to identify learning to take forward so as to extend and develop their personal practice across a number of specific domains.

The first cohort of students commenced education in 2017 and as part of the ongoing evaluation of their developmental progress a small scale study was proposed to determine whether or not the knowledge,

learning and experience was helping students to recognize the development of professional values and to explore whether or not students reported that this was being translated into real-world practice.

2 METHODOLOGY

The research aims were to identify and describe students' perceptions of developing as an honest, caring, compassionate, conscientious and competent NA.

The objectives were

- (1) To survey participants' responses about development in the 5 domains (values) identified in the program aims.
- (2) Explore students' perception of how this development is likely to impact on patient care and
- (3) Explore students' views on enabler and barriers to achieving the NA role as being fit for practice in the 5 domains.

A mixed methods descriptive survey was designed to generate data. Two question sections asked students to rate and describe something about how the programme was developing their thinking about the domains (professional values) and then how it was developing their practice in those domains, i.e. exploring their learning about professional values and whether any learning was translating into personal practice. The final survey section sought free text insights into what students considered were barriers or enabling factors in developing professional values. The first two parts included self-rating five point nominal scales ('The programme is developing my appreciation of [a value] in practice' from strongly agree to strongly disagree) and 'The programme is impacting how I view and act with [value] in practice' (rated from 'No impact' to 'Impacts all of the time'). Each self-rating had a corresponding question seeking qualification of the choice of rating. Nominal data was tabulated to generate descriptive statistics and qualitative data was thematically analysed.

The study was granted ethical approval through the University of Bolton Faculty Research Ethics officer and comprised three principal stages as shown in Fig. 1. The sample group of participants was a NA group studying in year one of the programme. An information sheet about the study and consent form was distributed to this group during a classroom session in October 2017 and participation was entirely voluntary. A total of 56 students participated spanning ages 18-52 years, working in 4 NHS hospitals and their experience ranged from 1-20 years working in healthcare assistant roles. Fig 2.

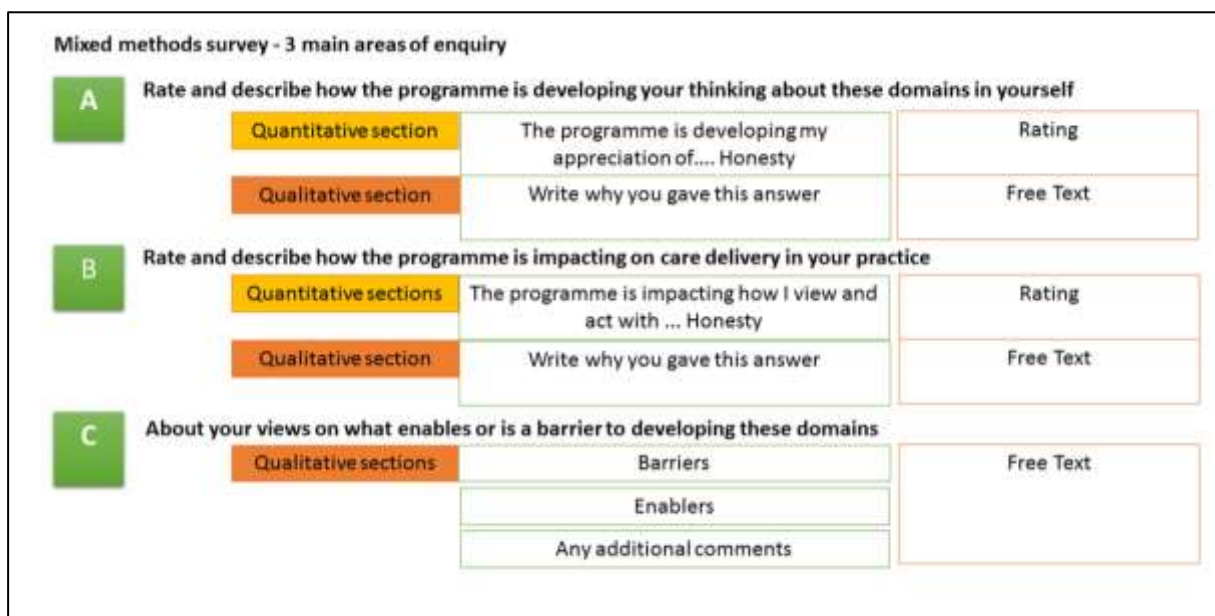


Figure 1 Overview of the survey design

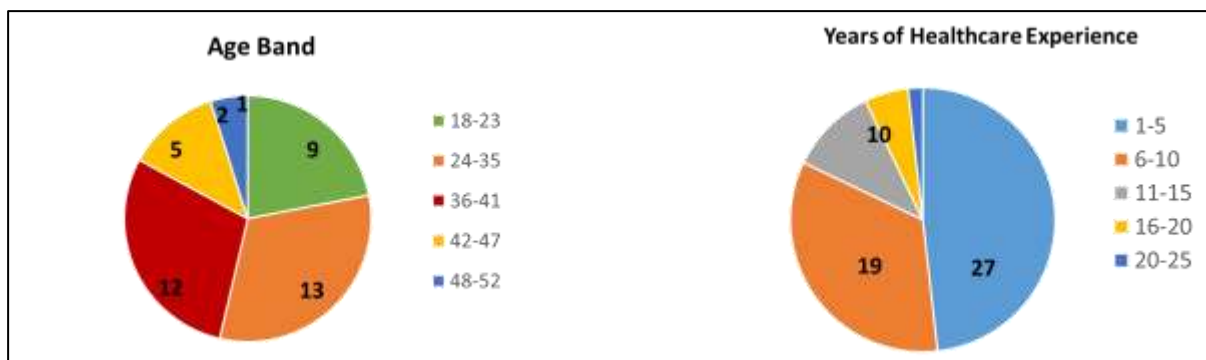


Figure 2 Respondent profile: Age bands and years of experience

3 RESULTS

The self-rating data showed some differences and whilst most reported that their education always or mostly impacted practice, it was not totally the case (Table 1) and the impact was only partial for each value (Table 2) with some students reporting no impact of the education on their values in practice.

Table 1 The programme is developing my appreciation of [value] in practice

Developing appreciation of...	HONEST	COMPASSIONATE	CONSCIENTIOUS	CARING	COMPETENT
Strongly Agree	25	36	30	37	36
Agree	23	17	25	11	18
Neither Agree or Disagree	7	2	0	7	0
Disagree	1	0	0	0	0
Strongly Disagree	0	0	0	0	0

Table 2 The programme is impacting how I view and act with [value] in practice

Impact of....	HONEST	COMPASSIONATE	CONSCIENTIOUS	CARING	COMPETENT
No Impact	6	6	4	7	2
Slight Impact	8	8	7	8	5
Impacts some of the time	1	1	3	3	2
Impacts most of the time	8	8	9	6	8
Impacts all of the time	31	31	32	31	37

3.1 Reported views on professional values

For each value there was always a cluster or respondents who claimed that the value was a given (i.e. it was something they were and embodied as an individual). Others rated themselves as having space to develop the values and their application to practice.

3.1.1 Honesty

Honesty was a given for some and for others the course was highlighting it as a journey from their current state of being to appreciating honesty and duty of candour as qualities to develop. Honesty was also reported as a selective act shaped by the context of care. Reported comments alluded to being:

'selectively honest', and: 'keeping quiet', especially where the response to being honest could be negative.

The impact of honesty on practice revealed the importance of patient care situations that required advocacy, such as speaking up to reduce risks to others, protecting patients and so contributing to improving the patient experience. In this way being honest was expressed as making a difference in front line care. However the context of honesty was raised and alluded to organisational values and building relationships. Thus there was an indication of decision making being shaped about whether to and when to exercise a duty of candour, and when the context curtailed the intention to act in that way.

3.1.2 Compassion

Developing compassion was for some a given state – it was how they perceived themselves and was therefore a position from which they could evaluate where it was lacking in some others in the workforce. There was a division between those who regarded themselves as compassionate: '*one of my best known qualities*' and those who can: '*reflectively learn to be more compassionate.*' It was typically seen as important and recognised for its impact on patients.

Overall studying compassion was helping some to: '*think differently*' and contributed to: '*changing views*' in terms of being: '*non-judgemental*' and having: '*more empathy*' and: '*a better understanding*' that contributed to being: '*more aware of showing compassion in practice*'.

If learning to be more compassionate was evidenced amongst some students, then the impact on practice was also informative. It was important to the (NA) role and included seeing the patient in an holistic rather than objectified way. This translated into acknowledging diversity of the individual and not acting in a discriminatory way. This also helped to develop a trusting therapeutic relationship as part of advocacy. Whilst some respondents considered themselves to be: '*always compassionate*', others regarded this as a developmental process. A minority referred to resource limited contexts that inhibited compassionate behaviour and curiously when it was deemed appropriate: '*to be less compassionate*'.

3.1.3 Conscientious

Some respondents saw being conscientious as a state of being, reporting that it was what they were prior to the programme and that they continued to be so: '*I have always been and continue to be conscientious.*' However, others saw it as something that they were developing: '*I grow more conscientious as I learn more*' and recognising a need '*to act more conscientiously*' reflecting that there was '*a heightened self-awareness it makes you aware of how you act and behave*' being: '*always aware of my actions in practice.*' This included dimensions of: '*knowledge*' and '*confidence*': 'This supported being mindful of how they think and its impact and was associated with: '*learning to see everyone as an individual*' and: '*consider[ing] other's feelings more*' with a view to: '*making a difference to somebody's life.*'

The impact of being conscientious was reported as being accountable, having a knowledge and confidence through deepening the understanding of: '*theory behind practice*'. This helped to identify boundaries of practice, recognising right from wrong practice and the implications of ethics and values. As a consequence some students had reported that they had changed their practice by spending more time: '*thinking before acting*', '*checking to avoid mistakes*', such as reading notes and not rushing.

3.1.4 Caring

Caring was (not surprisingly) seen as a key role without which one could not be a: '*good nurse*' and also an: '*attitude*'. Some described themselves as caring ('*always been a caring person*') whilst others had gained insights that led them to be: '*more caring*' towards patients. Others had: '*taken caring and empathy to a different level*' indicating self-awareness of personal development. Learning also extended to recognising challenges to caring and some had used their understanding of caring to evaluate its presence in practice and reported that: '*this programme has opened my eyes to just how many existing NHS staff are actually not that caring*' or simply were judged as [colleagues who]: '*don't care*' leading some respondents to: '*sometimes question why some staff are in the nursing profession*'. Overall, the impact of caring was recognised whether good or poor: '*I have a greater understanding of how treating people with a compassionate, caring attitude improved patient experience and outcomes.*'

The impact of learning about caring included patient-focused work: '*Giving more time to patients*' being: '*less judgmental*', identifying patients as people within family relationships: '*to care like I would want for my family*' [to be cared for]. It also included the way students wanted to behave around others linking to people with: '*a positive attitude*' and: '*continually aspiring or aiming to be caring*' and emphasizing: '*how*

important that is. This had also developed learning and impact having acquired: *'a greater understanding with difficult patients now'* and altering the way patients are viewed taking account of *'differences and individuality'*.

Areas of reflective practice were reported and its impact was evident in differentiating between what was done and how it was done, noting that: *'some nurses do sometimes complete the: 'task' without care. To me this makes me look at the 'care' aspect before completing the 'task'*. However there was also a group of respondents who stated no change in their practice: *'The way I act in practice has not changed as I have always been caring.'*

3.1.5 Competence

Competence was seen as: *'vital'* and many reported becoming: *'more competent'* and determining what could and could not be safely undertaken. This was also associated with a greater recognition of risk. Confidence was built as competence was developed through acquisition of underpinning knowledge and being able to have a rationale for actions taken. Competency development also developed decision making in terms of being able to differentiate between what was safe and within their role and what was not. This was described as: *'not taking on tasks I am not competent to do'* and realising the impact of competent actions on patient safety.

Some saw competency as a developmental trajectory whilst others saw themselves as competent in the tasks that they performed. The impact on personal practice was described as having knowledge to identify a distinction between competent and incompetent practice. It also highlighted the: *'importance of care [being delivered] correctly'*.

Learning impact on practice also included being aware of standards and policies and the limitations of tasks that they might be asked to undertake: *'I am always aware of limitations and training needs'*. This meant that students could identify and state their: *'own limitations'... 'work... within them'* and be confident enough to state this when it was the case: *'I do not perform any tasks I do not feel competent in.'* Closely linked to recognising boundaries was being accountable. This all contributed to accountable and self-aware practice.

3.1.6 Barriers and enablers

A range of barriers to NA development included staffing shortages, not being supernumerary, a lack of Trust support, not recognising the student role. Additionally negative and resistant attitudes encountered in practice included prejudice, jealousy and occasionally, hostility. This was compounded by misinformation presented through social media: *'Online chats are the worst'*, and there was an *'anti TNA Facebook group'*.

Reasons for these attitudes were explained as: *'it's a new role and not many staff know our role'*. And included labelling NAs as: *'cheap nurses'*. Whilst some were: *'very negative about the role'* the students did note being self-advocates and sought to make Registered Nurses: *'realise we are not a threat but a contribution to their role'*. This defence of their role included challenging: *'other health professionals [who do] not understand, recognise..support..' the role and its relevance as well as informing: 'what we are able to do in the role'*. This championing of the NA role also helped registered staff to: *'compare how [their own] role had changed since they trained'*.

On a positive note there were several enabling factors cited as: *'University lecturers: valuing the time spent at university to learn'* where: *'university lecturers are always helpful and listen to the NA'*. The pastoral and intellectual support was well recognised with the: *'Tutors' knowledge the university has a major impact'* even naming certain staff as being: *'irreplaceable in supporting the role'* and generally: *'Positive lecturers and clinical educators'* who were: *'great enthusiastic tutors'*. The University environment was linked with developing underpinning knowledge and being an opportunity for: *'exposure to other areas to learn, gain experience and reflect on what we have done in practice'*. The social dimension of university learning included *'learning from peers'* and *'positive co-workers'*.

The placement / study mix was also reported in terms of the quality of: *'good placement support'* as an enabler including: *'mentors in practice'* characterised as: *'competent mentors who want to teach and want you to learn'* and who recognised their status as a student rather than just an extra care worker. Positive patient feedback was also an encouragement to students and this supported their resilience in everyday practice. Broader factors also include the support from the student's family.

3.1.7 Discussion and implications

The survey generated some interesting overall insights into the varied experiences of the students and their self-appraisal of the five professional values. Whilst to some extent there was evidence to suggest that learning was shaping thinking indicating at least one mediating factor in individual practice. However, for some students their expression of embodying these values as an absolute (something that they either were or were not) possibly indicated a limited engagement with reflective practice and not recognising opportunities to extend their understating about what each professional value was and how that could incrementally develop in their practice. For others, there was an expression of transition having recognised that there was scope for personal growth and development. That in some respects should be anticipated as these professional values cannot be acquired and embodied without witnessing, experiencing and understanding different scenarios to determine different ways in which they can be expressed. Comments made about a lack of compassion and care might have arisen from situations where students had encountered resistance to their newly developing role. This certainly was the reported standpoint of some students in accounts that some registered nurses in the changing nursing landscape were allegedly hostile and less than supportive, perceiving the NA role as a threat to the roles of registered nurses. A strength of the students' experiences is that they are reporting their confidence to not only seek to embody professional values but also to distinguish when they are lacking and, on occasions, challenge others in the care setting so as to uphold these values. This indication of courage suggests that some of the students are starting to demonstrate the very features of leadership called for in UK national reports that are associated with improving the quality of patient care and patient safety.

4 CONCLUSIONS

Overall the NA is a new role that seeks to provide a nursing focused clinical workforce embedding professional values that were previously identified as essential to care. This study demonstrated that students were not only acquiring knowledge about their role and professional values but also indicated diverse ways in which students were developing and embodying these values. As with all change – change in the workforce to match the demands of the changing service requirements, there is resistance and this has also been reported as a feature of the students' experiences in this study. However through their education it is clear that they are developing both identity and resilience to surmount such transitional resistance to embody the very values that are fundamental to high quality patient care.

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