Making compassionate care the norm starts with our staff

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‘Emotional labour’ is a serious problem faced by healthcare staff who strive to provide compassionate care. The ability to manage it is central to the provision of the best possible care while supporting staff wellbeing, say Yvonne Sawbridge and Alistair Hewison

Compassion has become a problem to be solved. In response to episodes of poor care, the contemporary narrative is to blame uncaring individuals.

While this approach will be the right one at times, it is not the only answer. If it were, dismissing the “bad apples” would suffice.

If we are serious about delivering compassionate care, a number of organisational challenges need to be joined.

At Birmingham University we have been using the concept of emotional labour as a way of focusing activity in this area.

Yvonne Sawbridge

‘Delivering compassionate care involves suppressing emotions and managing those of others’

Developed by sociology professor Arlie Russell Hochschild, it describes work which involves suppressing emotions and managing those of others.

A 999 call handler needs to reduce anxiety when a caller is distressed to gain sufficient information to direct appropriate help. A nurse needs to suppress her grief when witnessing a death that mirrors that of her own parent, and help the patient and their loved ones feel cared for, calmed and supported.

Emotional labour

Management of this emotional labour is central to the provision of compassionate care.

Although the NHS workforce is, for the most part, committed, dedicated and compassionate we are deluding
ourselves if we think that this costs nothing. Not a direct financial cost perhaps, but demanding in terms of emotional wellbeing.

It is difficult to meet the eyes of all the patients waiting on trollies in accident and emergency when you know that you cannot care for them adequately. This contributes to feelings of frustration and failure.

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When boards do not recognise this and integrate support systems into everyday management practice, it is not surprising that some staff burn out and shut down to save their own mental health, which results in poor care delivery.

Alistair Hewison

This supports the need to be purposeful and formalised. After all, boards recognise their health and safety responsibilities by ensuring hoists are available on wards to prevent staff injuring their backs, yet rarely consider the impact on their emotional health.

However, providing the right support system for staff is not easy. Models including Schwartz rounds, led by the Point of Care Foundation, and restorative supervision have been introduced at some organisations to address this, however there is not a “one size fits all” solution.

The Samaritan solution

In view of this, we secured funding from the former West Mercia Primary Care Trust cluster and worked in collaboration with three trusts in the West Midlands to investigate the feasibility of introducing the Samaritans model of volunteer support in a healthcare setting.

The Samaritans telephone line, to support distressed callers, recognises the emotional labour of their work, and take this responsibility seriously. Their volunteers are the service; this is not simply rhetoric of the kind often heard in the NHS, but a lived reality.

‘One nurse slept more soundly after a Samaritan shift than she ever did after a shift on an NHS ward, despite the distressing calls she had dealt with’

All volunteers “buddy up” and support each other as well as the callers. They discuss their feelings after calls and have a formal debrief before they leave every shift.

This has a positive impact. For example, one nurse reported she slept more soundly after a Samaritan shift than she ever did after a shift on an NHS ward, despite the distressing calls she had dealt with.

Following some extensive preparatory work involving numerous meetings with key stakeholders in the trusts and the Samaritans, an action research approach to the project was agreed.

Look after patients and each other

The Samaritans, our partners, provided training for staff on six wards; intended to help them see how they could look after each other as well as their patients, and the importance of this for both patients and staff. These sessions were valued by the staff and received positive evaluations.

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- Compassionate commissioning makes a real difference to patients
- Every board must commit to collective leadership and culture

The next stage of the project was to work with the staff and Samaritan colleagues to develop team based support systems across the ward.

The project took over 12 months, and while there were some positive outcomes for the ward teams, the overall finding was that the Samaritans approach was not readily transferable into the wards involved in our study.
There were several reasons for this, and reviewing the findings using the Beckhard-Harris change model helped us clarify some of the issues.

The model describes a balanced equation for successful change as “DxVxF>R”.

‘Staff frequently expressed concern about being understaffed, under pressure and unsupported’

This equates to “dissatisfaction” (or compelling data) times by a clear “vision” times by clear “first steps” as scoring higher than any “resistance” to the change.

In our work, while there is compelling data from the literature about emotional labour, it was a new concept to the nursing teams, and their dissatisfaction with this aspect of their work was not expressed in these terms.

They were interested in the idea of support and recognised the high levels of emotional labour in their work, yet maintained they managed it by looking after each other.

While this was not borne out in practice because staff frequently expressed concern about being understaffed, under pressure and unsupported, it remained their perception despite this evidence to the contrary.

In terms of a vision for how the future could look, finding time to develop a team based system of support was felt to be unattainable.

Learning from feedback

In addition, they were anxious that if they did try and give someone “space”, the time pressures would increase for everyone else which would have a negative impact on patients.

Also, in contrast to the Samaritans’ experience, there was often no suitable place like a quiet room where staff could have a conversation focused on providing support for colleagues.

In view of this, it is not surprising perhaps that even the first steps were problematic.

One original idea had been for team members to stop and debrief at key points during their shift, but this was deemed impractical.

‘We hope will have a lasting impact in providing support for staff who strive to provide compassionate care in a pressurised service without formal support’

Similarly, a proposal that staff debrief at the end of a shift, as the Samaritans do, was rejected because staff were understandably keen to get home after work. The resistance to the idea of change was much stronger than any of these three important steps.

Bill Gates has observed that it is fine to celebrate success, but it is more important to heed the lessons of failure.

We learnt that more preparatory work was necessary to enable staff to recognise the need for developing a system of staff support, and engage them more directly in its design, consistent with Beckhard and Harris’s change equation.

We have been fortunate to secure funds from Health Education West Midlands to develop this work further in a second action research project with two other trusts, based on our learning from the first project.

It was a privilege to work with the Samaritans and the ward teams, and although a new support system was not developed, important lessons were learned which have shaped the design of the second project.

The hope is that this will have a lasting impact in providing much needed support for staff who strive to provide care and compassion in a pressurised service, with no formal support for their own emotional wellbeing. We have to feed the roots.

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