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Time to care? Responding to concerns about poor nursing care

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Introduction

Why is it that stories of poor nursing care surface with depressing regularity? Nurses work in a healthcare system which is extremely complex, constantly changing and subject to a high level of external regulation. Yet despite the existence of this extensive regulatory framework, there have been a number of high profile reports over the last few years citing shocking cases of poor nursing care - including the Francis Inquiry (2010); The Health Service Ombudsman's report (Abraham 2011); Maidstone and Tunbridge Wells (Healthcare Commission 2007); and most recently the Care Quality Commission report (Care Quality Commission 2011). Whilst complaints about poor care are not new, and can be traced back as far as the 1960s and 1970s when Ely and the Normansfield Hospitals were the subject of national inquiries (Walshe and Higgins 2002), there has been a noticeable increase in negative stories about unsatisfactory care of late.

These official reports are generally followed by an investigation and/or an Inquiry, which in turn produces recommendations, and action plans to address the issues in the organisation concerned and to be cascaded throughout the NHS. However before long it seems a similar story is exposed in another hospital or care home. This suggests that the 'standard' formulaic response to these scandals is not having the desired effect. This begs the question: what else can be done? Rather than seek to address the wide range of factors that have been identified in these reports (see Walshe and Higgins 2002 below), this policy paper focuses on three themes to provide a framework for an examination of key issues in more detail, to direct attention to the relevant literature, and most importantly, to identify actions that can be taken to address concerns about care. The discussion centres on one branch of nursing only - acute hospital nursing - although it is likely that some of the findings will be applicable to other care settings, and other healthcare professionals.

The three themes are the:

1. Environment of care
2. Education and development
3. Emotional labour of care.

The paper considers the practical solutions identified by members of a nursing think tank convened in September 2011 to debate the issues and share good practice, and identifies key concerns for the future.

Key messages

The paper outlines the more detailed findings under the three themes but Box 1 provides a summary of the key messages. Whilst some of the findings may be familiar, the recognition of the emotional labour of nursing, and the need to support nurses to achieve professional detachment from patients rather than unhealthy detachment and burn out, may offer a new perspective. The evidence review and discussion cover this in more detail.

Box 1: Key Messages

Environment of care

1. Ward Sisters/Charge Nurses need to have a clearly defined role as the clinical leader of their ward. They need to be recruited based on attitude and competency; developed and supported as leaders, and their role recognised at all levels of the organisation as the linchpin of good patient care and key role model to help develop the next generation of compassionate nurses.
2. The invisibility of the complexity of caring means that Boards and policy makers may have difficulty recognising that the leadership of nursing - both at ward and Board level - is a full time occupation in its own right. Nurse leaders need to be freed from competing demands placed upon their time to enable them to fulfil this prime role.
3. Where the ward design limits the visibility of nurses from their patients and vice versa, Intentional Rounding should be introduced. Care needs to be taken to introduce this in a way that encourages an attitude of compassion rather than compliance.
4. Clinical dashboards which capture and measure nursing care indicators and are regularly reported to the Board are an important tool and should be introduced into every hospital setting.

Education and development

5. Student nurses need to feel a greater sense of belonging to the nursing profession rather than being identified primarily as a university student. This can be achieved by ensuring their placement instills this identity and gives them pride in their profession. Stronger partnerships with the universities to achieve this are key, and there are emerging examples of this type of arrangement.
6. Healthcare support workers would benefit from a recognised training programme in every organisation, underpinned by a probationary period for all new starters.

Emotional Labour of Nursing.

7. Boards should recognise the emotional labour of nursing and establish a systematic approach to supporting nurses, using one of the models suggested in this paper. The application of these models should be evaluated to assess impact upon nurses as carers and the subsequent outcome for patients.

Findings from Inquiries

The NHS is no stranger to inquiries seeking to identify the causes of failures to provide the right care for patients. The Normansfield Inquiry for example (Secretary of State for Social Services 1978) identified a serious breakdown in the relationship between the lead consultant and the nursing workforce which had an adverse impact on patient care, and culminated in the nurses taking strike action out of a sense of frustration that their concerns were not being responded to by senior management.

Walshe and Higgins (2002) examined a selection of major inquiries in the NHS from 1969-2001, and identified a number of consistent themes which indicate that the lessons are not being learned by the service. They suggest that “*often these failures are organisational and cultural, and the necessary changes are not likely to happen simply because they are prescribed in a report*” (p895).

Higgins (2001) identified the themes as follows:

- *Organisational or geographical isolation* - which affects the ability to transfer innovation and experience peer review and constructive critical challenge and exchange of views.
- *Inadequate leadership* - lacking vision and not addressing known problems.
- *System and process failure* - in which organisational systems and processes are absent or flawed.
- *Poor communication* - both within the organisation itself and between it and its patients, families or carers, meaning that issues are not raised.
- *Disempowerment of staff and patients* - which means people do not feel able to raise issues of concern as the culture inhibits this.

These wide ranging themes illustrate the complexity of the care environment, and that the nursing profession is not the only discipline which contributed to the poor care identified in the inquiries listed above. They may also help to explain why there isn't one simple solution, and challenge us to move beyond 'soundbite' characterisations such as solely apportioning individual blame (“good/bad nurse”) or recommending educational changes (“too posh to wash”).

What matters most is that we look beyond the issues and seek out solutions. To explore this complex and important issue, HSMC convened a Nursing Think Tank to focus on nurses and nursing to examine factors which are in their control, and to identify steps which may be taken to help nurses find ways to restore public confidence by championing and delivering compassionate care for patients.

Nursing Think Tank

The work was organised into three main phases. Firstly key stakeholders at local, regional and national level were consulted to ascertain their perspective on the current situation. Then a critical literature review was conducted to explore the existing knowledge base in relation to the dimensions of poor care. The findings from these two phases were combined to develop an 'agenda' for a focus group involving Executive Nurses. Two focus group meetings were held at HSMC attended by a number of Directors of Nursing, and one Deputy. They were from a range of acute hospital trusts in the West Midlands. A number of other interested parties, from the RCN and the NHS West Midlands also attended (see p37). The rationale for inviting nurse leaders was that the prime function of Directors of Nursing is to oversee good nursing care. There is no blueprint for their work, and they discharge this responsibility via a range of means and methods, drawing on their own considerable experience in clinical and management roles. In view of this it was felt that it was important to access this accumulated knowledge and expertise and explore the views of the Directors concerning practical solutions to current nursing challenges. The outcome of this process was the identification of three main themes below:

The evidence base

A review of the evidence base relating to the three identified topics was undertaken. These were:

- The environment of care - including physical structures, organisational culture and leadership.
- Education and development - including the implications for the non-registered nursing workforce.
- The emotional labour of care - identifying factors which support nurses to give compassionate care day in, day out to all of their patients.

1. *The environment of care*

Factors included under this broad heading ranged from hospital design and ward layout, to the role of the Ward Sister/Charge Nurse; the culture of the organisation; societal context, and the impact of performance targets on nurses' work.

1.1 Hospital design-ward layouts.

There have been a number of major capital redevelopment projects in recent years, which in turn have directed attention to issues of hospital design (Gesler et al 2004). The traditional design for hospitals was a number of single sex, multi-bedded wards known as "Nightingale wards". A nursing station was usually situated at the top or middle of the ward, and the patients identified as being the most ill were placed as close as possible to the nursing station to ensure the nurses were able to observe them closely and frequently. A benefit of these wards was that nurses could see, and be seen, by all the patients.

However hospitals are now designed with very different ward layouts which take account of the evidence base demonstrating that single-bedded rooms are beneficial because they lower hospital/health care acquired infections; improve patient confidentiality and privacy; and reduce noise levels (Ulrich 2004). Although some dispute this evidence (van de Glind et al 2007), the challenge has not been sufficient to affect the advance of this new design. Modern day hospitals are often built to this formula incorporating four bedded bays with bathrooms and toilets, and single en suite rooms. The intention is to improve privacy and dignity for patients, and make the environment more therapeutic. It seems clear that the new designs are here to stay.

This does have implications for practice however. Because patients are no longer constantly visible to nursing staff, it has been necessary to change practice to make purposeful, regular contact with patients to avoid them feeling isolated and neglected. This has led to some hospitals formalising this process by introducing the practice of "Intentional Rounding". This originated in the USA where evaluations have demonstrated the positive impact it had on patients and staff (Meade et al 2006). It has now been adopted in a number of hospitals in the UK under a variety of titles such as care rounds or comfort rounds (Studer 2006).

Another aspect of this changed hospital design means that patients are now accommodated in mixed sex wards - albeit single sex bays in the main. Patient concerns about this situation eventually led to a policy directive being issued to reduce mixed sex accommodation, which was then reinforced in the Operating Framework which set targets to eliminate mixed sex accommodation in Trusts (Department of Health 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.

1.2 Ward/Nurse Leadership

The role of the Ward Sister/Charge Nurse is acknowledged as "*the linchpin of healthcare services*" (Cole 2010 p6). The RCN report "*Breaking down barriers, driving up standards*" (RCN 2009) summarises the findings from both the literature and a number of focus groups held with over 90 ward sisters. It identified three key components of the role which involves being a:

1. Clinical nursing expert
2. Manager and leader of the ward staff team and the ward environment
3. Educator (of nursing and nurses, other health care professionals, patients and carers)

However it was found that the role is often ill defined and ill supported. There are real tensions between being perceived as the clinical expert by nurses and doctors but primarily seen as a staff manager by healthcare managers

*"Ward sisters viewed their management work as one component of their role alongside clinical expertise, leadership and teaching, but perceived health care managers to view them **primarily** as managers of staff and ward resources"* (RCN 2009 p6)

Westmoreland (1993) revealed the isolation and loneliness experienced by ward managers as they strived to balance what they regarded as two competing paradigms of health care (which she characterised as being dominated by nursing concerns about the patient/carer on one hand and management/economic priorities on the other). In addition to these tensions the RCN report highlighted their role in delivering on key performance measures such as waiting times, which were of significant importance to the organisation and therefore needed to be prioritised, but diverted time and attention away from the three core components of their role identified above.

These pressures are played out at ward level and affect the environment of care. For example, Thomas (2006) used systems theory to describe how organisational factors can affect staff. She describes a scenario in which a manager becomes frustrated because of an inability to meet unrealistic targets which results in anger borne of this frustration being transmitted to staff in the department, culminating in the receptionist being unhelpful to a patient.

The change from Ward Sister/Charge Nurse to the more commonly used "Ward Manager" title adds further dissonance concerning whether the prime purpose of the role is clinical leadership or ward manager. In the RCN report (2009) the ward sisters/charge nurses unanimously rejected the title of 'ward manager' as they had taken on the role in order to... "*manage their ward and ward team by a passion for nursing, rather than an aspiration or desire to be 'a manager' per se*" (p6)

They were clear that they were the lead nurse in charge of the ward. This identity as a nurse was important to them and they wanted to be the senior nurse on their ward, with a focus on improving patient care. Their frustrations lay in dealing with staff management issues (HR); budget responsibilities; and a myriad of other roles which impeded their capacity to find time to be the clinical leader. They were often held accountable for decisions which they did not have the authority to make. Ward Sisters/Charge Nurses reported having no ability to expedite repairs so that they were without the equipment they needed to care for patients. For example one sister reported how she was unable to weigh patients for several days because a set of working scales was not available. They had no control over the budget and every decision was scrutinised and countersigned by their line manager. Another Ward Sister reported how she bought batteries for ward equipment herself, rather than incur the delays of having her order signed in duplicate and processed as part of the protracted ordering system over which she had no control.

In wide ranging discussions, many Ward Sisters/Charge Nurses report that they enjoy their role and overcome these challenges to create an environment which supports the delivery of effective care for patients. However the findings from the literature, and indeed, the focus group, provide a strong indication that more work is needed for this role to be enabled to function consistently, and effectively to "*lead the delivery of high standards of nursing care*" (Stockwell 2010 p13).

The issues facing Ward Sisters/Charge Nurses in terms of being able to focus on their clinical role are replicated at other layers in the nursing hierarchy. Stockwell (2010) describes The Salmon report of 1966 which proposed the introduction of a career structure for senior nurses which involved reclassifying nursing roles with the intention of increasing levels of clinical authority. In the implementation of its recommendations, however, senior nurses became more involved in management and administrative duties and had fewer direct patient care responsibilities. This is in contrast to the model in medicine where clinical expertise and seniority coexist. This conveys an interesting message about the value of nursing as a discipline, and may have been the rationale behind the development of Nurse Consultant roles in the 1990s. However Guest (2004) found that the impact of these roles has been variable, and they tend to focus on groups of patients with specific disease conditions, thus mirroring the medical structure. In addition they do not have a direct impact on ward management, other than to attract staff who in the past may have become Ward Sisters/Charge Nurses, and to introduce another level of expertise which may be perceived to challenge the clinical authority of the Ward Sister/Charge Nurse.

The competing pressures of leading nursing and fulfilling organisational priorities exist for Board level nurses too. Directors of Nursing are rarely employed to lead nursing alone. They often have responsibility for Human Resources, Clinical Governance and even Estates (Burdett Trust 2006). Whilst some hold operational management roles, others have professional responsibility but no managerial authority with which to enact their vision. Research by Newchurch (1995) found that 75 per cent of nurse directors did not have line management responsibility for nurses and nursing.

Despite the wealth of evidence collated over a number of years re-iterating the importance of the Ward Sister/Charge Nurse role, (Ogier 1982; Orton 2001; Pembrey 1980), the recommendations from the RCN and other reviews have not been extensively adopted in practice. For example role definition and overload continues to be an issue, as highlighted later in the report of the focus group. This may suggest that senior managers, policy makers and indeed the public, may have difficulty recognising that the leadership of nursing - both at ward and board level is a full time occupation in its own right.

McKenna et al (2006) proffers an explanation by stating that: *“Many people feel that nursing is common sense, a trait with which you are born, that the caring woman next door can do it expertly and that kindness, respect and compassion are the main criteria for becoming a nurse”* (p135).

Whilst these behaviours are undeniably important, McKenna argues that being a registered nurse involves much more than demonstrating this trait, because they are accountable for the care of patients who have a myriad of complex health and social care needs. Patients present from varied cultural backgrounds, with expectations of individualised care being provided for them as partners and consumers of healthcare rather than passive recipients. However if this is not recognised, and nursing is viewed as a simple task, then the leadership requirements will also be seen as undemanding, and this may explain why nurse leadership roles do not have a singular focus on nursing. It would also explain why the current debate is focusing on uni-dimensional issues - such as individual behaviour, or educational changes alone - rather than the wider determinants of practice highlighted in the literature.

A picture emerges therefore that the roles and responsibilities of nurse leaders are multi-faceted in today's NHS, and this can lead to their focus being diverted away from professional practice, standards and the development of nursing, towards management concerns and targets.

It has also been found that only 10 per cent of junior nurses interested in career progression aspire to being a Ward Sister/Charge Nurse (Wise 2007). The reasons given included lack of direct patient contact; significant workload pressures; long hours, and poor pay. Although the Ward Sister/Charge Nurse job description matches Band 7 in the national framework for pay (Agenda for Change), the RCN (2009) found many Ward Sisters/Charge Nurses were paid at Band 6. Other band 6 roles in the NHS include IT Trainer, and procurement negotiator - neither of which have the levels of responsibility for patient care, or the unsocial hours commensurate with that of the Ward Sister/Charge Nurse.

Therefore the role that is widely considered to be the most important post in acute nursing care is not always adequately supported by the system to enable delivery of its prime focus on clinical care nor is it sufficiently remunerated or rewarded at a level which encourages others to take it on. This is an important, though far from new finding.

1.3 Targets

There has been considerable discussion relating to the effect of performance targets on behaviour. The Health and Safety Executive (2001) describes the importance of measurements in developing the right environment for safety, summarising this approach by citing Drucker (1993) who maintained '*You can't manage what you can't measure*'.

The King's Fund (2010) conducted a literature review to assess how the NHS had progressed across number of performance measures (2010, Box 2) and found that the NHS had been largely successful in delivering the Government's targets and that this indicated an improvement in patient care. For example no-one could argue that reducing waiting times from 18 months to 18 weeks for a critical operation such as a heart bypass did not represent a significant improvement for patients. However it also summarised some of the 'problems' with targets, particularly with regard to how they can affect behaviour and divert attention from away from clinical concerns.

Box 2

Have targets improved NHS performance King's Fund 2010 (available on line - this is a direct quote from this report)

So what's wrong with targets?

*Targets have been blamed for distorting clinical priorities. **The Conservative party** has claimed that the four-hour target for waiting times in accident and emergency (A&E) has led to distortions such as holding emergency patients in trolley waiting areas. And media reports based on internal ambulance service documents suggest that some patients have been held in ambulances outside emergency departments to avoid 'starting the clock' (**Guardian 2008, Telegraph 2009**).*

*Analysis published by the **Information Centre** in 2009 found that the number of patients leaving A&E reaches a peak as the four-hour deadline approaches: 66 per cent of patients are admitted to inpatient wards from A&E in the last ten minutes before the four-hour deadline, while the figure for all patients who pass through A&E is 21 per cent.*

*In relation to the inpatient waiting time target a survey of consultants in eight NHS trusts (**The Kings Fund, 2005**) found that a "significant minority" of clinicians felt that "attempts to meet maximum waiting times targets can clash with their own clinical judgments concerning when to admit patients from waiting lists". However, the same research concluded that 'no evidence was found of substitution of lesser for more serious cases' and that 'serious and extensive clinical distortions are likely to have been fairly limited'. More recently, Dr Colin-Thomé's report on failures in emergency services at Mid Staffordshire NHS Foundation Trust concluded that an over-reliance on process measures and targets had come at the expense of focusing on the quality of services provided to patients (**Colin-Thomé 2009**). But it is very difficult to establish how widespread such problems may be.*

*Another concern is that targets concentrate resources on one area at the expense of others. Infection control targets, for example, have been successfully met, but apply to a limited range of infections and at-risk populations (**Millar 2009**). MRSA, for example, has been the focus of media attention and was the first healthcare-acquired infection for which a target was set, but it accounts for only 2 per cent of healthcare-acquired infections in the NHS (**Millar 2009**).*

In summary, enforced targets do appear to have been successful in improving aspects of NHS performance, particularly in relation to waiting times, but there is some evidence of unintended consequences – for example, distortion of priorities or neglect of other non-targeted activities. However, it is important to recognise that such unintended consequences may not be the inevitable result of targets in themselves, but rather of the particular way in which those targets were designed and enforced."

However as both Bevan and Hood (2006) and the King's Fund report (2010) found, the focus on targets can have an undesirable effect on behaviour. Effectively what begins to happen is that the focus shifts to deliver the targets (i.e. 'what matters is what's measured'). This creates difficulties for nurses as their prime function is to deliver compassionate care, which can be difficult to describe, let alone measure.

Box 3 describes the findings from a study of accountants in a number of organisations across the UK (Beekes et al 2010). These findings resonate with the King's Fund Review (2010 Box 2) and confirm that human behaviour is the common denominator, regardless of the setting. The King's Fund report reflects this because, whilst recognising the positive impact that targets in the NHS have had, it urges caution in how they are implemented and enforced.

BOX 3

The use and consequences of performance management and control systems (Beekes et al 2010) investigated the impact targets had on employee behaviour at a large UK-based accounting firm.

Key Findings:

- *Targets are a useful means to motivate and assess the performance of employees in the organisation; however an excessive focus on targets, both financial and non-financial, in the organisations' performance evaluations may have a de-motivational impact on employee behaviour.*
- *The superiors were found to be important factors in mitigating the negative impact of targets on employee behaviour caused by a heavy emphasis on targets in performance appraisal.*
- *If targets are perceived to be unreachable, this results in undesirable behaviour (for example, taking undesirable actions to meet budget targets (p1).*

The performance management context has led to the introduction of methods to measure nursing care and the development of clinical dashboards locally (see focus group section). On a broader scale, the NHS Institute has developed *High Impact Actions for Nursing and Midwifery* (2011). However many of these are process rather than outcome measures. Arguably, only the recipient of care can decide whether it was compassionate and met their needs or not. This has led to a growth in activities to assess the patient experience such as the Dr Foster Patient Experience Tracker tool and the NHS Institute for Innovation Patient Experience Tools. There has also been a growth of sites such as Patient Opinion and NHS Choices which mirror the travel sector's Trip Advisor type review. In addition Nurse Directors reported that real care experiences are now discussed in the form of patient stories presented at Board meetings.

However even asking the patient is not a simple process. For example if you ask them was their call bell answered within 10 minutes, they may be able to provide a yes or no answer. If you ask them was their care compassionate then they may tick no - but in reality they might wish to say “yes by everyone but staff nurse x - except on Tuesday when they were short staffed and nobody seemed to have time to care”. These levels of complexity make the science of measuring care a continuous journey of improvement.

1.4 Wider society

The current negative coverage of nurses and nursing in the press creates a difficult background in which to explore the issues openly and honestly, and identify what needs to change. This coverage usually takes a simplistic, often blaming view (Marrin 2009), rather than engaging with some of the wider issues such as the complexities of the care environment. The lack of recognition that patients in hospital are sicker, require more time, and have more complex needs are overlooked in the simplistic characterisations of poor care. It is easier to blame uncaring nurses (Odone 2011) than tackle the endemic organisational barriers to good care. Whilst poor care cannot be condoned, it is not unreasonable to call for a more informed analysis of the issues. An understanding of the reality of caring is needed if solutions are to be found.

Take for example the practice of administering medication to patients. This is a procedure with inherent risk to patients and a report highlighted an increase in reported medication errors which can have serious consequences for patients (National Patient Safety Authority 2009). In an effort to reduce this risk, many hospitals have introduced the use of red tabards which nurses wear when undertaking the medication round. The intention is to protect the nurse (and therefore the patients) from distractions which could increase the risk of medication errors. However this has been reported in the media as another example of nurses wishing to distance themselves from patients and led to criticism in an article in the Daily Telegraph (Beckford 2011). The response to this article posted on the Daily Telegraph website by a nurse, serves as a useful vignette of how many nurses are feeling:

“... the majority put their patients first, the NHS relies very heavily on their goodwill in terms of long hours of unpaid overtime, missed legal breaks, high levels of job stress due to staffing shortages where they are often expected to do far more than one nurse’s share of the work which at times is to the very limits of human possibilities and they also contribute far more than this, putting their own health, well-being and private life at risk, and with constant threats to their job security, pensions, retirement age, inadequate salaries, ill defined career structure, lack of continuous professional development which they often have to seek out and fund themselves, etc. They are also under constant scrutiny from employers, patients, colleagues, other healthcare professionals, the public and the media and often subject to harsh and unjustified criticisms.”

This conveys a powerful message about the importance of recognising how nurses are feeling, and the reality that nursing is a difficult job. This aspect is not widely discussed in the current debate about poor nursing care, and will be returned to later in this paper.

1.5 Organisational culture

The importance of culture in determining the way organisations function has attracted a great deal of interest since the 1980s when the pioneering work of Peters (1982) brought its importance to prominence. He argued that if the organisational culture was 'right' excellent performance would result. This continues to be a key concern for management (Collins 1998) and it has been the focus for extensive empirical study in the English NHS. For example in a recent comprehensive examination of organisational culture in the NHS Mannion et al (2010) concluded that culture matters in terms of "*high levels of quality and performance in NHS*" (p217). However it is very complex and it defies "*simple categorization and is context dependent*" (p217). Also in a study examining the links between organisational culture and patient safety, McKee (2010) found that the value that is attached to patient safety and staff well-being by senior staff - and particularly by the Chief Executive - does seem to be important in galvanising the organisation and that leadership does appear to matter. It is beyond the scope of this paper to examine the vast amount of literature which addresses organisational culture (see Mannion 2005 for a helpful review). However it is important to note the influence of culture on the way nurses deliver care as this is a crucial determinant of quality.

A key question is how to create a culture that supports nurses to deliver good patient care? A number of projects have identified steps which can be taken. For example, the Boorman review (2009) identified the economic costs of staff stress and called on Trusts to implement staff well being strategies. An example of these principles being implemented successfully can be found in the USA in the work of Aitken et al (2000) who identified "Magnet Hospitals" and demonstrated that hospitals which paid attention to a number of important human factors such as staffing levels, engagement and autonomy, attract and retain committed nurses. This then became a virtuous circle which improved mortality and morbidity outcomes for patients. She summarised this by saying "*Magnet hospitals work. American Nurses Credentialing Center recognized Magnet Hospitals nurses had lower burnout rates and higher levels of job satisfaction and gave the quality of care provided at their hospitals higher ratings Our findings validate the ability of the Magnet Nursing Services Recognition Program to successfully identify hospitals that provide high quality care*" (p31).

Similarly, the Chief Nursing Officer in the Department of Health published a framework for best practice entitled "*Confidence in Caring*" (2008). This identified how nurses could create an environment in which patients felt secure by identifying five "Confidence creators":

- A calm clean safe environment
- A positive friendly culture
- Well-managed care with efficient delivery
- Personalised care for and about every patient
- Good team-working and good relationships

This looks to be a simple checklist to follow - however in our discussions we found that few Hospitals have implemented this. This resonates with the findings from the Inquiries (Walshe and Higgins 2002), in that making even small changes in a system as complex and unwieldy as the NHS can be an exacting challenge, and often unachievable. However the evidence demonstrates that efforts to make the necessary changes in the culture must continue, and is the basis of all good management practice:

“The findings reported here make it clear that cultures of engagement, positivity, caring, compassion and respect for all - staff, patients and the public - provide the ideal environment within which to care for the health of the nation. When we care for staff, they can fulfil their calling of providing outstanding professional care for patients.” (West and Dawson 2011 p7)

This concept of looking after staff is far from new, and is the basis of all good management practice. An indicator that this is still far from widespread however can be inferred from the recent circulation of this West and Dawson report (2011) to all NHS organisations, by the Department of Health. If the issue had been systematically addressed, such communications would be rendered unnecessary.

Aitken et al's work (2000) demonstrates that where effort is concentrated on creating the right work environment for staff, improvements in patient care result. The current debate in England which apports blame to nurses and their education, does not take account of these findings. However the evidence is clear on the importance of organisations creating a culture in which what matters is measured; nurses are supported and nurtured; and good leadership is evident at all levels in the organisation.

2 Education and development

This section examines pre-registration education, continuing professional development and the preparation of the non-registered nursing workforce.

2.1 Pre-registration

There has been considerable debate in the medical (Delamonth 2011) and popular press (Templeton 2004) about pre-registration nurse education failing to produce nurses who are able to deliver compassionate care.

The history of formal and regulated nurse training began with the Nightingale Model (Baly 1997) and developed into the establishment of nurse training schools housed in each hospital. Student nurses stayed largely within the hospital setting throughout their training, and had classroom - based tutorials covering nursing theory, anatomy and physiology pathology, pharmacology, and so on, provided by Nurse Tutors. These tutors also visited the students on their wards, and indeed conducted a number of assessments of their practice as part of the pre-registration course. Student nurses were apprentices in effect, and worked on the wards and departments as part of the nursing staffing establishment. Whilst the emphasis on the apprenticeship model of nurse training is regarded by some as beneficial, it also resulted in junior nursing students being in charge of wards on nights without the requisite experience to provide safe care. Both Menzies (1960) and Benner et al (1989) refer to the inadequacies of this training programme, and in the early 1990s Project 2000 was launched which led to a significant change in nurse training, in the form of Diploma and Degree level qualifications, provided by universities. The new model also incorporated supernumerary status for students in practice (often misconstrued as 'observation only'). The overall format of the programmes is 50 per cent university based study and 50 per cent in clinical practice, where students are given a placement mentor to develop their competencies in both practical and applied theoretical skill whilst being supervised. There is widespread misunderstanding of nurse education with many commentators confusing university provision with degree level training, and limited access to practical "on the job" training.

Although these approaches to nurse education are fundamentally different, they share a common feature in terms of the number of students failing to complete their programmes identified by Menzies (1960). This thorny issue persists and it has been reported that attrition rates range from 6 and 20 per cent (Waters 2008) even though education providers are penalised if attrition rates exceed 13 per cent (Department of Health 2009(a)). In 2005 a task group was established in Scotland to investigate this issue and noted that whilst the student nurse attrition rate averaged 27 per cent, the rates for Allied Health Professionals (such as physiotherapists and dieticians) were at 3.5 per cent and 3.2 per cent respectively (NHS Scotland November 2011). Whilst universities are subject to a level of performance management to reduce attrition, this does not appear to be the solution - probably because the underlying causes of students leaving programmes are outside of the universities' control. These have been summarised as the discrepancy between expectation and reality on the part of students, and stress (Orton 2011). These are part of the wider educational experience of students involving balancing studying and working, and the pressures inherent in the clinical environment. This issue is explored in more detail in the section on emotional labour. These tensions are unlikely to be ameliorated under the new system without a purposeful approach. Supporting the nursing workforce systematically and proactively may provide a solution.

In spite of concerns about the education of nurses (Dealmonthe 2011, Templeton 2004), there is a considerable body of evidence which links higher education with improved outcomes for patients. McKenna et al (2006) supports this stating *"To meet present and future health and social care challenges, nurses must also be analytical, assertive, creative, competent, confident, computer literate, decisive, reflective, embracers of change and the critical doers and consumers*

of research. Most of these qualities were not inculcated in the old apprenticeship system of nurse training” (p135). Similarly Maben and Griffiths (2008) found there is no objective evidence to support the anecdotal view held by some that educating nurses is linked to the ‘loss’ of caring from the heart of the profession. On the contrary the evidence suggests that those who are degree educated are just as competent and caring.

Degree entry to nursing is not new. Degree programmes have been preparing people for entry to nursing for more than 40 years; fast track programmes have existed for graduates from other disciplines for more than 30 years; and a degree has been mandatory for entry to the register in Scotland, Wales, and Northern Ireland since 2002. Although data on nurses’ qualifications are not currently kept centrally, around 30 per cent of nurses in the UK are estimated to have a degree (Gough and Masterson 2010). However, in October 2008, the Nursing and Midwifery Council decided to bring England in line with the rest of the UK nurse education system meaning that the minimum academic level for pre-registration nursing education will be a degree, and by September 2013, there will only be degree level pre-registration nursing programmes offered in the UK (NMC 2011). As well as geographical conformity, this also creates a situation of parity with all health professions now requiring a degree as the route to registration.

This development has been greeted with admiration in the USA by campaigners seeking to increase the numbers of nurses trained at Baccalaureate level from current levels of 50% to 80% of the workforce by 2020 (Institute of Medicine 2010). They have also looked at the evidence base and view this as an important development to meet the healthcare needs of an ageing population. When launching this significant change to nurse education, Dame Christine Beasley the Chief Nurse of England in 2009 (BBC News) said :

“We need to make sure that not only do nurses need to care and have compassion, but they also need to have real ability to think, to make critical decisions and have technical skills. What we’re doing now is to look to the future, to make sure we are preparing nurses to do the very best they can for our patients and community.”

Even though evidence demonstrating the benefits of degree level entry to the nursing register exists, changing the academic level of nursing in the present climate of strongly held views about nursing being too academic could be regarded as a bold move. It is likely to be scrutinised and reported on by a range of commentators from all sides of the argument.

2.2 Continuing professional development

In order to comply with the requirements of the Nursing and Midwifery Council, and be able to remain on the register, nurses need to undertake a specific amount of Continuing Professional Development, known as Post Registration Education and Practice ('PREP' NMC 2008). This requires a minimum of 35 hours of learning activity during the three years prior to renewal of registration, as well as a minimum of 450 hours of registered practice in the previous three years as a nurse or midwife.

In addition, organisations also have a number of training requirements that are statutory or mandatory for all employees. Anecdotally these requirements have increased although staffing levels have not kept pace with the demands. One of the authors analysed the number of hours required to meet the organisations requirements - not including PREP- and found that it had risen from 3-6% of the budgeted nursing hours in the agreed staffing levels since 2002 (Sawbridge 2005). This increase was not reflected in the budgets allocated to wards to manage their establishments and caused a real tension in balancing the staffing needs to deliver patient care and the organisational imperative to attend mandatory training. It is a continuing and increasing challenge to staff the wards, meet the needs of patients, and provide mandatory staff training, in a climate of economic constraint.

2.3 The non-registered nursing workforce

There are currently over 660,000 nurses and midwives on the Nursing and Midwifery Council's register, although not all of them are practising (NMC 2011) and the NHS employs over 300,000 non-registered nursing and medical support staff (NNRU 2010). There is no standard nomenclature for this workforce however individual employees are generically referred to as Healthcare Support Workers (HCSW). Their training and development is not nationally determined and so varies from Trust to Trust. 'Front Line Care' (Department of Health 2010c) the (then) Prime Minister's Commission on the Future of Nursing and Midwifery recommended a scoping paper to consider regulation of this workforce, and in 2010 the NMC commissioned a report from the National Nursing Research Unit to analyse the risks to the public of unregulated HCSWs. It presented a strong case for regulation of this group of employees in order to protect the public (Griffiths and Robinson 2010). This has not been enacted so far.

However even if regulation is not introduced, there would seem to be merit in reviewing the training and development of HCSWs from a national perspective. Sir David Nicholson, Chief Executive of the NHS and Chief Executive (designate) of the National Commissioning Board was asked at the Public Inquiry into events at the Mid-Staffordshire NHS Trust (2011) whether a national initiative was being developed to train and develop Healthcare Assistants across the NHS. He responded by agreeing to consider this suggestion. Indeed speaking at the NHS Employers conference in Liverpool on 15th November 2011, The Secretary of State for Health, Andrew Lansley set out plans to develop a code of conduct and minimum training standards for healthcare support workers and adult social care workers in England. This suggests that the important contribution HCSWs can make to patient care is to be enhanced, whilst recognising that some of

the current concerns about standards of nursing relate to the care provided by the unregistered workforce.

In summary, therefore, the education and development of the nursing workforce, both registered and HCSWs, is changing. Whilst there is no evidence that intellect and compassion are mutually exclusive attributes, concerns have been expressed that 'over' educating the nursing workforce will compromise care. National and international evidence refutes these claims and suggests that other contributory factors to poor care merit attention.

3. *Emotional labour of care*

The role of the nurse involves supporting people at vulnerable times in their life. Often they are dealing with distress, tragedy, death and dying. This is not a typical working experience for most of the British public and the literature describes the impact of this on the health and well being of nurses. Menzies (1960) described nursing as fulfilling the primary purpose of the hospital as they are the only workforce which *"...must provide continuous care for patients, day and night, all the year round. The nursing service, therefore, bears the full, immediate, and concentrated impacts of stresses arising from patient care"* (p97). She went further, using graphic language to say that *"Nurses are confronted with the threat and the reality of suffering and death as few lay people are. Their work involves carrying out tasks which, by ordinary standards, are distasteful, disgusting and frightening"* - a truth which is rarely discussed.

In her study of flight attendants Hochschild (1983) identified the emotional labour that was required for them to provide good customer service regardless of their own feelings. She defines emotional labour as *"The induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for"* (cited in Smith (1992) p7). Further work by Gray and Smith (2009) described how emotion in nursing is rendered invisible and therefore not managed and they suggest that this emotional dissonance arising from the constant suppression of powerful emotions is likely to affect practitioners sufficiently to cause burnout.

Current work has found that in the past ambulance staff used a variety of coping mechanisms to deal with issues they may face in their working day and at the heart of this was the camaraderie of their team (Rowland in progress; Crouch 2011). They would use their time in between calls to debrief in an informal and unstructured way. This often included the use of humour or anecdotes which may appear superficial - but which fulfil a more profound function. The introduction of higher performance targets including faster response times resulted in the use of standby locations across the patch, such as lay bys, so that they could get to callers more quickly. However this reduced the frequency of returning to base between calls and meant that some staff felt more stressed and stated they were prone to increased sickness levels, because an important source of informal support could no longer be accessed. The unintended consequence of the organisation's response in meeting these targets was the removal of an important coping mechanism from their staff. This is a good example of how modes of coping with stress are often invisible and poorly

understood - not least by the staff themselves, and a further example of how management practice can have effects that were not foreseen in a similar way to the hospital design changes discussed earlier.

These coping mechanisms were present in nursing, though may not have been viewed in this light. For example, Menzies (1960) describes how she witnessed previous nursing procedures which involved a task-centred approach rather than patient centred care. She asserts that the human state requires us to manage our anxiety to avoid it overwhelming us, and a certain level of emotional detachment is healthy. Whilst Menzies did not find the organisation of nursing into task-based approaches to be a successful strategy, given that the levels of anxieties in nurses were still high, she recognised its potential to enable nurses to cope with the stress of caring. However there are signs that some of the rituals of nursing have been eroded over the years. One example is the introduction of the nursing process – described as: “*patient allocation as opposed to work allocation. It’s more thinking of the patient as a whole as opposed to one nurse being responsible for bedpans etc.*” (Smith 1992 p39). This personalisation led to patients being referred to by name rather than by condition (e.g ‘the stroke patient in Bed 5’), and nurses being encouraged to build a therapeutic relationship with individual patients. This required that nurses cared for their patients ‘holistically’ and this meant a personal rather than a distanced basis for the relationship. This makes emotional demands on the individual practitioner. Other rituals which may have fulfilled a support function have changed too. Changes to shift handover arrangements, whereby many now take place at the bed side rather than in an office, have removed an opportunity for nurses to express concerns about their work, and thus alleviate their stress through sharing ‘vocabularies of complaint’ (Turner 1987) in private. Similarly the closure of nurse laundries and even changing rooms mean that staff do not always take off their uniforms prior to leaving work, and so may not divest themselves of their work concerns along with their uniform before leaving the hospital. These may have been important if unrecognised processes for managing anxiety and their removal makes it harder for nurses to deliver compassionate care, day in and day out. We are not arguing for a return to the practice of task-based approach to care, or an idealised era of the ‘good old days’, but for the need to recognise the effect these changes to working practice can have on nurses and the care that they provide. There needs to be a balanced approach taken to changing working practices to ensure there are no negative impacts on patients.

The literature therefore identifies a strong emotional cost to caring, but it is rare that this aspect of nursing care is discussed in the media. Coverage takes no account of these issues, and the reality of a working day is rarely described. To create this background understanding, Benner and Wrubel (1989 Box 4) describe a personal nursing experience which they state was not untypical. This paints a picture of the relentless stresses that a routine working day involves. Whilst this is based in the USA context, every nurse can describe similar experiences, which occur with depressing regularity. Most would say that they had failed in their duty that day - but would be unable to describe how they could have operated differently given the situation in which they were placed.

Box 4

Coping with Caregiving. Benner and Wrubel (1989 p365)

“I am in charge tonight with five nurses and 30 patients. Two of my nurses are floats who have never been on the floor; one will be an hour late, so I will have to cover her patients. Our medical-surgical patients have diagnoses (including) failure of the kidney, stroke, diabetes, cancer, sickle-cell disease, hepatitis, AIDs, pneumonia and Alzheimer’s disease.

*The average age of our patients is 79. We have five fresh post-operative patients and one going to surgery in two hours. As I come out of report one of our stable patients who transferred from Coronary Care Unit yesterday, is having chest pain. There is a Dr on the phone waiting to give admission orders and the anesthetist for our pre-operative patient wants the old chart, **now**. Down the hall an elderly confused patient has just crawled over the side rails and fallen. Two of our fresh post-op patients, are vomiting as a side effect of the anesthesia, (and) their families are very tense and need reassuring. One of the patients I am covering for has just pulled out his IV; another wants something for pain; another needed the bed pan and I got there too late. The lab has called with a critical low haemoglobin level on the patient who pulled out his IV; he’ll be getting a few units of blood as soon as possible.*

This condensed version represents the first two hours of my working day.....it is no fabrication.”

Sustained exposure to these pressures can result in burnout which Leiter and Maslach (1988) describe as having three components- emotional exhaustion, depersonalisation and diminished sense of individual achievement. Vaughan and Pilmoor(1989) states *“The concept of burnout as an end result of response to stress is highly relevant in this context”* and in her book cites a further definition from Maslach as *“....a shift from the positive and caring to the negative and uncaring”*(p297) This finding seems as relevant today as it was in the 1980s - and yet there is little evidence that we have found the mechanism to prevent burnout in nurses.

If the argument is accepted that providing nursing care is emotionally difficult then methods of supporting nurses in their role need to be identified and embedded in organisations. The literature suggests that this approach would address the fundamental aspects of care whereas the tried and tested model of action plans and mechanistic tasks has not succeeded.

However a number of models have been identified which may offer some solutions to the issue of how best to support nurses in their role as carers. One is based on the principle of reflective practice and was introduced as clinical supervision. This was recommended as best practice in the 1990s, and supported by a position statement from the United Kingdom Central Council for Nursing and Midwifery (1995) as an important source of ongoing professional

development. Practical guides to implementation were produced (Bassett 1999) and there was recognition that nurses needed time away from their busy environment to reflect and review their practice. In reality clinical supervision has not been rolled out systematically across the nursing profession. As part of its “*Point of Care*” programme the Kings Fund commissioned an evaluation of Schwartz Center Rounds (Goodrich 2011). These had been piloted in two UK hospitals as a tool to support staff. They take the form of a facilitated multi-disciplinary discussion around the impact a case had on healthcare professionals, and provide space for group reflection and acknowledgement of the emotional labour of care. The evaluations were positive in terms of:

- *“supporting staff to improve patient care*
- *improving organisational culture*
- *reducing isolation*
- *the value of a multidisciplinary approach to problem solving, especially one involving senior staff”* (Goodrich 2011 p4).

In a similar vein, NHS West Midlands has recently invested in a system of clinical supervision support for Health Visitors as it was found that morale was low in Health Visiting services. Indeed the stress levels of a group of health visitors was assessed by psychologists prior to the intervention (Wallbank and Preece 2010) who found:

- 76% of respondents indicated that their psychological wellbeing was poor or ok with only 24% reporting good psychological wellbeing at the time of testing.
- They scored 33% higher (meaning worse) than ambulance workers who were asked to reflect on a recent traumatic episode.
- They scored 23% higher (meaning worse) than soldiers pulling their deceased colleagues from the battlefield.

After a programme of “restorative supervision” had been implemented participants were re-assessed and it was found that:

- Post-Supervision Burnout was reduced by 36% to non-clinical levels in most participants.
- Stress was reduced by 59% post-supervision to non-clinical levels in most participants.
- Qualitative results showed participants valued the experience of supervision and it appeared to restore their ability to think clearly and make decisions.

Box 5 describes the approach that the Samaritans use to support their volunteers on every shift. Prior to working as a volunteer, they are given appropriate training and support to enable them to provide the emotional support which callers need. The level of emotional distress which callers are experiencing is often very high - for example some callers are in the act of suicide, and needing emotional support whilst they enact this decision. Clearly this is an extremely difficult task for volunteers, and the Samaritans recognise this and provide a structured support system for their volunteers. This model appears to have much to offer in terms of helping nurses cope with the emotional labour implicit in their role.

Box 5

The Samaritans

Each volunteer undergoes a period of training prior to taking calls.

Each shift is between 3 – 5 hours, and the volunteers work in pairs.

The callers are often in highly distressed state, and the volunteers are actively encouraged to share the last call with their partner in the “down times” in between calls.

If the volunteer needs longer to debrief, the telephones will be turned off to enable this to happen (it is rare that this action is required as most debriefs are possible in a few minutes). However it signifies the importance that the organisation gives to the emotional support of volunteers. They recognise that if the carer isn't cared for then they can't care for the callers, and by this action they demonstrate that they really mean this.

At the end of each shift, the volunteer “offloads” to the shift leader. This process involves a summary of the types of calls taken by the volunteer **and** how the volunteer is feeling.

The leader will make a judgement about the emotional health of the volunteer, and if they feel they were particularly affected, they will call them the next day to see how they are.

All of the models described above are not routinely practiced in hospitals. The type of support which is provided to nurses is mainly ad hoc, and discussed further in the focus group section below.

The focus groups

Having explored the formal evidence we now turn to the views from practice. As outlined previously, the focus group of senior nurses explored the three main themes identified from wide ranging stakeholder discussions and validated by the literature review. This was a senior group with significant leadership experience, and met twice (once to explore the key issues and again to focus on potential solutions).

1. The environment

1.1 Hospital design-ward layouts.

Most of the group worked in organisations which had a mixture of Nightingale and Hotel-style wards. One had recently moved to a new hospital and witnessed at first hand the need to change nursing practice by putting in hourly care rounds.

There was general agreement that this practice, often called “Intentional Rounding”, was essential in order to overcome the constraints of the new environments and enable nurses to care for patients properly.

However caution was expressed about the way this was introduced. The benefit was in the **way** the nurses interacted with patients, not just completing a tick box form to record that a round had been carried out. This requires a wider set of cultural influences and role modelling than simply introducing this system, although mechanistic or routinised tasks can fulfil a purpose in terms of raising awareness of the new ‘task’.

1.2 Ward Leadership

Of all the topics discussed this generated the most debate. All participants recognised the importance of the Ward Sister/Charge Nurse role, and were taking steps to improve its effectiveness. They had found the policy imperative of reintroducing 2,000 Matrons by 2004 unhelpful (Department of Health 2001). Despite the best efforts of the matrons themselves, these roles added a layer of complexity to the management of nurses and undermined the authority of the Ward Sisters/Charge Nurses.

This was regarded as an example of an ill thought out political response to public views about nurse leadership. Trusts complied with the performance measures initiative and hit the target they had been set - but most felt it missed the point. There was a view that Ward Sisters/Charge Nurses are effectively the matrons that the public is looking for to lead care, and they need to be given the authority, responsibility, training and ongoing support to meet these responsibilities. That is not to question the competency of the existing matrons, but to recognise that the introduction of an additional role in the nursing hierarchy was not the solution envisaged by the Government. *Front Line Care* (2010 c) called for all Nurse Directors to be no more than two levels removed from Ward Sisters/Charge Nurses and the Nurse Directors supported this stance.

In terms of developing Ward Sisters/Charge Nurses the participants recognised the importance of leadership development programmes and many had used the RCN Clinical Leadership programme which had consistently evaluated well. The group highlighted however that this required a considerable and ongoing investment, as staff would often move into different roles over time, and new incumbents would then need this personal development.

There was considerable discussion about whether the Ward Sisters/Charge Nurses should be supernumerary, but no clear view emerged. Some Trusts gave Ward Sisters/Charge Nurses one or two days management time a week, but this also had its drawbacks as it meant they were engaging in administrative tasks rather than nurse leadership for some of the week. Clearly in a time of economic constraint this was likely to be difficult for Boards to agree unless there was strong evidence of patient benefit. However they all recognised the value of supporting the Ward Sister/Charge Nurse in their role and many had introduced secretarial support for them-although often shared across several wards. A review of the ward clerk role was taking place in one Hospital to release time for them to offer support to the Ward Sister. Very few managers in the NHS operate without administrative support so the fact that Ward Sisters/Charge

Nurses do, could be seen as symbolic of the lack of support provided routinely to Ward Sisters/Charge Nurses in their crucial task of leading and managing nursing care at ward level.

Supporting the findings of the RCN report (2009), the participants reported that the number of applicants for Ward Sister/Charge Nurse roles were at an all time low, with often only one application being received. To counteract this for the future, one Trust had introduced a “Rising Stars” scheme to encourage staff nurses who showed early promise, and help them become the Ward Sister/Charge Nurse of the future.

The role tensions described in the literature were recognised by the focus group members, and there were frustrations expressed about the management of nursing being outside of their remit. This added to the dissonance for the ward leaders as daily priorities were addressed under the managerial line, and may conflict with the overall nursing principles of good *individualised* patient care. This tension between “good nurse” and “good employee” is discussed below, and the drive to meet performance targets was felt to be a real issue in practice, and could distract energy and focus away from the prime role of caring for patients.

Overall, there was unanimous agreement that the role of the ward leader needed to be understood and valued by the whole organisation. No one route to success was defined, but all participants were exerting considerable effort and energy in addressing this issue, and considered it an ongoing challenge.

1.3 Nurse Leadership

Nurse leadership in general was also discussed and the group confirmed the Burdett Trust findings (2006) that the issues of role overload faced by Ward Sisters/Charge Nurses are replicated for nurses at Board level. Nurse Directors have a myriad of responsibilities which take their time away from nursing. The energy required to create a culture of caring and develop, support and inspire the nursing profession does not appear to have been articulated in ways which Boards can understand or relate to. Participants reported that this is in sharp contrast to the recognised responsibilities of the Finance Director in a Foundation Trust where Monitor, the external regulator, only grant approval for this Director to have additional responsibilities (such as Information Technology or Estates) where a convincing case is made to them.

Those Directors of Nursing who did not manage nursing were still held to account by the Board for nursing numbers and organisation of care. This had echoes of the Ward Sister/Charge Nurse comments in the RCN study (2009) where they were ostensibly in charge, but without the tools (or authority sometimes) with which to effect change directly. As discussed previously, most Ward Sisters/Charge Nurses would be given instructions by their line managers usually the Directorate Managers which might conflict with their duty of care to the individual patient. For example when there are bed management pressures they may be asked to move patients to meet the needs of patients in A&E waiting for a bed, but this may not always be in the interest of the patient that they need to move.

Also whilst the Director of Nursing may introduce a principle that patients are not to be moved late at night, the ward staff may find themselves in the position of being given a different set of instructions by their line/directorate manager—not because general managers are disinterested in patient care but their focus may be on the safety issue of patients in the A&E department, rather than individualised, personal care for all patients. Clearly this will create dissonance for the nurses, as their Code of Conduct states “*make the care of people your first concern, treating them as individuals and respecting their dignity*” (NMC 2008 p3).

In addition, the priorities of the directorate manager may not always match the priorities of the nurses. A “good nurse” might be expected to know who were the illest patients on their ward, how many needed help with eating, or the number of patients with pressure ulcers. However the managers may want them to know how many patients are in A&E waiting for a bed, and how many beds they will have on their ward to accommodate this need. Whilst these are not mutually exclusive requirements, it serves to illustrate the tension between system pressures and priorities, and nursing care. For nurses struggling to identify how to measure the components of compassionate care in a way which are widely accepted and can be bench marked, the management culture can distort priorities and the personalisation of care can be overlooked as the needs of the organisation, in terms of achieving high profile performance measures, takes precedence. This can create internal conflict between being a “good nurse” and responding to what is important to individual patients, and being a “good employee” and responding to what is important to the organisation/their managers. One Nurse Director described the relationship with the Operations Director as “an uneasy truce”.

The political nature of the Nurse Director role had caused increasing pressure for many participants. Most reported that their deputies had no desire to become Nurse Directors, citing the pressure and the high workload as negative influencers. Whilst the satisfaction and rewards of the role were reported to have been eroded over recent years due, in part, to the bureaucratic burden of regulation, and hostile criticism and unreasonable workloads now becoming the norm, all of them felt both a personal and professional responsibility to drive through the improvements they wanted to see for their patients.

Mirroring the findings from the literature review therefore, this pressure for nurses at the top of organisations has echoes of the concerns raised by those in ward leadership positions. A serious question then is how will we retain and support the nurse leaders of the future?

1.4 Organisational and societal culture

Culture was identified as the driving force behind good patient care, hence the need for strong ward leaders as they set the right tone. Participants cited the Burdett Trust report (2006) as useful guidance in closing the gap between Board understanding of patient care and the reality on the wards. As part of this process, all participants had developed their own methods of staying in touch with front line staff and patients and working clinical shifts was now common place. This would have been very rare a few years ago.

A significant change in culture was the continuous pressures in the system and the increased acuity of patients. One Nurse Director described how fast throughput meant that they had 3 patients admitted using one bed in sequence in a 12 hour period on occasions. The days of patients staying in hospital until they were feeling well enough to take the tea trolley round to others, is a distant memory. Despite this a rudimentary examination of staffing levels would not indicate a significant rise commensurate with these changing demands. It is fundamental to ensure that staffing levels on each shift are sufficient to meet the ever changing needs of patients. The Care Quality Commission (CQC) (2011 Box 6) highlighted this issue again.

Box 6

National report on dignity and nutrition reviews published.

Press release CQC 13/10/11

“Having plenty of staff does not guarantee good care – inspectors saw unacceptable care on well-staffed wards, and excellent care on understaffed ones – but not having enough staff increases the risk of poor care. The best nurses and doctors can find themselves delivering care that falls below essential standards because they are overstretched. Staff must have the right support if they are to deliver high-quality care that is clinically effective. In the current economic climate this is harder to deliver; but hospital management must ensure that budgets are used wisely to support staff.”

There are a number of tools available to enable Trusts to assess their staffing requirements, but even then, this is a much more difficult task than it sounds. Introducing electronic rostering helps the organisation of the staff - and may well release time for ward leaders, but how to agree the funded establishment is much more difficult. The nursing wage bill is one of the largest recurring expenditures any Trust Board will make, and therefore always vulnerable when Boards are under financial pressure. Nurse Directors' roles as the guardian of safe staffing establishments - whether or not they hold the financial and managerial responsibility for them - is unlikely to diminish over the coming years.

In terms of setting the culture, participants all recognised the importance of rewards and incentives which focus on delivering good patient care. They had numerous examples of staff awards, which often included patient nominations. One example was a Trust who had worked with patient groups and governors to develop a set of values and behaviours that the public and professional staff expect from their nurses and midwives. Nurses and midwives who sign up to these values, provide evidence of living these values in practice (e.g by citations from patients/relatives) and who achieve a 100% pass in the Trust's assessment of professional knowledge (VITAL), can apply for the newly designed Nursing and Midwifery badge. This and all of the other initiatives discussed in the focus group, was designed to help create the right culture which rewards nurses who demonstrate a focus upon their patients.

1.5 Targets

In the early days of targets and the developing performance regime within the NHS, there was little that related to outcomes for patients, or focused on nursing care specifically. To redress this and ensure that nursing could also be measured, managed and improved, all participants had developed “clinical dashboards” which captured a range of nursing metrics such as falls assessment and nutrition (Box 7) and also included patient experience measures (Box 8). The design of these tools had been informed by national work for example the National Nursing Research Unit (Griffiths et al 2008). Initially this highlighted areas that needed improving, and often meant that the Nurse Directors felt exposed at the Board meetings because of this. However, it also meant that they had some good news stories to report as the dashboards demonstrated the good and improving care that was being delivered in the majority of wards. By reporting to the Board it meant that Governors, local press and the public were hearing about good and improving practice and it was hoped to rebalance some of the negative views of nursing which are constantly in the public eye. Whilst all participants were aware of the sensitivity of this, and concerned about looking complacent in the eyes of patients and carers who had received poor care, they felt a real need to highlight achievements too. Without this they were concerned that the morale of individuals and the profession would continue to decline, and this would be counterproductive to the goal of delivering compassionate care to patients.

Box 7

Measuring Standards of Nursing Care

Falls assessment	Medicine Administration
Nutrition	Observations
Pain Management	Infection Prevention
Pressure Area Care	Diabetes

Box 8

Patient Experience Measures

Include questions such as:

- - do staff wash their hands?
- - have you been treated with respect and dignity?
- - do you get enough help from staff to eat your meals?
- - have staff been available to talk about any worries you have?

There was a general view however that the implementation of these dashboards was patchy across the NHS, and would often be reliant on the tenacity and enthusiasm of individual Nurse Director. As a baseline for improving practice this was seen as a tool that every Trust should employ.

1.6 Wider society

There was recognition that the nursing profession is facing a loss of public confidence, and this was a significant regret for all. The group spent some time discussing this and agreed that this was not a simple issue, relating only to an inadequate education system, or to individual nurses' attitude and behaviour, as much of the coverage might suggest (Cavendish 2011). Indeed difficulties with nurse education or the presence of some unsuitable individuals are not new problems. Menzies (1960) highlighted that the apprenticeship training was causing serious pressures in one London hospital as it tried to balance the demands of patient care with releasing students for their training. Project 2000 had introduced super-numerary status for student nurses which addressed this issue. The inquiries reviewed by Walshe and Higgins (2002) are a sad testament to previous poor NHS care, most of which preceded the introduction of Project 2000. This highlights that some of the contributory factors are more deeply rooted, and led the group to discuss a wider number of issues which impact upon current practice.

The burden of regulation was seen as an issue. On occasions the amount of time spent collecting information and responding to requests from the number of external regulators served as a further time pressure. One participant said they were "drowning in initiatives and guidance" – and yet more continued to be issued. This served only to make people feel that they could never achieve all the requirements, and that being punished for failure was all but inevitable.

The focus group members also reported that the culture of risk aversion and competency assessments was becoming increasingly difficult to manage. As an example they described how every member of staff now has to have a competency assessment before collecting blood from the blood bank, despite having safely managed this for a number of years. Whilst not objecting to competency assessments per se - indeed some of them had introduced their own numeracy tests for example, there was a general consensus that common sense no longer prevailed and the demands of competency training and risk assessments created further pressures on staffing levels and therefore impacted adversely on patients. This culture of defensive/protective practice was becoming a vicious cycle.

In addition participants felt that in the current emotionally charged atmosphere, not all the judgements appeared proportional. There were reports of some external inspectors concluding there were significant issues to be addressed, based upon the lack of knowledge of one junior staff member who had just arrived for her first shift. Not only did this raise issues about the reliability of the inspection process, it also meant a further round of negative media coverage, and action plans to develop and monitor - all of which may or may not improve care, but would definitely divert attention and energy from the initiatives that were being implemented prior to the inspection. However this is clearly difficult territory because it is impossible to defend even one poor experience of care,

though important to ensure that a realistic perspective can be gained in order to inform a more effective response.

A particular frustration reported by the participants was the difficulty in managing poorly performing staff. They all reported making judgement calls which led to the sacking of staff, which then resulted in Industrial Tribunals which were both time consuming and stressful. Whilst not seeking to remove the rights of workers, they did express views about the ease with which staff can seek a Tribunal, even when it seems a prima facie case for dismissal has been established. One focus group member said “being brave costs time”.

They also described a punitive culture as endemic within the NHS. This meant that it was often difficult to do the right thing - for example it would have been difficult to persuade the Board to ignore the policy directive and subsequent performance management reports regarding the introduction of a specific number of Modern Matrons, despite this appearing to undermine the role of the Ward Sisters/Charge Nurses.

The political climate was also seen as unhelpful by the participants. They argued that politicians and civil servants increased public expectations of service provision without taking adequate account of the reality of practice. For example the commitment that service users can expect that the principle “No decision about me without me” (Department of Health 2010a) will underpin their care, presents substantial challenges in terms of meeting individual patient needs in the face of daily bed pressures. The need to make beds available for patients who must be admitted as emergencies can result in other clients being discharged – for example to a nursing home, when this may not be their choice. Patient rights are also enshrined in the NHS Constitution (Department of Health 2010 b). Nurses and other health care staff are then faced with managing the mismatch between policy rhetoric and practical reality.

This backdrop of conflicting pressures made their role in supporting, directing and enabling the nursing workforce to achieve their vision of compassionate care for all, even more challenging. One participant described it as “pushing a snowball up the mountain in the sun”.

2. Education and development

2.1 Pre-registration

The learning environment in the acute setting is recognised as shaping the practice and attitudes of learner nurses. The Nursing and Midwifery Council set the curricula at a national level and all programmes are 50% theory and 50% based in the practice setting. All the participants recognised that ensuring students had a good clinical placement was vital. They accepted their partnership role with the universities, and described student learning as a judicious blend of challenge and support, with staff being brave enough to fail those students who are not able to care, and/or those who do not have the appropriate personal attributes and capabilities.

The role of the Ward Sister/Charge nurse was again seen as pivotal here. They need to engender a culture which welcomes students and ensures they are properly supported and encouraged. They also need to ensure there are good role models in action, demonstrating the delivery of technically safe, effective and compassionate care. This is the most powerful learning of all.

The importance of preceptorship and mentors was also discussed. All participants were developing improved preceptorship for newly qualified nurses and ongoing support for the mentors who are responsible for signing off students from each placement and need encouragement to fail any that do not meet the requirements. One Trust employed all new nursing graduates on a 6 month fixed term contract and provided a graduate development programme which was competency based. If they did not achieve their competency level within this time with additional support, their contract was terminated. This Trust was also in the process of developing a partnership with its local University to award academic credits for the training. This initiative was supported with funding from NHS West Midlands.

In addition there was a recognition of the value in developing closer partnerships with education providers. Some Trusts had more than one University provider however, so this was not always easy. Where the students were shared between one (main) provider and one education establishment, it was simpler to create a learning and practice community. However, equipping students to nurse outside of hospitals is also an important part of their pre-registration programme, which was not considered as part of this work, and adds to the complexity of enabling students to develop an appropriate identity and affiliation with the service.

It seems that both the original apprenticeship system of nurse education, and its successor - Project 2000 are both flawed to some extent. The balance between sufficient theoretical and practical learning to create "a knowledgeable doer" is the Holy Grail. As pre-registration nurse education changes once more, it needs to take these lessons into the future. The combination of good practical placements and sufficient classroom and reflective time are crucial. It is clear that clinical areas need to take responsibility for their students and create the right environment of "belongingness" (Levett-Jones et al 2007). There also needs to be sufficient role models to demonstrate the delivery of skilled compassionate nursing care on a daily basis. The role of mentors is important, as is the partnership with Universities. However the fundamental requirement for good student training is the presence of a strong Ward Sister/Charge Nurse who will create the right environment, support staff and students to manage their stress, and be a strong clinical leader who sets the culture in which good patient care can flourish.

2.2 Continuing professional development

This was not discussed in detail in the focus group though there was a clear recognition that it was important to release nurses' time to support the PREP requirements for registered nurses (Nursing and Midwifery Council, 2011). Many were also using e-learning for mandatory updates on Fire Training or Safeguarding Children procedures for example, as this could reduce the amount of time staff needed to be released from their duties to attend updates.

2.3 The non-registered nursing workforce

Healthcare support workers are hugely important members of the nursing team and we discussed previously the absence of any national standards for training support or regulation of this staff group. However, all participants had invested in some form of training and development for this staff group. NVQ 2 was required as a minimum level in some trusts and was linked to a competency programme to provide an assessment framework to develop staff appropriately.

In summary therefore the focus group cited a range of initiatives they were using to address the needs of students, develop their HCSWs and develop the graduate nursing workforce of tomorrow.

3. Emotional labour of care

There were a number of ideas discussed about the emotional labour of nursing, but most of the group did not appear to be using a specific set of actions to support nurses that would meet their needs as identified in the literature. Participants did relate to the evidence identifying the importance of support mechanisms to avoid nurses from detaching themselves in order to protect their mental well being (Menzies, 1960). They also recognised that the impact of caring for people day in and day out went largely unnoticed and therefore was not accounted for in organisational policy or management practices, other than counselling services for staff exhibiting signs of stress. This contrasts with The Samaritans' approach highlighted earlier, who invest considerable time and effort in supporting and developing their volunteers, including a debrief for volunteers after every shift. This type of systematic support is rare for staff working in hospital wards.

Whilst the participants had not introduced a systematic approach specifically to counteract the emotional labour of caring, they had each developed a number of ways in which to support staff by developing the wider culture. For example one Trust had implemented a coaching programme which involves individuals being accredited as coaches in order to support cultural change in leaders' ways of working. Whilst preceptorship concentrates on an individual's competence, coaching has enabled the behavioural skills of leaders to be developed in order to drive improvement as part of an organisational development approach. This Trust is planning to provide all Ward Sisters/Charge Nurses with a coach rather than mentors, and are rolling out the development of coaches to ensure this resource is available across the Trust. One participant described how hard it was to learn to adopt a coaching approach - she called it

“developing a new muscle”, but welcomed the fact that her Trust viewed it as an important means to support and develop its staff more effectively. This had Board ownership, and the Chief Executive had also undertaken the training, and was actively involved in the scheme.

Another initiative related to changing shift patterns and Nurses were working 12 hour shifts in most of the participants’ Trusts. As a way of reducing stress and tiredness, this seemed counter-intuitive and participants had all expressed reservations. However, nurses themselves welcomed the opportunity to work fewer days and have longer breaks from work. They felt this re-energised them and helped them de-stress and avoid burnout. Where this had been in place for 18 months or more, there were no reported increase in incidents, complaints or sickness, and no obvious reason not to adopt the practice given that the nurses themselves found it beneficial. This paper did not explore the evidence base for this practice.

The negative image of nursing currently is in danger of contributing to a further loss of professional pride and morale and may well impact adversely on patient care. The rationale behind the national initiative introduced by the Department of Health, “*Energise for Excellence*”, is that highlighting good practice will enable both the spread of this practice, and improve morale. The website provides access to tools and approaches which can be used to improve care. It also highlights good practice that exists and the contribution of nurses to the challenge of reducing costs and the wider quality agenda.

There are five domains:

1. Getting staffing right - *(for example using the Safer Nursing Care Tool from the NHS Institute for Innovation and Improvement)*
2. Deliver care - *(for example using the productive tools; safety express; essence of care; high impact actions for nursing and midwifery; Clinical dashboards)*
3. Measures impact - *(for example - productive care; safety express; nurse sensitive outcome measures; high impact actions)*
4. Patient experience - *(for example real time monitoring; experience based design; single sex accommodation; patient stories)*
5. Staff experience - *(for example high impact changes; real time monitoring; Listening into Action)*

More information can be found at www.dh.gov.uk/energiseforexcellence and www.institute.nhs.uk/hia

In summary therefore, lessons from the literature about the importance of focusing on the emotional labour of nursing have not been systematically enacted in practice. Although the Nurse Directors described actions they were taking to develop and support Ward Sisters/Charge Nurses, and wider strategies which were planned to impact upon the culture to create the right environment for care, none of them were using any of the models identified in this paper.

Conclusion

A number of key factors which affect nursing practice have been examined and there was considerable synergy identified between the evidence and practice for most of the issues. The main points are summarised below:

- Changes in hospital design have contributed to the need for nurses to amend their practice in order to interact with patients in a purposeful way.
- The Ward Sister/Charge Nurse role has evolved and incorporates both clinical leader and ward manager responsibilities. As the manager they have assumed a responsibility for performance targets and this may mean they have conflicting priorities between their role as a “good nurse” and a “good employee”. The development of a support structure, such as administrative assistance, is beginning to emerge to help them deliver their wide – ranging responsibilities, but the issue of clarity of purpose remains.
- The literature identifies the emotional cost of care, but this recognition is not embedded in practice. Whilst many participants had taken actions to create the right culture for compassionate practice, there was no systematic programme of support as seen in the Magnet hospitals in the USA or the model the Samaritans adopt for their volunteers. There was an acknowledgement by the participants that nursing is a difficult job, although this discourse seldom features in the current debate, and organisations rarely discuss nursing in these terms. Whilst nursing has always been a difficult role, the challenges may have been compounded, albeit unknowingly, by the removal of some of the rituals of nursing, which may have acted as a defence against anxiety (Menzies 1960).
- In addition, the increasing complexity of healthcare: increased patient acuity; pressures on beds; delivery of targets, and meeting the requirements of numerous external and regulatory bodies, cannot fail to have an impact upon the pressures nurses face. Indeed the development of a performance culture may have affected nursing disproportionately, as it is hard to measure compassionate care. If it is the case that “what matters is what’s measured”, then nursing might be seen not to matter - until there are issues of poor care, when investigations, disciplinary action and blame prevail.
- Nurse education has changed significantly in the last thirty years. Whilst the original apprenticeship model had its share of difficulties, students did seem to feel they “belonged” to the hospitals as nurses. Project 2000 had the benefit of protecting student status by making them supernumerary, but it may have been more difficult for ward staff to view students as “their own”, and create the right culture in which they can learn.
- Stress is evident in nursing at all levels and at all stages of nurses’ careers. The attrition rate for student nurses has remained high for the last forty years or so. There is a marked difference between student nurse attrition and that experienced in the Allied Healthcare Professions. This issue needs further consideration as nurse education changes once more.

- Nursing is part of an increasingly regulated society, and this has affected the training and competency assessments, particularly in terms of additional time required to meet these requirements.
- The increased, and often hostile, scrutiny to which all public services are increasingly subject, has contributed to a situation where there is a growing perception amongst nurses that they are trying to meet unrealistic expectations, and that failure is all but inevitable.
- The invisibility of the complexities of caring may be the reason why nurse leadership is not recognised as a full time role. Directors of Finance in Foundation Trusts rarely have other duties beyond their financial brief. The reverse is true for nursing.

The CQC chair states in her overview of the Dignity and Nutrition Inspection that “Kindness and compassion costs nothing” (CQC 2011). This assumes an economic cost of care, but fails to take account of the emotional cost of care giving. This paper makes a different case. Throughout this paper we have consistently returned to the need to recognise and address the emotional labour of care. We have identified a range of other issues which are also important and many are highlighted in the key messages at the beginning - for example the need to recognise the importance of nurse leadership at Ward and Board level, and to ensure post holders have sufficient time to focus on nursing; the need to support student nurses throughout their clinical placements and provide preceptorship post qualification; the importance of clinical dashboards as a mechanism for identifying, measuring and improving nursing care; and the need to train and develop the Healthcare Support Workers who provide patient care. All of these are important, but are not a solution in themselves.

Ironically, policy for informal carers (family, friends and neighbours providing practical and emotional support) has emphasised the need to ‘care for the carers’ (Larkin and Dickinson 2011). Over time, such policies have recognised that this is: a) a good and cost-effective way to support the person being cared for; and b) that carers have the same rights to a good life as anyone else and deserve support in their own right. Interestingly, the same logic does not seem to have been applied to paid carers.

Mechanistic approaches such as nursing metrics, red trays to identify patients who need help with eating, and “intentional rounding”, also have their part to play - but will be less effective unless we address the fundamental issue: that caring is hard work. We need to understand how to develop systematic support for nurses which replaces old fashioned ritualistic practice, and means that patients are properly cared for. It is time to reshape the care environment and develop models of support which enable good nurses to provide the care they are trained to deliver and patients have a right to expect.

Cornwell in her blog on the King’s Fund site (Care and Compassion in the NHS 17th Feb 2011) states:

“Staff don’t need more blame and condemnation; they need active, sustained supervision and support. In the high-volume, high-pressure, complex environment of modern health care it is very difficult to remain sensitive and caring towards every single patient all of the time. We ask ourselves how it is possible that anyone, let alone a nurse, could ignore a dying man’s request for water? What we should also ask is whether it is humanly possible for anyone to look after very sick, very frail, possibly incontinent, possibly confused patients without excellent induction, training, supervision and support.”

It may seem counterintuitive to suggest that nurses need to be valued and supported when there is a public outcry to address poor practice and hold people to account. However if we are serious about solving the current concerns, the evidence suggests that this may be the missing link in much of the work carried out by organisations in order to improve care for their patients. Perhaps now then, it really is the time to care?

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Chris Ham

http://www.hsmc.bham.ac.uk/publications/policy-papers/Kaiser_policy_paper_Jan_2010.pdf

Policy paper 7

GP Budget Holding: Lessons from Across the Pond and from the NHS

<http://www.hsmc.bham.ac.uk/publications/policy-papers/HSMC-policy-paper7.pdf>

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Policy Paper 8

'The Billion Dollar Question': Embedding Prevention in Older People's Services - 10 'High Impact' Changes

Kerry Allen and Jon Glasby

<http://www.hsmc.bham.ac.uk/publications/policy-papers/policy-paper-eight.pdf>

Policy Paper 9

All in This Together? Making Best Use of Health and Social Care Resources in an Era of Austerity

Jon Glasby, Helen Dickinson and Robin Miller

<http://www.hsmc.bham.ac.uk/publications/policy-papers/policy-paper-nine.pdf>

Policy Paper 10

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Policy Paper 11

Liberating the NHS: orders of change?

Ross Millar, Iain Snelling, Hilary Brown

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