Editor’s view

Compassion is at the very core of nursing practice, and a quality most nurses possess in spades. However, reports in 2011 from the Health Service Ombudsman and the Care Quality Commission showed that not all patients receive compassionate care from nursing staff. And unsurprisingly, the reports concerned the most vulnerable of patients such as older people and those nearing the end of their lives – the very people in greatest need of humanity and kindness from the people providing their care.

There are probably many reasons why the often-shocking situations contained in these reports occurred. Doubtless a lack of compassion among a minority of the health professionals concerned played a part, but that is far from the whole story – staffing levels and skill mix, and the fact that patients in hospital are increasingly dependent are also to blame. Other local factors will also have played a part in the individual situations.

At Nursing Times we recognise that the vast majority of nurses go to work wanting to provide compassionate, high-quality care to patients and their families. We also recognise how difficult this can be in the less than perfect environments in which they work.

This special supplement aims to support you in providing compassionate care. It offers articles to help you reflect on the nature of compassion in general and on how experts believe health professionals should respond to the Ombudsman’s findings. There is also a selection of articles on care for the vulnerable patients highlighted by the Ombudsman and the CQC, as well as their loved ones. We hope it will give you both food for thought and some useful information to help you and your colleagues to improve systems and environments in ways that will help you to offer the compassionate care most of you joined the profession to provide.

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“We can read Nightingale as a credo for compassion today”

Compassion, or the lack of it, has been at the heart of nursing reform. The slovenly, drunken ways of nurse Sairey Gamp depicted by Charles Dickens in his novel Martin Chuzzlewit, symbolised the ills of the old order.

But Sairey and her ilk were to be stamped out and replaced by her more compassionate – and compliant – Christian counterpart, the new model nurse.

The Christian morality associated with the early days of nursing was condensed into the character training of nurses advocated by Florence Nightingale. Under her tutelage, character training became the moral compass for a nurse’s actions. Nightingale’s writings are filled with rhetoric that reveals not only her skill as a practitioner, but the premium she put on compassion. This was not an untutored compassion – it was informed by imagination, empathy and intelligence, and allied to action.

Nowhere is this more evident than in her Notes on Nursing. Take noise, for example. She wrote: "Unnecessary noise then is the most cruel absence of care, which can be inflicted either on sick or well.... A nurse who rustles (I am speaking of nurses professional and unprofessional) is the horror of a patient, though perhaps he does not know why. The fidget of silk and of crinoline, the rattling of keys and of shoes, will do a patient more harm than all the medicines in the world will do him good."

Nightingale deployed the full might of her intellectual and emotional energy in Notes on Hospitals. It is not just the encyclopaedic range of her knowledge of hospital design, sanitary arrangements and statistics, but her intimate acquaintance with the details of patient care that mark out her authority.

The environment in which patients were cared for was central. She recognised, for example, that light played a major role in recovery. She noted the value of “being able to see out of a window, instead of looking against a dead wall; the bright colours of flowers; the being read to in bed by the light of a window close to the bed-head”.

Every detail of nursing care is illustrated with precision, from food, nutrition and cooking and the role and position of laundries to the comfort and composition of mattresses.

We can read Nightingale as a credo for compassion today. She recognised that systems needed to foster and institutionalise compassion, and that small touches and details mattered. Leading by example, and embedding a code of behaviour that could be sustained even in your absence was and should remain our goal today.

The challenges we see in care are not new. We continue to fail the most vulnerable members of our society. We need to acknowledge there is a problem, accept responsibility and understand the dynamics of why some organisations succeed and others fail.

Clarity of purpose, moral courage and a coalition for action was Nightingale’s response to the call. We need to do likewise – to light and lead the way.

Anne-Marie Rafferty is dean of the Florence Nightingale School of Nursing and Midwifery, King’s College London
Compassion has been an essential quality for nurses since Florence Nightingale’s time. How have historical authors described the concept?

Compassion: what history teaches us

This article...
- Historical views on compassion in nursing
- The importance of the “compassionate character” in nursing literature
- The qualities nurse writers and educators believed were necessary to excel in the profession

Author
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Abstract

Although the government and nursing bodies agree that patients have a right to be treated with compassion, reports such as the Health Service Ombudsman’s report Care and Compassion? have criticised the NHS, and nurses in particular, for lacking this quality. This article considers how compassion has been characterised by nurse writers and educators throughout the profession’s history and considers what lessons can be learnt by the profession today.

Earlier this year, the Health Service Ombudsman’s (2011) report Care and Compassion? criticised the standards of care for older people. The document described a number of cases, representative of some 9,000 complaints, saying they “present a picture of NHS provision that is failing to respond to the needs of older people with care and compassion”. Two years earlier, the Healthcare Commission reached similar conclusions. It said trusts needed to resolve shortcomings in nursing care – specifically compassion, empathy and communication (Healthcare Commission, 2009). Earlier reports had also expressed concern about a lack of care and compassion in healthcare, particularly towards older people (Health Service Commissioner for England, for Scotland and for Wales, 1998; 1997).

Government and nursing bodies agree patients have a right to be treated with compassion (Prime Minister’s Commission on the Future of Nursing and Midwifery, 2010; Knight et al, 2008). In addition, compassion, care and communication are designated as elements of an “essential skill cluster” by the Nursing and Midwifery Council (2010). The question is: can nurses be taught to be compassionate?

The compassionate character
Historically, developing the “compassionate character” was the impetus for care, and gave the nursing profession its ethos. In Florence Nightingale’s view, good nurses were good people who cultivated certain virtues or qualities in their character – one of which was compassion. Patients were expected to be the centre of all nurses’ thoughts. Nurses had to always be kind (but never emotional) because they were caring for living people, unlike plumbers or carpenters. As Nightingale reiterated in letters to probationer nurses, it is what the nurse is inside that counts, “the rest is only the outward shell or envelope” (Nightingale, 1873-1897).

From Nightingale’s time until the 1960s, numerous nurse writers championed similar ideas of care. Most textbooks began with an introductory chapter on the moral basis of nursing and the importance of developing a virtuous character. Writers used the same language and approach as Nightingale.

One of the earliest was Florence Lees, who oversaw the care of the wounded in the Franco-Prussian War. She listed the qualities nurses needed to learn in training school, which were cleanliness, neatness, obedience, sobriety, truthfulness, honesty, punctuality, trustworthiness, quickness and orderliness. Nurses also had to be patient, cheerful and kindly (Lees, 1874).

Nurse training was about becoming kind and compassionate, as well as technically competent. Nursing teachers believed that, in order for nurses to be compassionate, they needed to be trained to develop a compassionate character.

Inborn love of nursing
Rachel Williams of St Mary’s Hospital, London, and Alice Fisher of the Fever Hospital, Newcastle upon Tyne, entreated women not to enter nursing simply to earn...
5 key points

1. **Government and nursing bodies agree patients have a right to be treated with compassion**

2. **Historically, developing a “compassionate character” was the impetus for care, and gave the nursing profession its ethos**

3. **Throughout nursing history, compassion has been viewed as a quality associated with an individual’s character**

4. **Compassion is about the intent and practised disposition of the nurse**

5. **Genuine compassionate care is not a quantifiable skill, an assumed technique or an emotion or feeling – it is the humane quality of kindness**

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a living. Nursing had to be about an “inborn love” of the work. Nurses needed to combine unselfishness and a strong resolution not to be conquered by difficulties” (Williams and Fisher, 1877).

Catherine Wood, the lady superintendent of the Hospital for Sick Children, Great Ormond Street, took a similar view. Nurses were not born but made; they needed to have six qualities, which are outlined in Box 1. She advocated that nurses must think only of their patients’ comfort, not of themselves, that they should be conscientious and diligent, unseen as well as seen. In 1878, she wrote:

“Gentleness of the heart will teach gentleness to the hand and to the manners. I can give no better rule than to put yourself in your patient’s place.”

Eva Lückes, matron of the London Hospital, argued the personal qualities of the nurse were the absolute basis for nursing. Above all, the “character” of the nurse made the “real” nurse. She believed the indispensable qualities of this vocation were: self-discipline, personal responsibility for learning, truthfulness, obedience, punctuality, loyalty and the kindliness of genuine compassion (Lückes, 1886).

EJR Landale taught that nurses needed certain qualities – quietness, presence of mind, gentleness, accuracy, punctuality, memory, observation, forethought, promptness, unselfconsciousness, obedience, kindness and courtesy. Service before self was the only motivation suitable for the nurse. To escape the monotony of a narrow home life, to earn a living or raise social status were unacceptable reasons for taking on the role (Landale, 1893).

Similarly, at the turn of the 20th century, Mary Annesley Voysey considered the nurse’s qualities and motivations, concluding that nurses needed to be “...obedient, truthful, conscientious, careful, kind and faithful, and work without looking for results” (Voysey, 1905).

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**Development of virtue**

MN Oxford, a sister at Guy’s Hospital, stressed the importance of virtuous qualities in her nursing textbook. Nurses should be temperate, sober, careful, clean and busy, and in behaviour “virtuous, loving, diligent” (Oxford, 1900). This was also the view of E Margaret Fox, matron of the Prince of Wales’s Hospital in north London’s Tottenham. Character was more important than cleverness; attributes such as reverence, gentleness, discretion and uprightness needed to be cultivated for the wellbeing of patients (Fox, 1914).

This teaching on the development of virtue was also evident in the writings of A Millicent Ashdown, a lecturer in bandaging and practical work at King’s College, London, and former examiner to the General Nursing Council. Ashdown suggested nurses’ main qualifications be a “real love” for attending to the sick and helpless, a strong constitution and an equable temperament. Discipline, obedience, loyalty, generosity, tenderness, gentleness and cheerfulness were the basis of her work:

“[Nurses] must look upon their patients as individuals to be cared for personally, not merely as ‘cases’ to be treated medically” (Ashdown, 1917).

M Vivian, former matron of Victoria Hospital in Deal and Princess Christian Hospital in Weymouth, reiterated these same values and stated that the hardships nursing involved – overwork and underpay – and the lessons of self-denial formed a nurse’s character and methods of thought. This formed the “rule of life”, which gave them the highest possible ideals and standard of work (Vivian, 1920).

E Maude Smith, former matron and superintendent of nurses at Withington Hospital in Manchester and examiner for the General Nursing Council, reminded nurses they could not be a good nurse without being a good woman (Smith, 1929).

A year later, the matron of Charing Cross Hospital, Mary Cochrane, wrote that, despite changes in nursing brought on by the First World War, “many restrictions and apparent hardships are abolished, but the profession still calls for high principles and courage; in fact, all the essentials, which went to make the first nurse” (Cochrane, 1930).

**Modern age of nursing**

As the modern age of nursing approached and biomedical nursing knowledge...
Discussion

progressed, the profession’s ethical foundation remained. Esther Fisher, matron of New End Hospital, in London’s Hampstead, described nursing as “a sacred calling” – its purpose being to alleviate the sufferings of humanity – and so not to be taken up lightly. For this reason, the qualities of the nurse were extremely important (Fisher, 1937).

Evelyn Pearce, a former senior nursing tutor at the Middlesex Hospital and a member of the General Nursing Council, reiterated this vision in her textbook and continued to do so in subsequent editions. She saw nursing as evolving technically while maintaining the Nightingale tradition:

“The present generation of nurses has grown up entirely in the technological age of this century. The modern nurse, like the modern doctor, is the product of an evolutionary process, but one where, nevertheless, her compassionate approach to patients remains unchanged” (Pearce, 1937-1971).

In a later edition, Pearce developed her teaching:

“Character is what we make of ourselves through the acquisition of moral virtues – the ‘cardinal virtues’ of prudence, justice, temperance and fortitude.”

Compassionate care is not expressed so much in words but in actions, such as a firm touch, gentle and courteous manner and kindness. In 1969 she explained that:

“Kindness cannot be overestimated. It endows the character with qualities which make it rich and warm as the sentiments of the heart temper the efficiency of the work of head and hands.”

Margaret Houghton began her textbook with a history of nursing as a vocation and described the qualities of character and mind nurses had to develop or acquire during training. These included kindliness, sympathy and a cheerful and pleasant manner towards patients to relieve their anxiety and encourage confidence (Houghton, 1938).

Similar views were expressed in 1950 by two sister tutors from Guy’s Hospital, Hilda Gratton and Dorothy Holland, who were both General Nursing Council examiners. While they agreed patterns of nursing had changed from old traditions of nursing, which rested on nurses being utterly devoted to the profession, they argued they must not lose their idealism or need for self-discipline. Training started and should continue at the bedside, they asserted. Patterns changed but virtues did not. Nurses absorbed these values through examples of others’ daily practices. The good nurse was the kind nurse who took pleasure in spending time with patients and developed relationships with them.

Lillian Darnell, secretary of the Nursing Recruitment Service at King Edward’s Hospital Fund, suggested Nightingale’s list of the qualities required of a good nurse could not be bettered (Darnell, 1959). Winifred Hector, principal tutor of St Bartholomew’s Hospital, wrote that nurses needed not only mental and physical health, but also reserves of spiritual strength as the foundation for their work (Hector, 1960).

For a century, nurse writers thought compassion was an essential virtue to be developed by nurses to cope with the discipline, hardship and stress associated with nursing life. This was part of training and fundamental to the apprenticeship model. Compassion was a quality of character in nature to be nurtured by training.

Jarvis, an educationalist, rather than a nurse, referred to this historical approach to nurse training as a “process of induction”. Nurse educators were guardians of a tradition about the meaning of nursing. This involved the education of character, and the character of the nurse was as important as the knowledge she or he possessed (Jarvis, 1996).

Conclusion

Throughout nursing history, compassion has been viewed as a quality associated with an individual’s character. Compassion stems from virtue. It is about the intent and practised disposition of the nurse. It is nurtured in, and by, the culture and ethos of clinical practice.

Compassion is not strained by pressure or displaced by stress. The greater the hardship, the more compassion is required. Genuine compassionate care is not a quantifiable skill, an assumed technique or an emotion or feeling. It is the humane quality of kindness.

References


Nightingale F (1877-1879) Letters and Addresses to the Probationers in the “Nightingale Fund” School at St Thomas’s Hospital and Nurses who were Formerly Trained There. Original Letters and Prints for Private Circulation. Letters dated 1873, 1874, 1888. London: University College Library Holdings.


Ensuring compassionate care in hospital

In this article...
- Why compassion is important in nursing
- The elements of compassion
- Barriers to providing compassionate care
- Practical changes to ensure compassion

The King’s Fund Point of Care programme explores the barriers to providing compassionate care in hospital and how nurses can ensure such care.

C

are, compassion and respect have always been enshrined in the value statements of the health professions (Nursing and Midwifery Council, 2009; 2008).

However, ‘compassion’ has recently gained a higher profile with policymakers. The NHS Constitution sets out certain NHS values including respect, dignity and compassion: ‘[The NHS] touches our lives at times of most basic human need, when care and compassion are what matter most’ (Department of Health, 2009).

We wanted to look more closely at compassionate care – what it is, what prevents it and what enables staff, day in and day out, to be compassionate towards every patient in their care. To do this, we held a one-day workshop bringing together people who work in hospital (nurses, doctors, psychologists, chaplains, managers) and experts who have written on or researched the topic.

We have also published a short paper reviewing the literature on compassion and concepts related to it (Firth-Cozens, 2009). This article is based on the discussions at the workshop as well as the paper (www.kingsfund.org.uk/pointofcare_compassion).

Why does compassion matter?
Healthcare staff want to be able to care for patients with humanity and decency and to give patients the same kind of care that they would want for themselves or their loved ones (Goodrich and Cornwell, 2008).

For many staff, such a desire may have been a motivating factor in their decision to enter the healthcare professions in the first place. Practitioners want to be able to show compassion to their patients.

Compassionate care matters to patients. Anecdotally, it is the presence or absence of compassion that often marks the lasting and vivid memories patients and family members retain about the overall experience of care in hospital and other settings.

Improving patients’ satisfaction about their experience of care is an outcome most patients and families agree has value in itself, and is emphasised in the goals in recent key policy documents (Department of Health, 2008).

Research evidence suggests that compassion affects the effectiveness of treatment. For example, patients treated by a compassionate caregiver tend to share more information about their symptoms and concerns, which in turn yields more accurate understanding and diagnoses (Epstein et al, 2005).

In addition, since anxiety and fear delay healing (Cole-King and Harding, 2001), and compassionate behaviour reduces patient anxiety (Gilbert and Procter, 2006), it seems likely that compassionate care can have positive effects on patients’ rate of recovery and ability to heal.

The elements of compassion
Compassion, in simple terms, is ‘a deep awareness of the suffering of another coupled with the wish to relieve it’ (Chochinov, 2007). It requires that staff give something of themselves. When fatigue, personal factors and organisational circumstances conspire to create workplace stress, it becomes more difficult for staff to feel and show compassion, creating a gap between their intentions and their capabilities.

Sometimes it is easier to identify when compassion is missing than when it is present. In the broadcast and print reports of failures in hospital care – such as, for example, the reports of the Healthcare Commission’s (2009) and (2007) investigations into Mid Staffordshire and Maidstone and Tunbridge Wells NHS trusts – it is the apparent lack of compassion that fuels media outrage.

It is important to note that the focus on compassion should not reside merely at the ‘sharpest ends’ of care – that is, in emergency situations, or when a patient is known to be dying. Lack of compassion in mundane aspects of care also takes its toll on patients and staff. Indeed, it is the ‘little things’ that patients or carers often recall as having been either present or lacking in their experiences of care. For examples of these ‘little things’ go to www.kingsfund.org.uk/pointofcare_compassion.

Assessing compassion
How do we assess how good we are at delivering compassionate care? The question is important, but it also presents an immediate, inherent challenge in an NHS reliant on quantified targets and measures.

If we accept that compassion is a felt experience, it follows that the closest we can come to measuring compassion is to...
5 key points

1 The concept of compassion in healthcare has gained a higher political profile recently

2 Compassion requires health professionals to "give something of themselves"

3 It is sometimes easier to identify when compassion is not present than when it is

4 Regular exposure to trauma can cause health professionals to withdraw compassion as a defence mechanism

5 Senior staff can help staff to demonstrate compassion by acting as a role model and by enabling good teamworking

ask patients whether or not they experienced it. Measures of compassion must rely to a large degree on patients' own subjective assessments of their experiences of care, which can be obtained in a variety of ways: interviews; questionnaires; frequent feedback mechanisms; and surveys.

There are other types of measure that might also be considered – measures of process and measures of structure. Since compassion can demonstrate itself in very practical ways, there are objective, practical measures that may indicate or point to its presence or absence (the 'feeling for' the patient) in the way care is delivered.

In this way, we can say that many of the physical indicators already assessed, while they might not measure compassion directly, do point towards it. The measures we have in mind are ones such as: how quickly staff respond to call bells; whether patients' feeding needs are attended to; how well pain is managed; and how often and at what times of day or night patients are moved from ward to ward. All of these have an impact on continuity of care and relationships between staff and patients.

These basic indicators of aspects of quality of care may tell us something about attitudes and behaviours that are important with respect to compassion. Poor performance in any of these dimensions may not be caused by a lack of compassion but rather might be taken as indications of environments in which patients are at risk of feeling uncared for, and therefore merit further investigation.

Structural measures that complete the more rounded attempt to measure compassion would be measures of risk in the physical environment or risk to staff capability to deliver compassionate care. Risk in the physical environment of care would need to be observed and audited. Risks to staff capability would be available from feedback in staff surveys to questions about the quality of leadership and support and teamworking. They would also be available in some of the human resource data such as: measures of staff turnover; vacancy rates; and the use of bank and agency staff in different locations.

What prevents compassionate care?

Why, when staff may have entered the healthcare profession with high ideals, abundant stores of compassion and a strong motivation to treat patients as they themselves would want to be treated, do lapses in compassionate care occur?

The main reason may involve the natural defences we develop in reaction to trauma. In care settings, staff experience regular, frequent or in some cases continuous exposure to human beings in varying states of pain and distress. Sometimes the defence takes the form of inappropriate joking; sometimes it manifests itself in numbing, a distancing reaction and withdrawal, as described by an acute care nurse in Box 2.

The key point is that under these conditions, practitioners must develop coping mechanisms – some more effective or appropriate than others.

Staff who do not find effective ways of coping may be more susceptible to stress and burnout. Self-reported stress of health service staff in general is considerably greater than that of the general working population (Wall et al, 1997).

Stress and depression is evidenced by high self-criticism (Brewin and Firth-Cozens, 1997), and a lack of compassion towards oneself is likely to work its way through to a lack of compassion towards patients (Gilbert, 2009).

Stress and burnout have their origins in different sources, some of them individual, some of them situational:

Box 1. The Elements of Compassion

- Compassion starts with good basic care and can be demonstrated in very practical ways, e.g. ensuring a patient’s feeding needs are addressed, that pain is managed and that the patient is helped to the toilet as needed. It can be equated with providing both dignity and respect.
- Compassion goes beyond this, to encompass empathy, respect, a recognition of the uniqueness of another individual and willingness to enter into a relationship in which not only the knowledge but the intuitions, strengths, and emotions of both patient and [caregiver] can be fully engaged (Lowenstein, 2008).
- As such, compassion involves ‘real dialogue’ – communication that is human to human rather than clinician to patient.
- The compassionate caregiver never stereotyped but appreciates difference, recognising the common humanity shared by both patient and caregiver.
- Compassion should not necessarily be seen as being sweet and nice. It includes honesty and may require courage.
- It is not a one-size-fits-all approach. Compassion can mean very different things in different situations and to different people. In recognising the individuality of each patient, compassionate carers will also recognise how best to tailor their behaviour to show compassion based on an individual’s needs.
- In short, for healthcare professionals, compassion means seeing the person in the patient at all times and at all points of care.

Box 2. A Nurse’s View

On exposure to death and dying

- I went to work on an elderly ward where patients died daily and there was great pressure on beds. At first, I did all I could to make the lead-up to a death have some meaning and to feel something when one of them died. But, gradually, the number of deaths and the need to strip down beds and get another patient in as fast as you can got to me and I became numb to the patients; it became just about the rate of turnover, nothing else. (Firth-Cozens, 2009)
Individual factors:
- Age and experience;
- Self-esteem levels;
- Personal resilience;
- Job satisfaction.

Situational factors:
- Regular exposure to pain and distress;
- Conflicting information about what the organisation expects from staff or what is valued in the organisation;
- Poor feedback systems or lack of recognition or praise for individual acts of compassion and care;
- Lack of time and simultaneous pressure to meet targets.

Compassion, too, can become problematic for staff in settings where displays of emotion are treated as a failure to maintain an appropriate professional distance or authority. Though not necessarily unique to any one profession, this is particularly relevant to those in roles that place a high value on professional detachment. Such attitudes are more commonly associated with doctors but perhaps increasingly prevalent in nursing.

The role of education in teaching healthcare staff professional values and standards is also important. In medicine, the psychosocial aspects of caregiving have tended to command secondary status, and workshop participants felt this was increasingly common in nursing training. Training that emphasises professional detachment and positions compassion as ‘soft and fluffy’ may have a detrimental impact on interpersonal relationships between staff and patients – and to the quality of care delivered.

Even where the value of compassion is taught in the syllabus, there is a concern that, without systematic modelling and explicit endorsement and support for striving to be compassionate towards every patient, every time, it will be eroded and more difficult to practise.

**Enabling compassion**

When staff caring for patients feel under pressure and are subject to time constraints, it is often difficult to do just that one thing for the patient that makes the individual feel cared for. Enabling staff to feel and be compassionate towards patients in their care, at all times, requires action on multiple levels.

At an individual level, a powerful resource that healthcare professionals consistently cite is patients’ stories. In cases where professionals themselves, or their loved ones, become patients, the nature of their personal experience of care very often has a profound effect on how they carry out their clinical practice. Where first-hand experiences of care are not available, exercises in which staff are asked to role-play or write a narrative imagining themselves as patients can have a similar usefulness.

Providing practitioners with a forum for open and honest dialogue about their experiences of delivering care is similarly important. A safe and recrimination-free environment in which to discuss the everyday challenges, frustrations and pressures of the job – in which sharing stories and feelings about patients and their care is legitimised – is essential.

It helps to remind busy staff that every patient is individual and unique; it provides support to individuals; it encourages communication within the team; and it helps to improve team dynamics.

Good team relations make a difference not only to the quality of interactions among team members but also to the quality of care delivered to patients (see Box 3 for the markers of a good team). As such, enabling good teamwork is important.

Within teams, those in senior positions can enable compassion among staff by modelling compassionate behaviours – towards themselves, other staff and patients – often through relatively simple gestures, for example by encouraging a junior colleague to take a meal break or by taking one themselves.

We also need to focus our attention on the formative stages of the professions, while nurses and doctors are learning their roles within a hospital. If modelling compassionate behaviour is crucial in the message it sends to all levels of staff, it is especially so when students are in hospital to observe and learn. Mentoring is particularly important in teaching settings and for practitioners at the start of their careers.

None of these suggestions will make much impact, however, if staff remain unaware of what is valued in the organisation or feel undervalued in their jobs. Providing regular feedback to staff on their performance and providing recognition when they deliver compassionate care can help alleviate stress and counter poor organisational morale.

Finally, acute care could learn from palliative care. With its primary emphasis on patients’ experience, on their physical and psychological comfort and quality of life, the palliative care setting can serve as a model of how to better integrate a focus on compassion into care delivery.

**Box 3. WHAT MAKES A GOOD TEAM?**

- Its task is defined and its objectives are clear
- It has clear boundaries and is not too large (ideally fewer than 10 people)
- Its members know who leads it and the leadership is good
- There is participation in decision-making by all members, good communication and frequent interaction between them
- It meets regularly to review its objectives, methods and effectiveness
- Its meetings are well conducted
- Its members trust each other and feel safe to speak their minds
- There is a shared commitment

**References**


What can we learn from the ombudsman?

Expecting dignified, pain-free care, in clean surroundings in hospital should be the right of all older people. However, a report by the health service ombudsman (see her comment, right) that addresses serious complaints against the NHS, has highlighted cases where older patients have suffered unnecessary pain, neglect and distress.

The ombudsman report, Care and Compassion? (Health Service Ombudsman, 2011) is based on the findings of in-depth reviews of 10 independent investigations, concluded in 2009-10, into complaints about NHS care for older people across England. Nine of the 10 patients died during the events described in the case studies or soon afterwards. A selection of the cases are summarised in Boxes 1-3.

Of nearly 9,000 complaints made to the ombudsman about the NHS last year, 18% were about the care of older people. In total, it accepted 326 cases for investigation – twice as many as for all the other age groups combined. In a further 51 cases, the ombudsman resolved complaints directly without the need for a full investigation.

The issues highlighted in these cases – dignity, healthcare-associated infection, nutrition and hydration, discharge from hospital and personal care – featured significantly more often in complaints about the care of older people.

In the wake of these stories, health service ombudsman Ann Abraham is demanding an urgent change in the health service’s attitudes towards the over 65s.

Nursing Times asked a range of expert nurses and commentators to analyse what this report means for nursing and what the profession can learn from its findings.

Jonathan Webster: A challenge to ways of working

This report highlights a number of failings in care that cannot be condoned or excused. The cases should act as a wake-up call for nurses, our managers, employing organisations and policy makers.

The report also brings to the fore the need to challenge and question values, beliefs and ways of working that diminish dignity and the essentials of skilled compassionate nursing care.

Leadership in older people’s nursing – at all levels – along with effective work-based cultures are fundamental to quality. Leaders set the scene – they enable and support while challenging unsatisfactory practice. The culture reflects the values underpinning care and skilled therapeutic working.

Meeting the needs of older people with multiple needs can be complex. Understanding the interplay of physical, psychological, social and spiritual needs, at a time when the person and family may be highly vulnerable, requires skill and knowledge.

Frequently, the term “basic care” is used to describe meeting such needs – but there is nothing basic about essential, skilled care.

We need to understand what leads to poor care and to address these failings. Day-to-day practice can bring immense challenges, but fundamental to our role as nurses working with older people is the need to ensure they are central to care, irrespective of where that care is delivered.

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Jonathan Webster, assistant director, quality and clinical performance, Bexley Care Trust; honorary senior research fellow, Christ Church Canterbury University, and honorary nurse clinical director for older people, NHS London.

Jocelyn Cornwell: Why not say sorry?

Nurses and doctors often say they are not allowed to say sorry because their employers or their insurers won’t let them. This is actually not true: NHS policy changed some time ago, as have the insurers, but people still believe it.

No one likes being judged or being in the wrong. They like it even less if they are unhappy about the thing in the first place, or feel guilty and ashamed.
Our first instincts are always defensive and people really hate criticism if they feel it’s unfair; perhaps others were involved; it was not their fault; or they feel the circumstances prevented them from doing anything about it. Nurses may find it hard to say sorry when they feel they have been left carrying the can for other people and feel powerless to do anything differently.

The same simple psychology plays out in organisations: corporate bodies are instinctively defensive.

For decades, governments and ombudsmen have urged NHS organisations to respond differently to complaints, to apologise when things go wrong, and to take complaints seriously and learn from them.

But they continue not to do so. Most NHS trust boards will receive reports on numbers of complaints received and how long it took to respond to them, but very few examine what caused them. Every trust has an established process for investigating complaints and punishing wrongdoers, but hardly any have established processes for learning from complaints and supporting staff when things go wrong.

Unless and until that changes, I don’t expect to see nurses or anyone else lining up to say sorry.

Jocelyn Cornelius, director, The Point of Care, The King’s Fund

“Each of my investigations led to change… [but] I have yet to see convincing evidence of a shift in attitude towards older people across the NHS”

The opening words of the NHS Constitution say: “The NHS touches our lives at times of basic human need, when care and compassion are what matter most.”

Yet my investigations reveal an attitude – both personal and institutional – that fails to recognise the humanity and individuality of the people concerned and to respond to them with sensitivity, compassion and professionalism. They present a picture of NHS provision that is failing to meet even the most basic standards of care.

There are very many skilled nurses in the NHS who provide a compassionate and considerate service to patients. Yet the cases I see confirm that this is not universal. Instead, the actions of individual staff add up to an ignominious failure to look beyond a patient’s clinical condition and respond to the social and emotional needs of the individual and their family.

The difficulties featured in Care and Compassion? were not solely a result of illness, but arose from the dismissive attitude of staff, a disregard for process and procedure and an apparent indifference to deplorable standards of care.

Each of my investigations led to real change at the hospitals or GP surgeries concerned, including staff training, new systems to ensure better information provided to families and improved record-keeping. I have yet to see convincing evidence of a widespread shift in attitude towards older people across the NHS that will turn the commitments in the NHS Constitution into tangible reality. An impetus towards real and urgent change is needed.

Every member of NHS staff should pause and ask themselves if any of their patients could suffer in the same way. I know from my caseload that in many cases the answer must be “yes”. The NHS must close the gap between the promise of care and compassion outlined in its constitution and the injustice that many older people experience.

Every member of staff – no matter what their job – has a role to play in making the commitments of the Constitution a felt reality for patients.

Ann Abraham, health service ombudsman

“A PICTURE OF NHS PROVISION THAT IS FAILING TO MEET EVEN THE MOST BASIC STANDARDS OF CARE”

Care and Compassion? tells the stories of 10 people over the age of 65, from all walks of life and from across England.

Many of them were people with energy, creativity and vitality, active in their retirement and well-known and liked within their communities. They wanted to be cared for properly and, at the end of their lives, to die peacefully and with dignity. What they have in common is their experience of suffering unnecessary pain, indignity and distress while in the care of the NHS.

Their stories, the results of investigations concluded by my office in 2009-10, illuminate the gulf between the principles and values of the NHS Constitution and the felt reality of being an older person in the care of the NHS in England. These are not exceptional or isolated cases and the issues highlighted – dignity, healthcare-associated infection, nutrition, discharge from hospital and personal care – feature significantly more in complaints I receive about the care of older people.

“Care and Compassion?” tells the stories of 10 people over the age of 65, from all walks of life and from across England. Many of them were people with energy, creativity and vitality, active in their retirement and well-known and liked within their communities. They wanted to be cared for properly and, at the end of their lives, to die peacefully and with dignity. What they have in common is their experience of suffering unnecessary pain, indignity and distress while in the care of the NHS.

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CASE STUDY 1: MR W

Mr W was 79 years old. He suffered from dementia and depression, was frail and had not long been widowed.

He was admitted to St Peter’s Hospital (part of Ashford and St Peter’s Hospitals Foundation Trust) with recurrent dehydration and pneumonia. The hospital treated Mr W with intravenous fluids and antibiotics, which were stopped when his chest infection cleared up.

A week later, his daughter, a former nurse, told a doctor caring for Mr W that she was concerned that his general condition had deteriorated during his admission and that he would be better off receiving IV fluids. The doctor said he could not do this as it would “prevent his leaving hospital” and that “he can meet his needs orally”.

Mr W’s daughter disagreed as he frequently refused to eat and drink more than small amounts. The doctor said that Mr W was medically fit for discharge, but that he was frail and prone to further infection and any further treatment should be palliative.

Over the next few days, Mr W ate and drank very little. He refused most meals and drank about one cup of fluids each day. Feeding him through a percutaneous endoscopic gastrostomy tube was considered but ruled out because of the high risk of death associated with PEG feeding of patients with advanced dementia.

Despite his daughter’s concerns, the hospital discharged Mr W to a care home on Christmas Eve. He weighed just 6st 7lb. They did not tell his family who therefore “could do nothing to stop it.”

Three days later, Mr W was admitted to a different hospital with breathing difficulties. He was severely dehydrated and had pneumonia. This hospital treated Mr W’s pneumonia and fed him through a PEG tube. His daughter told the ombudsman that, once the tube had been inserted and Mr W received adequate nutrition and fluid, he had been “transformed”. She said that, after this treatment, Mr W had not needed to be hospitalised since, enjoyed life and participated in activities in the care home.

After complaining first to the trust and then to the Healthcare Commission, Mr W’s daughter came to the ombudsman. She felt the trust had put Mr W’s life in danger by discharging him and then to the Healthcare Commission.

Mr W’s daughter later called and she was taken to Ealing Hospital Trust at about 10.30pm, accompanied by her husband. She was admitted to accident and emergency and assessed on arrival by a senior house officer who asked Mr W to wait in a waiting room.

Mrs J was very ill. She was taken to the resuscitation area, but was moved later when two patients arrived who required emergency treatment.

She was then seen by a specialist registrar as she was vomiting and had become unresponsive. It was decided not to resuscitate her. She died shortly after 1.00am. At around 1.40am, the nursing staff telephoned the nursing home and were told that Mr W had accompanied her wife to hospital. The

Gaye Kyle: Continence care is essential for dignity

Whenever the media reports poor nursing care, you do not have to look far to find a continence issue – soiled linen left unchanged, slow response to call bells for help with going to the toilet, dirty toilets, and verbal abuse because a patient has had an incontinent episode.

Loss of patients’ dignity comes about by diminished control of their bodily functions and loss of privacy, particularly during intimate care such as washing, toileting and bowel interventions. Do older people receive such poor care on grounds of age discrimination, because nurses lack the basic skills and compassion, or both?

Incontinence is often a consequence for older people with long-term conditions and complex healthcare needs, particularly when mobility is compromised. The continence care they receive depends on the competence of those providing it. Indeed, effective assessment and care can reduce the embarrassment and lack of self-respect associated with continence problems.

Continence care is essential for dignity and must be with nurse training and the Nursing and Midwifery Council, but it also lies with the style of ward management. When I trained to be a nurse, the ward sister/charge nurse was totally in control, knew every patient and what care that patient should receive – and woe betide any nurse who failed to give that care.

What should be done? Better education, particularly in the field of continence, and a rethink on the style of ward management.

Naomi Campbell: Dehydration is not a simple issue

The ombudsman highlights yet again the problem of dehydration, leaving nurses struggling to defend their public image as the “caring profession” and at risk of losing the nation’s trust and respect. But...
dehydration is not unique to patients in the UK; it is an international, persistent and escalating problem, facing all modern healthcare providers.

The sheer enormity of the problem in terms of human suffering and health economics is immeasurable and will only increase unless a sustainable cost-effective solution can be found. The very fact that dehydration is such a widespread problem surely suggests that there is as yet, an unidentified flaw or weakness in the process of providing adequate hydration.

In theory, the problem should not exist. It is universally acknowledged that dehydration can be easily prevented or treated by giving patients adequate fluids. This, combined with an unlimited supply of clean drinking water makes it all the more puzzling why this problem persists today.

Ironically, it appears that the problem lies with the assumption that giving a patient a drink is a “simple” task. Anyone who has cared for a vulnerable ill patient of any age, or indeed who has been such a patient themselves, will know that task is not all that it might seem. It is affected by an interplay of a combination of complex and holistic issues around the patient, clinical environment and staffing levels.

Until we acknowledge its complexity and that it cannot be left to others, we will not eradicate dehydration from our hospitals.

Naomi Campbell, Cornwall Hydration Project for Vulnerable Infirm Patients, Cornwall and Isle of Scilly PCT

Graham Pink: Silence over bad practice is no longer an option

These revelations must force nurses, individually and as a body, to seriously consider how such despicable behaviour by colleagues is to be tackled. I accept that most nurses work to very high standards. But there is a problem with the minority and we now need to see action on many fronts. Two thoughts.

First, where care of older people is concerned, staff ought to be full time. Most of my fellow workers (trained and untrained) were part time – on duty usually two nights a week. Older people want to see familiar faces, like to get to know us as individuals and establish a close relationship.

Nurses must see that silence over bad practice is no longer an option. Basing my observations not just on what happened when I blew the whistle at Stepping Hill Hospital, but on the evidence of thousands of letters from nurses, doctors and members of the public, I concluded staff were far too submissive and powerless with national leadership. At all levels no one was prepared to accept responsibility, to say “the buck stops here”. As a body, nurses and midwives are two-thirds of a million strong but our mouse-like demeanour ensures we are often treated as easily pushed-around handmaidens, the tame gofers of the NHS.

Graham Pink, retired nurse, who blew the whistle on poor standards of care at Stepping Hill Hospital in the 1980s and lost his job...
First steps in mindfulness skills

Using the mindfulness technique can help nurses support patients with both physical and mental health problems.

Mindfulness is the skill of being able to bring our attention to what we want to focus on. It involves noticing when our attention wanders, and gently bringing it back to the present moment. It also involves being able to notice – without judgement – our thoughts, emotions, sensations and urges, and not getting caught up in them; in doing this, we can choose when to act on these and when just to observe them.

By using mindfulness, we can focus on being effective in the pursuit of short or long term goals, even in the presence of unhelpful thoughts, emotions or physical sensations.

Evidence base for mindfulness techniques
In physical or mental health settings, mindfulness has been shown to be effective when used with patients with a range of problems (Didonna, 2009).

It is a core component of dialectical behaviour therapy (DBT) for people with borderline personality disorder (Linehan, 1993). In DBT, patients use mindfulness skills to: gain better control over where they focus their attention; recognise their urges without necessarily acting on them; and increase their awareness of their thoughts, emotions and bodies. In this way, they open themselves to experiences rather than avoiding them or acting in impulsive and harmful ways.

Lynch (2011) expanded on this approach to incorporate mindfulness into an adaptation of DBT designed for people with treatment-resistant depression.

Major depression is predicted to be the second leading cause of disability worldwide by 2020 (Murray and Lopez, 1996).

Segal et al (2002) developed mindfulness-based cognitive therapy (MBCT) for people who had suffered three or more episodes of depression and were currently in remission. They showed it was effective in reducing relapse for this patient group (Teasdale et al, 2000) by helping patients to recognise their unhelpful thinking patterns without getting caught up in them.

Chadwick (2006) developed a mindfulness approach to help people living with the experience of hearing voices. By carrying out mindfulness practices, patients learn that they can tune into their life experiences in the moment and “turn down” their experiences of the voices. This reduces the significance of the voices enabling them to increase their sense of control and positive beliefs about themselves while increasing their engagement in activities they value.

Kabat-Zinn developed the use of mindfulness with people suffering from chronic pain (Kabat-Zinn et al, 1987). He developed a 10-week mindfulness-based stress reduction programme and showed that people experienced improvement on measures of depression, pain, negative body image and reduced activity due to pain.

Carlson and Garland (2005) developed a programme for people with cancer that is based on Kabat-Zinn’s work. It involves patients practising mindfulness to help them develop a non-judgemental acceptance of situations as they are, and to loosen attachment to unknowable or uncontrolable outcomes.

There is a growing interest in the use of mindfulness with older people, their family and informal carers, and staff involved in their care. McBee (2008) argued that mindfulness practice reminds older people of their inner strength and resources, rather than their losses and disability.
CASE STUDY 1. OVERCOMING PHYSICAL AND EMOTIONAL PAIN

Richard Jones’* wife died after a brief illness. He coped with her death by keeping busy, which was exhausting. He also had arthritis, which was painful at times and periodically restricted his mobility. When unable to do tasks, he would blame himself, which made him depressed.

Mr Jones’ therapist thought mindfulness practice would help him to stand back from his thoughts and not get caught up in self-blame. She also thought it could help him become more accepting of his physical limitations.

During 12 sessions of mindfulness practice Mr Jones was taught to regularly observe his breath. This helped him to bring himself into the current moment and was a practice he could repeat wherever he was. He used this when his thoughts were running in a negative spiral to bring himself back to the present.

Mr Jones went on to practise mindfulness of his internal environment by noticing his thoughts and sensations and how they would come and go.

This helped him to become aware of his emotions, such as sadness, without feeling he needed to block these with constant activity. It also helped him to unhook from his self-critical thoughts. The metaphor of watching his thoughts and emotions like passing carriages on a train rather than getting on to the train was helpful.

The therapist introduced the idea of doing activities mindfully, which Mr Jones practised, for example, when brushing his teeth or making a drink. He found he could use mindfulness in this way when he had pain from arthritis and it helped him to realise the pain was only one input from his senses. He learnt to turn down the “volume” of the pain and turn up the impact of other areas of his life.

Finally, his therapist introduced a mindfulness “body scan” and the idea of noticing experiences in a non-judgemental way – letting go of the impulse to categorise experiences as good or bad, or right or wrong.

She gave examples of how, when we judge something as good, we want to hold on to it and, if we judge it is bad, we want to push it away.

Mr Jones learnt to accept the painful parts of his body without focusing on them intently or trying to ignore them. He became open to his experiences whatever they were, being willing to let them come and go. He developed an acceptance of the pain in the moment, letting go of the struggle with the pain and was able to focus on doing things he valued irrespective of the pain.

The outcome for Mr Jones was that, over time, while there were occasions he was still sad at the loss of his wife and still had pain from his arthritis, they were transient experiences which were less debilitating and did not prevent him from getting on with his life and doing things he enjoyed.

* The patient’s name has been changed

BOX 1. EXERCISE: MINDFULNESS OF A LEAF

During this exercise, I will give instructions to guide the focus of your attention. It is likely that while you are doing the exercise, your mind will wander off to other things. This is normal. When you notice this happening, just gently guide your mind back to the instructions. Don’t worry if you have to bring your mind back many times, because when you are doing this you are being mindful.

- We are going to pay attention to a leaf. Start by holding the leaf in the palm of your hand.
- Can you notice the weight of it? Can you notice the sensation on your palm?
- Allow your eye to follow the contour of the leaf – all round the edge. What do you notice?
- Take in the colours of the leaf – notice variations in shade. How does it change as you turn it in the light?
- Notice the details of the leaf – the veins, stalk, indentations and unique features.
- Notice the differences and similarities between the front and back of the leaf.
- Feel the texture between your fingers. Is it rough or smooth? Is it hard or soft?
- Notice the temperature of the leaf.
- Does the leaf have a smell?
- If you tap it or rub it between your fingers, does it make a sound?
- Now, bring your attention back into this room and let’s find out what happened for you, when you did this exercise.

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5 key points

1. By 2020, major depression is predicted to be the second leading cause of disability
2. There is a growing evidence base for using mindfulness in the treatment of illness
3. The technique is said to help people with depression or chronic pain, and those living with the experience of hearing voices
4. Mindfulness is a core component of dialectical behaviour therapy for people with borderline personality disorder
5. There is a growing interest in the use of mindfulness with older people and their carers
How to use the “four-quadrant” approach to analyse different restraint situations

Ethical issues in patient restraint

In this article…

› The use of restraint in nursing practice
› The four-quadrant approach to analysing ethical dilemmas
› Using this model to analyse different restraint situations

Author Ann Gallagher is a reader in nursing ethics, director of the International Centre for Nursing Ethics, University of Surrey, and editor of Nursing Ethics.


This article examines the ethical issues that arise in relation to restraint in mental health, dementia care and stroke care. The themes can, however, be applied to all areas of healthcare. The article also discusses how “four quadrants” of practice situations – medical indications, patient preferences, quality of life and contextual features – can be used to analyse three different restraint situations.

A recent opinion piece about the role of restraint in UK nursing practice (Morgan, 2010), published on the Nursing Times website, generated a great deal of discussion and dissent among readers, particularly in relation to patient safety. These comments prompted the question: “In what circumstances, if any, might restraint in care be justified?”

The author, American nurse Sara Morgan, expressed surprise that UK nurses concerned with patient safety should be against restraint. She stated: “In the US, nurses and doctors were pragmatic about this and we happily used whatever tools we could get our hands on to stop confused patients from getting out of bed without help. Yes, this included restraints.”

She went on to qualify what she meant by restraint by describing a “posey vest”. This fits over a patient’s clothing and has a zip at the back and cloth ties at either side. Arms and legs can move freely, and the waist ties are attached to a bed or chair to prevent the patient from getting up.

Ms Morgan concluded: “I would rather have a conversation with a patient or their family about why a posey vest is a good idea, than have to explain afterwards why a hip fracture occurred in the middle of the night.” She expressed surprise at UK nurses’ reticence to use restraint when they are so concerned about patient safety.

Responses from UK nurses revealed diverse views about the role and ethics of restraint:

“A blanket system (either yes or no to restraint) is not the best way.”

“Dignity has to be our guiding principle. Please explain to me what is dignified about confused or aggressive patients creating mayhem on a ward or in a nursing home, upsetting all the other confused patients and putting staff on edge as they try to ‘think around the problem’.”

“To see your mother bruised and bloodied because she has lost her faculties and become a danger to herself is awful. I’ll be honest, if someone had talked to me about restraint I would have agreed.”

“I work with [older people] and dementia patients. The idea of physical or chemical restraint is abhorrent to me.”

These comments suggest how challenging the issues are; the head of patient safety at the National Patient Safety Agency acknowledges that there are situations when nurses have to intervene to prevent harm to a patient (Healey, 2010). However, according to Healey, vests, as well as belt and cuff devices are unacceptable and have resulted in deaths and serious harm.

As well as an ethical imperative to prevent unjustifiable restraint, there is also a legal framework that includes: Offences Against the Person Act 1961; the Mental Capacity Act 2005; Adults with Incapacity (Scotland) Act 2000; Human Rights Act 1998; and the Mental Health Act 1983 (see Royal College of Nursing, 2008).

Types of restraint

Let’s Talk about Restraint: Rights, Risks and Responsibility (RCN, 2008) identified five types of restraint: physical, chemical, mechanical, technological and psychological. Physical restraint involves holding patients down or physically intervening to stop them from leaving an area. Chemical restraint is when a restless patient is sedated as a form of restraint.

The posey vest described earlier is a form of mechanical restraint. Other examples include bedrails and baffle locks, but furniture, such as tables and chairs, positioned in such a way as to restrict freedom of movement are also forms of mechanical restraint.

Technological developments have resulted in more sophisticated forms of restraint such as tagging, door alarms and closed-circuit television. What is called technological surveillance amounts to restraint when the technology results in people being prevented from leaving an area or having their movement controlled.

Psychological restraint deprives patients of choices and involves them...
there are five types of restraint: physical, chemical, mechanical, technological and psychological.

2. Restraint is not a panacea and can present significant risks to patients.

3. The four-quadrant approach is a helpful framework for ethical analysis of situations involving restraint.

4. Understanding the legal requirements of healthcare practice is necessary to protect patients from unjustifiable restraint.

5. Restraint should be considered as a last resort and practitioners should consider alternative interventions to promote safety and respect the dignity of the person.

being told they are not permitted to do something; setting limits on what they can do, such as times to go to bed; and depriving them of the means to be independent. This can include keeping them in nightmare and not letting them have outdoor clothing, walking or visual aids.

Restraint in nursing practice

The following three scenarios, drawn from anonymised practice examples, show the complexity of this issue in everyday practice. Put yourself in the position of the nurse then respond to these questions:

» Can the nurse’s actual or expected intervention be described as restraint?
» If so, what type of restraint?
» What ethical arguments can be presented for and against the intervention?
» What alternatives are there?

Scenario 1

Charlotte Morgan is an inpatient on an acute mental health unit and has a diagnosis of bipolar disorder. She is experiencing psychotic symptoms and is refusing oral medication, fluids and nutrition. Ms Morgan is overactive, appears refusing enteral feeding via a nasogastric tube. Mr Freeman pulls out the first two tubes so nurses are now considering whether they should use mittens or a nasal loop or bridle to hold the tube in place.

Scenario 2

Ronald Freeman has been admitted to hospital after a stroke. He has been assessed and it is agreed that his swallowing is impaired. He is restless and has communication difficulties. His family agree with the need to protect him from harm. Mr Freeman pulls out the first two tubes so nurses are now considering whether they should use mittens or a nasal loop or bridle to hold the tube in place.

Scenario 3

Cora Jamison recently moved from her home to a nursing home. She has a diagnosis of dementia and is becoming increasingly frail. She wanders continuously around the home and repeatedly goes to the front door and says she wants to go home. One of the staff tells her: “You cannot go home today. It’s Sunday and there is no transport.” Mrs Jamison accepts this and continues to wander from room to room.

Staff discuss how to manage Mrs Jamison. Her husband is particularly anxious that she remains safe; he tells staff when she was at home he had to ensure doors were locked and she had a table fixed on her chair to prevent her from getting up so she could rest. He suggests staff might use a tracking device that will sound an alarm if she attempts to leave the home.

Scenario analysis

Each of the scenarios is analysed using the four-quadrant approach in Figs 1-3 (Jonsen et al, 1992). This is used in clinical ethics and is outlined by the UK Clinical Ethics Network (2011) as a “series of questions that should be worked through in order”:

1. Indications for medical intervention – what is the diagnosis? What are the treatment or intervention options? What is the prognosis for each of the options?
2. Preferences of the patient – is the patient competent? Does he/she have capacity to make a decision about treatment and care? If so, what does he/she want? If not, what is in his/her best interests?
3. Quality of life – will the proposed treatment or intervention improve the patient’s quality of life? Or will the burdens or risks of the intervention outweigh the benefits?
4. Contextual features – what cultural, religious, contextual or legal factors affect decision-making?

Chemical and physical restraint in mental health

The four-quadrant approach can help with analysing the ethical issues and decision-making processes involved in Ms Morgan’s case. Patterson (2011) describes such a case as one where “restraint, seclusion or rapid tranquillisation may be warranted in exceptional circumstances”. If Ms Morgan continues to refuse, staff are considering physical and chemical restraint with a view to enabling her to have rest, fluids and nutrition. Staff should consider the questions in Fig 1.

Mechanical restraint in stroke care

In Mr Freeman’s case, nurses and family members have agreed that he should have enteral feeding via a nasogastric tube. However, he pulls out the first two tubes.
Discussion

Restraint

FIG 2. ANALYSIS OF SCENARIO 2

Medical indications
What are the goals of care and treatment for Mr Freeman after his stroke? "The first question should be ‘what are we trying to achieve?’" (Royal College of Physicians and British Society of Gastroenterology, 2010). Crucially, is mechanical restraint necessary? What are the alternatives?

Patient preferences
Does Mr Freeman have capacity? If so, what does he want? If not, has he expressed prior preferences, for example in an advance directive? Is he willing or unwilling to cooperate with care and treatment? Why? Is his autonomy respected?

Quality of life
What impairment and distress is Mr Freeman experiencing? Will his quality of life after intervention be acceptable to him? Will the long-term benefits outweigh the short-term discomfort? What interventions will enhance Mr Freeman’s quality of life?

Contextual features
What family issues might influence decision-making? What are the religious, cultural or legal issues? Are there conflicts of interest? Who is best placed to contribute to a “best interests” assessment if Mr Freeman lacks capacity? Are practitioners working within the law?

FIG 3. ANALYSIS OF SCENARIO 3

Medical indications
What are Mrs Jamison’s capabilities in the context of her dementia? What are the goals of her care? What other interventions might be considered that support her and her family, for example, person-centred care, palliative care and supportive care? (Nuffield Council on Bioethics, 2009)

Patient preferences
Does Mrs Jamison have capacity? (It should not be assumed she has not.) If so, what does she want? If not, has she expressed prior preferences about care? Is she willing or unwilling to cooperate with care? Why? Is her autonomy respected?

Quality of life
What distress, if any, is Mrs Jamison experiencing? Will her quality of life after intervention be acceptable to her? What interventions will enhance her quality of life? Will the benefits of a tracking device outweigh the loss of privacy and freedom?

Contextual features
What are the family issues that might influence decision-making? Mrs Jamison must be involved. What legal, religious or cultural issues must be taken into account? Are there conflicts of interest, for example, between her and her carers? Are staff acting within the law?

and there is a question as to what he is communicating (is he, for example, refusing feeding or demonstrating irritation and a lack of understanding about the purpose of the tube?) and how to proceed ethically. Also under consideration is what can be described as mechanical restraint in the form of mittens or a nasal loop or bridle to keep or hold the tube in place.

Hand-control mittens make it more difficult for patients to pull out their nasogastric tube. Williams (2010) concluded that mittens “have a place in clinical practice” but their use should be in accordance with a clear protocol and decision-making process, and that “older people and their next of kin must be informed about the use of mittens and involved as fully as possible in the decision-making process”.

Nasal loops or bridles involve securing a nasogastric tube to a patient’s septum with a tape. This can also be labelled mechanical restraint and is ethically more problematic as it involves an invasive and uncomfortable procedure. Analysing Mr Freeman’s situation using the four-quadrant approach suggests asking the questions in Fig 2.

Psychological restraint and technological surveillance in dementia care

Mrs Jamison’s case suggests psychological and technological restraint. Staff try to deter her from attempting to leave the home by saying: “You cannot go home today; it’s Sunday and there is no transport.” This may appear innocuous but is nonetheless deceptive and dishonest. The second consideration relates to technological surveillance, in the form of a tracking device that will sound an alarm should Mrs Jamison attempt to leave the home.

The Nuffield Council on Bioethics (2009) states: “These technologies may also be of significant benefit to carers in terms of reassurance as to the wellbeing and state of health of the person for whom they care.” The focus of the report is on supporting people with dementia, promoting their autonomy and wellbeing, and also considering the interests of carers.

In relation to Mrs Jamison, the questions in Fig 3 should be considered.

Conclusion

Sara Morgan’s views about UK nurses’ reluctance to embrace restraint in care stimulated much-needed discussion about this contentious issue. As responses to her piece highlighted, restraint is not a panacea and can present significant risks to patients. It should always be considered a last resort as it presents a significant threat to human rights, dignity, autonomy and wellbeing. Nurses must guard against choosing restraint, particularly when staff resources are limited. It may be the easiest option but it is rarely the most ethical. Restraint represents a compromise as it has the potential to undermine the values of nursing. More creative, collaborative and respectful responses to care are required.

References


Healey F (2010) UK nurses do care deeply about patient safety – which is why they don’t use restraining vests. Nursing Times. tinyurl.com/care-patient-safety


Nursing Times Ethical & Compassionate Nursing supplement 18
Think about it: a prompt to discuss end of life choices

In this article...

- Why effective communication skills are crucial in end-of-life care
- How a tool to improve communication was developed and implemented
- An evaluation of the tool and how it can help improve end-of-life care

Author Wendy Laycock is end-of-life care lead for East Lancashire Hospice and Blackburn with Darwen.


A team of nurses in East Lancashire developed a communication tool to help initiate end-of-life discussions and support advance care planning. This article describes the development, implementation and evaluation of the "Think about it" communication prompt.

In line with national developments and the Department of Health’s (2008) end-of-life care strategy, a number of end-of-life projects have been implemented across Blackburn with Darwen. Tools such as the Gold Standards Framework (www.goldstandardsframework.nhs.uk), the Liverpool Care Pathway for the Dying Patient (Marie Curie Palliative Care Institute, 2009) and preferred priorities for care (www.end-oflifeinadults.nhs.uk) are accepted best practice, and their use is supported by service providers and commissioners.

Research from the King’s Fund identifies two broad challenges in end-of-life communication: difficulty predicting prognosis; and communicating with patients to plan care. Conversations at the end of life may be avoided because they are difficult, and health professionals may have concerns that they will not be able to meet patients’ preferences (Addicott, 2010).

Health professionals across Blackburn and Darwen were developing end-of-life communication skills by accessing communication training. However, it became clear that discussions around end of life to support advanced care planning were at times avoided or delayed. The main reason for this was staff had limited confidence in their communication skills and concerns about discussing perceived negative topics such as late-stage management and practical elements at the end of life.

Preferred priorities for care

PPC is a patient-held document designed to facilitate patient choice. Monitoring of the numbers of PPC documents completed locally identified they were not being routinely used. The PPC document should be patient-led, reflecting conversations around the patient’s end-of-life care agenda. However, most of those audited recorded discussions about where the patient wanted to be cared for at the end of life. This could be because the PPC was initially implemented in its original version – preferred place of care – or because of outcome measures to monitor where someone dies. This is one of the end-of-life care quality markers that measures numbers of patients who died in their preferred place (DH, 2009).

During training sessions groups of professionals were asked the question: “If you were given a two-year prognosis, what would be your priority?” Those with clinical experience of palliative care gave answers relating to symptom management and where they would want to be cared for, but those with little palliative care experience talked about goals and ambitions. This emphasises the broad range of subjects patients may prioritise, highlighting the need for discussions to be patient-led.

Keywords: Communication prompt/Advance care planning/End-of-life care

5 key points

1. Advance care planning can prevent inappropriate hospital admissions
2. Communication is often avoided because the conversations are difficult
3. A tool helped determine patients’ priorities at the end of life
4. Topics discussed by patients ranged from medical care and support to organ donation
5. Supported discussions triggered by tool gained positive feedback from patients
Project development
Following a successful bid from North West NHS Regional Innovations Fund, the “Think about it” tool was developed to prompt patient-led communication (Fig 1). The tool was developed to initiate earlier discussions about advance care planning and determine patients’ priorities for care. It was developed, implemented and evaluated by professionals from East Lancashire Hospice and NHS Blackburn with Darwen community nursing services. The project was led by the end-of-life care lead and clinical practice lead for community nursing.

After feedback from hospice professionals, community nurses, primary healthcare teams and allied health professionals, we showed the tool to East Lancashire Hospice day therapy patients, and presented at a GP patient forum meeting.

Around 20% of the 145,000 people living in Blackburn with Darwen are Asian, so the tool was also shown to Asian carers. It was then translated into Urdu and a design company was recruited to improve its appearance. The final “Think about it” prompt incorporated 12 topics.

Implementation
Principles for implementation were agreed (Box 1), and the tool was piloted across Blackburn with Darwen between March and August 2010. We also provided copies of the tool to mental health and motor neuron disease services, and care homes.

Evaluation
A questionnaire was sent to all health workers who used the prompt over the five-month pilot. Of the 50 questionnaires sent out, just under half (22) were returned. The evaluation included questions about the number of times the prompt had been used, and whether it increased the professionals’ awareness and confidence to support discussions with patients.

The completed evaluations showed the topics discussed by patients included preferences (5), medical care and support, and legal issues (see Fig 1). Feedback from hospice day therapy professionals suggested the tool triggered discussions with patients. One patient said the tool’s subtle and indirect approach meant he felt more able to consider topics that concerned him. Discussions at the GP patient forum meeting also suggested people wanted to discuss important issues and the prompt helped them to do this.

The number of completed PPC documents and advance care planning discussions increased during the pilot phase, although this cannot be attributed solely to the prompt as “quality in healthcare is a multifaceted concept” (Sutherland and Coyle 2009). We also identified ways to improve implementation, such as leaving a paper copy with patients after discussion. The tool also received positive feedback from NHS Blackburn with Darwen Patient Advice and Liaison Service Readers Group.

Conclusion
Effective communication is vital to delivering high-quality care at the end of life, but professionals need training and support to maintain confidence and develop their skills. A team approach was vital to the success of the communication prompt, and partnership working across the region has improved the overall implementation of end-of-life care initiatives, improving outcomes for patients and their families.

References


Marie Curie Palliative Care Institute (2009) Liverpool Care Pathway for the Dying Patient. Liverpool: MCPCl. tinyurl.com/Marie-Curie-LCP.

How effective is the preferred priorities of care document?

In this article...

- An overview of the preferred priorities for care (PPC) document
- District nurses’ experiences of using the PPC in practice
- Developing a PPC protocol and guidelines for successful implementation of the document

Author Tracy Reed is education facilitator for end-of-life care, NHS West Essex Community Health Services.


Background Growing recognition that people nearing the end of life should have greater control over their care has increased the use of the preferred priorities for care (PPC) document.

Aim To explore district nurses’ experiences of using PPCs in practice.

Method A literature review and qualitative, unstructured interviews with 11 district nurses were carried out.

Results The study identified five key themes associated with the use of the PPC document: communication skills; hopelessness; empowerment; admission avoidance; and multiprofessional working.

Conclusion The PPC document was seen as a valuable end-of-life care tool by district nurses. Protocols and guidelines governing the use of the PPC, and the support required by health professionals using the document, would maximise its benefits. This could ensure a wider range of health professionals would use the document, rather than its use being confined to district nurses.

This study was carried out to assess district nurses’ experiences of the preferred priorities for care (PPC) document, and how it can be used to help improve end-of-life care.

Research from the past 15 years was reviewed, based on six key phrases: preferred priorities for care; end-of-life care; district nurse experiences; care of the dying at home; district nurses; and palliative care in the community. Data sources included the Anglia Ruskin University and Royal College of Nursing libraries, Medline, Cinahl, Cochrane and the British Nursing Index.

District nurses are the main implementers of the PPC, yet a lot of the research focuses on the availability of palliative care in the community rather than the experiences of district nurses. Several studies have shown that patients with a PPC are more likely to receive the end-of-life care they want (Henry and Fenner, 2007; Storey, 2007; Jones and Pooler, 2005; Pemberton et al, 2003).

Storey (2007) highlighted the challenges district nurses face in using PPC documents. A pilot study suggested some felt “vulnerable at being faced with something in print they do automatically as part of their routine care”. The study also suggested some district nurses avoided exploring the issues raised by the PPC.

District nurses often complete the PPC...
document and chose not to complete it (Storey, 2007).

The literature review also identified a lack of nurse training in communication skills and palliative care.

Caring for patients at the end of life can be extremely stressful for nurses (Wilkinson et al, 2008), yet end-of-life care is not a mandatory part of pre-registration nurse training or post-registration district nurse training programmes. This can leave some nurses ill equipped to initiate and manage complex conversations about end-of-life care with patients and their families (Henry and Fenner, 2007; Lowson, 2007; Chapple et al, 2005).

Taylor (2007) argued a lack of training in communication affected how nurses worked: “Communication appears to have low priority within training, so why would it have high priority within care?”

Some nurses’ lack of experience and knowledge made them reluctant to use the PPC tool (Henry and Fenner, 2007; McKenzie et al, 2007; Storey, 2007; Newton, 2006).

Method
This study took a descriptive, phenomenological approach.

After ethical approval was secured, district nurses at West Essex Primary Care Trust were invited to participate. They had to have completed two PPC documents in the community and agree to be interviewed to take part. Eleven district nurses were included in the study (Table 1).

In-depth interviews were carried out with all the nurses to determine their experiences of using the PPC document. The interviews were transcribed, and the data broken down into categories and themes. Although the sample size was small, limiting the study participants to district nurses who had experience of using the PPC document produced in-depth data.

Results
Five major themes emerged from the interviews (Fig 1). These were: communication skills; hopelessness; empowerment; admission avoidance; and multiprofessional working.

Communication skills
Study participants said the PPC document enabled in-depth conversations. The more they used the document, the more confident district nurses felt in starting difficult conversations:

“The document is quite straightforward and is a good tool for opening up discussions with families” (P1).

Study Participant Profiles

<table>
<thead>
<tr>
<th>Participant</th>
<th>Years of experience</th>
<th>Number of PPCs completed</th>
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</thead>
<tbody>
<tr>
<td>P1</td>
<td>30</td>
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<td>P11</td>
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</table>

“<I have 30 years’ experience but these subjects can be quite difficult to raise for junior staff. The PPC is helpful as it gives them something to work with” (P9).

The nurses acknowledged that using the PPC document was initially challenging, but said that experience gave them confidence. Personal experiences and reflection through peer support also helped them to achieve the confidence required to start and maintain conversations around end-of-life care:

“It’s difficult for nurses with not as much experience. I think that, as you form your own personal experiences, you know how to deal with situations” (P3).

“Get a good relationship going with your patient, then gently introduce the document. Showing empathy will help” (P4).

“You need practice, and time to share with the patient and your colleagues. This is what we do in our team and it helps our confidence” (P10).

Active listening was a key skill required to use the PPC effectively. The nurses felt they needed time to get to know patients so they could listen to them and build a rapport.

Some participants felt they would like to take part in advanced communication skills training. Others expressed dissatisfaction at nurse training, saying it did not prepare them for the types of conversations they were experiencing. With no formal guidelines to consult for clarification, they relied on peer support.

Hopelessness
Participants recognised that lack of confidence in using the PPC prevented some members of the team from using it.

Some staff felt the PPC document was seen as a “death” document for patients, and that talking to families about their preferred priorities for end-of-life care could take away any hope and goals they had left. To prevent feelings of hopelessness, participants used empathy to build a rapport with patients and their relatives so they felt able to discuss priorities for care with the nurse:

“It is taking away hope for some people. Different people accept things in different ways, and when you start discussing the PPC you can still feel you’re taking away hope” (P3).

“I find it quite difficult to introduce [the PPC] because sometimes it feels like you are taking away people’s hopes when they are striving to survive. We shy away from using it as it feel it may upset people” (P4).

Challenges Associated with End-of-Life Care

- Health and social care staff often find it difficult to initiate discussions about end-of-life care. This makes it difficult to determine people’s needs and preferences for care and to plan accordingly
- People frequently need care from several services, yet care is often poorly coordinated.
- People approaching the end of life need around-the-clock access to care and support. Even when services are available, they do not always meet people’s needs. This may be because health and social care professionals have not received adequate training.
- When people enter the dying phase, health and social care professionals may not know what to do or have the resources to ensure maximum comfort for the patient and support for carers.

Source: Department of Health (2008)
Effective communication requires a balance of listening, speaking and understanding (Osbourne, 2008). The study findings echoed the literature, suggesting nurse training in communication skills did not adequately prepare nurses for practice.

A second important issue identified by the study is who should take responsibility for introducing the PPC document. District nurses said other professionals who had been involved in a patient’s care for longer, such as the GP, may be better placed to raise the issue and complete it.

Both the study and the literature suggested the PPC was sometimes introduced too late, or when individuals were too vulnerable to discuss their choices (Storey, 2007). This could be attributed to the document’s former title and role – preferred place of care rather than priorities for care. This meant the document and process focused on where the patient wished to die, something that could be left to relatively late in the disease progression.

The district nurses felt the document enabled them to give something back to patients and their relatives. Although completing a PPC can be time consuming, the district nurses were positive about the time spent with patients doing this which was seen as empowering for both professionals and patients. Participants also said the PPC could be used as a tool to focus discussion between themselves and the multidisciplinary team.

The PPC is about more than just completing a document – it is about mutual trust, dignity and respect. It provides a “wish list” for patients and lays the groundwork for advance care planning. The district nurses saw this as a major benefit as it gave patients and relatives an insight into what to expect.

However, the findings suggested that, without reflection, peer support and clear guidelines, the tool would not be embedded into practice. The study highlighted that some nurses shied away from using the document through lack of experience and knowledge. However, they said effective use of the tool improved with experience, and the PPC process improved their communication skills.

Developing a PPC protocol

Clear guidelines and protocols on how and when to introduce a PPC document, and how to complete it, are needed. This would also help health professionals to understand the document and provide guidance on where to obtain advice, support, and training.

All members of the multidisciplinary team need to be educated in how to use the document and identify their needs, especially around communication skills. A multiprofessional group formed locally to support staff and develop the PPC protocol is essential.

The protocol should show when and how a PPC document should be implemented, who by and who to contact if there are problems or further support and guidance is required. Implementing the protocol would require all members of the team to look at changing practice, and improving communication skills.

The protocol should also take account of patients who prefer not to have their wishes and preferences formally recorded on a PPC; nurses can still engage in advance care planning with patients through less-structured conversations.

This change in practice is in line with the aims of the National End of Life Care Programme (www.endoflifecareforadults.nhs.uk) and quality markers set out by the Department of Health (2009). It will ensure everyone can access and receive high-quality end-of-life care from confident and skilled professionals in all settings.

Conclusion

The district nurses who took part in this study found the PPC to be an effective communication tool. While it could lead to difficult conversations, it provided an opportunity to build relationships and allowed patients to voice their expectations and choices for care. District nurses saw PPC as a tool to empower patients, families and professionals in improving end-of-life care.

However, the study does raise questions about whether other professionals should introduce the document, especially as district nurses typically begin working with patients at a relatively late stage in their journey along the end-of-life care pathway. Patients are often treated in the community from diagnosis and by a range of professionals, yet completing a PPC is often seen as the sole responsibility of district nurses.

A strong relationship with the patient is vital when introducing a PPC, and this must be governed by guidance and reflexive support to ensure successful implementation across the board.

References


Safe haven: transforming relatives’ rooms

Providing high quality facilities for the relatives of dying patients is not always given priority in hospitals. A trust aimed to address this service gap.

In this article...
- Carrying out an audit of existing premises
- Devising a template for rooms that meet relatives’ needs
- Combining a domestic feel with infection control policies
- Choosing artwork, colour, furnishings and other contents

Keywords: Relatives’ rooms / End of life care / Ward environment / User experience

This article has been double-blind peer reviewed

The first End of Life Care Strategy for the UK aimed to promote high-quality care for all adults nearing the end of their lives (Department of Health, 2008). It outlined a number of quality markers and measures for end of life care for both commissioners and providers of healthcare.

One of the quality markers for acute hospitals was “suitable quiet spaces in wards for families and carers, which are specifically used for this purpose” (DH, 2009).

According to Lomas and Timmins (2004), best practice when breaking bad news is to deliver it in a private, non-clinical area where no disturbances are likely, and where patients and relatives can use the space for a time after the event.

However, the quality of facilities available for relatives and carers, particularly when distressing news is being given, often receives little consideration.

After a relative recounted a traumatic experience when receiving bad news (see box), we decided to improve facilities at the hospital.

The relative was invited to become the carer representative on the palliative care practice development unit’s (PDU) steering group at the trust. One of the group’s aims is to improve facilities for carers and relatives of patients receiving palliative and end of life care.

Using relatives’ experiences, as well as user needs and attitudes, to inform the design of relatives’ rooms creates a partnership between relatives, patients and healthcare staff in leading service design (Bate and Glenn, 2006).

Additionally, consultation with users, staff and artists generates greater ownership and commitment, and ensures that the project really meets the needs of users (Waller and Finn, 2004).

The project
To meet the aims of the project, it was vital to secure the involvement of a multidisciplinary team. The team included:
- PDU steering group;
- Ward staff;
- Relatives/carers;
- Patients;
- Estates department.

The project was led by the trust’s arts coordinator and the carer representative of the PDU steering group, with valuable support from the maintenance manager in the initial stages. It also had the full backing of the trust’s executive team.

We took an evidence-based approach to designing and refurbishing ward relatives’ rooms. This was informed by a review of the literature, audit results and the outcome of a survey of carers, relatives, patients and ward staff. Trust policies were followed.

The rooms serve two purposes:
- They provide a private space where staff can talk to families in a calming atmosphere;
- They give family members a place to go when they need rest and respite.

The audit
We carried out an audit of the areas used by carers and relatives of palliative care patients in April 2008. Eight wards were included in the audit, which revealed:
- Two had no dedicated areas for carers or relatives;
A poor environment and a lack of privacy can add to relatives’ distress when they hear bad news.

A collaborative approach that involves staff, patients, carers and relatives was vital to the project’s success.

Minimum standards for relatives’ rooms were met using existing NHS suppliers.

An evidence-based, designed approach was adopted.

The project helped raise the profile of the needs of carers and relatives of patients who are receiving end of life care.

Three had rooms used for several purposes, including as a relatives’ room, staff handover area, interview room and ward clerk’s office, while three used the rooms for storage purposes.

Decoration in all rooms needed upgrading and furniture and facilities were in a varied state of repair.

Views on existing facilities – from patients, relatives and ward staff – confirmed the audit findings. Lack of privacy and comfort were highlighted as the main concerns.

Following the audit and feedback, we compiled a minimum standard for the relatives’ rooms, which included:

- A secure, heated room with a window that could be opened;
- At least two chairs and a small table;
- A folding bed with linen;
- A small TV;
- Tea and coffee making facilities;
- Ensuite toilet and handwashing facilities;
- Attractive decoration and artwork.

RELATIVES’ EXPERIENCE OF BREAKING BAD NEWS

“In 2004, my world turned upside down. My husband was diagnosed with terminal gastric adenocarcinoma. ‘A Whipple’s procedure was attempted but immediately abandoned. This news was broken to me in a room labelled Sister’s Office, but it was also used as a storeroom and as a thoroughfare for the ward staff toilet.

“What I was told about my husband’s chances of recovery left me feeling totally devastated, needing to escape. However, I was in this hectic environment with no safe haven to digest what I was being told or to think about the questions I should be asking. This memory lives with me today.”

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Refurbishment model

Art and design in health settings has long been recognised as playing an important role in reducing stress, improving outcomes and enabling effective communication (DH, 2007).

To inform the design of the relatives’ rooms, we researched four areas.

Colour

We initially thought there may be one ideal colour to improve the environment and reduce stress.

However, research showed that colour and design should be harmonious (Tofle et al, 2004) and reflect colours found in nature. We therefore chose three colour combinations: green and fawn; red and green; and turquoise and mocha.

Lighting

The rooms can be used for intense periods of up to 48 hours, and by families needing a short rest.

After consulting a lighting supplier and the estates project team, we used two types of lighting – dimmable overhead lighting and dimmable spotlights over the wall art.

This provided high quality light for formal discussions between staff and relatives that could be turned down if relatives needed a short nap.

Music

Originally we envisaged making a CD player available in the rooms. However, research showed that music can carry memories and associations related to the time it is heard (Ashley and Luce, 2004), so we decided that a television would be installed, which could be used for distraction.

Art

Patients, carers and relatives have a clear preference for nature scenes or unthreatening abstract art (NHS Estates, 2004).

The project team and ward staff were shown a variety of art fitting these criteria, and based their choices on creating harmony with their chosen colour scheme.

Like music, art carries memories so, rather than use widely available prints, we commissioned original artwork for a small fee by a local artist.

After this research, we drew up a design layout, and showed a series of mood boards incorporating all elements of decoration, furnishings and art to ward staff.

Refurbishment plan

Although relatives’ rooms are not in the main clinical ward area, the fixtures, fittings and furnishings still needed to comply fully with hospital policies. Therefore, when planning the refurbishment of the rooms, we considered issues relating to health and safety, infection control and people with disabilities.

Discussions with the equality and diversity, infection control, and estates and facilities departments identified a number of standards that had to be met. These related to access, temperature control, sanitary facilities, lighting, suitable fabrics and non-slip flooring. All fixtures, fittings and furnishing were sourced from existing hospital suppliers.

Based on the results of the audit, questionnaire, literature review and trust standards, we devised a new template for the relatives’ rooms. This differed from the original minimum standards and included:

- Redecoration;
- Artwork;
- New flooring/lighting;
- Lined curtains;
- Wall mounted flatscreen TV;
- Modular furniture allowing for some flexibility in use;
Innovation

» Toilet and handwashing facilities;
» Replacement of windows and ceiling.

Guided by the ward staff, including the matron, ward manager and housekeeper, we decided not to include drink making facilities or bedding in the rooms as these would be available from the ward at any time.

Silk flowers, complying with infection control and fire safety standards, and covered bins more in keeping with the domestic feel of the room were specified.

To date, four relatives’ rooms have been refurbished and the refurbishment of a fifth is being planned. The protocol for the relatives’ rooms is being used to refurbish approximately 20 wards. The refurbishments are being undertaken as part of the trust’s ward upgrade scheme over a period of five years. The scheme is due to be completed in three and a half years.

Costs

The total cost of the refurbishment of a relatives’ room was up to £18,500. This included replacing the flooring, windows, ceiling, lighting and sanitary fittings, as well as purchasing furniture, soft furnishings and artwork. The bulk of the cost was for the capital works, with approximately £3,000 spent on furniture and soft furnishings.

The first relatives’ room was fully funded by the hospital, while some refurbishments were made possible ahead of schedule by using charitable funds. For example, the Kay Kendall Leukaemia Fund paid to refurbish the relatives’ room on the ward providing care to patients with haematological conditions.

Discussion

The first refurbished relatives’ room opened in May 2009. Soon after completion, it provided a non-institutional setting for the wedding of a terminally ill patient.

Our design-led approach has set a standard that the trust is committed to for the future refurbishments of relatives’ rooms. The project has shown that, by using standard hospital materials and suppliers, it is possible to create a relatives’ room that is appropriate for the identified need: the provision of a safe and calm space for carers or relatives receiving distressing news (DH, 2009).

However, in some instances, it was not possible to meet all the identified requirements. For example, due to limited space, wheelchair access to the toilet facilities could not always be provided.

Other needs were met by existing facilities – a hotel within the hospital meant that long term sleeping areas were not needed, and there was no need to provide hot refreshment facilities as these were readily available on the wards.

After further consultation with ward staff and the project team, we produced a relatives’ room leaflet to provide carers, relatives and patients with information on the hospital facilities available.

Conclusion

Nothing can ease the pain of hearing difficult and distressing news about a loved one. However, we can try to ensure that a poor and degraded environment does not add to the distress of the situation. It is possible to create a comfortable and safe environment, without an institutional feel, by using a design and research-led multidisciplinary approach.

The environment should not leave distorted memories of the place the news is received, or of the person sharing difficult news. It should provide a safe haven in which relatives can digest what they are being told and give them the time and space to formulate the questions they will need to ask at this difficult and distressing time. NT

References


Left, before: some relatives’ rooms also doubled as storage rooms. Above, after: refurbished room with modular furniture, lined curtains and silk flowers.
Breaking news of death to relatives

In this article...
- How, when and where to tell relatives about a death, and who should tell them
- Honesty, sensitivity and ethics on breaking news of a death
- Advice on support, respect and privacy

Authors: Megan Reid is a staff nurse in the intensive care unit, Royal Alexandra Hospital, Glasgow; Joan McDowell and Robert Hoskins are lecturers in the Nursing and Healthcare School, Faculty of Medicine, University of Glasgow.


Breaking news of death can have a significant impact on bereaved relatives if it is not carried out appropriately. This article explores best practice on breaking news of death, and discusses why it is so important for nurses to get it right.

Breaking news of death to relatives is a frequently performed task for nurses, and one of the most stressful and sensitive they are asked to take on.

Using best practice guidelines to break news of death (see Box 1) can help prevent relatives enduring complicated grieving processes.

This article explores how news of death should be communicated, including where and when it should be delivered, and who should be the bearer of the news. It discusses the nurse’s role in this process.

Because there has been a surprising lack of recent research on this subject, literature from the past 30 years has been used.

Breaking news of death

When patients die, their medical practitioner has a duty of care to their next of kin and relatives (Buckman, 1992).

Communicating the news of a patient’s death to a relative can be likened to breaking bad news to a patient with a terminal diagnosis. However, although both are covered by the umbrella term “breaking bad news”, the finality of death means communicating the news of a terminal illness and news of death have significant differences.

The initial communication of the death of a loved one is the first step in the bereavement process. To facilitate a normal grieving process, it is essential that relatives receive excellent communication and support from healthcare professionals. The way in which news is given will always be remembered by the bereaved, whether delivered well or not (Harrahill, 2005; McCulloch, 2004).

Who should communicate news of death?

Doctors have the legal authority to certify death (General Medical Council, 2009), so it is normally the medical practitioner in charge of a patient’s care who informs relatives of the death (Buckman, 1992).

However, this practice was criticised by Wright (1996), who said the doctor communicating the news of death would usually be a complete stranger to the relatives. At this vulnerable time, it would be better if they received the news from an individual with whom they had established some sort of relationship and rapport, usually a member of the nursing staff.

Wright (1996) suggested this issue could be addressed by doctors continuing to break the news, but always accompanied by a nurse to provide support for the family; this nurse should be known to the family where possible.

Jurkovich et al (2000) investigated which elements of delivering bad news were most important to relatives. A survey tool was designed and administered to family members who had lost a relative in the accident and emergency department or the trauma intensive care unit over an 18-month period. The final sample included 54 interviews with relatives in relation to the deaths of 48 patients.

The authors found 81% of participants were informed of the death of their relative by a doctor, with only 5% being informed by a nurse. Fewer than half (46%) of participants felt the seniority of the news giver was of medium or high importance.

Faulkner (1998) said the responsibility of breaking bad news should rest with the person the recipient would feel most comfortable with. Lomas et al (2004) supported this, suggesting the person receiving the bad news should know the medical professional communicating it.

How and when should news of death be communicated?

Buckman (1992) created a six-step protocol for breaking bad news (see Box 2). This is based primarily on Buckman’s experiences of breaking bad news in a clinical setting, and was originally created for breaking bad news to patients. The protocol can be adapted, however, to provide nurses with a structured, organised approach to communicating with relatives.

The term patient is used in the original protocol but is interchangeable with the term relative, which has been used for the purposes of this article.

Step 1

Buckman (1992) stressed the need for face-to-face interaction between the doctor and
BOX 1. BEST PRACTICE IN BREAKING NEWS OF DEATH

Who?
- A doctor and nurse who are familiar with the relatives and who have provided care for the patient.

Where?
- A private, non-clinical area, which can be used by the relatives for as long as they need. This needs to be a spacious room with adequate seating where interruptions will be kept to a minimum.

How and when?
- Where possible, death should be anticipated and relatives encouraged to spend time with the patient before death occurs.
- Face-to-face communication with relatives is preferable to a telephone conversation.
- Consider body language. Medical professionals are advised to sit when breaking bad news and maintain eye contact.

5 key points

1. Breaking news of death is one of the most stressful and sensitive tasks that a nurse will have to perform.

2. The amount of information about the death wanted by relatives will vary.

3. Information must be given clearly, and euphemisms such as “passed away” avoided.

4. Staff should avoid telling the truth on the telephone, and ask the family to come to the hospital, may lose the family’s trust when they find out the death occurred before they were contacted.

5. Relatives should be advised on practical matters after a death, such as registering it and organising a funeral.

Step 1

According to Harrahill (2005), before the news is broken to relatives, it is good practice for nurses to assess their existing knowledge of the situation.

This provides a good understanding of exactly what information needs to be communicated. It also allows a quick assessment of the family’s style of language, enabling staff to adapt their communication style and use the most suitable vocabulary.

Nurses can facilitate this with statements such as: “I am aware you may have spoken to a number of my colleagues. Tell me what you already know and I’ll try to avoid repeating what they may have previously told you.”

Step 3

Harrahill (1997) said the person breaking news of death should tailor the information to the relatives’ needs and answer their questions.

It will be enough for some relatives to simply know that their loved one is dead; others may wish to know details of the events that led to death. It is in this step that nurses’ existing relationships with relatives will be useful – they may have an understanding of the relatives’ wishes regarding receiving information if they have communicated with them before.

The study by Jurkovich et al (2000) found a mixed reaction to the amount of detail families wanted. Only 13% of those studied wanted just general information with 50% requesting far more detail.

Step 4

Information should be given to relatives in an unhurried manner, giving them time to process the news and ask any questions (Cooke, 2000).

Technical language and jargon should be avoided to ensure the message is clear (Harrahill, 2005). Giving information in small chunks allows relatives to process it and reduces the likelihood of them becoming overwhelmed and not retaining any of the information (Buckman, 1992).

Nurses will often have an important role in deciphering information for relatives, reiterating it and explaining any terms they may not understand.

BOX 2. SIX-STEP PROTOCOL FOR BREAKING BAD NEWS

1. Get the physical context of the conversation correct. Avoid breaking the news over the telephone where possible.

2. Assess how much the relatives already know about the patient’s situation.

3. Find out how much the relatives want to know. It will be enough for some to simply know that their loved one is dead; others may wish to know the events that led to death in detail.

4. Provide information. This should include a diagnosis where possible, the treatment that was given before death, and an offer of support.

Assess how much relatives already know.
Discussion

Step 5
The success or failure of the process of breaking bad news rests on how the relatives react, and how healthcare professionals respond to this reaction (Buckman, 1992). Good listening skills and an awareness of non-verbal communication are key to ensuring practitioners deal with relatives in the most appropriate manner.

This stage relies on a good relationship between the nurse and relatives, allowing the nurse to provide verbal and non-verbal support. The importance of responding to relatives’ feelings was emphasised by Harrahill (2005) who said staff need to ensure relatives have all their questions answered. It is also suggested that relatives are given contact details for the hospital to ensure they are able to contact staff if questions arise later (Harrahill, 2005).

Best practice guidelines
The guidelines developed by Buckman (1992) provide direction on breaking bad news. However, Farrell (1999) argued that some families felt healthcare professionals relied too much on formulas or guidelines, resulting in the loss of a personal element with no emotion shown.

Finlay and Dallimore (1991) used a retrospective questionnaire to investigate how parents felt the death of their child was handled. Results showed that participants were more satisfied with how the news of death was communicated to them by a police officer than by a nurse or doctor. These families felt they received a greater sense of empathy from police officers, who restrained their emotions less and appeared to be visibly upset when breaking the bad news. This gave the relatives the impression that the police officers had connected to them on a personal level (Finlay and Dallimore, 1991).

Buckman’s protocol is widely followed by medical professionals. However, the suggestion that the news should not be imparted to relatives until step 4 conflicts with the opinion of another researcher. Harrahill (1997) said the death of the patient should be spoken of early in the conversation to prevent suspense building. This suggests that in some scenarios the professional should modify the guidelines, communicating the news earlier in the conversation, to avoid unnecessary apprehension.

Step 6
Step 6 of Buckman’s original protocol involves planning a terminally ill patient’s future regarding treatment and prognosis. However, it could also be applied to planning the future of bereaved relatives (Buckman, 1992).

This may be the first time relatives have had to deal with the death of a family member so they must be prepared for what is expected of them. Nurses can advise relatives on what will happen to their loved one next, such as carrying out last offices. They can also advise the family on when the death certificate can be collected, explain the format of the certificate, offer guidance on where to register the death and when they can begin to plan the funeral (Harrahill, 2005). The study by Jurkovich et al (2000) found that only 24% of relatives felt good attention had been paid in providing direction after death, showing this is an area requiring improvement.

After the relatives have been informed of the death, healthcare professionals should invite them to spend time with the deceased. According to Wright (1996), relatives feel they no longer have total ownership of their loved one once in hospital. They feel they must be granted permission to do things such as view the body, hold the deceased’s hand or speak to them.

If families are not present at the time of death, they may feel guilty that their relative died “alone” and were unable to say goodbye (Wright, 1996). This highlights the need for nurses to encourage family members to spend as much time as they wish with the deceased, allowing them to say final goodbyes, which will help to promote normal grieving processes (Cooke, 2000).

Telephone communication

The literature is inconclusive on the preference method of breaking news because relatives may have no support to hand immediately after receiving the news (Kendrick, 1997). Wright (1996) suggested if the hospital is near to the relatives, it would be best to tell them face to face. However, this leaves the nurse with the ethical dilemma of having to lie to relatives or avoid the truth. Kendrick (1997) suggested lying in this situation can be ethically justified as staff are trying to prevent harm to the relative, and are trying to provide the best possible environment for the news to be given.

However, staff may feel uneasy about lying, and may feel unable to do it due to their own morals. Wright (1996) said that, if the relatives live some distance from the hospital, it is essential to be honest and disclose the news of death. This is to prevent them rushing to the hospital, possibly endangering themselves.

Buckman (1992) said it is essential that healthcare professionals do not imply or state that a patient is alive if they are not. If asked a direct question about whether a patient is alive or dead, nurses must answer honestly, regardless of where they are in the process of breaking the news (Buckman, 1992).

If news must be broken over the phone, the informer should identify themselves at the beginning of the conversation and be certain of the identity of the relative, ensuring it is an adult (Harrahill, 1997).

When calling a mobile phone, it is vital to establish the location of the relative to ensure they are not driving or in an inappropriate place. If this is the case, they should be encouraged to move to a private, safe place where they can be called back (Taylor, 2007). This will act as a warning and help prepare the relative for the news to follow.

The nature of a telephone conversation removes non-verbal support so it is crucial to listen intently and respond appropriately to relatives’ reactions when breaking bad news over the phone (Taylor, 2007).

Although older literature mentions the need for support when attending the hospital (Adamowski et al, 1993; McLauchlan, 1990; Dubin and Sarnoff, 1985), it does not seem to have the same significance in recent literature. It is common sense to advise the next of kin to bring support, and

“Make sure the talent in your team gets noticed”
Hazel Holmes

Verbal communication
The death of a relative is a traumatic time. Family members must receive clear, understandable information from a knowledgeable member of staff who is not afraid to speak of the death in an empathetic manner (Fallowfield and Jenkins, 2004; Jurkovich et al, 2000; Wright, 1996). Euphemisms, such as “passed away” or “we lost them” should be avoided as these are open to misunderstanding. Words such as “dead” and “died” must be used and repeated several times to ensure relatives understand what is being said and the message is clear (Cooke, 2000; Harrahill, 1997; Wright, 1996). The need for this is highlighted by Jurkovich et al (2000) who found that only 52% of the family members studied felt they were told clearly that their relative had died.
it may not be included in protocols because it is done so routinely it is assumed health-care professionals will do this.

Healthcare professionals know it is better to break bad news in person. However, by avoiding the truth on the telephone, they may lose the trust of the patient’s family when they find out that the time of death was before they were contacted.

This has implications for nurses, particularly since the Nursing and Midwifery Council (2008) states that nurses “must be open and honest, and act with integrity”.

**Non-verbal communication**
The importance of body language should be considered throughout the conversation. Harrahill (2005) suggested that medical professionals should be seated, if possible, while breaking the news of death to reduce any “medical team intimidation” that the family may feel.

Regardless of the setting, medical practitioners should try and face the people they are communicating with squarely, with uncrossed arms and good eye contact. Undoing jackets or laboratory coats can also help create a sense of openness (Harrahill, 2005).

The study by Jurkovich et al (2000) found that touch – through hand holding, hugging or a gently placed hand – was unwanted in 30% of participants, but 17% desired this human touch. The researchers noted that this may be gender dependent as those that objected to touch the most were men. Jones and Buttery (1981) found that relatives of patients who had died suddenly felt that being touched supportively and compassionately was beneficial to them. The family may feel.

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Additionally, McLauchlan (1990) said it is a natural reaction for staff to comfort the relatives by touching them or holding their hand. Radziwicz and Baile (2001) agreed, believing touching may be supportive.

**Where should relatives be told of death?**
Best practice guidelines state that when giving bad news to others, a private, non-clinical area should be used with interruptions anticipated and avoided (Department of Health, 2005; Harrahill, 2005; Lomas et al, 2004; Cooke, 2000).

Wards will often have a dedicated relatives’ room and this should be used where possible. If no such room is available, the ward manager’s office can be used. There should be ample space for the family and healthcare professionals, with chairs provided for everyone.

Before inviting the relative to the room, it should be checked to avoid the embarrassment of taking them to a dirty or occupied room (Harrahill, 2005). After discussions with the family, the room should be made available for them to stay for as long as they need to compose themselves (Lomas et al, 2004).

However, these guidelines are not always followed. Jurkovich et al (2000) found that 19% of participants described the attention given to the location of their conversation as poor. The study also found that 56% of participants felt the location of the conversation was of medium or high importance.

Farrell (1999) said public disclosure of bad news shows a lack of respect and consideration. This can have wider implications for families, such as a lack of confidence in other aspects of care.

**Conclusion**
Excellent communication skills when breaking news of death are essential. The importance of both verbal and non-verbal communication should be recognised, along with the significance of setting and attitudes of staff.

It is recognised how important good communication is when breaking news of death, but quality research on this subject is lacking. The guidelines and ideas around best practice are dated and do not appear to be evidence based. More research is needed to ensure conveying news of death is carried out appropriately.

**References**


Taylor E (2007) How best to communicate bad news over the telephone. End of Life Care; 1: 1, tinyurl.com/telephone-news