What is nursing care and who owns it?

In this article...
- How we define caring
- Why nurses should stop thinking about patients as consumers
- Why nurses should adopt a humanising approach to care

Keywords: Compassion/Patient experience/Francis report/Wellbeing

Author: Ann Hemingway is senior lecturer in public health, School of Health and Social Care, Bournemouth University.


The Francis report into the failings at Mid Staffordshire, out last week, demands practical responses from all health professions if they are not to be repeated in other NHS providers. This article explores why nurses need to re-examine their philosophy of care and move beyond the notion of patient-centred care to develop a compassionate, humanising approach.

What is the role of the nurse?

For many of us, the point of nursing is to care for others. This may seem a simple objective but, for nursing in the UK, there is tension between how we define caring and how to maintain this as a primary focus in an increasingly business-focused, target-driven organisation like the NHS. I would argue the profession needs to go further than a focus on caring: we need to consider what the point of our practice is – what is the goal, what are we striving to achieve for each person we care for?

We need to develop a greater focus on the promotion of wellbeing through seeing illness as a life experience and recognise that this goes beyond the priorities of our organisations or profession and requires us to have the patient experience as our primary consideration.

Caring for wellbeing

What do we mean by wellbeing as a focus for care? Galvin and Todres (2012) offer a view on wellbeing underpinned by a philosophical tradition grounded in the life-world-led perspective (Hemingway, 2011); they frame the phenomenon of human caring from the central perspective of “the world of the person” receiving care. This has many dimensions, but its guiding principles focus on vitality, movement and peace. This perspective on wellbeing considers people as having individual potential for creativity and problem solving, even during periods of vulnerability, such as illness. It moves away from dividing wellbeing into social, economic, political, physical and mental domains and focusing on patients as “consumers” of healthcare.

While the current emphasis on patients as consumers and the aspiration for more choice begins to put patients at the centre of care, it does not offer a comprehensive framework or value base for care. Patients can understand their own “journeys” through symptoms or long-term illness better than anyone and, in that sense, each patient is an expert. As professionals we need to acknowledge this without relinquishing our expertise.

However, the way in which we provide care should be guided not only by technical knowledge but also by our understanding of others’ experiences, feelings and stories. Such a partnership approach will support people’s own strategies to improve health and wellbeing and do so in a dignified and respectful way.

Current issues in caring

The NHS is under stress and there is growing concern about its capacity to sustain a high-quality and safe service. Highly
publicised failings such as those in Mid Staffordshire Foundation Trust (Francis, 2010) and in other places have shaken public trust but have not led to a clear resolution. For several years, there has been a sense that “there could be another Mid-Staffs” and that lessons from earlier failings have not been learnt and implemented.

Much of the current government’s term of office has been overshadowed by the long-awaited second Francis report. Undoubtedly, countless health professionals and managers are quietly getting on with changes and innovations that are improving NHS care. What seems to be lacking is any sense of urgency to implement change and innovation on a system-wide basis. Instead, “waiting for Francis” appears have had a paralysing effect.

The first section of the original Francis Report (2010) is headed Patient Experience, and illustrates how the very way that “care” is thought about and conceptualised is fragmented and misses the point. The headings within the section are:

- Continence and bladder and bowel care;
- Safety;
- Personal and oral hygiene;
- Nutrition and hydration;
- Pressure area care;
- Cleanliness and infection control;
- Privacy and dignity;
- Record keeping;
- Diagnosis and treatment;
- Communication;
- Discharge management.

All these are fundamental aspects of nursing practice, and need to be undertaken in a dignified, safe, caring manner; however, the way individual nurses do this is controlled by our attitudes, beliefs, values and actions. We need to reflect on our beliefs and values, our guiding principles and our underpinning philosophy as nurses. Without a clear articulation of these within practice and education, how can we assure the quality of our own and others’ practice?

Nursing care matters
Commenting on the culture at Mid Staffordshire, Francis (2010) identified that the primary issue raised by patients and families was the attitude of trust staff.

So what are attitudes, how do we develop them and how can we influence them? They emerge from our beliefs and values and are influenced by the setting in which we work and those around us – and they influence the way we behave.

Whether we label nursing care as basic, fundamental or essential is not important. What we must accept is that this care matters just as much as the technological and curative elements of healthcare. We need to move beyond a critique of how the relational and social aspects of care are overshadowed by the technical, and so move beyond patient-centred care to focus on an authentically compassionate, humanised approach to caring (Galvin and Todres, 2012).

Nurses need to place wellbeing and individual patients – with all their complexities – at the centre of what we do and, crucially, we need to be able to argue our case. We must defend what is right and ensure that all those working in healthcare understand what we do, how we act as role models, teach and assure quality of care is as essential as any technological and curative element of healthcare. Mid Staffordshire has shown us that when care is neglected, people’s suffering is greatly increased.

Developing the capacity to care
While one cannot deny the great achievements of medical technology and increasing specialisation, care is more than cure – and, arguably, needs to be more than patient centred. Care needs to recognise us all as human beings whose experiences affect health and wellbeing directly.

I believe nurses need to develop the “head, hand and heart” approach, which integrates practical know-how with empathic understanding and technical knowledge (Galvin and Todres, 2012) to provide humane and sensitive care. We need to teach nurses and healthcare assistants about caring and what attitudes they need to achieve it safely and with dignity for everyone involved.

It is laudable and essential to demand that the NHS listens to patients and families (National Voices, 2012) but, as the initial Francis Report (2010) highlights, in an organisational culture that accepts bullying, lying, intimidation of staff and prioritising targets above patient health and wellbeing, we are bound to find resistance to change. So, how should we respond?

Work on practice development in health and social care has shown that, unless the attitudes of staff towards those they care for and each other change, nothing else will (McSherry and Warr, 2008).

What influences our attitudes, beliefs and values? What do we see as the most important factor in what we do? If we prioritise treating each other as valued human beings with respect, dignity and care, then everything we do for and with those we look after will reflect that. All the issues outlined within the Francis Report (2010) will be dealt with to the best of our ability with a caring attitude, with the experience of those we care for put at the centre. Our thoughts and actions will be dominated at all times by a desire to do things in a way that would be acceptable for ourselves, our partners, our families and our friends, with empathy.

As we educate and develop the attitudes of student nurses and healthcare assistants, we need to consider how best we develop their ability to “walk a mile in another’s shoes”. We need to ensure that everyone – including managers and hospital board members – who works with vulnerable sick individuals has an attitude that enables them to empathise and listen to and learn from another’s experiences.

This shift in attitude means that dangerous staffing levels and standards of practice must be challenged. The nurse’s responsibility to maintain the best standards of care; this may mean that, if individual organisations ignore reports of dangerously low staffing levels and standards of care, then as a profession we need to consider how we share this information.

The label “whistleblower” is unhelpful when reporting dangerous and inappropriate care or staffing levels, as it smacks of the playing field or school yard. Perhaps we need to think in terms of safeguarding within the care environment, safeguarding safety and dignity by ensuring attitudes and actions are exemplary. We are the ones on the front line and know when things go wrong.

Reflection
On reflection, I believe we need to articulate our philosophy for care as nurses, which will inform our values, beliefs and actions, and we need to own it. We need to demand it of each other, our colleagues, our organisations and ourselves. NT

References