How should Francis change nursing practice?

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- Key nursing themes in the Francis report
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- Overview of the recommendations

With a total of 290 recommendations, the Francis report contains much food for thought. However, while some of the recommendations require strategic or government action, there are actions that nurses can adopt or champion immediately to ensure patient care in their organisation is both safe and of high quality. Here, a selection of clinical, academic and professional experts reflect on how the report might be used to inform day-to-day nursing practice.

INFECTIOUS: Julie Storr, president of Infection Prevention Society

The Infection Prevention Society acknowledges that the report highlights unacceptable failures at all levels of the NHS. More than 100 pages focus on infection issues, including basic hygiene and cleanliness. IPS remains steadfast in its focus: simple measures, such as hand hygiene, prevent patient harm. We welcome the recommendations, some of which can be acted on immediately.

OLDER PEOPLE: Deidre Wild, senior research fellow (visiting), consultant R&D older people, University of the West of England, Bristol

The report highlights the damage inflicted on older people from a misguided and uncaring NHS culture. However, if its findings are to be internalised and recommendations acted on, they will need to prevail over longstanding ageist attitudes.

Where, other than in older people’s care, has the nurse’s role been so eroded by replacement with the minimally trained care assistant, thereby falsely implying high-quality nursing is neither required for older people, nor compatible with cost-effectiveness? In terms of common language, who else is accused of “blocking” beds or being a “burden” on services, both of which older people have equal rights to access? Attitude change requires professional recognition that adult care in hospital and the community involves meeting the complex needs of the ageing population, as much as meeting those of people who are younger.

The recommended registration of healthcare support workers, with a uniform code of conduct, standards and training to be maintained by the Nursing and Midwifery Council is an important step towards quality improvement, and the recommended role of a registered older person’s nurse is even more welcome. However, if it is to spearhead change towards a non-ageist culture, which enhances care and protects older adults, the role must include specialist gerontological nurse training with an emphasis on essential and remedial skills, and it must be held by sufficient numbers of nurses.

CULTURE: Steve Mee, senior lecturer, Faculty of Health and Wellbeing, University of Cumbria, Lancaster

Mr Francis’ report has portrayed a vivid picture of a culture with a profound, scarcely believable, lack of care. It rightly focuses on NHS culture and suggests a host of actions to refocus on caring. These include changing recruitment and training, as well as developing leadership, appraisal by patients, transparency and clarity about the guiding principles we should all adopt.

The overall picture is that of an organisation in meltdown. Volume 2 of the first report in 2010 gives 363 pages of chilling individual stories that could lead committed nurses to despair. Yet Mr Francis’ investigation into Stafford includes positive stories such as the patient who could not speak highly enough of the care he received on several wards:

“Everyone who dealt with him was passionate and caring and the staff often worked ‘above and beyond’ the call of duty. He thinks that the constant barrage of criticism is ‘counter-productive and unnecessary’.”

The report rightly focuses on NHS culture, suggesting actions to refocus on caring

Steve Mee
In all the horror there were people going about their work – at least during that patient’s stay – in a “professional”, “courteous” and “timely” manner.

The report also refers to times when care on a ward was generally abysmal, yet an individual nurse still behaved with compassion to ensure a patient was well cared for. These individuals had an internal moral compass that ensured they would do the job properly, whatever the culture. As professionals we have a choice: to make a personal commitment to do the moral thing, I salute those at Mid Staffordshire who did just this.

**TISSUE VIABILITY:** Irene Anderson, principal lecturer, tissue viability, and reader in learning and teaching in healthcare practice, University of Hertfordshire

Sadly pressure ulcers and skin breakdown feature in the report – the detrimental effect of a target-driven culture and staff forced to comply whatever the consequences. There is a national focus on pressure-ulcer prevention; things are improving but there are still failures to record (and act on) pressure-ulcer risk, and patients waiting for equipment, lying in wet beds and experiencing poor handling. Making pressure-ulcer prevention initiatives public is recommended – and already happening in some services.

**We must ensure we focus on tissue viability for all patients in all settings**

Irene Anderson

The report also points out that basic – or essential – care is not simple, and that patients are harmed when specialist nurse advice is ignored and untrained staff take roles for which they are unprepared. We must ensure patients with other types of wounds are not sidelined by pressure-ulcer targets but that we focus on tissue viability for all patients in all settings; they need and deserve skilled and compassionate care.

**WARD ROUNDs:** Liz Lees, consultant nurse and senior research fellow, Heart of England NHS Foundation Trust, Birmingham

Over the last 21 years I have witnessed the insidious demise of nurses routinely participating in multi-disciplinary ward rounds.

**ANALYSIS: CLEAR ROLES, REGULATIONS AND ACCOUNTABILITY ARE LONG OVerDUE**

There is no escaping that some nursing care at Mid Staffordshire was appalling. Some stories beggar belief – for example: how busy do you have to be to ignore a patient with dementia, lying naked, in public view, covered in faeces?

The report gives the profession much to reflect on, but also acknowledges that nursing can put its own house in order. If accepted, Mr Francis’ recommendations will affect nursing staff at every level, from the chief nursing officer to healthcare assistants and could have a positive effect on day-to-day nursing practice and standards of patient care.

Mr Francis calls for a strengthened clinical role for ward managers, in which they are on the ward rather than office-bound. They should act as role models to their teams and know about every patient’s care plan.

This should free ward sisters and charge nurses to fulfil a key aspect of their role, which has been gradually eroded. Their primary focus will be on the quality and safety of patient care, and on managing, motivating and supporting their teams. This will, of course, depend on them having resources to free them from some responsibilities that keep them office-bound – and this has to happen. While wards on which patients suffered and died in Stafford were poorly managed, others provided excellent care thanks to skilled and committed leadership.

A root cause of many problems in Stafford was a lack of clear accountability. No one took responsibility for particular patients because they assumed someone else would. Mr Francis’ solution is the notion of a key nurse for each patient on every shift. This nurse should be responsible for coordinating the patient’s care and, where possible, be present every time they see a doctor. He also calls for annual revalidation and, until that is set up, mandatory annual appraisals at which nurses must produce a portfolio demonstrating an up-to-date knowledge of nursing practice and evidence of training and other learning.

In calling for the regulation of HCAs, Mr Francis points out that: “the minicab driver who takes a patient to hospital and the security guard who may be at the door when the patient arrives are likely to be subject to regulation under which they can be disqualified from the role if not a fit and proper person, but the healthcare support worker who washes the patient and accompanies him or her to the toilet is not.” How can that be right?

He also wants a code of conduct, the HCA role to be standardised nationally, and nursing staff to wear clear labels and uniforms so patients know who’s who. These suggestions are long overdue. For too long the HCA role has been undefined, benefiting neither HCAs nor patients, and lack of regulation allows bad apples to move from job to job with impunity.

To many nurses the recommendations may be unnecessary. Most ward sisters want to lead a team that patients and their families would recommend to others. Most nurses do their best to provide compassionate care under often difficult circumstances. Most HCAs want to adhere to standards of good practice and have a clearly defined role. But the recommendations are not aimed at them – they are aimed at the minority who fail to meet these responsibilities and aspirations. And at government and those with the power to give us an NHS in which it is possible to achieve high-quality, safe and compassionate care for every patient.

Ann Shuttleworth, practice and learning editor
Routine has been replaced by ad hoc, as and when they feel able to join. However, patient care and discharge processes have evolved over this period, resulting in increasingly frequent patient reviews and ward rounds – in some areas going from weekly to twice a day. This has increased nurses’ workloads, and it is time to recognise this through tools to measure patient dependency and acuity. We urgently need the necessary evidence to produce tools capable of measuring this often invisible nursing workload.

Ward rounds are the cornerstone of ward leadership, organisation of patient care and processes thereafter. A registered nurse is an essential member of a ward round – the sooner this standard of nurse advocacy is reinvigorated, the sooner patient care will improve.

CONTINENCE: Debbie Yarde, chair, Association for Continence Advice

It is sad day for the NHS when it requires 290 recommendations to ensure patients are treated with care and compassion. We should all know this is a fundamental ethos of looking after the sick and vulnerable, but apparently not all of us do. While I welcome much of what is recommended, I mourn the missing recommendation that would specifically endorse the need to toilet patients.

There is nothing to promote active continence assessment for older people

Debbie Yarde

Yet again continence fails to attract attention in its own right. There is a catalogue of reported incidents involving patients being left in urine and faeces and, while responding to patient requests and hygiene have rightly been singled out, there is nothing to promote active continence assessment and promotion within care settings for older people. This is a disappointing omission.

STUDENTS: Ann Hemingway, senior lecturer public health, School of Health and Social Care, Bournemouth University

This report indicates yet again that organisational culture and individual attitudes are key and that those who are not open to criticism and who don’t put patients first are giving warning signs about the standards of care they offer.

The report considers a range of themes related to nursing practice:

- The decline in standards of care was associated with inadequate staffing levels and skills, and a lack of effective leadership and support
- Candidates for entry into nursing should be assessed on their ability to provide compassionate care through work experience, aptitude testing and nationally consistent training
- Nurses’ continuing professional development should be reinforced by a revalidation system
- A specialist registered status should be created for nursing care of older people
- Ward nurse managers and named nurses should be an intrinsic part of medical ward rounds and other contacts between doctors and patients
- Healthcare support workers should have compulsory registration, common training standards and a code of conduct

FRANCIS ON... NURSING

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Other health professionals must recognise the importance of nutrition and allow patients to eat and drink uninterrupted

Liz Evans

Nutrition and hydration are still not being recognised as essential to patients’ recovery, as the report highlights. Despite a plethora of national guidance and recommendations on the importance of good nutritional care, it is clear the message is not always getting through.

It is easy to blame nurses for not feeding patients, and the National Nurse Nutrition Group maintains they are crucial to good nutrition. However, as the report states, other health professionals must recognise the importance of nutrition and allow patients to eat and drink uninterrupted. All health professionals are capable of recognising a tray of uneaten food or a cup of tea that has not been drunk and reporting this to the nurse in charge of that patient.

There is clearly still a lot of work to be done to ensure all organisations provide good nutritional care. But we do not need more guidance – steps must be taken to embed current guidance in practice to guarantee patients in hospital receive sufficient food and drink. Nutritional care must be taken seriously and not just seen as another tick-box exercise.

BULLYING: Kim Holt, Patients First, campaign to improve transparency and accountability in the NHS

Unless the pervasive bullying culture of the NHS is ended, it will remain dangerous for staff to raise concerns about patient care.

The experience of Helene Donnelly, a staff nurse in Stafford who gave evidence to the Francis inquiry shows how ignoring concerns can have huge implications for safety. Her evidence exposed the hollowness of the promises in the whistleblowing policy. What powerful words.

Patients First is contacted regularly by nurses who raise concerns about serious matters affecting patient care; the problem is not the raising of concerns or lack of people to do that, but the often bullying response they receive or fear receiving.

We urge ministers to immediately strengthen the law to protect whistleblowers and arrange effective monitoring arrangements to ensure the duty of candour is discharged by all within the NHS. We need specific assurances, not warm words.

We are calling for a Health Select Committee inquiry into the continued bullying and victimisation of whistleblowers.