For many years there has been an emphasis on the development of nurses as leaders, culminating in the development of the Leadership Framework and the NHS Leadership Academy in 2012.

Robert Francis QC has called for a change in culture within the NHS (Francis, 2013). Several witnesses involved in the Mid Staffordshire Foundation Trust public inquiry made reference to a negative and uncaring culture that was detrimental to patient care. Mr Francis’ response to this is to propose a “common culture” throughout the NHS.

However, he acknowledges simply recommending staff change their behaviour is unlikely to be successful. The report suggests several areas where improvements can be made as well as actions to take to ensure positive values and ways of doing things are common throughout the organisation.

In addition to developing a caring, committed and compassionate outlook, the report places emphasis on the creation of a “safety culture”. This refers to a culture that aspires to cause no harm and to provide adequate, and where possible, excellent care and treatment.

Where things went wrong

It is clear that a safety culture did not prevail at Stafford hospital (Box 1). The report suggests three reasons why:

» “Denial of injury”, believing that things are not as bad as they seem;

» “Denial of responsibility”, believing the problems are due to a lack of resources and that nothing can be done;

» “Condemning the condemners”, seeing criticisms as coming from people who do not fully understand the situation.

During the inquiry into Stafford Hospital and the wider trust, Mr Francis exposed several areas where a compassionate, safety culture was not upheld.

Hospital board meetings were conducted privately with no one outside of the board being involved in the discussion. Mr Francis points out the content of the meetings is of public interest and suggests this secrecy creates misplaced trust, particularly surrounding finance and the benefits of becoming a foundation trust.

The poor standards at the hospital were largely tolerated – the peer-review process highlighted several specific deficiencies within the critically ill and injured children’s services. These were recognised in the peer-review report, but no steps were made to rectify them.

There was a general assumption within the trust that the matters of concern were no different from what was happening at other trusts. Mr Francis notes that this attitude “can lead to the comforting conclusion that more cannot be done”.

Patients were not put first and care was not patient-centred. Staff numbers were reduced and the skill mix diluted without assessment of the risk this may pose to patients. Mr Francis notes that concerns about patient safety were raised but little or no action was taken and there tended to be a focus on coding rather than on patient care. He attributes the “relentless drive to reach foundation trust status” as being a cause of the willingness to play down safety concerns, continuing to run services known to be deficient and priority being given to confidentiality and support of colleagues and organisations over the duty to warn others of safety risks.

Keywords: Safety culture/Stafford Hospital/Francis report/Recommendations

5 key points
1 A “common culture” has been proposed throughout the NHS
2 The report places emphasis on the creation of a “safety culture”
3 An organisation should have shared values from top management to frontline staff
4 The NHS must have strong, consistent leadership to motivate staff
5 Everyone employed by the NHS should have a “questioning attitude, a rigorous approach and good communication skills”
How is a safety culture achieved?

Calling on evidence from organisations with a positive culture, Mr Francis identified key factors that are vital for a compassionate, safety culture to exist. In particular, having shared values throughout the organisation, from top management to frontline staff. For this to work, the NHS must have strong, consistent leadership to motivate staff as well as ensure everyone understands and supports objectives. Mr Francis stresses this change must come from the top and leaders need to have direct contact with frontline staff where they can reinforce the safety culture message.

All staff need a “questioning attitude, a rigorous approach and good communication skills”. When errors are reported, this should be seen as a “learning opportunity” rather than a punishable offence.

The report reinforces the idea of “patient-centred” care and suggests everyone with anyone involved with a patient should take personal responsibility for making sure everything they do is for the benefit of the patient, and this attitude should be recognised and rewarded.

There should be less tolerance of low standards; the inquiry found that errors and potential hazards were frequently highlighted but as those responsible stated they were in the process of making changes, no action was taken. Ideally, if a service is found to be providing poor care, the moderator should take immediate action; this could include closing a service if the necessary resources are not available to run it safely. Less tolerance also refers to individuals who persistently underperform so that providing poor care has negative consequences for individuals. Conversely, those providing exceptional care should be recognised and rewarded for doing so.

The report stated that throughout the NHS there are frequent ward-level changes and new objectives being introduced. This results in wards not having enough time to achieve objectives and as such not feeling motivated to do so. It is suggested “less radical solutions” should be used where possible to meet the same ends.

In order to promote an open and honest culture, the report suggests information on outcomes, such as patient experience and satisfaction, should be openly available to anyone who wants to view it including the public. Patients should also be able to access other relevant information such as the performance record of their surgeon.

Francis report recommendations

Mr Francis has made several direct recommendations to bring the culture of the NHS in line.

On admission, patients should be given information, both orally and in written form, that relates directly to their care. This will include: the reason for the admission, plan of treatment, and when this will happen, the names of those responsible for care, contact details for leaders of the care, the approach to sharing information with friends/family and so on, which will include a list of all those authorised by the patient to have access to information.

All patients should also be given general information, again both orally and written, concerning the hospital and ward. This will include: ward layout, the standards the patient can expect, how help can be summoned, the ward routine/time-table, visiting restrictions and reasoning for them, information about secure storage, a list of staff working on the ward and an explanation of what the different uniforms mean and how to raise concerns.

All staff should wear clearly displayed name badges stating their role and seniority level. To make it easier for patients and visitors to know the role of the person they are speaking to, staff members of different levels and roles should wear clearly distinguishable uniforms.

All staff should communicate in a friendly manner and offer help as needed. If it is not possible to help, they should give the patient a reasonable explanation and do everything within their means to ensure the patient’s needs are attended to. Every one working on the ward is responsible for keeping it clean and should remind others of the handwashing policy.

Where the patient has authorised them, staff should freely interact with visitors and allow them to be included in the care, for example help with feeding.

Staff on all shifts, including nights, should have up-to-date knowledge of patient care plans. All disciplines should also be involved in all aspects of patients’ care and be present at review meetings.

Nutrition and hydration is the responsibility of all staff; everyone should be identifying if a patient needs help with feeding and taking steps to ensure they receive it. All members of the multidisciplinary team should recognise the importance of nutrition and ensure treatment does not coincide with mealtimes.

Evidence-based, standardised procedures, for example surgical checklists, are to be widely used so that care is consistent. If any member of staff thinks a discharge is inappropriate or unsafe they should be empowered to voice their concerns without being criticised. All incidents of concern should be reported and these reports responded to.

Statistics and performance reports should be easily understood and widely available and should be compared between different wards and departments. Regular appraisals should reflect these reports and be mandatory, with emphasis placed on these being genuinely useful for professional development and including peer review. Staff need to be willing to both give and accept constructive criticisms.

Top managers should spend more time on wards and interacting with frontline staff to give them a better picture of how the wards are run. Managers can then use real-life examples of care in meetings and develop more patient-centred strategies.

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References


Charles Vincent, professor of clinical safety research at Imperial College, London, defines the term “organisational culture” within the BMJ as having the following characteristics:

● Shared basic assumptions
● Discovery, creation or development of those assumptions by a defined group
● Group learning of how to cope with its problem of external adaptation and internal integration
● Identification of ways that have worked well enough to be considered valid
● Teaching new members of the group the correct way to perceive think and feel in relation to any problems

“A caring and compassionate nature is the cornerstone of every good nurse”

Jane Robinson  p28

BOX 1. CULTURAL PROBLEMS

Cultural themes identified include:

● Bullying
● Target-driven priorities
● Disengagement from management
● Low staff morale
● Isolation
● Lack of candour
● Acceptance of poor behaviours
● Reliance on external assessments
● Denial

BOX 2. WHAT IS “CULTURE”?

Charles Vincent, professor of clinical safety research at Imperial College, London, defines the term “organisational culture” within the BMJ as having the following characteristics:

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