Francis in brief: key nursing recommendations
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.

In this article...

> What the inquiry found at Mid Staffordshire trust
> Recommendations for future practice

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”

Managers should spend more time on wards

The Mid Staffs inquiry said the NHS has a “negative, uncaring culture”. Robert Francis has made recommendations on how this can be addressed.
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 any involvement 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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Reference

“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:
● 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

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How nurses can lead from the frontline

In this article...

- What the Francis report says about frontline nursing
- The role of the key nurse
- Ward rounds as a central point of communication

In his inquiry into Mid Staffordshire Foundation Trust, Robert Francis QC identified what he describes as “a completely unacceptable standard of nursing care” (Francis, 2013). From the evidence given to the inquiry he concluded that the decline in standards was associated with inadequate staffing levels and skills, as well as a lack of effective leadership and support.

To address this, Mr Francis has made several recommendations on changes to the way nurses work in order to improve the quality of care offered by frontline NHS staff.

Recommendations

“Key nurses” should be responsible for coordinating provision of care

The report recommends that patients should be allocated key nurses on a shift-by-shift basis to ensure that patients have a specific nurse who is responsible for their care at all times. A lack of someone to take direct responsibility for the provision of care was one of the main failings found at Mid Staffs. This differs from the “named nurse” or “key worker” role, whereby patients are assigned to a nurse for the duration of their admission. Instead, nurses will be allocated at the start of each shift as the main port of call for a patient and their family.

Key nurses would have to accompany doctors during ward rounds and any other interaction with their allocated patients. This will keep nurses updated on everything that is happening and allow them to communicate decisions and progress confidently to patients and family members.

Nurses’ role in ward rounds to be extended

This recommendation relates to nurses acting as “a central point of communication between the patient and medical staff”. Mr Francis wants senior nurses to be in attendance at all ward rounds so the senior nursing team are kept informed of, and have a say in, all key decisions.

As well as improving communication between medical and nursing teams, this recommendation aims to place nurses in a position where they are better able to advocate on behalf of patients. Nurses are likely to spend more time with patients than other members of the multidisciplinary team so they need to be present to pass on information from the preceding 24 hours of the patient’s care that only the nursing staff will know.

The initial inquiry found that often there were difficulties in locating nurses who were available to attend ward rounds. Mr Francis argues that nurses’ active involvement in ward rounds is essential to be incorporated into best practice, and that a nurse should always be present. He also stresses the importance of full and comprehensive handovers between shifts and to the rest of the multidisciplinary team.

All members of the multidisciplinary team to prioritise ward rounds

This recommendation is inspired by a publication from Royal College of Physicians and the Royal College of Nursing, Ward Rounds in Medicine: Principles for Best Practice, which was published in October 2012. It highlights the importance of ward rounds – these give the multidisciplinary team an opportunity to review a patient’s condition from different specialist angles, and the information can then be used to develop a multifaceted plan of care.

The recommendation suggests that all members of the team who care for a patient recognise ward rounds as an important part of care and attend as a priority. The initial inquiry found that often ward rounds happened early in the morning, a time of day when nurses in particular tended to be busy. Part of prioritising ward rounds could involve considering the timing to make it easier for all members of the team to attend. Mr Francis stresses that the team should ensure that patients’ ward rounds allow full engagement of the patient and/or their carer to enable shared decisions about care to be made.

Summary

These recommendations aim to develop a health service with frontline leadership by improving the flow of information between members of the healthcare team. The recommendation of key nurses should improve patient care by making sure someone is responsible for each patient at all times. By enhancing the importance of ward rounds, everyone involved should be kept informed of the plan of care for each patient and know who is responsible for ensuring it is carried out. The recommendations encourage a multidisciplinary approach, centred on patients so they receive specialist care that is tailored to their specific needs.

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References


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Mandatory registration for healthcare assistants

Healthcare assistants are far less regulated than other professionals. Robert Francis QC, in his inquiry into Mid Staffordshire Foundation Trust, pointed out that a minicab driver taking a patient to hospital is likely to be subject to strict regulation but the HCA who washes the patient and accompanies him or her to the toilet is not.

Currently, it is up to the ward or setting employing HCAs to decide how much experience and what qualifications they need. There are no minimum standards of training. Although the NMC code of conduct stipulates nurses must supervise junior staff, this depends largely on their judgement. Mr Francis highlighted much of HCAs’ work is unsupervised.

Recommendations
Mr Francis’ recommendations include:
» All HCAs working in the UK should be listed on a professional register. Only those whose names are on the register will be permitted to provide direct physical care to patients under the care and treatment of a nurse or doctor.
» HCAs who are deemed unsafe should be removed from the register and potential employers would be able to find out about any past concerns. A register would also record name changes.
» A code of conduct relating to HCA work, training and standards must be developed and maintained by the Nursing and Midwifery Council. This would contain national minimum standards of education and training and require HCAs to undertake the same training and achieve common qualifications.
» A code of conduct would also provide a common standard against which HCAs can be measured to assess their competency to do the job.
» Until the NMC is able to write and maintain this code of conduct, the Department of Health should institute a national system. This should include a fair due process for HCAs who have been dismissed by employers because of a serious breach of the code or being otherwise unfit for the post.

Uniforms and name badges should ensure patients can distinguish between nurses and HCAs easily. The inquiry noted that patients are often unclear about staff roles. As well as common training, it suggested that HCAs should have a standardised job title. The report suggests “nursing assistant”, “community nursing assistant” and “midwifery assistant”.

The government has commissioned Skills for Health and Skills for Care to develop a code of conduct and standards of good practice, and it is considering a voluntary register. However, Mr Francis raised concerns that, unless there was an obligation to be registered, this might not raise standards. He does, however, concede that trusts are more likely to hire HCAs who are registered than those who are not.

The government has suggested mandatory regulation would be costly; however, Mr Francis has countered that saying the cost would largely be covered by registration fees. An amount that HCAs would be charged has not yet been put forward.

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BOX 1. NURSING TIMES SURVEY RESULTS

Do you welcome the Francis report recommendations on regulating healthcare assistants?
» Yes: 95%
» No: 6%

How far do you think regulation of HCAs will improve your working day?
» Regulation of HCAs will be of great benefit to nurses: 73%
» Regulation of HCAs will not affect nurses: 22%

» Regulation of HCAs will disadvantage nurses: 5%

On a scale of 1 to 5, where 1 shows no benefit and 5 shows great benefit, how far do you think the regulation of HCAs will improve patient care?
» 1 (no benefit): 4%
» 2: 6%
» 3: 24%
» 4: 31%
» 5 (maximum benefit): 35%
The government will be introducing training standards for healthcare assistants that focus on 10 key areas of knowledge.

Minimum training standards for HCAs

In this article...
- The government response to the Francis recommendation to regulate healthcare assistants
- Minimum training standards for HCAs

The government has announced it does not plan to regulate healthcare assistants despite the recommendation in the Francis report to do so. It does, however, plan to introduce a set of mandatory minimum training standards and a code of conduct applicable to all HCAs who report to nurses, midwives and adult social care workers in England (Skills for Care and Skills for Health, 2013).

Skills for Care and Skills for Health were commissioned to publish the code of conduct and training standards. The code of conduct is based on the principle of protecting the public by promoting best practice. It aims to ensure HCAs are working to defined standards, providing high-quality, compassionate healthcare and support.

The training standards define the minimum knowledge workers must have. They focus on 10 areas designed to cover the key knowledge HCAs need and set out what should be included in their induction.

Standards
1. Understanding the role
All support workers should understand their own role and how it fits in with the team. It includes understanding of workers’ rights and knowing the aims of the service.

2. Personal development
HCAs need to be able to learn and reflect. This includes having a personal development plan and being given regular feedback.

3. Effective communication
These staff must be taught how to communicate effectively with their client group, and why this is important and what constitutes “good communication”. This includes recognising barriers to communication and knowing how to access information and support services, such as interpreters. This standard also covers an understanding of confidentiality.

4. Equality, diversity and inclusion
This standard relates to ensuring all HCAs have an understanding of how discrimination occurs in the workplace and steps they can take to reduce the likelihood of patients being discriminated against. It includes awareness of legislation and agreed ways of working that relate to equality, diversity, discrimination and rights.

5. Duty of care
This relates to knowing how duty of care contributes to safe practice, safeguarding and protection of individuals, including how to handle dilemmas. HCAs’ responsibilities with regard to complaints and adverse events are also covered.

6. Safeguarding
HCAs are to have a standardised level of knowledge of what constitutes abuse and how to reduce the likelihood of it occurring, including risk management and awareness of the relevant legislation. They will also be taught what to do if abuse is reported or suspected.

7. Person-centred care and support
This covers knowing how to work in a way that promotes patient-centred values, including recognising steps that can be taken to promote dignity and individual preferences, and recognising how cognitive issues might impair an individual’s decision-making capacity.

8. Health and safety
HCAs must all understand their own and others’ responsibilities in promoting safety. This covers fire safety, moving and handling, food hygiene and understanding the importance of good nutrition and hydration in maintaining health and wellbeing.

9. Handling information
HCAs must know why it is important to have secure systems for storing information and be able to keep records up to date, complete, accurate and legible.

10. Infection prevention and control
This standard relates to having a basic knowledge of how infectious agents can enter the body and steps that can be taken to reduce the likelihood of this happening. This covers hand hygiene as well as principles for safe handling of potentially infected linen and clinical waste.

There has been a mixed response to the minimum training standards and code of conduct. Although they will standardise certain aspects of the role, they do not cover areas such as tissue viability and continence, and could perhaps go further in ensuring all HCAs have the same base-level of knowledge in more subject areas. NT

The code of conduct and national minimum training standards are available at tinyurl.com/SFH-HCA-standards

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Reference
Nursing Practice
Review
Student nurses

The Francis report suggests changes to pre-registration training to improve skills and to ensure students have the requisite attributes.

Keywords: Pre-registration training/
Basic care/Student nurses

Recommendations on student nurse training

In this article...
- What the Francis report says about student nurses
- Proposed changes to selection criteria
- Recommendations to improve pre-registration training

Much of the care at the Mid Staffordshire Foundation Trust was below an acceptable standard due to a lack of staff, but Robert Francis QC also attributes some of the failings to nursing staff not being skilled enough to provide the care required.

The evidence collected by the inquiry shows several examples of poor care putting patients at risk and delaying recovery; this was the result of some of the nurses not having the skills to cope (Francis, 2013).

To combat this, Mr Francis has suggested changes in nurse education to create a more compassionate workforce that is able to provide the care required.

Recommendations
Student nurse selection criteria
The report stresses a need to recruit onto nursing courses only those who possess "the appropriate values, attitudes and behaviours". Mr Francis said that student nurses need to be intelligent, caring and possess an intrinsic desire to help others.

To ensure that nurses are motivated to maximise the welfare of others, Mr Francis suggests that one of the minimum requirements to study nursing should be three months’ experience of working in direct patient care, under the supervision of a qualified nurse. He argues that this will ensure only students who are committed to becoming good nurses and who possess the necessary qualities will be given the opportunity to train.

In addition, this recommendation would give potential student nurses an insight into what is involved before they start a nursing course. Mr Francis said that "even in a well-run organisation, the stark differences between nursing as they imagined it to be and the reality will challenge their ability to maintain their motivation".

But the government’s response published last week suggests pilot schemes should be rolled out to make students work for a year as a healthcare assistant before receiving funding for a nursing degree.

He also suggested that, before starting their training, potential student nurses undertake an aptitude test designed to ensure they are willing to undertake hands-on care and are capable of doing this, and are not just interested in the more technical aspects of nursing. The thinking behind this test is not to assess knowledge but to check that prospective students have the caring and compassionate qualities to be a good nurse.

Changes to nurse training
Reassuringly, the report acknowledges that the existing education system does not make nurses incapable of providing personal care.

However, the evidence collected by the inquiry included examples of poor basic care and the conclusion was drawn that the current model of training does not focus enough on the impact of culture on caring.

The report highlights the need for student nurses to be provided with more training on practical elements of nursing, such as lifting and personal care, and for this to be governed by national standards. It stressed that these are skilled tasks that require an appropriate level of training to ensure nurses are competent in them.

Currently, student nurses are expected to learn these skills while on placement. However, as students undertake different placements, the amount and type of practical training they receive vary considerably. Mr Francis recommends that all student nurses, regardless of where they train, are taught practical nursing skills to a consistently high standard.

The report recommends that students all take the same exams and achieve the same qualification at the end of the course. Exams should include practical elements of care in addition to testing knowledge. The aim of making all student nurses take the same exams is to reduce differences in the standard of education provided by different institutions, and to prevent anyone who is not capable of providing compassionate and safe care from working as a nurse.

Conclusion
Mr Francis has advised that there should be a greater focus on nurse training, education and professional development. The report recommends that more emphasis should be put on the practical requirements of delivering compassionate care, in addition to the theory.

The first step to achieving this is by recruiting student nurses who already possess compassionate qualities and the potential to be caring, practical nurses.

This, along with including more practical elements in nursing courses, is intended to produce workforce of skilled, caring nurses who can change the culture of the health service. NT

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Reference
The Francis report highlights the ward sister’s role in setting standards of care, and calls for sisters to be more visible to patients and staff

Redefining the ward sister role to boost frontline care

In this article...

- What the Francis report says about the ward sister role
- Characteristics of successful ward leadership
- Recommendations for future practice

The Francis report is clear that a significant proportion of poor care at Stafford Hospital was due to low standards of nursing. It explores possible causes and highlights poor leadership and declining professionalism as contributory factors.

During visits to the hospital, Robert Francis QC found that the terrible experiences reported by patients and relatives "came largely from wards lacking in strong, principled and caring leadership". Conversely, wards that were well led generally had acceptable standards and were prioritising the delivery of safe, excellent care.

Leaders of the successful wards shared a number of characteristics. Ward sisters were found to:
- Care for the staff they lead;
- Be given responsibility for budgets and recruitment;
- Seek out ways of applying best practice from their team and externally;
- Be listened to by senior management;
- Welcome measurement of their performance;
- Develop a team ethic embracing all staff;
- Receive training and seek out personal mentorship and coaching.

Recommendations

The report describes the ward sister role as "critical" to patient care and aims to promote and strengthen it.

Mr Francis says ward sisters should not be "office bound" as this prevents them from fulfilling the supervisory part of the job. The report states: "As a supervisory leader, the ward sister should, and would, know about the care plans relating to every patient on her or his ward."

Ward sisters need to work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. An important part of their job is to monitor performance and ensure training needs are met and that staff receive a "robust" annual appraisal.

Not being office bound means ward sisters should be visible to patients, relatives and staff and available to discuss concerns. Evidence about ward 10 at Stafford Hospital included the following comment from a relative: "Nursing staff were very quick to respond and answer questions, at the same time assessing and observing their condition and needs."

The Francis report recognises the importance of frontline nursing leadership, particularly by ward sisters. This contrasts with attitudes to ward sisters' views at Stafford Hospital. When Sue Adams raised concerns about ward reconfigurations and staff shortages, she was told she was "only a ward sister" and that decisions had been made at a higher level.

Today, leadership is needed to deliver excellent nursing care and the acknowledgement that this cannot be done from within an office will have implications for the way in which wards are run.

Re-establishing the role of the ward sister and increasing its visibility could be a significant legacy of the Francis report.

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Keywords: Francis report/Healthcare assistants/Patient safety/Staffing levels