

Francis
Report

NT RESPONSE

Narratives from the Francis reports can guide the implementation of ethical leadership and improve the organisational culture of the NHS

Learning from family and nurse narratives

In this article...

- › Summary of two witness stories
- › Francis report recommendations to leaders
- › How ethical leadership can be implemented

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Abstract Gallagher A (2013) Learning from family and nurse narratives. *Nursing Times*; 109: 19, 18-19, 22.

Now the initial flurry of media attention relating to this year's Francis report has subsided, it is a good time to take stock and ask what implications the 2010 and 2013 reports and their recommendations will have on nurses and nursing. This article discusses two areas that have significant potential to contribute to sustainable caring practices: leadership in practice and education; and organisational culture informed by research and scholarship. It also discusses the findings of both Francis reports and provides a summary of the stories of two witnesses.

In 2010 the first report from the independent inquiry into care at Mid Staffordshire Foundation Trust, chaired by Robert Francis QC, was published, detailing many distressing details of avoidable deaths and suffering endured by patients and their families. The primary aim of the first report was "to give those most affected an opportunity to tell their stories and to ensure that the lessons were fully taken into account in the rebuilding of confidence in the trust," (Francis, 2010).

The second Francis report, published in February 2013, had a broader aim:

...to examine the operation of the commissioning, supervisory and regulatory organisations, and other agencies, including the culture and systems of those organisations

in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009, and to examine why problems at the trust were not identified sooner, and appropriate action taken. (Francis, 2013)

Few organisations mentioned in the report were unscathed, few reputations untarnished and, although no-one was blamed, many organisations and professions have been made responsible for now bringing about change. The 2013 report and its 290 recommendations highlight the responsibilities of service commissioners, regulators, the Department of Health, the NHS and all who work in it, education providers and the Royal College of Nursing.

Witness account: patient and relative

The first Francis report (2010) discussed a wide range of failures in fundamental care. The inquiry received oral evidence from 113 witnesses and published a summary of their stories.

One account was from the daughter of an 86-year-old patient, Mrs Brown,* who was admitted to Stafford Hospital with recurrent vomiting. The daughter explained to the inquiry that her mother's time in the emergency assessment unit was particularly confusing for her as she saw a number of junior doctors and there was a lack of "coordination between clinical and nursing care". Mrs Brown was then transferred to a ward, which her daughter described as "utter chaos" and where she observed poor practice, such as food being

5 points to discuss

1 The Francis reports uncovered details of, and explanations for, care failings and avoidable deaths at Mid Staffordshire Foundation Trust

2 Mid Staffordshire should not be seen as a unique case

3 In order to lead effectively, health workers need to be able and willing to challenge others

4 Leaders need to promote ethical practice by giving and inviting feedback on everyday care practices

5 A better ethical climate within a healthcare organisation results in less moral distress for nurses as they are able to provide a higher standard of care



Listening to patients ensures better care

placed in front of a patient who was unable to feed herself and then removed without any help being offered.

While on the ward, Mrs Brown collapsed, which prompted a doctor to ask her daughter to sign a Do Not Resuscitate form. The doctor was quoted as saying:

Listen... the prognosis is very poor[...]her stomach has pushed up... she is going to die over the weekend and it is going to be a very painful death.

Mrs Brown's condition improved for a few weeks and her family remained at her bedside constantly. However, she deteriorated after she was dropped by a healthcare assistant who attempted to lift her onto her bed without help.

It was two days before Mrs Brown was examined by a doctor, who failed to recognise the symptoms of heart failure. Several days later it was decided she should have a blood transfusion, which made her daughter particularly anxious. When she voiced her concerns she was reassured the transfusion would be given slowly and her mother would be given frusemide at the same time to reduce the risk of oedema. However, Mrs Brown was not prescribed frusemide and so was given the transfusion without it. When her daughter was notified about this, she asked if a doctor could be called to the ward to amend the prescription. She described the reaction of the nurse she spoke to:

[the nurse] responded by putting her hands on her hips and saying she was in charge of the ward and would therefore decide when a doctor was called.

The daughter said:

I went home in tears; I had seen enough. The confused man in the next bay was once again being shouted at and told to stay in bed. I was exhausted, since my mother's fall, she had not slept one night...

They were bullies. They bullied... the other staff and they bullied the patients. There was no word for it... particularly during the two weeks that Mum was dying, effectively they [patients] were calling out for the toilet and they would just walk by them.

Witness account: staff member

The narrative of a nurse "whistleblower", Helene Donnelly, who worked in the accident and emergency department, is included in the 2013 inquiry report. She stated:

Nurses were expected to break the rules as a matter of course in order to meet targets, a prime example of this being the maximum

four-hour wait-time target for patients in A&E. Rather than "breach" the target, the length of waiting time would regularly be falsified on notes and computer records. I was guilty of going with this if the wait time was only being breached by 5 or 10 minutes and the patient had been treated, as it seemed unfair and unreasonable to declare a breach just because we were waiting for a porter to come and collect a patient. However, when wait times were being breached by 20-30 minutes or more, and the patient had still not been seen, I was not prepared to go along with what was expected.

Ms Donnelly described how she reconciled poor practice in the A&E department with the requirements of her nursing code of conduct:

I was, of course, aware of my nursing code but it was not even this that convinced me to raise concerns. My own moral code told me that the standards of care were not right. I would go home in tears because people were being treated so badly in that hospital and were suffering so unnecessarily.

She said that "the fear factor kept me from speaking out, plus the thought that nobody wanted to know anyway, due to lack of response to the incident report forms I had logged". She felt, at the time, that she should exhaust internal complaint processes before approaching an external body and commented to the inquiry that bad practice can become routine.

Ms Donnelly described how she was subjected to harassment and threats, was told to "watch her back" and that she should not have spoken out. She described how she was physically threatened and became afraid to walk to the hospital car park alone at night.

It is important to remember, however, that while essential care was lacking and even dangerous in some areas of Mid Staffordshire Foundation Trust, in other parts of the hospital there were many examples of compassionate and competent care.

Ethical leadership

The above experiences raise several questions, such as:

- » Why was ethical leadership lacking?
- » What contributed to the development of a bullying culture?
- » Why did senior managers not respond effectively to the many reports of unethical practices from practitioners such as Ms Donnelly?

FRANCIS ON... LEADERSHIP

- The decline in standards of nursing care at Stafford Hospital was associated with inadequate staffing levels and skills, and a lack of effective leadership and support
- Leaders can change behaviour for the better, but this is best achieved by leaders having direct, personal and visible contact with frontline staff to continually reinforce their message
- Leadership by example is vital: if the board continually asks about safety, the message will permeate the organisation. Most staff join the NHS to do good for others. However, this motivation can be crushed out of all but the most determined individuals if it is not reinforced by positive indications of the value placed on their work. This requires the leadership of organisations to ensure their workforce do not feel taken for granted

There is much to learn from the second Francis report regarding leadership. It identifies several qualities of leadership that are essential in healthcare, including the following:

- » Visibility and example;
- » Listening to patients and staff;
- » In-depth understanding;
- » Lateral cross-boundary thinking;
- » Sharing leadership with all staff through empowerment;
- » Clinical engagement;
- » Collective leadership skills;
- » Ability and willingness to challenge others.

The report emphasises that leadership should be neither too appreciative, nor too critical. Leaders also need to promote ethical practice by:

- » Giving and inviting feedback on everyday care practices;
- » Role modelling ethical practice;
- » Celebrating the activities of those who put patients first;
- » Challenging those practices that compromise patient care.

It has been argued that nurses are ethical leaders when they demonstrate a commitment to caring practices (Gallagher and Tschudin, 2010) and lead by example. Nurse managers are responsible for setting the tone for their team and should "act as arbiters between organisational and

professional values”, challenging the former when they compromise the latter. Storch et al (2013) argue that ethical leadership is needed in every level of nursing. At the macro level, where a political role is assumed, ethical leadership ensures nurses’ voices are heard to promote patient-centred care. At the meso level (between micro and macro), nurses should serve as “the conscience of the healthcare team”, avoiding compromise that diminishes standards of care. At the micro level, nurses contribute to the development of healthy and ethical work environments providing “meaningful involvement in decision making”.

Nurse educators can provide ethical leadership by teaching students, both pre- and post-registration, to evaluate the increasing number of values statements that practitioners are required to apply to their practice. They also have an important role in providing opportunities for students to rehearse challenging ethical situations and reflect on how they would react, so nurses are better able to respond confidently and competently when they see unsatisfactory levels of care.

Although the government has stopped short of regulating healthcare support workers, as was recommended in the 2013 Francis report, a code of conduct and minimum training is supported (Department of Health, 2013). The government recommendation that all potential students of nursing have experience as healthcare assistants needs to be approached with caution. Adequate resources need to be in place so practitioners are able to act as ethical role models and can support potential students to ensure the experience promotes ethical sensitivity and caring values.

Organisational culture

Both Francis reports gave significant attention to the culture of the NHS. In the 2010 report, the factors identified as contributing to the negative culture at Mid Staffordshire were:

- » Attitudes of staff;
- » Bullying;
- » Target-driven priorities;
- » Low staff morale;
- » Isolation;
- » Lack of openness;
- » Acceptance of poor standards of conduct;
- » Reliance on external assessments; and
- » Denial (Francis, 2013).

The 2013 report helpfully identifies the “essential ingredients” of a caring culture as including:

- » Acceptance that patients’ needs come before one’s own;
- » Recognition of the need to empathise with patients and other service users;
- » A willingness to provide patients and other service users with the assistance that one would want for oneself, or to refer them to a person with the ability to provide that help;
- » A willingness to listen to patients and service users to discover what they want for themselves;
- » A willingness to work together with others for the benefit of patients and other service users;
- » A commitment to draw concerns about patient safety and welfare to the attention of those who can address those concerns (Francis, 2013).

The witness accounts described on the previous pages, along with other cases of care failings, highlight the morally corrosive organisational culture that existed. Family members had reason to mistrust – and even fear – those who were responsible for providing competent and compassionate care.

Research into the relationship between organisational culture and leadership and nurses’ experiences of moral distress shows that the better the ethical climate of a healthcare organisation, the less moral distress nurses experience; this is because they are better able to report problems and provide high-quality care (McCarthy and Deady, 2008).

What is clear from both of the Francis reports is that failings were found at all levels within Mid Staffordshire Foundation Trust (Gallagher, 2013). To understand adequately what went wrong and to prevent it from happening again we need insights from different disciplines, including:

- » Philosophical and empirical ethics – to understand phenomena such as moral distress and ethical climate, to interrogate values such as compassion and dignity, and to consider the political arguments for an ethic of care;
- » Psychodynamic perspectives – to understand the implications of unmet needs on behaviour;
- » Social psychology – to challenge the commonly accepted view that bad apples corrupt good barrels and not the other way around;
- » Sociology – to engage with the role and devaluation of care in society;
- » Biosciences – to understand the impact of fatigue and stress on practitioners;
- » Education – to investigate the best means to promote professionalism; and

- » The arts and humanities – to engage with the meaning and implications of suffering and caring responses.

Conclusion

The 2013 Francis report arrived at a time when there are many challenges to quality care. A changing demography, patterns of illness and chronic disease require practitioners to be more confident and competent in dealing with increasing complexity. Meanwhile, there is little opportunity for them to undertake any professional development. It seems likely the pressure to prioritise and meet targets will continue to be valued above a sensitive and calm approach with a patient who is confused.

It is inexcusable to neglect fundamental care, to bully patients and colleagues, and to demand adherence to targets that miss the point of care. We should not consider, however, that the Francis reports describe a unique story that will never be repeated. We must learn from the findings of the Francis report and understand that individuals, cultures and political contexts contribute to the ethical and unethical practices. Solutions then cannot be simple and we cannot be complacent.

If we genuinely care about care, we need to be aware this could happen in our organisations and be prepared to say “no” when our professional values are threatened. We need to consider what we would be willing to do to defend standards of care. **NT**

*Names have been changed; no names appear in the report, in which people are referred to as daughter and patient.

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● For more articles on the Francis report, go to nursingtimes.net/francis