Invisible care in ‘soulless factories’? The challenges of humanising healthcare for patients and nurses

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• Hospitals as soulless factories in which to receive care (especially if older person) and to work in
• The importance of listening to patients and the extraordinary ordinary
• Valuable and valued care being invisible in an audit culture
• Learning from other countries- An inspiring revolution in organising nurses work
• Increased patient demand → increased throughput and ↓ LOS
  = Production line
• Professionalising project RN → less hands on care ↑ HCAs
  = fragmented routinised tasks
• Dissatisfying for staff and patients....

Factors that affect the nature of care - the 5 winds:

1. The digital revolution
2. A culture of audit
3. The triumph of managerialism
4. A change in the nature of politics
5. The role of anxiety
Soulless factories?

In our times cutting edge medicine has been practised in purpose built hospitals served by an army of paramedics technicians, ancillary staff, managers, accountants, fundraisers and other white collar workers, all held in place by rigid professional hierarchies and codes of conduct. In the light of this massive bureaucratisation, it is a small wonder that critiques once again emerged. The hospital was no longer primarily denounced, however, as a gateway to death but as a soulless, anonymous, wasteful and inefficient medical factory, performing medicine as medicine demanded it, not as the patient needed it.
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What matters to patients?

• Feeling informed and being given options
• Staff who listen and spend time with the patients
• Being treated as a person, not a number
• Patient involvement in care and being able to ask questions
• The value of support services, such as voluntary organisations, support groups etc.
• Efficient processes that provide the patient with a sense of continuity of care

What do patients want?

“Make me feel comfortable and make me feel valued. Make me feel like I’m in good hands.” (Older People’s Focus Group)

I like (nurses name) ... she allows me to try, I know I am old and slow but she does not treat me like that- she is kind and helps me to help myself when you have not much left that’s really important ..

(Patient 1 site 2- Nicholson)
“Nobody asked me what I did, no. In fact, I had no conversation in X hospital) at all. They would come in and say ‘good morning’ and I’d ask what it was like outside and they’d tell me and then they’d go out”
(George 92, Nicholson data)

“One nurse got to know my father the day after admission. My father knew she was in her 30’s had children and he asked her about Romania under Ceausescu. I watched her relate to other patients and a guy pulled her over and thanked her for her care. She was allowing herself to be herself, not afraid to be human” (Ian, Carer)
So you’re constantly watching, watching, watching. Your focus isn’t completely on that person. [...] It can’t be, because you’re constantly thinking you’ve got 11 more – six of them need feeding; two or three or four of them still haven’t had a wash and probably laying a soiled pad, because you have not had that time to go get to them yet because there’s too many other things going on [...] you can try as hard as you like, but if you ask anyone, they’ll probably tell you, if they’re honest, that they don’t come away feeling that they’ve done everything they could have done because time restraints don’t allow it [...] staff are running around like headless chickens [...] ’cause you can’t slow down, because if you did, someone would suffer because of it. [...] You’ve got to try and do everything you can do, the best you can do it at the fastest speed possible. And that is rubbish, really, when you look at it like that. ’Cause these aren’t loaves of bread that – it’s like you’re pushing through a machine, is it? [...] This is people. And that does upset you a lot.” (Site 1: HCA S08)
‘in the end, I feel like I’m being moved around like a parcel, I’m being moved like a parcel from chair to commode to bed. I feel like a parcel and not a person anymore’ (Patient 3).
“Hospitals are being restructured to accomplish goals that are not traditionally those of nurses and the standpoint of nurses in the activities of caring is being subordinated” (Rankin and Campbell 2006 p165).
“I’d like to see the client as an individual and having time to support them in a holistic way. Being able to pick up when they are worried or distressed while at the same time ensuring their independence.”
‘Sometimes I’d go home, thinking, I didn’t even see a patient today, you know, and it did feel like that sometimes... a terrible shift, where all you’ve done is paper work and drugs, and that’s it, you haven’t even spoken to any of your patients..... It wasn’t care, because you just didn’t see them’

[Heidi: Interview 2]
Ideals and values

- Sustained idealists: 8
- Compromised idealists: 14
- Crushed idealists: 4
COVERT RULES
Rule 1: ‘hurried physical care prevails’ (to the detriment of psychological care);
Rule 2: ‘no Shirking’ (do a fair share of the work)
Rule 3: ‘don’t get involved with patients’ (keep an emotional distance); and
Rule 4: ‘fit in and don’t rock the boat’ (don’t try and change practice).
“I care too much to stay here”
Extraordinary ordinary

“The difference between ordinary and extraordinary is a question of recognition, The extraordinary work of caring and being cared for with frailty.”

Caroline Nicholson

“Much of what we do as nurses cannot easily be measured. For instance, how many other healthcare professionals know what it is like to sit at 3am with a patient who is afraid to switch off the light and close their eyes in case they never open them again?. Although all the nurses I spoke to were able to describe the skills they used in their work they all believed that their real value lay in their ability to care. And how do you begin to measure the value of a nurse who takes time to listen to a worried patients concerns?” (Nursing Times 2002).
Nursing Care Left Undone
Because of Lack of Time

Country
% Reporting the Following Tasks Left Undone

<table>
<thead>
<tr>
<th>Task</th>
<th>England</th>
<th>Norway</th>
<th>Spain</th>
<th>Switzerland</th>
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</thead>
<tbody>
<tr>
<td>Administer medications</td>
<td>22</td>
<td>15</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Treatments and procedures</td>
<td>11</td>
<td>7</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Skin care</td>
<td>21</td>
<td>30</td>
<td>24</td>
<td>16</td>
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<tr>
<td>Educating patients and family</td>
<td>52</td>
<td>24</td>
<td>50</td>
<td>30</td>
</tr>
<tr>
<td>Comfort/talk with patients</td>
<td>66</td>
<td>38</td>
<td>39</td>
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ABSTRACT

Background There is strong evidence to show that lower nursing staff levels in hospitals are associated with worse patient outcomes. One hypothesised mechanism is the omission of necessary nursing care caused by time pressure—"missed care".

Aim To examine the nature and prevalence of care left undone by nurses in English National Health Service hospitals and to assess whether the number of missed care episodes is associated with nurse staffing levels and nurse ratings of the quality of nursing care and patient safety environment.

Methods Cross-sectional survey of 2917 registered nurses working in 401 general medical/surgical wards in 46 general acute National Health Service hospitals in England.

Results Most nurses (86%) reported that one or more care activity had been left undone due to lack of time on their last shift. Most frequently left undone were: comforting or talking with patients (66%), educating patients (52%) and developing/updating nursing care plans (47%). The number of patients per registered nurse was significantly associated with the incidence of 'missed care' (p<0.001). A median of 7.8 activities per shift were left undone on wards that are rated as 'failing' on patient safety, compared with 2.4 where patient safety was rated as 'excellent' (p<0.001).

Conclusions Nurses working in English hospitals report that care is frequently left undone. Care not being delivered may be the reason low nurse staffing levels adversely affect quality and safety. Hospitals could use a nurse-rated assessment of 'missed care' as an early warning measure to identify wards with inadequate nurse staffing.

INTRODUCTION

The National Health Service (NHS) in England, like many healthcare systems in the world, is facing intense pressure to maintain the quality and safety of care provided in hospitals at the same or less cost than in previous years. 1 The quality of nursing care—and the potential for poor nursing care to do patients great harm—has been the focus of numerous recent reports in England. 2 3 Poor quality care is a source of significant increased cost internationally, 4 The Francis Inquiry 5 examined the reasons why hundreds of patients experienced poor care at The Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009. The Inquiry was instigated when hospital standardised mortality ratios (case mix adjusted mortality rates) indicated that between 400 and 1200 more patients than expected had died over a 2 year period. Numerous patient accounts were heard by the Inquiry, including negative experiences of fundamental aspects of nursing care including care such as communication, maintaining dignity, discharge planning and safety. Failure to ensure adequate nurse staffing was a central factor identified in the report.

There is clearly a need to understand the scale of potential problems in care delivery across the NHS and internationally. There is also a need to understand mechanisms which link nurse staffing to quality and safety outcomes—including our focus here—the nature and extent of care that might be 'left undone'. 6 The purpose of this study is to describe the nature and prevalence of care left undone (as reported by nurses) and explore its association with nurse staffing levels and nurse ratings of the quality of care and patient safety environment.

BACKGROUND

The body of evidence demonstrating an association between patient outcomes and nurse staffing is substantial. A systematic
Right levers for humanising healthcare?

“Most people accept “person-centred care” as a good thing. But there aren’t the procedures and incentives in place to make it a priority, so most people would just ignore it”. Ward sister. Maben (2008)

“What you are rewarded for doing, or expected to do, are all the procedures and protocols - and NOT to have cared”. Staff nurse Maben (2008)
The organisation of care

1991 organisation of nursing care
N=132 ward sisters

- Primary nursing
- Team nursing
- Patient allocation
- Task allocation
- Other

The organization of care: its influence on health education practice on acute wards

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Summary

- This paper explores the relationship between organization of care and nurses' health education practice at ward level and is based on data from a larger 2-year Department of Health-funded study examining the health education and health promotion role of the nurse in acute-ward settings.

- Concepts such as continuity of care, autonomy, accountability and responsibility are examined in terms of their association with organization of care and primary nursing in particular.

- Other factors closely associated with organization of care such as ward democracy and the empowerment of nurses, are also discussed in relation to ward-based health education practice.

- Data analysis reveals that the way in which care is organized on the ward may have a direct influence on the type, quality and consistency of health education advice given to patients.

Keywords: acute practice, health education, organization of care.

Introduction

In recent years emphasis has been placed on the health education and health promotion potential of the nurse's role. As a result all nurses, including those in acute hospital settings, are being urged to take on this responsibility and integrate health education and health promotion into their nursing practice. It has been suggested that nurses are in a key position to undertake health education, being in continuous contact with patients and because of their overall numbers and preponderance in the health service (Hovan et al., 1988). A number of professional and statutory bodies have also advocated nurses' key role, for example the Department of Health (1989) in its document The Strategy for Nursing, and the Royal College of Nursing (1989). The changes in nurse education with Project
Primary Nursing....

“facilitates professional nursing practice despite the bureaucratic nature of hospitals [...] services in bureaucracies are usually delivered according to routine pre-established procedures without sensitivity to variations in needs.” Marie Manthey 2002
Autonomy and empowerment

Staff nurse: Can I go home early today?

Ward sister: I don't know can you? Is all your work done or handed over, are all your patients well cared for? You need to decide if you can go early?
Buurtzorg: better care for lower cost
Buurtzorg overview

• New model of organizing and providing Community Care
  – 2007: 1 team/4 nurses
  – 2014: 800 teams /9000 nurses
  – Back office: 45 staff
  – 15 coaches, 0 managers, 2 directors
  – 70,000 patients a year
  – Turnover 2014: € 280.000.000
What was the problem with homecare?

- Fragmentation of cure, care, prevention
- Standardization of care-activities
- Low quality / high costs
- Big capacity problems – high turnover of staff (shortage of 400.000 nurses within 10 years)
- Poor continuity -clients confronted with many caregivers
- Information on costs per client/outcomes: none!

Policy Review 2006
Buurtzorg started 2007

– **independent teams** of max 12 nurses - 40 - 50 clients

– Working in a neighborhood of 10,000 people.

– who organize and are responsible for the complete process and episode of care in self organising teams
Self organisation

• Optimal autonomy and no hierarchy
• Complexity reduction (also with the use of ICT)
• Sophisticated IT systems so that data is collected and analysed easily – Buurtzorgweb
• Assessment and taking care of all types of clients: generalists!
• 70% registered nurses (average 10%)
• Their own education budget
• Informal networks in the neighbourhood and close collaboration with GP’s
Improving productivity

• Staff are asked to focus on prevention of future problems
• Give staff permission to solve problems
• Train staff in improvement
• Measure whether patients needs are met
• Develop self managing teams

KPMG 2012: Netherlands: Buurtzorg empowered nurses focus on patient value
Staff satisfaction

Thousands of nurses left traditional organizations to work for Buurtzorg:

• They appreciate:
  – Working in small teams
  – Working autonomously
  – Independence
  – Strong team spirit
  – User-friendly ICT (iPads)

• Prize for best employer of the year 2011/2012

• Sickness rate: 3% (average 7%)
"What we want to show is that if you have the autonomy, if you develop your skills and craftsmanship, then it's the most beautiful job you can find."

Jos de Blok
Netherlands: Buurtzorg empowered nurses focus on patient value

Background

In the Netherlands, the financing and delivery of home care is highly fragmented with various actors involved, such as hospitals, nursing homes, and local authorities. This fragmentation can lead to complex decision-making processes, which can be challenging for patients and their families. As a result, patient satisfaction and overall quality of care can be affected.

To improve these challenges, Buurtzorg, a home care organization in the Netherlands, has implemented a new model of care delivery. The organization has adopted a management approach that focuses on empowering nurses and other care providers to make decisions that are in the best interest of the patients.

Organizational Innovation by Integrating Simplification

Learning from Buurtzorg Nederland

Sharda S. Nandam

Organizational innovation by integrating simplification can lead to improved efficiency and quality of care. Buurtzorg Nederland has implemented a new management approach that focuses on empowering nurses and other care providers to make decisions that are in the best interest of the patients.

Management for Professionals

Organizational Innovation by Integrating Simplification

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Reinventing organizations

A Guide to Creating Organizations
Inspired by the Next Stage of Human Consciousness

FREDERIC LALOUX

FOREWORD BY KEN WILBER

“Impressive! Brilliant! This book is a world changer!”
— JENNY WADDE, Ph.D., author of Changes of Mind

[Image of a book cover with butterflies and a keyboard]
Thank you for your attention
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