The Impact of culture on staff and patient experiences

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Final report.....

- Patients' experiences of care and the influence of staff motivation, affect and wellbeing.

NIHR Service Delivery and Organisation programme 2012.
Does NHS staff wellbeing affect patient experience of care?

It may be reasonable to presume that patients receiving better care from staff who feel happier in their work. However, little is known about the strength or possible impact of associations between staff wellbeing and patient outcomes, including their experiences of the care provided. Previous research has tended to focus on single aspects or one staff group [1,2], or have looked at associations at the whole hospital level rather than using the national staff and patient surveys, and hospital-level outcomes [3,4]. Researchers in the NRRN have completed a study to explore the links between patients’ experiences of health care and staff experiences of work such as staff motivation and wellbeing at work [5,6]. Staff and patient views were captured at the team/unit level—where possible matching staff to individual patients they cared for to test associations between staff and patient experience [7].

What do we mean by wellbeing at work?

‘Individual’s subjective experience and functioning at work’ [6] which includes job satisfaction, positive and negative affective reactions (feelings and responses) at work and motivation, emotional labour, and issues of emotional exhaustion and burnout.

How did we explore staff wellbeing and patient experience?

We selected eight case studies (four acute and four community) in four different trusts in England: an Emergency Admissions Unit, Maternity Service, Care of Older People ward and Haematology- oncology ward, and two Adult Community Nursing Service teams, a Community Matron Service and a Rapid Response Team. The study involved 200 hours of direct care observation, interviews with 55 senior managers, 100 patients and 86 staff, and surveys of 300 patients and 300 staff (nurses, health care assistants and medical staff).

What did patients tell us about their experience?

Patients recollected their own and other patients’ experiences vividly in the interviews. They focused largely on the ‘relational’ aspects of their care, i.e., how they were treated and how they felt cared for by staff [8]. Patients wanted prompt, kind and compassionate care. Their views of the relational care they received was influenced by judgments of whether the care was generally ‘good’ or ‘bad’, and whether individual staff were ‘good’ or ‘bad’ at their job. They made a distinction between staff who were tense and emotionally exhausted, versus those who were laid back, and were clear on the importance of the latter.

In the case studies where patients rated their experience more negatively (elderly care and acute admissions, community nursing service and rapid response team), we consistently found poor relational care and staff largely failing to ‘connect’ with individual patients. Patients and relatives considered that they had limited ability and or desire to directly question staff about poor care and poor caring behaviours. Some patients commented on the influence of the workplace on staff behaviour towards patients: busy or challenging service areas, a poor built environment and poorly managed wards.

What did staff tell us about their experiences of wellbeing at work?

Staff wellbeing was defined as ‘individual’s subjective experience and functioning at work’ and included measures of job satisfaction, feelings at work, motivation, emotional labour, and burnout [6].

Staff experience varied across the eight case studies. Staff in many settings spoke of high job demand and low control over their work, leading to emotional exhaustion, stress and for some burnout [7,9]. Some also spoke of bullying and an unsupportive work environment resulting in poor wellbeing at work [5,7]. Other staff felt well supported by colleagues and managers and suggested this buffered some of the pressures exerted by the challenges of day-to-day patient care.

A multi-level analysis of the survey data revealed that both job demands and job resources (support at work) have a strong effect on wellbeing at work [9]. Social support from supervisors, co-workers and the organisation more generally had a positive effect on wellbeing by helping to...
## Four organisations.... 8 case studies

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<th>‘Low’ performing microsystem</th>
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Staff wellbeing an important antecedent

• There is a relationship between staff wellbeing and (a) staff-reported patient care performance and (b) patient-reported patient experience. Staff wellbeing is an important antecedent of patient care performance.

• Seven staff variables (“wellbeing bundles”) correlate positively with patient-reported patient experience:
  – local/work-group climate
  – co-worker support
  – job satisfaction
  – organisational climate
  – perceived organisational support
  – low emotional exhaustion, and
  – supervisor support
Factors shaping staff experience

• Demanding work: high-demand work with little control
• Colleagues: A family at work: local work climate
• Job satisfaction and ability to deliver high quality care
High Demand - low control work

- Inadequate or unpredictable staffing levels.
- The movement of staff at short notice into other staff depleted service areas.
- The felt lack or inadequacy of training in specialist care skills for nursing staff (e.g. dementia and delirium).
Staffing....

And, you see, so I feel that, you know, “Excellence in care”, I think that’s fantastic. But if you came to my ward half of the time, em, we’re not staffed to be like that. You know, we had a patch after Christmas with quite a few patients all of whom had quite severe dementia with behavioural problems......one of the patients in particular was very restless and would get up, em, and he usually knew when he wanted to pee, but often couldn’t get there or would get lost. And so he’d be in the corridor sort of stripping off, peeing in the corridor, there would be two nurses trying to either get him to the loo or take him back. When you tried to move him...... he didn’t know how to cooperate with walking anymore, so he’d get frozen to the spot. And so quite often you’d have this sort of semi-naked man peeing in the corridor in front of everybody. But there aren’t enough staff on the ward, because there can be someone else needing a pee, needing two people to help them there, and so then that’s it, there’s no staff left to do anything. And so I just don’t think people understand how many staff I think you need to run a ward for older people ward to provide excellent care” (Consultant Geriatrician).
A family at work: local work climate

- Ward leadership
- Co-worker relationships
Fissures in co-worker relationships…

- Qualified staff (registered nurses) and unqualified staff (HCAs);
- Staff from different cultural or ethnic backgrounds;
- Staff who practised or experienced incivility and bullying
• “Well, it used to be more of a family affair. We used to go out... and chat. These days, we don’t do any of that. We don’t seem to be held together.” (21736)

• “it’s changed a lot...when I first started....we were all equal, but we all had our different jobs to do... that no longer exists on the unit, it is a case of the staff up there and the Level A Grades and HCAs are down here.... the HCAs ..they’re there to do all the mopping up and the toileting, and all the dirty work for the staff doing all the paperwork, which I understand, but sometimes we need the help of the staff nurses because if you’re on your own and the buzzers are going you can’t answer every buzzer” (21771)
Incivility and bullying

“If one kicks off they join together, there’s a ringleader, it’s very much a ‘them-and-us’ atmosphere – nursing staff, ward clerk and management versus the healthcare assistants” (JM field notes 7/7/10).

“There’s a fair amount of, I’d say, bullying, if you like, goes on on the ward, depending what staff you’re working with. (It’s) not outward. (..) There is an undercurrent of bullying…..It does impact on the day, on that particular working day, yeah. We all feel that.” (21736).
Not just nursing teams....

“it’s been particularly stressful. To be honest, I have struggled a bit I think.. it’s been...really difficult, and I am the most junior person as well, so the fact that I'm not getting that much support from the ...locum SHO basically, and she had taken a 15 year gap from medicine... and ...the fact that the consultant is always in a bad mood, and very sort of touchy, and tends to scream and yell at people, myself sometimes, but not as often, but to see it happening to other people kind of gets you a bit twitchy as well...so I'm particularly stressed.....”

Dr J
Ward leadership: ‘Good’ and ‘bad’ leaders

‘our manager’s very good; she’s hands on; she’ll get on the ward and help out with the patients’ (HCA 4).

‘caused a lot of trouble (..) s/he’d come onto the ward and order you to do something whether you were busy (..) or not. You immediately dropped everything to do their bidding’ (HCA 1).

This senior nurse was equally unsupportive of ward managers:
‘S/he hasn’t supported them when they’ve needed it, but s/he has gone over the top on small points when they’ve been really not in the mood for it’ (Manager 1).
Inspiring staff to empathise

‘You trying to hold that ice cube is how patients feel when they want to go to the toilet, and they’re holding it because nobody has answered the buzzer.’

(Ward sister ward 3)
Leading by Example... The importance of Ward Manager / Team Leader:

- 1. instils a sense of pride in our ward by focusing on what we do well
- 2. inspires confidence by saying positive things about the ward
- 3. ensures the interests of team members are considered when making decisions
- 4. consults with the team about daily problems and procedures
- 5. acts in a caring and supportive manner towards members of the team
- 6. is clear and explicit about the standards of care expected
- 7. takes initiatives to establish strong standards of excellence in care
- 8. sets clear care goals and objectives for this team
- 9. is an on-going “presence” on the ward – someone who is readily available
- 10. actively coaches individuals to help them improve their care delivery
- 11. sets an example by involving herself/himself in hands-on patient care

(Patterson et al 2010)
Managers who listen and act?

We have struggled a lot with the feeling that the senior management team don’t understand what it’s like on the ground, and that middle management filter things. Because you get the strong impression that they don’t really want to know how bad it is, and that actually if you tell people how it is, they think you’re being difficult and negative, rather than telling them the truth... and the impression I have is that managers who feed up real information get into trouble.  
(Consultant 3)
- Meaningful work
- Feeling valued
- Opportunities for development
- Improving practice
- Maintaining healthy relationships with managers / rest of team
- Working for a larger good
### Positive Environments of care

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<th>Good role models</th>
<th>Adequate staff and good skill mix</th>
<th>Ideas welcomed and change encouraged</th>
<th>Support for staff – mentorship and preceptorship</th>
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<tr>
<td>Motivated and receptive colleagues</td>
<td>Where staff feel valued and receive feedback</td>
<td>Where staff performance is well managed</td>
<td>Where staff feel heard and their voice counts</td>
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<td>Philosophy of care that supports compassionate care</td>
<td>Excellent team leadership</td>
<td>Supportive co-workers ‘Family at Work’</td>
<td>Space and opportunity to ‘process’ work challenges with colleagues</td>
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<td>Low demand- high control</td>
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• Nurses aspire to therapeutic relationships with patients, to....

  – connect with patients

  – get to know individual patients

  – involve patients in their care

Bridges et al 2012
If not....moral distress....

“I think it is like a plastic shield that you put up and I think if you stick at it long enough and you’re in the job long enough, it becomes a natural way“

(Macintosh 2007 Quoted in Bridges et al 2013)
Coping mechanisms

• ‘ability to switch off’: work persona that included switching off/withdrawal (Mackintosh 2007)
• Avoiding over-involvement with patients (Hopkinson et al. 2003, De Bal et al. 2006, Nolan 2006, 2007)
• Reluctance to return to work (Gutierrez 2005)
• Loss of caring and depersonalization of individuals and situations (Mackintosh 2007)
• Avoiding certain patients and families (Gutierrez 2005)
• Reluctance to care for patients at all (Gutierrez 2005)
• Block out feelings/try to forget (Hov et al. 2007)
• Frustrated aspirations lead to stress, burnout, patient abuse (Nordam et al. 2005)
• Ignoring patients (Eriksson & Saveman 2002)

• “I think it is like a plastic shield that you put up and I think if you stick at it long enough and you’re in the job long enough, it becomes a natural way” (Mackintosh 2007, p.986)
Impact on care

• Nurses’ reported a lack of time to spend with patients; treating larger number of older patients with a shorter length of stay reducing staff satisfaction with the care they gave. (De Bal et al. 2006; Eriksson & Saveman 2002; Hopkinson & Hallett 2002; Nolan 2006; Nolan 2007; Nordam et al 2005; Quinn 2003; Wilkin & Slevin 2004).

• A “constant demand from the top of the organization for reducing the care time” with patients with dementia (p.82). (Eriksson & Saveman 2002-Sweden).

• Nurses did not have enough time to get to know patients’ needs or to learn how they communicated so nurses had to guess or failing that, resorted to force or ignoring the person with dementia. (Nordam, Torjuul, & Sorlie 2005- Norway).

• Nurses worried about becoming “emotionally stunted” in relation to patients (Nordam, Torjuul, & Sorlie 2005- Norway- p.1251).
Patients noted the difficulties of caring work....

• Gloria suggested ‘I shouldn’t like to work here’ and Rose, reflected:
  “I think that it must be traumatic in lots of ways. Obviously, they’re faced
  with a number of people who don’t recover, who die. In fact, on the first
  admission three patients died in the ward I was in, in a week, so that must be
  traumatic for them to deal with that’. (PT ID 21099)

• “everybody in that ward was very ill and they spent so much time looking
  after them. They could spend an hour changing someone’s dressing or giving
  them a bed bath or something” (PT ID 21110)

• “The paperwork, of course, is so tremendous these days that everybody is
  filling in forms and charts and everything else which leaves less time by the
  bedside. That’s how I saw it”. (PT ID 21099)
‘Poppets and parcels’: the links between staff experience of work and acutely ill older peoples’ experience of hospital care

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Poppets and parcels

• ‘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).

• ‘(they’ve) got something that just endears to you and you just feel, ‘Oh, she’s gorgeous.’ You just click with them as well’ (HCA 3).
How does the system support or impede high quality care delivery?

“nurses’ frustrations are predominantly related to a sense of powerlessness over organisational factors that influence what they are able to do...”

Bridges et al 2012

“If the job is making doctors sick, why not fix the job rather than the doctors?”

(Chambers and Maxwell 1996 BMJ)
Do we have the right levers in place?

“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”

“What you are rewarded for doing, or expected to do, are all the procedures and protocols - and NOT to have cared”
Thank you

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