



Editorial

Nursing must acknowledge and address systemic problems which lead to poor care



In a discussion paper published in this issue of the *International Journal of Nursing Studies* Richards and Borglin (2019) ask the profession to consider whether something is rotten at the heart of modern nursing as a result of which poor nursing care has become the norm rather than the exception. The examples of what Richards and Borglin refer to as 'shitty nursing' are very worrying, involving either inattention to, or complete neglect of fundamental personal needs, for example mobility, nutrition and cleanliness.

In addition to providing concrete examples of omissions in care, we note that the examples provided by Richards and Borglin are devoid of any broader sense of compassionate care, which has been defined in the following way:

"in providing compassionate care: we respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for those we serve and work alongside. We do not wait to be asked, because we care . . ." (DH, 2009: p5).

Whether 'shitty nursing' is the new norm leading to an erosion of trust in the nursing profession by the public is debatable, as is the extent to which it is truly a new phenomenon. Perhaps neither matters because nursing which is devoid of compassion is all too frequent, as demonstrated by enquiries of care failures in several countries (e.g. Francis, 2010, 2013; Lown et al., 2011; Youngson, 2011) and countless media reports from across the world. Such reports frequently highlight not only failure of nursing staff to meet patients' basic care needs, but also poor attitudes towards vulnerable people.

So how has this sad state of affairs come about? Richards and Borglin (2019) argue that fundamental nursing care, which involves helping or assisting patients to meet their essential personal needs has been abandoned by both registered nurses (RNs) and nursing auxiliaries. RNs are incentivised to move into specialist roles vacated by medical staff and other health professional groups and into 'leading' nursing care rather than 'doing' it; and nursing auxiliaries, rather than focusing on providing basic nursing care needs, appear to be picking up the minor technical roles abandoned by RNs and so following them down an increasingly technical nursing path.

Another explanation, which receives considerable support in the popular media (Gill, 2004; Phillips, 2011), is that inappropriate individuals are being selected for nursing programmes, with selection based upon academic qualifications rather than positive values. It is argued that university based nursing education reinforces this bias through rewarding academic achievement

rather than compassionate care - although there is sparse evidence for the validity of such explanations (Norman, 2014).

In the UK, following an enquiry into care failures in Mid-Staffordshire NHS Foundation Trust, "values based recruitment" for nursing schools was introduced in 2014. The intention was to select appropriate candidates for training to ensure that new recruits possess appropriate values, attitudes and behaviours. Our experience suggests that this process can indeed eliminate those who are unable "to put themselves into the patient's shoes" from the recruitment process. However, values based recruitment does not do much to identify someone's day to day behaviour or their ability to maintain empathy once working in a challenging healthcare setting.

More significantly, available evidence simply does not support the claim that the wrong people are being recruited into the profession. Several studies show that students enter the profession with aspirations for delivering high quality care and but within a short time have their ideals crushed or compromised by professional and organisational constraints (e.g. Maben et al., 2007). Others have their aspiration to deliver compassionate care thwarted by the negativity and lack of support demonstrated by many older nursing staff (e.g. Horsburgh and Ross, 2013).

Moreover, in spite of its pervasive appeal as an explanation in the popular press, there is still no research evidence to suggest that degree-level education is to blame (Willis Commission, 2012); indeed there is evidence to suggest that hospitals with the highest levels of degree educated nurses not only have the safest care but also the highest levels of patient satisfaction (Aiken et al., 2014).

The explanation for poor care most favoured by professional nursing bodies is low staffing levels. The Francis enquiry, for example, reports 'the Trust was some 120 WTE nurses short of what was required, nearly 13% of the total nursing establishment' (Francis, 2013a, p. 212). It seems that low staffing may impact the priority that nurses give to aspects of their role. For example, an analysis of missed care by Ball et al. (2014) concludes that when resources are short nurses give priority to delivering medical treatment and accept that they cannot spend time comforting, educating and discussing treatment with their patients. Richards and Borglin recognise that contextual issues such as low staffing levels may be in part responsible for poor fundamental nursing care. But they argue that nursing as a profession is too willing to lay the blame on the context of nursing rather than take responsibility for failings as a mature professional group should. It certainly seems that a compassionate care environment needs more than adequate staffing levels. A meta-ethnography of literature examining the nurse-patient relationship

(Bridges et al., 2013) found that whilst nurses sought to build therapeutic relationships with patients, they reported being thwarted by organisational factors such as lack of time, but also the lack of value and support displayed by their organisation towards relationship building, and the lack of attention by the service to patient autonomy and preferences for treatment.

The causes of shitty nursing are complex and almost certainly multi-factorial. So what can be done about this sad state of the profession? Richards and Borglin suggest that nurses should seek to repair the social contract between the public and the profession, which they perceive to be fractured or at least fracturing, through a process of truth and reconciliation. This would involve the profession accepting responsibility, hearing the voices of others affected by nursing action (or inaction) and so move away from distrust and relationship breakdown to towards reconciliation. Richards and Borglin also recommend that nurses be oriented and incentivised to adhere to the core values of the profession and return their focus and attention to meeting fundamental personal care needs and also that there should be also substantial investment in intervention studies to build the evidence base to support fundamental nursing care.

While the 'shitty nursing' described by Richards and Borglin may not, primarily, be exemplified by a lack of evidence on what should be done, we would not deny the need for more and better research to guide nursing interventions. However, the bigger lesson is that nurses and nursing need to acknowledge that the issues described relate to real systemic problems that are common. Richards and Borglin are publically saying what many say in private. Their experiences reflect those of many. While we must not forget that for every example of 'shitty nursing' there may be many more examples of nurses making positive contributions that go unheralded that should not be an invitation to complacency. A profession that merits such a description needs the maturity to acknowledge and address such problems. They are not new, but equally they are unlikely to simply disappear by themselves.

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Ian Norman*

Faculty of Nursing, Midwifery & Palliative Care, King's College
London, London, UK

Peter Griffiths

Faculty of Health Sciences, University of Southampton, Southampton,
UK

* Corresponding author.

E-mail addresses: ian.j.norman@kcl.ac.uk (I. Norman),
peter.griffiths@soton.ac.uk (P. Griffiths).