**Comment**

“It’s one thing to raise concerns – but another to act on them”

We’ve come a long way since Graham Pink raised concerns about safety at Stockport in 1990, but have we come far enough? Pink wasn’t the first or the last nurse to do so and the importance of identifying poor practice has been raised recently by Sir Robert Francis QC in his two reports on Mid Staffordshire and in his most recent review, Freedom to Speak Up.

The 2014 NHS Staff Survey includes a new question on this issue. Nationally, 68% of staff said that they felt secure raising concerns about unsafe clinical practice, leaving one third who presumably do not. Despite this, 94% said that the last time they witnessed an error, near miss or incident, they or a colleague reported it. So why do we still have safety failures?

Some of the answers can be found in the NHS Staff Survey. Unlike in 1990, clear processes are now in place and 93% of staff reported they know how to raise concerns. However, only 57% felt confident that their organisation would address concerns and only 29% reported that senior managers acted on feedback from employees. The major problem seems not to be raising concerns but acting on them.

Is this because managers do not want to hear employees’ concerns? While there are clear examples of some staff being intimidated or even bullied by managers, 74% of staff said they were able to make suggestions on how they could improve the work of their team. I think this shows that it is important not to conflate failure to listen with failure to act on concerns. Staff at all levels want the best for patients, but change is complex and making well-intentioned changes in one part of the system often creates unintended consequences elsewhere. The best example of this is the four-hour wait target in accident and emergency departments. Introduced to improve the patient experience, this had the unintended consequence of an increase in moves between wards and an increase in unplanned patient discharges.

The staff survey suggests that a lack of understanding of how to manage unsafe practice is our major challenge rather than poor reporting processes. Escalating reporting and creating Freedom to Speak Up guardian posts in each organisation is unlikely to deliver the improvements that all whistleblowers ultimately desire.

Skilled managers and boards who are confident and competent to respond to concerns will focus on creating safety, encouraging staff who raise concerns and welcoming their input. For the small number of cases where concerns are not taken seriously or staff raising them are victimised, trusts will already have been lost. It will be too late to carry out internal processes so an independent, external body should investigate and mediate.

Creating a safety culture requires protected time for improvement activities with both managers and direct care staff who are skilled in creating active safety rather than counting past harms. In such a culture, peer pressure rather than bureaucracy will ensure concerns are celebrated rather than tolerated.

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**Spotsight**

**Nutrition is vital during critical illness**

Critically ill patients are at a high risk of malnutrition and not just because they are unable to eat or drink easily. They are under physiological stress, which increases their metabolic rate and energy requirements, leading to a breakdown of the body’s store of nutrients.

Malnutrition must be addressed as it has a negative impact on recovery. It slows wound healing, causes muscles to break down and can lead to organ dysfunction.

Our extended article on page 12 describes different ways in which the nutritional needs of critically ill patients can be met. It explains refeeding syndrome, which can be life threatening. This can occur when a person who is malnourished is given sufficient nutrition. Our article also details those who are at particular risk of it.

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