Clinical Practice
Discussion
Nursing interventions

Keywords Research/Training/Wellbeing/Older people

In this article...

- How four nursing interventions organise patient care and support for nurses
- The findings of research studies into the effectiveness of each intervention
- How nursing teams can use them optimally, particularly during the pandemic

RESEARCH THAT SUPPORTS NURSING TEAMS: PART 3 OF 4

Applying research findings to the organisation of nursing care

ARE YOU OK

Key points

Studies have explored the application of four interventions to the organisation of nursing care

One intervention uses a systematised checklist approach, emphasising transactional care delivery and documentation

The other three allow staff to reflect on the emotional impact of care delivery and focus on individualised patient care

Organisational buy-in and the way in which nursing teams are organised are often barriers to taking up opportunities that have been identified

Rapid changes during the coronavirus pandemic have emphasised the importance of supporting patients' relational care and nurses' mental health

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Abstract This article, the third in a four-part series about using research evidence to support nursing teams, discusses the evidence from four studies funded to evaluate interventions that strengthen organisational capacity to deliver compassionate care. The interventions were developed to address the key recommendations of the two Francis inquiries into care failings at Mid Staffordshire NHS Foundation Trust. Each study evaluated one of the four interventions in terms of its ability to improve the compassionate care delivered to patients. The findings suggest that the success of each relies on organisational buy-in; during the coronavirus pandemic this is particularly important for both the relational care of patients and the mental health of staff.

Citation Harris R et al (2020) Research that supports nursing teams 3: applying research findings to the organisation of nursing care. *Nursing Times* [online]; 116: 12, 50-52.

Delivering essential nursing care that is tailored to patient need is of utmost importance to high-quality healthcare. How care processes are organised and the way in which the nursing team is organised and supported contribute to the delivery of care. However, changes to the composition of the team and the way it works are frequently made without evidence that such changes will result in better or more efficient care or improved outcomes for patients.

This article – the third in a four-part series that brings together findings from four National Institute for Health Research-funded studies of interventions designed to improve the care delivered by nursing teams – examines what the evidence from these studies tells us about the organisation of nursing care. The studies were commissioned in the wake of the Francis reports (2013 and 2010) into care failings at Mid Staffordshire NHS Foundation Trust. Each study evaluated an intervention in terms of its ability to strengthen compassionate care. One study evaluated Intentional Rounding (IR), an intervention that changed how teams organise nursing care; the other three evaluated interventions that develop and support staff to enhance the quality of the relational care they deliver to patients.

Intentional Rounding

IR is a structured process that systematises nursing ward rounds every 1-2 hours for every patient, using standardised protocols and documentation (Harris et al, 2019; Sims et al, 2018). Each check aims to ensure comfort and care needs are systematically being met and is often focused on the four Ps:

- Positioning;
- Personal needs;
- Pain;
- Placement of items.

The study found that, although IR had been implemented in the majority of trusts across England, there was considerable

variation in how it was organised, including which members of the nursing team undertook IR, its frequency and content, and how it was documented.

Most trusts also added additional clinical assessments – including pressure ulcer risk assessments and the checking of intravenous lines and food and fluid charts – to the rounds, which increased the time needed to complete them. When short-staffed, nursing staff prioritised tasks other than IR on the basis of patient need. Senior nursing staff were aware of this issue and encouraged them to undertake IR alongside other care activities, which they often did. However, when undertaking IR, staff were frequently interrupted by patients, carers and other healthcare staff and sometimes had to stop to check a call bell or answer the telephone. As a result, staff were often observed documenting rounds retrospectively or catching up.

IR was seen by many nursing staff as a helpful checklist to prompt them to complete particular tasks, and as especially useful for less-experienced and temporary staff. None of the nursing staff in Harris et al's (2019) study thought IR should be undertaken prescriptively; instead, they talked about using their clinical judgement and common sense to tailor it to each patient. IR was rarely observed to be carried out consistently or as per protocol:

- Patients were not often asked about the four Ps;
- Patients were not often told when the staff member would return to see them;
- Patients were rarely aware that IR was happening.

They valued the more relational elements of their interactions with nursing staff, which occurred during care activities other than IR, suggesting that it makes a minor contribution, if any, to how nurses engage with patients (Sims et al, 2020). Similarly, few frontline nursing staff felt IR improved the quality or frequency of their interactions with patients and families but they valued the evidence of care delivered that IR documentation provided, feeling it aligned with the prevailing NHS culture of 'if it's not documented, it's not done'.

Although senior nursing managers expressed uncertainty about the accuracy of IR records on the delivery of nursing care, it was clear it reassured them that care had been delivered; some acknowledged that IR was used as a safety net or defence against allegations of poor practice on individual, ward and organisational levels. Senior nursing managers described IR as a minimum standard rather than something to aspire to. However, although they were keen to develop how nursing practice was organised beyond the confines of IR, they felt constrained by what they perceived as a performance-management approach and culture of risk aversion in the NHS.

"Staff support and development activities should be considered essential to the provision of compassionate, relational care to patients"

Older People's Shoes

Older People's Shoes is a two-day training programme for healthcare assistants (HCAs), designed to improve the relational care they provide to older patients by helping them consider ways to get to know them and understand the challenges they face (Arthur et al, 2017). Intended to develop HCAs' communication skills, the approach to strengthening the organisational capacity of teams to deliver compassionate care was different to that of IR. Instead of providing a checklist of activities, Older People's Shoes drew on the strengths HCAs already brought to their work to develop their relational care skills and incorporate them into everyday activities.

As the proportion of HCAs in the workforce of ward teams increases, their contribution to improving the experience of older patients and their carers will also increase. As Older People's Shoes training is grounded in evidence about HCAs' daily work, it can help them deliver relational care in this challenging context. The organisation and delivery of relational care that focuses on individual patients' needs and challenges will support not only those receiving care but also other members of the ward team, some of whom are accountable for the tasks delegated to HCAs.

Creating Learning Environments for Compassionate Care

Creating Learning Environments for Compassionate Care (CLECC) is a multifaceted, team-based programme that promotes compassionate care in health and social care teams by developing them to support relational work between individual staff members and between staff and patients (Bridges et al, 2018). As a learning intervention for the whole team, CLECC offers another approach to strengthen organisational capacity to deliver compassionate care. It comprises a range of activities, including team manager learning sets, peer observations of practice, and classroom learning.

Longer nursing shifts can reduce the overlap time between shifts and so also the time available for teams to meet, reflect and learn together, and support each other. CLECC builds space into the shift that is not usually available due to the intensification of nursing work caused by increasing patient complexity and financial efficiency measures. These spaces give nursing teams opportunities to:

- Think differently about care;
- Support each other to be innovative and compassionate in care delivery.

Bridges et al (2018) found that nursing staff valued CLECC's contribution to their own wellbeing, more-cohesive team working and supporting good patient care. However, sustaining CLECC practices was challenging and determined by the extent to which managers understood and valued the intervention, and whether it fitted with the wider organisation's priorities.

Schwartz Center Rounds

Schwartz Rounds are an organisation-wide intervention that aims to support healthcare staff to deliver compassionate care by providing a safe space in which they can openly share and reflect on the emotional, social and ethical challenges they face at work. Schwartz Rounds are underpinned by the idea that caregivers are better able to make personal connections with colleagues and patients if they have insight into their own responses and feelings; the intervention thereby offers another approach to strengthening capacity to deliver compassionate care that is aimed at the whole organisation. Maben et al (2018) found that attending Schwartz Rounds:

- Increased staff empathy and compassion for their colleagues and patients;
- Supported them in their work;
- Helped them make changes in practice.

This happened because the rounds offered them a 'counter-cultural' reflective space where tick-boxes and protocol-driven outcomes were 'left at the door', allowing staff members to focus on individual patients, carers or colleagues. This provided opportunities for nurses to process challenging experiences and hear from others about their work and ways of organising it.

Schwartz Rounds are not outcomes oriented and are the antithesis of checklist culture but they do result in behaviour change. A Schwartz Round is a reflective space that allows nurses to reflect on what they are doing and why, reconnecting them with their values and why they initially joined

the profession. However, Maben et al (2018) found the positive impact of Schwartz Rounds on nursing staff was limited by structural and organisational barriers that prevented ward staff from attending; 12-hour shift patterns offer little scope to release frontline nursing staff or those with no control over their own schedules.

Organisation of nursing work

Taken together, the findings of these studies suggest that, while the organisation of nursing teams' work is shaped by patient demand, ward practices, and hospital and system-level needs, there are sometimes tensions between these pressures. All four interventions were developed as a direct or indirect response to suboptimal care practices, illustrated in their most extreme form in Francis' (2013; 2010) reports. However, each intervention suggests a different solution:

- IR is a top-down, standardised approach whose checklist ostensibly ensures patients' needs are being met but it also checks on team members and is seen to protect the wider organisation from criticism;
- Older People's Shoes encourages staff members to organise their care delivery by focusing on interacting with patients;
- CLECC's focus on team-based learning, dialogue and innovation aims to prompt a bottom-up approach to care delivery;
- Schwartz Rounds were designed in response to the challenges staff face in providing compassionate care in high-pressure work environments.

There is nothing implicitly superior about any of these approaches: top-down approaches can be affected by the variation between local contexts and staff understanding, and bottom-up approaches will not be sustainable without wider organisational and system-wide support. Both approaches ultimately need buy-in at different levels of the organisation to become established in practice and be effective.

Applying the findings during the coronavirus pandemic

All the studies discussed above were conducted before the current coronavirus pandemic. However, there are some important messages that, collectively, all four studies can convey about how nursing teams and the care they deliver are organised.

Patients' and relatives' experience of hospital care is shaped by their relationships with the staff who care for them. During the pandemic, rates of anxiety may be higher and relatives' visits are restricted; the delivery of compassionate care is, therefore, even more important than usual. Additionally, the need to use personal protective equipment may challenge how nurses organise their work, is likely to be labour intensive, and may limit and compromise the amount of time that is available to provide relational care.

All four studies have demonstrated the importance of relational care to patients and their families. This suggests that, as work and care processes are rapidly developed and reorganised in response to the pandemic, consideration of the impact of these changes on the contact staff have with patients is fundamental to genuine engagement and the delivery of relational care to ensure high-quality patient experience.

"The organisation of nursing teams' work is shaped by patient demand, ward practices and hospital and system-level needs"

The rapid reorganisation of the nursing workforce and care delivery processes during the pandemic has inevitably had an enormous impact on staff members; many have been redeployed to unfamiliar clinical areas and are working as part of new clinical teams. Research has shown growing strain on the mental health of UK nurses and midwives who are working during the pandemic, with signs of post-traumatic stress disorder already being reported (King's College London, 2020; Maben and Bridges 2020; Maben et al, 2020).

The studies into the four interventions discussed in this article have shown the benefits to individual staff members and nursing teams of having the space and opportunity to acknowledge and reflect on the emotional impact of care delivery. As such, these staff support and development activities should be considered essential to the provision of compassionate, relational care to patients and their families. They do, however, also pose challenging questions about how to optimise the organisation of nursing care and support for nurses:

> *"We don't have these professional conversations. We don't have those types of forums because we're so caught up just trying to keep it safe at the moment in most organisations. There'll be more and more decisions that are made politically because we don't have those right conversations and we're caught on the back foot, and because we don't have a plan and a visual sense of how you do it."* (Senior nursing manager – Harris et al, 2019)

These questions also apply in the midst of the pandemic and beyond.

We plan to host an event in spring 2021 to engage nursing leaders, policy makers and practitioners in considering how nursing policy and practice should respond to the findings of these studies; register your interest at Bit.ly/NursingTeams. **NT**

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