

The impact of staff vulnerability; does nurses' vulnerability affect their ability to care?

Abstract

Recent reports from the Department of Health (DoH 2008) and the Parliamentary and Health Service Ombudsman (2011) have been highly critical regarding the care that some patients' have experienced. They have highlighted that fundamental aspects of care are missing resulting in a lack of high quality individualised nursing care which is in contrast with holistic nursing philosophy. We have to ask ourselves what is happening within nursing, as many enter the profession due to a desire to "make a difference".

This paper draws upon focus group data exploring perceptions of caring for residents with dementia in a care home setting. The findings demonstrated that the nurses and health care assistants experienced a mutual vulnerability with patients. This paper explores whether this mutual vulnerability could lead to nurses focusing upon the clinical aspects of their role to the detriment of the compassionate, caring components of nursing.

Key words: Vulnerability, Dementia, Older People, Care Homes

Vulnerability and nursing.

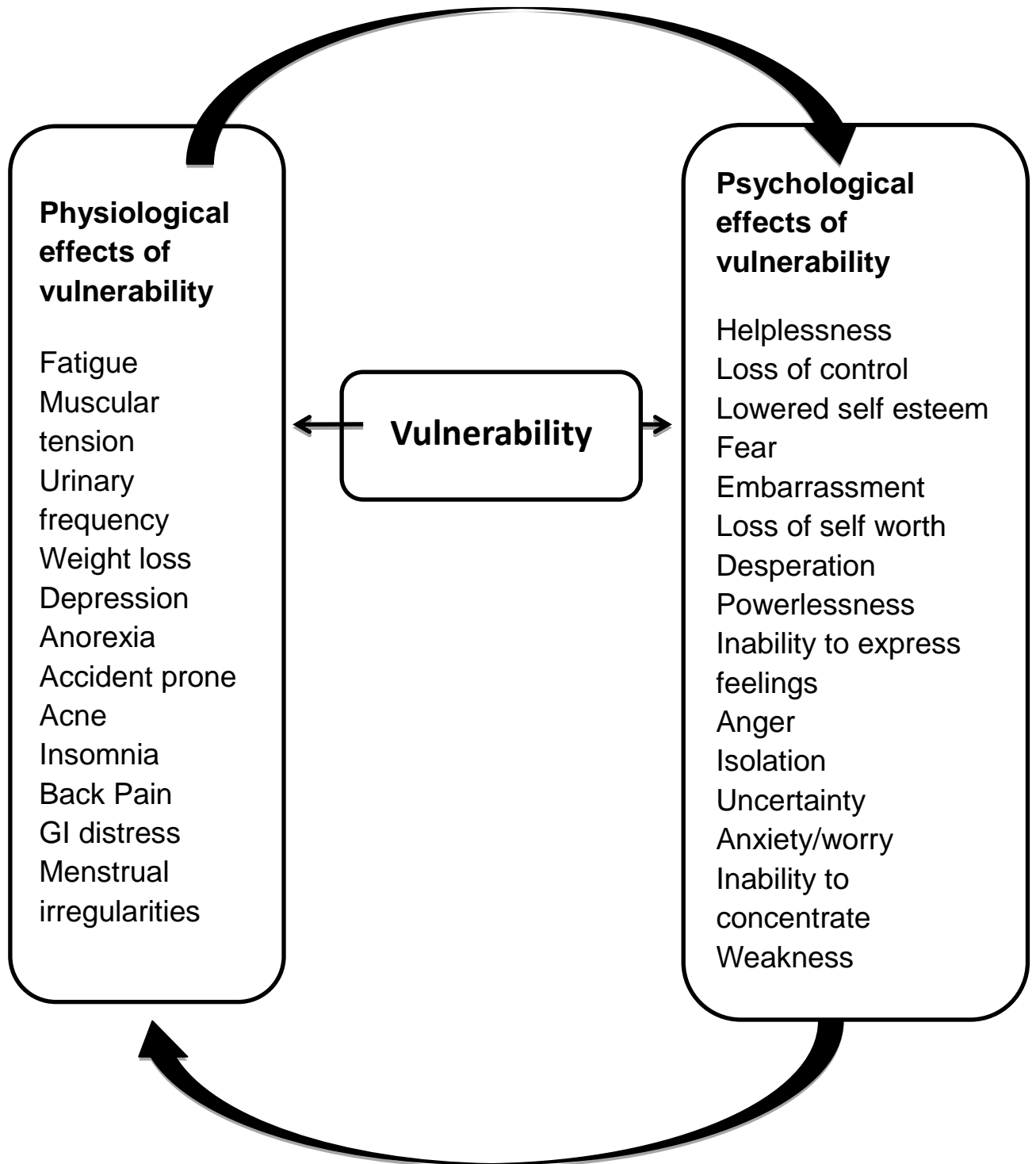
Historically nurses have "ministered" to vulnerable populations (Drake 1998), from the time during the Crimean War in which both Mary Seacole and Florence Nightingale, albeit differently, sought to minister to those in need. Contemporary nurses are also likely to encounter what are described as "vulnerable people" during their nursing careers. Indeed the statutory body for nurses and midwives notes that people can experience vulnerability whenever their health or usual function is compromised, thus vulnerability increases when they enter unfamiliar surroundings, situations or relationships (Nursing Midwifery Council 2002). It is perhaps therefore unsurprising that vulnerability is a central theme within healthcare that often emerges from patients' stories about their experiences of ill health.

Before we can explore the links between vulnerability and a lack of "humanised", compassionate care, a better understanding of the term is required. The Latin root of the term vulnerability is '*vuln*' which means wound, or '*vulnare*' meaning to wound. A concept analysis conducted by Spiers (2000; p716) identified two main approaches to viewing vulnerability; the "etic" and "emic". The etic perspective relates to outsider perspective and focuses upon the "susceptibility to and possibility of harm". As such it is externally evaluated or judged and is the predominate approach used in health care to identify vulnerable groups in society. In contrast, the emic is much more silent in the literature and represents the lived

experience of feeling vulnerable, the “state of being threatened and a feeling of fear of harm” (Spiers 2000; p716). To date, the majority of the published nursing literature focuses upon the ethic perspective of patients’ vulnerability, yet there is little recognition that nurses and other healthcare practitioners’ can also experience feeling vulnerable.

It is important to note that there are physiological and psychological health implications of experiencing vulnerability (Figure 1). As such we argue that an awareness of staff vulnerability is integral to having a workforce that is fit to practice. The link between staff health and wellbeing and patient satisfaction regarding their care has been identified in the Boorman Report (DoH 2009) which concluded that the NHS has a responsibility to provide a comfortable stress free working environment. However, given the nature of the nurse’s role, we recognise that this is difficult to achieve, as caring carries an emotional burden for the nurse (Edward and Hercelinskyj 2007). A study conducted within a dementia care setting by Duffy et al. (2009) identified that 68.6% of the 61 staff that participated, experienced moderate levels of burnout and were emotionally exhausted by their work.

Figure 1. Health Implications of Vulnerability (Adapted



Barriers affecting nurses' ability to care.

Edward and Hercelinskyj (2007) argue that if contemporary nursing defines itself as valuing individuality and human potential, then in practice its very image will be shaped by the popular perception of how far its clinicians actually achieve these qualities in the healthcare environment. Yet recently there are a plethora of reports that have been highly critical of the care that patients have received (DoH 2008; Parliamentary and Health Service Ombudsman 2011; DoH 2012). A common thread in all of these reports is an apparent lack of caring and compassion within the profession; we have to ask ourselves why this occurs, when many people are attracted to the profession due to a desire to enhance the lives of others. One possible reason for this shift maybe the increasingly technological and specialised focus in care which is obscuring the human dimensions (Todres et al. 2009), resulting in a "clinicalization" of human experience (Cowling 2000). Other reasons may lie within the debates around the emotional labour of nursing (Smith 1992; Gray 2009), which emphasise the therapeutic value of having an emotional relationship with patients, whilst maintaining professional boundaries (Edward and Hercelinskyj 2007). What is missing is the recognition of staff vulnerability and how this may hinder the ability of nurses to provide competent care. Research undertaken by Stenbock-Hult and Sarvimäki (2011) with qualified nurses caring for older people identified that the nurses felt vulnerable due to being exposed and confronted by the vulnerability experienced by their patients, which in turn increased their own feelings of vulnerability. This paper builds upon this work as it presents staff's emic experiences of vulnerability which emerged during a qualitative evaluation of an educational programme. The educational programme was devised to personalise dementia care provided to residents in three care homes (Board et al. 2012) in which the participants worked. In order to evaluate whether the programme had any impact on the care delivered, two focus groups explored how the care of residents with dementia was managed. The first focus group took place at the beginning of the programme and the second at the end of the programme six weeks later.

Method

Focus groups were chosen as a mechanism to evaluate the experiences of staff, as they are ideal in exploring beliefs and attitudes that underline behaviour (Carey 1994). The management of the focus groups included splitting the 22 participants into two groups (Focus group one (FG1) and Focus group 2 (FG2)). Each focus group included staff from 3 different care homes involved in the educational programme, as well as a mixture of staff

including deputy matrons, qualified nurses, care assistants, activities coordinators and trainers (table 1). As this was an educational evaluation and the purpose of the focus group was to assess whether the programme had impacted upon their practice, formal ethical approval was not required; nevertheless, permission was gained from the care home provider that commissioned the work. In addition, the participants were given a choice whether they wished to participate in the focus group, and their confidentiality, if they choose to participate was also stressed. Each focus group was facilitated by an experienced qualitative researcher, and to ensure consistency between the two groups, both researchers used the same question “How is care for clients with dementia managed within the care home where you work?”. Two follow up questions were then later included during the focus group to stimulate further debate and discussion; “*How much do you know about working with people with dementia?*” and “*How confident are you in working with people with dementia?*” Both focus groups were audio taped, and then the interviews were transcribed verbatim, providing written notes to enable the researcher to analyse the data. The data was analysed using a thematic analysis advocated by Holloway and Wheeler (2002) in order to identify common themes that arose.

Focus Group 1 (FG1)	Focus Group 2 (FG2)
6 health care assistants 3 registered nurses (1 was a deputy manager; 1 was a trainer) 1 social carer	7 health care assistants 2 registered nurses (1 was a deputy manager) 1 social carer 1 trainer

Findings

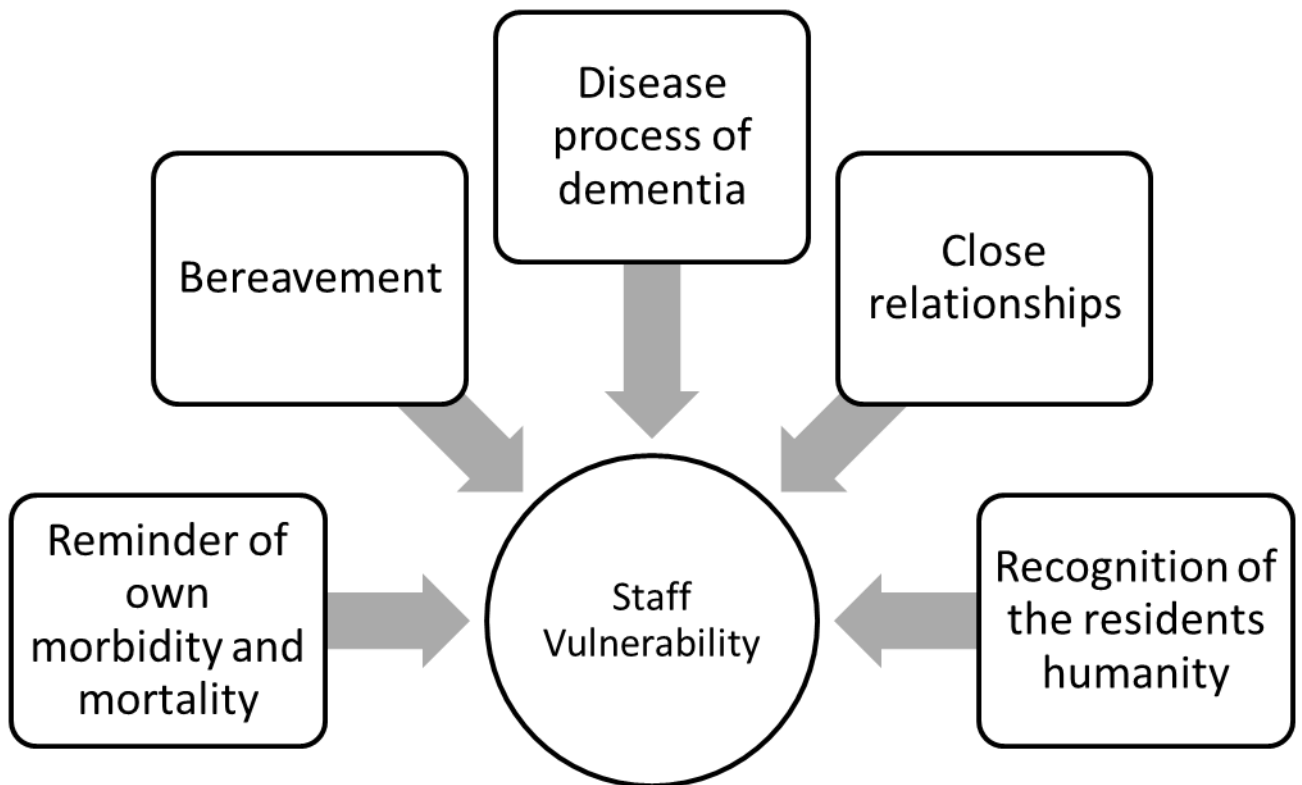
Whilst the focus groups identified a variety of themes (Table 2), exploring all of these is beyond the scope of this paper. Instead this paper plans to explore one theme that emerged related to staff’s experience of feeling vulnerable. The staff experienced feeling vulnerable for a variety of reasons (Figure 2) and these will be explored further in the rest of the paper.

Table 2. Focus Group Themes

- Informed and effective workforce
 - Knowledge of staff regarding dementia
- Improving quality of care of people with dementia in care homes
 - Person centred care
 - Resources

- Relationships with the clients' relatives and or carers
- Staff vulnerability
- Peer Support

Figure 2: Staff Vulnerability



One reason for staff feeling vulnerable was due to the disease process of dementia. Dementia is an unpredictable disease, in that residents experience extreme changes of emotion during short periods of time and this unpredictability resulted in the staff feeling threatened and therefore vulnerable. The participants shared how residents would be fine with them one minute, laughing and joking and the next moment verbally or physically abusing them. They found this very difficult, especially the care assistants, who did not have the in-depth understanding of the disease. In addition, a lack of knowledge of the brain and how it is affected by dementia made it more difficult for staff to rationalise the residents' behaviour as they did not understand the part of the brain that was affected influenced the behaviour that was manifested. As a result many of the staff (both qualified and unqualified) took the residents behaviour personally and would become distressed by it.

“.....I can remember an instance where I was helping her with many things all through the day and I was the most wonderful person in the world and then later on in the

afternoon I went in and she just said something to me that was so hateful and I burst into tears and ran out!” (FG2)

“... you’re a bit wary of them and whether they are going to flip now, or are they not?” (FG1)

“I find, for myself, the thing that reduces me to tears is when, a resident can be quite agitated and aggressive or violent and then they can suddenly switch into a moment of clarity and the present timethat’s the thing that reduces me to tears. I’m just thinking of an incidence and I’m feeling a bit choked .. they’ve realised just how they are and how they’re behaving, and that I find really, really sad.” (FG1)

In addition to this, the nature of dementia as a progressive degenerative illness, coupled with longevity of the care home setting meant that the staff would witness the inevitable worsening of the disease and its impact upon the resident, which was traumatic for them to witness. They also spoke of their sadness when a resident died, how they grieved due to the close relationships that they had established with the residents.

“There’s also another thing when you grow a close relationship with them and then all of a sudden that person is no longer, it’s..it is hard to get past that stage” (FG2)

“You’ve got emotions as well” (FG2)

These close relationships really enabled the staff to see the residents as human beings rather than just recipients of care. It was evident that the participants really cared about the residents and valued their relationship with them, which is in contrast to some of the recent press regarding nursing losing its caring focus. However, a by product of this closeness and acknowledgement of their shared humanity, resulted in an increase in staff vulnerability due to fearing their own fragility, their own potential morbidity and mortality.

“These are people, they are human beings, they have feelings, and they have lives” (FG1).

“..but you can’t help but get attached though, can you?” (FG2)

“It’s normal; we’re only human at the end of the day” (FG2)

....for the grace of God, ** and I we are that age, She’s seven months difference to me in age and you look at her and it’s a bit close to home (FG1)***

What was interesting within the focus groups was their discussion regarding whether staff should “allow” themselves to become close to the resident or whether they should distance themselves in order to be professional. This links to the earlier points made about the emotional labour in nursing and caring about a patient as a person whilst maintaining

professional boundaries. It appears from the participants' quotes below that there is a culture amongst some staff in health care which shuns emotional attachment to patients, and this may also contribute to the recent national reports regarding caring and compassion in healthcare.

"...you get people saying 'you're here to do a job, you shouldn't get attached'" (FG2)

"....some people don't, they look upon it as just a job. And I don't think you should be doing dementia care if that's how you feel" (FG1)

Discussion

Both the Confidence in Caring (DoH 2008) and Parliamentary and Health Service Ombudsman (2011) reports have opened debates regarding whether nurses have lost their ability to care. The findings from this evaluation do not support this, instead they show that the staff cared deeply about the residents they were working with. They saw them, not as "patients" or a diagnosis but as a person, and acknowledged a joint humanity between the nurse and the patient, in the sense that they were both on life's journey together. They spoke of a vulnerability that they both shared, but they did not seem to run away from this, but rather seemed to value it as a mechanism for providing high quality care. Galvin and Todres (2009) talk about nursing open-heartedness as central to caring. They consider three dimensions;- one of which is the notion of "embodiment; our shared vulnerable heritage". In this dimension the possibility of reversibility with others becomes apparent. This was noticeable within this study as one participant said "*...for the grace of God, ***** and I we are that age, ...*" (FG1). They argue that nursing with open-heartedness requires the nurse to see the body as both a physical being but also and maybe more importantly a window into someone's soul, in order to provide sensitive care to others.

Perhaps nurses are focusing upon the technological and specialised aspects of care in order to protect themselves from feeling vulnerable, almost as if they are switching off their emotions to prevent themselves from being hurt. A previous Castledean column (2002) explored nurses' communication skills and examined whether by using standardised phrases such as 'How are you? Alright?', nurses are trying to armour themselves to reduce the anxiety and stress of the situation, which we would acknowledge as their vulnerability. There are however implications of this, in that patients' may then experience a worse standard of care as they are no longer seen for who they are but reduced to a medical condition and dehumanised in the process. Nay (2011) refers to this type of practice as I-it (doing to), as opposed to I-thou (being with). Relating to a patient as an I-it reflects a task or disease focussed nursing practice which we feel is the practice that has been highlighted by reports

criticising nurses' ability to care. In contrast, a focus upon an I-thou relationship reflects living authentically (Stenbock-Hult and Sarvimäki 2011) see (Table 3), as it focuses upon being with, and encountering other as humans.

Table 3 – Living Authentically (Stenbock-Hult and Sarvimäki 2011)

Living authentically means

- 1) Being aware of ones own mortality
- 2) Being true to oneself and involved in life
- 3) Taking responsibility for ones personal choices
- 4) Being a participant in the world,
- 5) Encountering others as real human beings

Perhaps living and working authentically is a good philosophical basis for providing high quality, compassionate, individualised care; recognising that we are the same as patients, we are all human beings who are vulnerable to being wounded, as vulnerability is a human experience (Erlen 2006). We have to be true to ourselves and involved in our patients lives; we cannot care as passive observers but only as active participants, both physically and emotionally. How many times have we heard a nurse say that they are too busy to talk to patients, that the demands of the job are too great or the volume of paperwork affects their ability to care. Living authentically includes taking responsibility for the choices we make, both as a profession as well as individual practitioners. Who are we raising those concerns to?. We have to question whether we are truly advocating for patients if we are not highlighting the constraints which reduce our ability to provide high quality care as governed by our professional body (NMC 2008). However we also have to challenge ourselves, by asking whether it really takes longer to talk to a patient whilst assisting with personal care, than it does to wash a body, and which would we prefer for ourselves or our loved ones. It is only when we encounter others as real human beings, that the care we provide will be truly individualised.

This does not negate employers from their responsibilities in supporting staff to manage and live with their vulnerability, and indeed they have a vested interest in staff not becoming burnt-out. The participants in this study identified informal support networks of colleagues with whom they spoke regarding their thoughts and feelings. Both clinical supervision and reflective practice have been shown to reduce burn out (Evardsson et al. 2009). We would advocate that both these mechanisms could enable staff to share their mutual vulnerability in an open and constructive way, assisting each other to develop strategies to deal with the

ongoing emotional commitment that we would argue is integral to providing high quality humanised care.

Conclusion

Staff vulnerability is a major issue due to its long term implications upon physical and psychological health which can lead to staff burnout. Yet it is largely a silent issue in the professional literature to date. Understanding how and why staff can feel vulnerable can assist in putting strategies in place to support them, so that they do not protect themselves by “switching off their emotions” and practising un-authentically by focussing upon an I-it relationship with patients, seeing them as a task or a disease and thereby ignoring the caring aspect of the nurse’s role.

Whilst this study was based within a care home setting its findings can be easily translated into other settings as we do not believe that psychological stressors are limited to working with patients with dementia or even in the care home sector. For example it can be argued that nurses who work in primary care or even in the acute setting also develop long standing relationships with patients. Likewise, nurses in the acute setting are often exposed to working with clients who may be “unpredictable” due to the nature of their physical health needs. Nurses need to be supported by their employers to develop strategies to help manage their feelings of vulnerability, for the benefit of their patients and themselves..

References

- Board M, Heaslip, V, Fuggle K, Gallagher J, Wilson J (2012), How education can improve care for residents with dementia. *Nursing Older People* 24(5); 29-31.
- Boorman S (2009). NHS health and wellbeing. Department of Health. London
- Castledine G (2002), Nurses’ bedside manner: is it deteriorating? *British Journal of Nursing* 11 (10): 723;
- Carey M, 1994. The Group Effect in Focus Groups: Planning, Implementing and Interpreting Focus Group Research. In Morse, J., ed. *Critical Issues in Qualitative Research Methods*. London: Sage Publications
- Cowling W, R (2000). Healing as Appreciating Wholeness. *Advances in Nursing Science*. 22(3): 16-32.
- Department of Health (2012). *Commission on Dignity in Care*. Department of Health.
- Department of Health (2008). *Confidence in Caring*. Department of Health.
- Drake V (1998). Process, perils and pitfalls of research in prison. *Issues in Mental Health Nursing.*, 19: 41-52.

- Duffy B, Oyeboode J, and Allen J (2009). Burnout among care staff for older adults with dementia. *Dementia*. 8: 515-540.
- Edward K, Hercelinskyj G (2007). Burnout in the caring nurse: learning resilient behaviours. *British Journal of Nursing* 16(4): 240- 242.
- Erlen J 2006. Who speaks for the Vulnerable? *Orthopaedic Nursing* 25(2):133-136.
- Galvin K, and Todres L (2009). Embodying nursing open-heartedness. *Journal of Holistic Nursing*, 27: 141-149.
- Gray B (2009). The emotional labour of nursing – Defining and managing emotions in nursing work. *Nurse Education Today*. 29: 168-175
- Holloway I, Wheeler S, 2002. *Qualitative Research in Nursing*. 2nd ed Oxford: Blackwell Publishing.
- Nay R (2010). Is Care still the ‘essence’ of nursing. *International Journal of Older People*. 5(3): 189-90.
- Nursing Midwifery Council (2008). The code: Standards of conduct, performance and ethics for nurses and midwives. London: Nursing Midwifery Council.
- Nursing Midwifery Council (2002). *Practitioner - Client Relationships and the Prevention of Abuse*. London: Nursing Midwifery Council.
- Parliamentary and Health Service Ombudsman (2011). *Care and Compassion?*
- Smith P, (1992). *The Emotional Labour of Nursing*. Macmillan, London.
- Spiers J, (2000). New perspectives on vulnerability using emic and etic approaches. *Journal of Advanced Nursing*, 31 (3): 715-721.
- Stenbock-Hult B, and Sarvimäki A, (2011). The meaning of vulnerability to nurses caring for older people. *Nursing Ethics*. 18(1): 31-41.
- Todres L, Galvin K, and Holloway I, (2009). The humanisation of healthcare: A value framework for qualitative research. *International Journal of Qualitative Studies on Health and Wellbeing*., 4 (2): 68-77.