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What is care and who owns it?

What is the role of the nurse? For many of us the point of nursing is to care for others, a simple objective? However the definition of caring and how to have this as a primary focus within an increasingly business focused, target driven organisation like the NHS one could argue is the main tension for nursing in the UK today. Indeed as a personal reflection I would argue that we need to go further than a focus on caring we need to consider what the point of our practice is what is the goal, what are we striving to achieve for each and every person we care for? Possibly we need to consider a greater focus on the promotion of wellbeing through seeing illness as a part of our life experience, we need to recognise that this goes beyond the priorities of our organisation or profession and requires us to have the patient experience as our primary consideration.

Caring for Wellbeing

However, what do we mean by wellbeing as a focus for care, Galvin & Todres (2012) have offered a perspective on wellbeing underpinned by a philosophical tradition grounded in the lifeworld led perspective (Hemingway 2011). This perspective frames the phenomenon of human caring from the central perspective of `the world of the person` receiving care. This perspective on wellbeing has many dimensions however its guiding tenants focus on vitality, movement and peace. This perspective on wellbeing moves away from dividing up wellbeing into social, economic, political, physical and mental and focusing on patients as `consumers` of health care and considers people as having individual potential for creativity and problem solving even within periods of vulnerability, such as illness.

The current emphasis on patients as consumers and the aspiration for more choice is positive as it helps to start to put patients at the centre of care we must recognise however,

that it does not offer a comprehensive framework or value base for care. The patient can understand his or her `journey` through symptoms or long term illness better than anyone and in that sense is an expert. As professionals we need to acknowledge this but not relinquish our expertise. However how we care should not be dominated only by `technical` knowledge but by our understanding of others experiences, feelings and stories. Such a partnership approach will support peoples own strategies to increase health and wellbeing and do so in a dignified and respectful way.

Current issues in caring

The NHS is under stress as demand rises and money tightens. There is growing concern about the capacity of the NHS to sustain a high quality and safe service. Highly publicised failings such as those in Mid Staffordshire NHS Foundation Trust (2010) and in other places have shaken public trust but have not led to a clear resolution. There is a sense that “there could be another Mid-Staffs” and that lessons from earlier failings have not been learned and implemented. Much of the current government`s term of office has been overshadowed by the long awaited second Francis inquiry. Undoubtedly countless dedicated health professionals and managers are quietly getting on with changes and innovations that are improving things for patients, service users and families. What seems to be lacking is any sense of urgency to get things done on a system wide basis. Instead, “Waiting for Francis” is having a paralysing effect.

The first section of the contents page in the original Francis Report (2010) is headed patient experience but itself shows how the very way that `care` is thought about and conceptualised is fragmented and misses the point. The headings within the section on patient experience are:

- Continence and bladder and bowel care
- Safety

- Personal and oral hygiene
- Nutrition and hydration
- Pressure area care
- Cleanliness and infection control
- Privacy and dignity
- Record keeping
- Diagnosis and treatment
- Communication
- Discharge management

All these areas are vital for nurses to learn about and focus on in practice. However how we effectively deal with them is dictated by our attitude to our role. All these issues need to be dealt with in a dignified, safe, caring manner but how we do this is controlled by our attitude, our beliefs, values and actions as nurses.

While the lack of `basic care` is referred to in the report it is not seen as impacting on mortality and morbidity indeed is referred to as not concerned with `medical neglect or errors leading to injury or death` (Francis Report 2010 p414). As a nurse I would beg to differ, all these things impact directly on mortality and morbidity however they are all impacted on or quality controlled by something else which is missing from this list. What are our beliefs and values, our guiding principles, our underpinning philosophy as nurses? Without a clear articulation of these within practice and education how can we quality control our own and others practice?

Within the Francis Report (2010) under the heading of the culture of the trust the most important and first concern raised by patients and families was the attitude of the staff. What are attitudes, how do we come by them how can we influence them? They emerge from our beliefs and our values and are influenced by our setting and those around us and crucially they impact on our actions.

Discussion on how we label care, basic, fundamental, essential is not an important debate, what we need to accept is that nursing care matters just as much as the technological curative elements of health care. We need to move beyond a critique of how the relational and social aspects of care are overshadowed by the technical, and in so doing move far beyond patient centred care to focus on an authentically compassionate humanised approach to caring (Galvin & Todres 2012). We as nurses need to place wellbeing and the person with all of their complexities at the centre of what we do and crucially we need to be able to argue our case, defend what is right and ensure that all those working in health care understand that what we do and how we role model, teach and quality control care is as essential as any of the technological curative elements of health care. Mid Staffordshire has shown us that when care is neglected peoples suffering is greatly increased.

Developing the capacity to care

One cannot of course deny the great achievements of medical technology and increasing specialisation however care is more than cure and arguably needs to be more than `patient centred` (with a primary focus on increased choice, DOH, 2010). Care needs to recognise us all as human beings whose experiences impact directly on health and wellbeing. I would argue that we need to develop knowledge for the `head, hand and heart` as nurses which integrates practical know how, empathic understanding and technical knowledge (Galvin & Todres 2012) in order to provide humane and sensitive care. We need to teach nurses and health care assistants about caring and what attitude is required from them to achieve it safely and with dignity for everyone involved.

It is laudable and essential to demand that the NHS listens to patients and families (National Voices 2012) however as the Francis Report (2010) highlights in an organisational culture which accepts bullying, lying, the intimidation of staff, the putting of targets above patient health and wellbeing and a resistance to change what can the response be? As work on practice development in health and social care has shown unless the attitudes of the staff

towards those they care for and each other change nothing else will (McSherry & Warr 2008). What influences our attitudes, our beliefs and values, what do we see as the most important factor in what we do? If we see treating each other as valued human beings with respect, dignity and care then prioritising each and everything we do for and with those we care for will come from that. All of the issues outlined within the contents page of the Francis Report (2010) will be done to the best of our ability with a caring attitude putting the experience of those we are caring for at the centre of what we are doing. Our thoughts and actions will be dominated at all times by, how can I do this in a way which would be acceptable for me, my partner, mother, brother, with empathy. As we educate and develop the attitudes of student nurses and arguably health care assistants we need to consider how best we develop their ability to `walk a mile in another`s shoes`. We need to ensure that everyone (including managers and hospital board members) who works with vulnerable sick individuals has an attitude which enables them to empathise and listen to and learn from another`s experiences. In addition this shift in attitude would mean that dangerous staffing levels and standards of practice must be exposed. It is the nurse`s responsibility to maintain the best standards of care, this may mean that if individual organisations ignore our reports of dangerously low staffing levels and standards of care that as a profession we need to consider how else we share this information effectively. Possibly the label of `whistleblower` is unhelpful when reporting dangerous and inappropriate care or staffing levels as it smacks of the playing field or school yard. Maybe what we as nurses along with other health care professionals need to think about is `safeguarding` within the care environment, safeguarding safety and dignity through ensuring attitudes and actions are exemplary. We are the ones on the front line that know when things go wrong. On reflection I would consider that we need to articulate our philosophy for care as nurses which will inform our values and beliefs and inform our actions, and own it. We need to demand it of each other, our colleagues, our organisations and ourselves.

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