Reorienting cultures of nursing care through the development of a psychosocial safe space.

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Introduction

Building on the findings of a critical ethnography that investigated the impact of workplace culture on the delivery of person centred care (PCC) in an acute surgical ward in regional Queensland, this presentation outlines a solution to the problem of dehumanisation, moral distress and distancing. It concerns the development of psychosocial safe spaces; that is, workplace environments that ensure nurses are valued, heard, engaged and able to practice safely and autonomously. This represents a shift from the current work climate in which participants believed their work was confined by doctors’ orders, the requirements of patient safety and fiscal restraints.

It is argued that while participants retained a philosophical commitment to providing compassionate person centred care they were constrained in a system that rendered them unable to consistently do so. The necessity for measurable outcomes and achievement of tasks disempowered and silenced nurses and diminished opportunities for compassionate care. Findings indicated that while nurses struggled to maintain their professional commitment to compassionate caring practice, high levels of moral distress ensued causing nurses to further emotionally distance themselves from patients.

Background

Nurses are pivotal to the delivery of person centred care because of their caring philosophy and commitment to holistic care (Queensland Health, 2013). In Qld Australia where this research was situated, the Chief Nursing Officer Dr. Frances Hughes stated that ‘Nurses in Qld are renowned for their patient-centred care based on their intrinsic values’ (State of Queensland, 2013). It is also true that many nurses cite altruistic or ‘caring’ motives for
entering nursing and express a commitment to providing therapeutic, high-quality, safe care (Eley, Eley, & Roger-Clark, 2010).

That said, not all patients experience effective person-centred care, evidenced by people’s physical and emotional needs sometimes remaining unmet (Eriksson & Svedlund, 2007). It is evident that nurses are not always able to deliver the level of care they want to, and, despite a theoretical commitment to person-centred care, such a commitment is not always easily enacted in practice (Dunbar, Reddy, Beresford, Ramsey, & Lord, 2007). Previous studies have shown that there is sometimes an incongruity between nurses’ stated intentions, values and attitudes and their actual care-giving behaviours (Dempsey, 2009; Milton-Wildey & O’Brien, 2010). Nurses attribute this mismatch to insufficient time to care, and believe they are powerless to effect positive change in their workplace (Abdelhadi & Drach-Zahavy, 2012; Dempsey, 2009; Milton-Wildey & O’Brien, 2010).

Therefore, this research intended to investigate how person-centred care is enacted in practice and determine what barriers and facilitators to its implementation exist. Specifically, this research investigated tacit cultural aspects that govern clinical practice without actors being aware of their influence. This approach acknowledges that much human behaviour is socially organised (Hardcastle, Usher, & Holmes, 2005). As Nesbit, (2012) states ‘One’s perspective is not one’s own, it derives from social interaction’.

**Methodology**

Carpsecken’s (1996) model of critical qualitative research provided the framework for this research conducted in 2014/15. Critical ethnography is based in critical social theory and differs from traditional ethnography in its attempt to go beneath the surface to uncover hidden and taken-for-granted structures that influence behaviour (Madison, 2012). The
intent of critical inquiry is to reveal those oppressive organisational structures that might hinder the delivery of person centred care (Stewart, Holmes, & Usher, 2012). By revealing these dominant ideologies, nurses are free to question many of the assumptions on which nursing practice is based and perhaps generate new ideas for practice (De Forge, van Wyk, & Salmoni, 2011).

Prior to entering the field ethical approval was obtained prior to data collection. Participants comprising 14 registered and 3 enrolled nurses provided fully informed consent to participate and were able to withdraw from the study at any time.

Sources of data included participant observation, individual and focus group interviews and examination of pertinent documents. Initial thematic analysis highlighted aspects that were pertinent to the research problem and appropriate for further hermeneutic reconstructive analysis. This analytical method explicates cultural understandings that are tacit in nature and makes then overt (Carspecken, 1996; Hardcastle, Usher, & Holmes, 2005).

Findings

A key finding in this research was that whilst nurses espoused compassionate, person centred, holistic practice they found themselves delivering mostly task focused care. Task focused work practices were justified because:

If you are not task focused you will fall behind

An inability to practice in accordance with their values led nurses to experience high levels of workplace dissatisfaction and negative emotions consistent with moral distress.

We just don’t go home with any satisfaction.

I’d find nursing very soul rewarding if it wasn’t so busy

And I think that’s legitimate. Having a mental health day ...... there’s people that just can’t come because they’re just – their head can’t handle it.
Threats to person centred practice arose from several factors including: the system; the individual & the nursing ‘team’. These factors will be discussed briefly and the potential of self affirming activities to enhance congruence between values and behaviour explored.

The System
A key threat to person centred care was the perceived priority for parsimony and measurable targets.

*It’s all about money nowadays and I’ll defy anyone to tell me otherwise.*

*We’re under so much more pressure from above nowadays …., get this one in and that one out.*

At local level this was enacted in shorter admission times and increasing acuity along with increased audit and documentation. Participants expressed frustration and believed that the local leadership was ignorant to the extent of workload pressure.

*People up there in their ivory towers should come down here and work for a day.*

*It’s not like t was 20 years ago when they were on the ward.*

Anders and Cassidy (2014, p.133) posit that most organisational change emerges from external factors, including ‘government policy, financial cuts, and the need to improve the quality of services’. Therefore, the group that exerts the most profound effect on any health care setting is the one that influences health care policy and funding. Decisions made in this sphere, although far removed from the day-to-day work of nurses, have a direct impact on the working conditions and practices of nurses working in this setting (Taylor & Field, 2003). In turn, working conditions affect staff morale and, thus, patient care. According to Boltz et al. (2008), decisions made at policy level either limit or support nursing practice, yet many nurses accept these decisions as taken-for-granted realities, out of their sphere of influence and not amenable to change. Accordingly, nurses might experience feelings of powerlessness
that leave them unable to practice autonomously (DeForge, van Wyk, Hall, & Salmoni, 2011). Consequently, it is vital that nurses develop a degree of political astuteness to enable them to comprehend how the context of their work, and workplace culture are so fundamentally affected by external factors (Mahon & McPherson, 2014).

The Individual

Whilst nurses in this research espoused caring nursing practice, in many ways this work was not legitimised or valued. Instead, efficiency and demonstrable outcomes dictated a task focus, and this way of working had become more highly valued. As a result participants reported an inability to develop and sustain effective therapeutic relationships and felt ill equipped to address patients’ emotional needs. Describing an incident when she had been unable to respond to a patient’s emotional needs one participant said:

‘It was horrific, because I knew I just left her there crying in her room by herself.’

Incidents such as this had an emotional impact on nurses and were associated with feelings of failure and neglect (Bridges et al., 2013).

*I can’t find the right word. But, you know, like, just – the self-worth. You put your level there and you’ve come below your level.*

*I get grumpy with me saying ‘you’re just a bad nurse’.*

A potential explanation was offered:

*I think that comes back, getting nurtured yourselves. I think if the staff aren’t nurtured, then…*

The emotional overspill from moral distress affected nurses’ personal lives and activities, as the following quotes illustrate:
It’s not just dealing with emotion at work, it’s dealing with your home life.

The term ‘moral distress’ was first coined by Jameton (1984), who defined it as the negative emotions provoked ‘when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action’ (p.6). Moral distress occurs when there is a mismatch between nursing aspirations and actual practice; it can lead to stress, burnout, avoidance and even withdrawal from patients (Bridges et al., 2013; Pauly, Varcoe, & Storch, 2012).

Bridges et al. (2013) describe how the inability to meet self-expectations results in the experience of a range of negative emotions, including feelings of failure and guilt. Furthermore, moral distress affects nurses in a number of ways, ‘including threats to their self-image as good nurses, defining quality care in relation to physical care only, and measuring quality of care as a reflection of their own output rather than considering patient outcomes’ (Pauly, Varcoe, Storch, & Newton, 2009, p.562). This tendency was evident in this research where nurses prioritized tasks and measured success in the efficient completion of these.

‘Team’ Factors

An understanding of the importance of the ‘team’ is vital to understanding the culture in this workplace.

The team…that’s why I love working here, we are all in it for each other.

Being in it for each other meant that each individual nurses was expected to be efficient, to carry their share of the workload and work in ways so as to minimize undone work by the end of the shift. This knowledge was tacit in nature:

When you start working here you just kind of get the vibe that if you are not on top of things.....

Failure to achieve ‘team’ goals was associated with a range of negative emotions:
You just feel awful going home at all if you haven’t done everything.

You just stay back until it’s under control ... so that you can unburden yourself a bit more and make sure you go to sleep.

Passive aggressive reactions from their colleagues reinforced the task focus and ensured nurses knew that inefficiency was inappropriate.

‘They smile and stab you in the eye….last time it happened they didn’t speak to me for two weeks!’

Conversely, nurses who were efficient earned the respect and admiration of colleagues, and met nurses’ esteem and belong needs that were not being met by nursing work.

Discussion and Recommendations

Task-focused ways of working found in this study can lead to dehumanisation and deindividuation. Deindividuation occurs when people assume for themselves, or ascribe to other people, a shared or corporate identity (Haslam, Loughnan, Kashima, & Bain, 2008). For example, in the context of health care, people are labelled as patients or as nurses, with associated historical connotations and power inequalities. Even by wearing a uniform, nurses can lose themselves and effectively become ‘the other’, assuming their nursing identity. Reimann & Zimbardo (2011) postulate that, once nurses and patients lose their individuality, nurses are abso- lved of personal responsibility and accountability to treat other people as individuals, making a task focus easier to manage. Scientific language and terminology are another feature of health care that can reinforce the de-individuation and objectification of people by reducing patients to diagnoses or interventions (Curtis, Tzannes, & Rudge, 2011). This process was exemplified in this study when nurses viewed people in their care as a list of tasks to be completed, sometimes to the exclusion of the individual. As one nurse said ‘It’s not like there’s a patient there, it’s just, oh, there’s a pump.’
Social identity theory provides a framework for understanding how individual nurses found their belongingness through team membership and explains why they were motivated and acted to achieve the common purpose of efficiency and completion of tasks rather than act in accordance with their intrinsic values (Willett & Clarke, 2014). Social identity theory purports that an individual’s self-worth and belongingness are aligned to the level of respect the individual has within their peer group. Furthermore people are more likely to act in a specific way if there is a group expectation that they do so.

Perhaps a potential means to overcome the power of the collective is through self-affirming activities (Ehrlich & Gramzow, 2015). Self-affirming activities are those that enhance personal identity and shift the focus toward personal beliefs, motivations and achievements. When individuals are self-affirmed they are more likely to act in accordance with their intrinsic values (Ehrlich & Gramzow, 2015).

In order to practice self-affirmation Correll, Spencer & Zanna, (2004) advocate that actors draw on previous success. An example might be to encourage nurses to reflect, write or discuss examples of nursing care they have delivered that exemplify person centredness (Lindsay & Cressell, 2014). This level of reflective practice enhances self-knowledge; and self-knowledge is an essential prerequisite for person centred nursing (McCormack & McCance, 2006).

Opportunities to engage in facilitated reflection might also provide a vehicle for participants to process their concerns and to cope with the level of moral distress they experience. It might enable nurses to focus on the intrapersonal and interpersonal aspects of nursing care, and can improve team processes and workplace culture (Dawber, 2013). Dawber (2013) evaluated the use of reflective practice groups in acute care settings and reported that participants experienced increased self-awareness, increased awareness of
patients’ needs, and improved team functioning. Over time, these factors can have a positive impact on workplace culture, team functioning and person centred care.

Cultivating psychosocial safe spaces through reflective practice might encourage nurses to keep hold of their aspirations and values based practice, use warmth and creativity in their patient care, and support and validate each other’s efforts to make the workplace a friendly and humanistic environment. This strategy could help redress the prevailing culture of efficiency that tends to produce defensiveness and dehumanizing practices.
References


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