

PROF. ALISON LEARY (Orcid ID : 0000-0001-7846-5658)

Article type : Editorial

Safety and service. Reframing the purpose of nursing to decision makers.

Prof Alison Leary PhD RN FRCN FQNI
Chair of Healthcare Modelling
London South Bank University
103 Borough Rd
London, England
SE1 0AA

Telephone 020 7815 7815

alisonleary@yahoo.com

No competing interests

Safety and service. Reframing the purpose of nursing to decision makers

On Good Friday I watched a nurse colleague resuscitate a man at a football match in front of thousands of people. It was a high pressure situation but to a colleague with thirty years' experience it was a calm and ordered intervention. The outcome was a good one for the patient and the process seemed effortless-belying the skill and expertise needed to do it. The environment is a difficult one-with plenty of decisions to make and risks to manage in addition to delivering care-all done with expertise and compassion. In other safety critical industries I have worked with, it's considered axiomatic to have the highest level of expertise close to the areas of risk-keep the most experienced and skilled workers on the frontline. It's safer, more productive and cost effective.

When people talk about nursing the words they use are not ones like skill, risk, safety or expertise despite the fact that nursing is a safety critical activity. Florence Nightingale's writings on vigilance (Nightingale 1860) provide us with insight into the value that nurses have always brought to the safety of patients. However many decision makers seem to miss this important dimension of nursing work and see professional nursing in a singular way-as a service activity, a series of tasks with little deviation from routine and very little dynamic decision making. Many of the decision makers I speak to assume nurses are the skilled enablers of others clinical judgement-an adjunct to medicine. Nurses and their leadership rarely seem to challenge that assumption.

This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.1111/jocn.13885

This article is protected by copyright. All rights reserved.

Nursing's reticence to challenge the false assumptions that others make could be a costly one for patient safety, for safety is more than the absence of harm (Reason 2000). A series of fundamental changes have swept through the nursing workforce in England which have caused turbulence and uncertainty. Added to a combination of existing factors such as challenges with recruitment and retention these changes are likely to have a profound impact on the profession for many years to come.

Increased demand for registered nurses (RN) post the Francis Enquiry (Francis 2013) and a reduction in training places has left a deficit in the RN workforce of around 15,000 (NHS Improvement 2015). Recent work by the Department of Health in England estimates this to be even higher-combined with a "Brexit" effect it could be as high as 40,000 (Lintern 2017a). This shortage has been exacerbated by the growing awareness of the body of evidence that graduate RNs improve outcomes and skill dilution at point of delivery increases risk. In short, the supply of registered nurses has failed to keep up with demand and the complexity of caring. This failure to keep up with demand is not as simple as a poor pipeline of students, but an inability to retain nurses in the workforce or encourage returners.

In response to workforce supply issues caused by the boom bust approach to workforce modelling, Lord Willis led The Shape of Caring review (HEE 2015) making thirty four recommendations including "the need to develop a defined care role that would act as a bridge between the unregulated care assistant workforce and the registered nursing workforce". The nature of this bridge or the gap it is meant to cross is unclear-however the result appears to be the new nursing associate role. The message that front line hands on care is something for less skilled workers to do is a theme that runs through much of the commentary around this role. A senior leader within Health Education England was reported as commenting that the nursing associate role will stop RNs getting "dragged down into fundamental care" (Ball 2016) but the evidence suggests survival benefits if registered nurses are delivering as well as managing care (Aiken et al 2016). As in other safety critical industries the benefit of expertise is when that expertise is close to risk.

In the consultation for nursing associates HEE referred to the role as "the new nurse" and even in these early days the idea of a bridge between care assistant and RN looks doubtful. Examples of these roles replacing RNs are becoming evident (Lintern 2017b). Substitution of graduate RNs with trainee nursing associates should be considered with extreme care given the evidence we do have. A second level practitioner is not new-many countries have roles such as the enrolled nurse (EN). It is challenging to find any proof that a second level of registrations improves outcomes or studies on the risk of introduction. Most of these roles appear to have been introduced historically at a point of crisis such as outbreak of disease or war (Abel-Smith 1975, Wood 2016). They were also introduced at a time when care was far less complex. The enrolled nurse in the UK was exploited and led to worker dissatisfaction which forms part of the history of the role (Briggs 1974, Seccomb et al 1997) some commentators note how the EN role effectively excluded groups such as black nurses from career progression (Kings Fund 1990) as Joyce Bleasdale-Lumsden notes in "Many Rivers to Cross" (Talent Media 2006) *"They had me measured for a green uniform and I saw one or two nurses in purple uniform. So when I went back I asked my Jamaican friend what is the green uniform? She said, 'We are pupil nurses, a lower grade of nurses, stupid nurses'".* It seems incredible that any profession would treat its members in such a way but nursing in the UK still rejects meritocracy for hierarchy.

On social media some directors of nursing are stating they will use the nursing associate to fill RN vacancies as “surely someone is better than no one” but without adequate assessment of risk, that assertion is not a safe one. Adding in a second level nurse means a dilution of frontline expertise-a sum skill down drift of the whole workforce and the underlying issues such as poor retention still exist-there is no evidence nursing associates will be easier to retain.

Aikens work on RN 4Cast (Aiken et al 2016) shows that an increase in a nurses' workload by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7% and every 10% increase in bachelor's degree nurses was associated with a decrease in this likelihood by 7%. These associations imply that patients in hospitals in which 60% of nurses had bachelor's degrees and nurses cared for an average of six patients would have almost 30% lower mortality than patients in hospitals in which only 30% of nurses had bachelor's degrees and nurses cared for an average of eight patients. There is much work in this area but the burden of proof is high. Skillmix is also important. Graduate RNs are associated with better outcomes and high RN:Pt or HCSW:RN associated with poorer outcomes (Griffiths et al 2016). It's a complex relationship (Hall 1964, Ebright et al 2003, Leary et al 2016) as the causal relationship is not fully understood. However we know from other studies that there is a deficit in care. For example in a study by Ball et al (2014) nurses (86%) reported that one or more care activity had been left undone due to lack of time on their last shift (Ball et al 2014). Most care frequently left undone were: comforting or talking with patients (66%), educating patients (52%) and developing/updating nursing care plans (47%). The odds of care being left undone halved when nurses had 6 or less patients to care for. More recent work suggests that adding nursing associates and other categories of assistive nursing personnel without professional nurse qualifications may contribute to preventable deaths, erode quality and safety of hospital care (Aiken et al 2016). Where studies have explored the impact of second level nurses, similar to enrolled nurse qualification, the evidence is not supportive of the role (NNRU 2009). It's hard to see why this body of evidence is being completely disregarded in the decision making process.

Other questions about the role exist but have yet to be answered. One of the reasons that the enrolled nurse was phased out in the UK was a recommendation by Asa Briggs (1974) who reviewed nursing for parliament. Lord Briggs noted enrolled nurses had limited career prospects and the role was exploited by some employers. The nursing associate may become part of a schism in the workforce-two groups effectively will drift toward similar technical work but one for much lower pay. With no nursing associate role in countries outside England there is limited opportunity elsewhere. The nursing associate role is meant to widen access to nursing careers by offering apprenticeships. With the withdrawal of the bursary the apprentice role could be more likely to attract poorer students who do not want the perceived debt of university-but will it guarantee them a higher paid RN post in the long term? Will the introduction of the Nursing Associate actually decrease social mobility? This may affect diversity within the profession. It's hard not to frame this as social engineering even if that's not the intent.

How will this role fit with the existing support worker role? Does it devalue their work? Nursing Associates are a dependent workforce as are support workers-will there be a redistribution of work or will supervising another group put more strain on already overburdened RNs?

Perhaps the most concerning aspect of the introduction of this role is the lack of professional debate-the introduction has been swift with no meaningful consultation. The introduction of the role also makes clear the assumptions emerging about the work of nurses, that nursing is simply time filled with tasks. Whilst most people appreciate the emotional burden of nursing they do not recognise the enormous complexity of the work and intellectual challenge that the role brings. Decision makers look at technical tasks not the complexity behind them. When the attributes of nursing are discussed they are values rather than ability. Nursing tells its story to others through virtue and dismisses its own knowledge by using language such as basic care (Burnesh & Gordon 2013) and homilies like the "nursing family". Its own insecurity seems to generate an anti-intellectualism that is not found in other safety critical professional groups.

Watching a colleague use the depth of wisdom that comes with the synthesis of knowledge skills and experience to save a life really does crystalize the mind into understanding the value of the registered nurse' contribution to safety. Wisdom we must keep within the profession for the sake of patients before it is lost forever. Whilst there is undoubtedly a challenge ahead, short term solutions like skill dilution may simply be adding to these challenges in the long term rather than solving them.

References

Abel-Smith B (1975), *A History of the Nursing Profession*, London, Heinemann.

Aiken LH, Sloane D, Griffiths P, et al (2016) Nursing skill mix in European hospitals: cross-sectional study of the association with mortality, patient ratings, and quality of care *BMJ Qual Saf* Published Online First: 15 November 2016. doi: 10.1136/bmjqs-2016-005567

Ball J (2016) Who cares? Nursing Associates and safe staffing
<http://www.southampton.ac.uk/healthsciences/news/2016/04/who-cares-jane-ball.page#> Accessed March 2017

Ball J (2016) Low registered nurse staffing levels cause patients to die *Nursing Times* 27 April, 2016
<https://www.nursingtimes.net/break-time/expert-opinion/low-registered-nurse-staffing-levels-cause-patients-to-die/7004285.article>

Ball J, Murrells T, Rafferty AM, Morrow E, Griffiths P (2014) Care left undone' during nursing shifts: associations with workload and perceived quality of care *BMJ Safety and Quality* 2014 Feb;23(2):116-25

Briggs A (1974) *Report of the Committee on Nursing*, HMSO, London

Buresh B Gordon S (2013) *From Silence to Voice* (3rd Edition) Cornell University Press, Ithaca, New York USA.

Ebright P Patterson ES, Chalko BA, Render ML (2003) Understanding the complexity of registered nurse work in acute care settings. *Journal of Nursing Administration* 2003 Dec;33(12):630-8

Francis R (2013) *The Mid Staffordshire NHS Foundation Trust Public Inquiry*, TSO, London.

Griffiths P, Ball J, Murrells T, et al Registered nurse, healthcare support worker, medical staffing levels and mortality in English hospital trusts: a cross-sectional study *BMJ Open* 2016;6:e008751. doi: 10.1136/bmjopen-2015-008751

Hall L (1964). Nursing – What is it? *The Canadian Nurse* 60 (2): 150-154.

Health Education England (2015) *Raising the Bar Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants*

HEE (2016a) *Health Education England announces training places for over 2,000 Nursing Associates* <https://hee.nhs.uk/news-events/news/%E2%80%8Bhealth-education-england-announces-training-places-over-2000-nursing-associates>

HEE (2016b) *A new support role for nursing* <https://www.hee.nhs.uk/our-work/developing-our-workforce/nursing/new-support-role-nursing>

Kings Fund (1990) *Report of the equal opportunities taskforce*, Kings Fund, London

Leary A, Cook R, Jones S, Smith J, Gough M, Maxwell E, Punshon G, Radford M (2016) Mining routinely collected acute data to reveal non-linear relationships between nurse staffing levels and outcomes. *BMJ Open* 6(12),e011177

Lintern S (2017) Leak reveals worst case scenario for nursing after Brexit, *Health Service Journal* 6th April 2017 on lime edition <https://www.hsj.co.uk/topics/workforce/exclusive-leak-reveals-worst-case-scenario-for-nursing-after-brexit/7017082>.article accessed April 2017

Lintern S (2017) NHS trust replacing qualified nurses with nursing associates *Health Service Journal* 10th March, 2017 <https://www.hsj.co.uk/hsj-local/providers/east-and-north-hertfordshire-nhs-trust/nhs-trust-replacing-qualified-nurses-with-nursing-associates/7016401>.article Accessed April 2017

NHS Improvement (2016) Evidence from NHS Improvement on clinical staff shortages. A workforce analysis NHS Improvement https://improvement.nhs.uk/uploads/documents/Clinical_workforce_report.pdf accessed March 2017

Nightingale, F. (1860/1969). Notes on nursing: What it is, and what it is not. New York: Dover.

NNRU (2009) Policy Plus Is there a case for the UK nursing workforce to include grades of qualified nurse other than the registered nurse? National Nursing Research Unit, Kings College London. [http://www.kcl.ac.uk/nursing/research/nnru/policy/Policy-Plus-Issues-by-Theme/Whodeliversnursingcare\(roles\)/PolicyIssue21.pdf](http://www.kcl.ac.uk/nursing/research/nnru/policy/Policy-Plus-Issues-by-Theme/Whodeliversnursingcare(roles)/PolicyIssue21.pdf) accessed March 2017

Seccomb I Smith G Buchan J Ball J (1997) *Enrolled Nurses-A study for the UKCC*, Institute of Employment Studies <http://www.employment-studies.co.uk/system/files/resources/files/344.pdf> accessed March 2017

Talent Media (2006) *Many Rivers to Cross-The history of the contribution of Caribbean nurses to the NHS* http://www.manyriverstocross.co.uk/chapter4/pupil_nurses.html accessed April 2017

Reason J (2000) *Safety Paradoxes and Safety Culture Injury Control and Safety Promotion* 7(1) pp3-14

Wood P (2016) Managing boundaries between professional and lay nursing following the influenza pandemic, 1918–1919: insights for professional resilience today? *J Clin Nurs*, 26: 805–812.
doi:10.1111/jocn.13570