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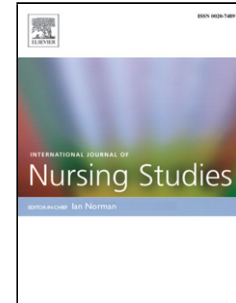
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'Shitty Nursing' – the new normal?

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Abstract

In this article we ask our profession to consider whether something is rotten at the core of modern nursing. We will use our own experiences as patients, together with published literature, to ask questions of our profession in perpetrating what one of our colleagues recently, and with great embarrassment, referred to as '*shitty nursing*'.

Our intention is most certainly not to offend any readers, for this term has been used in literature for more than one hundred years to describe bad situations, including those where events or people's behaviour are of a low standard. Our intention instead, is to challenge ourselves, the profession and you the reader by raising a measured debate which seems at present to be missing within the profession.

We examine the potential idea that poor nursing care may not be the exception, but horrifyingly, may be the new normal. We are particularly concerned that patients' fundamental care needs may be falling into an ever widening gap between assistant and registered nurses. Whilst we acknowledge the potential causes of poor nursing care, causes that are often cited by nurses themselves, we come to the conclusion that a mature profession including clinicians, educators, administrators, researchers and regulators cannot continually blame contextual factors for its failings. A mature profession with an intact contract between itself and society must shoulder some of the responsibility for its own problems.

We do suggest a way forward, including a mix of reconciliation, refocus and research, underpinned by what we argue is a much needed dose of professional humility. Readers may take us to task for potentially overstating the problem, ignoring non-nursing drivers, and downplaying other significant factors. You may think that there is much in nursing to glory in. However, we make no apology for presenting our views. Our lived experiences tell us something different. As professional nurses our main aim is to ensure that our adverse experiences as patients are statistical anomalies, and our future encounters with nursing care represent all that we know to be excellent in our profession. We leave you to judge and comment.

Keywords: nursing care; fundamental care; quality; patient experience

Introduction

At a recent international nursing research seminar, a registered nurse from Europe undertaking a PhD was explaining her research to the seminar group. At one point she became visibly upset and began to explain her distress at the nursing care she was witnessing during her empirical observations. She stopped her presentation and said, "I am sorry, all I can call it is: *shitty nursing*". What did she mean?

The Oxford English Dictionary (Oxford University Press, 2018) provides two adjectival definitions: 1. defiled by excrement; 2. disgusting, contemptible; low-grade, degrading. Sadly, she was using the term '*shitty nursing*' according to the second meaning; '*shitty*' being a term that has been used for over one hundred years in literature to describe bad situations, including those where events or people's behaviour are of a low standard. Some readers may be offended by our verbatim reporting of her use of the term. However, we noted that she herself felt embarrassed, but she was unable to find another term that adequately expressed her feelings about what she had witnessed. She simply had to resort in a formal public environment to mild profanity in order to communicate the emotion behind her observations of nursing. So, despite being at risk of causing offence, we will continue to use her term here and hope that our readers understand the rationale for our choice of wording.

Framing a Debate

Such an intimately shared experience at a formal seminar gave us cause to pause and reflect. Was her experience unusual? Is there any evidence that her observations could be generalised outside of her personal experience? What if her observations were not unique; that *shitty nursing* has become widespread or – even more disturbing – is now the norm. In this discussion piece we will share our reflections – some anecdotal, some reported by others – to raise these issues within the profession, including clinicians, teachers, researchers and managers. Our objective is to prompt a debate, a debate that is honest, and a debate that we hope is unencumbered by professional defensiveness.

Firstly, we want to set the parameters of this debate. We start this piece from a belief that nursing is an activity undertaken by appropriately educated and registered professionals who assist people to do things that they would normally do for themselves if only they were able (Henderson, 1966). Although we certainly recognise that much 'nursing' is carried out by non-registered 'assistants', we conceive of these assistants as the operational arm of registered nurses (RNs), carrying out nursing behaviours under supervision and leadership from RNs. We start from the premise, therefore, that

nursing care is delivered and evaluated according to professional nursing values and codes. In terms of Wilkinson's triple definition of nursing actions (Wilkinson, 2011) we conceptualise RNs as being able to perform independent, dependent and interdependent actions, but assistants as only able to perform the latter two, and only then under supervision from RNs or other members of the health care team. From now on we will use the term 'nurse' as shorthand to refer to nurses with a professional registration.

We also focus here on 'fundamental' nursing care. Like Henderson (Henderson, 1966) we understand, a critical element of nursing should be directed at assisting with a person's essential personal needs such as mobility, nutrition, cleanliness etc. These have been most recently re-articulated by Kitson and her research group (Kitson et al., 2013, Kitson et al., 2010) to combine the physical, psychosocial, and relational dimensions of the nursing care encounter. Put simply, we concur with this recent work that nursing is a professional activity that, if done well, addresses people's fundamental physical, social and psychological needs using a skilled relational framework of empathy, respect and compassion. If done badly, missed, or if fundamental care is left undone (Aiken et al., 2013, Ausserhofer et al., 2013, Ball et al., 2014), nursing can injure, cause harm and even lead to death, for example, through 'failure to rescue' (Ball et al., 2018, Kendall-Gallagher et al., 2011)

Finally, we also recognise that nursing has many actors, many constituent players. These players include clinical nurses, university educators, researchers in nursing, nursing regulators, clinical managers, and even governments. All play a role. The most important role of all, however, is that played by a patient, carer or member of the public who receives care from nurses.

Experiencing Nursing Care

We would like to start our discussion with two personal anecdotes. Both of us have recently had to swap roles from professional nurses to patients. One of us spent six days in a prestigious hospital

receiving treatment for an acute hand infection. At no time did any nurse ask about our fundamental care needs. With one arm bound, raised and immobilised, and the other receiving intravenous antibiotics it should have been obvious to the most cursory observer that maintaining basic hygiene, never mind urinating and defecating, was likely to be troublesome. And yet no nurse or assistant explored these needs. Aside from having to accept personal uncleanliness, the obvious response was enforced constipation, whose painful outcome several days later does not need elaborating to this readership. There is no way to describe it other than as neglect of fundamental patient care needs.

The other one of us recently suffered a high-speed traumatic accident and was triaged by a nurse at the local Emergency Department and then left alone in a side room on a stretcher by a health care assistant with no explanation of what would happen next or how to summon assistance. Although in pain and unable to walk, lift or move the right leg – caused by two pelvic fractures – no nurse or other health care professional attended for 8-9 hours. Eventually, by leaving the stretcher, requiring huge and painful effort to first find and then press an alarm bell located way out of reach, a nurse was summoned. Once summoned by this weeping person clinging to a stretcher, the nurse quickly made an assessment, got a toilet chair, and fetched a blanket, a pillow and painkillers. Even her quick response clearly did not remove the fact that a patient had been left all alone for almost nine hours, with no care or communication (or indeed knowledge how to communicate). Despite having informed the triage nurse about the possible severity of the accident, the pain and about not being able to walk; nursing care, regular observation and communication was neglected for someone with the potential for significant complications such as severe bleeding, internal organ damage etc.

We are both professional nurses. Are our experiences as patients a statistical anomaly? Or is this now the new normal for nursing care? Are we, like our European PhD nursing colleague, shocked precisely because we have the nursing knowledge that allows us to distinguish and object to *shitty nursing* when we experience it? Had we not been nurses, had we been ordinary members of the public, would we

have accepted what we, in our knowledgeable state, perceived to be clear nursing neglect, as just ‘one of those things’ or the ‘way it is done’?

Evidence for *Shitty Nursing*

Looking beyond these personal anecdotes it seems that in reality *shitty nursing* could actually be everywhere. It is certainly described in formal reports (Department of Health, 2013, Department of Health, 2012, Garling, 2008, Heslop et al., 2014, MENCAP, 2012), in discussion articles (Heslop et al., 2013) and in the UK, in the wide variations in care quality are reported by the health services regulator – the Care Quality Commission – where 35% of NHS acute hospital core services were rated as either requiring improvement or inadequate (Care Quality Commission, 2016). One does not have to look very far to see and hear people complaining about *shitty nursing*.

Shitty nursing is even present in environments engaged in nursing research. In healthcare it is often asserted that in units and health care facilities where research is embedded, patient care is of a higher standard (Comis et al., 2000, DIPEX, 2018, Westfall et al., 2007). However, our European colleague was observing nursing care on a unit where research into nursing is embedded in practice, where the nurses were socialised into a philosophy of engagement with research, by not only finding and implementing results, but also producing the evidence for others. But still, even here, our colleague observed something different; something she felt could only be described as *shitty nursing*.

Indeed, is there any evidence that research in nursing itself is addressing this problem? Sadly, the evidence suggests that the majority of research in nursing is either irrelevant to clinical practice or so poorly conducted that its findings are of little value. Review after review has demonstrated that the evidence for nursing practice is barely credible (Hallberg, 2006, Hallberg, 2009, Mantzoukas, 2009, Richards et al., 2014, Richards et al., 2018, Richards et al., 2018, Yarcheski et al., 2012) and many commentators have called for urgent reform (Borglin and Richards, 2010, Melnyk, 2012, Richards et

al., 2018, Richards et al., 2018, Yarcheski et al., 2012). For example, in the most recent review of research published in nursing journals by European researchers (Richards et al., 2018), less than 20% of published articles reported experimental research designed to investigate the impact of nursing interventions on patient care. Similarly, and even more starkly, a review of international research into four components of fundamental nursing care found that only one out of 149 research reports was of sufficient quality and relevance to be able to guide nursing practice (Richards et al., 2018). If nursing researchers are so little concerned with the fundamentals of nursing care then it is of no surprise that, with no evidence to lean on, evidence of *shitty nursing* can be found even in nursing research environments themselves.

Cause and Effect

In this discussion, we must of course acknowledge the widespread belief that a current shortage of nurses and/or nursing resources is causing this emergence of poor nursing care (Buchan and Aiken, 2008, Littlejohn et al., 2012). 'Missed care', where fundamental nursing actions are left undone, is a reported concern of nurses themselves (Ball et al., 2014). This issue has been further investigated by the same research group (Ball et al., 2018), who did indeed find an association between missed nursing care, which was '*highly related to nurse staffing*' (p10), and patient mortality. However, a recent review of 14 studies found only modest evidence for missed nursing care acting as a mediator in the relationship between nurse staffing and adverse patient outcomes such as increased risk of infections, falls, readmission and critical incidents (Recio-Saucedo et al., 2018). We know, therefore, that staffing levels are related to adverse patient experiences, but their impact on nursing behaviours is by no means the whole story.

Therefore, whilst we acknowledge these concerns, it does not seem credible to us as both patients and professional nurses that nursing as a profession can abdicate responsibility for poor nursing care by placing all the blame on the current context. As Griffiths pointed out in a published debate ten

years ago, the 'good old days' of nursing are a myth (Griffiths, 2008). As part of the same debate, one senior nurse was bemoaning the absence of caring from nurses in her experiences of being a patient (Corbin, 2008). Since Nightingale's time, nursing has always had to operate in potentially restricting contexts, has always had to balance caring with curing, and has always had to face workforce and technological challenges. *Shitty nursing* is not a new phenomenon, nor one whose sole cause we can lay at the door of our current circumstances.

In preparing this article, we also mused on the manner in which nurses rush to specialism soon after they qualify. Cost cutting and medical workforce shortages do indeed drive task shifting (Ausserhofer et al., 2013, Oulton et al., 2016) and help push nurses into clinical spheres only recently vacated by medical and other health professionals. Furthermore, we also find ourselves in a situation where leadership in nursing is being touted as *the* essential criterion for advancement. We are besieged by conferences and programmes on 'nursing leadership' (European Academy of Nursing Science., 2018, Sigma Theta Tau International, 2018). Is nursing at risk of only being validated by comparison with, and replacement of, medical roles, and in terms only of nurses leading rather than actually 'doing' nursing?

It is certainly the case that in many health systems unqualified and often poorly trained assistants now provide, or attempt to do so, the majority of fundamental nursing care. Even here, however, it seems that these assistants are following the registered nurses' path. Returning to our personal anecdotes, in both recent hospital admissions we cited earlier, the assistants spent their time wheeling mobile physical observation trolleys around the clinical environment, collecting blood pressure and temperature data from each patient in turn, never once straying from their technical activities into the realm of patient comfort; never once seeking information on the equally important fundamental care needs of their patients. In the first personal anecdote above, patients were seen slumped in their beds, never cleaned and only approached for cursory attempts to provide basic nutrition and

hydration. Oscillating pressure mattresses and frank neglect replaced any attempt at fundamental nursing care.

Is it true, therefore, that in the wake of registered nurses exiting stage left for medical substitution or administrative roles, lie patients unable to feed, clean, clothe and care for themselves? It seems to us there is an argument to be made that into the gap between registered nursing and assistant nursing has fallen patients' fundamental care needs. As registered nurses either run from traditional nursing roles or are forced into administrative tasks away from the patient's bedside, and assistant nurses studiously navigate around the messy business of fundamental nursing care – satisfying and supporting essential human needs like nutrition, hydration, cleanliness, elimination and mobility – a chasm of *shitty nursing* has opened up, and it is we patients who tumble headlong into it.

A Broken Social Contract

So, we would like to ask this question, is something rotten at the core of modern nursing? Does a collective myopia exist that includes individual nurses all the way to hospital directors, academics and professional regulators? Does this myopia prevent nursing acknowledging the possible breakdown of the social contract that exists between society and the profession (White and O'Sullivan, 2012, Wynd, 2003)? In this contract, in return for society allowing a profession the autonomy to conduct its own affairs, a mature profession is required to act responsibly and ensure its members deliver their activities to the highest standard (White and O'Sullivan, 2012, Wynd, 2003). Is this contract now routinely being broken in the era of *shitty nursing*?

If we accept that there is a strong possibility that our profession is no longer acting according to the social contract noted above, then we must accept that our profession is not mature; that despite protestations of patient centredness (McCormack et al., 2011) and compassion (Chief Nursing Officer and DH Chief Nursing Adviser, 2012, Hewison and Sawbridge, 2016), it is more concerned with its own

internal preoccupations than with acknowledging the experience of patients. As George Bernard Shaw put it, all professions are '*conspiracies against the laity*' (Broad and Broad, 1929), and although Bernard Shaw was talking about medicine, his words may be as prescient today for nursing. Is one shocking example from the UK an isolated example – where the UK Nursing and Midwifery Council regulator was, at the same time as being preoccupied by the minutiae of nurse training, responding inadequately to reports of poor midwifery practice to the extent that its chief executive felt obliged to resign (Jones-Berry, 14/05/2018) – or a symptom of something more global? Is our profession now apparently blind to the existence of routine neglect and indifferent to patients' discomfort? Are we comfortable with the delivery of routine *shitty nursing*?

Proposals for Action

What might be done about this parlous state of affairs? It would be easy for nursing's many actors to fall upon each other and engage in an internal war of blame and recrimination. Clinicians and politicians could blame university educators for training nurses who are out of touch with the 'realities' of modern nursing practice (Norman, 2014) and 'too posh to wash' (2020health.org, 2012). Educators may blame senior clinical nurses for presiding over a culture of poor clinical standards that saps the enthusiasm of nursing students. Nurses will blame governments and hospital managers for inadequate funding, poor decision making and understaffing. Everyone can blame nursing regulators for their remoteness and inattention to the things that really matter. None of it gets us anywhere.

We argue that these positions will merely entrench the status quo, trapping patients in an ever more vicious circle of nursing decline. Unless all nurses, qualified and unqualified, clinicians, educators, researchers, managers, policy makers and others first acknowledge the possibility that *shitty nursing* could in fact be the new normal, not the exception, nothing will change.

Therefore, we propose three urgent actions that nurses and nursing must take. Firstly, we contend that it is no longer appropriate for nurses to ignore the possible risk that the social contract at the heart of our professional relationship with society may be broken. Repairing such a possible breakdown will not be an easy matter for us as a profession. In such cases, where mediation between parties is required, there is one potential method that could remedy this. We could try to follow the lead of countries who have faced similar breakdowns in trust, for example where it has been necessary to heal the divisions caused by past conflict or political repression. These countries have used 'Truth and Reconciliation Commissions' (Hayner, 2011) to allow both parties in a broken relationship to come together; one side can atone for their part in it, hear the voices of those others affected by their actions, and move away from distrust and relationship breakdown towards reconciliation, converting 'knowledge into acknowledgment' (Smith et al., 2014).

Secondly, if the main career advancement options open to registered nurses are medical substitution or clinically remote administration roles, the fundamental care chasm will only grow wider. We therefore propose that nursing requires re-orientating back to its core values by the incentivisation of registered nurses to undertake fundamental nursing care (Henderson, 1966, Kitson et al., 2013, Kitson et al., 2010, Nightingale, 1859). This is not so fanciful a suggestion. There is indeed evidence that programmes can be successful in re-orientating nurses to their core roles. For example, twenty years ago in the UK the 'Thorn' programme (Gournay and Birley, 1998) both educated and incentivised nurses to work with people who had the most complex and enduring serious mental health problems, where previously working with these patients had been the least attractive career option in mental health nursing. Modest investment plus a policy initiative returned UK specialist mental health nurses to their fundamental care roles.

As well as incentivisation and education, a critical reason for the success of the Thorn programme was the strong evidence base for psychosocial interventions (Mairs, 2017, National Institute for Health and

Care Excellence, 2014). Thirdly, therefore, we suggest that there needs to be a major investment in fundamental nursing care research. As we noted earlier, currently the evidence for nursing interventions to address people's fundamental care needs is woeful (Richards et al., 2018). There will be little point in valuing fundamental nursing care and incentivising registered nurses to deliver it, if that care is merely custom and practice rather than evidence based. Investment in such research is critical to the future of nursing, given that evidenced based care is the cornerstone for one of the six nursing standards of safe care (Cronenwett et al., 2007).

Conclusion

We have outlined the perhaps contentious proposition that *shitty nursing*, a phrase coined by a European nurse undertaking a PhD to reflect her shocked observations of nursing care, may be much more widespread than previously acknowledged by our profession. We have shamelessly used our own participant observations as patients being 'nursed' to provide anecdotal evidence, but we have also looked elsewhere for evidence that all is far from well in nursing. We have suggested that in many places the social contract between society and the nursing profession may at least be on the verge of becoming severely damaged if not already broken. We have made three suggestions for a way forward: 1) that a mature, rather than a dismissive or defensive, conversation between nurses and patients be undertaken using principles drawn from reconciliation processes such as Truth and Reconciliation Commissions; 2) that we instigate programmes to re-value and re-incentivise the practice of fundamental nursing care delivered by *registered* nurses compared to specialist nursing roles driven by medical substitution and task shifting initiatives; 3) and that we drive a concerted effort to produce the evidence for the practice of nursing in general, and fundamental nursing care in particular.

Make no mistake, however, if our personal experiences do represent the fact that *shitty nursing* is indeed the new normal, it will take an enormous and highly mature effort by the profession before

nursing regains the societal trust it once considered its natural entitlement. We invite the profession to reflect on our opinions, to engage with us in this debate, and to send us your own examples of *shitty nursing* in order to chart our way forward.

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