‘SHE WOULD WASH THE PATIENTS AS IF SHE WAS SCRUBBING A DIRTY PLATE IN THE SINK’: EXPLORING NURSING STUDENTS EXPERIENCES OF CARE DELIVERY

ABSTRACT

Background

Whilst much is known about nursing students’ clinical placement experiences in general, less has been reported about their specific encounters with poor care delivery. A few small-scale qualitative studies have been undertaken, which suggest that nursing students do witness poor care but often decide not to act on what they see. This study sought to explore a wider international perspective on this issue.

Aims

To explore nursing students’ experiences of the care delivery practices witnessed during clinical placements and to provide descriptions of poor care.

Setting and participants

Nursing students from undergraduate pre-registration nursing programmes across three universities, two in the United Kingdom (UK) and one in Australia.

Design and analysis

A qualitative/quantitative survey design was utilised, and data were descriptively analysed.

Results

Two hundred and sixty-five students participated in the study. Overall the results were positive. Nevertheless, the participants did provide multiple and recurring examples of poor nursing care which related to a lack of compassion, poor communication, unkind and indifferent provision of personal care, and patient safety. Reporting of poor care was viewed as difficult and many participants highlighted potential repercussions should they take this course of action.

Conclusion

This research provides contemporary international insights into care delivery practices from the perspective of a large number of nursing students. The results, although mainly positive, outline multiple examples of poor and ineffective practice.

While the precise prevalence of these remains unknown, educators, practitioners and students should consider how best to address them when they occur.
Key Words

Poor care, nursing students, compassion, vulnerability, personal care.

INTRODUCTION

Nursing remains one of the most trusted professions in the eyes of the public (Hutchinson, 2018; Milton, 2018), although this trust may be eroded due to the growing concerns about the quality of nursing care which has attracted considerable interest in recent years. Numerous healthcare reports (Hindle, 2006; Mohr, 2009, Francis, 2013; Kirkup, 2015; Jones, 2018) from across the world detail instances of abuse, neglect and incompetence by nursing staff. Add to this the frequent media reports of care failure, and the empirical and academic work which has sought to understand the phenomenon of poor care, and it becomes increasingly clear that there may be a problem at the heart of our profession (Ion et al, 2019). While this is entirely possible, we are a long way from being able to confidently make this assertion and further still from providing the evidence to support it. What we can be certain of is that nursing staff have been found to be culpable in some high-profile failures and that these appear to occur with depressing frequency (Darbyshire & Ion 2018). Without doubt, the catastrophic failures such as occurred at Mid-Staffordshire NHS Trust (Francis, 2013) and Gosport War Memorial Hospital (Jones, 2018) are troubling, but by their nature these cases may say more about the toxic reality of those particular services than they do about the everyday experience of patients and the work of the nurses who provide care. To extrapolate therefore, from these reports is problematic in two related ways. First, generalising from a few extreme cases allows those who would defend the status quo to argue that, although poor care might be a significant issue, it is one which is limited to a small number of atypical clinical environments. The extension of this position is that neglect, abuse and incompetence, while regrettable, need not concern most of the profession. Second, a focus on the high-profile may allow us to forget the everyday misery and suffering, which patients and carers are likely to experience if poor care is more common, for example, in those environments where care may not be heinous, but might be better described as sub-optimal.

In this paper, we consider the issue of care quality as viewed from the perspective of nursing students who represent the future of the profession. Drawing on Francis' idea (2013) that these novice nurses approach clinical practice with a view which is

untainted by years of experience, we explored their perceptions of care delivery practices witnessed during clinical placements.

BACKGROUND

In the UK, the need to promote safe and effective care delivery has been brought into focus in recent years. The high-profile Mid Staffs Public Inquiry Report highlighted stark failings in relation to care of people and maintenance of their safety at a hospital in England (Francis, 2013). Against the backdrop of the Francis Inquiry, the then Chief Nursing Officer launched the 6 Cs Strategy, a set of values integral to the delivery of compassionate care (NHS England, 2016). From an educational perspective, the United Kingdom (UK) Nursing and Midwifery Council (NMC) have recently launched their revised Standards Framework for Nursing and Midwifery Education (NMC, 2018a) and Student Supervision and Assessment (NMC, 2018b). These standards are driven by the need for safe and effective care delivery.

Like the UK, Australian healthcare reports (for example Garling, 2008) have identified the need for increased attention to quality patient care. Emerging in response to recurring concerns about patient safety and quality, The National Safety and Quality Health Service (NSQHS) standards were developed to provide a nationally consistent set of measures to support clinical governance and risk mitigation in acute care (Australian Commission on Safety and Quality in Health Care, 2017). The NSQHS standards are also used to inform nursing curricula. The Australian Nursing and Midwifery Accreditation Council (ANMAC, 2019) is the independent accrediting authority for nursing and midwifery education and seeks to protect the health and safety of the public by ensuring curricula are of high-quality. To be accredited, nursing programs must demonstrate that graduates are prepared to provide safe, appropriate and responsive quality nursing practice measured against the registered nurse standards for practice (Nursing and Midwifery Board of Australia, 2016).

While there is a wealth of material which examines nursing students' experiences of clinical placement more generally, we know relatively little about their actual encounters with poor care. The work which has been undertaken to date is mainly characterised by small scale localised studies. For example, Fisher and Kiernan (2019) reported on breaches of patient safety witnessed by 12 nursing students from

one UK university. Similar to research by Ion et al. (2015) and Belafontaine (2010), the authors concluded that students carefully considered the personal consequences of raising concerns before doing so. Where a negative consequence was deemed possible, participants frequently decided against action, privileging self over the needs of patients. This contradicts the requirements of regulatory authorities and professional bodies which leave no room for the weighing up of potential outcomes for those who witness poor care, with the emphasis firmly on the protection of the patient. However, the reticence to report poor care is often echoed in the wider whistleblowing literature (Jackson et al, 2014), as well as in two recent literature reviews examining the topic in relation to students (Ion et al. 2017, Milligan et al. 2017). There is much that educators might learn from these studies in terms of how to prepare students for the reality of practice, but their small scale and specific local context makes it difficult to generalise more widely. Thus, the international study profiled in this paper sought to explore the perspectives of a large cohort of students from three sites in the UK and Australia.

METHODS

Study Aim

The study had two aims. First, to explore the care delivery practices experienced by nursing students while undertaking clinical placements. Second to describe instances of poor care described by participants.

Study Design

To achieve the above aims the study adopted a survey design using a self-report instrument that included a mixture of open, closed and mixed items. Survey respondents were asked to rate their agreement to statements on a four-point Likert-type response format. There was also an opportunity to leave comments through open-ended questions relating to each theme.

Setting and Participants

In this study Site 1 was a small university in Scotland, UK, where one BSc (Hons) Nursing Programme is offered, with one branch; Mental Health. This programme recruits approximately 50 students annually.

Site 2 was a large metropolitan university in New South Wales, Australia. It provides a Bachelor of Nursing program for direct entry, graduate entry and students with a previous Enrolled Nurse qualification. Approximately 900-1000 students enroll in the program each year. Because of the generalist nature of Australian nursing programs, each student undertakes a variety of clinical placements that reflect the broad landscape of contemporary nursing practice.

Site 3 was a large metropolitan university in the North of England where two undergraduate pre-registration nursing programmes are offered. These include the BSc (Hons) Nursing with two branches; Adult and Mental Health. The Adult branch is the larger programme recruiting approximately 200 students annually with the Mental Health branch recruiting approximately 20 students per year.

All enrolled students were invited to participate in the survey. Following the survey launch, a reminder email was sent two weeks later. The survey was closed after one month.

Recruitment and Ethical Considerations

Ethical approval was obtained individually from each of the participating institution's Research and Ethics Committees. Subsequently, informed consent was obtained from the students and they were assured of anonymity in the reporting of the study results and that they could also withdraw from the study at any time. Students were informed about the study via email, which included a link to an online survey. Involvement in the project was voluntary and students had a period of four weeks to consider whether they wanted to take part. In order to minimise influence on the students to take part in the study, where possible, researchers were independent of the teaching team and had no direct contact with potential participants. This was not possible in one institution. The students at each organisation were informed that they would be entered in a prize draw for a gift voucher if they completed the survey.

Data collection

A qualitative/quantitative survey design was utilised for this study. The survey consisted of four sections; Demographic Data (eight closed questions); University Support and Preparation for Placement Learning (one scale with fourteen items and

one open question); Quality of Care for Patients (one scale with thirteen items and one open question) and Mistreatment of Patients (one scale with seven items and four open questions). The open questions provided space for those who had witnessed poor care to expand upon their experiences. To enhance content and face validity survey items were informed by the relevant literature and reviewed by an expert panel consisting of academics with expertise in patient safety, nursing education and survey design. They were also reviewed by two students who provided comments on readability. The survey took between five and eight minutes to complete. The response rates to the open-ended questions were 35% (Site 1), 31% (Site 2) 22% (Site 3)

Insert Figure One Placement Survey here

Data analysis

Quantitative data were descriptively analysed using frequencies and percentages. Qualitative data was transferred to an Excel document where it was thematically analysed following a process of reading and re-reading of free text comments. Data was independently coded, using a manual process, by two members of the research team. Following individual coding, themes were then compared, discussed and, where necessary reformulated by those who had conducted the original coding. Where disagreements occurred, a third member of the team supported the process by providing an additional perspective. All members of the research team were invited to review and comment upon the resultant analysis. ~~and themes were agreed through discussion between the research team.~~ ~~themes were agreed through discussion between the research team.~~

RESULTS

Demographic characteristics of participants

Overall there were 265 participants; their ages ranged from 18 to over 40 and they came from a variety of ethnic backgrounds. Most of the participants were studying full time and female students were more highly represented. Specific details for each of the sites are provided in Tables 1 and 2.

//Insert Table 1 about here – Merged Demographics Table//

Quantitative Results

The majority of survey participants expressed positive views about nursing staff being compassionate, good role models, and delivering safe and effective care. However patient neglect was commonly reported (26% of students in Site 1 either agreed or strongly agreed to having witnessed neglect, 31% in Site 3 and 16% in Site 3), while a smaller number of students had witnessed verbal abuse (22% of students in Site 1, 15% in Site 2 and 9% in Site 3) and physical abuse of patients (7% in Site 1, 11% in Site 2 and 4% in Site 3). Less commonly reported was sexual and financial abuse (See Table 3). Participants felt strongly that they had a professional obligation to report patient mistreatment and most stated that they would report cases of poor care should they witness it. However, many of the participants (29% from Site 1, 26% from Site 3, 40% from Site 3) knew of other students who had witnessed patient mistreatment and not reported it. Further, while agreeing that they had a professional obligation to report mistreatment of patients (100% of students in Site 1, 92% in Site 2 and 100% in Site 3), some participants indicated that reporting would be likely to have negative repercussions (13% of students in Site 1, 16% in Site 2 and 13% in Site 3).

In some instances, there were clear differences between responses from students from the different countries. For example, answers to the question about whether 'raising concerns about patient mistreatment was more trouble that it was worth' showed that twice as many Australian students agreed with this statement (33%) compared with students from the UK sites (15%). Similarly, a question asking students if they were confident that when raising concerns about their placement experience the university would support them, 21% of the Australian students disagreed with this statement compared with 8% of students from Site 2. When students were asked about whether a reason why they do not provide feedback on the placement is because they think that this would not be acted upon, 26% of the Australian students agreed with this compared with 15% at the UK sites.

//Insert Table 2 here – merged placement data//

//Insert Table 3 here – merged placement data//

//Insert Table 4 here – merged placement data//

Qualitative results

Notwithstanding the generally positive nature of the quantitative results, participants from the three sites also provided evocative and recurring examples of poor nursing care through the open-ended questions, which will be discussed below. Analysis of these qualitative data resulted in emergence of five key themes, that included:

1. Compassion and person-centred care
2. Personal care
3. Communication
4. Patient mistreatment/patient safety
5. Reporting and repercussions

In the findings below participants are identified only in terms of their context as Sites 1, 2 and 3.

Insert Table 5 here: Open Ended Questions Response Rates

Compassion and Person-Centred Care – 'The individual wasn't treated as a person but more as an inconvenience'

While the qualitative data illustrated some occasions when nursing staff provided high quality care, multiple examples of care that was devoid of compassion were nonetheless reported. It was also apparent that professional values such as person-centred care and dignity, although embedded into university curricula, were not always evident in clinical practice. This was particularly apparent in aged care and mental health settings, where some of the most vulnerable patient groups receive healthcare.

> *On the whole, most staff I have worked with have been fantastic however, there have been a handful who did not care for patients with compassion.* [S1]

> *Although we are taught about person-centered care, compassion and dignity in university classes, I was told by one of the nurses to get a patient ready in the morning and not to take no for an answer. The nurse literally told me that in real life there is no such thing as sitting with a patient and having a chat as that is just a luxury.* [S3]

Provision of Personal Care – 'She would wash the patients as if she was scrubbing a dirty plate in the sink'

Linked closely to the previous theme were the students' perceptions that the provision of personal care that appeared to be neither compassionate nor person-centred. Several of the participants provided extensive and sometimes shocking examples of personal care that they described as rough, negligent, unkind and even abusive:

> *She would also wash the patients very roughly, not engaging them as people but more as if she were scrubbing a dirty plate in the sink.* [S3]
>
> *I witnessed a healthcare assistant throw clothes at an elderly patient with dementia and demand for them to get ready.* [S2]
>
> *I have seen cases of neglect and emotional mistreatment, for example, watching patients be rolled, hoisted, or washed without knowing what is happening, or giving consent, and their distress being ignored by staff.* [S3]

One of the most recurring personal care issues described by participants was in relation to toileting and continence management. The issues included the length of time patients were left in dirty beds and waiting for help with toileting:

> *Elderly patients were often left in dirty beds.* [S1]
>
> *The nurses refused to take a patient to the toilet because they had already been multiple times*. [S2]
>
> *A patient was on a commode left for 25 minutes buzzing for help.* [S1]

In several cases the participants sought to justify some of the poor care they had witnessed, by referring to inadequate staffing ratios and the lack of appropriate equipment. Justifying inadequate care in this way is problematic as it normalises these situations:

> *Patients were left in soiled beds because no support workers or students were available at the time.* [S1]
>
> *When incontinent, patients were sometimes just left due to staffing issues and high levels of clinical activity.* [S2]

The ward lacked the appropriate lifting equipment, so staff had no choice but to use bad practice. [S1]

Poor Communication – 'The patient was called a fat heifer'

Effective communication is fundamental to empathic care provision, even when patients are unable to verbalise their own needs. Perceived poor communication was a significant theme across the data sets and a number of participants from each of the three sites identified 'poor communication' with patients as a common occurrence. This perceived poor communication ranged from ignoring patients to shouting, swearing and the use of confrontational language. In addition, communication was used to convey discrimination:

A nonverbal patient (that had in his notes he still liked to have people talk to him) was bed bathed by two nurses, and no one said a word the entire time. [S3]

I witnessed an unprofessional nurse shouting at an angry agitated patient. [S1]

Patients were left on their own with no one to speak to all day ... only being attended to when they start shouting. [S2]

A number of participants also noted that the use of stigmatism, derogatory comments and racism were common. In addition, students were particularly concerned about dismissive attitudes towards patients in mental health settings where their experiences fell well below their expectations of appropriate care:

Clinical staff can be dismissive of service users and their needs and they often have negative attitudes towards people with mental illnesses. This is displayed through derogatory comments and the use of stigmatising language, for example, 'kicking off', 'challenging' and 'attention seeking'. [S2]

I observed racial comments by healthcare staff about a patient. [S2]

> *The patient was called a fat heifer with staff complaining about their weight in front of patient*. [S2]

Patient Mistreatment/Patient Safety – 'I saw a senior staff member walk by a patient having a seizure on the floor and do nothing'

The theme of patient mistreatment/patient safety included all comments in which students highlighted care that fell significantly below acceptable standards. Across all three of the sites, participants listed explicit and deeply troubling examples of both mistreatment of patients and unsafe care. Amongst these examples, students identified instances of indifference, patient neglect, and overt poor practice. The two examples below identify clear breaches of professional standards of care:

> *The nurse would fill in her patient's hourly checks for the entire shift at 7am*. [S3]
>
> *I witnessed a nurse who had attempted to give an elderly man his morning medications which were in tablet form. As he was struggling to swallow them, she just put the remaining tablets in the bin in his room and left him choking.* [S2]

Further, a very small number of participants described how senior team members ignored potential medical emergencies. In the second comment below, it appeared that the staff member also trivialised the concern raised by the student:

> *I saw a senior staff member walk by a patient having a seizure on the floor and do nothing*. [S1]
>
> *I told a senior nurse that the patient was having trouble breathing. The nurse responded, 'tell me when they are unconscious'*. [S3]

Reporting and Repercussions – 'I've reported bad practice and was shunned by the staff'

A recurring theme in the data related to the actual or potential repercussions of reporting poor practice and some students left in-depth comments detailing incidents of poor care. Several participants expressed concerns about how reporting mistreatment of patients might impact their placement experience, clinical appraisals and future employment. While some felt that the risk of negative repercussions was worth taking, others felt that reporting would not make a difference and therefore, were disinclined to challenge poor practice:

> *I would expect negative repercussions if I reported a nurse for mistreating a patient/unprofessional conduct … although I would still probably do it*. [S3]
>
> *Overall care is good, but I have also seen bad care which has been endemic to certain ward areas. I have never reported these issues further because it would impact on my placement outcome. Students are scared to report things because they are worried about not being passed. This is especially relevant to third year*. [S1]
>
> *Raising a concern about patient mistreatment would be more trouble than it is worth. Although it might benefit patients and you would feel you had achieved something, there would be a significant personal impact if you reported something and it could lead to workplace bullying.* [S2]

Of particular concern were a small number of participants who detailed how they had experienced bullying after they had reported poor care. However reassuringly in the first example, the student described how this would not prohibit her reporting her concerns:

> *I raised an issue of patient care and was treated unfairly by staff after I submitted an incident form. My mentor then refused to give me a reference for a job application. Even this bad experience would not stop me from reporting an issue again as it's my obligation to my patients*. [S1]
>
> *I have reported bad practice and the ward sister told the staff I'd made a complaint and I was then shunned*. [S1]

On a more positive note other students felt they had been provided with learning opportunities that allowed them to consider and address practice issues should they arise. This was apparent both across clinical and academic settings:

> *I witnessed poor practice by a member of agency staff and when I reported it to the ward manager I was supported and given the opportunity to reflect. The issues were dealt with and nurse's attitude subsequently improved*. [S1]

> *Throughout my training I have been encouraged by university lecturers, mentors and senior staff to raise any concerns about patients care.* [S2]

DISCUSSION

Participants in our study reported care delivery, which was, in the main, of high quality, respectful, compassionate and delivered by caring role models. These are important findings and should provide some reassurance for a profession which has been heavily scrutinised and criticised in recent years (Richard and Borglin 2019). We should also be pleased that the great majority of participants understood their obligations in relation to raising concerns about care standards, that they believed they would be supported to do so, and that their concerns would be acted upon if they did. Without doubt these findings are to be celebrated. We may also take some, albeit lukewarm, comfort from the fact that those who witnessed poor care, were able to recognise it as such.

However, even though positive experiences appeared to outweigh the negative in their frequency, the descriptions of poor practice, which at times compromised patient safety, are of considerable concern. Each instance of sub-optimal, neglectful or abusive care is likely to impact students' views of nursing and, most importantly, cause suffering and distress to patients and families (Ion, Olivier and Darbyshire 2019).

A lack of compassion in aged care settings and verbally inappropriate behaviours in mental health settings were practices which students witnessed most frequently. Most participants indicated that they would report mistreatment of patients and were aware of ways in which they could do this. However, despite these positive findings, participants also described potentially negative repercussions if they raised concerns

about patient care. A number were reticent to escalate mistreatment of patients, believing that this could lead to failure of the placement and being ostracised from the team. Previous research supports this view identifying that nursing students are often passive when they observe poor care, as they prioritise the need to fit in, not 'rock the boat' and complete the placement successfully (Levett-Jones & Lathlean, 2009, Gunther, 2011).

In line with previous research (Jack et al, 2018), senior staff role modelling positive leadership by acting on students' concerns were not evident in this study. Students reported examples of poor leadership and staff who were disempowered and ineffective in their roles. Staff modelled care practices and coping mechanisms which were poor, for example, being physically rough when providing personal care and verbally abusive to people in mental health settings. In these instances, staff showed little empathy for the people for whom they were caring and for the students who were witnessing the care delivery. This is problematic, as clinical staff are students' main role models for learning how to care. Previous research, undertaken with medical and nursing students has shown that levels of compassion/empathy can decline by up to 50% throughout the duration of a nursing programme (Hojat et al, 2009; Ward et al, 2012), and reasons for this include a lack of appropriate role models and the negative attitudes of clinical teams. Along with preparing students to recognise poor practice and support them to challenge it, educators need to consider how empathy can be developed and enhanced in the profession. There is a risk that students who observe poor care may later perpetuate it, so supporting them to develop compassionate and empathic behaviours is paramount. Innovative experiential strategies are becoming more popular such as the use of the arts and simulation to support students' self-awareness and critical thinking to enhance compassion and empathy (see for example https://theempathyinitiative.org, Jack & Tetley, 2016)

Limitations

Participants' views were reflective of three sites and not therefore generalisable to other contexts. However, the mixed methods approach, international perspective and the relatively large sample size in this study enhances the representativeness of the findings. In one institution the researchers were known to students as members of

the teaching team. It is possible that this might have had a positive impact on participant response rate in that University.

CONCLUSION

This study sought to explore the placement experiences of three cohorts of students from the UK and Australia, with particular attention to their perspectives on the quality of patient care they observed. In many respects the quantitative results were encouraging, with students reporting they had had observed many positive role models who provided high quality compassionate patient care. However, examples of poor care were also reported across all three research sites.

In this study, when poor care was recognised, students generally knew how to escalate their concerns, and many were willing to do so. However, the qualitative findings also identified that many students have been exposed to situations where patients had been neglected, abused and treated with indifference. The findings also provided insights into students' responses to poor practice and the perceived ramifications of reporting their concerns to those in senior roles. It is hoped that these unique insights into contemporary clinical practice, grounded in the evidence and viewed through the lens of a diverse range of nursing students, will be used to facilitate in-depth dialogue, debate and reflection. We envisage that this reflection, both in educational and in clinical settings, will ultimately lead to more compassionate and person-centred care.

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