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Keywords Research/Training/Wellbeing/Older people

In this article...
- Details of four studies investigating different nursing interventions
- The studies' findings about learning opportunities for ward-based care staff
- How interventions can be successfully delivered, including during the pandemic

RESEARCH THAT SUPPORTS NURSING TEAMS: PART 2 OF 4

Learning opportunities that help staff to deliver better care

Key points

Four studies that investigated different nursing interventions were funded by the National Institute for Health Research in the wake of the Francis inquiries

The findings show that implementation of new care interventions is only meaningful when accompanied by staff learning

Good relational care underpins a positive patient experience and requires evidence-based staff training and prioritisation by managers

Providing good relational care is simultaneously more challenging and more important during the current pandemic

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Abstract This article, the second in a four-part series about using research evidence to support nursing teams, discusses the learning opportunities generated by four studies that were undertaken following the two Francis inquiries into care failings at Mid Staffordshire NHS Foundation Trust. It discusses how four different interventions directly or indirectly use learning to enable nursing teams to optimise care in acute hospital settings and argues that the profound impact of the coronavirus pandemic may have overshadowed the need for measures to support nurses' learning at a time when care quality is more important than ever.

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Acute hospital environments are only able to function effectively when populated by highly skilled nursing teams. Constant pressure is caused by the demand for hospital beds exceeding NHS supply and, when this pressure falls disproportionately on nurses, learning may seem like a luxury rather than a crucial activity.

This article draws on four different research studies to outline important opportunities for ward-based learning that can help nurses directly address issues around the quality of care. It is the second article in a four-part series bringing together findings from four studies funded by the National Institute for Health Research (NIHR); all of the studies explore interventions that aimed to improve the care delivered by nursing teams. In this article, we discuss what the evidence from these studies tells us about learning opportunities for ward-based care staff. The studies were commissioned in the wake of Francis' (2013; 2010) reports into care failings at Mid Staffordshire NHS Foundation Trust, which highlighted that older people were particularly vulnerable to poor care. To reflect this, much of the research reported in this article has particular relevance to the care of older people in hospital.

Nursing interventions

Creating Learning Environments for Compassionate Care

Creating Learning Environments for Compassionate Care (CLECC) is a multi-faceted team-based programme that promotes compassionate care in health and social care teams (Bridges et al, 2018; Bridges and Fuller, 2015). It uses workplace learning to develop practices that enhance the capacity of managers and teams to support relational work between staff members and between staff and patients. The CLECC programme includes:
- Learning sets for managers;
- Peer observations of practice;
- Classroom learning;

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- Team discussions for reflection and mutual support during shifts.

Bridges et al (2018) undertook an evaluation of CLECC with hospital nursing teams made up of both nurses and healthcare assistants (HCAs); they found it was possible for many of the activities to be put into practice, and that they were welcomed by staff and seen as beneficial.

Classroom learning provided opportunities to review how well the team was working together and to let staff get to know each other outside of their work roles. Quick, mid-shift conversations allowed staff to check on each other's wellbeing and offer help; however, reflective discussions were generally difficult to accommodate during the working day because of time pressures.

Teams varied in terms of how much of the programme they could implement and whether they continued with CLECC after the training period was over; these differences depended on the:

- Availability of managerial support to engage with CLECC;
- Organisational priority placed on staff learning and wellbeing.

Older People's Shoes

Older People's Shoes is a two-day training programme for HCAs; it draws on the accounts of older people, nurses and HCAs themselves to improve the relational care provided to older patients. The training programme:

- Explores ways to get to know the 'person behind the patient' during everyday care tasks;
- Uses age-simulation suits to enable the HCAs to experience for themselves impairments that may affect many older patients;
- Examines how lessons learnt from customer-care techniques used in non-health sectors can be used to redress some of the power imbalance between care recipient and provider.

Full details of the training programme can be found in Arthur et al's (2017) report on the study.

A survey of acute hospitals in England undertaken as part of this study showed that HCAs' in-house training provision is heavily concentrated during their induction period and tended to focus on health and safety aspects of both patient care and their own employment; relational care is largely absent from routine HCA training (Arthur et al, 2017).

HCAs who participated in Arthur et al's (2017) evaluation study reported that they appreciated the "asset-based" approach of Older People's Shoes, in which their experience was valued and built on during training, rather than dismantled and corrected. Participants also said they valued having practical take-home messages that they could easily apply to the context of the pressures of their work, and the fact that the training was explicitly targeted at those working as HCAs.

Age-simulation suits can help staff to experience the potential impact on older people of impairments related to the aging process

ALAMY

Schwartz Rounds

Developed in the US, Schwartz Rounds are an organisation-wide intervention that has seen rapid spread across healthcare organisations in the UK. By providing a safe space in which staff can openly share and reflect on the emotional, social and ethical challenges faced at work, Schwartz Rounds aim to support healthcare staff to deliver compassionate care. This is underpinned by the idea that care-givers are better able to make personal connections with colleagues and patients if they have insight into their own responses and feelings.

"Care givers are better able to make personal connections with colleagues and patients if they have insight into their own responses and feelings"

An evaluation of Schwartz Rounds in the UK, undertaken by Maben et al (2018), found that they provide learning opportunities by allowing participants to:

- Hear how colleagues have managed particular situations;
- Reflect on their own past experiences.

This enables them to shape the way they work and their ability to respond to similar experiences in the future (Maben et al, 2018).

Schwarz Rounds provide opportunities to learn about team working, building empathy and compassion, and taking care of oneself. However, for nurses, midwives and HCAs, these opportunities can only be realised if they are given the time to attend a Schwartz Round. The immediate demands of the ward will almost always take precedence and, during a 12-hour shift, there is rarely sufficient break time to provide an hour to attend.

As Schwarz Rounds are an organisation-wide intervention with great learning potential, there needs to be an organisational commitment to giving nurses, as well as other staff who have close patient contact, time to attend on a regular basis.

Intentional Rounding

Intentional rounding is a structured process that was developed in the US: nurses carry out regular checks – every one or two hours – of each patient in their care using a standardised protocol and documentation. The checks ensure comfort and care needs are being met and are often focused on the four Ps:

- Positioning;
- Personal needs;
- Pain;
- Placement of items.

In a study by Harris et al (2019), nursing staff often felt that intentional rounding was an intervention they were already carrying out. However, the fidelity of it – how often it was being delivered in accordance with how it was designed – was low. This may be due, in part, to a lack of training to prepare staff to deliver the intervention.

Where training was available, it was delivered locally on the ward and tended to focus on how to complete the docu-

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mentation, rather than the purpose of intentional rounding and its desired outcomes. Consequently, nursing staff tended to routinely undertake intentional rounding because they were told to, rather than because of any specific perceived benefits to patients.

For an intervention to work in a complex organisation in which staff turnover is high, frontline staff need preparation and education so they can be clear on not only *what* they are doing, but also *why* they are doing it. Harris et al's (2019) study showed that when organisations implemented intentional rounding, nurses were not given specific time to provide this care for patients; instead, they usually incorporated the intentional rounding checks into other care activities. This approach was encouraged by senior nursing staff who were aware of time constraints, particularly when wards were short-staffed; however, such an approach:

- Changes the nature of the intervention;
- Reduces the clarity of the purpose of intentional rounding;
- Reinforces the idea that intentional rounding is something staff are already doing and, therefore, requires no training or preparation.

By neglecting the learning needed for successful adoption of intentional rounding – including its purpose and potential benefits for individualised patient care – its emphasis shifts away from an active process of care towards a passive process of documentation.

Covid-19 and the changing context

All four studies discussed here were conducted before the coronavirus pandemic. The response to this crisis has brought about rapid and substantial changes to the way hospitals operate and how care staff perform their duties. These changes directly affect the experiences of hospital inpatients and may be particularly distressing for older people. It is useful to remember that older patients requiring hospital care are likely to be living with frailty and multiple comorbidities (Ruiz et al, 2015). In addition, older people are more vulnerable to infection with SARS-CoV-2 – the coronavirus causing Covid-19 – and those who contract the virus are likely to have worse outcomes than younger patients (Williamson et al, 2020).

There are also other ways in which older people's experiences of hospital care may be more difficult than those of younger patients. With hearing and cognitive impairment being more prevalent in older populations, the need for all hospital staff to wear masks poses an additional barrier to communication – and many older people already struggle to communicate their needs to staff (Chodosh et al, 2020).

Visiting restrictions may also be particularly isolating for older people in hospital, as many rely on family and friends to act as advocates and intermediaries, and to help them negotiate complex treatment decisions and discharge plans.

> *"Learning should not be considered an add-on or a luxury, but it inevitably involves time and resources"*

There have been a number of admirable developments in the NHS during these extraordinary past few months. These include rapid reorganisations of work processes and redeployment of staff. Training to upskill staff has been rolled out quickly and on a large scale; this has been in response to changes in demand, such as greater critical care capacity for patients requiring respiratory support, and dramatically modified practices that take account of the risk of transmitting the virus, such as cardiopulmonary resuscitation. In dealing with a pandemic, some of the challenges of providing good relational care to the most vulnerable patients may have been simultaneously overshadowed and exacerbated.

Many of the problems on which Francis' (2013; 2010) reports shone a stark light have not gone away; indeed, we have argued in this article that the current pandemic has made them harder to address. The learning opportunities identified by these four studies are ways in which nursing teams can help nurses directly address issues of care quality. Learning should not be considered an add-on or a luxury, but it inevitably involves time and resources. Research-based evidence helps ensure that these resources are deployed for the greatest benefit.

Collectively, the findings from the four studies demonstrate that meaningful changes in nursing practice involve staff learning but that training sometimes focuses on *how* to do things, rather than helping staff to understand *why* new practices are needed; as a result, this limits improvement potential. Supporting staff learning may require organisations to think creatively about how staff with full-time caring responsibilities can step away from the point of care to engage in reflective learning about relational care.

The studies' findings also point to the value of investing in continuing learning for all nursing team members. As nurses and healthcare providers deal with the coronavirus pandemic, attention to these issues may be reduced at a time when it would, in fact, likely benefit from being intensified. **NT**

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