

Raising concerns and reporting poor care in practice

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This is the pre-copyedited version of an article accepted for publication in *Nursing Standard* following peer review. The version of record

Ion, R., Jones, A. and Craven, R. 2016. Raising concerns and reporting poor care in practice. *Nursing Standard*. 31(15): pp. 55-62.

is available online at: <https://dx.doi.org/10.7748/ns.2016.e10665>

Raising and reporting poor care in healthcare

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Abstract

This article considers the issue of poor care and how nurses should respond when they encounter it. A series of reports and inquiries into failings in care have called into question the standards of care provided by nurses. Of equal concern is the observation that in some instances, poor care is unreported. While there may be underlying structural and organisational reasons for this, it is contended that nurses have a legal, moral and professional obligation to report unacceptable practice when they become aware of it.

failings in care, Francis report, poor care, raising concerns, reporting concerns, whistleblowing

Aims and intended learning outcomes

The aim of this article is to examine the issue of poor care in nursing. It defines the concept of poor care, distinguishes it from other patient safety issues, such as errors and mistakes, and outlines the steps that nurses should take when they encounter poor care. This article considers the challenges associated with raising concerns about poor care, while emphasising that this is a professional and legal requirement for healthcare professionals, a moral obligation, and an essential action to help ensure patients receive high-quality care. After reading this article and completing the time out activities you should be able to:

- Define poor care and distinguish it from errors and mistakes.
- Consider the factors that might explain the occurrence of poor care.
- Describe the professional, legal and moral requirements and obligations that underpin the requirement to report poor care.
- Describe the steps that nurses should take when they encounter poor care.
- Identify difficulties that might arise in raising concerns about care, including an awareness of the potential consequences, and consider ways to manage these challenges.
- Reflect on how you would respond to encountering an instance of poor care.

Introduction

For many years, it was commonly believed that healthcare professionals always delivered the highest standard of care possible. It may be suggested that most nursing care is high-quality. However, recent evidence indicates that it can no longer be assumed that standards of care are universally high. Citing examples of failings in care in a range of specialties, including midwifery, mental health and adult nursing, in several countries, including Australia, the UK, Canada and Sweden, Stenhouse et al (2016) described a complex and nuanced picture of healthcare practice, in which effective care may be the rule, but where there is much variation, with some examples of poor care.

There has been particular focus on the issue of poor care in the UK, where the quality of health care has come under increasing scrutiny (Holme 2015) since the publication of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis 2013). Francis (2013) detailed systemic failures, describing incidents of failings in care, including patients being left to lie in their own urine or excrement, staff not responding to call bells, and food and drink being left out of reach of patients with restricted mobility. In addition, patients and their relatives reported encountering callous and uncaring staff.

While the scale of failure and neglect reported by Francis (2013) may have marked a defining moment in the way healthcare staff are viewed by the British public, it has become increasingly clear that these findings were not an isolated incident. The Francis report was followed by reported failings in care in Scotland – at the Vale of Leven Hospital, north west of Glasgow, at maternity and neonatal services in Morecambe Bay NHS Foundation Trust in north west England, and in the learning disability services at Winterbourne View near Bristol

. Healthcare services in the UK are under considerable pressure to account for significant shortcomings in aspects of care and service delivery (Plomin 2013, Corlett 2014, Phelvin 2014). It might be that these problems are a symptom of a short-term crisis in care. However, Rydon-Grange (2015) claimed that failings in care have been a common occurrence in the UK for at least 40 years.

Defining poor care

There is no agreed definition of what constitutes poor care; however, the authors offer the following distinction between errors and poor care (Ion et al 2015, Ion et al 2016): errors are the unintended outcome of genuine mistakes, while poor care involves acts of neglect, abuse or incompetence, which occur for any reason other than error. Therefore, a nurse who makes an error while administering medication has not necessarily delivered poor care – after all which of us has never made an error? However, acts of abuse, neglect or incompetence constitute poor care. Thus, if a nurse makes one medication error and reports it according to policy, this is not considered poor care; reporting an error is actually best practice. However, if the nurse recognises the error and makes a deliberate decision to ignore it, this is considered an act of neglect, and possibly abuse – and the original error becomes a case of poor care. In this example, it is the decision to not report an error that constitutes poor care. Table 1 compares examples of practice that would be considered an error with examples of practice that would constitute poor care.

Table 1. Distinguishing errors from poor care

Error	Poor care
Misreading a patient’s prescription and administering the wrong dose of medication as a consequence.	Deciding to rely on memory and not to read a patient’s prescription, and administering the wrong dose of medication as a consequence.
Forgetting to check a patient’s blood pressure as a result of being busy with other tasks.	Deciding not to check a patient’s blood pressure, but completing a recording chart to indicate this had been done.
Giving the wrong medication to a patient by mistake.	Knowingly giving a patient medication that has not been prescribed.
Accidentally hurting a patient while assisting them with an activity of daily living.	Treating a patient roughly in retaliation for perceived reluctance to carry out an activity of daily living.
Misjudging a situation and making light of something that is important to a patient’s relative, without any intention to cause offence.	Mocking a patient.
Briefly becoming exasperated and unintentionally letting this show to a patient who is in need of help.	Shouting at and neglecting the needs of a confused older patient who repeatedly presses an alarm bell.

TIME OUT 1

Think of a time when you or a colleague made a mistake. What actions were taken to ensure that this did not become a case of poor care?

Explaining the occurrence of poor care

Several explanations have been suggested to explain the occurrence of poor care in healthcare settings. Randall and McKeown (2014) suggested that poor care is a consequence of the significant structural changes that have taken place in healthcare systems in recent decades. These might include: the breakdown of traditional, often hierarchical, structures that dictated professional behaviour and set standards for nurses; the rapid and considerable changes that are often made in many healthcare environments; job uncertainty and low staff morale, often as a result of change; the perceived devaluing of what was traditionally considered the work of nurses, such as 'hands-on care'; and low staffing levels and increasing demands placed on healthcare services that are already stretched. Therefore, examples of poor nursing care may be seen as a consequence of the climate of structural and strategic change in which nurses routinely work. Many healthcare practitioners may identify with the issues related to poor care, and acknowledge that there may have been occasions when the care they provided did not meet their own standards as a result of competing priorities. Paley (2014) suggested that nurses are sometimes too busy to notice that care is of poor quality. However, the authors are concerned that this position undermines nurses' autonomy by suggesting that being busy hinders nurses' professional judgement and the ability to notice suffering and distress (Darbyshire 2014).

TIME OUT 2

Reflect on an occasion when your workplace felt too busy to deliver high quality care. How did you feel about this? How did you manage this situation? What actions did you take?

Alternative theories to explain the occurrence of poor care have been put forward by Darbyshire and McKenna (2013) and Roberts and Ion (2015).

Darbyshire and McKenna (2013) contended that nurse education has lost sight of its mission to develop caring, compassionate and skilled practitioners. They rejected criticisms of nursing as a graduate profession and that problems in patient care were a result of too much education and a 'too posh to wash' attitude, as too simplistic. They suggested that while modern healthcare is demanding and complex, and it requires intelligence, education and training to deliver care effectively, degree-level nurse education has lost its focus, which should be on the delivery of care.

Roberts and Ion (2015) asserted that poor care has often been a consequence of a failure on the part of healthcare staff to step back from their day-to-day actions and activities and reflect on what they are doing and why they are doing it. Using the example of Mid Staffordshire NHS Foundation Trust (Francis 2013), they considered how, in the face of professional guidance and public expectation, a range of healthcare staff from different specialties could encounter and participate in instances of poor care, which were often uncaring and led to fatalities in some instances. They concluded that the focus of healthcare staff was often on meeting targets and the completion of tasks, when it should have been on patient care. Roberts and Ion (2015) suggested that prioritising the instrumental over the caring resulted from a lack of critical thinking; in particular, a failure to see, consider and respond to the distress of patients in their care, instead focusing on tasks, deadlines and outcomes.

The view that all nurses working in Stafford Hospital collectively failed to raise concerns has been challenged, and it has been claimed that 'organisational disregard' for employee concerns about care quality was a major factor contributing to episodes of poor care (Jones and Kelly 2014a). For example, contrary to the misconception that staff working at Stafford Hospital did not report poor care, there were 940 patient safety incident reports submitted by staff describing dangerously low levels of staffing to the National Patient Safety Agency* between 2005 and 2010 (Jones and Kelly 2014a). In addition, Helene Donnelly, a nurse, spoke out in October

2007 and was told by fellow nurses to 'watch her back' This led to inquiry counsel Tom Baker describing the repeated raising and subsequent disregard of concerns as 'a cry from staff who appear to be being ignored' (Jones and Kelly 2014a), primarily as a result of a top-down organisational culture in which senior management prioritised financial rectitude over the quality of patient care.

TIME OUT 3

Consider what role practice mentors should have in the education of nursing students? What can mentors do to ensure the students they support are equipped with the knowledge and critical thinking skills they require to deliver complex care to vulnerable people?

Legal, moral and professional obligations

One of the challenges facing nurses who encounter poor care is what to do about it, and there may be a difference between their intentions and their actions. For instance, when Mansbach et al (2013, 2014) asked nurses what they might do if they encounter unethical practice in a hypothetical situation, the overwhelming majority said they would speak out. However, when faced with a real-life problem, evidence indicates that many of those who encounter poor care make the decision not to do anything (Jackson et al 2014). While this may be understandable, for example because of fears about the potential negative repercussions of reporting poor care, the decision to ignore poor care might contravene legal and moral codes and professional guidance. In addition, failing to respond to concerns may be considered poor care in its own right, and contravenes the duty of candour (Nursing and Midwifery Council (NMC) and General Medical Council (GMC) 2015).

From a legal perspective, failing to report a criminal offence committed against a patient, or participation in criminal activity while carrying out professional duties, is likely to carry the same legal sanctions that it would in other circumstances. It may be suggested that most poor care does not meet the threshold for criminal action; however, this is not always the case. For example, legal action taken against staff who routinely abused and mistreated residents at Winterbourne View Hospital for people with learning disabilities resulted in six members of staff being imprisoned and five members of staff receiving suspended sentences (Phelvin 2014). Similarly, a recent case in Wales led to prison sentences for two nurses who admitted failing to check patient blood glucose levels and then entering false results into nursing notes (BBC 2015). Therefore, nurses must be aware of the legal frameworks within which they operate and adhere to them at all times.

Encountering and subsequently responding to poor care has an ethical dimension. Beauchamp and Childress (2012) outlined four ethical principles that should guide practice for nurses and other healthcare staff:

- Autonomy: the commitment to protecting the individual's right to self-determination.
- Beneficence: the requirement to act in a way that prioritises the needs of the patient.
- Non-maleficence: the commitment to do no harm.
- Justice: the belief in the importance of treating others fairly and equitably.

Nurses who deliver poor care, or fail to address it when they encounter it, may be in breach of one or more of these guiding principles. For example, a nurse working a night shift observes a colleague handling an older patient in a rough and hurried manner, to ensure the patient is out of bed and dressed in time for the arrival of day staff, when the patient has previously expressed a preference to remain in bed for a little longer. The nurse who behaves in this manner is overriding the patient's preference to remain in bed and thus breaching the principle of autonomy. The nurse is prioritising their own needs and those of the day staff over the needs of the person they are caring for, thus ignoring the principle of beneficence, and probably that of justice. In addition, by handling the patient in a rough

manner and undermining their stated wishes the nurse is breaching the principle of non-maleficence. A nurse who observes these actions is obliged to prevent, challenge or report this incident according to the ethical principles outlined. If they do not, they also fail to respect and protect the patient's right to autonomy and are complicit in actions that undermine the needs of a patient in their care. By not taking action to prevent or report harm, they are also failing to apply the principle of non-maleficence, and by allowing this to happen, they choose not to act in accordance with the need for fairness; thus, they are in breach of the principle of justice.

It is important to consider the place of professional and regulatory guidance in relation to poor care. The position of the NMC on reporting poor care is outlined in *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives* (NMC 2015a) and in *Raising Concerns: Guidance for Nurses and Midwives* (NMC 2015b). Similar advice is provided in the *International Council of Nurses Code of Ethics* (ICN 2012). These documents state clearly that nurses must safeguard patients and prioritise their care and safety. Failure to report poor care might be explained as a consequence of nurses' anxiety about possible repercussions or lack of knowledge. This may be understandable, however this does not make it acceptable. Nurses who encounter poor care and do not challenge it, risk breaching their commitment to meet professional standards and requirements.

TIME OUT 4

Read the NMC (2015b) guidance on raising concerns (www.nmc.org.uk/standards/guidance/raising-concerns-guidance-for-nurses-and-midwives). How would you explain the NMC's expectations to a colleague who was aware of poor care but was unsure what to do about it? What might be the consequences for your colleague if they decided to ignore the poor care?

Taking action and managing difficulties

There is a range of guidance available for nurses about the actions they should take if they encounter poor care. Guidance may be provided by trade unions and professional bodies such as UNISON or the Royal College of Nursing (RCN), regulatory bodies such as the NMC, employers in the NHS and the independent sector, academic literature, third sector organisations such as Public Concern at Work, and legal experts. This guidance might include formal policy and legal documents (for example Public Interest Disclosure Act 1998, NHS Wales 2013, Care Act 2014, NMC 2015a), training materials and factsheets (NHS Employers 2016, UNISON 2016) and telephone helplines, for example Public Concern at Work (2014). The plethora of recent information reflects a heightened awareness of the importance of supporting nurses to raise concerns about poor care. However, it also indicates how difficult it has been historically for nurses and other healthcare professionals to raise and respond to concerns about poor care.

For nurses, the workplace culture is a powerful influence on whether they raise their concerns about poor care (Jackson et al 2014). Research has shown that the act of raising concerns, often referred to as whistleblowing, may be perceived by many healthcare staff as 'grassing on' or betraying colleagues (Jones and Kelly 2014b). Such perceptions are reinforced by media coverage of bullying and intimidation of those raising concerns in the NHS (Donnelly 2016). As a result, the workplace culture in which nurses practise often overrides best-practice principles, codes of conduct and nurses' best intentions to raise concerns, regardless of whether the nurse is new to the profession or experienced (Jones and Kelly 2014b, Jones et al 2016).

Another difficulty for nurses wishing to raise concerns is that regulatory bodies such as the Care Quality Commission (CQC) and the Nursing and Midwifery Council (NMC) have not always been responsive or supportive when concerns were raised by staff. The chair of the CQC made a statement following the publication of the Francis (2013) report, which described how ‘people were badly let down by the NHS and those responsible for healthcare regulation and supervision’ (CQC 2013). This was in light of the fact that CQC inspections had not listened to concerns and not identified the failings in care in Stafford Hospital over the period during which, it is now estimated, hundreds of patients were harmed by poor standards of care. The NMC and other nursing organisations were also criticised in the Francis (2013) report; as a result, organisations that are intended to support nurses to raise concerns have introduced changes, with the aim of responding in a timely and appropriate way. For example, the NMC and the Royal College of Nursing (RCN) have introduced guidance for nurses on raising and escalating concerns and on the care of older people (RCN 2013, NMC 2015b). It remains to be seen whether these changes are effective in reducing poor care and protecting staff who raise concerns.

It should also be noted that regulatory bodies are further removed from the poor care they are trying to prevent. As the Professional Standards Authority (2015) stated in its paper on Right-Touch Regulation, regulation is a blunt instrument for promoting behaviour change and not always the ‘right answer’ in terms of preventing harm to patients. Strengthening employment practices and fostering improved professionalism in the workplace might refocus solutions closer to the problem and reinforce the responsibility of individual practitioners to prevent poor care. Therefore, high-quality care cannot be assured by regulatory bodies or inspectors alone. Indeed, they can only be the third line of defence, behind frontline professionals and the boards and senior leaders in the NHS.

As a result of this challenging context for reporting poor care, organisations such as trade unions and employers felt it was necessary to provide guidance that supports nurses who wish to report poor care. Table 2 provides a three-step overview of guidance for reporting poor care.

Table 2. Guidance for those wishing to report poor care

Step 1: Report your concern	Raise your concern directly with a more senior colleague, for example your line manager or shift supervisor. Nursing students should also contact their link lecturer and/or their practice placement mentor. You might also wish to involve a trade union or staff representative at an early stage of the process.
Step 2: Escalate your concern	If you are unable to take step 1 for any reason, or have taken step 1 but not had a satisfactory response, you should escalate your concern to a senior manager in your department or organisation. It might be worth finding a copy of your organisation’s policy for raising concerns for guidance.
Step 3: Raise your concern externally	If you are unable to undertake steps 1 or 2 for any reason, or have taken them but not had a satisfactory response, there are a variety of external organisations that offer support for employees to raise their concerns. For example, Public Concern at Work is a charity with a history of supporting people to raise concerns. In addition, trade unions and

	professional healthcare regulatory bodies or inspectorates can offer advice and support where appropriate.
(Adapted from Care Quality Commission 2014, Nursing and Midwifery Council 2015b, Royal College of Nursing 2015)	

It is clear that if nurses have concerns about poor care they should raise them. Where individuals are unsure about raising a concern, they should consider the following questions:

- What might happen if I do not raise my concern? Think about the short and long-term consequences of this.
- If asked to do so, could I justify why I chose not to raise a concern?

It is also clear organisations such as NHS trusts, universities and independent sector employers should be open and receptive to the concerns of staff and students. The Freedom to Speak Up report (Francis 2015) has made an important contribution to discussion of the ways in which universities should encourage and support students to report poor care. The review states that education and training organisations should (Francis 2015):

- Cover raising concerns in course curricula, and consider how credit for raising concerns that have contributed to patient safety can be given in student and trainee assessments.
- Make at least one officer available who is responsible for: receiving concerns from students and trainees; offering advice and support; ensuring any concerns raised are referred to an appropriate person or organisation for investigation; and monitoring the well-being of the student who has raised the concern.
- Ensure students are given protected time to reflect on their placements, including when they raise concerns, and have a support network in place to help them during challenging situations.
- Review any adverse assessment of the competence or fitness of a student or trainee who has raised a concern, to ensure this has not resulted in disadvantage or detriment to the student.

In addition, clinical placements should make available to students the same procedures for raising concerns, obtaining advice and support, and means of investigating concerns as for staff.

Whether a concern is raised by a support worker or healthcare professional, the employing organisation should support all employees to raise concerns. Public Concern at Work (2014) recommended that organisations assist their employees to raise concerns by:

- Maintaining confidentiality where requested.
- Making clear assurances to staff about protection from reprisal if they raise concerns.
- Identifying individuals in the organisation responsible for internal guidance and support, signposting to external sources of information and support, and maintaining organisational awareness about raising concerns.
- Ensuring there are mechanisms in place to review the effectiveness of arrangements for raising concerns or whistleblowing, and identifying particular concerns evidenced by patterns of reporting, with a particular emphasis on outcomes.

TIME OUT 5

Organisations such as NHS trusts or universities should clearly communicate how they support employees and students to raise concerns. For example, providing a webpage that has simple information and instructions about how to report poor care and gives the names of people to contact may be more useful than relying on a whistleblowing or raising concerns policy.

See if you can locate this information in an organisation you are involved with. Was the information easy to find and to follow? Give feedback to the organisation about the strengths and limitations of the information provided.

Conclusion

The issue of poor care and how to respond to it is one of the major challenges facing nurses in the UK, affecting all levels of the profession, from nursing students to senior executives. There is evidence that poor care is not uncommon and that it sometimes goes unreported. There may be many reasons why poor care occurs; however, the legal, moral and professional frameworks within which nurses must practise make it clear that nurses' primary responsibility is to patients, and they must do all they can to deliver optimal care. While fear of negative repercussions might explain why some nurses choose not to report poor care when they encounter it, this does not excuse their failure to act to protect the best interests of patients.

TIME OUT 6

What barriers and enablers to reporting concerns about poor care might exist in your workplace? What steps could your team take to address these barriers and facilitate enablers?

TIME OUT 7

Now that you have completed the article you might like to write a reflective account as part of your revalidation.

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* Note: On 1 June 2012, the key functions and expertise for patient safety developed by the National Patient Safety Agency (NPSA) transferred to the NHS Commissioning Board Special Health Authority (www.england.nhs.uk/patientsafety).