Advanced Critical Reflection, Risk and Decision Making

A day in the life of a NHS nurse in 21st Century Britain: An auto-ethnography

Introduction

I commence with a substantive narrative of my experience of working as a registered mental health nurse on a busy acute assessment ward in the National Health Service (NHS). Within the narrative I take you through a detailed account of one shift that I have worked and in doing so; I invite you to co- explore key moments from my practice. In my analysis which follows, I aim to illuminate the relationships between power and professional decision-making.

I explore my narrative in an attempt to improve my understanding of the social self and structural processes within the current UK context. My aim is to identify and expose the impact of these upon risk and decision making in my own practice. I aim to extend my knowledge to assist me in evaluating the range of theoretical and practical issues affecting the engagement of people accessing health care services and apply this understanding to my practice.

In evaluation and critical analysis of my narrative I ask the question: What am I learning from my narrative? What are the themes, tensions and productive moments pertinent to my practice? I begin to unpick my understanding of the social self and structural processes, identifying and exposing the impacts of these upon risk and decision making in practice.

Narrative

I am nurse on a busy acute assessment ward for older adults with dementia. I am the only qualified member of staff on duty. I come into work and I am in charge of a 14 bed ward and a team of 4 health care assistants. It should be five but one is sick. My first task is to receive handover from the night nurse. Then I organise the shift planner. Who is allocated to which patients, who is allocated to observation levels and when staff will have their breaks. I allocate the alarm response person, the infection control person and the person responsible for the fire board. I allocate myself to the monitoring of physical observations and completing assessments including updating risk assessments, care plans and completing Health Needs Assessments. I am acutely aware that there is a ward round today and a discharge planning meeting that I have to prepare for and run.

There is also a new member of staff on duty and I would ordinarily allocate time to give them an induction, which I am not able to do, so I delegate this to one of the Health Care Assistants (HCAs). My next task is to complete a safety walk of the ward where I proceed to check every area of the ward to make sure there are no hazards, no new ligature points and that the ward is clean and tidy. Next I commence the medication round. The first thing I do is to check the temperature of the clinic room and the fridge and document this. I commence the medication round while the healthcare assistants

help the patients to get washed and dressed and support them to the dining room to have breakfast. The medication round takes up to two hours to complete. I am conscious of best practice, check every chart thoroughly, right patient, right dose, right drug, right time, right route and whether a person is on covert medication and making sure that this is prepared in line with the pharmacists guidelines. In line with best practice I should take the medicine chart with me when I approach the patient and talk them through their medication. I do not do this. I do not have time. I know I am giving the right medication to the right patient for the right reasons. Most of the time the patients do not question me in relation to their medication and if they ever do then I will go through each medication with them. However, when this does happen I am conscious of time and the need to complete the medication round so that I can move onto the next task.

While undertaking the medication round I am approached six times by different healthcare assistants. One informs me that a relative has phoned and asked to speak to the nurse. I will call them back. Two ask me for patient's ointments. Another asks me to come and have a look at the wound on a patient's leg that needs redressing before she gets dressed, and I am approached a further two times with queries about covert medication. The doctor, the pharmacist, the discharge coordinator and the manager have also all approached me with queries while undertaking the medication round. I finally complete the medication round and make myself a drink and move into the room where the Multi-Disciplinary Team (MDT) are waiting for me so that Ward Round can commence. The Consultant commences and I provide an update of each patient as we progress through the review. There are five Health Needs Assessments that need completing as soon as possible, 8 Care Plans that need updating and 6 risk assessments need review. The emergency alarm is pulled and I leave the room to investigate. There has been an altercation between two patients and three members of staff are escorting a patient in arm support holds down the corridor. He is pushing them side to side. I approach and try to reassure and calm the patient. He lunges at me. He is taken to the Extra Care Area (ECA) in an isolated part of the ward. There he continues to remain agitated. I go to dispense PRN medication. When I return with this, a sandwich and a cup of tea he accepts and remains in ECA with two members of staff. I go and check on the other patient involved who is not injured but is shaken. I offer reassurance and another member of staff sits with her while I go and write the incident report.

Lunch time approaches and it is time to commence the lunch time medication round. It is a shorter round than the morning round. I also have to prepare to handover to the afternoon staff and commence the discharge planning meeting. I would allocate this to the nurse on in the afternoon but being a new agency nurse they are not familiar with the ward or the patient. I was asked by two patients if I could speak with them. I told them that a member of staff would be with them soon. I try to seek out one of the HCAs but all are currently busy. I mention it to one of them in passing.

Handover is delayed until I complete lunch time medication. I complete handover which takes longer because of the review information and the incident. I have not had a chance to look at any care plans, risk assessments or Health Needs Assessments

and I do not feel good about this. It has been discussed in the last team meeting and within supervision that we need to improve on our paperwork. Our figures are not good. We are not meeting our Key Performance Indicators (KPI's) and on paper we are the worst performing ward in the organisation. I remember that I was supposed to complete supervision with two healthcare assistants today but I have not had time and I will not have time before the end of the shift. This is not the first time supervision has been postponed and I am reminded that our figures for completing supervision very poor.

I commence the discharge planning meeting. Questions are fielded to me from the Social Worker and the family regarding the Health Needs Assessment. Reassurance is sought regarding the home that mum has been accepted into. Can they support her as she has been supported in hospital? Will they be able to meet all of her needs? The family did want mum home but it was deemed too unsafe and too risky for her to return home and the level of care that she would require at home was not realistically affordable. There was another home that the family had looked into but this too was out of their price range. Mum was ready for discharge, she no longer needed the bed in hospital and would soon be considered a delayed discharge if she did not move on soon. The meeting concluded with an understanding that the best decision had been made and a date was set for discharge.

When the meeting concluded it was time to go home. I struggled to get to sleep that night. I get up, go down stairs and cry. I did not get time to look at the care plans, risk assessments and Health Needs Assessments. I did not supervise the two HCAs. I barely spoke to the patients except where it was necessary and I had forgotten to call the relative back. I forgot to spend time with the patients who asked me for some of my time. I also realised that three patients still needed 132 rights completing and that there were four mental capacity act assessments to complete. I knew these would not be completed in the afternoon because we had temporary staff on. I would do my best to try again tomorrow. I have a sickening feeling in my stomach. What else have I forgotten to do? I ask myself what am I doing wrong and I tell myself I must be more resilient. I must do better.

Discussion and Evaluation

The first thing I am struck by from my text is the sheer enormity of what is required of me throughout the course of one shift. I had not really considered this properly, much less attempted to critically analyse it, until I wrote my narrative and had opportunity to present it in front of a group of other health professionals. I am far from alone in my experience. The Royal College of Nursing (RCN) policy report on safe and effective staffing from 2017 captures the experience of thousands of nurses across the UK, who have experienced increased demands, workload pressures and a reduction in resources. RCN research reveals there are 40,000 nurse vacancies in the NHS in England alone. Following the report the NMC published data showing there were now more nurses and midwives leaving the register than joining leading to a reduction of the number of nurses and midwives registered to work in the UK. NMC (2018)

I feel a sense of obligation and duty to carry out all of the tasks within my narrative to the best of my ability. When I look at each of these tasks individually they are all actions that I would expect to undertake. As the nurse in charge, I feel that I have an individual responsibility and a duty to undertake them. I feel that there are pressures in terms of what I should do, what I need to do and what I must do. I had done my best to prioritise during the shift but this could not prevent my inability to complete every task that needed completing. I feel like I am failing in my duties and this is reinforced by organisational and managerial approaches. In management supervision and team meetings the team is told that we are the worst performing ward on paper. We are not meeting our KPI's. We are falling below organisational expectations.

From viewing my narrative as data and evidence, I can see that my priorities are not in spending quality time with patients but in making sure I have completed all essential tasks and ticked all of the right boxes. It strikes me that the decisions being made, regarding the patient in the multi-disciplinary team (MDT), are being made with the limitations of affordability and risk aversion. In whose interests are these decisions being made? I do not think everything has been done to achieve the outcome most desired by the patient and their family. They have been constrained by a system and what it will allow both financially and in terms of risk taking.

When I am the nurse in charge, it is incumbent on me to make sure the ward runs well, the staff are fully supported, the relatives and visitors are welcomed and the patients have all their needs met to the highest possible standard. Should I fall short of this then I will face the consequences in line with workplace capability. Again, the emphasis is placed upon on me as an individual.

As a nurse, I have always held the personal belief that my primary motivation is to provide the best possible care to the patients I look after without prejudice and without judgement. I know that my history and my experiences influence who I am and how I feel, think and behave. This is why it is so important to be aware of my social self. Kinderman et al (2016) state that all decisions are vulnerable to human bias because they are based on beliefs and values. They state further that a myriad of non-rational factors are at play because humans actively use their emotions to make decisions. Even if I consider myself to have developed an advanced awareness of self, I have to acknowledge that as a human being I am still vulnerable to biases based on my beliefs, values and emotions and furthermore, that my professional consideration of self has been a highly individualised conceptualisation of self.

In reflecting on my understanding of self I came to a realisation that there are issues influencing my practice to a far greater extent than I have ever realised, and in a way that I had never considered before. The decisions that I am making are not necessarily the best decisions I could be making; even if I consider my decisions to be guided by individual good intentions and a work ethic based on my professional values and beliefs. I have come to the realisation that my decisions are based on what is expected of me, guided by a system which has been shaped by the current political landscape in the UK. My narrative; my evidence, tells a story of a system under strain and staff under immense pressure. The RCN in its 2017 policy report on safe and effective

staffing reflects the experiences of thousands of nurses from all over the UK and they are very similar to my own.

The issues outside of my authority and influence at an individual level that influence my practice and decision making are legislation, policy, protocol, guidelines and regulations. These impact significantly on my area of work. More often than not, I and my colleagues blindly accept them as unquestionable and valid But who determines what legislation and policy should be?

We currently live in an era of 'austerity' and neo-liberalism. Neo-liberalism, the current stage of globalisation, is a key ideology in spreading capitalism and market forces as globalising practices from a monetarist perspective. It focuses on individual self-sufficiency and I can relate to this with the weight of responsibility being put on me as an individual professional. It focuses on unregulated private business, regulating the private sphere of individual lives, regulating labour with reductions or workers' rights and Unions, internationalising the state, using the welfare state as a site for capital accumulation and exploiting natural and man-induced crises for profit opportunities, Klein, N. (2007). It is under this system that we have seen car manufacturing business models move into the NHS, NHS England (2018). Neo-liberalism places an emphasis on profit as things are driven by market forces and not by human wellbeing. Can this ever work well in Health and Social Care?

Contextually, The Health and Social Care Act (2012) extended market-based approaches, emphasising a diverse provider market, competition and patient choice as ways of improving health care. In its review of whether the NHS is being privatised The Kings Fund states "That there is evidence that this [The Health and Social Care Act 2012] led to a large number of contracts being awarded to private providers." (The Kings Fund 2017) However, it also stated that there was little evidence of widespread privatisation of NHS services or of any significant increase in spending on the private sector. Campbell, D. (2019) reports in the Guardian that NHS leaders want the government to scrap legislation that forces the tendering of contracts for care which could reduce privatisation of key health services. Health and Social Care professionals and professional bodies have been vocal in their opposition against the Health and Social Care Act 2012 since its inception but this fell on deaf ears. The British Medical Association opposed the act and reported on the damaging effects of the NHS reforms.

> "The Health and Social Care Act was opposed by patients, the public and NHS staff, but politicians pushed through the changes regardless. The damage done to the NHS has been profound and intense, but what is needed now is an honest and frank debate over how we can put right what has gone wrong without the need for another unnecessary and costly top-down reorganisation."
>
> (Porter, M. 2015)

If a government makes an ideological choice to enforce austerity upon citizens then what impact does this have on the health service and which groups gains from this? Austerity has consequences and this has shown itself in a reduction of resources and refined ways of working that do not serve the staff and patients. The UN report on poverty is a damning account of the negative consequences of austerity in the UK having the most negative impact on the most vulnerable. When I reflect on the MDT meeting in my narrative, the primary driving force was not what was in the patient's best interests but what could be afforded and what was most expedient. The decision made from that meeting is what the current system allowed for. It might all look good on paper with terms used including 'person-centred' and 'individualised care' and a record that choice was offered. However, I was restricted in what I could offer to the patient.

The nursing profession prides itself on the use of good knowledge and evidence. I should be making all of my decisions based on the best possible knowledge and evidence at my disposal. This must surely include knowledge of the wider ideological structural forces that impact upon the services I aim to deliver? My reality is that of blindly accepting the economic system under which I live because a) I have little time to question or understand how economics works, b) Until recently I was unaware about what neo-liberalism is and so it did not enter my mind and c) Neo-liberalism is not widely and openly discussed unless you actively try to find out more about it. In my experience, these are not issues that get discussed in the work setting. If collectively we do not show an interest in these issues outside of work then we stand little chance of understanding how they impact directly on our decision making, constructions and assessment of risk and our overall practice.

As a registered nurse, I am obligated to make sure I am continually developing professionally but what form does this development take? Is it to the advantage of the patients in our care or is it to meet unrealistic targets expected of a narrow business model? When I attend training on how we can use a car manufacturing business model in the NHS it causes me concern. Spicer, A. (2014). I work with human beings and they don't fit into the narrow scope of items, objects and machinery. I don't agree with the use of these models but they have shaped and influenced my practice even though I didn't realise it.

I have come to a realisation that I have been complicit in a current market-based system If my narrative goes to demonstrate anything, it is that I have very little time to think and reflect on my practice in any meaningful way.

> ". . . national bodies, commissioners, providers and individual clinicians are increasingly faced with tough decisions about patient care as they try to prioritise funding and balance their budgets."
>
> (The Kings Fund 2017)

I have personal power in the sense that I have a strong sense of self and I see this as a strength. I recognise that I have positional power as a registered mental health nurse. I

make decisions about people's care and this is based on my professional knowledge and the organisational and professional competencies I adhere to. What I have not really considered before is to what extent external influences impact on my decision making. Relational power is not something I have considered before and now I come to realise I have unwittingly played a part as conduit for the government of the day, via the legislation which shapes my very practice. Redman (2017) looks at bias in decision making and states that:

> "Poor decision making happens in our business, civic, and personal lives. But often we are perpetrators, participating in or making rigged decisions, even if we may not realize it."
>
> (Redman 2017)

Ways forward

I undertook a personal exploration examining my professional practice. I began as an individual practitioner with a focus upon how I managed an individual patient in relation to risk. Contrary to my personal and professional ethos of best practice and acting in the best interests of the patient, I was forced to – and am still coerced into - performing practices that are risk averse; minimising risk to the organisation i.e risk was used as a deciding factor in not sending the patient home when it was more to do with the affordability of this option.

Neo-liberalism places the importance of finance above human wellbeing and austerity limits choice in what the organisation can afford to support and what the individual can personally afford. It also places greater pressures on the system with increased poverty and ill health. This does not benefit the health service and it does not benefit the person. I have to conclude that it only serves to benefit an agenda of corporatisation via privatisation of service delivery. Professional bodies including the RCN, NMC and BMA have all highlighted concerns regarding government legislation and the impacts of this legislation on the NHS.

As a professional with access to legislative powers I act as a mediating force between the state and the individual. I find myself having made 'rigged' decisions in favour of the system despite my conscious effort to ensure I employed reflective mechanisms in order to have a good awareness of self.

Scrutinising my practice and situating it within a wider contextual backdrop has compelled me to significantly increase my level of scrutiny into the driving forces that influence my practice and lie beyond my auspices as an individual practitioner. From now on I will question the driving forces behind legislation and policy. I owe it to the patients I work with. I urge my professional bodies and training organisations to undertake the same level of scrutiny.

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I maintain confidentiality throughout this exploration. I reframe from using names of individuals, teams or organisations with the exception of the general use of the name NHS. I do not identify a specific NHS Trust.