Registered Nurses’
Attitudes of Respect
Towards Service Users

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Background

- Respect for service users is a key component of effective (Beach, Roter, Wang et al, 2006) and ethical nursing care internationally (ICN, 2012). Research into student nurses’ experiences found that role-modelling of respect in practice was variable (Chapman & Clucas, 2014). However, nurses’ experiences of respect and factors affecting their respect for service users are poorly understood.
Aims

- This study aimed to understand the nurses’ experiences of respect from their own perspective, and the factors influencing them, in order to inform policy and practice in health care settings.
Methods

- A qualitative Interpretative Phenomenological Analysis (Smith, Flowers & Larkin, 2009) approach was used to carry out and analyse semi-structured interviews (August 2014) with twelve Registered Nurses at an acute hospital Trust in the UK. Each interview was analysed in depth using a systematic approach to make sense of participants’ lifeworlds.
No time limit for examples to support attitudes

Previous experiences of management were important in current world view of participants

New and current initiatives (post-Francis) may need more time to change attitudes
Overall Findings

- Participants felt a strong obligation and motivation to be respectful.
- Respect is a core value in nursing.
- Examples of being respectful were given and all participants felt they were respectful most of the time.
- Examples of where they felt they had not respected service users were distressing to them.
Findings

Themes identified include:
• Stressors of the role and workplace
• The disrespectful / discredited person
• Benign compassion versus respect for autonomy
Stressors of the Role and Workplace

- Staffing Levels
- Moved to different speciality
- Scrutiny and feedback
- Demanding areas (elderly, orthopaedics)
- Physical, e.g., temperature
- “Conveyor belt” care and documentation
- Insufficient / inadequate direct contact?
Stressors (1)

- On relatives receiving bad news: “...pure frustration, they can get quite verbally hostile towards you.. ‘cause this is their mum ... their dad ... why aren’t they getting better?”

- “I’d been qualified about six months ... a gentleman ... died ... I cried all the way around the ward round ... the Consultant ... never asked me ... I had to go off and go and cry and then come back”
Stressors (2)

- **High expectations**: “I should have ... been pleasant ... tried my best ... I don’t think I did”
- **Difficult workplaces**: “people said to me: ‘don’t go ... and work in that particular ... speciality ... you’ll be killing yourself’ ... no-one else to put the blame on”
- **Staffing levels**: “profoundly affect nursing”; “you can’t do all the things you’re supposed to do” – could not take breaks, or would make ward unsafe. When numbers were increased, support staff went on sick leave
Stressors (3)

- Participant found it difficult to manage a young male patient who was shouting at her but pleasant when security guards or Consultant attended: “the sad thing was, I was left in a situation and nobody helped me ... my colleagues ... were all relieved that they weren’t looking after him”

- Patient transferred from theatre to different ward – not informed, relatives unhappy
Positives

- One participant identified that s/he was well-supported in caring for dementia patients
- They had signs saying that they would not tolerate verbal abuse (felt supported)
- Two participants felt colleagues in the Trust were supportive and respectful towards patients
- One participant identified that the ward reviewed all complaints, did their best to address them and were committed to good patient care
- Most participants felt that they could be respectful towards most patients most of the time, therefore, much of this research is about the exceptions, in their view
The disrespectful / discredited person

- More care “demanded” than perceived need
- Not respectful towards nurse (“aggressive”)
- Develop “rapport” over time - people expect focus
- Could this affect health outcomes?
“difficult patients”

- People with learning disabilities: “you get people who are really anxious and they might have a carer there, and you might want to sedate them, but they don’t want to be sedated, to calm them down, and then they might now want the operation... you’ve got like twelve patients, and one of them is... kicking off because they don’t want to go to theatre, I think that is difficult to deal with”

- “often the young ones” show a lack of respect for other patients, demanding care that they don’t need

- “I was thinking ... ‘you can do that’ ... and I was quite cool”

- “I think it’s hard if you’ve got anybody that’s rude”

- Rang the bell “potentially every ten minutes, every five minutes”
Benign compassion versus respect for autonomy

- Relationship between function, diagnosis and care need
- Emotional reward and sense of control increased by dependence of service user
- Increased autonomy leads to increased expectations (difficult to reconcile with vulnerability)
Decisions on autonomy

- “They don’t know what a bed rail is...they have to get over [it] to get to the toilet... and [the relative] say[s] ‘why didn’t you put the bed rails down... why wasn’t someone in there’ – person not deemed “at risk” until after fall “Before that you know, she just lay there and she was lovely”

- “Most of the time ... I come in the morning..’Oh, we missed you, we love you .. How are you?... You been OK?’ ... [they] love me” – identifies the reward of feeling needed and loved

- Lots of patients needing care, want to nurture them, and caring “reenergises you” but want to nurture patients who genuinely need youolhgf
It’s what you do next that counts
Future Research

- Quantitative research with representative sample across a number of Trusts
- Action research to work with organisations to promote change
- Explore underlying psychological processes related to feelings towards service users and relatives
Instrumental Support

- Long-term consistency in staffing levels
- Rotation to maintain skills / knowledge (or don’t move)
- Holistic nature of nursing – skills mix?
- Care of relatives as well as patients – time and privacy
Emotional Support

- Instil self-esteem for managing people’s expressed distress
- Value nurses and nursing – including other professions
- Counselling
- Clinical supervision
Nurse Education

- Introduce, explore and develop clinical supervision skills and knowledge in pre-registration nursing
- Collaborate to build capacity and capability in clinical supervision and team supervision
- Undertake clinical supervision within own roles
Key Trust Initiatives

- Investment in nurse staffing levels and specialist nurses (dementia / Parkinson’s)
- Ward manager staff supervision / clinical leader role
- Supporting people with challenging behaviour training
- Preceptorship - focus on leadership and communication
- Schwartz rounds – compassionate care
- Anonymous RN feedback to improve management support
- 4 days’ study leave built into staffing
- Band 1 “care and comfort” roles – 1:1 support
Trust Response

- Continue current initiatives
- Develop stronger communication and support
- Work with education to strengthen culture of clinical supervision from student nurses onwards
- Develop further research
References


