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Emotions at work: what is the link to patient and staff safety? Implications for nurse managers in the NHS

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Aims This paper sets the discussion of emotions at work within the modern NHS and the current prioritisation of creating a safety culture within the service.
Background The paper focuses on the work of students, frontline nurses and their managers drawing on recent studies of patient safety in the curriculum, and governance and incentives in the care of patients with complex long term conditions.
Methods The primary research featured in the paper combined a case study design with focus groups, interviews and observation.
Results In the patient safety research the importance of physical and emotional safety emerged as a key finding both for users and professionals. In the governance and incentives research, risk emerged as a key concern for managers, frontline workers and users.
Conclusion The recognition of emotions and the importance of emotional labour at an individual and organizational level managed by emotionally intelligent leaders played an important role in promoting worker and patient safety and reducing workplace risk.
Implications for nurse managers Nurse managers need to be aware of the emotional complexities of their organizations in order to set up systems to support the emotional wellbeing of professionals and users which in turn ensures safety and reduces risk.

Keywords: emotions, leaders, organizations, professionals and users, risk, safety, work

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Introduction

This paper situates the discussion of emotions at work in the current context of creating a safety culture within the National Health Service (NHS) by drawing on two recent case studies: the first on patient safety in the educational curricula of health care professionals (Pearson *et al.* 2008) and the second on governance and incentives in the management of chronic long term conditions (Ross *et al.* 2008). Both case studies employed focus groups, interviews and observations to generate findings. The role of emotions at an individual and organizational level and the importance of leadership are examined to argue that patient and worker safety are linked through emotions at work. The capacity of leaders to listen and learn facilitates the recognition and effective management of emotions and is germane to the development of a culture that

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promotes patient and worker safety, the reduction of risk and in turn quality of care.

The current context

Patient safety is currently high on the United Kingdom (UK) healthcare agenda and has also become an international healthcare priority in the US and elsewhere both in terms of policy initiatives and the developing field of patient safety research (Battles & Lilford 2003). In the UK there have been a number of influential policy initiatives relating to patient safety starting with the report **An organization with a memory** produced by an expert group, on learning from adverse events in the NHS (DoH 2000). The group's task was to advise how the NHS could learn from its experiences, so that risk of avoidable harm to patients could be minimized. The background to the report lay with the fact that NHS reporting and information systems provided a patchy picture of the scale and nature of serious failures in health care. The available data showed that around 400 people died or were seriously injured in adverse events involving medical devices and it was estimated that adverse events which caused harm to patients in NHS Hospitals occurred in 10% of admissions – a rate of approximately 850 000 each year. The significance of the **Organization with a memory** report was that for the first time there was a policy initiative that emphasized organizational learning within the NHS from 'adverse incidents' and 'near misses'. The report's emphasis was to promote a shift from a 'blame' culture to one that promoted learning and a mandatory national reporting system to support this. In addition, a number of steps were described that were seen as crucial components to patient safety such as national targets to reduce serious recurring adverse events and key questions for the patient safety research agenda. One of the themes – 'Learning lessons and disseminating them' asked that research uncover techniques to embed those lessons in practice and identify ways to achieve effective learning to improve patient safety and reduce risk.

The National Patient Safety Agency (NPSA) was established in 2001, following the publication of another policy document **Building a Safer NHS for Patients** (Department of Health 2001) and raised the profile of patient safety issues in the clinical environment. The Agency's role was to co-ordinate and implement government policy by reporting errors across the UK in order to learn from mistakes that affect patient safety. The NPSA's guide to good practice is encapsulated in the checklist **seven steps to patient safety** (NPSA 2003) as outlined below:

- building a safety culture;
- leading and supporting staff;
- integrating risk management activities;
- promote reporting;
- involvement and communication with patients;
- learning and sharing safety lessons;
- implementing solutions to prevent harm.

The items contained in the checklist are interesting in that they highlight the importance of interpersonal skills, teamwork, leadership which are of particular importance to promote an open learning culture and counter a tendency to scapegoat and blame individuals for mistakes and errors. The 'Incident Decision Tree' was introduced by the NPSA to encourage managers to move away from an individual to a systems analysis of adverse incidents and near misses in the NHS (http://www.npsa.nhs.uk/idt). The Incident Decision Tree bears similarities to measures employed within the aviation industry to analyse near misses and warns against 'an automatic decision to blame and suspend staff'.

Staff and patient safety and emotions at work

In 2002 accidents to NHS staff increased by 26 000 causing workforce shortage and a financial cost to the service of £170 m ($306 m) per year which indicated a rise of 24% with associated increase in workload and harm to patient services (PAC 2003). The main causes of accidents were related to equipment, stress and falls. Injuries and infections caused by needles were also highlighted (PAC 2003).

A survey undertaken for the Commission for Health Improvement (CHI 2003) during the same period (2003) revealed paradoxical results. The sample included 200 000 staff from all occupational groups, in 572 NHS Trusts and 21 Strategic Health Authorities and yielded a 56% response rate. Nearly a quarter reported injury or illness during the previous year with another 39% indicating they had experienced work related stress. In the month prior to the survey just under half reported they had seen one error that could have hurt either staff or patients. The survey hit the headlines of the national newspapers describing the results as the NHS paradox in which staff reported mixed emotions of feeling pilloried, hard worked, stressed and abused on the one hand but proud and satisfied on the other. These findings clearly demonstrated 'connections between how staff are managed, how they feel about their work and the outcomes for patients' (Cornwell 2004). The latest survey results were

not encouraging with only 26% of staff perceiving that their employing NHS trusts valued their work and a mere 22% reporting effective communication with senior management. More encouragingly 71% said that their individual managers encouraged team working (HCC 2008). If used as indicators of patient safety, these findings give a mixed picture in terms of the cultural conditions required to promote safety and reduce risk.

More recently a compassion index the first of several initiatives proposed in Lord Darzi's NHS Review **High Quality Care for All** (Department of Health 2008) will score how compassionate nurses are towards patients. Components of compassion include indicator smiles and by inference the emotional labour defined by Hochschild (1983) as 'the induction or suppression of emotions to make others feel safe and cared for' required to give empathetic care (Smith 2008). The compassion index also includes measures of good nutrition, hand washing and safety as key indicators of quality care.

The complex relationship between staff and patient safety (as characterized by experiences of bullying and violence), emotions at work associated with job satisfaction, stress and burnout and the impact on quality is highlighted by quantitative and qualitative studies spanning two decades in both the UK and US (Woodrow & Guest 2008) suggesting the importance of the field for further research.

Education for patient safety

The contribution of education to the promotion of a safer working environment was apparent in the 2001 publication **Building a Safer NHS for Patients** and the important role of education and training for medication safety was emphasized as a response to a series of serious medication errors that had occurred. It was also noted that education and training would be limited if a positive learning environment and a culture to support staff to promote patient safety were absent.

In this vein, the NHS Confederation's report – **Creating the virtuous circle: patient safety, accountability and an open and fair culture** (NHS Confederation 2003) advised educators to promote an open culture to error and the inclusion of patient safety in qualification courses at every level. Educators were also encouraged to promote and teach the skills that are crucial to patient safety: interaction, leadership, teamwork and communication.

To date however, there has been limited evidence to show that healthcare educators have incorporated patient safety themes into professional programmes. It is important therefore to investigate how current educational programmes incorporate themes of patient safety in order to provide an evidence-base that can be used to develop guidelines and recommendations for best educational practice both within the formal curriculum and in the clinical setting. A study of patient safety in health care professional education was recently completed by Pearson *et al.* (2008) to address this lacuna and is referred to below.

A study which Smith conducted in the 1980s when student nurses worked as apprentices and gave 75% of the frontline care (Moores & Moult 1979) demonstrated the importance of emotional labour and the conditions under which it took place producing in others an emotional state e.g. gratitude or fear and allowing the employer to supervise the emotional activities of the worker through training and supervision.

Because the students worked as apprentices they were required to be under the close supervision and control of ward sisters. This close supervision and control was essential in a work force that was in training. Furthermore, a large measure of emotional labour was required to sustain and manage the students (Smith 1992). During the 1980s the Project 2000 nursing curriculum that was college based and gave students supernumerary status was piloted. During the 1990s, the new curriculum was introduced nationally, withdrawing students from the frontline and replacing them by health care assistants. The literature was replete with research studies of student nurse training and the important role of the ward sister in promoting the caring ward (Pembrey 1980, Smith 1992). It was the ward sister who was found to be the one who created the conditions that permitted the production and reproduction of the emotional labour process. Smith's research (1992) confirmed and extended previous studies by identifying the ward sister as the key person in setting the emotional tone of the ward. An emotionally caring climate made the student feel cared for and thus better able to care for others.

One student explained that:

> 'When I know that the ward sister cares then I feel a bit more at ease. Otherwise I feel that I have to take the whole caring attitude of the whole ward on my shoulders' (Smith 1992).

The connection between the ward sister's ability to create good social relations among nursing staff and team working was a critical component of the ward atmosphere and the effects they had on the 'way they feel, their morale'.

The hierarchical ward sister also created feeling rules, which as one student concluded, resulted in 'fear (which) isn't a good way to learn'.

Although Smith's study did not directly address issues of patient safety the findings have implications for the promotion of a safety culture as discussed above. They emphasized the importance of leadership, team working, communication between all levels of staff and the promotion of an open culture that encourages listening and supports learning.

Examining patient safety at the frontline of learning and caring: illustrative case studies

We now draw on selected findings of the two case studies in which we were recently involved to examine patient safety at the frontline, one specifically designed to address learning (Pearson *et al.* 2008) and the other to investigate professionals' experience of governance and incentives in the care of patients with complex long term conditions (Ross *et al.* 2008). This second study revealed that safety and risk were key themes expressed by staff facing huge changes in the way care was delivered to these patients. In the current data extracts we have again referred to emotional labour (Hochschild 1983) as a means of analysing the range of emotions apparent within individuals and organizations and in particular the effects of organizational arrangements on learning about safety and feelings of risk against a background of change and uncertainty.

Pearson *et al.* (2008) found that nurse educators viewed the promotion of safe practice as primarily a nursing responsibility and that education about safety should be embedded throughout the nursing curriculum:

As one nursing lecturer said:

> 'practically everything that we do and teach our students is with regards to patient safety … drugs, drug calculations, drug administration, moving and handling, all the practical skills they have to do, it's all related to patient safety'.

Others suggested that it was the attitudes and behaviours of students and professionals that needed to be brought to the forefront in order to improve safety by learning to be 'mindful' in practice:

> 'to think about how you're doing what you are doing … If you are not mindful of what you are doing that's when error happens'.

A third year student had a similar view of patient safety describing it as 'the prevention of harm, risk management, identification of risks, building trust with public and patients (and) protection of patient wellbeing in physical, social and emotional terms'.

Users interviewed in the same study had strong opinions about the emotional aspect of patient safety stressing how feeling safe was crucial 'right at the start … when you come into hospital it's a frightening experience'.

Another user was of the view that 'patient safety is about perceptions … and an absolute assurance that your decisions will not be countermanded … that your wishes will be respected at all times and in all ways … and the feeling that you are going to be treated as an individual with the right to decide for yourself'.

They clearly linked patient safety and the role of the manager and their influence on ward routines to make patients feel safe:

> 'It comes from the top and the culture within a ward and that sort of personal care on admission, to ensure that people are secure'.

And:

> 'It's learning to see the patient as not just another medical problem, but as an individual and trying to fulfill their individual needs …'

For a newly qualified staff nurse patient safety was described as 'quite integral to things out in practice … I don't think you can separate it from doing the rest of your job, it's just part of it'. Some environments were said to be more positive for promoting patient safety than others. For some newly qualified staff the community was perceived to be 'proper holistic care' of which patient safety was a key component and integral to the dual notions of quality nursing care and the caring nurse. As one staff nurse observed:

> 'If you come across a caring nurse they are more than willing to promote patient safety'

And another:

> 'It's a joint relationship with the patients. They need to be able to trust you'.

Mental health practitioners linked patient and staff safety to risk assessment. One staff nurse recalled at a job interview she had been asked what she was expected to know and what she needed to know to do her job. She said: 'one of the big ones that comes up every time is risk assessment and managing risk, and that includes your own safety as well…'

Another respondent referred to the importance of **risk assessment** commenting that 'every time you see

someone you are assessing risk' as in the example of assessing whether patients were safe to take their own medication and manage at home.

In Ross *et al.*'s (2008) study of governance and incentives in the care of people with long term conditions, keeping individuals safe and free from harm was seen as a fundamental responsibility for community health and social care practitioners and underpinned much of their work. Safety was identified as an important factor particularly in mental health where in addition to risks of deteriorating illness, a patient might not only be perceived to be a risk themselves but also the society at large.

The environment in which people found themselves was described as an essential factor in relation to their safety. Frail older people, for example, were considered to be at risk especially when they were living at home 'unsupervised':

> As one practitioner commented: 'one of the things that has got worse in the last two years is access to Social Services, so again, if you are talking about this highly-ill co-morbid group at home, then this last year across the country, most local authorities have restricted even more access to home helps and … so I think that is likely to have a serious impact on people's health and people's ability to look after themselves…'

Different professionals were observed to have different perceptions of risk from being 'risk averse' to more or less comfortable with managing risk. As one community matron saw it:

> 'Many of the other disciplines are quite risk-adverse and say ''Oh no, you know, they can't do this, they can't do that'' and we know that some discharges will fail, but if you mitigate the risk as much as you can patients deserve a chance. That's what I mean the number of times we have ''I really want to go home, I really want to go home, I really want to go home.'' And we're all like ''Huh, she's going to be a disaster.'' But you've got to let them, they're not cognitively impaired, they can make their own decisions'.

It seems this community matron was prepared to support her patients to take risks with uncertain outcomes compared with 'risk averse' colleagues in other disciplines who in her view were unwilling to do so. This respondent was prepared to think flexibly and from her patients' point of view rather than constraining their chances like her colleagues who she saw as over cautious. In particular, caring for people at home was considered to carry risks for both practitioners and service users, which practitioners needed to assess, especially in relation to the advanced skills and new procedures which **Care in the Community** demanded of them to put resources and support in place to minimize risk. The community matron made the assumption that fulfilling the Primary Care Trust (PCT) requirement to undertake training 'modules' to ensure competency and confidence implicitly minimised risk:

> '… thinking about clinical governance, quality of care is really … I suppose the PCT naturally sending us to do the four modules which are compulsory for the role actually ensures then that we are properly trained, we are actually competent in what we are doing and that we have got the confidence to actually go out and use the knowledge and skills that we acquire from the course'.

The data from these illustrative case studies show that learning and working at the frontline are associated with a range of emotions and that care and safety are intimately related. Feeling safe involves both physical and emotional dimensions and formal education and supportive leadership to ensure confident practitioners able to give quality care and both assess and take risks. In other words the caring nurse is a safe nurse. In the next section I examine both the literature and data from the illustrative case studies to demonstrate further the link between emotions at work and their role in the development of sound systems to ensure and promote safety and reduce risk.

Emotions at work and systems to promote a safety culture and reduce risk

In the environments described in both literature and case studies, patients and service users require complex levels of care and as Taylor (2006) argues the emotional toil of caring for people in sickness and as they die is rarely referred to in policy even though stress is inevitable when working with sick patients and their relatives. Thus staff experience a range of emotions in their daily work over and above the uncertainty associated with policy changes. Raffaeli and Worline (2001) identify 'emotions as the central tenet in the future of organizations (p. 12) and their recognition and use have been shown to be integral to the development of emotional intelligence required by individuals and organizations to solve problems, facilitate learning and manage change (Goleman 1995). Huy (1999) suggests that emotional labour is a prerequisite of emotional intelligence and that its attribute hope 'implies a belief

that one has both the will and the means to accomplish one's goals. It buffers people against apathy and depression and strengthens their capacity to withstand defeat and persist in adversity'.

Organizations require systems to be in place to enable the recognition and effective use of emotions indicated by feelings of high morale and demonstrated by Revans (1964) over 30 years ago. This classic study revealed how organizations with high morale had effective communication systems, ward sisters who spoke often with junior nurses, a stable workforce and rapid patient recovery, demonstrating a clear association between an infrastructure for care and positive staff and patient outcomes. The caring organization therefore, is one that engenders high morale which in turn sustains and supports the delivery of frontline care. Revans' findings provide an important benchmark as to how high morale in organizations can have a specific impact on staff (low sickness and absenteeism; high recruitment and retention) and patients (shorter hospital stays). More recently similar outcomes have been reported in relation to favourable staffing levels and positive effects on staff and patients (Shields & Ward 2001, Finlayson *et al.* 2002).

Evidence can be found concerning the nature of stress in nursing (Deary *et al.* 2003, McVicar 2003) as well as media reports about growing patient dissatisfaction with care from nurses (Magnet 2003). It is interesting to note that patients and staff report dissatisfaction with similar aspects of the health and social care environment such as not being listened to, respected or supported (Edwards & Burnard 2003). There is further evidence provided by Gazoni *et al.* (2008) that demonstrates the need for systems to support staff in particularly stressful specialties such as anaesthesiology where the physician (and by inference nurse specialists) have to deal with the emotional impact of catastrophic events resulting in patient death. These authors identified evidence-based strategies including training programmes and open communication among colleagues, patients and their families to address profound emotions such as grief and guilt.

The nursing workforce and approaches to delivery of care have clearly changed since the 1980s when Smith undertook her study described above (Smith 1992). One major change is the shift from the closed systems of control by ward sisters over cohorts of student nurses to one of specialist nurses, unqualified healthcare assistants and international recruits with their different training regimes and expectations (Allan & Larsen 2003, Allan *et al.* 2008). The organizational changes which have taken senior clinical nurses away from hands on care need to be addressed with regard to their impact on a range of clinical issues, including patient and worker safety.

Local response to national agendas results in rapid change which may become the rule rather than the exception in complex community initiatives (Connell *et al.* 1995). Change has been shown to generate a range of emotions and profoundly affects whole organizations over and above the demands of the 'day job' particularly during transition (Slater 1998, Welch & Byrne 2002). The emotional effects of change are often overlooked even though judicious attention to emotions has been shown to facilitate organizational learning as part of the change process (Huy 1999). Leaders need to be aware of these processes and to be able to exercise the authority to create the systems that can then be employed to recognize and manage the emotions generated as a consequence of change at all levels and cultural contexts of an organization. Emotions are thus an integral part of adaptation and change and emotionally intelligent individuals are able to recognize and use their own and others' emotional states to solve problems.

A King's Fund research report **The Last Straw: explaining The NHS Nursing Shortage** encapsulates the contextual problem:

> 'Throughout the research a number of points were made about the organisational contexts within which nurses worked. Much dissatisfaction was attributed to organisations not being very good at listening to their staff and taking heed of what they said' (Meadows *et al.* 2000)

With regard to developing a safety culture, organizations that do not listen to their staff and by implication do not value them are not the type of organizations to promote an open culture, report and manage adverse incidents sensitively nor respond to a range of emotions (such as fear, anxiety, anger, apathy, helplessness) generated by such incidents.

Clinical supervision has been identified as a key element in helping staff to contain their anxieties as well as allowing them opportunities to think differently and to use their emotions to understand difficult situations they encounter with patients (Butterworth *et al.* 2008). Containment is a useful way of thinking about managing emotions which naturally arise when caring for individuals (no matter what their diagnosis) and against a backdrop of individual and organizational uncertainty. Containment or 'holding' in the psychoanalytic sense was used by Fabricius (1991) to describe the way in which nurses take over functions which the sick

person cannot perform temporarily until such time as s/he can perform them again in a way that is safe and does not create dependency. Supervision may provide a sense of containment by attending to the emotions evoked through practice and organizational change which Obholzer and Zagier Roberts (1994) argue are therapeutic and facilitative to good working practices and teamwork.

In Pearson *et al.*'s (2008) study there was a recognition that reporting systems and a 'no blame culture' needed to be in place which encouraged and supported 'learning from mistakes'. As one staff nurse noted 'on our ward we're quite open … if there's an incident we'll all sit down together immediately and discuss it.'

In relation to their placement assessments students recognized that their relationship with their mentor was crucial to promoting their learning about patient safety. A key variable was the amount of time they were able to spend with their mentor but also how willing the mentor was to teach them and to be open to questioning. This relationship also affected how confident and comfortable they felt to challenge unsafe practice in any member of staff.

One third year student explained how she would not do anything unsafe for a patient but still found it difficult to question the ward sister about 'bad' practice on the ward:

> 'I would never do something if I knew it would be unsafe for me or the person I was doing it on, but I still don't think I would be able to question the sister on the ward… I just don't think I could'.

The students were also aware that the mentors assessed their practice and whether they passed or failed their placement was in their hands. Students also reported that in a busy pressurized environment they felt guilty that they took the staff away from patient care.

On a more positive note a staff nurse recognized that the students 'learnt a lot by example … they pick up their ways from different staff nurses … they see ways that are safe and then they see for themselves things that they think ''I'm not sure about that''".

One staff nurse discussed the impact of low staffing levels on student nurses who she said were very aware 'when there aren't enough staff around … They get a feel for whether they are in a safe environment or they can feel a little bit vulnerable'.

A key factor in moving patient safety forward therefore was how much authority and leadership the senior staff had at ward or department level both in terms of student learning and to challenge unsafe practice. One director of nursing summed this up thus:

> '…the senior people in the clinical environment…that's the consultant, it's the ward sister, it's the matron, it's the senior physio – whoever it happens to be, but it's about them having ownership and leadership… authority to address some of the issues'.

Another important factor raised by the staff nurse above is the importance of staffing levels on ensuring a safe environment. There is now a growing body of evidence to support her view not only in relation to the quality of the nursing skill mix but also higher staffing levels and their positive impact on patient outcomes such as shorter hospital stays, reduction in post-operative complications and failure to rescue from catastrophic events (Needleman *et al.* 2002, Estabrooks *et al.* 2005).

Conclusion

There is now substantive evidence to suggest patient and worker safety are linked through emotions at work. Emotions may be either positive or negative and may affect the organizational culture, which in turn threatens or promotes safety and the reduction of risk at work with quite profound clinical outcomes for patients and emotional costs for staff. Key to the management of emotion is effective leadership, team working and the management of change against a backdrop of adequate staffing levels, clinical supervision and educational support to assist student nurses, eliminate victim blaming and increase feelings of competence, wellbeing and job satisfaction among all staff. The capacity of an organization and its leaders to listen and learn facilitates the recognition and effective management of emotions and is germane to the development of a culture that provides leadership for learning and promotes high standards of patient and worker safety and reduction of risk The nature of the NHS workforce is changing and responsive systems need to be developed to ensure these standards are attained and sustained by emotionally intelligent leaders to ensure the delivery of quality care that is competent, compassionate and safe.

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