
# UNIVERSIDAD DE MURCIA

ESCUELA INTERNACIONAL DE DOCTORADO

## Ethical and Legal Accountability in Nursing Clinical Practice: Analysis of Protocols and Clinical Activity in an English Emergency Department

## La Responsabilidad Ético-Legal en la Práctica Clínica Enfermera: Análisis de los Protocolos y la Actividad Clínica en un Departamento de Urgencias Inglés

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# Ethical and legal accountability in nursing clinical practice: analysis of protocols and clinical activity in an English emergency department

# La responsabilidad ético-legal en la práctica clínica enfermera: análisis de los protocolos y la actividad clínica en un departamento de Urgencias inglés

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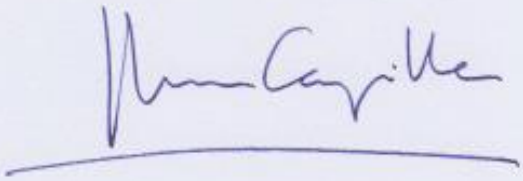
D. Diego José García Capilla, Profesor Asociado de Universidad, del Área de Filosofía Moral y Política en el Departamento de Filosofía, AUTORIZA:

La presentación de la Tesis Doctoral titulada "La responsabilidad ético-legal en la práctica clínica enfermera: análisis de los protocolos y la actividad clínica en un departamento de Urgencias inglés", realizada por D. Alfonso Rubio Navarro, bajo mi inmediata dirección y supervisión, y que presenta para la obtención del grado de Doctor por la Universidad de Murcia.

En Murcia, a 20 de Abril de 2018



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UNIVERSIDAD DE
**MURCIA**

Dña. María José Torralba Madrid, Profesora titular de Universidad del Área de Enfermería en el Departamento de Enfermería, AUTORIZA:

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En Murcia, a 16 de abril de 2018

Mª José Torralba Madrid

**Mod:T-20**

“A profession without its own distinctive moral convictions has nothing to profess and will be left vulnerable to the corrupting influences of whatever forces are most powerful.

[…]

Professionals without an ethic are merely technicians, who know how to perform work, but who have no capacity to say why their work has any larger meaning”.

Larry R. Churchill.

Dedication

A mi madre y mis hermanas.

Y sobre todo a Eugenia,

ya que sin su cariño y apoyo

habría perdido la cordura a mitad de camino

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## Glossary of acronyms and abbreviations

| | |
|---|---|
| ACB | Acute Care Bay |
| AFU | Acute Frailty Unit |
| AMA | American Medical Association |
| AMC | Acute Medical Clinic |
| AMU | Acute Medical Unit |
| ANA | American Nurses Association |
| ANP | Advance nurse practitioner |
| BMA | British Medical Association |
| BMJ | British Medical Journal |
| CAU | Children Assessment Unit |
| CBU | Clinical Business Unit |
| CCG | Clinical Commissioning Group |
| CDU | Clinical Decisions Unit |
| CEC | Clinical Ethics Committee |
| CHRE | Council for Healthcare Regulatory Excellence |
| CHSC | Commons Health Select Committee |
| CliPEAT | Clinical Policy Ethics Assessment Tool |
| COHSE | Confederation of Health Service Employees |
| CQC | Care Quality Commission |
| CSU | Commissioning Support Unit |
| DH | Department of Health |
| DNAR | Do not attempt Resuscitation |
| DPS | Dynamic priority score |
| ECA | Ethnographic content analysis |
| ED | Emergency department |
| EDU | Emergency Decisions Unit |
| EEA | European Economic Area |
| ENP | Emergency nurse practitioner |
| EPIC | Emergency practitioner in charge |
| GDC | General Dental Council |
| GGH | Glenfield General Hospital |
| GMC | General Medical Council |
| GOC | General Optical Council |
| GP | General Practitioner |
| GPD | Gross domestic product |
| GPhC | General Pharmaceutical Council |
| HC | Health Committee |
| HCA | Healthcare assistant |
| HCPC | Health and Care Professions Council |
| HRA | Health Research Authority |
| ICN | International Council of Nurses |
| IE | Interviewee |
| IELTS | International English Language Testing System |
| IR | Interviewer |

| | |
|---|---|
| ITU | Intensive Therapy Unit |
| LCAT | Leicester Clinical Assessment Tool |
| LGH | Leicester General Hospital |
| LRI | Leicester Royal Infirmary |
| MHRA | Medicines and Healthcare products Regulatory Agency |
| N/A | Not applicable |
| NALGO | National and Local Government Officers Association |
| NHS CB | NHS Commissioning Board |
| NHS | National Health Service |
| NIC | Nurse in charge |
| NICE | National Institute for Health and Care Excellence |
| NMC PIN | Nursing and Midwifery Council Personal Identification Number |
| NMC | Nursing and Midwifery Council |
| NQB | National Quality Board |
| NUPE | National Union of Public Employees |
| ODP | Operating department practitioner |
| P1 – P34 | Participant 1 – 34 |
| PCC | Primary care coordinator |
| PCT | Primary care trust |
| PGD | Patient group directions |
| PIS | Participant information sheet |
| PROMs | Patient Reported Outcome Measures |
| PSA | Professional Standards Authority |
| PTS | Patient Transport Service |
| QALY | Quality-adjusted life years |
| QCA | Qualitative content analysis |
| QMC | Queens Medical Centre |
| RAE | *Real Academia de la Lengua Española* |
| RAU | Rapid Assessment Unit |
| RCEM | Royal College of Emergency Medicine |
| RCN | Royal College of Nursing |
| REC | Research Ethics Committee |
| RePEAT | Roberts Research Protocol Ethics Assessment Tool |
| SAU | Surgical Assessment Unit |
| SBAR | Situation, background, assessment, recommendation |
| SCPHN | Specialist Community Public Health Nursing |
| SOP | Standard operating procedure |
| TDA | Trust Development Authority |
| UCC | Urgent Care Centre |
| UHL | University Hospitals of Leicester |
| UK | United Kingdom |
| UKCC | United Kingdom Central Council of Nursing, Midwifery and Health Visiting |
| UKCEN | United Kingdom Clinical Ethics Network |
| WHO | World Health Organization |

**Resumen**

Introducción:

La relación entre Ética y Derecho en la responsabilidad derivada de la práctica clínica enfermera puede parecer obvia, pero la evidencia en el área específica del cuidado urgente es muy limitada. En Inglaterra, los departamentos de Urgencias sufre una etapa de aumento de la presión asistencial crónico que relaja los límites de la responsabilidad a los que está sometido el enfermero, quien debe lidiar con la subjetividad de la presunción de emergencia y la rigidez del NMC. Debido a esto, los factores que afectan al proceso de toma de decisiones son decisivos para mejorar la calidad del cuidado y entender que influencia a los enfermeros a trabajar de una manera o de otra.

Los departamentos de Urgencias ingleses presentan varios problemas: no se cumplen los objetivos establecidos por el gobierno, el porcentaje de personal permanente está bajando y la satisfacción del público no es lo suficientemente alta. Se han explorado varias soluciones que han funcionado de manera parcial, pero en la actualidad estos problemas siguen formando parte de la rutina diaria de los departamentos de Urgencias ingleses.

La mayoría de las reformas propuestas y/o aplicadas son de índole administrativo o institucional, por lo que no se hacen reformas dirigidas específicamente a la evolución de la práctica enfermera en los departamentos de Urgencias. El *Nursing and Midwifery Council* solo ha implementado mecanismos para la detección de la mala praxis, dejando el estímulo de la buena praxis en un segundo plano.

El análisis de los problemas ético-legales en la práctica enfermera ha ayudado a mejorar dicha práctica en varios países, por lo que su aplicación en un área tan delicada como la atención emergente es necesaria. En el caso de la práctica enfermera inglesa, dicha área sufre vacíos legales, como la subjetividad de la presunción de emergencia y contradicciones deontológicas en el *NMC Code*. Sin embargo, el estudio de esta área de conocimiento en Inglaterra es muy limitado, evitando que se puedan apoyar en la evidencia científica en busca de soluciones.

Tras la búsqueda bibliográfica, se ha descubierto que el estado de la cuestión de la responsabilidad ética y legal en la práctica enfermera anglosajona en general posee bibliografía consolidada por autores como Griffith y Tengham o Dimond en el campo legislativo y Johnstone o Thompson et al. en el campo ético. Sin embargo, en estos documentos sólo se trata de manera superficial las particularidades de la responsabilidad ético-legal enfermera en departamentos de Urgencias.

Respecto a artículos recientes, solo unos pocos pueden ser relacionados parcialmente con la pregunta de investigación. Mientras que Langeland y Sørlie puntualizan la existencia de vulnerabilidad frente a los dilemas éticos presentados en un departamento de Urgencias en Noruega, Ebben et al. indican los factores que intervienen en el seguimiento de un protocolo nacional en los Países Bajos. Estos estudios identifican problemas éticos y legales en departamentos de Urgencias. Sin embargo, no conectan los conceptos entre sí, no tratan la responsabilidad del profesional como conector ético-legal y proceden de otros países con diferentes legislaciones, protocolos y corrientes éticas.

Teniendo solo en cuenta los estudios basados en Reino Unido, la lista se acota aún más. Por ejemplo, Recio-Saucedo et al. exponen una revisión de ratios enfermero-paciente seguros dentro de un departamento de Urgencias, la cual puede relacionarse vagamente con la responsabilidad del enfermero líder de mantener dichos ratios. Se plantea que existen problemas dentro del funcionamiento de los departamentos de Urgencias en auditorías como *Emergency Departments* en Escocia, o *Emergency Care* en gran parte de Europa, pero las soluciones planteadas en Reino Unido no contemplan a los profesionales y su responsabilidad en las mismas.

El uso de la Ética a favor de la práctica en un departamento de Urgencias ya se ha constatado en otros países como Taiwán, como muestra Lin et al. en un estudio cuasi-experimental. Sin embargo, no se ha de olvidar la relación entre la Ética y el Derecho, ya que ambas son formas de condicionar el comportamiento que pueden contradecirse entre sí.

Con todo lo expuesto anteriormente, ningún estudio inglés al que hayamos podido acceder hasta la fecha ha tratado como cuerpo principal la relación de la responsabilidad

ético-legal con la práctica enfermera, ni qué factores son lo que crean dicha relación. De esta manera se muestra un vació de conocimiento que pretende ser respondido por esta investigación.

Objetivos:

El objetivo general de esta tesis es estudiar los factores éticos-legales que afectan a la responsabilidad profesional en la práctica enfermera en el departamento de Urgencias del *Leicester Royal Infirmary*.

Asimismo, se plantearon dos objetivos específicos: revisar los protocolos de actuación enfermera relacionados con la responsabilidad profesional en el departamento de Urgencias del *Leicester Royal Infirmary* y analizar las experiencias del personal de Enfermería del Departamento de Urgencias del *Leicester Royal Infirmary* frente a su responsabilidad ético-legal en la práctica clínica

Metodología:

Esta tesis adopta un paradigma post-positivista, en la cual se realizó un estudio cualitativo a través de análisis etnográfico del contenido, facilitando el acceso a diversas fuentes de datos y a su verificación a través de la triangulación de los mismos.

Los participantes que formaron la muestra eran enfermeros que trabajan o trabajaban recientemente en el departamento de Urgencias del *Leicester Royal Infirmary*. La población considerada sería todos los enfermeros que trabajan o han trabajado recientemente en un departamento de Urgencias en Inglaterra.

Las tres técnicas de generación de datos en las cuales el estudio está dividido son las siguientes:

- Evaluación de la validez ética de los protocolos relacionados con la responsabilidad enfermera en la práctica clínica en el departamento de Urgencias del *Leicester Royal Infirmary*.
- Reflexiones de la práctica clínica en el rol de participante completo en el departamento de Urgencias del *Leicester Royal Infirmary* en el periodo 2014-2016.

- Entrevistas semiestructuradas individuales con 34 enfermeros que trabajaban en el departamento de Urgencias del *Leicester Royal Infirmary*. Para ser considerado como un posible participante, los enfermeros debían trabajar más de cuatro turnos por mes regularmente y no trabajar en otro departamento de Urgencias como miembro permanente del personal.

El análisis de datos procedente de cada técnica fue realizado de manera paralela a su recogida a través de un marco de codificación propio por cada técnica de generación de datos. Una vez que se realizó la codificación de todos los datos, estos se triangularon bajo un marco unificado y se recontextualizaron para evitar una abstracción excesiva del contexto en el que sitúan la investigación.

Consideración ética:

El proyecto de investigación que narra esta tesis fue aprobado por el *De Montfort University Faculty of Health and Life Sciences Research Ethics Committee*, la *Health Research Authority*, el *University Hospitals of Leicester Research and Innovation Department* y la Comisión de Ética de la Investigación de la Universidad de Murcia.

Resultados:

Los resultados se muestran a través de dos modelos teóricos que describen el fenómeno de la responsabilidad enfermera en un departamento de Urgencias inglés: el ciclo de la responsabilidad clínica enfermera y la relación entre los factores de la responsabilidad clínica enfermera.

El ciclo de la responsabilidad enfermera define la interacción entre el enfermero y la institución sanitaria tanto en la toma de decisiones per se como en el manejo de la responsabilidad procedente de las consecuencias de su decisión. Dada su variabilidad, la responsabilidad enfermera debe ser analizada como un concepto subjetivo, el cual depende del enfermero, de la institución sanitaria y del contexto en el que se toma la decisión.

Asimismo, se observó que la responsabilidad tendía a concentrarse en un único enfermero a través de la responsabilidad individual contractual subjetiva, mientras que cuando la responsabilidad jerárquica subsidiaria trasladaba la responsabilidad hacia la

institución sanitaria ésta tendía a disiparse a través de su estructura jerárquica, limitando o negando las consecuencias de la decisión tomada.

Las dos entidades involucradas en la toma de decisiones fueron deconstruidas para explicar detalladamente que factores influían en la toma de decisiones enfermera y la responsabilidad frente a dichas decisiones. El modelo resultante explica esta red de relaciones entre los 32 factores de la responsabilidad clínica enfermera, los cuales se dividen en éticos, legales, profesionales y personales. A través de este modelo se explica la subjetividad de la responsabilidad enfermera, la relación simbiótica entre enfermero y institución sanitaria y como diversas relaciones entre factores pueden ser limitantes o crear ciclos de retroalimentación positiva.

Durante el análisis de datos también se percibió como el enfermero y la institución sanitaria mostraban diferentes corrientes éticas. El enfermero centraba su rol en el cuidado holístico de sus pacientes, mientras que la institución sanitaria generalizaba a sus clientes para poder ofrecer atención sanitaria a toda persona que lo necesitase. Esta dicotomía ética se refleja tanto en los factores de la responsabilidad clínica enfermera de ambos entes como en las relaciones entre ellos.

Discusión:

Los factores éticos, profesionales y legales identificados en los resultados coinciden con los conceptos de ética profesional, deontología profesional y normativa legal respectivamente. Sin embargo, eso no explica la existencia de factores personales, los cuales pueden derivar en decisiones contrarias al deber profesional.

Estos factores personales representan el juicio moral que el enfermero debe realizar cuando existe un conflicto entre valores o principios profesionales y entre éstos y aspectos legales, el cual puede propiciar que el enfermero tome una decisión en contra de su deber profesional en un caso concreto.

Tanto la institución sanitaria como el enfermero se necesitan mutuamente para poder ofrecer un cuidado de cumpla los estándares de un país desarrollado, por lo que interactúan constantemente entre ellos para ofrecer dicho cuidado, aunque cada uno siga sus objetivos particulares. Sería injusto culpabilizar a un enfermero por no coser una herida si no tiene material para suturas o sentenciar a una institución sanitaria por las

consecuencias del cuidado malicioso de un enfermero, por lo que establecer los factores de ambos entes que afectan a la responsabilidad clínica que comparten es fundamental para fomentar que ambas parten realicen su rol en base a los estándares legales, éticos y profesionales adecuados.

La comprensión del concepto de responsabilidad enfermera subjetiva y los factores que lo describen son significativos en el manejo adecuado de recursos humanos y la provisión de cuidados seguros y eficientes, por lo que su aplicación en protocolos clínicos y en normativas institucionales por parte de las instituciones sanitarias conllevaría muchas ventajas. Concebir la responsabilidad enfermera dentro de un contexto y afectada por un número de factores permite a la institución sanitaria solucionar problemas actuando en su causa primaria e implementar medidas de control de riesgos relacionadas con dichos factores.

Una de las aplicaciones más importantes y más complejas de implementar de los resultados de esta tesis es la comprensión de la dicotomía ética en la provisión de atención sanitaria. Esta dicotomía crea una rivalidad entre los objetivos de los enfermeros y los de la institución sanitaria, limitando su eficiencia e impactando en la calidad de la atención provista al paciente. Si el *National Heath Service* cambiara su modelo competitivo de distribución de financiación pública basado en la eficiencia coste-beneficio por otro basado en la calidad de la atención prestada ambos partes coincidirían en su visión de la atención sanitaria y cumplirían las demandas del público ingles representadas a través de la *NHS Constitution*.

Aunque los resultados de esta investigación sean aplicables actualmente, éstos también tienen el potencial de ser la base de investigaciones futuras que expandan el conocimiento sobre la responsabilidad enfermera durante la práctica, las cuales seguirían dos rutas principales: ampliación del concepto de responsabilidad enfermera subjetiva y sus factores en otros contextos o profundización en la relación entre dos factores de la responsabilidad enfermera.

Si se confirmaran los mismos resultados en otros contextos sanitarios se podría aplicar el modelo de relaciones entre los factores de la responsabilidad clínica enfermera en la resolución de problemas en dichos contextos, llegando incluso a generalizarse en la

práctica sanitaria contemporánea si los resultados son consistentes a través de diferentes departamentos y países.

Por otro lado, relaciones entre factores como la presión asistencial y la satisfacción del personal o la influencia y el trabajo en equipo tienen un efecto considerable en la práctica clínica enfermera y multidisciplinar, por lo que un extenso estudio de estas relaciones específicas podría desvelar como influenciarlas, lo cual tendría aplicaciones teóricas y prácticas.

Conclusiones:

La responsabilidad enfermera es un concepto subjetivo cuya percepción y aplicación varía según el enfermero, en la cual ocurre una interacción continua con su institución sanitaria. La toma de decisiones es descrita a través del ciclo de la responsabilidad clínica enfermera, el cual muestra como el enfermero y la institución sanitaria influencian las decisiones y pueden ser responsables de sus consecuencias.

Cuando se profundiza qué factores afectan a la responsabilidad enfermera subjetiva, se puede apreciar que dichos factores están relacionados de tal manera que influyen decisiones presentes y futuras. El análisis de estas relaciones entre factores permite identificar cuales fueron decisivos en cada toma de decisiones individual, mejorando la comprensión de la responsabilidad enfermera subjetiva a través del razonamiento del enfermero.

Se confirma la hipótesis propuesta al constatar que la legislación vigente prima sobre los principios de la ética profesional en la responsabilidad profesional y la toma de decisiones enfermera en el Departamento de Urgencias del Leicester Royal Infirmary.

Como parte de la naturaleza exploratoria de esta investigación se descubrió información relativa a la responsabilidad enfermera que no está directamente relacionada con el objetivo principal, aunque puede ser vinculada con diferentes aspectos de la práctica clínica enfermera.

Se identificaron las fallas en la validez ética de los protocolos clínicos del *Leicester Royal Infirmary* en relación al *NMC Code* y al consentimiento informado, algunas de las cuales puede crear derivar en dilemas éticos, en los cuales ambas opciones podrían

comprometen la integridad profesional del enfermero. Asimismo, se observó el aumento del estrés de los enfermeros por la presión asistencial continua y el riesgo de perder su registro profesional, el cual está directamente relacionado con la reducción relativa de recursos humanos en proporción al aumento de la demanda de atención sanitaria urgente de la población.

**Abstract**

Introduction:

The relationship between Ethics and Law in clinical nursing accountability may seem obvious, but the current literature in the specific area of emergency care is very limited. In the case of England, emergency departments undergo a crowding stage that relaxes the limits of the accountability to which the nurse is subjected to, who must deal with the subjectivity of the presumption of emergency and the rigidity of the NMC Code. Due to this, factors affecting the decision-making process are decisive to improve the quality of care and to understand what influences nurses to work in one way or another.

English emergency departments show various problems: government targets are not met, the percentage of permanent staff is decreasing and public satisfaction is not high enough. Various solutions that worked partially had been explored, but at the moment those problems continue to be part of the daily routine of English emergency departments.

Most of the reforms proposed and/or applied are administrative or institutional, so no reforms directed specifically to the evolution of nursing practice in emergency departments were created. The Nursing and Midwifery Council have only implemented mechanisms to detect malpractice, leaving the encouragement of good practice aside.

The analysis of ethical and legal problems in nursing practice has helped to improve that practice in different countries, so its application in such a delicate area as emergency nursing is necessary. In the case of nursing clinical practice, this area suffers legal loopholes, such as emergency presumption subjectivity or deontological contradictions with the NMC Code. However, the study of this knowledge area in England is very limited, which avoids that scientific evidence is used to find practical solutions.

After the literature search, it was found that the state of the issue of ethical and legal accountability in English nursing practice in general is consolidated by authors like Griffith and Tengham or Dimond in the legislative field and Johnstone or Thompson et al. in the field of Ethics. However, the characteristics of ethical and legal accountability in emergency nursing are only mentioned superficially in these documents.

Regarding recent articles, only a few can be partially related to the research question. While Langeland and Sørlie point out the existence of vulnerability against the ethical dilemmas presented in an emergency department in Norway, Ebben et al. indicate the factors involved in monitoring a national protocol in the Netherlands. These studies identify ethical and legal problems in emergency departments. However, they do not connect the concepts together, do not address the accountability of the professional as an ethical-legal connector and come from other countries with different laws, protocols and ethical perspectives.

Taking into account only studies based in the UK, the list narrows further. For example, Recio-Saucedo et al. present a review of safe nursing ratios in an emergency department, which can vaguely relate to the accountability of the nursing leader to maintain these ratios. It is stated that there are problems in the management of emergency departments in audits like *Emergency Departments* in Scotland or *Emergency Care* in some parts of Europe, but the solutions proposed in the UK do not include healthcare professionals or their accountability.

The use of Ethics in clinical practice inside an emergency department has already been established in other countries such as Taiwan, as shown in Lin et al. in a quasi-experimental study. However, the relationship between Ethics and Law needs to be remembered, since both are methods of conditioning behaviour that may contradict each other.

With all the above, no English study that we could access has treated the relationship between ethical and legal accountability in nursing practice as their main objective neither which factors create their relationship. Consequently, there is a knowledge gap that aims to be answered by this research.

Objectives:

The main objective of this thesis is to study ethical and legal factors influencing professional accountability in nursing practice at the Leicester Royal Infirmary Emergency Department.

Likewise, two secondary objectives were proposed: inspect clinical policies related to nursing practice professional accountability at the Leicester Royal Infirmary Emergency

Department and analyse nursing staff experiences connected to ethical and legal accountability in clinical practice at the Leicester Royal Infirmary Emergency Department.

Methodology:

A post-positivist paradigm was adopted in this thesis, in which a qualitative study using ethnographic content analysis was utilised, facilitating access to more diverse data and its verification by triangulation.

The participants that formed the sample consisted of nurses who worked at the Leicester Royal Infirmary Emergency Department. The population considered was all registered nurses who worked in an emergency department in England.

The three data gathering techniques on which the study is divided are the following:

- Evaluation of policy ethical validity related to accountability in nursing clinical practice at the Leicester Royal Infirmary Emergency Department.
- Reflections on practice in the role of full participant at the Leicester Royal Infirmary Emergency Department between 2014 and 2016.
- Individual semi-structured interviews with 34 nurses that worked at the Leicester Royal Infirmary Emergency Department for at least six months before the interview. To be considered as a possible participant, nurses should work more than 4 shifts per month regularly and not work in another emergency department as a permanent member of staff.

Analysis of data from each technique was achieved parallel to its gathering through a unique code frame for each data gathering technique. When all data was codified, it was triangulated under a unified code frame and recontextualised to avoid excessive abstraction of the context in which the research is situated.

Ethical consideration:

The research project that this thesis develops has been approved by De Montfort University Faculty of Health and Life Sciences Research Ethics Committee, Health

Research Authority, University Hospitals of Leicester Research and Innovation Department and Murcia University's Ethics Research Commission.

Results:

The results are shown through two theoretical models that describe the phenomenon of nursing accountability in an emergency department: the clinical nursing accountability cycle and the relations amongst clinical nursing accountability factors.

The clinical nursing accountability cycle defines the interaction between the nurse and the healthcare institution both in decision-making and in the accountability management derived from the consequences of their decision. Due to its variability, nursing accountability needs to be analysed as a subjective concept, which depends on the nurse, the healthcare institution and the context in which the decision is made.

Likewise, it was observed that accountability tends to concentrate in a specific nurse through subjective contractual individual accountability, while when vicarious hierarchical accountability shifts the accountability to the healthcare institution it tends to dissipate through the hierarchical structure, limiting or negating the consequences of the decision made.

Both entities involved in decision-making were deconstructed to explain in detail which factors influence nursing decision-making and the nursing accountability base on those decisions. The resulting model explains this network of relations between the 32 clinical nursing accountability factors, which are divided into ethical, legal, professional and personal. Through this theoretical model, subjectivity in nursing accountability, the symbiotic relationship between nurse and healthcare institution and how various relationships between factors can be limiting or create positive feedback loops are explained.

During data analysis, it was also perceived that the nurse and the healthcare institution show different ethical theories. The nurse focuses his role in the holistic care of his patients, while the healthcare institution generalizes its clients to be able to offer healthcare to every person that needs it. This ethical dichotomy is reflected in both the clinical nursing accountability factors and the relations between them.

Discussion:

The ethical, professional and legal factors identified in the results coincide with the concepts of Professional Ethics, professional deontology and legal regulations respectively. However, this does not explain the existence of personal factors, which can lead to decisions contrary to professional duty.

Those personal factors represent the moral judgment that the nurse should make when a conflict between professional values or principles and between them and legal aspects arises, which can lead the nurse to make a decision against his professional duty in a specific case.

Both the healthcare institution and the nurse need each other to provide care that meets the quality standards of a developed country, so they constantly interact with each other to provide such care, even if each one follows their particular goals. It would be unfair to blame one nurse for not closing a wound if he does not have suturing equipment or to sentence a healthcare institution for the nurse's malicious care consequences, so establishing the shared factors of both entities that affect clinical accountability is fundamental to encourage both parties to carry out their role based on the appropriate legal, ethical and professional standards.

Comprehension of the concept of subjective nursing accountability and the factors that describe it is significant in the appropriate management of human resources and the provision of efficient and safe care, so its application in clinical policies and institutional regulations by healthcare institutions would entail several benefits. Conceiving nursing accountability inside a context and affected by a number of factors allows healthcare institutions to solve problems acting in their primary cause and to implement risk control measures connected to these factors.

One of the most important and complex applications of the results is the comprehension of the healthcare provision's ethical dichotomy. This dichotomy creates a rivalry between the nurses' objectives and the healthcare institution's ones, limiting their efficiency and impacting on the quality of care provided to the patient. If the NHS would change its competitive model of public funding distribution based on cost-benefit efficiency to another one based on the quality of care provided both parties would agree

on their vision of healthcare and fulfil the English public's demands represented through the NHS Constitution.

Although this research's results are applicable presently, they also have the potential to be the basis for future research that expands the knowledge about nursing accountability during practice, which could follow two main routes: extend the concept of subjective nursing accountability and its factors in other contexts or focus and expand the relationship between two nursing accountability factors.

If the same results were confirmed in other healthcare settings, the relations amongst nursing accountability factors model could be applied to solve problems in those contexts, even generalising it in contemporary nursing practice if the results are consistent across different departments and countries.

On the other hand, relations between factors such as clinical workload and staff satisfaction or influence and teamwork have a considerable effect on nursing and multidisciplinary practice, so an extensive study of these relations could reveal how to influence them, which would have theoretical and practical applications.

Conclusions:

Nursing accountability is a subjective concept which perception and application vary depending on the nurse, in which a continuous interaction with his healthcare institution occurs. Nursing decision-making is described through the clinical nursing accountability cycle, which shows how both the nurse and the healthcare institution influence decisions and may be responsible for their consequences.

When delving into which factors affect subjective nursing accountability, it can be appreciated that those factors are connected in a way that influences present and future decisions. The analysis of those connections between factors allows the identification of which one was decisive in each individual decision-making process, improving the comprehension of subjective nursing accountability through the nurse's reasoning.

The proposed hypothesis is confirmed by verifying that the applicable legislation takes precedence over professional ethical principles in professional accountability and nursing decision-making at the Leicester Royal Infirmary Emergency Department.

As part of the exploratory nature of this investigation, information relative to nursing accountability that was not directly connected to the main objective was discovered, although it can be linked to different aspects of nursing clinical practice.

Ethical validity flaws linked to the NMC Code and informed consent in Leicester Royal Infirmary's clinical policies were identified, some of which can lead to ethical dilemmas, in which both options could compromise nursing professional integrity. Likewise, a rise of stress levels in nurses due to continuous high clinical workload and the risk of losing their professional registration was observed, which is directly linked to the relative reduction of human resources in proportion to the rise of urgent healthcare demand from the public.

## Introduction

During their clinical practice, healthcare professionals face doubts about their responsibilities and competencies included within their role and how these responsibilities affect their clinical practice. These questions are answered individually with help from theory and experience depending on the type of healthcare professional, their role in the multidisciplinary team and the management structure.

This research will focus on the role of nursing professionals in clinical practice, particularly in the ethical and legal accountability arising from their practice, both in a purely clinical job and in a clinical job with added administrative and leadership functions.

The deontological code of the International Council of Nurses (1) establishes the following definition: “The primordial responsibility of the nurse is within people that need nursing care”. It must be clarified that if responsibility was just in relation to the patient, this would be less complex. However, nurses are accountable for their practice not only to the patient but also to their profession, their colleagues and society. If the clinical environment is also taken into account, in critical environments like the standard emergency department (ED) the situation may be more complex than just providing care to your patients.

Another important aspect that justifies this research is the current context of British Nursing. After constant government changes since 2013 and the British government new economic plan in relation to the National Health Service (NHS), which included the possible elimination of extra pay for nights and weekends (2, 3), the wage freeze for 3 years (4) and the privatization of some NHS bodies (5), confidence in the Health Minister Jeremy Hunt, the last representative of the NHS, is very low in media polls (6).

This has encouraged the proliferation of private recruitment agencies of healthcare personnel, which cover temporary vacancies of doctors, nurses or healthcare assistants (HCAs) for a salary based on supply and demand, which is between 2 and 8 times greater than in the NHS (7), even though England has a national public health service with preset salaries. The rise of these market-based salaries in recruitment agencies utilises a relevant percentage of the NHS budget, 5500 millions of pounds between

2010 and 2014 (8), which are justified as a short-term solution to alleviate the shortage of healthcare professionals in the NHS.

Evaluation and control of healthcare professions are carried out by regulatory bodies such as the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC), which were created to defend the population from healthcare professionals' malpractice, not to protect healthcare professionals (9). These institutions rarely struck a professional off their register, only after serious and repeated infractions. Nevertheless, in clinical practice the fear of losing the ability to practice that these institutions provide and control is widespread, increasing the fear of being punished by mistakes, excessive documentation and defensive practice. This situation worsens with the nurse-client model, in which the fear of being sued is added to the fear of being struck off their professional register.

Insecurities and fears of the aforementioned healthcare professionals should not happen with appropriate training, professional practice and clinical documentation. However, the efficient division of time and the 4-hours target (10) does not always facilitate the comprehensive documentation of all care provided to each patient in an emergency department, especially in crowded departments, during an internal incident or without an appropriate nursing skill mix. Additionally, clinical documentation loses its primary functions if it is not used as the essential part of clinical practice that it is, since it could be used only as a diversion of professional accountability or as a defence against any legal or professional accusations.

Another aspect that should be analysed is the British nursing hierarchy and its effect on clinical practice accountability, being this shared among several professionals or focus on a specific one according to the situation. This hierarchy, together with the clinical competencies system, obstruct nursing practice as an independent profession due to the nurses' reliance on other professionals both for their patients to receive nursing care and to make decisions regarding them. This indicates that nurses should not work alone; they should be part of the multidisciplinary team with a defined role within it. However, although a nurse cannot perform all the techniques that his patient needs or control all decisions related to his patients, he is accountable for the care of each of his patients, with the ethical, legal and professional weight that it entails.

There are four levels that define the scope of nursing ethical accountability, which define the type of approach that should be taken in each situation (11):

- Micro issues (Clinical Nursing Ethics):
    - Individual patient-nurse relationship
    - Hospital or community nursing practice
    - Palliative care
    - Healthy people screening
- Macho issues (Professional Nursing Ethics):
    - Codes of conduct and professional domination
    - Roles and relationships between nurses and between nurse and doctor
    - Teamwork, leadership and accountability
- Meso issues (Nursing management Ethics):
    - Nursing supervision and relationships between co-workers
    - Employment policies, job assignment and complaints
    - Corporate ethical standards and quality assurance
    - Human resource management and resource allocation
- Macro issues (Healthcare Policy Ethics):
    - Policies, administration and healthcare service shortages
    - Nursing research and health promotion strategies
    - Politics Ethics and cooperation of regional and national authorities
    - "Politics" and "Economy" in the National Health Service

In this thesis, all accountability levels will be considered, but we will focus on the first two, which concentrate the main conflicts in clinical practice.

Based on the hierarchisation of nursing practice and the creation of multidisciplinary teams as the basis of an emergency department, it can be deduced that communication between professionals on that hierarchy and between members of the multidisciplinary team is essential. However, this feature is also linked to patients' accountability and their private information.

A lack of communication between healthcare professionals can result in poor treatment and care, while an excessive amount of patient information may violate their privacy. It is all healthcare professionals' responsibility, including nurses, to disclose the necessary

information about the patient with the appropriate people through the adequate communication channel. To do this, the three issues related to poor communication indicated by Burley (12) should be avoided: interruptions, communication barriers and clinical workload overload.

This communication deficiency is accentuated in an ED divided into several areas. Due to the needs and characteristics of EDs, they are usually divided into several areas (Majors, Minors, Resuscitation, Assessment Bay, etc.) that must share information to allow continuous treatment and patient care. These result in different situations that may raise accountability conflicts between those areas in relation to the amount and type of patients seen.

In situations when an ED receives many patients of one type (many patients in emergency situations to the Resuscitation area, for example), patient distribution changes to adapt to the new situation. However, this change in favour of patients who need treatment and care in the Resuscitation area conflicts with patients who were already in this area and are transferred to other areas to make room for new patients.

The only way to fully understand an action, event or situation is to situate it in the context from which it belongs. Context gives it reason and purpose, which means that it can be understood by people who have not lived or experienced that situation. That is why before delving into the accountability of emergency nurses we need to understand the context in which that accountability is demanded and in what context that clinical practice is exercised.

An inevitable drawback is the generalisation of some aspects to be able to cover the reality of healthcare across the UK, losing part of its social and cultural wealth around the context spectrum. However, if all contexts are considered separately without generalising it is very difficult to find conclusions that can be applied nationally.

The choice taken in this research has been to opt for a local scale nationally generalisable, so we can compare local healthcare in context with national policies. This does not mean that this is the only correct choice. From specific care from a secluded village to the World Health Organization (WHO) health policies, all healthcare knowledge enriches practice at all the levels that can be applied: personal, local,

regional, national or international. Therefore, context is essential to understanding the life experiences that other people go through and the situations that they live, with motivations, desires and ideas connected to them, so we can learn from them.

We must also point out that any context to be complete needs to be complex. It is very difficult, if not impossible, to convey a situation or event without missing any detail. Several topics, such as the welfare state, the NHS, the English Law, Applied Ethics and UK Nursing are very complex, being worthy of a thesis individually. That is why the extensive and detailed description of the context will be delimited to reflect appropriately British Nursing in general and English Emergency Nursing practice in particular.

The definitions of key concepts in this thesis will be stated to specify its context.

The term responsibility is understood differently in the Spanish context (in which this thesis is originally written) and in the English context (in which this thesis was translated into). In Spanish, the *Real Academia de la Lengua Española* (RAE) defines responsibility with four meanings (13):

- Quality of responsible.
- Debt, obligation to repair and satisfy, by itself or by another person, as a result of a crime, a fault or other legal cause.
- Charge or moral obligation that results in a fault in a particular matter or thing.
- Existing capacity in all active legal subjects to recognize and accept the consequences of an act performed freely.

In these definitions, the quality of being responsible, legal responsibility, moral responsibility and the ability to accept the responsibility for an act are exposed. Therefore, the definition of responsibility in Spanish fits this writing's purpose, including the moral, legal and personal aspects of the word. However, in English two words are used: "responsibility" and "accountability".

Although both are often considered synonymous in most contexts, they have different connotations. While responsibility (14) is defined through power relationships, the duty to fix something or being blamed for something, accountability (15) refers to the fact of being accountable, to the need to justify your actions or decisions per se, without any

added connotation. This connotation is most evident in the definition of accountability by Lewis and Batey (16):

> The fulfilment of a formal obligation to disclose to relevant others the purposes, principles, procedures, relationships, results, income and expenditures for which you have authority.

According to their definitions, we can observe that accountability refers to being responsible to oneself and our actions on others, while responsibility is to be responsible for someone or something, exercising control over it (17). Although both definitions are complementary, the meaning that is closer to the purpose of this investigation is accountability, which can be considered a legal or moral obligation. However, responsibility is also relevant, although it will be relegated to issues related to professional duties or hierarchical and administrative relationships.

The next term, ethical-legal, is a combination of two, "ethical" and "legal", so we will treat them separately, since the provision of this two words as one, united by a hyphen, is a decision that does not affect their meaning. The term "legal" is used to refer to something related to the Law, both in Spanish (prescribed or pertaining to legislation or the Law (18)) and in English (related to, recognised by or permitted by Law (19)). Nonetheless, "ethical" can be defined in two ways, although those are not dependent on language but on the transmitter's intentions.

The words Moral and Ethics appear as synonymous words, although in some contexts they are differentiated. In their etymological base, both words mean "custom" or "habit", being *ethikos* (Ethics) in ancient Greek and *moralitas* (Moral) in Latin. Their use as synonyms is justified and they are used interchangeably in philosophical literature.

However, in some knowledge areas and in popular knowledge the Moral concept has been accepted as a code of individual and personal values that each human being has and Ethics as a more public and universal set of values (20). In this research, we will treat Moral and Ethics synonymously unless is specifically stated otherwise, avoiding confusion and facilitating the understanding of this thesis' purpose, content and function.

The concept of clinical nursing practice must be analysed from the definition of the words individually to not lose part of its meaning. Starting with the word "practice", it is adjusted to its definition in Spanish as "exercise of any art or faculty, in accordance with its rules" (21) and in English as "the actual application or use of an idea, belief or method, as opposed to theories relating to it" (22). This definition emphasises the application of Nursing itself, although we have to study the theory that supports it.

Regarding the word "clinical", its English definition "relative to the observation and treatment of actual patients rather than theoretical or laboratory studies" (23) is applied because it is a multidisciplinary definition, unlike the Spanish definition "pertaining to the practical exercise of Medicine based on direct observation of patients and their treatment" (24), which is framed only in the medical field. Furthermore, it should be noted that clinical practice is an individual concrete activity, being unique in each patient (25). Therefore, this sense focuses on the application of Nursing in relation to the observation and treatment of real patients.

There is no dispute that the word "nursing" indicates something related or relevant to nursing care. To define Nursing, the most widely used and successful definition is provided by the International Council of Nurses (ICN) (26):

> "Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illnesses, and care of the ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health system management and education are also key nearing roles".

The main function of Nursing is the holistic care of people and everything that affects them. Understanding people as social beings, Nursing must also be responsible for the care of groups and communities in which these people live. Not only the sick person receives care, the healthy person also receives care to improve their quality of life and to reduce their chances of becoming ill and the ailing person receives care to recover their lost autonomy. Ultimately, Nursing seeks caring for people so they can achieve the maximum independence and quality of life possible in every situation.

On the other hand, to understand this definition we must define what is caring and care. The RAE defines care as "the act of caring" and provides a generic definition of caring: attend, save and preserve (27). However, the Oxford Dictionary of English defines care as "the provision of what is necessary for health, welfare, maintenance and protection of someone or something" (28). The definition of care is still under discussion and is constantly changing, since it is the paradigm of a constantly evolving profession. However, we cannot provide a specific and universal definition of care from the nursing point of view because it does not exist at the moment.

Since 1990, several important authors in the Nursing history and development realised that the lack of progress in nursing theory was partly due to a lack of precision in the definition of care. One of the biggest problems is to unify the two meanings of care, to provide care and to worry about something or someone (29). Therefore, we can define nursing clinical practice, simplifying it only for this introduction and through its semantic meaning, as "holistic care provision in relation to the observation and treatment of patients."

The next concept to outline the theoretical framework of this thesis would be the Urgency Department in Spanish, commonly known as Accident and Emergency Department in English. There is no discussion about the word department as part of a territory or organization. However, there are two expressions for this specific type of department, Urgency Department and Accident and Emergency Department, even though in practice they are the same. Therefore, we must define if there is a significant difference between urgency and emergency since not everyone who has an accident needs to go to an emergency department, so its definition does not affect the purpose of the department itself.

Urgency is defined by the American Medical Association (AMA) as:

> "Urgency is the appearance of a problem of diverse aetiology and varying severity that generates the experience of immediate need of care in the patient himself, his family or whoever takes responsibility." (30).

This definition is not without controversy, since the term "immediate need" can be related to objective or subjective needs.

The definition of emergency is complex to define because it refers to several concepts intertwined with each other. First, we must consider emergency as a state, the WHO defines it as (31):

> Emergency is a term describing a state. It is a management term, demanding decisions and follow-up in terms of extraordinary measures. A "state of emergency" demands "to be declared" or imposed by someone in authority, who, at a certain moment, will also lift it. Thus, it is usually defined in time and space, it requires threshold values to be recognized, and it implies rules of engagement and an exit strategy. Conceptually, it relates best to "Response".

This definition is based on the "state of emergency", in which local resources are not enough and may lead to a disaster or a catastrophe. In these situations, the problem is humanitarian, affecting the human being as a whole, not only his health.

Another definition more focused on healthcare is emergency as an critical health problem. This aspect of emergency is defined by the WHO as "the case where the lack of care would lead to death in minutes" and by the AMA as "the urgent situation that puts the patient's life in immediate danger depending on the organ" (32). For the purpose of this research, we will consider the term emergency as health emergency or critical health problem, excluding its definition as a state of emergency unless specifically indicated. It must be taken into account that in popular knowledge these terms are defined as "when the person needs immediate attention" (urgency) or "when a person's life is in danger" (emergency) (33).

One can see that both terms refer to a need for immediate assistance (and therefore sometimes are used synonymously), but in an emergency the patient's life is always in immediate danger and urgency severity is variable. Therefore, we can extract the common factor and indicate, only for the purpose of this thesis and only through its semantic meaning, that an Emergency Department (ED) in a hospital department where patients are attended with a need for immediate assistance.

The two concepts that complete this contextualization feedback each other: protocols and clinical activity. Protocols are defined by the RAE as "a written and detailed plan for a scientific experiment, a clinical trial or a medical intervention" (34). Called

guidelines, protocols or policies in English, they share a similar meaning with the Spanish definition (35). Clinical activity describes healthcare through daily patient care with a holistic point of view to improve care and the professionals that provide it. Between these two concepts several contrasts are created, like theory/practice, deduction/induction and objectivity/subjectivity; and the reason for its use is to capture one of the purposes of this thesis: confront theory and practice in the field of emergency nursing accountability and feedback each other.

**Justification**

English EDs have several problems: the objectives set by the government are not met, the percentage of permanent staff is falling and public satisfaction is not high enough. They have explored various solutions that have worked partially, but today these problems remain part of English EDs' daily routine.

Most of the reforms proposed or implemented are administrative or institutional, so nearly no reforms aimed specifically at the evolution of emergency nursing practice are put into practice. The Nursing and Midwifery Council (NMC) has only implemented mechanisms to detect malpractice, shifting good practice stimulation to the background.

The analysis of ethical and legal problems in nursing practice has helped to improve practice in several countries, so their application in such a sensitive area as emergency care is necessary. In the case of English nursing practice, this area suffers loopholes like emergency presumption subjectivity and the deontological contradictions in the NMC Code. However, research in this subject area in England is very limited, preventing others to support new solutions with scientific evidence.

This research problem has been selected by the potential it presents. In the department in which the study will be conducted, ethical, legal and professional accountability rarely coincide, at least according to the previous observation period. If factors connecting ethical and legal accountability to clinical practice problems were identified, they could find solutions to these problems:

- Defining the accountability that the nurse is subjected to through specific standards could reduce stress and increase permanent staff recruitment and retention.
- Indicating ethical and legal factors related to nursing clinical practice in ED would enable the creation of policies and guidelines around them.
- Identifying legal violations and common immoral behaviour that is caused or suffered by nurses could find their origin and how to reduce them, which would increase patient satisfaction and quality of care.

- Analysing the relations between ethical and legal factors could avoid contradictions between them, resulting in a more secure and independent practice and reducing excessive documentation.

Even in the hypothetical situation where there was no relationship between ethical and legal nursing accountability factors in an ED, knowing them and how they are part of nursing practice is essential to analyse them holistically. Holistic care is considered excellence in care, so even if it could not be applied to solve problems in EDs information from this research could be applied to the overall knowledge about the care agent.

Therefore, the study of ethical and legal nursing accountability factors presents theoretical and practical potential, although the extent of this potential depends on the research's results and conclusions.

**State of the art**

A literature search through printed and computerised material was conducted to know the state of the art of ethical and legal accountability in English nursing practice.

This process was necessary to narrow the knowledge gap that this research project seeks to answer, placing its possible outcomes within the available scientific knowledge on the study topic in order to develop cohesive findings alongside data from other investigations.

In addition, this process also facilitates adequate use of material and human resources in research because it can confirm that there is not extensive knowledge on the research question and that future research may add relevant or previously unknown information.

Data sources chosen for the literature search have been mainly books, journals, theses, legal regulations, newspapers, government websites and verdicts from different courts.

To perform the literature search various databases were consulted to search computerised documents, as well as several government websites, which are listed below:

- Data sources in Healthcare Sciences
    - CINALH: Cumulative Index to Nursing & Allied Health Literature
    - Cochrane Library
    - LILACS: *Literatura Latinoamericana y del Caribe en Ciencias de la Salud*
    - Cuiden Plus
    - Cuidatge
    - ENFISPO: *Biblioteca de la Facultad de Enfermería, Fisioterapia y Podología de la Universidad Complutense de Madrid*
    - PubMed: US National Library of Medicine
    - SciELO: Scientific Electronic Library Online
    - NICE: UK National Institute for Health and Care Excellence
- Thesis searchers
    - TESEO
    - Dissertations & Theses

    - TDX: *Tesis Doctorales en Red*
- Institutional repositories
    - Digitum: University of Murcia
    - Buleria: University of Leon
    - Helvia: University of Cordoba
    - RUA: University of Alicante
    - Dialnet: University of La Rioja
    - Digital.csic: *Consejo Superior de Investigaciones Científicas*
- Government websites
    - NMC: Nursing and Midwifery Council
    - NHS Choices: National Health Service
    - Gov.uk: British Government
- Other search engines
    - Academic Google
    - Google books

On the other hand, to search for printed documents we mainly used bibliographic resources from the following institutions:

- Nursing School Library: UMU
- General Library María Moliner: UMU
- Regional Library: Murcia
- Kimberlin Library: De Montfort University
- Leicester Central Library
- Leicester Royal Infirmary Hospital Library

After the literature search, it was found that the state of the art of ethical and legal accountability in English general nursing practice has consolidated literature by authors like Griffith and Tengham (36) or Dimond (37) in the legislative field and Johnstone (38) or Thompson et al. (39) in Ethics. However, these documents only address the particularities of ethical and legal accountability in emergency nursing practice superficially.

Regarding recent articles, only a few can be partially related to the research question. While Langeland and Sørlie (40) indicate the existence of vulnerability to ethical dilemmas in an ED in Norway, Ebben et al. (41) indicate the factors involved in monitoring a national protocol in the Netherlands. These studies identify ethical and legal problems in EDs. However, they do not link these concepts; do not address the accountability of professionals as ethical-legal connectors and come from other countries with different laws, policies and ethical schools of thought.

Taking into account studies only based in the United Kingdom, the list narrows further. For example, Recio-Saucedo et al. (42) present a review of patient-nurse ratios within a safe ED, which can vaguely relate to the nursing leader's responsibility to maintain those ratios. It is stated that there are problems in EDs´ functioning in audits such as *Emergency Departments* (43) in Scotland or *Emergency Care* (44) in Europe, but the solutions proposed in the UK do not include healthcare professionals and their accountability.

The use of Ethics to improve ED practice has already been proved in other countries such as Taiwan, as shown in Lin et al. (45) in a quasi-experimental study. However, the relationship between Ethics and Law do not have to be forgotten, since both are ways of conditioning behaviour that may contradict each other.

With all the above, no English study that we could access has treated the relationship between ethical and legal accountability in nursing practice or which factors create this relationship as the main body of its research. Thus, there is a knowledge gap that aims to be answered by this research.

Therefore, to address that knowledge gap the following research question is proposed: which are the ethical and legal factors that affect nursing practice accountability in the Leicester Royal Infirmary Emergency Department, how they influence nursing practice and how they interact between each other?

# Chapter I:
# Historical outline of the United Kingdom healthcare system

### 1.1. United Kingdom and the welfare state

United Kingdom (UK) is a country located in the British Isles, which are separated from continental Europe by the North Sea to the east and the English Channel to the south, while to the west and north limit with the Atlantic Ocean; which consists of Wales, Scotland, Northern Ireland and mostly England (83%). This country houses, according to data from mid-2014, around 64.6 million people (46) in its 243,610 square kilometres of surface.

The migratory movement within the UK is positive; since even though there were 322,900 emigrations, these were compensated by 582,600 immigrations that year, leaving a net international migration of 259,700 people in 2014. This migratory movement constitutes 53% of the population growth in 2014 and the main contributing factor in the British population growth in the last decade (except 2012 and 2013). Comparing the 2011 and 2001 census, an increase in all ethnic minorities was observed, which is manifested in the 80% of the British population in 2011 that defined themselves as "White British" in contrast to the 87% that defined themselves as "White British" in 2001 (47).

To contextualize this research is also necessary to consider some facts about the city in which it will be done, Leicester. This city is located in the East Midlands area, in the county of Leicestershire. In the 2011 census, the population was 329,900 inhabitants, compared to 282,800 in 2001, indicating a 17% growth, which makes it the tenth largest city in the UK. The ethnic diversity in Leicester is noteworthy, as in the 2011 census 45% of the population was defined as "White British", 28% as "Indian", 5 % as "White Other" and 21% as part of other ethnic groups (48).

UK is a developed country and has the world's fifth largest economy by nominal gross domestic product (GPD), the second largest in Europe after Germany, and the tenth largest economy in the world by purchasing power parity. The UK is considered to have a high-income economy and is classified as "very high" in the Human Development Index (49), classified in 2014 as the fourteenth in the world in said index (50).

The UK was the first industrialised country in the world and one of the most important powers in the world during the nineteenth and early twentieth centuries, and today

remains an economic, cultural, military, scientific and political power internationally. It is a nation that recognizes the possession of nuclear weapons and its military budget ranks fifth in the world (51).

The UK has been a permanent member of the United Nations Security Council since its first meeting in 1946. It is a member state of the European Union and its predecessor, the European Economic Community since 1973. It is also a member of the Commonwealth of Nations, the Council of Europe, the G-7 finance ministers, the G7 forum, the G20, the North Atlantic Treaty Organization, the Organization for Economic Cooperation and Development and the World Trade Organization.

Health expenditure in 2013 was 8.8% of the GDP, compared to 9.3% in 2012 and 9.8% in 2009 (52), even if health spending increased 2.2% between 2012 and 2013. In 2013, 83.3% of that spending was publicly funded, being higher than the Organization for Economic Cooperation and Development average (71.8%) and the highest percentage of any of the G7 countries (53). The proportion of public expenditure on health budget is one of the characteristics of the governmental model born to fight the "five giants": want, disease, ignorance, squalor and idleness; known as the welfare state.

Although some experts say that the welfare state in the UK began to form under the liberal reforms in the 1906-1914 legislature under the leadership of H.H. Asquith, it was in 1942 when the *Report of the Inter-Departmental Committee on Social Insurance and Allied Services*, also called *Beveridge Report* (54), initiated the creation of the welfare state in the UK. This report was aimed at trying to rebuild Britain after World War II fighting the "five giants on the path of reconstruction," for which he proposed the welfare state.

The welfare state is a government concept in which the state plays a key role in protecting and promoting the economic and social welfare of its citizens through Keynesian policies. It is based on the principles of equality of opportunity, equitable wealth distribution and public responsibility for those who cannot obtain minimum victuals for a good life. Standard measures to establish a welfare state are creating a social security, a national health service, free education, social housing and full employment, so the British government began producing reforms to establish the welfare state after World War II (55):

- Social Security:
    - *Family Allowances Act* (1945): 5s (5 Shilling = 60 pennies) per week for each child after the first.
    - *National Insurance Act* (1945): Unemployment benefits for six months and sickness subsidy during the time someone was sick.
    - *National Insurance - Industrial Injuries Act* (1946): Additional subsidy for people injured at work.
    - *National Assistance Act* (1948): Allowance for anyone who needed it that could not acquire the minimum supplies for a dignified life.
- National Health Service:
    - *National Health Service Act* (1948): Doctors, hospitals, dentists, opticians, ambulances, midwives and health visitors were freely available to all inhabitants.
- Free education:
    - *Education Act* (1944): Richard Austen Butler established the age of compulsory schooling at age 15 and introduced free secondary schools.
- Social housing:
    - *Town and Country Planning Act* (1947): It was planned to build 300,000 new homes a year and 1.25 million housing units were built between 1945 and 1951. It also defined an area of forest land that should be kept rural.
    - *New Towns Act* (1946): It authorised the construction of new cities in places like Stevenage, Basildon, Newton, Aycliffe and Peterlee.
    - *Children's Act* (1948): Subsidised housing was required to provide decent housing and dignified care for all children "deprived of a normal family life".
- Full employment:
    - *Marshall Aid* (1948): The government nationalised transport by road, the rail and the coal industry in 1947 and the steel industry in 1951. With the adoption of the ideas from the J.M. Keynes' book *General Theory of Employment, Interest, and Money* (1936), the government understood how to maintain the economy active by increasing public spending.

It has been over 60 years since the reforms linked to the *Beveridge Report* started, with their corresponding changes made by the elected governments. After the economic decline of the 60s and 70s, culminating in the Winter of Discontent in 1979, the privatisation measures, union legalisation and reduced welfare state linked to how Margaret Thatcher's government addressed the economic situation in UK in the early 80s; the attempted reconstitution of the welfare state by Tony Blair and Gordon Brown's new labour party in the first decade of the twenty-first century and David Cameron's conservative government between 2010 and 2016 reduced the *Beveridge Report*'s effects today.

Nevertheless, UK remains a thriving and internationally influential country, which minimised the effect of the North American crisis that propagated throughout Europe. In 2015, UK continues to enjoy free health care, social security and the option of free basic education. However, housing and employment are only partially and conditionally subsidised by the government, thus facilitating a free market.

If the governance model towards which the UK is leading is a welfare state or not is a decision of the British population, since in a democracy one of the most descriptive expressions of a society is voting the political party that share ideals or interests with the population and the reaction of said population to the government's adherence to these ideals.

### 1.2. National Health Service, British healthcare foundation

To understand the relationship between British healthcare and British society, we must consider the National Health System (NHS). It was a revolution in healthcare services, its way of conceiving healthcare created one of the companies with more employees worldwide and it is a source of national pride and debate. It is a recurrent theme in electoral campaigns, political debates, newscasts and most table talks. Being fully funded through taxes, the British National Health System maintains a transparency policy, which has served to show its flaws and try to fix them. However, the current situation is far from perfect. Continuous budget and services cuts, many hospitals' debts of thousands of millions of pounds, the NHS workers' salary freeze and the presumed public budget derivation to its privatisation create debate and discontent in the British society, weakening the credibility in this long-lived system.

The British National Health System is divided into four branches, of which only NHS England will be discussed, even though there is no significant difference between them (56), so results could be generalised. These four branches are:

- National Health Service (England)
- Health and Social Care in Northern Ireland
- NHS Scotland
- NHS Wales

The current healthcare system is far from the one created in 1948. There have been significant changes, many of them derived from national reports showing serious failures or inequalities in the system. That is why before delving into this healthcare system, we have to mention its history, how it emerged and how it evolved, so its current situation can be understood.

### 1.2.1. The history of the National Health Service

The National Health Service (NHS) was born on the first of July 1948 in England and Wales as the first national health system only funded through taxes. In its creation, the NHS followed three key principles (57):

- That it meet the needs of everyone.
- That it be free at the point of delivery.
- That it be based on clinical need, not ability to pay.

In its time, the NHS was the pioneer in joining different types of healthcare professionals within a single organization and offering that service funded through national taxes, free at the point of delivery, only three years after World War II. This was an example followed by many European countries for the creation of a fairly distributed healthcare system controlled by the state.

Nonetheless, the NHS has not only been a sum of achievements that have improved the health and quality of life of British society, but has also been and is an important part of British society, symbol of the welfare state in its creation and social and political progressive changes throughout its history (58, 59):

Creating a system fully funded through taxes did not immediately imply a healthcare workers' increment in numbers, but a fairer distribution of the healthcare services available in 1948. This change caused a revolution in the UK healthcare system old structure, therefore large organisations like the British Hospitals Association, an association of charity hospitals, ceased to have an essential role in the healthcare structure.

Campaigns promoting health started, increasing population's health awareness through the *Family Doctor* magazine; and disease prevention with vaccines or new antibiotics. The population that previously could not access treatment (women and children, who could not be insured) collapsed the new services offered by the NHS, which had a severe shortage of doctors and nurses.

General practitioners (GPs), forced to transform their consultations to the public system without any economic incentive, with serious staff shortages and frustrated by the long

waiting lists that their patients suffered were demoralised without discussing how they could improve the situation.

After the *Collings Report*, which identified large differences in care quality between urban, industrial and rural GP surgeries, and the British Medical Association (BMA) survey, which pointed out the alarming results of the *Collings Report*; The Cohen Committee compiled the information available to improve GP surgeries. In addition, the NHS' creation caused an uncontrolled increase in health spending, since it had not have its own allocated percentage of the national budget and it had to absorb capital belonging to the Ministry of Education, Transportation, Industrial Equipment and Defence. In 1954, The Ghillebaud Committee assessed the NHS expenditure since its inception, finding that the expenditure was too low to maintain the estimated standards and highlighting the need to raise health spending to the level before the Second World War.

Ten years passed, and the social gap in healthcare started to shrink. People with social and mental illness requesting healthcare increased considerably, a fact derived from the decline of religious and community support in the 1960s. New social problems arose: suburban neurosis (attributed to boredom), loneliness, the lack of values and the increased use of illegal drugs and civil disobedience, derived from the hippie movement.

Screening for various diseases spread, especially in child welfare clinics. Health promotion and disease prevention expanded through the media despite censorship, with programs such as *The hurt mind*, which reported 5000 suicides by depression each year in the UK despite the help that was available, prompting depressive patients to seek healthcare support. The continuous diagnosis was implemented, unlike the previous method of a GP visit per person, and community care was more common, reducing hospital admissions.

The university training that medical specialists received was expanded, allowing greater hospital services' specialisation. These hospital services were centralised in regions according to the population they were accessible to, even if they overestimated it and a beds surplus was created.

With the *Porritt Report*, Sir Arthur Porritt, chairman of the Royal College of Surgeons and the BMA, established a tripartite model in which public and private health services were combined to avoid the monopoly of any of them, even though Enoch Powell, Health Minister, considered unfeasible to meet that all the NHS objectives without increasing funding or cutting services. However, Kenneth Robinson believed that the NHS could be stable financially if it suffered an administrative restructuration, proposing it in his *Green Paper* in 1968.

After improvements in health, housing, food and the environment in the 1970s, it was discovered that the diseases with the highest mortality (heart disease, lung cancer and bronchitis) derived from the urban and consumerist society that prevailed, although the only governmental preventive measure that was implemented was raising the price of tobacco and alcohol repeatedly.

The British lifestyle changed with the increment of international holidays, the spread of the automobile, the introduction of aerobic and altered eating patterns. This renovation also introduced music festivals, criticised by the British Medical Journal (BMJ) due to the increasing drug use and multiple sexual intercourses during these events. In 1968, there was a large reduction in prescription production due to the return of prescription fees for all patients, except for chronic patients, children, the elderly and people receiving supplementary benefits, which accounted for half of the prescriptions produced.

Hospital services specialised even more, so much so that they could treat a patient with multiple pathologies of different specialties in the same hospital, increasing the survival rate in large institutions with the appropriate resources, especially in paediatric patients. The *Bonham-Carter Report* would emphasise the need for service centralisation in larger hospitals, with at least two consultants for each specialty, who were organised by divisions following the *Cogwheel Report* guidelines.

The 1970s would be marked by the first NHS administrative and financial restructuration, even if it did not have the expected results. After the conservative restructuration proposal through *The White Paper*, which did not convince doctors due to its high administrative jargon content, the labour party proposed a restructuration of community and hospital services administration, adding inflexible and specific roles to

all NHS workers according to their jobs through the *Management arrangements for the reorganized NHS* (also called "the Grey Book").

After the election of Barbara Castle as Secretary of State in 1974, her attempt to ban private practice within the NHS ended in a service withdrawal warning from the BMA and a strike by NHS nurses demanding better pay, which disabled NHS services. Also during her tenure, NHS funding was redistributed following the document *Priorities for health and social services staff in England*, which clarified the need to cut funding from various parts of the NHS due to the economic recession.

Looking for a clever use of NHS funding, and following the government's refusal to a financial investigation requested by all Royal Colleges, the BMJ proposed reforms to simplify the elaborate administrative system, improve the use of trained professionals, improve health spending transparency and increase health education.

Despite all the reforms since its inception, NHS resources were misallocated, facilitating social and territorial segregation. This discrepancy was the seed of The Resource Allocation Working Party, a working group whose mission was to reduce disparities in healthcare between different England regions, despite tensions between the rich London and poorly funded northern England.

In 1978, successive strikes by doctors, nurses and paramedics seeking a salary raise and improved working conditions increased the NHS waiting lists and quality of care fell quickly, even though the minimum services were covered.

In 1979, the first legislature of the conservative Margaret Thatcher began, who would continue until 1990 as prime minister after three terms. Before that, the labour party attempted to curb NHS spending growth, but it had already risen by more than 1% of the GDP, so the conservative party sought different solutions when it came to power. Upon receipt of the *Royal Commission report* that the former party requested to address the NHS financial problems, Patrick Jenkins, Secretary of State, created his own document to restructure the NHS, simplifying its administrative structure and reducing its cost, *Patients First*.

In 1982, the longest union dispute the NHS has seen shook UK healthcare. While nurses fought for a 12% wage increase, waiting lists were even longer and patient care was

even poorer. After more than a year of strikes and negotiations, nurses got a smaller salary increase and salary review body, reaffirming their power in the NHS.

Thanks to the NHS restructuration, it was estimated that she could save between 0.5% and 1% of total capital available from the NHS each year. However, when Margaret Thatcher began her second term in 1983, she decided to allow private practice, raise the existence of private health insurance and cut one billion pounds of public spending, directly reducing public employees' salary between 0.75% and 1%, including doctors and nurses, despite her electoral promise to not dismantle the NHS.

During these years, the number of staff and admissions increased, but that staff observed the deterioration in the quality of the treatment and care that patients received, knocking staff morale and patient confidence in an NHS that was grossly underfunded. The NHS economic situation became a political conflict between the restructuration's apparent economic efficiency and the apparent lack of funding for acute care services in regards to the increased healthcare costs.

The society of that time abandoned confidence in science, fearing new scientific advances, calling them catastrophic and seeking alternative treatments like meditation or ginseng to supplement medical treatments despite the media advertising against them, which talked about health issues regularly. However, uncertified information did weaken the media credibility regarding health, as exemplified by the case of the television program about brain dead patients that recovered, who were misdiagnosed but cast doubt on the population and managed to freeze organ donation numbers for two years.

Each generation's expectations never met, since job security was not something assured, family support was laxer, social security support was threatened, the real estate market began to decline and dreams of prosperity began to disappear. So much so that the generation of young adults born between 1961-1981, the so-called Generation X, was characterised by a sceptical view of society.

In the 1990s, new factors entered the healthcare environment internationally: large buyers, governments and private companies, demanding better profitability; patients with greater knowledge of healthcare sciences, in part due to the creation of MEDLINE

by the United States of America Department of Health in 1997; new technologies like Internet and Molecular Biology; changes in Healthcare and Medicine boundaries, considering the complex relationship between environment and health; and ethical debates on issues such as dignified death, resource distribution and new technologies.

Although NHS spending was only increased by a third in the past 10 years, the fifth decade of its history began with a financial crisis, in which the NHS was technically bankrupt. A solution was negotiated, excluding the medical profession for the first time in history, and concluding that a health insurance scheme would be the most feasible solution. *Working for Patients* was published in 1989, which separated service acquisition from provision. This situation intended to create a competitive market and to increase the NHS funds' profitability, simulating the American liberal healthcare model.

Despite its detractors, among which it was the BMA, which argued the need for a pilot study; NHS Trusts were created, autonomous entities with an industrial management model; and the *fundholding* model, in which GP surgeries could control their own budget. Maintaining the patient-based model, medical audits were implemented in public and private healthcare to assess their quality and the *Citizen's Charter* was enforced to mark the standards to which healthcare institutions should aspire to and how to measure them, being a minimum requirement for those services to be hired by the NHS.

In 1996, the administrative structure was condensed again into eight regions so each region could represent a competitive area in a publicly funded mercantilist system. Therefore, the most economically efficient hospitals in the NHS history were achieved, even if the financial pressure they suffered increased discharges and shortened hospital stays, which led to a record increase in assistance to emergency departments. Between 70% and 95% of hospital admissions went through the emergency department, and in the period 1990/1 - 1994/5 they increased by 10%.

Other factors involved in this increase were an ageing population, greater ability to help patients in emergency situations, higher expectations from patients, changes in primary care, social factors, defensive medicine, lack of beds in key departments and shortage of emergency surgery theatres.

Thanks to The Audit Commission, other issues were discovered, such as inappropriate admissions, unexplained variations in hospital stay length, lack of consensus in clinical practice, poor discharge procedures and outdated bed allocation systems. To alleviate some of these problems, evidence-based medicine started to be applied, supported by the UK Cochrane Collaboration and the Clinical Outcomes Group.

*White Paper, The health of a nation* was created to reduce the incidence of the most common diseases in the UK, which was focused on supporting the reduction of coronary heart disease, stroke, cancer, mental illness, accidents and sexually transmitted diseases. Another method to ration resources in primary care was the use of quality-adjusted life years (QALY) as a measure of healthcare efficiency.

### 1.2.2. The National Health Service today

After more than 65 years of history and evolution, the NHS has established itself as a global healthcare referent. This system serves one million patients every 36 hours, for which it employs 1.6 million employees, constituting the fifth largest workforce in the world (after the United States of America Department of Defence, McDonald's, Wal-Mart and the Chinese People's Liberation Army).

The NHS in England is the biggest part of the system, serving 52.9 million patients through 1.3 million employees. Of these employees, within the registered staff there are 40.236 doctors, 351.446 nurses, 18.576 paramedics and 111.963 GPs and dentists in hospital and community services. The NHS in Scotland, Wales and Northern Ireland employs 159.748; 84.817 and 62.603 people respectively (60).

This system is maintained fully and directly through taxes, which are supported by English Law. Prices are calculated by the Department of Health with NHS England and Monitor, which are responsible for it based on *The Health & Social Care Act 2012*. When it was created, the NHS had a budget of 437 million pounds, almost 9 thousand million pounds at current value. For 2015/2016, the NHS had a budget of 115.5 thousand million pounds.

This system follows principles and values that have changed with its evolution. Currently, these derive from the NHS Constitution, which lists them in its seven principles and six values (61):

- Principles:
    - The NHS provides a comprehensive service, available for all: Irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.
    - Access to NHS services is based on clinical need, not an individual's ability to pay: NHS services are free, except in limited circumstances sanctioned by Parliament.
    - The NHS aspires to the highest standards of excellence and professionalism: In the provision of high quality care that is safe, effective and focused on patient experience; in the people it employs, and in the support, education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population. Respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.
    - The NHS will be at the heart of everything the NHS does: It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and

preferences of patients, their families and their carers. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services.

- The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population: The NHS is an integrated system of organisations and services bound together by the principles and values reflected in the Constitution. The NHS is committed to working jointly with other local authority services, other public sector organisations and a wide range of private and voluntary sector organisations to provide and deliver improvements in health and wellbeing.

- The NHS is committed to providing the best value for taxpayers' money and the most effective, fair and sustainable use of finite resources: Public funds for healthcare will be devoted solely to the benefit of the people attending the NHS.

- The NHS is accountable to the public, communities and patients that it serves: The NHS is a national service funded through national taxation, and it is the Government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose.

- Values:

  - Working together for patients: The value of "working together for patients" is a central tenet guiding service provision in the NHS and other organisations providing health services. Patients must come first in everything the NHS

does. All parts of the NHS system should act and collaborate in the interests of patients, always putting patient interest before institutional interest, even when that involves admitting mistakes. As well as working with each other, health service organisations and providers should also involve staff, patients, carers and local communities to ensure they are providing services tailored to local needs.

- Respect and Dignity: Every individual who comes into contact with the NHS and organisations providing health services should always be treated with respect and dignity, regardless of whether they are a patient, carer or member of staff. This value seeks to ensure that organisations value and respect different needs, aspirations and priorities, and take them into account when designing and delivering services. The NHS aims to foster a spirit of candour and a culture of humility, openness and honesty, where staff communicate clearly and openly with patients, relatives and carers.

- Commitment to quality care: The NHS aspires to the highest standards of excellence and professionalism in the provision of high-quality care that is safe, effective and focused on patient experience. Quality should not be compromised. The relentless pursuit of safe, compassionate care for every person who uses and relies on services is a collective endeavour, requiring collective effort and collaboration at every level of the system. The delivery of high-quality care is dependent on feedback: organisations that welcome feedback from patients and staff are able to identify and drive areas for improvement.

- Compassion: Compassionate care ties closely with respect and dignity in that individual patients, carers and relatives must be treated with sensitivity and kindness. The business of the NHS extends beyond providing clinical care and includes alleviating pain, distress, and making people feel valued and that their concerns are important.

- Improving lives: The core function of the NHS is emphasised in this value. The NHS seeks to improve the health and wellbeing of patients, communities and its staff through professionalism, innovation and excellence in care. This

value also recognises that to really improve lives the NHS needs to be helping people and their communities take responsibility for living healthier lives.

- Everyone counts: We have a responsibility to maximise the benefits we obtain from NHS resources, ensuring they are distributed fairly to those most in need. Nobody should be discriminated or disadvantaged, and everyone should be treated with equal respect and importance.

Following these principles and values, the NHS expands into a complex structure to encompass completely and efficiency the population's healthcare. To understand this system, the NHS organizational structure has to be briefly explained (62):

- The Secretary of State of Health: The Secretary of State has overall responsibility for the work of the Department of Health.

- The Department of Health: This department is responsible for the strategic direction and funding for health and social care in England. The Department of Health is a ministerial department, assisted by 23 agencies and public bodies.

- NHS England: It is an independent public body which conducts independent work for ministries or the government. Its main role is to improve health and care outcomes for people in England. NHS England monitors the performance and allocates resources to the clinical commissioning groups and manages primary and specialty care.

- Clinical commissioning groups *(*CCGs): These are NHS statutory bodies managed by the clinical staff responsible for the planning and implementation of healthcare services in their local area. They replaced the primary care trusts in April 2013. CCGs members include GPs and other clinicians, like nurses or consultants. They are responsible for 60% of the NHS budget and organize most secondary care: hospital care, rehabilitation, urgent and emergency care, most community health services, mental health services and learning disability services.

  The CCGs can hire any service provider that meets the NHS standards and budget. These can be NHS hospitals, social businesses, charities or private sector providers, which are selected and organised through a process called commissioning (63).

However, they must be assured of the quality of the services they authorised, taking into account the National Institute for Health and Care Excellence (NICE) and the Care Quality Commissions (CQCs) guidelines. Both NHS England and the CCGs have a duty to consider patients, carers and the public in decisions related to the services they organize.

To assist the CCGs there are several national, regional and local organisations, which ensure that the healthcare providers' production focuses on improving the health and wellbeing of the local population (64):

- Commissioning Support Units *(*CSU): These units support the CCGs on the practical aspects of their role, providing support in several areas, including:
  - Transactional commissioning: For example, market management, contracts, negotiations, information and data analysis.
  - Transformational commissioning: For example, redesigning services.

  There are 9 CSU groups across England, which have no defined limits and can serve any CCG. The CCGs can utilise CSUs as they considered appropriate, from a minimum function to a much wider contract. There is no obligation to use them and the CCGs will always be responsible for the contracted services.

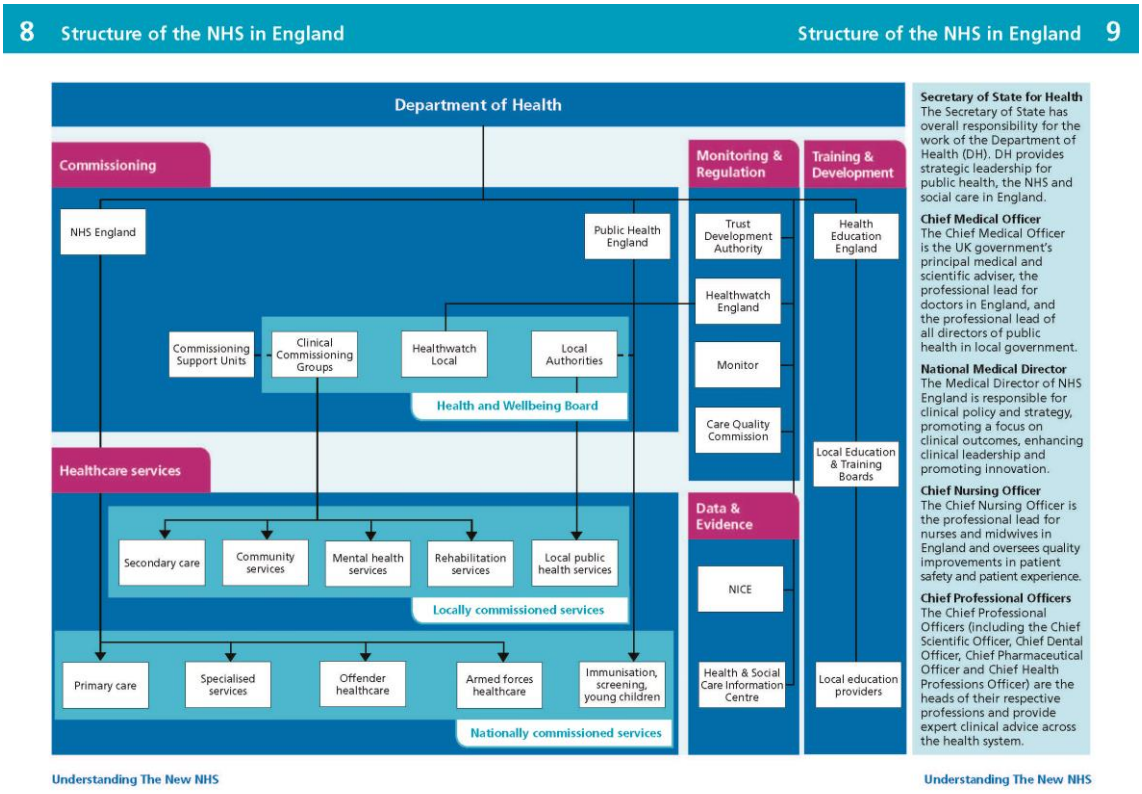
- Strategic Clinical Networks: They focus on specific areas to improve healthcare equality and quality for its population. They gather those who use, provide and contract services (including local governments) to support an effective service provision. The current areas of interest are: cardiovascular diseases (including heart disease, stroke, kidney disease and diabetes); maternity, children and the youth; mental health, dementia and neurological disorders and cancer.

- Clinical Senates: They are multidisciplinary expert advisory groups on health and social care, which include patients, volunteers and other groups. There are 12 Clinical Senates, covering the whole of England. Their purpose is to be a source of independent strategic advice and guidance to CCGs and

other stakeholders to help them make the best decisions around health provision for the populations they represent.

- Health and wellbeing boards (65): Each higher level local authority has established a health and wellbeing board to act as a forum for local commissioners, social services, public health and other services throughout the NHS. The meetings are intended to increase the democratic input into strategic decisions about health and welfare services, strengthen working relationships between health and social care and encourage integrated commissioning of health and social care services.

**Diagram 1: Structure of the NHS in England**




Recovered from: NHS England. Understanding The New NHS [Internet]. London: BMJ; 2014 [quoted 17 jul 2015]. Available at: http://www.nhs.uk/NHSEngland/thenhs/about/Documents/simple-nhs-guide.pdf

- Public Health England (66): Provides national leadership and expert services to support public health, and also works with local governments and the NHS in emergencies. Its main functions are: coordinating a national public health service, building an evidence base to support local public health services, assisting the public to make healthier choices, providing leadership for the public health delivery system and supports the development of the public health workforce.

After describing the NHS organisational structure (see diagram 1) and before delving into the structure of NHS healthcare service distribution, we must mention the differences between NHS Trusts and NHS Foundation Trusts, which can provide the same healthcare services, but their management, regulation and finance are different:

- Direction: NHS Foundation Trusts, unlike NHS Trusts, are not directly managed by the government, so they have more freedom to make strategic decisions.

- Regulation: Although the quality of both institutions is valued by the CQCs, NHS Foundation Trusts' financial evaluation is done by Monitor, while the Trust Development Authority does this assessment for NHS Trusts.

- Finance: While NHS Trusts are economically accountable to the government, NHS Foundation Trusts are free to make their own financial decisions according to the agreed accountability within a framework set by the government through Law, allowing them to keep and reinvest surplus funds.

The distribution of healthcare services is done through different institutions, each specializing in a service or group of services:

- Primary care services: They include a wide variety of providers like GPs, dentists, optometrists, pharmacists and the service NHS 111. There are more than 7500 GPs providing primary care in England.

- Acute trusts: They offer secondary care and specialised services. Most activities in acute trusts are commissioned by CCGs, even though some specialised services are centrally organized by NHS England.

- Ambulance trusts: They manage emergency pre-hospital care for non-fatal and fatal diseases, including the service NHS 999. In some areas, ambulance trusts can be hired to do non-urgent hospital transport or to cover the NHS 111 service.

- Mental health trusts: They provide community, hospital and social services for a wide range of psychological and psychiatric diseases, being contracted and funded by the CCGs. Mental health services can also be provided by other NHS organisations, charities and the private sector.

- Community health services: Generated by foundation and non-foundation community health trusts, these services include community and district nurses, health visitors, school nurses, community specialized services, hospital at home services, walk-in centres and community rehabilitation.

In order to assure the public that all services that are accessed through the NHS are safe, efficient and effective, healthcare institutions are evaluated through regulatory organisations (monitoring) and healthcare professionals are assessed individually through their regulatory professional bodies (revalidation), making sure that their practice is correct. Different institutions assume different roles in the same function, so it is necessary to investigate their functions and features:

- Monitoring:
    - Monitor: The financial regulator of NHS Foundation Trusts. Monitor works to ensure that:
        - NHS Foundation Trusts are well structured and well-led, so they can provide quality care.
        - NHS essential services are maintained if a provider finds any difficulties.
        - The NHS payment system promotes quality and efficiency.
        - Recruitment, choice and competition are directed to patients' interests.
    - National Quality Board (NQB): It is a multidisciplinary panel established to certify quality and to ensure unanimity in the objectives set throughout the NHS. Its aim is to bring various organizations with an interest in improving their quality together to approve the NHS quality objectives while respecting the participants' independence.
    - Care Quality Commission (CQC): CQCs are the independent regulators of quality in health and social care in England (including private providers). They register and inspect hospitals, nursing homes, GP surgeries, dental

clinics and other healthcare services. If services are not meeting basic quality and safety standards, the CQC has the power to issue warnings, restrict the service, issue a permanent fine notice, suspend or cancel the registration or prosecute the supplier.

- Trust Development Authority (TDA): It is responsible for ensuring that NHS Trusts develop the ability to achieve the independent status of NHS Foundation Trusts. TDA key features include performance monitoring, clinical quality assurance assessment, transition to the state of NHS Foundation Trust and appointment of the NHS Trust's chairmen and non-executive members.

- Healthwatch: It has been established as an independent advocate for health and social services consumers. It aims to represent the public by collecting opinions on health and social care, both locally and nationally. Each local authority in England has a Healthwatch. It is expected that through the Healthwatch network the voices of people using the NHS are heard. To do this, Healthwatch meets these views by conducting research in local areas, identifying gaps in services and feeding back through local health plans.

- Revalidation:

  - General Medical Council (GMC): The GMC is the independent regulator of almost 260.000 doctors in the UK and was established in the *Medical Act 1958*. Its main roles are:

    - Establish the standards required of doctors practising in the UK.

    - Decide which doctors are trained to work in the UK and abroad, their education and their training.

    - Ensure that doctors continue to meet these standards throughout their careers through a five-year revalidation cycle.

    - Take action when a doctor can put patient safety at risk.

- Nursing and Midwifery Council (NMC): The NMC regulates more than 670.000 nurses and midwives in the UK. Its key responsibilities include:
    - Establish professional standards in education, training, performance and behaviour; ensuring that these standards are followed.
    - Investigate nurses or midwives who fail to meet those standards.
- General Dental Council (GDC): The GDC regulates all odontology professionals, including dentists, nurses, technicians and hygienists.
- General Pharmaceutical Council (GPhC): The GPhC is the independent regulator for more than 70,000 pharmacists, pharmacy technicians and pharmacies in the UK.
- General Optical Council (GOC): The GOC encompasses about 26,000 optometrists, opticians, optical and optometry students and optical businesses.
- Health and Care Professions Council (HCPC): The HCPC systematises a wide range of professions, including art therapists, biomedical scientists, paramedics, podiatrists, clinical scientists, dieticians, audiologists, occupational therapists, social workers and speech therapists.

Although each of these regulatory institutions has different roles, all aim towards excellence in the quality of NHS healthcare. However, to strive for quality in healthcare is necessary to specify what NHS quality means. The definition offered by the NHS is "quality is defined as excellence in patient safety, clinical efficacy and patient experience" (67). To improve this quality, each year the Department of Health publishes the *NHS Outcomes Framework* (68), a document containing the objectives that the NHS should achieve. These objectives are grouped into five domains, which coincide with one of the three parts of the definition of quality:

- Clinical efficacy:
    - Domain 1: Prevent that people have a premature death.
    - Domain 2: Improve the quality of life of people with chronic diseases.

- Domain 3: Help people to recover from episodes of illness or after an injury.

- Patient experience:
  - Domain 4: Ensure that people have a positive experience in regards to the care provided

- Patient safety:
  - Domain 5: Treat and care for people in a safe environment and protect them from avoidable harm.

To meet and surpass the objectives that the NHS proposed each year in the *NHS Outcomes Framework*, there are several institutions or financial measures that support the goal of care quality excellence differently.

- Guide institutions:
  - NHS IQ: It was established in April 2013 to help promote and support NHS improvement by building evidence and improved knowledge and skills. NHS IQ has been built on many existing organizations such as the NHS Institute for Innovation and Improvement and NHS Diabetes and Kidney Care.
  - National Institute for Health and Care Excellence (NICE): It provides guidance and advice to improve national health and social care. This is achieved through:
    - Evidenced-based advice and guidelines for healthcare, public health and social services.
    - Legally bounding quality standards to those providing healthcare, public health and social services.
    - A wide range of information for commissioners, professionals and managers across the spectrum of health and social services.

- Financial measures:

    - CQUIN: It is a system that was introduced in 2009, in which a proportion of the healthcare provider's income is only perceived by demonstrating improvements in quality or innovation in specific areas. Its value varies, but is usually around 2.5% of the total contract value for that organisation. When implemented effectively, it can lead to improvements in patient care. Examples of CQUIN objectives include Friends and Family questionnaires, risk assessment for patients that could develop a blood clot in hospital and screening of patients with dementia.

    - Premium Quality: NHS England is able to reward CCGs to reflect the quality of the services they hire and their associated health outcomes, and Premium Quality is one of those incentive methods. A guide is published annually on the areas in which the CCGs will be rewarded with a Premium Quality payment if they fulfil the necessary improvements in service quality. These areas may change annually depending on clinical needs, but some recurrent examples are improving access to psychological therapies and reduce avoidable emergency admissions.

Once the NHS system has been briefly explained, it is necessary to understand how the system offers services to patients, detailing in more depth how urgent and emergency services are distributed. As noted above, patients within the NHS have free choice in most healthcare services. However, a service classification is made according to the type of disease and its severity to avoid resource misuse, increase service specificity and efficiency and improve patient satisfaction, allowing critical patients to be treated faster. Considering only disease severity, those resources can be classified as follows (69):

- Not urgent: If a patient feels ill but is not urgent, he can make an appointment at his GP surgery, dentist, mental health service or optometrist depending on the type of disease. He can also ask his pharmacist for advice.

- Urgent (non-emergency): If a patient needs urgent medical attention but his life is not in danger he can visit a walk-in centre, minor injuries unit or urgent care centre if the illness or injury is not serious but needs attention before his GP surgery opens.

He can also call NHS 111 for urgent advice in case he does not know which healthcare service is appropriate for his situation. If it is an urgency related to the patient's mental health and is not an assault (for which he has to call the police) or an emergency situation, there are phone numbers for urgent psychological help. In addition, if it is a dental urgent disease there are emergency dentists, but it is a service for which the patient has to pay a fee (18.80 pounds in 2015).

- Emergency: If the patient is seriously ill or injured and his life is in danger he should go to an emergency service immediately or call NHS 999 if he can not arrive on his own to an emergency department quickly and safely. For non-emergency urgent patients, they can be transported by ambulance to the emergency department if required but the critically ill patients will be prioritised before them.

  When an ambulance is necessary and the patient call NHS 999, a telephone triage process occurs, during which NHS 999 staff assesses the patient's condition and sends the necessary resources at the appropriate priority. Calls are categorised as follows (70):

  - Immediate emergency situations (category A):
    - Red 1: 75% of category A Red 1 calls (most of them critical, where patients do not breathe or do not have pulse) are responded in less than 8 minutes.
    - Red 2: 75% of category A Red 2 calls (serious but not critical situations, like strokes or seizures) are responded within 8 minutes. Timing begins 60 seconds after the Red 1 countdown.
    - A19: 95% of category A calls are answered in 19 minutes or less.
  - For all calls that do not fall into category A, the time response objectives are proposed locally. For the year 2013/2014, 16.1 calls per minute were attended, according to the report of Health and Social Care Information Centre (71).

Some CCGs regularly hire patient transport services (PTS) to free NHS 999 services from inadequate calls and transfers regarding their established role as emergency transportation services.

Once the patient arrives at the emergency department, either by ambulance or by his own means, he must go through a triage process with a doctor, a nurse or a practitioner (advanced nurse practitioner, emergency nurse practitioner, etc.) that will use the techniques and guidelines dictated by the hospital. The only exceptions are category A Red 1 patients, who are automatically assigned the highest level of acuity in the triage scale and moved directly for diagnosis and treatment. Most emergency departments are operating continuously, even though in some departments the minor injuries area is closed during the early morning.

To accelerate patient flow and increase satisfaction with the care received, the 4-hours target was approved in 2002, which prohibit that any patient spends more than four hours in the emergency department from arrival until admission, transfer or discharge. The limit set by the government in 2003 was 98% of patients admitted, transferred or discharged in less than four hours, which was changed to 95%. However, during the winter months emergency departments were crowded (72-4), making it difficult to fulfil this rule and involving millions of pounds in fines to those departments.

To solve these problems and other ones related to NHS urgent and emergency care, and after being considered a priority by the strategic plan *Everyone Counts Guide: Planning for Patients 2013/14* (75); the NHS Medical Director, Professor Sir Bruce Keogh, announced in 2013 a comprehensive review of the NHS emergency services in England. This review, called *Keogh Urgent and Emergency Care Review*, aims to restructure the system so it is more efficient and safe. After being approved, this project was defined in various phases:

- Phase 1: To assess the need for this change, patients, the public, NHS staff and organisations were consulted on the scientific evidence and the principles to be followed for a change in the current situation of urgent and emergency care. 97% of respondents felt that the current system needed changes and two-thirds of respondents supported all or the majority of the proposed principles. At the end of phase 1, the document *Urgent and Emergency Care Review: End of Phase 1*

*engagement report* (76) highlighted five key changes, which must be followed to ensure the project's success:

  - Provide better support for self-care.
  - Help people with urgent needs to receive the right advice at the right place the first time they request it.
  - Provide high-speed response urgent services outside the hospital, so people no longer choose to queue at the emergency department.
  - Ensure that people with serious or life-threatening diseases are treated at centres with the appropriate facilities and expertise in order to maximise the chances of survival and optimal recovery.
  - Connect all urgent and emergency services between them so the system as a whole becomes more than the sum of its parts.

- Phase 2: This phase aims to transform the work done in phase 1 onto a framework to guide and support commissioners, doctors and healthcare providers in the transformation of urgent and emergency services. Professor Keith Willett, director for acute episodes of care, and Professor Jonathan Benger, national clinical director for urgent care, have led this second phase of the review on Sir Bruce Keogh's name. They gathered doctors across the NHS to transform the proposed changes in real innovations. Following the work of this group of doctors, the results were delivered to Urgent and Emergency Care Delivery Group (77) to resolve the practical aspects needed to create this integral system change, which results were reflected in the *Urgent and Emergency Care Review* (78).

- Phase 3: At this stage, initiated in 2015, the establishment of Urgent and Emergency Care Networks (79) was raised, which are regional institutions that work with the local System Resilience Groups to implement an organizational structure for urgent and emergency services.

This project is ongoing, so there are no final results yet. However, the structure within an emergency department is not considered one of the goals, so at the moment the current distribution will be maintained. This distribution is dependent on each hospital

or each NHS Trust, since they only have to maintain the minimum standards required by the NHS. However, most emergency departments have the same key areas within them:

- Triage/assessment: In this area, the patient is triaged so he can be transferred to the most appropriate area relative to his condition with the adequate quickness. Each hospital decides if a complete triage or just a quick evaluation is necessary, since the patient will be evaluated more thoroughly in another area. A 15-minutes target is set to assess the patient, avoiding using most of the 4 hour limit in triage. Moreover, the required analytical and radiological tests are done so the patient does not have to wait more for them, since to receive some tests' results it could take more than an hour. After this triage, the patient is referred to another area according to the result of said triage.

- Minors: The only area of the department that could not be open 24 hours a day, Minors is dedicated to treating urgent musculoskeletal injuries, since it can perform the same function than a minor injury unit if necessary. Minors has a faster patient flow compared to other areas, since injuries are less critical and patients are assessed and treated quicker. When it is closed at early morning, patients that would be referred to Minors are transferred to Majors.

- Resuscitation (Resus): When an emergency patient is in a critical situation, he is transferred to the Resuscitation area, commonly called "Resus". In this area, the ratio of doctors and nurses per patient is the highest in the department, in addition to having adequate equipment and staff trained to monitor and treat a critically ill patient.

- Majors: Area where patients with urgent or emergency pathologies that are not critically enough to go to Resus but need more attention than in Minors are diagnosed and cared for.

- Children's ED: It is the paediatric emergency department. It may not be present in all hospitals or be separated from the adult emergency department. It has its own triage area, Majors and Minors, and it can have a Resus area on its own or share it with the adult emergency department.

# Chapter II:
# Ethical and legal accountability basis in Emergency Nursing practice

### 2.1. Ethical and legal context

In the twenty-first century, each of the healthcare professions follows a code of Ethics that has accompanied them since their inception and evolved with them, resulting in a deontological compendium of rules which reflects each profession's ideals. These deontological codes define the model behaviour of a doctor or nurse, which serve as a pattern for the formation of future generations and the progress of the profession itself. Although deontological codes are not mandatory per se, many professional associations adopt such codes as a sign of good practice, imposing their alleged implementation as an indispensable condition for membership.

Nevertheless, within a globalised and marketable healthcare system, healthcare professionals have to deal with their patients' privacy, health and lives within public health systems and private companies, which limit their own ethical code as an implicit contractual constraint with their employers through mandatory compliance with their professional deontological code. For example, in the UK it is mandatory for all nurses adhere to the NMC Code of Conduct to practice legally (80).

Patients would solely depend on the subjective moral adherence to professional and institutional codes of practice if it was not for the law applied to patients' rights, defended by professional bodies like the NMC (9). However, Kim, Kang and Ahn argue that moral sensitivity is also needed to implement and improve ethical codes (81).

Patients' rights as healthcare service consumers allow them to demand high-quality treatment and care according to the established standards and how those are funded (taxes, health insurance or cash). The transition from the doctor-patient relationship to the doctor-client relationship that started in the mid-twentieth century is derived from the transformation of Bioethics' and Law's roles from a paternalistic perspective, in which the doctor decided on the patient's best interest, towards the defence of patient autonomy, where the client has full control over any decision related to his health and the doctor is only a mean to gain that control; trend that is spreading gradually from the United States of America to the rest of the world (82). However, despite its acceptance, autonomy is not always applied in practice, especially with mental health patients.

In the case of Nursing, given its short history as a recognised profession, the evolution of the nurse-patient relationship to the nurse-client relationship occurred at the same time as it was growing as a discipline (with theories like Peplau's (84)), thus enabling legally competent independent nurses to be considered guilty of breaching their duties as nurses, which are governed by the applicable nursing deontological code.

The use of deontological codes as a legal basis entails that the moral rule is validated as legal duty, giving it the dual function of minimum Ethics for clinical practice and legal definition of healthcare professionals' duties. However, this duality implies that deontological codes shift from recommended to mandatory, diluting their moral influence within the legal contract despite their origin was moral, as has happened with the creation of many other laws.

For emergency care, a number of ethical problems have not been legislated in a concrete way, the exception being the presumption of emergency due to its promptness and complexity. This not only happens in the UK, as will be discussed below, but in most countries with legislated healthcare. For example, this exception exists in Spain in the Act 41/2002 of the 14$^{th}$ of November, also called *Ley de Autonomía del Paciente*. In article nine, section 2, subsection b) of this Act, the emergency situation as an exception to the informed consent requirement is presented (85), even though there are more exceptions in the Civil Code (86), the Criminal Code (87) and the *Ley General de Sanidad* (88). That is why in order to understand how ethical problems are solved we have to know which ethical code is applicable, what are its influences, the laws that accompany it and the context in which the problem is situated.

## 2.2. English ethical base and its influence on clinical practice

### 2.2.1. Utilitarianism

The UK has gone through several ethical theories from the establishment of a society in the British Isles. However, one of the facts from which British contemporary thought and its moral derives is that Britain was the pioneer of Utilitarianism.

Coined by Jeremy Bentham, Utilitarianism is a moral theory that affirms that happiness is the sole end in itself, relegating everything else to be means to that end. The aim of Utilitarianism is to combine individual and collective happiness to achieve the greatest happiness for the greatest number of people, which is measured in pleasure or absence of pain. For it, it matched the concepts of usefulness and happiness, defining the utility principle axiom as "the greatest happiness for most is the measure of good and evil" (89).

Later, the concept is refined and driven by John Stuart Mill, a Bentham's disciple, who distinguished the pleasures' quality, not just their quantity. By differentiating the pleasures' quality, Mill argued that the intellectual and/or moral pleasures are superior to physical pleasures. Also, he distinguished between happiness and satisfaction, giving more value to happiness, a fact expressed in his quote: "It is better to be a dissatisfied human being than a satisfied pig; is better to be Socrates dissatisfied than a fool satisfied. And if the fool or the pig has a different opinion is because they only know their own side of the question ".

Although he does not demonstrate that the happiness principle is fundamental, Mill understood it as a "concrete all", which is known by intuition, formed by different values like health, virtue, excellence, self-respect, money or fame (90).

According to Esperanza Guisán, the justification of the utilitarian principle, derived from its premises, would go through three steps (91):

- Everyone desires happiness (psychological hedonism).
- It is desirable that everyone seek their happiness (selfish ethical hedonism).

- It is desirable that everyone seeks happiness around the world, including his own (universal ethical hedonism).

To avoid confusion regarding Utilitarianism, we must expose its ramifications and interpretations, since some of them are so disparate that do not seem to belong to the same body of knowledge, leading to misinterpretation. These interpretations are divided into different groups (92):

- Act Utilitarianism and Rule Utilitarianism: Act Utilitarianism only considers the concrete and direct consequences of an action to determine its goodness or badness, while Rule Utilitarianism considers the consequences arising from the routine application of the rule under which the actions subsumes. In the case of lying, an act utilitarian would assess if lying would cause more good than harm, while a rule utilitarian would not ever lie because the moral rule is that lying is wrong.

- Hedonic, Semi-idealistic and Idealistic Utilitarianism: Distinction done by Smart, which separates Bentham's perspective (hedonic), in which the value of all pleasures is the same; Mill's perspective (semi-idealistic), in which the value of each pleasure is different and the pleasure's worth not only depends on its type but also on the evolution of the happiness concept in the person; and Moore's perspective (idealistic), in which happiness is replaced by good without any hierarchy or distribution.

- Quantitative Utilitarianism and Qualitative Utilitarianism: In Quantitative Utilitarianism only the amount of pleasures is counted while Qualitative Utilitarianism also considers their value.

- Preference Utilitarianism and Happiness Utilitarianism: As an alternative to Happiness Utilitarianism, in which the concept of happiness must be ruled by a group of people to apply it universally, which could lead to paternalism and dogmatism; Hare proposed Preference Utilitarianism, which emphasises impartiality valuing the wishes that people would have if they understood the possible objects of desire, not the desires of a majority or a minority that supposed to create happiness.

- Expanded or Strengthened Utilitarianism: Driven by Farrell, although present in Mill's writings, this extension of the concept of Utilitarianism includes the notion of

prima facie rights to prevent possible attacks to individual rights, making utility a relative concept in favour of the rights of each individual.

According to Victoria Camps, there is a widespread rejection of Utilitarianism by the Principles Ethics. John Rawls presented his *Theory of justice* as an alternative to Utilitarianism, distinguishing between good and justice, unlike Utilitarianism, which considers fair what people think is good for them, which can be considered fallacious and ethically dangerous (93).

Nevertheless, Esperanza Guisán states that the two issues most criticised by Principles Ethics, equitable distribution of happiness and concern to safeguard the rights of all individuals, have already been answered by Mill and the difference between Principles Ethics (e.g. Kantianism) and Consequences Ethics (e.g. Utilitarianism) can be shortened bearing in mind Mill's Rule Utilitarianism and extending Brandt's principle of happiness fair distribution (94).

The influence of Utilitarianism in English clinical practice was stronger during the twentieth century that during the first decade of the twenty-first century, due to the criticisms of Utilitarianism from various ethical theories and its apparent neglect of minorities. However, it continues to be reflected in English society and practice, like in the hospital departments' efficiency and care quality evaluation through the Friends and Family questionnaire or the policies proposed in the NHS Constitution.

### 2.2.2. Neocontractualist Ethics and Neoliberalism

The prevalence of Utilitarianism in the UK and the NHS during the twentieth century does not exclude the influence of other ethical theories, especially since Rawls' critique of Utilitarianism in his *Theory of Justice* in 1971, during the welfare crisis, placed Neocontractualist Ethics or social liberalism as the alternative.

The focus on moral reasoning and justice of Rawls's work continues to create debate and influence English Ethics today. In his articles, he argued that it is not possible to create an established moral code, what differentiates Ethics and Law and is not considered in Rule Utilitarianism. In addition, Rawls presented the person as a subject

of rights in a context that understood justice as fairness, in which each individual is treated as equal and is able to understand the interests and feelings of their peers: he has dignity and morality.

Unlike Utilitarianism, in Neocontractualist Ethics each individual is an end in itself, rather than the mean to achieve global happiness, and its principles of justice reflect the ideas of liberty, equality and fraternity. To regulate the basic structure of a society, Rawls divides and gives priority to the "right" instead of the "good" and imposes two principles to the concept of justice as fairness (95):

- First principle: Each person must have an equal right to the most extensive system of equal basic liberties with a similar system of liberties for all.

- Second principle: Economic and social inequalities are to be articulated so that at the same time they:

    a) redound to the greatest benefit of the least disadvantaged, compatible with the principle of just savings.

    b) are attached to offices and positions accessible to all on equal terms of equitable opportunities.

In order to establish the theoretical original position through which the principles of justice can be determined, social institutions' justice and the absence of obstacles to an agreement on the principles of a just society must be assumed, which are obstacles intertwined with social relationships. The situation that would allow the reproduction of the original position consists of four conditions:

- The circumstances of justice: Moderate scarcity and mutual interest.

- The formal constraints of the concept of "right": Generality, universality, advertising, ordination and definitiveness.

- The "veil of ignorance": The restriction of particular knowledge to balance the parties and avoid the use of force, threat or haggle.

- The parties' rationality: Not being aware of their particular situation, the parties should contribute to the primary goods, things that every rational person wants (96):

- Social bases of self-respect
- Basic rights and freedoms
- Freedom of movement
- Free choice of employment
- Eligibility for positions of responsibility
- Basic earnings

Although the original position only exists theoretically to demonstrate the principles of justice, the role of Neocontractualist Ethics is practical, being one of its objectives the implementation of the concept of justice as fairness as the basis for a constitutional, modern and liberal democracy. However, one must distinguish Neocontractualist Ethics or social liberalism from Neoliberalism or modern liberalism, since even though both are based on classical liberalism, their development is completely different.

The basis of both is developed in part from the life and work of John Locke, highlighting the document *Two Treatises of Government*, published in 1689. In this paper, his ideas on natural law and the influence of nature's state in the political ambit were developed, noting the defence of freedoms and property rights as a primordial natural right (97). His reflections have had a great influence on modern and contemporary history, inspiring the two declarations of Human Rights and the American Declaration of Independence (98).

Modern liberalism or Neoliberalism emerged during the two World Wars, the industrialisation and the economic crisis of the 30s, during which the values of classical liberalism were not ready for large-scale industrialisation and multinational companies, so it was proposed to understand the new economic and social model. In the following decades, it symbolised the social market economy, but it ended up linked to an extremist position of laissez-faire and capitalism following the 1981 reforms.

The current Neoliberalism includes concepts such as free market, elimination of public spending on social services, deregulation, privatisation and elimination of either public or community goods (99). Driven by Thatcher's conservative bloc in the UK and

Reagan's in the USA in 1980-81 and supported by international financial institutions, the International Monetary Fund, the World Bank and the World Trade Organization; Neoliberalism was imposed as a capitalist model in the Anglo-Saxon countries, facilitating the creation of multinational corporations by economic elites and the acceleration of technological development.

As a social, economic and philosophical model, Neoliberalism has spread worldwide through the phenomenon of globalisation, promoting free trade and increasing social inequality between the advantaged and the disadvantaged by limiting or eliminating the State's regulatory capacity (100-1).

The influence of Neocontractualist and Neoliberalism has been very strong over the last decades of the twentieth century and the early twenty-first century, primarily Neoliberalism in Britain. The latter is reflected in a consumerist and individualistic society, where the concept of family care is diminished and health is a consumer product that can be bought and sold to the highest bidder (102-3), which is expressed in the NHS Trusts' structure and the attempt to create a national health system with the structure and management of a private institution.

Nevertheless, the NHS and the British social services partially cover some social inequalities in a Neocontractualist model through care and social support funded by the State, covering the role that family has in other countries. This Neocontractualist model is strongly influenced by the change in the concept of justice, and specifically in distributive justice, reflected in English law and its significance in the personal, social and professional relationships in British society.

### 2.2.3. Kantianism and its evolution

With the publication of *Groundwork of the Metaphysics of Morals*, *Critique of Pure Reason* and *Critique of Practical Reason*, Kant proposed in the eighteenth century an Ethics model based on duty that was revolutionary in its time, and has been the basis for duty-based Ethics. Although its heyday was in Germany and it spread through Europe's socialist countries more easily, its global influence in various aspects like Professional Codes of Ethics is indisputable. In the most important work of modern Ethics, *Groundwork of the Metaphysics of Morals*, he exposed a moral law a priori that reflects what we must do based on our duties. This moral law is derived as follows (104):

- "Good will" as a starting point.
- A will is good if it acts based on duty.
- The moral duty is the representation of the Law.
- Every law is universal and necessary.
- The moral law has the form of a categorical imperative.

After this process, Kant created his categorical imperative, which is described by three concepts:

1. Universality: Act only as a maximum that at the same time you want it to become universal law.
2. Humanity: Act so that you use humanity, whether in your own person or in the person of any other, always with an end at the same time and not only as a medium.
3. Autonomy of the will: The idea of every rational being's will as a universally legislating will.

Thanks to the categorical imperative, concepts such as dignity or autonomy are described, which are of great importance in any society. However, Kant was heavily criticised for his theories' formalism, which allowed rigid moral principles that could lead to dogmatic or immoral positions. In addition, Kantian Ethics does not promote happiness as the ultimate end of humankind, only to be worthy of that happiness.

Through failures within the intention Kantian Ethics, Weber, and later Jonas, proposed Responsibility Ethics, which take into account not only the intentions but also the consequences, proposing a more practical and realistic Ethics (105).

Several ethical theories have evolved from Kantianism, but the Discourse or Communicative Ethics of Apel and Habermas recently reinstated Kantianism solving the "factum of reason" (universal norm of the universalised reciprocity of all claims of validity) from implicit assumptions in the ordinary pragmatic language (106).

Furthermore, Discourse Ethics is considered Responsibility Ethics, avoiding Intuition Ethics' excessive theorisation, reinventing Kantianism concepts and giving them a more plural and understandable nature through the discourse. These features make Discourse Ethics the base of a pluralistic Ethics in which the foundation of various moral dilemmas is founded through the rationality of discourse, one of the key objectives of Bioethics, so Bioethics' method of reasoning is very similar to it in many aspects (e.g. rational discussions in Ethics Committees).

The influence of Kantianism in English clinical practice is not very noticeable, given the limited influence that it had in England. However, the Kantian concept of Duty is expressed in professional codes of conduct (Medicine, Nursing, Pharmacy, etc.) and legislated duties, such as the Duty of Care or the Duty of Candour.

In contrast to the more purist Kantianism, Responsibility Ethics, especially Discourse Ethics are beginning to influence clinical practice and society from the last decades of the twentieth century, not only in solving ethical problems in clinical practice through rational discourse but also as a method of bringing Ethics to society in a way that does not alienate them, since the ability to communicate is a trait shared by all societies.

### 2.2.4. Bioethics

In parallel with the evolution of Utilitarianism and Neocontractualist Ethics in social and political fields, Bioethics has been incorporated especially in healthcare practice and society. Given its relationship with clinical practice, unlike previous ethical theories, Bioethics will be developed more thoroughly for the purpose of this document.

According to Garcia Capilla, the crisis of medical paternalism in the 1970s triggered the need for a discipline that could regulate the control and management of values related to the body and life (107). Supported by neoliberal and neocontractualist influences, the population demanded autonomy of their own body and their own life, fighting for rights that supported that claim. In addition, medical practice beneficence was questioned and concerns about the power of multinational pharmaceutical companies started to increase.

To confront this scenario, a similar path than the Discourse Ethics developed by Apel and Habermas was taken, in which the practical use of Ethics is supported by the discourse's intersubjectivity. However, Bioethics does not seek universal concepts through dialogue but a way of tackling biomedical and biological challenges that started to appear in the second half of the twentieth century.

Regarding Bioethics as a term in itself, even though Potter first proposed the term Bioethics (Greek *bios*, meaning "life" and *ethikos*, *ithiki*, meaning "Ethics") as a term that integrates biology with human rights to discuss the threats of technological progress; Hellegers proposed the same term to refer to medical Ethics and the Ethics of biomedical research. Although both definitions are correct, it was Hellegers' definition of clinical Bioethics and biomedical research which ended permeating academia and society through debate and controversy. This definition focuses on three aspects (108):

- The rights and duties of patients and healthcare professionals.
- The rights and duties of research subjects and researchers.
- Creating public policy guidelines for clinical care and biomedical research.

In its current situation, the term Bioethics is still been oriented towards Medicine and biomedical research, focusing on the "big" problems of Bioethics: abortion, euthanasia, organ donation, assisted reproduction, Ethics committees, informed consent,

confidentiality, economic rationalisation of healthcare services and research Ethics. Therefore, although the Potter's concept of Bioethics is beginning to break through, for the purpose of this writing, Hellegers' idea of the word Bioethics will be the only one considered.

Bioethics is understood as a practical and pluralist Ethics, so it does not fall in the discussion of metaphysical subjects but in solving various situations through rational debate and the creation of various policies for their present and future application in bioethical issues. Some authors claim that Bioethics and its relatively rapid expansion could serve to introduce moral life concepts like rationality, dialogue, deliberation, transparency and autonomy in our societies (109).

Although Principlism is the best known method for resolving bioethical problems, there are several theories that can be applied, which focus on different principles or values (110-1):

- Principlism: Derived from the Belmont Report and the work of Beauchamp and Childress, *Principles of Biomedical Ethics*, Principlism is based on the application of the "four great principles" to research and clinical problems:
    - Autonomy: Self-government that is free of interferences controlled by others (manipulation, intimidation, suggestion, etc.) and certain limitations such as lack of understanding that prevents making significant decisions.
    - Nonmaleficence: Related to the maximum *Primum non nocere*, it refers to the obligation not to inflict injury to others.
    - Beneficence: Moral obligation to act for the benefit of others.
    - Justice: Although there is no unanimous definition of justice, since no theoretical or material principle can cover every problem related to justice, in Bioethics distributive justice is usually applied: fair, equitable and appropriate distribution determined by justified rules that structure the terms of social cooperation.

  These principles are considered prima facie, and even though they have established a hierarchy between maximum Ethics and minimum Ethics the consequences and

circumstances of each situation delimit the answer to the problem, so there are no explicit rules.

Given the possible development of a legalistic Ethics and the vague definition of the principles and the relations between them, Principlism received criticism from various humanistic disciplines. In response to such criticisms, Beauchamp and Childress redefined their definition of principle (normative generalisations that guide the actions, but must be interpreted, specified and balanced in each case), specified the need for a context to guide concrete actions with abstract rules and indicated that additional rules would be needed (112). That is why Beauchamp and Childress considered other bioethical theories as adjuncts to Principlism, not as antagonists.

- Casuistry: Disused since the Enlightenment, Casuistry has been extended during the second half of the twentieth century and is considered an alternative to Principlism, especially since the publication of the work of Jonsen and Toulmin, *The Abuse of casuistry*, in 1988. It is considered an analysis method from the case and is guided by the corresponding maxims and paradigms, understanding these concepts as shown below:

    - Case: Confluence of people, events and actions in a given time and place. It is concrete, unique, typeable and comparable.

    - Paradigm: It is a common clear case, in which most people agree.

    - Maxims: Particular rules dependent on the case type, which include circumstances and relevant recommendations. They are recommended but not universal.

  The casuistical reasoning works in a similar way than English common law, describing and typifying the case and then applying the corresponding maxims to the corresponding paradigmatic case. Depending on the type, casuistry can be considered only for problem-solving, recognising the principles' validity (weak Casuistry) or renege on the principles and consider the case method as the only method of moral discovery (strong Casuistry).

Thanks to his method, Casuistry best reproduces the functioning of human beings' common morality and jurisprudential reasoning. However, consensus could not be generated when reviewing a case, since that consensus could have ideological connotations or could promote ethical relativism.

- Utilitarian approach:

  In this approach, Utilitarian Ethics is applied in the field of Bioethics through three principles: consequentialism, welfarism and aggregationism (113).

  Consequentialism is based on determining the moral quality of an action by its consequences through some moral rules based on observing the consequences of actions. Rules omissions are included within these moral, since even though the person has not taken any action or did not have any intention, to do nothing has consequences.

  The welfarism considers welfare as an unbiased measure to quantify the consequences, which is defined as "the obtaining to a high or at least reasonable degree of a quality of life which on the whole a person wants, or prefers to have" (114). Therefore, the actions' consequences are analysed in relation to the increment or decrement of the welfare of those affected.

  Aggregationism defines the Utilitarianism's distributive justice technique, in which the differences between people or groups are ignored and the total welfare is maximised.

  Despite being a theory about consequences, something that is not usually treated as a basis per se in other theories, it suffers from the same weaknesses that are often attributed to Utilitarianism and made it impractical for use in clinical practice: unfair and irregular distribution, it does not consider intentions or actions and treats people as means to achieve the general welfare, not as ends in themselves.

- Exceptionless rule approaches:

  Finnis argues that there are few absolute moral values that can be the basis of morality, as in the case of natural law and the absolute principle of rational concern for the good of humanity. Consequently, not only acts against this principle, like

murder, are avoided but accidental damage will be prevented. This derives from the exceptionless or absolute precepts that play a distinctive role in moral thinking within a broader plane of moral rules or precepts.

Moral action deliberation is eliminated with an absolute prohibition, avoiding the possibility that the immoral action occurs. These theories have been criticised for their rigidity; their inability to adapt to the intent or context, establishing prohibitions that ignore collateral events and facilitating the double effect principle (115).

- Virtue Ethics: From the moral vacuum left by the principles and cases in Bioethics, Virtue Ethics treat people's internal acts (emotions, habits, attitudes, predispositions, etc.). Virtues are character traits that are valued morally, acts or habits in accordance with moral principles, obligations or ideals. They are indicated to improve how to practice or being in an ethical manner, since they cannot be applied in specific cases or practical dilemmas but are complementary to them.

- Care Ethics: Driven by Feminist Ethics like the ones proposed by Gilligan or Noddings, Care Ethics focus on relationships and the obligation to care for people and other beings and objects. It is based on two basic assumptions:

    - We are all interdependent to achieve our goals, and the awareness of that interrelationship must generate a willingness to care for everything.

    - The particularly vulnerable deserve further consideration to the extent that they depend solely on us.

  Care Ethics depends on the context, leaning toward the reception and care of others. Its impact on healthcare and Nursing Ethics has been significant, since positive changes in health education introduced concepts like communication and emotions in them. However, they tend to ignore the carer, reaffirm women's subordination and they are not useful at institutional or social level, since it is only applicable at interpersonal level.

Bioethics, given its short existence as a discipline and its plurality in the topics it covers, it is considered an unfinished and uncomplicated discipline, especially since the Potter's

concept of Bioethics amalgamated with the concept of clinical Bioethics. Since it deals with complex issues like life, Bioethics is a constantly evolving discipline that needs experts from multiple disciplines to cover all knowledge areas linked to human life and life in general, who engage in a rational, plural and critical dialogue to find a consensus among them.

We also have to consider the Bioethics' ability to be public and private, since it treats both individual autonomy and community morals, managing sometimes conflicts between them and diluting the classical division between public law and private morality. This encourages further dialogue and debate, not only among experts but also in different culture societies, strengthening the autonomy and diversity in life and body management.

The institutional dimension of Bioethics is linked to its epistemological character, which had a decisive influence on its evolution through institutional and legislative conflicts and the social debate on individual health autonomy, healthcare economic constraints and new biomedical technologies. The resolution of institutional conflicts predisposed the creation of Bioethics committees, which are divided into three types (116):

- Research Ethics Committees: Created to ensure the quality of research with human subjects and their protection.

- Clinical Ethics Committees: Groups responsible for resolving ethical conflicts in the hospital environment and the development of clinical policies in the applicable contexts.

- National and international committees: Permanent or punctual, they have a continental or global bioethical impact. Several examples are the National Commission of the Protection of Human Subjects of Biomedical and Behaviour Research (1974-1978), the President´s Behavioural Research (1980-1983), the Comité Consultatif National d´Éthique pour le Sciences de la Vie et the la Santé, the Law Reform Commission of Canada and various Council of Europe's documents.

Funded by the NHS Health Research Authority, Research Ethics Committees' (RECs) main function is to review research applications, give an opinion regarding participant

involvement and decide if the research proposal is ethically valid (117). The RECs are totally independent from sponsors, funders and researchers; even though they work with the Medicines and Healthcare products Regulatory Agency (MHRA) in experimental drugs and medical devices research (118).

Regarding the Clinical Ethics Committees (CECs), they began to appear since the beginning of the twenty-first century following the American model (119), responding to the need for support in clinical bioethical decisions (120) that were emerging following the development of Bioethics. Members of the CECs include healthcare professionals and other professionals who aim to support decision making on ethical issues arising from patient care provision within NHS Trusts and other healthcare institutions.

The CECs were grouped in January 2001 in the UK Clinical Ethics Network (UKCEN) to provide support for the growing number of committees and clinical ethics groups that were created in NHS Trusts and some private hospitals in the UK, facilitating information and best practices exchange between CECs and offering support to established CECs and institutions that considered the creation of a CEC (121).

To monitor the CECs' status in the UK, a survey was conducted by UKCEN in 2002 to describe the CECs' situation at that time (122):

- The biggest CEC had 26 members and the smaller ones had 6 members. On average, the number of CEC members was 13.
- Most members had medical or nursing training, but more than half of the interviewed CECs also had a legally qualified member and secular and religious representation.
- Most of the CECs met monthly.
- The CECs had different functions:
    - 54% often contributed to Trust's policies, protocols and guidelines.
    - 20% assiduously interpreted national guidelines.
    - 37% frequently offered Ethics education in the Trust.
    - 66% repeatedly provided ethical support to practitioners.

- CECs discussed a variety of issues that arise in the clinical field, which include:
    - Treatment retention and withdrawal
    - DNAR orders
    - Advance Directives
    - Informed consent
    - Decision-making capacity
    - Treatment refusal
    - Confidentiality
    - Topics that were added after the survey (123):
        - Resource distribution
        - Patient restriction
        - Genetic testing

In 2000 there were 20 CECs, while in 2015 there were 85 known committees or groups in the UKCEN, all part of different institutions like acute trusts, mental health trusts, primary care trusts, palliative care trusts, professional bodies, private hospitals, regional groups, student groups and specialty groups such as the UK Genethics Club (124). The structure of each CEC, the functions that performed and its position within the institution varies between them, since each was developed in the context of the organization's needs and resources to which it belongs. Some, like the Royal United Hospital Bath NHS Trust CEC, have even created guidelines to support their clinical colleagues with ethically challenging decisions (125).

In the present day, after the inclusion of Bioethics in healthcare institutions and society, the "professionalisation" of Bioethics and the emergence of Bioethics experts or bioethicists have developed moderately. However, given the multidisciplinary and pluralistic nature of Bioethics, this phenomenon goes against its foundations.

Some authors, like García Capilla (126), state that the "professionalisation" of Bioethics compromises CECs' plurality and the epistemological status of Bioethics, annulling it as a knowledge field. However, this does not rule out the presence of moral philosophers in CECs, who can be a guide in the development of rational and plural deliberation processes.

The influence of Bioethics in clinical practice and in society has been propelled by the same social reasons that facilitated its creation, from environmental protection or population's pursuit of autonomy from medical paternalism to the CECs, RECs and methods of making ethical decisions that influence clinical practice. Moreover, if we look at the literal definition of Bioethics any problems or ethical dilemmas related to ecology (Potter) or biomedicine and bioengineering (Hellegers) would be part of Bioethics.

If only clinical nursing practice is taken into account, the application of Care Ethics in Bioethics is important, since care (represented as "nursing") is one of the four nursing metaparadigms and Care Ethics has been developed through nursing practice.

For example, Tronto presented the four phases of responsible care that correspond to the four elements of care (127):

- Caring about → attentiveness
- Taking care of → responsibility
- Caregiving → competence
- Care receiving → responsiveness of the care receiver

Applying Care Ethics in a structure that includes all holistic care phases is only a small sample of the potential of Bioethics and its various theoretical ramifications in Nursing.

## 2.3. Institutional values in hospitals and the etiquette-Ethics correlation in clinical practice

Institutional Ethics and healthcare Professional Ethics (Medical Ethics, Nursing Ethics, etc.) cover different aspects of clinical Bioethics; being Institutional Ethics in charge of meso and macro issues, while the healthcare Professional Ethics is applied to the micro and macho issues. This difference, despite their similarity in content, arises from their origin, since healthcare Professional Ethics is shaped by healthcare professional bodies, which seek excellence in individual and group practice, while Institutional Ethics is dependent on each organisation, which aims to manage and improve its general production regardless of its parts.

An NHS Trust or an NHS Foundation Trust, as any institution, can present a set of values that guide its decisions and represent its ideals. Despite not following an ethical code per se, it combines professional ethical codes and the seven principles and six values set out in the *NHS Constitution* with a set of own values. Each healthcare institution has similar but different values, generally focused on efficiency, excellence, compassion and respect for dignity.

Adhering to this research's context, the institutional values to consider would be the ones from University Hospitals of Leicester NHS Trust, five values which contain various behaviours associated with each value, created under the premise "Caring at its best", which are developed as follows (128):

- We treat people how we would like to be treated.
    - We listen to our patients and to our colleagues, we always treat them with dignity and we respect their views and opinions.
    - We are always polite, honest and friendly.
    - We are here to help and we make sure that our patients and colleagues feel valued.
- We do what we say we are going to do.
    - When we talk to patients and their relatives we are clear about what is happening.
    - When we talk to colleagues we are clear about what is expected.
    - We make the time to care.

    - If we cannot do something, we explain why.
- We focus on what matters most.
    - We talk to patients, the public and colleagues about what matters most to them and we do not assume that we know better than them.
    - We do not put off making difficult decisions if they are the right decisions.
    - We use money and resources responsibly.
- We are a team and we are best when we work together.
    - We are professional at all times.
    - We establish common goals and we take responsibility for our part in achieving them.
    - We give clear feedback and we make sure that we communicate with one another effectively.
- We are passionate and creative in our work.
    - We encourage and value other people's ideas.
    - We seek inventive solutions to problems.
    - We recognize people's achievements and celebrate success.

These values are non-specific, which helps them to not confront with any other code of Ethics or conduct and to be easily understandable, even if dilutes their role of institutional indoctrination by exposing behaviour too general to be followed without personal interpretation.

These values are similar to those presented in the *NHS Constitution* (first and second value, seventh principle, sixth principle and first value, third principle and third value, and fourth principle, respectively). Although they cannot be used as legislation in court if an employee broke them, the violation of the healthcare institution's values may involve a temporary suspension without pay or dismissal if is regulated in the terms of the employment contract or in one of the institution's policies.

CECs also have the role of supporting ethical decisions and creating policies for the institution to which they belong as an advisory body. However, the CECs' potential, specifically in the context of the University Hospitals of Leicester Clinical Ethics Committee, is not utilised completely due to the healthcare professionals' lack of knowledge about the existence and functions of CECs. This misinformation does not

occur in the case of RECs, which are known by the vast majority of professional researchers.

The goal of Ethics and etiquette is to guide behaviours and conducts, leading to confusing Institutional Ethics and etiquette in some cases. However, they are completely different, since they achieve their goal differently and for a different purpose. According to Johnstone, Ethics morally manages good and bad with behaviours guided by critical and reflective moral thought and the application of deep moral values that seek to maximise the moral interests of all people equally; while etiquette consists in maintaining style and decorum through behaviours guided by arbitrary and unreflecting requirements of custom and convention (129). In addition, etiquette paves the way for a practical, coordinated, consistent, predictable and aesthetically pleasing conduct, serving only the interests of certain people in certain circumstances.

In the case of healthcare institutions, this assertion rests primarily on the history and evolution of Nursing. Since Nursing did not have a deontological code institutionally established until the mid-twentieth century, its subordinate status to the doctor turned etiquette into the conduct implemented in nursing training before and during clinical practice, since it was also included in nursing training books (130). It was not until 1953 when the International Council of Nurses presented its deontological code, leading to a progressive and continuous change toward ethical nursing practice. That change was assimilated faster by nurses and their associations than by healthcare institutions and society, so etiquette as behavioural guidance is still used given its long history in relation to Nursing. Nevertheless, etiquette does not affect Nursing only but all healthcare professions, including Medicine (131-2).

At present, despite that healthcare institutions' etiquette is intermingled among their policies and guidelines, influencing professional conduct in a more flexible way, it is still counting as a professional attitude comparable to clinical experience, management capabilities or leadership skills (133), inspiring literature around it (134).

To practice any profession that interacts with the population, they must have minimum social skills that enable them to perform their duties adequately, being an indispensable requirement for healthcare professionals to care for and treat patients. However, it is

essential to distinguish etiquette from social skills, since etiquette is built on forced customs based on arbitrary requirements and social skills are learned behaviours naturally present in all cultures and are studied and reasoned by disciplines such as psychology and psychopedagogy.

Nonetheless, several modern authors argue that etiquette has evolved and is not so limited. In the case of etiquette between human and machine, Miller extends the concept of etiquette in a cloud of interconnected protocols with soft and strong restrictions (135). Therefore, etiquette could be adapted to the context in which it is situated placing behaviours in the acceptable behaviour cloud or in the unacceptable behaviour cloud and moving them breaking the soft restrictions if necessary. Although for the human-machine relationship etiquette can be a viable tool, for inter-human relationships there are not enough studies to confirm that this new etiquette concept can be applied.

In the specific situation of healthcare in an emergency department, social skills play a decisive role in controlling certain situations, such as managing patients frustrated by waiting several hours to be transferred to an emergency department and be cared for, which is reflected in the increment of complaints in relation to this issue each year (136). To be able to communicate and empathise with a patient is necessary to adapt to the patient's condition and the context in which he communicates, flexibility that etiquette does not have. In addition, etiquette can hinder communication with some patients with mental health problems or from other cultures, who do not share the established etiquette or could misinterpret it.

The described features of etiquette are accentuated during periods of increased clinical workload, in which it is impossible to satisfy all patients simultaneously. This situation is considered a breach of etiquette, since it does not take into account the context when managing patient’s discontent (if we understand etiquette through Johnstone’s definition). That is why prioritising time on the principles of autonomy, justice, beneficence and non-maleficence and distributing resources in a rational, realistic and fair manner is a more plausible option than the use of the existing hospital etiquette.

### 2.4. Emergency Nursing Ethics: a Care Ethics

Care (as part of “nursing”) is one of the metaparadigms of Nursing and the most common role for nurses. In most deontological codes, derived from the International Council of Nurses (ICN) code, the care of people in need is prioritised above all other duties. If we apply the ICN definition of Nursing (26), holistic care must be provided to healthy individuals or groups, to promote their health and prevent disease, and ill individuals and groups, to restore their health and alleviate their suffering.

We do not intend to differentiate between the "standard" Nursing Ethics and the Ethics to be followed in an emergency, since the ethical dilemmas are the same as those of any nursing field. However, the specific context of an ED must be taken into account, since the resolution of ethical issues is dependent on the environment in which they take place, forcing us to consider various aspects that would not be a major issue in most hospital wards:

- Environment: In EDs under increased clinical workload predominates a noisy, crowded and intimidating environment, where everyone seems to be busy and there are no individual rooms for permanent stay, only temporarily during assessment. This environment makes it difficult to engage the patient, maintain confidentiality and preserve his privacy; apart from increasing mortality and worsening the quality of care (137).

  In the case of pre-hospital emergencies, they can happen anywhere, creating a theoretically infinite number of scenarios that may inhibit or prevent the interaction with the patient. In addition, due to the characteristics of pre-hospital care, sometimes problems beyond physiological conditions can be ignored.

- Clinical workload: Unlike scheduled visits, emergency services (ambulance service, NHS 111, emergency dentist, hospital ED, emergency mental health services and outpatient urgent care) have a relatively infinite demand with finite resources, both material and human. This happens because aid cannot be denied to anyone since it is both immoral and illegal.

  This situation entails that in certain demand overload situations those services cannot provide holistic care to every person who needs them due to the lack of

material and/or human resources. The solution most often used is a combination of severity triage (138) and order of arrival, in which patients are organised by severity groups according to the classification model (e.g. Manchester, dynamic priority scoring, Canadian, etc.) and inside each group they are classified by arrival order.

Triage is necessary because studies have shown that between 60-70% of patients seen in emergency departments suffer mild illnesses that could be addressed by other healthcare facilities (139). The lack of an appropriate triage system would slow care for urgent or emergency patients in favour of non-urgent patients if arrival order is the only factor considered, which could be considered unfair or lead to involuntary manslaughter by omission. Emergency Nursing has the role of judging who needs to be treated and in what order with respect to predefined health standards, which do not always meet the patient's needs, causing an ethical issue.

Another problem would be care management in "states of emergency": multiple traffic accidents, fires, terrorist attacks or any situation that exceed the available healthcare resources to attend a large number of urgent or emergency patients at the same time. This situation forces that patients must be triaged following minimum Ethics, even if a maximum Ethics is not reached, as is done in war scenarios and major natural disasters, applying a specific triage for disasters with a massive number of victims (140).

- Reaction time: Patients in emergency situations must be treated in a short period of time, including potential ethical conflicts like verifying the psychological autonomy of the patient to make the decision of not being resuscitated or administering a unit of red blood cells to a Jehovah witness' patient. The problem is that these decisions must be made quickly or the patient's life could be in danger, hindering rational dialogue or the use the CECs advice to resolve these conflicts.

  If the healthcare worker who must make the decision, usually a doctor, makes a decision that for the nurse is apparently wrong, an ethical dilemma is created between the choice of an practitioner prepared to make that decision (even if clinical workload, inexperience, fatigue or any factor could cloud his judgment) and the nurses' duty to promote an environment in which human rights, values, customs and spiritual beliefs of the individual, family and community are respected (26).

- Length of stay: In an ED or in an ambulance the stay is limited because resources have to be allocated to the largest number of patients who need it in a fair way within a service with uninterrupted demand. This entails that complex ethical problems that do not endanger the person's life have to be resolved in another place and/or time if the ED's resources are insufficient or the dilemma requires a long debate. This type of problems is referred to another team that will solve them at another time, even if the problem is very important for that person: cultural or religious customs, family problems, DNAR orders, etc.

  Although the goal to pursue is holistic care for all patients, the short stay in the department, the lack of individual rooms and the possible clinical workload overload limit the nurses' ability to perform care beyond the physical in certain occasions where the use of time should be prioritised towards life preservation, disease treatment and pain management in most patients instead of a holistic and personalised care for a few patients, ignoring the rest (with various exceptions, like palliative patients in EDs or patients with non-urgent pathologies). However, care in EDs, according to Turner et al., can be improved but needs further research due to its complexity (141).

- Technification and dehumanisation of care: Since an emergency patient's life is threatened by his condition, the healthcare multidisciplinary team (doctors, nurses, HCAs, technicians, etc.) must make every effort to preserve the patient's life with dignity, if it is his desire. This involves the use of machinery, techniques and guidelines to facilitate and increase his survival rate. However, not every patient in an ED has a life-threatening disease. Moreover, some spend hours, or even days if the service is crowded, waiting for a bed in a hospital ward or a medical specialist review.

  Nevertheless, the tendency is not to provide holistic care due to lack of time, training, experience, habit or fear of reprisals from a superior due to "wasting time", so only a few experts nurses do not interpret policies strictly (designed as a guide but used as a rule). This premise derived from patient interviews (142), nurse interviews (143) and qualitative studies (144), even if, as indicated by Turner et al., further research on this issue is needed.

This leads not only on ED, but especially in specialised services, to a degradation of the nurse-patient relationship towards a "nursing techniques provider-nursing techniques receiver" relationship. This relationship not only degrades patient care to a single physiological level but also makes it very difficult to identify problems beyond the body.

This is another issue that is in continuous discussion, alongside care humanisation and the claim for holistic care (145). However, if we assume that all nurses are trained to perform holistic care when possible, care dehumanisation should only be patent under excessive workloads, staff shortages or in states of emergency.

Talk about Emergency Nursing Ethics separated from Nursing Ethics is meaningless, since care for urgent and emergency patients follows the same deontological code that with any other patient, since the care receiver remains the same. However, the urgency of treatment, the risk of losing the lives of these patients and the services available hinder ethical decision making, so they should be taken into account.

As an example of an ethical code for emergency nurses, the Emergency Nurses Association (ENA) shows its ethical code on its website, which states the following (146):

- The emergency nurse acts with compassion and respect for human dignity and the uniqueness of the individual.
- The emergency nurse maintains competence in emergency nursing practice and emergency nursing practice responsibility.
- The emergency nurse acts to protect the individual when health and safety are threatened by incompetent, unethical or illegal practice.
- The emergency nurse exercises good judgment with responsibility, delegating and seeking consultation.
- The emergency nurse respects the individual's right to privacy and confidentiality.
- The emergency nurse works to improve public health and secure access to healthcare services for all.

This code is general and incomplete, in which no major issues like the defence of fair resource distribution, the need to inform the patient or any mention of inter-professional

relationships are mentioned. We can deduce that this code is only an addiction to another nursing deontological code like the ones created by the CIE (1) or the American Nurses Association (ANA) (147). Otherwise, this deontological code would not be feasible, since it does not contemplate important aspects of emergency nursing practice.

Another aspect related to Emergency Nursing Ethics would be the nature of the nurse-patient and the nurse-client relationship. It has always been taken for granted that following nursing deontology indicates that the nurse's personal duty is to care for people, communities and the environment in which they live. Moreover, from the very creation of Modern Nursing with Florence Nightingale, gender essentialism assumed that nurses should ensure the wellbeing of individuals and communities altruistically (148). This "duty of care" relates to the second definition of care: care about something or someone. This situation is very controversial, since we live in a globalised society in which we are less concerned with the individual within the anonymity of the masses following a utilitarian and neoliberal philosophy, in which Nursing is tasked with creating altruistic nurses (149) in a selfish society.

Bioethics and Responsibility Ethics are good methods to focus Nursing Ethics around nursing practice, but if they are not inculcated in nurses in their training is a slow and unpredictable process as they acquire them in practice, since they depend on their empathy to develop that altruistic feeling. If we reach a point where no Ethics is taught to nurses selfishness will always prevail, which is pre-moral according to Smith, and altruism would only be developed through empathy based on the nurses' experiences, which is moral (150 ).

Moreover, considering the extreme of rational selfishness, Ayn Rand argues that relieving the suffering of others is an act of generosity, not a moral duty [1](151). This leads to the nurse-patient relationship to transform into a care provider-care recipient

[1]Ayn Rand, in her book The Virtue of Selfishness, reflects on Ethics in an emergency and the metaphysics of human reaction, how ethical principles are based on emergency situations and the antagonistic relationship between altruism and selfishness in that situation. She concludes with this statement:
The moral purpose of a man's life is the achievement of his own happiness. This does not mean that he is indifferent to all men, that human life has no value for him and he has no reason to help others in emergencies. But it does mean that he does not subordinate his life to the welfare of others, he does not sacrifices himself to their needs, relieving their suffering is not his main concern, that any help given is an exception, not a rule, an act of generosity, not a moral duty, which is marginal and punctual - as disasters are marginal and punctual in the context of human existence - and values, not disasters, are the goal, the first concern and driving force of his life.

relationship, since the emotional and psychological relationship between the nurse and the patient is essential in order to achieve holistic care.

Replying to the question posed in the title of this section, Emergency Nursing Ethics could be considered a Care Ethics in an ideal situation, in which human and material resources were never insufficient for the demand in ED. This view of Bioethics centred around Care Ethics promulgated by Gilligan and Noddings and expanded by authors as Tronto (152), Sprengel and Kelley (153), Green (154) or Nortvedt, Hem and Skirbekk (155) not only advocates holistic care but also directly or indirectly proposes a social reality in which care is not only the healthcare professionals' role but the role of the entire person's social circle, especially the family. This would positively affect ED patient flow, reducing the influx of people with social problems (e.g. people with dementia without social support in the community), mental health problems or poorly controlled chronic illnesses that without a social support network will worsen until it becomes a health or social emergency.

Nevertheless, when an ED is crowded, holistic care is secondary to basic care, but that does not deny its great importance in clinical practice as the standard of all nurses in their daily practice. This situation facilitates burnout, frustration and moral anguish (156) in nurses practising in an ED due to the importance of their role as the patient's advocate (157) and the dilemmas in time-critical decision-making (158), which limit their ability to provide patient-centred holistic care. This context is analysed by Aacharya, Gastmans and Denier (159), who propose an interaction between Principlism and Care Ethics in the ED environment as a solution to the inclusion of Care Ethics in acute or critical patients' contexts.

### 2.5. The Nursing Midwifery Council and its code

Thanks to the influence of Adam Smith and his disciple James Graham in the freedom of practice during the twentieth century, the professional register was implemented as a healthcare professions' regulatory tool (160). Nursing, belatedly recognised as a healthcare profession, was regulated in 2002 by the Nursing and Midwifery Council.

The Nursing and Midwifery Council (NMC) is the governmental healthcare regulator and charity that monitors nursing practice in the UK. This institution is responsible for protecting the population from the malpractice of nurses and midwives through training, educational, behavioural and performance standards. The NMC maintains a register of all nurses and midwives working in the UK, in which is necessary to be included to practice legally, examines that the professionals in its registry follow the standards required and judges those who have not maintained these standards, revoking their NMC registration.

Nevertheless, there are roles related to Nursing that the NMC does not possess. The NMC does not regulate healthcare institutions, register HCAs, establish safe staffing levels and represent or campaign on behalf of nurses and midwives (9). This last point is the most controversial, since thanks to the mandatory annual fee of more than 670,000 registered nurses and midwives (which is 120 pounds per professional registered in 2015) the NMC is financed, increasing registered professionals' discontent regarding its management (161).

The method used by the NMC to define behavioural standards is a code of conduct known as *NMC Code* or *The Code: Professional standards of practice and behaviour for nurses and midwives*. The *NMC Code* is structured into four blocks, each with various duties and several behaviours associated with each corresponding duty. Its last revision was released in March 2015 (see annex 1).

Unlike most nursing regulatory agencies in other countries, which follow a code of conduct similar to the *International Council of Nurses Code of Ethics* (1), the NMC governs the conduct standard of its registered nurses and midwives with a code of conduct dependent on specific behaviours. This limits the interpretation of the *NMC Code* strictly to the related behaviours with each duty, curtailing the ability to respond

in specific situations while facilitating the application of the code during decision-making.

Since its primary function is to protect the population of the malpractice of nurses and midwives and does not represent or campaign on behalf of nurses and midwives, its code is focused primarily on preventing malpractice and protect the population. This is more evident in duties 12 (professional insurance), 22 (registration requirements) and 23 (investigation cooperation).

It is also necessary to consider that the first and prior to the current NMC Code was called *The Code: Standards of conduct, performance and Ethics for nurses and midwives* (162), while the current is titled *The Code: Professional standards of practice and behaviour for nurses and midwives*. Changing the term Ethics to the term behaviour, especially when dealing with a deontological code that also serves as legislative material, indicate that the behaviours set by the new NMC Code do not have a legal obligation to be considered ethical, unlike the first version.

These behaviours mentioned in the current NMC Code fall within the scope of what Gracia called Ascetics (163)[2], the good nurse or the virtuous nurse, who can do the techniques with great skill and has extensive knowledge of nursing policies but does not take into account his ability to reason and reflect on values such as justice or autonomy, essential in any healthcare profession.

This ascetic conception of Nursing has replaced etiquette in many countries through nursing education based on evidence, that although necessary for safe and effective practice it is not enough on its own. Not only it condemns that evidence to never be updated, since it depends on reason to create new content, but also makes the nurse a nursing techniques technician, merely providing only physical standardised care rather than personalised holistic care.

This phenomenon does not occur so drastically in other nursing ethical codes like the Canadian (164), the American (165) or the Australian (166), in which the concepts on which the duties are based on are explained and their interpretation is encouraged depending on the context, particularly in the American (in which interpretative

[2] Gracia's references to Ascetics in Medicine have been adapted to the field of Nursing.

declarations are indicated) and in the Australian (in which the ethical code and the professional code of conduct (167) are separated).

Another aspect which distinguishes the *NMC Code* is its dual ascetic and legislator function, eliminating any flexibility when interpreting it and facilitating the criminalization of decisions that may not exactly match it. This stems from the creation of the NMC in 2002 under the parliamentary order *Nursing and Midwifery Order 2001* (168), which was created under the powers of the *Health Act 1999* (169). This order also links several monitoring mechanisms like the Privy Council (170), the British Department of Health and the Professional Standards Authority (171). All legislation from the NMC, including the NMC Code, can be used as secondary legislation (legislation that allows the government to make changes to the existing law through powers conferred by an Act of Parliament (172)).

Within the legislative role, not only malpractice can be judged to eliminate a registered professional from their register but also the NMC Code can be considered secondary legislation in court, since such legislation is part of an order under an Act. The NMC, apart from the order which enabled its creation, has its own regulations and orders imposed by the Privy Council, which can also be used as secondary legislation in court (173).

Even within the NMC Code there are references to cooperation with investigations, that even though they are necessary as a citizen are not an ethical priority, since the priority for a nurse should always be the patient. Moreover, the NMC's purpose is not to create an independent and capable nurse able to reason in ethical dilemmas, but a nurse who follow its standards, which is shown textually in how self-define its role (9):

> We regulate nurses and midwives in England, Wales, Scotland and Northern Ireland. We exist to protect the public. We set standards of education, training, conduct and performance so that nurses and midwives can deliver high-quality healthcare throughout their careers.
>
> We make sure that nurses and midwives keep their skills and knowledge up to date and uphold our professional standards. We have clear and transparent

> processes to investigate nurses and midwives who fall short of our standards. We maintain a register of nurses and midwives allowed to practise in the UK.

The misunderstanding between Ethics and Law and between Ethics and codes of Ethics is relatively common, but in both cases they are not the same, according to Johnstone. For Ethics and Law, although they share several common features, they guide the way people behave differently. Law, even though it should be created based on the principle of justice, it does not always coincide with what is morally right, since Ethics needs people to be considered autonomous for its interpretation, while the Law does not allow subjective interpretation. While the laws are fixed, morality is more flexible through a rational process, which even allows the judgement of "morally wrong" laws (like the Nazi laws during World War II) (174).

In the case of Ethics and codes of Ethics, although codes of Ethics are created through a process of consultation, discussion, refinement, evaluation and review by various professionals over a period of time and serve as guides to ethical behaviour, they cannot adapt to the infinite number of possible contexts, being necessary to employ ethical deliberation for each context. Although they are a great tool to inculcate professional values, codes of Ethics follow the values and ideas of those who created them, so they must be prima facie in regards to other stronger own moral values to not restrict each person's values (175).

Even though the *NMC Code* could be considered only as a legislative document and a code of professional conduct and not as an ethical code due to its rigid and schematised content, its legislative origin through the *Nursing and Midwifery Order 2001* and its protective function against nursing malpractice rather than promoting ethical practice characterises the only enforceable document that marks a behavioural pattern for all nurses and midwives in the UK.

There are other more specific codes, such as the *Research Ethics: RCN guidance for nurses* (176), specific to the role of the nurse researcher, but there are no other applicable national codes applicable to all nurses in the UK. They could apply the ICN's deontological code, but following the *NMC Code* is mandatory to practice in the UK, so the values and ideas of the latter prevail over any other code of Ethics or any moral reflection.

By limiting the response in a given context to the prefixed behaviours in each duty, it is easy to judge the moral validity of nursing practice regarding the *NMC Code*, even if it does not always correspond with the actual context. In addition, the NMC holds legislative, executive and judicial powers within British Nursing; creating ethical and legislative codes like the *NMC Code*, managing standards of education, training, conduct and performance and judging the validity of nursing practice within the values that the NMC has set.

It is crucial to consider the consequences of maintaining the legislative, executive and judicial powers in one administrative body despite its divisions in various committees, especially when the NMC's transparency and efficiency has been questioned after investigations and audits of the Council for Healthcare Regulatory Excellence (CHRE), (177) the Professional Standards Authority (PSA) (178), the Health Committee (HC) (179) and the Commons Health Select Committee (CHSC) (180) in relation to the *Mid Staffordshire NHS Foundation Trust Public Inquiry* and its relation to the NMC roles.

The present and future of British Nursing are controlled by an NMC that does not consider nurses to regulate them within a country that has maintained a nursing shortage since the creation of its healthcare system. This entails that the evolution towards a more ethical and humane practice is a challenge that British Nursing currently faces.

### 2.6. English Law and its impression on clinical nursing practice

The legislation associated with any profession reflects the acceptable practice limits. Although ethical codes mark the ideal and/or minimum moral that represents a profession, on their own they are a non-mandatory behavioural guide, which support the development of any profession and prevent malpractice.

It is the Law, both national and international, which must sanction or punish actions or situations that may infringe citizens' rights. However, given the theoretical similarity in the origin of ethical and legislative codes that facilitates the misinterpretation of Law and Ethics as synonymous, in different contexts their functions entwine, giving the role of moral guide to the Law and the role of statute to codes of Ethics. This confusion is common in English healthcare professions, where the use of Professional Ethics as secondary legislation misinterprets its instructional function, especially if the cause of creating a behavioural code is only legislative, not moral.

The British legal system is divided into three systems, English Law for England and Wales, Northern Ireland Law for Northern Ireland and Scotts Law for Scotland. For the purpose of this document, we will consider only the law applicable in the context in which this research is situated: English Law.

The English Law follows a common law pattern, so the decisions of the higher courts (Court of Appeal and Supreme Court) become part of the Law. Sources of legal material in English Law not only come from common law, but from several different sources, in which English judges base their verdicts (181):

- Legislation:
    - Acts of Parliament: Called statute law or lex scripta (written law).
    - Secondary legislation: Statutory instruments, delegated legislation or subordinate legislation.
- Court decisions in other cases in the Court of Appeal and the Supreme Court, also known as common law or lex non scripta (unwritten law).
- European Convention on Human Rights, incorporated into English Law through the Human Rights Act 1998.

- Community legislation: The UK is a European Union member, which means that Community Law takes precedence over British Law, which was expressed in the European Community Act 1972.
- Other sources like:
    - Royal prerogatives.
    - Received wisdom from legal writers or public opinion.
    - Deontological, behavioural or good practice codes, like the *NMC Code*.
    - Laws of other countries.

Although there is a distinction between public law and private law, the most common distinction for practical purposes it is between civil law and criminal law. Civil law covers areas such as contracts, negligence, family matters, employment, inheritance and land law. Criminal law, as a branch of public law, defines the limits of acceptable behaviour, considering a crime against English society as a whole when it is violated.

Judges cannot question the laws (Acts) of the British Parliament, since they are considered the supreme source of Law. That is why judges must apply and interpret the relevant laws before they consider any other source of law. If the case is not legislated by an Act the other sources will be applied, including common law. Legal courts are structured in a hierarchical order, allowing a series of appeals to higher courts within the same case, which are presented below in ascending order of appeal (182):

- County Courts: They manage most civil litigations according to the nature of the claim.
- Tribunals: They hear appeals on immigration, social security, child support, taxes, pensions and land.
- Magistrates' Courts: They solve summary judgments, internments for sentencing by a Crown Court and proceedings from family courts and juvenile courts.
- Crown Court: It decides in serious crimes trials, Magistrates' Courts appeals and cases for sentencing.
- The High Court: It has 92 Justices or Puisine judges and is divided into three divisions, which are characterised by having more than one judge:

    - Queen's Bench Division: Contractual administrative and liability tribunal that oversees the legality of the decisions of lower courts, tribunals, local authorities, ministers of the Crown and other court officials or public bodies.
    - Family Division: It manages Magistrates' Courts appeals.
    - Chancery Division: It hears appeals from the County Courts in insolvency and land law.
- Court of Appeal: It has 32 Lord Justines of Appeal in two divisions:
    - Criminal Division: It receives Crown Court appeals.
    - Civil Division: It considers appeals from The High Court, Tribunals and specific cases from County Courts.
- United Kingdom Supreme Court: The judicial court on the top of the hierarchy, whose members are appointed as Justices of the Supreme Court, has 12 members and up to 9 judges. They study appeals from the Court of Appeal, and in exceptional circumstances The High Court.

Narrowing the legislative level in the healthcare field and the NHS, the premium legislative source above all are the *NHS Acts* and the *Health Acts* (183-8). Other Acts for specific topics are added to complement these main Acts, like the *Mental Health Act* or the *Health and Medicines Act 1988*, for example. Through them, several orders have been created, covering various topics that are not large enough to create an Act but which are related to one, as the orders for creating healthcare regulators.

If we narrow it even more to consider nursing practice only, secondary legislation like the *Nursing and Midwifery Order 2001*, and therefore the *NMC Code*, should be included. If we focus the discussion on emergency nursing practice, the presumption of emergency has to be added, in which a nurse is not considered negligent simply because a reasonable and competent nurse would have made a different choice, giving her more time and information. In cases like *Wilson v Swanson* [1956] or *Wilsher v Essex HA* [1988], the presumption of emergency was used to declare not negligent an unnecessary treatment (189) or to find acceptable a practitioner's skill level that in a standard situation would have been considered negligent (190). In addition, according to the specific context, any of the aforementioned sources of legal material could be applied if they were applicable.

Although it is the NMC who check the standards of care that a nurse should follow, he must legally answer to five entities for his practice (191-2):

- The patient through tort law.
- The society through criminal law.
- The employer through the contract of employment.
- The nursing profession, through written or statute law from the *Nursing and Midwifery Order* 2001 and the *NMC Code*.
- The Department of Health, through the independent regulator Care Quality Commission.

Another concept to consider would be the Duty of Care. It is legally defined as (193):

> The Duty of Care is the duty to provide a level of care to an individual, as is reasonable in every circumstance, to prevent injury to that person or his property. Therefore, the Duty of Care is based on the relationship of the parties, the negligent or omission act and the reasonable foreseeability of loss for that individual.

The Duty of Care is not required in standard circumstances in England and Wales, so aiding another person is not imperative. However, in particular situations, called duty situations, the nature of interpersonal relationships gives rise to a Duty of Care. The nurse-patient relationship is recognised as a duty situation, so nurses have a duty to care, be careful with their patients and be accountable for the damage suffered by their patient if they breach that duty.

The standard of care that delimits the violation of the Duty of Care is marked by NMC or NICE standards, demonstrating through the Bolam test (194) if the nurse may have committed negligence or not due to malpractice, inexperience and/or inattention. The Bolam test requires that skilled professionals, such as nurses, meet the standards of the ordinary skilled person exercising and professing to have that special skill or art, which are evaluated by the relevant professional institution respected (195).

Care neglect is understood as a Duty of Care violation, which, according to *Caparo Industries PLC v Dickman* (196) is defined by three criteria (197):

- It was reasonably foreseeable that someone would be harmed by a careless act or omission.
- It is shown that there is a legal proximity between the parties.
- It is just and reasonable to impose a duty of care in these circumstances.

This duty is not only limited to clinical practice, but, according to *Sidaway v Bethlem Royal Hospital* [1985] (198) it covers every way in which a nurse is called upon to exercise his skill and judgment in the improvement of the patient's physiological and mental condition, among which we could include (199):

- The care given to his patients.
- Giving advice to his patient or to another about the patient.
- Explaining risks inherent in a procedure to patients.
- The standard of his handwriting when giving instructions regarding a patient.
- The standard of his record keeping in terms of legibility and content.
- The timing on a decision to act.
- Seeking the assistance of others.
- Failing to recognise the limits of his competence.
- Failing to report substandard care.

*Blyth v Birmingham Waterworks Co.* (1856) (200) specified when the Duty of Care is legally violated, regardless of the aspect that is infringed. This measure is based on the "reasonable man" test, which consists in comparing the alleged breach of duty with what an ordinary prudent person would or would not do in that situation, considering a Duty of Care breach if the particular case does not match the hypothetical decision of a reasonable person (201). To avoid using the "reasonable man" test, institutions such as the NMC, NICE or the Royal College of Nursing (RCN) create evidence-based guidelines and policies, which help nurses to improve their clinical practice and mark a more rational limit through the Bolam test than the "reasonable man" test for alleged violations of the Duty of Care.

The Duty of Care not only occurs between nurse and patient but also between employer and employee. In the specific case of the nurse and the Duty of Care in clinical practice, the healthcare institution must provide training, policies and guidelines for the nurse to

care for his patients safely while the nurse agrees to follow these policies, protect confidentiality and cooperate with the healthcare institution. This is why legal accountability is assessed in two different ways in Duty of Care breaches:

- Vicarious accountability: The employer is accountable for the injury or death of an employee or any person who was injured or died due to the employee's actions. This accountability is void if the employee disobeyed instructions or regulations intentionally and indisputably.

- Professional accountability: Following the Bolam test concept, an action must be performed in the same manner than a standard member of that profession is expected to execute it, following commonly accepted procedures by a group of experts from the profession as good practice.

With the implementation of the NMC revalidation for registered nurses and midwives, the Department of Health produced a report (202) to cover the NMC policies' exposed flaws in the *Mid Staffordshire NHS Foundation Trust Public Inquiry*, from which a draft of a future amendment to the *Nursing and Midwifery Order 2001* was created, the *Nursing and Midwifery (Amendment) Order in Council 2014* (203).

As discussed above, European and international Law has precedence over English Law. Internationally, no law explicitly interfere in the specific case of current nursing legislation, even though one could argue the standards' incompatibility between the NMC and the rest of the European Union (204) or the evolution of European public health towards a marketable system like the NHS (205). However, the most influential international legislative material on this topic would be the *European Convention on Human Rights* (206) and its relative support from Britain through the *Human Rights Act 1998* (207).

The *European Convention on Human Rights* presents, in Article 1, "that [The High Contracting Parties of the Council of Europe] shall secure to everyone within their jurisdiction the rights and freedoms defined in Section I of this Convention". Being Britain a founding member of the Council of Europe, the *Human Rights Act 1998* does not constitute a commitment to the defence of human rights in itself, but a reaffirmation of compliance with the Council of Europe.

Section I, called "Rights and Freedoms" presents concepts such as the right to life (Article 2), prohibition of slavery and forced labour (Article 4), right to a fair trial (Article 6), freedom of thought, conscience and religion (Article 9), freedom of expression (Article 10), or prohibition of discrimination (Article 14). In the *Human Rights Act 1998*, section 1; it specifies that it recognises Article 2 to 12 and 14 to define the fundamental rights and freedoms. However, even though these rights are recognised in national Law, Article 13 is excluded from it, which states the following (208):

> Everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity.

Theoretically, it is indicated that, although these rights are defended by the *Human Rights Act 1998*, if a declaration of incompatibility is not filed by the UK Supreme Court (as shown in the fourth section of this Act (209)), any legislation that would prevent the defence of any of the rights and freedoms discussed above would nullify its defence in British territory, forcing the appropriate party to refer the case to international courts. The defence of people who might violate these rights and freedoms in their official duties would be also protected if national legislation does not contradict this statement. However, the defence of the *European Convention on Human Rights* by the UK Supreme Court is consistent and the fact that European legislation has a higher degree of validity than British legislation and is incorporated in it thanks to the *European Community Act 1972* covers, in theory, any voids that the *Human Rights Act 1998* could have.

The reason why this is important in clinical nursing practice is based on two contexts, one related to Nursing as a profession and another linked with practice in emergency situations:

- Regarding the nursing profession, the *NMC Code* as a code of conduct would violate Article 9 and 10 of the *European Convention on Human Rights* in the following duties and conducts:
    - In the twentieth duty sixth conduct, it is indicated that the nurse must not express his beliefs in an inappropriate manner. However, the inappropriate

concept is vague and subjective, so it censors his freedom of expression and thought since it prevents an inappropriate hypothetical conception of his ideas. Although wrong, this behaviour would be more tolerable if it was applicable only during clinical practice, but in the twentieth duty specifies that conducts under that duty are applicable at all times.

- In the twenty-first duty fifth conduct, it explicitly states that "never use your professional status to promote causes that are not related to health". Since nurses are the champions of holistic care, prevent nurses to identify themselves as such and to use their resources as a professional community in the defence of concepts like justice in developing countries or human rights violate their freedom of expression. In the case where these concepts are considered as health-related, sticking to a concept of physical, mental, spiritual and community health; virtually any topic could be related to health in one way or another, invalidating this conduct.

- The twenty-fifth duty second conduct quotes: "you must support any staff you may be responsible for to follow the Code at all times." This requires nurses to indoctrinate the *NMC Code* duties onto their colleagues who may or may not be nurses (HCAs, doctors, porters, etc.), violating not only nurses' freedom of thought and expression but also their colleagues', who do not have to be guided by the *NMC Code* or follow any of its duties. The concepts explained in the two previous paragraphs are extended to anyone who forms part of a healthcare multidisciplinary team and has been trained in the NMC duties and conducts.

- If we only consider clinical nursing practice in emergency situations, theoretically Article 4, Section 3, subsection c of the *European Convention on Human Rights* may conflict with practice in EDs and pre-hospital services. This subsection states that "the term forced or compulsory labour shall not include any service exacted in case of an emergency or calamity threatening the life or wellbeing of the community". By not indicating the definition of emergency, European governments could theoretically force healthcare professionals, including nurses, to work in a situation that they denominate an emergency.

> The problem is not the obligation to work in critical emergency situations, since it is not civic or ethical to ignore the emergency needs of a community, but what is considered an "emergency or calamity" and under what conditions this work would be carried out by giving the government freedom to impose such conditions. For example, theoretically the British government could force healthcare professionals to work in the conditions they considered appropriate once the emergency protocol was activated in a major incident, which is activated when the healthcare demand exceeds the ED's resources. It is commonly understood that this article refers to natural disasters and national emergencies, and that the government should not take advantage of these situations, but the lack of specificity in the drafting of this subsection could create a legal loophole that could lead to the situation indicated above.

Although the purpose of this section is to give an overview of the legislation applied to Nursing, given the context of this thesis we have to focus on some aspects that have not been mentioned regarding nurses practising in EDs. First, we have to consider that acts like obeying orders in an emergency can be seen as situations that may be under the presumption of emergency, but it is valid only in very specific cases, since the independence and accountability that the nurse has acquired in recent decades forces him to discuss decisions that do not seem correct to him, avoiding blind obedience (210).

A very common misunderstanding in clinical practice in an emergency is to assume that a patient with an acute illness, even an unconscious patient, may be subject to techniques and care based on implied consent. Implied consent occurs only when the patient gives consent through non-verbal communication, which is not possible in an unconscious patient. However, as *F v. West Berkshire Health Authority* [1989] (211) clarified, in this case the nurse does not have the patient's consent but is exercising his Duty of Care in an emergency protected under the *Mental Capacity Act 2005* (212), which allows him to act in the best interests of a mentally incapacitated person (213).

Although the presumption of emergency in a specific situation could favour the defendant professional, and even if an ED is dangerously short-staffed and under high clinical workload, an adequate standard of care for each and every one of his patients is

legally required. Nonetheless, the context in which the problem is situated (staff, clinical workload, number of simultaneous emergencies, etc.) and the triage done to the patient will be taken into account by the court.

This entails that although physically human resources cannot meet the appropriate standard of care for all patients, the healthcare professionals involved and/or their employer would be guilty of the consequences of offering care that was not good enough to reach the expected standard of care (214).

As a population's entry point to healthcare services, EDs and their professionals maintain a Duty of Care to the person once he enters the department. This means that even if the patient has been incorrectly referred to the ED, the healthcare professional that assesses the patient must ensure that he gets an adequate standard of care before leaving the department, even if this requires a referral to another hospital or a recommendation to visit his GP. It is the department's responsibility to offer an adequate standard of care for each patient while efficiently using all available resources that are appropriate, even though an erroneous referral would also be the responsibility of the professional that referred the patient (215).

## 2.7. Defensive clinical practice: malpractice or legal protection

During clinical practice, according to an RCN survey in 2013, nurses employed 17.3% of their time on non-essential documentation and office tasks, which represents 2.5 million hours a week of work for NHS nurses, twice as much than in 2008 (216).

Other findings of this survey were that 81% of nurses said that completing non-essential documentation prevented them from providing direct patient care, 86% insisted that the amount of nonessential documentation tasks such as filling forms, photocopying and ordering supplies have increased over the past two years and 69% said the use of information technology has increased the amount of time they spend on documentation and administration. This phenomenon is part of the evolution of the NHS over the past decade and is based on two concepts: care technique marketing and defensive clinical practice.

Care technique marketing is the transference of business policies to the healthcare field, in which only goods or services that can be measured can be bought or sold. It is based on quantifying the techniques needed to control patient care's staff requirements, clinical workload and cost-benefit ratio in certain areas. This health policy stems from the NHS model as a public service with private structure, in which NHS Trusts need to justify the funding they receive as healthcare providers for the NHS to increase or decrease funding appropriately. However, this corporate model is clinically ineffective, since more than 17% of the time spent by NHS nurses is used documenting what they do, whatever it may be, in a way that justifies their work.

Another disadvantage of this management model is that non-physical care cannot be measured in this system due to its subjectivity and variability, so only taking into account the time spent on nursing techniques as the total time spent on clinical practice limits the nurse's ability to perform holistic care. This model results in the conversion of nurses in care technique providers, similar to workers from the old assembly lines, as they repeat the same techniques over and over without understanding their full context or their work's purpose.

The next concept is defensive clinical practice, inherited from the liberal American healthcare system as a reaction from the healthcare professionals to the aggressive

litigation of demands from patients, who were defending their rights as healthcare service consumers. This phenomenon stems from the legal concept in which any document containing failures or gaps will favour the party that has not drafted that document, in this case nursing records would favour the patient against the nurse.

This argument does not deny the importance of records and care documentation in the nurses' role, but points out that the need to increase non-essential documentation to avoid any gaps in nursing records absorbs a lot of time, as demonstrated by a multicentre study in 15 USA states with a 35.3% of the total clinical time used only in documentation (217).

This litigation trend of patients' demands in search for damage compensation rather than improving the services that failed in the first place moved to the UK through its private management public healthcare model, changing the patient's role to client. Therefore, the demand for law firms with the slogan "No Win No Fee"[3] grew (they do not charge fees for legal representation if they do not win the case), eliminating the risk of superfluous demands since the claimant never loses anything.

This situation has been exploited by lawyers who have inflated their fees against the NHS, receiving up to 80 times the sum received by the claimant (218). In the period 2013/2014, this situation cost 1.1 thousand million pounds to the NHS, doubling the period 2008/2009 medical malpractice claim costs (219).

To reduce the magnitude of this problem, the Department of Health proposed to fix the compensations over 100,000 pounds, restructuring legal fees as a percentage of the claimant's compensation, since only the legal fees themselves have cost the NHS 259 million pounds during the period 2013/2014.

Another reason for the growth of defensive clinical practice in the UK was the results of the *Mid Staffordshire NHS Foundation Trust Public Inquiry* (220-23), the issues that were found and the 290 recommendations made. Considering this document a breakthrough for improving the quality of treatment and care in the NHS, it has also led to the discovery that techniques and care that were considered basic and were not

[3] There are many of these firms, being some examples First4lawyers or National Accident Helpline, which websites are https://www.first4lawyers.com and https://www.national-accident-helpline.co.uk , they were consulted on the 23 October 2015.

documented were not properly executed, so the documentation of everything that is done is mandatory if the nurse wants to prove to a court that he did not commit any negligent acts or omissions.

Nonetheless, the most obvious reason for the proliferation of defensive clinical practice is the consequences of the vicarious and professional accountability. If a nurse does not follow guidelines, policies and protocols strictly and the institution can prove it, even if the applicable policies are not considered appropriate in a specific context through a rational process and/or professional experience, the employer is not accountable for any consequences that may arise from that decision. The nurse would not only have to deal with his professional accountability, which would be judged independently of his adherence to hospital policies and the validity of the employer's vicarious accountability, but he would also have to demonstrate a robust reasoning process to act without following established policies.

In an ideal situation, in which there were acceptable staffing levels, no active emergencies and all staff were trained in all the skills they need and they did not need any advice, defensive clinical practice would not be a problem in itself, since documentation and prudence in decision-making are good attitudes. However, in a real clinical situation they deal with a continuous assessment of priorities due to the lack of time, resources and experienced staff. Nurses must choose between exhaustive documentation or devoting more time to holistic care; between following policies, even if their implementation does not fit the context, or spending time documenting the rationing and actions made outside the policies, avoiding losing their job, their licence and prison sentences for carrying out poor documentation that does not reflect the care and tasks expected, even if they have been performed.

That is why, in defence of their profession and way of life in a dehumanised society in which touching a person without explicit consent (regardless of intent) is theoretically considered battery (a crime), healthcare professionals protect themselves even if sometimes this impacts on the quantity and quality of their service.

Prioritising professional safety over patient safety could be considered immoral, but while healthcare professionals fight for working conditions that enable them to end this defensive position and care for their patients with the highest quality that the context

allows them defensive clinical practice will be an evil that is implanted in current clinical practice, since diminished care is better than no care in the future, even if they should always aim for excellence.

The absence of an ethical code for nurses, not derived from a law as behavioural guidance, government threats of salary and staff numbers cuts in Medicine (224) and Nursing (225-6) and the current legislative healthcare professional situation are some of the many reasons why British doctors and nurses migrate to USA or Australia in search of clinical freedom, better wages and better quality of life.

In a country like Britain, where the nursing shortage has been almost constant since the creation of the NHS, NHS's recruitment program should prioritise making Nursing a more efficient and attractive profession. This would avoid making precipitous and temporary short-term decisions like lowering the immigration requirements when hiring nurses from outside Europe, which may have an indirect impact on patient safety (227).

# Chapter III:
# Evolution of the nursing profession in the English National Health System

### 3.1. England, cradle of Modern Nursing

Baly considers that the changes made by Florence Nightingale in her nursing school facilitated the transition from the Dark Age of Nursing to the modern age. Nightingale's use of miasma theory, formulated by Sydenham and Lancisi in the seventeenth century as cause and nature of disease, led to the concept of Hygienist Nursing (228). This Nursing model prioritises observation and hygiene in the care of ill people, initiating the need for an observant nurse with basic training.

Nightingale also settled value and etiquette codes that were very advanced for the time, giving greater freedom of action to nurses, even if they were always under the orders of medical personnel. This made Nightingale the figure of Modern Nursing, being her nursing schools' model copied around the world and her teachings on the concept of Nursing disseminated in her *Notes on Nursing* (148) as the body of nursing theory.

At present, although some notions have become obsolete, concepts from Nightingale's theory still being used in British Nursing practice. Several authors argue that her health management style is universal and timeless as her environmental theory (229), the struggle for universal health (230), morality in Nursing (231), the need for nurses' continuous education (232) or the support of nursing research through Biostatistics (233). Other authors have indicated the theoretical (234) and practice (235) presence of Nightingale's theory of Nursing in contemporary nursing clinical practice.

Nightingale's figure is not only important in Nursing's history but also in the history of Britain. She is a national figure that has appeared printed on the 10 pounds note for over 100 years and she received the Royal Red Cross, the UK Order of Merit and the Keys of the City of London. Known colloquially as the lady of the lamp or the most influential woman in Victorian England after Queen Victoria herself (236), Nightingale and her healthcare reforms in the Crimean War created a legend which expanded her work in Biostatistics, health management and nursing education in the UK and India. This work was extended worldwide, catalysing Nursing development worldwide beyond the Dark Age of Nursing.

Although Nightingale’s model is globally recognised and accepted as the engine of nursing evolution, some authors have criticised the relationship of Nursing and religion in her model and the evolution that the discipline has taken since.

Peet delved into the theoretical study of Nightingale’s writings, after which he postulates that Nightingale should not be considered the founder of Modern Nursing. This is because, according to Peet, the characteristic religious pragmatism of Nightingale's writings is their raison d'etre and her Nursing model is an accidental success that would not exist if it were not for its religious function (237). This theory links the optimism about humankind's ability to extinguish diseases and maintain a permanent state of health with her view of Nursing as a vehicle to implement moral lessons about the union of humankind and God, leading to the unintentional support of moral zeal and the social reform (238).

Nonetheless, according to Nightingale, the nurse attended God's call to practice as such, since Nursing was women's work, not a profession, so nurses should not worry about mundane acts like woman emancipation, professional registration or union groups (239).

Peet also refers to the concept of nursing education within the Nightingale model, which despite using observation, practice and reflection as study tools was dependent on a moral-religious discipline that followed a similar cycle that Dewey’s philosophy of education (240). However, Bradshaw notes that the Christian virtues, present in the Nightingale model, have been the method to train "good nurses" in the past, and that the return of these virtues to Contemporary Nursing is relevant to British and global Nursing (241).

Since the Nursing model proposed by Nightingale was developed in the UK, its influence is stronger and more long-lived in the UK than in any other country. Independently of being considered the founder of Modern Nursing or not, Nightingale restructured British Nursing and gave it a new raison d'etre. That is why the context of English Nursing from the nineteenth century to the present day cannot be understood without Nightingale’s postulates and her influence on the evolution of Nursing.

### 3.2. The nurse in the National Health Service: Nursing in a welfare state

Although the historical period between the second half of the nineteenth century and the first half of the twentieth century is not absent from important moments in British Nursing history, the theoretical framework after Nightingale will focus on the evolution of Nursing within the English welfare state, outlining the theoretical framework to the relevant historical context in this thesis.

The UK's historical period after World War II is considered the beginning of the welfare state in England. Among the popularisation of Nightingale's teachings and the welfare state rise there was a gradual shift from nursing subservience to the pursuit of professionalism and professional registration. This progress was slowed by the emergency measures imposed in both World Wars despite nurses having an active role both on the battlefield and in field hospitals. This is reflected in the minimum training reduction during World War II, the lack of a restitution of previous formative values after the war and the nonexistent nursing training planning in the *NHS Act 1946* (242).

One of the welfare state achievements was the NHS creation in 1948, three years after the Allies won World War II. The protection of Nursing within the NHS would create a turning point in the nursing training and practice, directing it down a path that might have been different under the support of nursing schools alone. That is why it is vitally important to understand the trajectory that Nursing followed since then to understand holistically the current context of English Nursing (243-5).

#### 3.2.1. Period pre-NHS (1945 - 1948)

Nursing remained a mainly female job after World War II, but its role had expanded outside hospital wards to wherever an emergency occurred. This occurred through the nurse's education, as the London County Council affirmed, who was an assistant proficiently trained in a career of dignity and responsibility. The definition of the Nursing status before and immediately after the end of World War II in England can be seen in some notes from a newly-qualified nurse explaining the nurse's role in the St. George Hospital in 1946 (246):

> Women should not take the nursing profession unless they are prepared for hard work, constant subordination of their will, and continuous abnegation... She must be trustworthy, conscientious and faithful to the smallest detail of her duty. She must be observant and have a real power to gather all the details about her patient. She must be promptly obedient and respect hospital etiquette... The nurse's behaviour with her patient should be decent, kind and gentle, but no expression of affection should be used. She should surround herself in mystery and never talk about her own private affairs.

From this fragment can be deduced that, even though Nursing was considered a profession in the NHS, the nurse remained an attendant subordinate to the doctor, so the fact that Nursing is considered a profession at that time is relative to the definition of profession used.

Nursing training occurred in hospitals under the control of matrons, apex of the nursing hierarchy and managers of human and material hospital resources, including nursing training and staffing. They used nursing students as free labour, integrating their training in a practical way. After three months of training, the nurse had to study and work simultaneously in the hospital for three years, while during the first year of registered nurse he must sharpen his skills to be officially considered a nurse, retaining staff more time. This situation was denounced by the Royal College of Nursing (RCN), which pointed out the inability of nursing students to relate theory and practice due to the inadequate division of training and clinical practice (247).

Another problem that plagued the nursing profession was the shortage of nurses, resulting from recruitment difficulties and marriage for which Nursing was an alternative and were not compatible. To try to find a solution, the Department of Health produced the *Wood Report* in 1947 (248). Its data served to create recommendations that define the situation of Nursing at the time:

- Wide variance in the intellectual capacity of nurses, who received the same training: To solve this issue, they advised the creation of the registered nurse role, and for candidates who did not reach the necessary intellectual level a nursing assistant role, creating a division between the most specialised tasks and domestic work.

- Nursing education retention issues, during which 54% of nursing students recruited during their training were lost: They blamed the matrons and experienced staff for not supporting students and facilitating their departure from nursing training. In addition, a more comprehensive selection of nursing education candidates was needed. To solve this problem a battery of measures in favour of a more attractive practice for potential candidates were suggested, thus reducing abandonment:

    - More comprehensive selection of candidates
    - Cessation of the domestic tasks' delegation to nursing students
    - Three shifts a week rotation
    - Scholarships for nursing students
    - Student's management by the training institution, not the hospital
    - Two years training, with professional registration after a third year of clinical practice
    - Emphasis on preventive, social and community medicine and bed-side care of healthy and ill patients

Even if they were contemporary recommendations, they were not free from criticism. Hospital administrations needed nursing students as labour, the Association of Hospital Matrons refused to lose control of nursing students and the RCN warned of the danger of reducing the duration of nursing education and the unnecessary alleged infiltration of the English Department of Health in nursing education through scholarship funding.

Regarding nursing practice itself, a continuous supply of nursing care was maintained in the hospital wards, even in some hospitals the nurses lived in housing provided by the hospital. However, since 1948 the Department of Health recommended that nurses should find their own homes, like any other professional.

Etiquette and discipline in practice were really rigid. The uniform had to be perfect, including measurements, and a complete subordination to the medical personnel was expected. Nurses from teaching hospitals were considered the elite, even having their own street uniform, sharing the hospital etiquette with society.

During these changes, the RCN had to exercise both as a union and as a professional organization in the absence of another institutional body that could take over these

roles, claiming the need for a multidisciplinary relationship rather than servitude between the doctor and the nurse. Where nursing practice was more independent was in community practice, of which there are records from 1863 in Liverpool, from where it spread nationwide, especially in small towns or isolated locations.

Alongside community nurses, there were midwives, carers of the pregnant woman and her child from birth until several months after birth, and health visitors, who were in charge of providing social support related to health. Despite the difference in roles between these three professions, as there were no professional duties delimitations sometimes the same person was the community nurse, midwife and health visitor of an area.

### 3.2.2. The Wood Report and the birth of the NHS (1948-1957)

In the creation of the NHS through the *NHS Act 1946*, nursing training and its organization was not considered. It would not be until after the *Wood Report* when the *Nurses Act 1949* would be created, which proposed other models of training, even though it rejected ideas such as the student role of nursing military recruits or a separate educational organisation from the hospital.

The nursing shortage was a problem, as confirmed by the *Wood Report*. The NHS needed 48000 nurses more and was very dependent on nursing students to cover staffing problems. So much so that there were cases like the Aberdeen Royal Infirmary, which had 98 trained nurses and 330 nursing students for 600 beds (249). One of the main reasons for the lack of nurses was the high dropout rate of nursing education, 55% according to the *Wood Report*, which favoured a nursing shortage despite that 21000 students applied annually to study Nursing.

This was not only due to unattractive conditions for nursing students and the effect of marriage on students but also during World War II the educational standards for new candidates were reduced due to the emergency of the situation, but they remained low after the end of the war. This was one of the reasons that prompted hospitals like St. George Hospital to screen nursing student requests based on intellectual capacity and social skills, skills found essential in a test carried out to 126 nurses (250).

The type of training itself was another problem because, unlike most professions, nurses offered a service before completing their training. Professor Revans, from the Department of Industrial Administration at the University of Manchester, was commissioned to study the nursing profession. He concluded that it was in a process of change, a time when women were incorporated into the labour market, in which only housework and nursing were seen as ways of God to ensure that middle-age working class inactive women were not let to evil by the Devil. This produced many candidates for nursing students, but after being treated as cheap labour and not being supported by the hospital, many left before finishing their training (251).

Another related study was the Lord Horder's Nursing Reconstruction Committee study on economic factors and nursing recruitment (252). It exposed that 15,000 students were required each year and that they should not subordinate their training to favour the NHS as free labour, since students only demanded training and education that connected theory and practice in their clinical practice placements.

It also proposed recommendations to healthcare institutions to prevent student exploitation, to encourage an appropriate wage and to facilitate nurses' contribution to hospital policies. The RCN, based on what was set forth in the Horder recommendations, exposed horizontal problems in nurses' recruitment and retention and vertical problems on the need to explore the future of the profession with university training and positions in professional organisations.

From the 50s to the present, English Nursing has been influenced by the development of American Nursing (253). This is due to several factors, which include an increased academic career as the first unit of nursing studies in the United States was established in 1899 in the Teachers College at Columbia University (cornerstone of global Nursing since 1930), while the first unit of nursing studies in the UK would not be created until 1956 in Edinburgh.

Other factors were the domain of social sciences in Nursing, derived from the need for nursing professors to doctorate in social sciences to teach in the University, the struggle of American nurses against the hospital administration and the cultural concept of Nursing that focus in autonomous evidence-based practice, not on tradition and etiquette.

At that time, a change in the nurse's role was promoted, since from the 50s the hospital started to reduce hospital stay length and care needs as much as possible, not only physical but also psychological, like pain management. Community nurses had to cover the early discharges with a more exhaustive care to acute patients. This fact and several more were discovered in the report *The Work of Nurses in Hospital Wards*, also called *Nuffield Report* (254), which revealed flaws in nursing training and practice across the whole hierarchy:

- Trained nurses' jurisdiction was satisfying patients' human needs, not only performing nursing techniques.
- Nursing practice should be done by nurses, not being supervised by them. As nurses increased their training and experience, they were more devoted to performing techniques and less to patient care, so basic care was delegated to nursing students and nursing assistants.
- Trained nurses should be responsible for the integral care of a specific group of patients. In the United States, the division of care between head nurse, registered nurse, nurse practitioner and nursing assistant was clear, but in the UK seemed very complex to delegate basic and technical aspects of care of someone who was not or was not on the process of becoming a registered nurse.
- A break without interruption was not possible, since their shifts lasted from 5 am to 10 pm.
- The time spent by the sisters to teach nursing students was negligible, about five minutes a day.
- The end result of nursing education appeared not to be nursing but hospital administration, to which they derived part of their working day, more as more experienced was the nurse.

After these results, the House of Lords and RCN reaffirmed the inadequate distribution of human resources and the care fragmented by tasks, which was cheaper but derived in poor care. While the Americans focused on democratic team organization, the British stress the importance of the registered nurse, who performed nearly 100% of the care in the community and about 25% in the hospital setting.

Although a suggestion derived from the *Nuffield Report* punctuated the British nurses had a duty to be as active in research as their American peers (even if British nursing research was not funded nor supported, unlike American nursing research), British nursing was reluctant to change. One of the characteristic features of this situation was the uniforms, which still retained the design of a nurse with a religious vocation with cap and apron, instead of following infection prevention guidelines like USA nurses' plain dresses.

### 3.2.3. Salmon Report and the division of labour (1958-1967)

Although the number of nurses increased by a third in 10 years, there never were enough nurses (255). The limiting factor was not funding but the ability to recruit and retain nurses. Not only had to compete with other occupations for young unmarried women and the few women who worked until retirement but also the problems that were discovered in the *Wood Report* and the *Nuffield Report* remained valid:

- Student selection without screening, deriving in a drop rate between 30% and 50% (about 10,000 students per year)
- Unpredictable shifts patterns
- Excessively long shifts
- Classes taught in the student's free time
- Outdated discipline
- Inadequate working conditions
- Excessive responsibility on night shifts
- Inadequate screening of students' health
- Not standardised practical training
- Sisters without human resource management training
- Entrance to nursing training with insufficient preparation through the professional practice model called cadet scheme

This situation precipitated that once the new registered nurses were subjected to responsibilities which could not undertake alone, even with support, they left nursing education or practice in the UK.

To try to alleviate the problems of nursing education, the RCN established a committee that produced the report *A reform of nursing education* in 1964, derived from the *Platt Report* (256). This report set out the need to put an educational limit to access nursing education (at that time it was proposed to be five "O" levels) and the division of Nursing into three levels: registered nurses, trained in nursing schools; enrolled nurses, who follow a simpler training program; and ward assistants, clinical support without any training. Following this report, nursing schools that did not have a reference hospital with over 300 beds and different specialties were eliminated, going from 660 to 560 nursing schools in the UK in 1964, enriching nursing students' educational experience.

Other measures that were implemented to increase nursing employment were the working hours' reduction from 94 to 85 hours a week and the ability to offer part-time shifts, which made it easier to keep employees or re-employ married nurses. The implementation of enrolled nurses and ward assistants eased the administrative and domestic work burden of registered nurses.

Courses were also offered to expand training, especially in departments with problems recruiting nurses. In regard to wages, the RCN, along with two other unions, NUPE and COHSE, went on strike against a wage freeze in 1961 that affected the precarious nursing salaries. However, negotiations had no result, since the government considered that nurses could not manifest radically without harming the patient by omission, which would violate their Duty of Care.

Unlike Medicine, Nursing did not evolve with the technological progression. Despite the stay shortening, the daily stays, the active geriatric policies and the reduction of the limitations of bedridden patients, nursing practice remained the same, based only on the advances in Medicine. Progression was a complex challenge for Nursing, since it did not focus completely on traditional practice nor technical practice, even the research nurse's goal was not clear.

Perhaps due to this or derived from this, nurses graduated in the University and nursing research departments remained virtually non-existent in the UK, despite some opinions that were raised in favour of their proliferation and a few nursing university education programs that were created. Nevertheless, criticism from doctors and nurses trained in schools regarding the incompatibility between the nurse's identity and higher education

and its attributed reduced practical usefulness were delaying the academic progress of English Nursing.

Regarding nursing administration, training courses and diploma-level education were offered to sisters and matrons to improve their administrative capacity. This was done due to the nonexistent evolution of nursing hospital management from Nightingale's time. In 1964, the RCN proposed a new hierarchical structure that was similar to the hospital administrative structure. These changes were facilitated by the report that uncovered the inefficient administration of British hospital wards and proposed a new model through the *Salmon Report* in 1966 (257).

This report highlighted the inefficiency of matrons and sisters in their administrative role and their zero influence on the creation of hospital policies and guidelines. This encouraged the proposal of a management model in three lines: upper, middle and first line, each with two ranks of nursing manager. Training for nurses was provided so they could access these positions, which were open for everyone.

Nonetheless, staff saw the change from another perspective. Each of these degrees of management was a well-paid low physical effort job, so an overloaded management structure gave a high-status impression, despite its inefficiency. When the matrons disappeared, non-healthcare officials took their positions without any training while professionals that applied for the same job that they used to have, now with a different name, were rejected despite having successfully performed their work for years.

### 3.2.4. Briggs Report and the progression of American Nursing (1968-1977)

Nurses and midwives were the NHS largest staff group, widely growing since the previous decade. The economic expansion after World War II extended the available career opportunities for women, so Nursing had to compete with them. There were fewer dropouts, recruitments were static and there never were enough high-quality candidates. However, the dropout rate remained high, up to 36% in Central Middlesex, due to job responsibility, long stays away from home, excessive emotional involvement with patients or lack of confidence in their own abilities (258).

Registered nurses shortages remained a problem, so the number of enrolled nurses more than doubled between 1949 and 1968. The proliferation of a healthcare professional with less training than registered nurses within their field of practice threatened to dilute the nurse's role and concept, even if it was a short-term response of hospital administrations to personnel shortages. These assistants began to obtain roles and responsibilities not covered by the registered nurse, creating the state enrolled nurse, with his own uniform and badge, in the same way as United States created the social worker.

Thanks to the evolution towards a more open society, nursing academic groups and unionised nurses could engage in a debate about which way Nursing should head towards. Other circumstances arising from this social aperture were the relaxation of nursing practice discipline and the relative adaptation of nurses' shifts to their social lives.

Nevertheless, in hospital wards problems remained the same: shortage of nurses, nursing assistants and secretaries, nurses' low status within the healthcare professional groups, too many working hours and lack of continuous education.

After reviewing the nursing salary, administrative, rights and duties structure in the *Prices and Income Board no. 60*, a salary increment and the implementation of the measures proposed by the *Salmon Report* were proposed.

Another report, this time done by the professor and historian Asa Briggs, intended to review the role, education and training of nurses and midwives. In 1971, the *Briggs Report* (259) noted that many past reports were ignored, and that the old problems remained valid, for which he proposed several recommendations:

- Two educational modules of 18 months
- Link theory to practice in four clinical areas: medicine, surgery, psychiatry and community practice.
- A process of continuous training in a profession undergoing changes
- Nursing schools' quantity reduction and size increment
- Need for more non-university nursing training courses
- Creation of a unified professional body for Nursing

This report and its consequences were delayed by the implementation of European directives when the UK entered the European Community. For example, the creation of the United Kingdom Central Council of Nursing, Midwifery and Health Visiting (UKCC) in 1983 comes from this report.

The evolution of technology and patient's length of stay reduction provoked an identity crisis in English Nursing, which sought what was its role while following the technological developments and entering medical teams. It would be in 1970 when the first English Nursing studies university department in Manchester would be created, where a nursing role independent of medical diagnoses would be sought. Also between 1972 and 1975 the RCN financed several research projects related to patient contact (260), hospital anxiety (261), patient's nutrition (262), hospital management (263), communication (264), nursing techniques (265) and the nurse's role (266).

In contrast, there were the American Nursing theories, which distinguished the concepts of nursing therapy and patient care several years ago, but were trying to recover part of the role assigned to nursing assistants. This new understanding of the American Nursing role is expressed in the ICN Nursing definition commissioned by Virginia Henderson, which had and has a great influence on the English and Spanish speaking Nursing community (269):

> The unique function of nurses in caring for individuals, sick or well, is to assess their responses to their health status and to assist them in the performance of those activities contributing to health or recovery or to dignified death that they would perform unaided if they had the necessary strength, will, or knowledge and to do this in such a way as to help them gain full of partial independence as rapidly as possible (269).

Nonetheless, this research impulse on the concept of Nursing itself and its roles was not transferred to clinical practice, in which clinical nurses did not adapt to the change of care needs or the evolution of their medical colleagues. That's why experts like Virginia Henderson stressed the need for nursing academic to exercise clinical practice part-time, as often happens with medicine scholars, which would facilitate the expansion of nursing theory, clinical practice research and the improvement of the relationship with doctors and patients.

### 3.2.5. Project 2000 and the nurse practitioners (1978-1987)

NHS nurses and midwives were almost half of all human resources in the NHS, using one-third of the NHS budget and assuming almost 3% of the total public budget. Despite the reduction in working hours from 48 hours to 37.5 hours and salary increments driven by the *Cleggs Report* (270), nursing staff were still missing in several priority specialties, geriatrics and mental health. This happened because, despite the *Wood Report* and subsequent reports' contributions, Nursing remained a profession with good recruitment rates but high dropout rates, which attracted the largest number of women who had not finished secondary education.

When the situation reached a 20-25% deficit in nursing staff, more unskilled staff was hired, especially subcontracts for laundry, catering and cleaning services since 1983. Although money was saved through these measures, the lower efficiency of these services had laid the remaining tasks on a nursing staff already suffering high clinical workload. This scenario caused that in 1987 nurses' morale fell and the dropout rate increased even further, even if the NHS tried to accommodate the situation with eight-hour shifts, part-time contracts and mandatory maternity leave.

The UK maintained a nursing education system based in more than 200 non-university schools. Students felt like cheap labour moved from one specialty to another without time to meet patients, learn clinical practice or reaffirm the corresponding theory.

The RCN reaffirmed by a commission the need to transfer nursing training to higher education through a two years diploma, which would be complemented by an internship program for healthcare workforce development and training financed by the British Treasury. These measures were aimed at avoiding the high recruitment and high dropout model that was characteristic of nursing studies before the NHS creation. All these measures were taken into account by the government healthcare regulator United Kingdom Central Council of Nursing, Midwifery and Health Visiting (UKCC) to create the document *Project 2000 - a new preparation for practice* (271), also known as Project 2000, in 1986.

Project 2000 took into account all nursing education revisions since 1940, after which it indicated the following recommendations:

- A tripartite division of labour:
    - A single registered nurse level
    - A more advanced specialist level, such as health visitors or community nurses
    - A social worker
- The registered nurse should be a knowledgeable healthcare worker
- An 18 months common training program followed by another 18-month program in a specific branch (adult, paediatric, mental health or learning disabilities)
- Acute patients' treatment reorientation towards community care
- Connecting nursing schools to higher education
- Students' supernumerary status 80% of the time
- Nursing studies financed through scholarships
- Academic recognition of nursing professional qualifications.

After the parliamentary debate and the almost universal acceptance of all healthcare professional groups, in 1988 the Secretary of State John Moore accepted the implementation of most recommendations while they waited for further information on upgrading the nursing training process and a formal proposal on the role and training of the health visitor.

In clinical practice, hospital stay length reduction, increased specialists and new sisters' inexperience hindered the relationship between medical and nursing teams. The team management system was successfully implemented, even though nursing academics suggested holistic and personalized Nursing as the next step. To do this, the nursing process derived from Virginia Henderson's principles was trialled as a method to provide Nursing with a holistic and independent model.

Despite its success in the United States, this change was not well received by managers, midwives and doctors in the UK, since they saw it as a lot of useless documentation that only distanced Nursing from their colleagues and stole time that could be used in other clinical activities. However, this nursing process was defended as a process in pursuit of health promotion and disease prevention, not the healing process that characterises Medicine.

A holistic nursing project in a ward controlled only by nurses was held in Burford, where medical staff only visited the patient at the nurse's request. The project did not reach any conclusion by faulty randomisation and the threat of medical personnel to withdraw their support if it was not clear who was responsible for the patients, forcing the health authorities to stop the project ahead of schedule.

Later, the RCN proposed nurses' responsibility as patient advocates, even against the doctor. However, the struggle of Nursing for a holistic view of care within an independent medical practice was largely ignored. During this conflict, community nurses worked closely with family doctors and health visitors as a key part of the community health team, oblivious to the problems of nursing hospital care.

While in the United States nurse practitioners were established since 1971 and were indispensable to overcome the 1970s doctors' shortage, in the United Kingdom they began to be implemented in 1982. These nurse practitioners were an academic echelon higher than registered nurses, who worked with the doctor as physicians, proving themselves better at chronic diseases monitoring and empathetic patient treatment. However, given the lack of nurse practitioner training programs in the UK and the traditional view of Nursing, the concept of nurse practitioner was developed gradually.

This traditional view of Nursing also came from and was reinforced by the English society through various stereotypes: the helpful and religious nurse who did not deserve professional rights and whose prize was marriage, the lascivious nurse perceived as a sexual object, the quarrelsome matron, the male homosexual nurse, the black unionised nurse, etc.

### 3.2.6. Recruitment agencies and Project 2000 development (1988-1997)

The contemporary nurse was better paid and worked fewer hours than the nurse in 1940, but was less socially valued as a professional and had to worry about legal consequences arising from his clinical accountability. Registered nurses and nursing students dropping rates remained high and recruitment was very poor, even if it was slightly re-launched by three factors: the economic recession, the new salary structure and *Project 2000*.

After four decades, the number of nurses in the NHS stopped growing, reducing recruitment of Project 2000 type students in nursing education to 11000, recruitment rates that were comparable with those of 1948. In the mid-1990s, recession dropping rates were about 20%.

The *Project 2000* launch had several problems despite its promising premise. The research focused on nursing philosophies, especially of feminist nature, overshadowing clinical nursing research. The implementation of an American-style academic training model without adding concepts from British clinical practice led to academically acceptable but clinically negligent nurses, given the centralisation of nursing as a profession and theoretical field and the omission of clinical and practical concepts in classrooms. The training model changed to the one proposed in *Project 2000*, with a baseline 18-month program and a specific program in Adult Nursing, Paediatric Nursing, Mental Health Nursing or Learning Disabilities Nursing.

Even if nursing students should practice under supervision for one to three days a week, the gap between theory and practice was still not cross. Students could not implement a training focused on social sciences, psychology and research to a clinical practice that demanded physiological knowledge and nursing techniques from them, being forced to supplement their education with extracurricular work as HCAs (healthcare assistants). This problem is lengthening in time to the present, over 20 years after its implantation, when the nurse is accused of being "too academic" and of having "abandoned his basic vocation of caring" (272).

Although nurses' migration was common since 1960, the lack of nurses led to the creation of recruitment agencies and the search for nurses in areas such as Australasia and Scandinavia, even though the NHS salary was lower than in the private sector and foreign nurses did not geographically adapt to the job. While, sickness absences increased due to false illnesses and professional absenteeism, with 30% of nurses working in more than one place.

In the 1991 census, 140,000 nurses, midwives and health visitors trained for free by the NHS stopped working for it, of which 50% worked in other jobs and 40% denied the possibility of returning to practice (273). To alleviate staff shortages resulting from

these problems, managers exploited the resource of hiring more HCAs in order to maintain a minimum amount of staff.

The patient rights' document *The patient's charter* implemented that every patient should have a specific nurse who was responsible for him. This evolution of patients' rights and nursing accountability facilitated the implementation of holistic Nursing, in which a nurse is responsible for the patient's care and all tasks related to that care are executed by him or another nurse. However, this model only worked in wards with an adequate amount of staff and low patient flow, given the poor short-term cost-benefit efficiency of acute patients' holistic care. Also, the transition from the subservient nurse to the advocate and counsellor nurse derived into the delegation of basic care such as hygiene, nutrition and rest to HCAs in favour of nursing documentation and patient psychological support.

In 1992, the UKCC created a guide to professional competencies and professional codes of conduct. In these, the ethical duty of nurses to uphold patient and social rights, to justify public trust and to maintain the profession's reputation was displayed. Furthermore, it indicated that the nurse had legal freedom to do what he considered adequate if he had the skills, knowledge and skills necessary, except prescribing medication and signing death certificates. Only in private hospitals the traditional role of the dutiful and subservient nurse with cap and apron was maintained, like they publicised it.

In specialised services, and since medical budgets were being reduced, nurses experienced in an area were trained to support medical staff in different aspects like asthma, diabetes, neonatal care or intensive care. These specialist nurses began to expand and came into conflict with registered nurses and nurse practitioners, since the creation of these specialties was unregulated and has not been regulated yet.

In the administrative role, Nursing had less and less impact. Management positions were occupied by professionals in various fields, especially from business and industrial management. The few nurses who came to management positions after training in business studies focused on concrete government priorities, not in improving individual care.

Nursing was becoming a profession focused on health promotion, forgetting its patient care role. Its focus on higher education and its identity as an individual profession overshadowed the very raison d'etre of Nursing, care.

### 3.3. English Nursing in the twenty-first century

English Nursing has had to adapt to the NHS' constant institutional and legislative changes in the first 15 years of the twenty-first century, such as those produced by documents like the *NHS Constitution* (274) or *Compassion in Practice* (275) and reports like *Next Stage Review* (276), *The Mid Staffordshire NHS Foundation Trust Public Inquiry* (220-23) or *The Keogh Mortality Review* (76). It has also had to endure the economic recession of 2008-9 (277-8), the change from the UKCC to the NMC in 2002, two different codes of conduct between 2008 and 2015 (80, 162), a chronic nursing shortage and an increment of foreign and temporary nurses while practice needed to be updated through Evidence-Based Nursing.

Presently, the nurse has more responsibilities in relation to patients than in the twentieth century, even if these do not match his freedom or ability to act on them. Incomplete university practical education and the evaluation of skills and knowledge through competencies derive in a responsibility for a patient who cannot be cared for holistically if the nurse does not have the right competencies. These situations are solved with good team dynamics, but under increased clinical workload this premise changes.

Comprehending the current socio-economic, educational and clinical English Nursing situation in depth is a colossal task that this thesis does not intend to unravel, even though it is necessary to describe a contemporary context so the results can be placed in it and lead to consistent conclusions. That is why the following sections describe the main aspects of current English nursing practice and what surrounds it.

#### 3.3.1. The competent nurse

English Nursing follows a training system divided into two main stages: the first stage of university education, in which students obtain theoretical knowledge, perform clinical practice and acquire skills, and the second stage of continuous clinical training, in which the concepts and skills learned during the first stage are reinforced and expanded. However, there is an inconsistency between one stage and the other: the skills acquired as a nursing student are not legally transferable into practice, since only after specific post-graduate training in each technique the nurse is legally competent in

that specific technique. This method facilitates a gradual adaptation to the workplace and keeps technical knowledge relatively updated, but it abstracts technical skills from the main nursing body of knowledge and slows down and segregates the ability to provide care.

The features of the technical competencies system are shared by doctors, nurses and HCAs, who are trained in courses of varying duration (from 2 hours to several days) and receive a certificate with an expiry date which allows them to perform this technique legally until the certificate expires, if it is not renewed. In these courses, a limited amount of theory linked to the technique is taught, implying a minimal theoretical basis by the student. However, even though it is based on the same structure, the application of the technical competencies system is different for each professional group:

- For doctors and practitioners, all the basic technical competencies to perform their roles are obtained during their university education, which are permanently valid after graduating, so they do not need to renew them (279). This does not exclude that these practitioners could acquire more specific skills during their clinical practice and rise in rank and seniority.

- The basic technical competencies to perform their role as nurses are learned during their university education, even though they are not legally valid and must be obtained again in clinical practice, commonly in the first year. However, during this period of "temporary technical incompetence" the nurse has full responsibility for the patients under his care (280), depending on other colleagues to provide holistic care.

- Considering English HCAs' training through the *Care Certificate* (281), technical competencies are not part of their role. Despite the lack of theoretical foundation, HCAs are able to acquire several technical competencies like peripheral venous cannulation or plaster cast immobilization. Acquiring these competencies gives them access to a promotion to assistant practitioner with better pay and a more independent practice, even if it may lead to negligence caused by the lack of theoretical knowledge of the performed technique.

These differences in a shared technical competencies system come from the type of training received by each professional group, always following the regulatory organisations' guidelines.

University and clinical education for doctors have a nationally standardised structure through documents like *A Reference Guide for Postgraduate Specialty Training in the UK* (282), which has been agreed by the four UK Departments of Health for basic and specialised training programs.

For nurses and HCAs, training is different in each university and each hospital, being incompatible for an automatic competencies transfer between hospitals. However, in the case of agency nurses their competencies are valid at any hospital, since an external organisation (recruitment agency) guarantees the nurse's competencies despite not knowing the hospital policies linked to these competencies.

Although nursing training is different in each university and hospital, they should always follow the standards imposed by the NMC, ensuring that any nurse that will likely cause harm to the public can be struck off the NMC register. This task is undertaken by faculty members and clinical mentors, who ensure that the student will be a clinically safe nurse when he graduates. However, in 2003 a report funded by the NMC, the *Duffy Report* (283), revealed that student evaluation was very lax, passing students who might be negligent in their clinical practice.

Despite the introduction of documents such as *Standards to support learning and assessment in practice* (284) and the emphasis on training professors and mentors in the need to fail a student who does not meet the standards, incompetent nurses are still graduating. This situation requires extra support and supervision of junior nurses while they obtain their competencies and demonstrate that they can practice safely.

In clinical practice, the competencies of the most experienced nurses cover the lack of competencies, knowledge and/or skills of junior nurses. However, this cover unbalances the clinical workload of the nursing team, which is balanced differently under moderate or very high clinical workload, affecting patient care or creating a bureaucratic loop if leadership is inadequate (285). Furthermore, the nurse has to be considered within the

multidisciplinary team and the competencies and/or responsibilities arising from multidisciplinary work, which differ depending on the area, specialty and hospital.

Obtaining technical competencies is something relatively new for English nurses in comparison with American nurses, so it is not common outside specialised services. This is reflected in the need for medical support and technical personnel like phlebotomists or plaster technicians to cover the competencies that nurses do not have or cannot obtain, since to practice as a nurse is not required to obtain technical competencies even if patients under his care need them. However, they are a desirable requirement to rise through the nursing hierarchy.

Nursing training needs to be approved only by and follow the NMC standards (286). Different universities or hospitals do not have to share nursing education content, form, policies or quality, since it is evaluated by different organisations with different scales. However, even though it is evaluated differently, it should always follow at least the NMC standard policies (284, 287-8), which are so dense and lengthy that transform practical learning into a tedious exercise for the mentor, who must practice while he is training and assessing the nursing student.

Another problem arises with the evolution of nursing education within NMC guidelines. By its own definition, its function is to protect the public, not to represent nurses (9). This entails that the development of Nursing and nursing training is guided by the public representatives, the government, not by the nurses themselves.

This whole situation can be translated with the concept of Ascetics, the good nurse or the virtuous nurse, who never evolves into the moral nurse. A competent nurse does his job without questioning its purpose or that is good or bad about it. This concept is also consistent with the change between the first and second NMC Code (80, 162).

A significant example of the competent nurse's concept is revalidation, which is official from April 2016. The revalidation implies that to be part of the NMC register, and therefore to be able to practice as a nurse in England, nurses have to demonstrate that they have satisfied these conditions every three years (289):

- 450 hours of clinical practice, or 900 hours if they revalidate as a nurse and a midwife

- 35 hours of continuous professional development including 20 hours of classroom training
- Five samples of practice-related feedback
- Five written reflections
- A reflexive discussion
- Health and character declaration
- Professional indemnity arrangement
- Confirmation of all the aforementioned revalidation requirements through another person who can be considered a confirmer.

Revalidation was already a reality before 2016, but in it only a randomised small group of nurses and midwives was asked if they had practised more than 450 hours in the past 3 years. The change applied in 2016 is based on the addition of training, discussion and reflection to the requirements prefixed by the NMC for all British nurses and midwives to maintain their registration, which will be confirmed by a confirmer (usually their line manager) and will be sent to the NMC.

Given that revalidation aims to assess the full professional competence of the nurse or midwife, it can be argued for or against the development of the revalidation process depending on the depth with which the subject is scrutinised. Extending the revalidation requirements to not only practice, but training, discussion and reflection should be considered as a constructive addition to the nurses' professional competence assessment. Therefore, the NMC facilitates nurses' professional development, forcing the use of essential skills in any healthcare profession. Moreover, it avoids any randomisation through its confirmation system.

Nonetheless, if revalidation is analysed deeper, inconsistencies can be found in the way this change in the revalidation system has been implemented:

- 24 of the 35 hours of continuous professional development are met only with mandatory institutional training (manual handling, basic CPR, fire safety, etc.). While the importance of these courses is not denied, they are not part of the nurse's professional competencies, so the revalidation training requirements are achievable with a one day course every three years, which is not enough to update his professional competencies using Evidence-Based Nursing.

- Feedback samples and the five reflections can be manipulated or invented, since there is no way to prove the contrary beyond the confirmer's analysis.

- It is proposed that each nurse or midwife spend the time necessary from their spare time to complete all parts of the revalidation, being alongside doctors a professional group which is institutionally expected to use their free time to perform professional tasks.

A recurring criticism of revalidation is its existence. Before this change, the NMC only examined if their members continued to practice, eliminating inactive members from the registry. However, now it aims to evaluate each member's practice, assuming that it is wrong per se, since if the nurse does not revalidate will be struck off for not meeting the NMC requirements. The new revalidation, next to the new 2015 NMC Code, are tools to keep nursing practice within the NMC safety standards even if they do not perpetuate good nursing practice or facilitate the development of Nursing as a discipline.

Revalidation may be considered a step towards a more exhaustive control of nursing practice or as the natural evolution of patient's rights against negligent practice, but its evolution has a cause. If the *2014-2015 NMC fitness to practice report* (290) is examined several trends can be perceived:

- The accusations to nurses and midwives to the NMC in the 2014-2015 period increased 10.5% in relation to the 2013-4 period, reaching 5541.

- Considering the percentage of accusers between 2013-2014 and 2014-2015, the only one that increased was patients or the public (22% to 29%), even if the employer remained the highest one (45% to 40 %).

- Regarding the nature of the accusations, misconduct was the highest and had increased in relation to the rest (51% in 2001-2002 to 80% in 2014-2015); while criminal act stands at 11%, incompetence at 5% and serious health issue at 3% in the 2014-5 period.

- The percentage of final adjudications of the Conduct and Competence Committee and the Health Committee present an increased number of not-incapacitated fitness

to practice adjudications (14% in 2011-2012 to 23% in 2014-2015) and a reduction of eliminations from the NMC register (48% in 2011-2012 to 28% in 2014-2015).

If these trends are analysed it a simplified context, these claims can be deduced: a population discontented with nursing care and/or more aware of their rights as healthcare costumers, an allusion of misconduct as the main reason to suspend a nurse and an increment of baseless adjudications in relation to adjudications based on facts.

One thing to note in this context is the increase and percentage of misconduct allegations, which shows that 4 out of 5 accusations to the NMC occur for allegedly not following the *NMC Code*. However, all these trends are a response to what was discovered in 2013 at *The Mid Staffordshire NHS Foundation Trust Public Inquiry*, also known as the *Francis Report*.

The *Francis Report* (220-23) presented a generalised negligence from employers and employees, from the lack of transparency and human resource management deficiencies to lack of empathy or respect for human dignity. The recommendations presented have been used nationally as a reference to improve the NHS and the care it provides. These recommendations address issues such as the need to create a core set of values, the establishments of minimum standards for various parameters, the promotion of transparency with professional regulators, medical and nursing training and practice and the duty of candour.

Among the recommendations for Nursing (recommendations 185-213), there are explicit recommendations that push the NMC to modify the *NMC Code* (recommendation 212) and the revalidation system (recommendation 194). It also recommends changes in training (recommendations 185-90), values (recommendation 191), leadership (recommendations 195-7, 203-6) and professional representation (recommendations 192, 201-2). If we broaden the spectrum of recommendations to consider, the recommendation 229 reaffirms the need for a change of the revalidation process.

All recommendations had as main function to improve the Mid Staffordshire NHS Foundation Trust and be an example to improve the NHS as a whole. However, several

measures proposed by the British government and its organizations in 2015 and 2016 do not meet these recommendations:

- The contract that the Department of Health wants to impose to junior doctors (291) violates recommendation 163 on the safe number of doctors, as it reduces the required hours but no limits the overtime imposed by the employer, so there could be fewer doctors working at once or more doctors working an illegal number of hours with the current legislation. It also reduces extra pay for nights and weekends and hinders recruitment in areas like emergency medicine and psychiatry.

- The implementation of the *Care Certificate* (292) for HCAs intends to comply with recommendations 210 and 211, but only meets recommendation 211 on the evaluation of the HCAs' skills and knowledge, not discussing at any time values beyond the Duty of Care, offering only a code of conduct.

- The end of nursing students scholarships (293), which is part of the economic reform *Spending Review* (294), is counterproductive to recommendation 188, since without scholarships the entry into nursing education will be biased by the applicant's purchasing power. Since the representative profile of a nursing student in England for more than 50 years is the middle-class middle-aged woman with family burdens, this change would decrease nursing student recruitment further.

- The abrupt cessation of the NICE investigation on safe nurse-patient ratios (295) and the transfer of that research from NICE, an independent institution, to the NHS England Workforce Board, a government organisation, goes against recommendations 10, 22, 124 and 199. It has been discussed and voted on the RCN public health forum, with 99.45% of votes in favour of NICE continuing and publishing its research on safe nurse-patient ratios (296).

- The NMC register revalidation process, despite following recommendations 194 and 229, does not follow recommendations 185, since none of its sections specifically addresses care culture, and 197, as 35 training hours every three years are not enough to keep nurses trained and encourage their progress.

These examples show how the *Francis Report* has impacted the direction of the reforms imposed on healthcare personnel and the competencies expected of them without being

binding, since they are only recommendations that the British government and the NHS are not required to comply.

The nurse's image and his competencies will be reflected on what recommendation 185 considers the skills to look for in nursing students candidates:

- Possession of the appropriate values, attitudes and behaviours
- Ability and motivation to enable them to put the welfare of others above their own interests
- Drive to maintain, develop and improve their own standards and abilities
- Intellectual achievements to enable them to acquire through training the necessary technical skills

This values shift could indicate an evolution from the technocratic model to the humanistic care model, if the humanistic values system would spread through hospital administration and management. However, given that the UK is the most individualistic country in the world according to the model developed by Geert Hofstede (297), the percentage of people who put the welfare of others above theirs would be very low.

Furthermore, is expected that a person with extensive intellectual achievements changes or adapts his values to the values approved by the NMC. These requests not only reduce the percentage of eligible candidates but also skew nursing practice in favour of a particular set of values and knowledge (and without scholarships, they also discriminate possible candidates with low purchasing power).

### 3.3.2. Nurse ramifications as a care agent, what defines a nurse?

The term nurse carries a long history of subservience that has been recently replaced by an independent profession, even if the concepts that define a nurse are not entirely clear to the public. The division of tasks related to care and the knowledge and responsibility aspirations of the contemporary nurse has resulted in the creation of professions covering delegated roles and new roles in Nursing.

Although most healthcare professionals, if not all, have among their roles the provision of care, the professionals referred to in this section are divided into two broad categories: nurses that have expanded and/or focused their field of knowledge and responsibility, leader nurses, specialist nurses, nurse practitioners, advanced nurse practitioners and nurse consultants, and professionals who have inherited the basic care delegated by nurses, HCAs and professional carers.

#### 3.3.2.1. Advanced Nursing

The leader nurses, nurses with team leadership and/or hospital management roles, are recognised since the institutionalisation of nursing care in Christian churches in the III century A.D. (298). The matrons and sisters (charge nurse in masculine) are classic leadership positions in British Nursing (299), but many other different leadership positions were added since the management model change derived from the *Salmon Report* in 1966 and the reduction of nurses in hospital management in the 90s.

These positions were not necessarily occupied by nurses and hospital management was eliminated from the traditional nursing roles. However, the *Francis Report* in 2013 reaffirmed the need to reintroduce nurses in hospital management with recommendations 195, 203, 204, 205 and 206 (220).

Given that despite the proposed recommendations the hospital management role is not exclusively a nursing role, the role of nursing team leadership should be which defines their status as nurses. The role expected by the current leader nurses is indicated in recommendation 195 (300):

> Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team.

> As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.

This recommendation encapsulates the base characteristics of the English leader nurse: supervisor of care plans and the care performed by other nurses, support for nurses in their professional development and leader who represents his team against patients and relatives.

Specialist nurses, according to the RCN, are nurses who specialise in a specific area, being able to work independently or as part of a multidisciplinary team. They also provide education and support for patients to manage their symptoms, particularly patients with long-term conditions and multiple comorbidities.

The high quality of care and support that specialist nurses offer facilitated the reduction of readmissions and unnecessary hospital admissions, reduced waiting times, released time for doctors to treat other patients, improved access to care, trained healthcare professionals and social workers and supported patients in the community (301). However, the evidence of their economic efficiency was limited (302) until several studies emerged since 2010 that prove the cost-benefit viability of specialist nurses' practice in various roles (303-8).

There are many types of specialist nurses, even though only two postgraduate training programs for specialist nurses are recognised by the NMC: Specialist Community Public Health Nursing (SCPHN) and Specialist Practice Qualification (309). While the SCPHN focuses on the role of the nurse or midwife in communities and populations, the Specialist Practice Qualification nurse encompasses hospital and community environments, within which there are various specialties that focus on groups of patients suffering from a specific disease: diabetes, epilepsy, cancer, Parkinson's disease, rheumatic diseases, multiple sclerosis, dementia, etc. (310). This group also includes the clinical specialist nurse, an expert subgroup of nurse specialists in the UK.

Despite their evidenced efficiency, specialist nurse training is not validated uniformly in Europe, as the ICN denounced (311), even if some specialties can be validated under specific restrictions.

Nurse practitioners are healthcare professionals with a nursing foundation trained to have diagnostic and care management roles. Although they officially exist in the United States since 1986 as a response to the doctor shortage (312), their implementation in the UK is relatively new.

These nurse practitioners diagnose and manage nursing care plans for their patients within their specialty range (e.g. emergency nurse practitioner, theatre nurse practitioner, acute care nurse practitioner, etc.). In the specific case of the advanced nurse practitioners, they follow nursing philosophy and have the diagnostic skills traditionally annexed to medical professionals, being able to diagnose and treat patients independently (and working with the medical team to manage the most complex cases) (313). However, the coincidence of the roles of junior doctors and advanced nurse practitioners should not be misinterpreted, since the latter should provide care that doctors are unable to provide (314).

Nurse consultants were established in 2000 in the UK to improve the quality of patient care and facilitate that expert nurses continued in clinical practice and do not migrate to hospital administration (315). Their role includes four basic functions: expert practice, leadership and consulting, education and training and service, research and assessment improvement with a minimum of 50% of their time spent in clinical practice (316). According to a systematic review by Kennedy et al. (317), there is evidence that nurse consultants have potential to influence clinically and professionally, even though the difficulty in assessing the complex role of the nurse consultant requires more research using quantitative and qualitative methods.

The study *Maxi nurses: advanced and specialist nursing roles* (318) develops the role, employment status and benefits of specialist nurses, nurse practitioners, advanced nurse practitioners and nurse consultants. Since all of these professions come from Nursing, they are encapsulated in what the British Department of Health calls Advanced Nursing (319), so they must follow the NMC Code. The second section of this study points out the activities that characterise each profession:

- Specialist nurses and clinical specialist nurses have a smaller range of activities that the other advanced nurses, but they have case management listed as their most important activity, which defines their role.

- Nurse practitioners consider case management and diagnosis equally distinctive in their professional role. However, advanced nurse practitioners tend to perform more diagnostic activities, and they see them as the only common denominator of their professional role.
- Nurse consultants, even though they perform various activities in case management, diagnosis and organization, they consider that diagnostic and organizational activities define their role.

Although 90% of these professionals work independently, less than 1% are not part of a team, with a large percentage of them working as part of two or more teams at the same time. All Advanced Nursing professions generally feel part of the nursing team (between 37% and 45%). However, while nurse practitioners and advanced nurse practitioners perceived themselves as part of the medical team (between 30% and 34%), specialist nurses and nurse consultants perceive themselves as part of the multidisciplinary team (between 43% and 47%).

The service offered by these professions is rarely pigeonholed in a single specialty (23%) or in a single workplace (21%). The most common scenario is offering their services in different settings to different patients. However, given the general lack of knowledge in relation to these roles, their scope of practice is not always recognised, causing the cancellation of referrals or diagnostic tests.

Another consequence of these professions' short history is that the positions held were the first to be offered (especially in the case of nurse consultants and advanced nurse practitioners), so their scope of practice continues to expand, only limited by lack of time or funding.

This study concludes with two major reasons hampering the development of these disciplines: temporal and financial constraints and lack of understanding of these professions and their role. It is a natural response to the youth of these disciplines, even if this does not exclude the need for greater social diffusion and more research to test their effectiveness and efficiency, as it happened with specialist nurses.

#### 3.3.2.2. The delegated professions

On the other side of the nursing role diversification, there are the professions created to cover the activities delegated by the contemporary nurse that used to be part of his own identity. These professions, endowed with less training and salary that registered nurses, cover and/or support nursing elementary functions such as patient hygiene and nutrition. Although they have many names, these professions can be grouped into two categories: people who work directly with the nurse assisting him and/or covering his delegated tasks, HCAs, and people that provide basic care independently or without direct supervision based on their knowledge and skills, professional carers.

HCAs have many names in the English healthcare system. The most common are healthcare assistants (HCAs), auxiliary nurses and nursing auxiliaries, but may have different nomenclatures depending on the roles assigned to them. To practice as an HCA before the *Francis Report* recommendations, no training or experience was needed and the training that the employer offered to the HCA did not have to meet any standards (320-1). Following (322) recommendations 209-12, a minimal level of training had to be implemented, which is dependent on the employer.

For example, The Ipswich Hospital NHS Trust trains its HCAs with nine days of lectures and 10 supernumerary shifts (323), while in Norfolk and Norwich University Hospital NHS Foundation Trust two weeks of theoretical and practical training are provided (324). The entry requirements for the HCA profession have also been hardened, expecting previous professional or volunteer experience in healthcare (325).

The basis of all these changes is the implementation of the *Care Certificate* established by Skills for Care, Skills for Health and Health Education England in 2015. The *Care Certificate* is based on 15 standards, which must be completed fully to receive the certificate (326):

- Understand your role
- Your personal development
- Duty of care
- Equality and diversity
- Work in a person centred way

- Communication
- Privacy and dignity
- Fluids and nutrition
- Awareness of mental health, dementia and learning disability
- Safeguarding adults
- Safeguarding children
- Basic life support
- Health and safety
- Handling information
- Infection prevention and control

To demonstrate their competence in these standards, the future HCAs should read and complete a 369 pages activity book (327-41) and be evaluated in all these standards by a member of the nursing team. They have to complete that activity book after receiving a theoretical foundation for less than two weeks and during their supernumerary period and clinical practice, since HCAs can be involved in clinical practice while completing their activity book. This creates a period of time when the HCA acts as such without being authorised to do so because he is in the process of completing his *Care Certificate*, being responsible for his actions without completing his training, since the HCAs code of conduct do not discern between those who have obtained the *Care Certificate* and those who have not (342).

A promotion for HCAs is assistant practitioner, who has greater responsibilities than HCAs and work under the supervision of other professionals, not only nurses (343). Assistant practitioners must have previous experience as HCAs and train part-time to obtain a healthcare qualification (344). However, they must follow the same code of conduct that HCAs (345).

Professional carers, also known as care assistants or carers, represent a group of people who care for others for a salary without any specific training, experience, knowledge or values that identify them. This group does not include relatives or friends who care for their loved one altruistically. The practice of this group of professionals is against recommendation 209, even though they still practising in nursing homes (346) and live-in care (347).

The existence of HCAs and professional carers is a by-product of nursing professional evolution and financial healthcare management. These professionals cover basic nursing roles, which should not be delegated. However, professional carers are not supervised by a nurse and HCAs are gaining independence and responsibilities in the tasks that were delegated to them, which now they identify as their own in their skill set (342). The independence of these professionals is not only useful as a way to reduce healthcare spending in the short-term but can also soften the nursing shortage, increasing care workforce numbers at a lower cost (348).

Nonetheless, despite the economic and employment benefits in the short-term, the proliferation of healthcare professionals with inadequate training and without direct supervision in favour of registered nurses is an error in the medium and long-term. Not only it would leave professionals with limited training to manage important aspects of care like nutrition and hygiene but the nurses would also lose control over those segments of care, obstructing the provision of holistic care.

Furthermore, it will facilitate care fragmentation and nursing practice dehumanisation, being this limited to care plan supervision, medication administration and documentation. Only the creation of nursing teams between registered nurses and HCAs can lead to an economically competitive practice without encouraging negligent care, since the qualities of both professions are combined (349).

### 3.3.3. The Nursing concept in English practice

In previous sections, the ICN definition of Nursing has been discussed (26), but not what defines a person as a nurse. If the ICN's definition is not taken into account, RAE defines nurse as "person dedicated to the care of the sick" (350). This quote is vague and inconsistent, since anyone can assist sick people, although this does not mean that they will do adequately. Moreover, if we consider the ICN's definition, care is provided to people who are sick or healthy.

If we observe the English definition of nurse, it is similar to the Spanish one. The Oxford dictionary defines it as "a person trained to care for the sick or infirm, especially in a hospital" (351). Even if it considers the nurse as a professional and expands nursing

care to the sick and infirm, it ignores health promotion, research, health policy management, training, secure environment promotion and patient advocacy.

Since the NMC has not created a definition of Nursing, since it does not represent it, the most accurate definition of English Nursing would be the one provided by the RCN in its document *Defining nursing*. In this document, a definition of Nursing with six main characteristics is mentioned. To understand it is necessary to understand Nursing in its entirety, since even though other healthcare professionals share some of its features, the Nursing's uniqueness lies in the combination of all of them. This definition takes into account Nursing's diversity and includes care provision for individuals and groups and healthy and sick people (352):

> The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death.
>
> Its defining characteristics are:
>
> - A particular purpose: The purpose of Nursing is to promote health, healing, growth and development, and to prevent disease, illness, injury, and disability. When people become ill or disabled, the purpose of Nursing is, in addition, to minimise distress and suffering, and to enable people to understand and cope with their disease or disability, its treatment and its consequences. When death is inevitable, the purpose of Nursing is to maintain the best possible quality of life until its end.
> - A particular mode of intervention: Nursing interventions are concerned with empowering people, and helping them to achieve, maintain or recover independence. Nursing is an intellectual, physical, emotional and moral process which includes the identification of nursing needs; therapeutic interventions and personal care; information, education, advice and advocacy; and physical, emotional and spiritual support. In addition to direct patient care, nursing practice includes management, teaching, and policy and knowledge development.

- A particular domain: The specific domain of Nursing is people's unique responses to and experience of health, illness, frailty, disability and health-related life events in whatever environment or circumstances they find themselves. People's responses may be physiological, psychological, social, cultural or spiritual, and are often a combination of all of these. The term people includes individuals of all ages, families and communities, throughout the entire lifespan.

- A particular focus: The focus of Nursing is the whole person and the human response rather than a particular aspect of the person or a particular pathological condition.

- A particular value base: Nursing is based on ethical values which respect the dignity, autonomy and uniqueness of human beings, the privileged nurse-patient relationship, and the acceptance of personal accountability for decisions and actions. These values are expressed in written codes of ethics, and supported by a system of professional regulation.

- A commitment to partnership: Nurses work in partnership with patients, their relatives and other carers, and in collaboration with others as members of a multi-disciplinary team. Where appropriate they will lead the team, prescribing, delegating and supervising the work of others; at other times they will participate under the leadership of others. At all times, however, they remain personally and professionally accountable for their own decisions and actions.

This broad definition takes into account the Nursing definition paradox, the Nursing definitions and scope of practice from the UK and other nations and the state of Nursing and nursing research in the UK. This document also contextualised this definition within the current English Nursing situation, in which nursing research is poorly developed and nursing diagnosis is rarely used (353). Another issue that *Defining Nursing* adds in its second annex (354) is the inclusion of the nursing specialisations and Advanced Nursing, indicating the need for new policies regarding the education and scope of practice of those nurses.

Understanding the concept of Nursing in the UK is not only a crucial theoretical basis that helps to understand the context in which this thesis is situated, but it is also necessary to understand who can be considered a "nurse" to screen people correctly for the research project described in the following chapters. Given the definition described in the document *Defining Nursing*, HCAs and professional carers cannot be considered nurses because they do not meet all the defining characteristics. In the case of leader nurses, they meet all the features leading the nursing team, even if they do not perform care themselves. Finally, all Advanced Nursing variants are included within Nursing in the second annex of *Defining Nursing*, even if according to the evolution of their knowledge and their scope of practice they may not be in the future.

In order to extrapolate this context and this thesis internationally, the differences in the concept of Nursing in the UK and other countries or organisations must be considered. The UK is the only country in the world that does not train generalist nurses (355), reason that might influence the laxity of its definition of Nursing, since they do not have a generalist nurse to refer to as a foundation model for Nursing.

On the other hand, the RCN definition agrees with the one proposed by the ICN in every but one detail: while the ICN indicates the need to promote research, RCN only considers the need to develop knowledge, which could be done inadequately if the Evidence-Based Nursing model is not followed.

In the case of Advanced Nursing, the ICN has created a network of nurse practitioners and nurses in advanced practice roles (356), in which resources for the development of these disciplines as part of Nursing are offered. Regarding specialist nurses, there are present in many countries apart from the UK, so the ICN established in 2009 a competency framework for nurse specialists (357), trying to unify specialist nursing practice in the world.

Nursing as a recognised professional discipline is young and is still exploring how far its knowledge and practice can evolve. Furthermore, as Nursing aims to care for people, it must adapt to socio-cultural, economic and institutional changes in order to provide holistic care to everyone. That is why the Nursing definition dilemma is still active, and will remain active, since it bases its definition on a dynamic concept: care. However,

this should not prevent national and international professionals to try to contextualise and adapt the concept of Nursing to the environment in which they apply it.

### 3.3.4. Unions: Royal College of Nursing and UNISON

Nurses, as any professional group, are organised in unions to defend their profession and practice. Since the reduction of union power promoted by Thatcher in the 80s, in which five laws that obstruct the right to strike were included (358), unions have been an institutional figure with a small portion of the influence they used to have.

Regarding trade unions per se, they have been losing members over the past decade, more in the private sector than in the public sector. As union representatives, they are more effective in the public sector in contrast to the private sector, as stated by several employees (359). Although there are dozens of unions, some centralised in a profession or professional field and others more open (360), there are two main unions for English Nursing: the Royal College of Nursing (RCN) and UNISON (361).

The RCN is the world's largest nursing professional association and trade union, with more than 425,000 members (362). However, the RCN attempted since its creation to separate itself from its union role, being registered as such since 1972, 56 years after its creation. Another sign of the RCN reluctance to being recognised as a union is that despite several warnings (363-5), the RCN has never driven any nursing strike in its 100 years of history (366), maintaining an anti-strike policy (367) and blaming the pro-strike nurses (368), even though that policy was institutionally repealed in 1995. Currently, the RCN promotes healthcare policies and nursing research as a professional association and protects the rights and practice of nurses as a moderate union (369).

UNISON was formed in 1993 when three public sector unions, National and Local Government Officers Association (NALGO), National Union of Public Employees (NUPE) and Confederation of Health Service Employees (COHSE), merged. UNISON has grown to accommodate about 1.3 million members (370). Its members are part of various public sectors: local officials, healthcare, education, police, employees of public companies, employees of the Environment Agency, volunteers, etc. UNISON has recently begun to cover private companies employees like cleaners or school chefs

(371). Some of its objectives are the professional defence of its members, developing campaigns for quality public services and the defence of the welfare state (372).

Regarding their role as a union, both RCN and UNISON have conflicts of interests that stand in that role. The RCN was created only considering the educated and upper classes in Nursing, delaying the professional register, vetoing the right to strike and avoid confronting the status quo, winning this way the favour of wealthy patrons and the government (373).

In this way it surpassed all other nursing association options, and even though its vision is more open today it continues to have the anti-strike and classist mentality that facilitated its settlement as Royal College, perhaps due to this they still accept third-party funding apart from its members' fees (374). Meanwhile, UNISON has a direct relationship with the Labour Party through an economic relationship, the Labour Link, and a politic bond through sympathetic parliament members (375).

The conflicts of interests and the social gap between workers and their union are not exceptional problems to any British union, independently of the profession represented. Union bureaucracy, as described by Darlington, is an example of the union's role dichotomy as class struggle organisations and their adaptation against the power of capital. Within this union bureaucracy, union leaders are characterised by five fundamental aspects (376):

- They occupy a unique place between the employee and the employer, and their position and way of life depend on the class struggle stagnation.
- Their role as intermediary negotiators between capital and workers forced them to seek a legal compromise, since the changes in British Law from the last 30 years severely punish unions that promote illegal strikes.
- The material benefits enjoyed by them, much higher than the ones enjoyed by the workers they represent, facilitate sympathy and social immersion with their assumed opponents.
- Their political affiliation to the Labour Party has limited their union ability to act against them or against what they represent.

- Unions’ highly specialised and centralised structure facilitates that they can override the decisions taken at democratic national conferences by union members, and their intervention in the field of collective bargaining can be crucial.

According to Darlington, the lack of leadership prevents that union militants exceed the problems arising from union bureaucracy and union leaders. Although there are other types of union structure, without appropriate organisation and leadership the current provision of trade union activity cannot be changed.

The history and structure of British unions, especially the RCN, has influenced how Nursing developed in the UK compared to other countries. Since the RCN did not perform union functions until 1972, being those always moderate, the struggle for professional nurses’ rights was delayed compared to other countries. This slowed professional registration and higher education in Nursing, even though higher education was promoted only for a few high-class professionals.

At present, unions claim that the defence of their members is their raison d'etre, but we already shown that may not be completely accurate. While their function is dependent on third parties, the conception of union activity in itself prevents any protest against the status quo, maintaining salary and staffing cuts and slowing the evolution of the nursing discipline.

### 3.3.5. Staff providers: healthcare professionals’ banks and recruitment agencies

The methods that healthcare providers employ to obtain human resources had to be made more flexible to minimise the impact of healthcare workers shortage and to adapt their working conditions to the workers' demands. That is why both the NHS and private companies have devised various models different than the permanent contract. The most important models are healthcare professionals’ banks and recruitment agencies.

Healthcare professionals’ banks are the NHS Professionals response to two problems: the lack of equilibrium between work and family life and the irregular demand for healthcare services in different seasons, months or days of the week. This system

consists of enabling workers to choose vacant shifts in any hospital service that requested staff in advance.

The bank staff's holidays are proportionally included in their salary, whose base salary is similar to that of their permanent companions (different in each NHS trust), but they can also choose when to have annual leave and their weekly working hours without restrictions. Training is also similar and they benefit from incentives like pensions and maternity or paternity leave (377). Currently, the shift distribution system is further simplified by a computer program that allows workers to choose their shifts from home without any intermediary (378).

Professionals can access these banks in two ways: being a member of the NHS Professionals bank exclusively, which gives the professional access to about 62 NHS Trusts, or being part of the specific NHS Trust bank for which they also are permanent employees, allowing full or part-time workers to do overtime through said bank (379).

Nevertheless, unless the professional always ask shifts in the same department, this system involves a number of disadvantages that are assumed when temporary staff is requested (380):

- Although the professional has been trained by the hospital and he should know the general policies, he does not have to know the specific policies of the department, its operation, its distribution or its staff. This causes a waste of time and reduces quality of care due to the lack of working environment knowledge.

- Particularly in specialised departments, professionals may not have the knowledge or competencies necessary to perform their clinical activity in these areas, since there is no control or division within bank professionals, only shift choice discretion by the aforementioned professionals.

- Since they do not always work in the same area and their managers are disconnected from their clinical activity, assessing the quality of their care provision, their performance and any other aspect concerning to their practice cannot be evaluated or improved by their managers.

- Care continuity breaks constantly due to the continuous fluctuation of personnel.

- The quality of care is reduced and vicarious accountability risks are increased.
- Permanent staff morale is reduced as they are forced to do more complex tasks to compensate temporary staff deficiencies, in addition to withstand the pressure of overtime shifts and temporary staff support.

Despite its drawbacks, working as part of a healthcare professionals' bank allows many to continue their careers under more flexible conditions, avoiding the loss of human resources and allowing professionals to balance family and leisure with work. However, overusing this resource can be a sign of staff management failure, since human resource adequate control can increase quality of care and reduce healthcare expenditure (381).

The recruitment agencies situation is similar but different. These are private companies that primarily provide temporary or permanent healthcare human resource management and distribution. In their role as temporary staff providers for hospitals, their members are self-employed, so they do not impose a cost on the company, which only acts as an intermediary between the hospital and the healthcare freelancer.

The main incentive for self-employed professionals linked to an agency is the salary (382), which is calculated according to service demand, always being higher than the salary of permanent personnel (383). As temporary staff, their members suffer all the already discussed disadvantages of temporary staff to a greater extent, since not only do not know the department, but they are also unfamiliar with the hospital and its policies. Also, being private companies disconnected from healthcare service providers, they have specific disadvantages:

- Like any business, they need to make profits, so the cost of a temporary professional not only includes his salary but also the costs associated with the recruitment agency, increasing spending further.
- Their training is certified by the agency, so they do not know the policies of the hospital or the department. In addition, even if it is certified by the agency, such training does not have to meet the quality standards expected from NHS training.

- It is very difficult to trace a mistake or negligent act committed by an agency professional, especially in departments with large numbers of agency staff, since their existence does not appear in departmental, hospital or NHS records.

Agency professionals also have an added advantage: when they are experienced professionals they can share new knowledge with permanent staff (384). However, the persistent lack of continuous professional development and the tendency of some agencies to embellish the experience and training of their members (385) denigrate this advantage.

In the last three years, while the salaries offered in healthcare professionals' banks have remained stable in line with permanent staff, spending on agency staff has soared. According to an investigation by the newspaper The Telegraph, spending associated with a Medicare agency nurse could account for between 43 and 76 pounds per hour (386), representing expenditure 3 to 6 times higher than a permanent nurse. Moreover, the agency nurse only receives half of that money, since the recruitment agency keeps the other half. This trend has also been observed in agency doctors (387).

To limit this problem, Monitor and NHS Trust Development Authority launched a consultation (388) culminating in an NHS spending limit guide for agency staff that was implemented in November 2015 (389). This guide shows the spending limit on agency staff in relation to permanent staff's base salary, which will be reduced following the approved schedule (390). In addition, they implemented a total spending limit on agency nurses in (391) to avoid their overuse.

Nevertheless, these measures have the risk of triggering two unwanted responses: staff shortages, through the lack of agency staff, and the breach of the measures imposed, which would mitigate their benefits. This was already mentioned in the Monitor and NHS Trust Development Authority impact analysis (392), so they are risks that are taken into account in favour of the economic and quality of care benefits that are predicted and the agency professionals' transfer to permanent contracts once the salary benefit is minimised.

Another recruitment agencies' role, which is separated from their collaboration with self-employed healthcare personnel, is to recruit staff from overseas to practice as

permanent staff in the UK. Staff shortages have been a recurring problem in the NHS, so foreign recruitment is not a new phenomenon, but their sources have changed.

While in 2004 the largest number of nurses came from India, Philippines and South Africa (393), in 2015 the majority of new foreign nurses who were registered as such in the UK belonged to the European Union. This is partly due to the ease of recruitment, the economic recession in southern Europe and the changes in British immigration laws in regard to immigrants who do not belong to the European Union (394).

Driven by staff shortages and temporary staff overuse, Christine Fitzgerald, one of the Hillingdon Hospitals NHS Foundation Trust matrons, undertook a project that compares the cost of overseas recruitment against temporary staff usage (395). Heeding only to the economic section, local recruitment, 403.70 pounds per nurse, is more profitable than international recruitment, 6,371.41 pounds per nurse.

Nonetheless, local recruitment and staff retention alone are insufficient to meet hospital staffing needs, so they are forced to rely on temporary staff. According to Fitzgerald's calculations, a nurse recruited abroad takes 2.54 months to provide greater economic profitability than an agency nurse, so international recruitment is a good resource in the medium-term (396).

According to Fitzgerald, there are several disadvantages associated with the use and abuse of international recruitment. Their training is different and English is not their native language in many cases. This requires hospitals to increase their supernumerary periods and impose more pressure on coordinators in order to ensure an adequate quality of care that meets NHS standards.

To reduce foreign nurses' linguistic problem (397), the NMC implemented in January 2016 the requirement of a 7.0 in the academic IELTS (International English Language Testing System) test for foreign professionals from inside (398) and outside (399) the European Economic Area (EEA). This level represents the "good user" of the English language as defined by IELTS (400), level expected in UK nursing students (401), even though it differs at each university. However, according to Moore (402-3), the academic IELTS test is focused on university study, not clinical practice, which has sown suspicion regarding the IELTS validity for evaluating nurses' language level.

Another foreign recruitment problem is that retention is low (404), so it is not a valid long-term resource. According to several studies (405-6), two of the main reasons for the low retention of foreign staff in the UK are discrimination and lack of equal opportunities, which are manifested through the promotion and participation mechanisms in the workplace. Other reasons include loss of practice and contempt for the skills and techniques that foreign nurses have, since there is no standardised competency validation system and they are not allowed to perform techniques or apply knowledge that they have not been previously approved in the UK, regardless of the nurse's previous training and experience (407).

Nevertheless, given the reliance on temporary staff and the generalised staff shortages (408-9), a considerable percentage of new contracts, 25% according to The Guardian (410), were dependent on foreign nurses, hence the Department of Health announced temporary changes in the restrictions for hiring nurses from outside the EEA to ensure adequate staffing throughout the NHS (411).

These changes clash with the new immigration law (412), which does not allow a level 2 settlement to people who do not earn more than 35000 pounds a year. Applying these changes to the context of international nursing recruitment, a nurse's salary does not exceed the limit imposed by the government, so even if retention was increased, the nurses recruited from outside the EEA would be deported in six years. According to the RCN, this change in immigration laws, with the rising national demand to train nurses and the limits on agency staff expenditure (in total, not per person) will intensify the nursing shortage in the UK, compromising patient safety and NHS finances (413).

UK is eighteenth on the list of OECD countries in the proportion of nurses per capita, 5.8 per 1000 inhabitants (414), which is the recipient of nurses during a global shortage of nurses. However, according to Li, Niea and Li (415), even though immigrant nurses choose countries for their economic and political strengths, policies should be promoted between sending and receiving countries to guide nursing migration in a positive direction, not depending on such immigration to stock healthcare workers.

### 3.4. The Leicester Royal Infirmary Emergency Department

Leicester Royal Infirmary (LRI), one of the three hospitals that form the University Hospitals of Leicester (UHL) NHS Trust (alongside Leicester General Hospital and Glenfield General Hospital), has 890 beds and an adult and paediatric emergency department, the only one in Leicestershire (416), covering a population of over one million inhabitants (417). In this ED between 400 and 500 people are treated each day, more than 150,000 a year, 24 hours a day, 365 days a year (418). Within it, there are more than 200 nurses, HCAs, emergency care practitioners and support staff; 35 junior doctors, 24 doctors and 12 senior medical consultants (419).

Given the increased clinical workload in this ED (420), which is only prepared for 100,000 patients a year, and the population and demand growth, 43.3 million pounds have been invested in the construction of a new ED building (421). This 4250 square meters expansion should accommodate all patients and facilitate their flow, thanks to its ground floor model (422). The opening was on April 2016.

The current ED is divided into several areas with different distributions and patients (423):

- Adult ED:
    - Assessment Bay: Contains 5 boxes and a room to assess patients in less than 15 minutes by a nurse and/or a doctor, perform diagnostic tests and provide emergency treatment. It also has 4 spaces for stretchers and 3 seats for patients waiting to be assessed.
    - Majors: It is distributed in 15 boxes for diagnosis, treatment and care of patients with urgent conditions transferred from Assessment Bay. It also contains 5 spaces for stretchers and 8 seats for patients who do not need to be in a box at that time.
    - Minors: It is divided in 10 boxes for assessment and treatment of mainly musculoskeletal injuries. It also has more than 40 seats for patients awaiting assessment or treatment.

- Children's ED:
    - Triage: It has two boxes for patient assessment in the first 15 minutes by a nurse and/or doctor. It also has a waiting area of more than 40 seats for patients awaiting assessment or treatment, which it is shared by all areas within Children's ED.
    - Majors: It includes 6 rooms for diagnosis, treatment and care of patients with urgent conditions transferred from triage.
    - Minors: It is sectioned into seven boxes for assessment and treatment mainly of musculoskeletal injuries.
- Resuscitation (Resus): It has 8 boxes for assessment, treatment and care of adult and paediatric emergency patients, who can come from any area or being directly received from the ambulance.

Furthermore, there are different areas or departments that do not belong to the emergency department per se but interact with it constantly, influencing patient flow and care continuity:

- Emergency decisions unit (EDU): Observation area that has 16 beds and four seats, intended for patients who have already been diagnosed in another area and do not need to be admitted under any specialty, but require observation and/or treatment for more than four hours.
- Urgent care centre (UCC): Ambulatory care area, in which patients with urgent and non-urgent conditions are assessed, diagnosed and treated by a nurse and/or a doctor. It contains boxes and doctor offices, allowing diagnostic tests and treatment provision in a limited way. When the patient's pathology exceeds UCC service capabilities, he is transferred to Assessment Bay. Also, it has more than 20 seats for patients waiting to be assessed.
- Ward 15: In it, adult patients transferred from ED are cared for and treated for a short period of time before being referred to another specialty ward or discharged home. It has 4 rooms with 6 beds each and four single rooms. It also has a clinic,

Acute Medical Clinic (AMC), which can receive patients referred by GPs bypassing ED (424).

- Ward 16: Also called Acute Medical Unit (AMU) alongside ward 15, it is distributed in two rooms of 6 beds, two rooms of 3 beds and 4 single rooms. It has the same functions as ward 15 but does not have its own clinic. However, the two 3-bedded rooms, or Acute Care Bays (ACB), are specialised in critically ill patients with additional needs, such as high-flow oxygen or continuous monitoring.

- Ward 33: With the same functions as ward 15 and 16, ward 33 or Acute Frailty Unit (AFU) specializes in the care and treatment of geriatric patients. It is segmented into 4 rooms with 6 beds each and four single rooms.

- Ward 9: Also called Children's Admission Unit (CAU), ward 9 receives paediatric patients transferred from ED or other services. It has a triage room, 4 rooms with 6 beds/cots each and four single rooms.

- Clinical Decisions Unit (CDU): Located at the Glenfield General Hospital, in CDU patients with cardiac or respiratory problems (425) derived from ED or other healthcare providers are assessed, treated and cared for, since the LRI does not have specialised cardiology and pneumology services. CDU distributed its patients in 25 beds and a waiting area.

The LRI ED also refers patients to various specialties and services in the three hospitals, but those mentioned are the most important in volume of referred patients.

The LRI ED, like every ED in England, was evaluated through the 4-hours target, also called NEAT (426), until 2011. This objective was founded on the premise that the patient should be discharged, admitted or transferred within four hours from admission to ED. This objective proved to reduce waiting times in EDs (427), but caused increased clinical workload and a detriment in quality of care, in addition to increased staff turnover (428). Given this situation, in April 2011 the Department of Health implemented a new model, which consisted of five quality indicators (429):

- Left department before being seen for treatment rate: Maximum 5%.
- Re-attendance rate: Minimum 1%, maximum 5%.

- Time to initial evaluation: Maximum for the 95th percentile, 15 minutes.
- Time to treatment: Median 60 minutes.
- Total time in ED: Maximum for the 95th percentile, 240 minutes; total maximum time individually reported, 360 minutes.

Other quality indicators were including later, like the evaluation of ambulatory care, patient's experience or senior review of patients with high-risk presentations (430).

In January 2016, due to the continuous clinical workload increment (431-2), the CQC decided to make a surprise visit to the LRI ED, during which they raised concerns about ED staffing, clinical policies and patient transfer times (433).

The previous visit in 2014 already showed the need for improvement in several areas of the hospital (434), and the last visit reaffirmed those problems, so the CQC ordered immediate action (435) to address them. The demanded actions revolve around the 15-minutes limit for patients' first assessment, but they also assess the compliance with the 4-hours target and the sepsis-six guideline (436), among others, within the weekly report that the CQC demanded from University Hospitals of Leicester NHS Trust managers.

One of the main causes of the problems identified by the CQC is patient flow, since the number of patients treated in 2015 was 60% greater than the planned LRI ED capacity. Given the erratic nature of the demand for urgent and emergency healthcare, three different situations can be generalised:

- When patient flow entering and leaving ED is balanced and moderate, it should meet all quality indicators. If this did not happen, it may be due to organisational failures, inadequate clinical practice or a high proportion of critically ill patients.

- In the event that urgent and emergency healthcare demand suddenly exceeds the healthcare provision capacity of the department, in human and/or material resources, an entry block is created, in which patients arrive at the department faster than they can be triaged, creating a positive feedback loop that increases triage waiting times.

  If this frequently occurs, it often reflects that the department does not have enough resources to meet the population healthcare needs, that triage is very slow or that

there is an organisational failure in the management of recurrent patients or "clinical peaks", timeframes when there is a greater patient influx than normal (like the hours following the end of office hours or school hours).

- The most difficult situation to analyse and solve is when patient inflow is moderate and constant, but patient outflow is slower than patient inflow. The problem is not that patients cannot be admitted to a ward, but that those patients remain in ED while more patients are coming in, resulting in crowding. This phenomenon, called exit block, is an international problem, which is dependent on the entire hospital, not just ED. It is a very complex problem, but the main factor that causes it is the lack of beds in hospital wards, which occurs partly due to failures in the discharge process (437-8).

A risk from exit block is crowding, the biggest problem that EDs around the world face, according to the Royal College of Emergency Medicine (RCEM) (439), which increases mortality rate (440) and length of stay and decreases quality of care and patient satisfaction (441). Research has been conducted (442-46), even though the evidence remains poor, recommendations have been proposed (447) and guidelines have been created (448-9) about how to solve the problems of emergency healthcare in general and crowding in particular, especially through patient transfer and discharge improvements.

The aforementioned studies suggest a major cause of exit block, unnecessary elongation of hospital stays due to flaws in discharge policies. According to RCEM, the six causes of exit block, in descending order of importance, are as follows (438):

1. Patient waiting for non-urgent NHS care.
2. Patient waiting for the completion of his assessment.
3. Patient waiting care package at own home.
4. Patient waiting nursing home placement or availability.
5. Patient or family choice.
6. Patient waiting home placement or availability.

The two main causes of exit block underlie in the hospital, especially in the lack of coordination between departments and the application of different policies between different departments and hospitals. The discharge process is different in each hospital,

so only some have established policies and dedicated teams to ensure an appropriate discharge.

Despite the importance of the discharge process, there is another factor that affects exit block: the lack of social services like home care, homes for the dependent (nursing homes and residential homes) or chronic patient clinics (450). In addition, social deprivation entails that the patients who cannot attend other healthcare services or are unable to take care of themselves would end up in ED (451).

NHS England launched a guide in August 2015 that aims to connect all healthcare services to provide better urgent and emergency services, even though it has not been applied widely yet (439). However, Monitor acknowledges that more evidence is needed to link the length of stay in ED and hospital discharge delays in relation to community care (452).

In the case of University Hospitals of Leicester NHS Trust (UHL), which has one of the emergency services that treats more patients in the UK and one of the UK's largest cardiac and respiratory services at Glenfield General Hospital, exit block is a recurrent problem, while entry block is an isolated phenomenon. To fix it, three solutions have been proposed: avoid unnecessary admissions, improve hospital flow and improve the discharge function (453).

Nevertheless, in 2016 the problem remains unresolved, and even though measures have been imposed in ED, like expanding its infrastructure and recruiting more staff (as it does not have enough staff to meet care demand), the exit block continues to create delays in patient assessment and ambulance handovers (454).

Patients are counted within the department when they are physically present in it or when an ambulance is waiting to transfer them inside when the department is crowded. When triage cannot be performed in the department due to crowding, paramedics, technicians and/or emergency care assistants will perform a basic assessment in order to prioritise patient care if necessary.

Nonetheless, a paramedic is not always part of the pre-hospital team, so is the emergency care assistant, whose training lasted from 6 to 9 weeks (455), who performs the basic initial assessment, which validity is limited to his training and experience. This

entails an added difficulty to hospital triage, since it must start from the beginning and not be conditioned by the pre-hospital assessment (even if can be supported by the information that could only be obtained by the pre-hospital team).

When the exit block results in multiple ambulances waiting to hand over, the LRI ED designates a person to triage patients waiting in ambulances every hour, thereby preventing that their current state and/or their further deterioration are ignored and facilitating that the patient and his treatment are prioritised if necessary.

Another problem affecting the LRI ED is communication failures and documentation misuse. As we already discussed in other sections, these two factors affect most NHS hospitals' clinical practice differently, so the context of this issue must be specified to understand it.

According to Durley, the three obstacles in ED communication are interruptions, crowding and communication barriers (12). Crowding impacts communication when it exceeds the department's resources, so maintaining order is more difficult and communication is affected.

In the case of interruptions, these occur more frequently among senior staff, and they can lead to clinical errors (456). They are more dangerous during triage, since nurses have little time to perform an appropriate evaluation and they have to overcome language barriers like reduced level of consciousness or the patient's inability to speak the country's native language, which happens frequently in Leicestershire given its multiculturalism.

In the LRI ED, there is a team nurse coordinator for each area of the department, and a nurse in charge of the whole department. These nurse coordinators ensure that resources are distributed correctly, that patient flow is adequate and that communication with other departments is constant and efficient. They are also responsible for conducting 5 minutes meetings every two hours with doctors and nurses to clarify and change action plans. On the other hand, despite the measures imposed to improve oral communication, written communication through clinical documentation continues to experience a communication barrier.

Clinical documentation in the LRI ED, in April 2016, remains on paper, except for the computer programs EDIS, ICE and CRIS. Therefore, all nursing and medical documentation, vital signs and prescriptions are handwritten. This not only leads to time waste for all professionals as they have to handwrite, the possible misinterpretation of calligraphy and the possibility of irregular changes in clinical records, but also creates a recurrent problem in the department: the temporary loss of clinical patient documentation.

This phenomenon occurs because only one person can physically have the clinical documentation at a time, so if that person moves with the clinical documentation prevents that other people find it. This is a problem that slows down the work of all professionals, since the documentation is needed to records vital signs, prescribe or administer medication, write their respective records, etc. In addition, not having continuous access to clinical documentation, healthcare professionals cannot communicate through it, lengthening the wait to give a prescribed treatment or encouraging misunderstandings between professionals, for example.

Current technology applied to clinical practice also has its disadvantages, as shown by Popovici et al. (457), so more evidence is necessary for it to completely replace paper effectively. Meanwhile, to minimise this problem it is necessary to foster a multidisciplinary work culture, which is difficult if there is not a team of permanent staff.

A situation affecting most ED, including the LRI ED, is staff recruitment and retention issues. The ED environment is challenging, shifts are random and responsibility is high, which does not attract a large number of professionals. If crowding, stress and high clinical workload are added, it is difficult to recruit and retain staff in one of the EDs with the highest clinical workload in the UK. It has resorted to international recruitment on several occasions and economic incentives to retain staff, but it remains highly dependent on temporary staff. The temporary staff's overuse problem impacts on the department's ability to form a coordinated multidisciplinary team, in its financial distribution and in the creation and application of policies.

Despite the lack of permanent staff, EDs hire temporary staff every day to cover the amount of staff planned. However, according to the RCN, new NICE research

discovered that emergency departments are understaffed "nearly half of the time" according to appropriate standards (458). That research was not published, and these investigations were transferred to the NHS England's Workforce Board, which is not independent from the NHS (296), so there is a conflict of interests.

According to Wise et al., ratios cannot be used to determine optimal staffing levels in each clinical situation, but their purpose is to force an increased supply of nursing staff and prevent that departments are understaffed (459). The lack of nurses is linked to a greater number of patients who leave without being triaged, longer stays in the department and lower patient satisfaction, even though more evidence is needed (42). However, the recommendations on staffing ratios are not legally binding, but can be an aggravating factor in negligence cases, except in Wales, which has managed to legally bind a safe patients per nurse ratio (460).

# Chapter IV:
# Objectives and hypothesis

## 4.1. Objectives

### 4.1.1. Main objective

- Study ethical and legal factor influencing professional accountability in nursing practice at the Leicester Royal Infirmary Emergency Department.

### 4.1.2. Secondary objectives

- Inspect policies related to nursing professional accountability at the Leicester Royal Infirmary Emergency Department.
- Analyse nursing staff experiences connected to ethical and legal accountability in clinical practice at the Leicester Royal Infirmary Emergency Department.

### 4.2. Hypothesis

- To verify that the influence of the current legislation on the responsibility of nursing professionals predominates over the principles of Applied Bioethics in nursing decision-making in the Leicester Royal Infirmary Emergency Department.

# Chapter V:
# Methodology

### 5.1. Methodological perspective

The phenomena this thesis analyses and its factors are complex and remain interconnected within the context in which they are situated, so choosing an appropriate methodology for this study is important to allow results to be replicated and to ensure that conclusions are relevant.

Choosing a qualitative methodology derives mainly from the connection between ethical and legal factors in clinical practice and the individual perception of healthcare professionals of their professional accountability, without which the comprehension of these factors is limited due to the disregard of human factors.

The information obtained enables a descriptive and analytical approach, which allows not only to corroborate the ethical and legal factors observed during clinical practice but also to expand these factors through nurses' experiences and the responsibilities that they must manage daily. Furthermore, it is also able to contextualise nurses' obligations within the policies they have to follow.

Given the above, we aim to create conceptual relationships within routine clinical practice, thus avoiding biasing results utilising theoretical concepts only.

The proposed research project allows us to answer questions that motivated the creation of this study, being some of the most important ones listed below:

- What ethical and legal factors affect nursing accountability in clinical practice?
- How ethically valid are nursing practice policies?
- What motivates nurses to follow or not follow clinical policies?
- What are the experiences of nurses regarding decisions and actions that they are accountable for?
- Is defensive practice real? If so, what can be done to avoid it?

Moreover, a method that encompasses the experience of several nurses, analysis of clinical policies and clinical practice context has been designed to achieve the objectives proposed; thus allowing a holistic study of nursing accountability in an English ED and the factors influencing the transfer of theoretical accountability to clinical practice.

### 5.2. Paradigmatic approach

Choosing a paradigm for this study was an arduous task since the ethical, legal and clinical complexity could indicate the use of an interpretative paradigm, but its limitations when verifying theories and its mainly subjectivist epistemological dimension would hamper results' accuracy at national and international levels and their possible applications in clinical practice.

Due to this, we chose a post-positivist paradigm as proposed by Phillips and Burbules (461), who develop concepts from mid-twentieth century authors like Popper or Dewey to present a paradigm that pursues objectivity but understands that it is just an ideal to follow, not an achievable end, comprehending that to glimpse the truth we must analyse data in the context in which it was collected, not only the data per se.

This paradigm is established in nursing publications since the late twentieth century (462), due in part to the influence of social sciences in the evolution of nursing research.

To understand the choice of this kind of paradigm and its application in this study, it must be described from different analytical dimensions:

- Ontological dimension: Under this perspective, it is proposed that there are natural laws that govern ethical and legal nursing accountability factors, but given their complexity they could be only partially understood.

  That is why the research carried out in this thesis aims to know and understand these factors and their relationships, although we are aware of the study limitations and we do not intend to find a theoretical nursing accountability universal truth.

- Epistemological dimension: In this dimension, the use of qualitative and quantitative instruments together to obtain information from different facets of reality is assumed, choosing the most suitable technique for each one, although the methodology is mostly qualitative.

  A concept that guides the interpretation of data is intersubjectivity, through which is accepted that human perception is never completely objective and a subjective study does not generate generalisable results, so finding a middle ground allows a systematic analysis of reality without underestimating the results' scope.

Paraphrasing Munroe (463), intersubjectivity is an intermediate position that sociologists use to solve the main problem generated by studying human participants: neither objectivity nor subjectivity are sufficient to explain individual life experiences.

Finally, it must be considered that when classifying this study within the post-positivist paradigm inductive theorising is possible, which creates a generalisable holistic model from the specific reality of both the participants and the researcher in his full participant role.

- Methodological dimension: In this dimension is essential to mention the use of a transversal qualitative methodology that allows utilising complementary data gathering techniques, which provide a holistic view of the study phenomenon.

  This entails that both nurses' experiences and the context in which they practice are represented, allowing an intersubjective analysis that links factors from different data sources.

### 5.3. Ethnographic content analysis as a research method

To achieve the proposed objectives, ethnographic content analysis (ECA) was chosen as the research method. This decision is based not only in its ability to analyse various data sources systematically without marginalising their complexity, but it also allows linking concepts that facilitate the creation of a unifying theory.

ECA, established by David L. Altheide, emphasises similar qualitative characteristics between ethnography and content analysis, both based on the discovery of the meaning of cultural activities and social context examination (464). This allows the use of numerical and narrative data, unlike the decontextualisation of narrative data forced by quantitative content analysis to adapt it to its model.

Altheide considers that ECA is a systematic and analytical method without being rigid, in which guide variables are set but others are allowed to appear during the study. Thus, ECA is able to count and classify concepts into categories while providing descriptive information thereof (465).

Although it was initially created for the analysis of TV news, ECA can be applied in various disciplines such as Education (466), Social Sciences (467), Economics (468), Labour Studies (469) or Healthcare Sciences (470- 2).

ECA features are perfectly suited to the context in which this research is situated and the resources available to complete it, since a hospital department is a social context in which specific activities are performed.

As a major part of any research project, the project manager has to take into account both the objectives and the accessible resources to choose the appropriate methodology. In this case, it was necessary to analyse short and medium-term nursing accountability in theory and practice to produce results that represent the current situation of nursing accountability and its function in ED practice. However, only one person who could do both field research and theoretical analysis was available, since there was no budget for hiring more staff. Therefore, the use of ECA was justified based on several reasons:

- Unifies data from field notes, interviews and theoretical documents as part of the same context, analysing them together and facilitating data triangulation.

- Allows the researcher to use the same experience during data collection for its analysis, eliminating the need for at least two researchers like in qualitative content analysis.
- Facilitates the analysis of the relationship between different nursing accountability factors without completely abstracting them from their context, creating results that can be condensed without being decontextualised.
- Produces narrative results that allow a holistic study of nursing accountability, which can be triangulated to increase their validity and reliability beyond the investigator's experience.

For all of the above, ECA's analytical and research characteristics to discern meaning, context and theoretical relationships of a certain reality coincide with the objectives of this research.

### 5.4. Study objects and participants

Since there are multiple sources of data in this study, we must discern objects of study and study participants, thus delimiting their characteristics and the data obtainable from each one.

Study objects in this research are policies related to accountability in nursing clinical practice at the LRI ED, which were obtained through the UHL intranet.

Participants in this study were divided into two branches: one participant who produced data during an extended period of time (in this case the researcher) and several participants who participated in a punctual interview.

The characteristics of the researcher's contribution to data production focus on the role of full participant, during which he worked full-time as a nurse in the period 2014-2016 without any difference artificially implemented compared to other emergency nurses at the LRI.

Regarding the punctual participants, they were nurses who work or have worked frequently in the LRI ED, defining nurse from the description given by the RCN in the document *Defining Nursing* (352). This enables that are all nurses working in EDs in England can be considered as the target population.

To recruit participants in this study, convenience sampling was chosen due to the difficulty in obtaining volunteers, which evolved to a theoretical sampling to increase data quality and reach data saturation.

The phenomenon of data saturation can be defined as the moment when more data will not lead to more information related to the research questions. This means that once the researcher observes the same similarities in data constantly and does not find new properties or categories within it he can be empirically sure that data saturation has been reached. In this research, data saturation is considered as the determining factor to stop the recruitment of participants, since data quality is more important than sample size.

To select participants, inclusion and exclusion criteria were established to demarcate a sample that was suitable to achieve the research objectives:

- Inclusion criteria:
    - Being a registered nurse with the NMC.
    - Actively work (at least four shifts per month) in the LRI ED six months before the interview.
    - Able (in the investigator's opinion) and willing to comply with all study requirements.
    - Able to give an informed consent and willing to do so after considering it for at least 30 minutes.
- Exclusion criteria:
    - Nurses who work less than four shifts per month regularly.
    - Nurses working in another ED as permanent staff members.

## 5.5. Data gathering techniques

In this investigation, three different data gathering techniques were used to obtain data from different clinical practice contexts, which was codified and triangulated to create coherent results considering the complexity of clinical practice. These data gathering methods will be described briefly, since they are developed in their respective chapters.

### 5.5.1. Ethical analysis of clinical policies

For the analysis of clinical policies, a tool that certify a quantitative representation of the policies' ethical validity applied to nursing practice at the LRI ED was created. This tool, derived from a tool focused on research protocol analysis, is called Clinical Ethics Policy Assessment Tool or CliPEAT, which considers the main factors that any clinical policy should include.

Furthermore, a qualitative analysis of these policies was conducted, situating them within the *NMC Code of Conduct*, under which British nurses practice.

### 5.5.2. Reflections on clinical practice

Reflections on clinical practice in the period 2014-2016 in the full participant role were documented through field notes and a field diary, which contained no information related to any patient. They only described situations, contexts and conversations related to clinical practice rituals and customs in the LRI ED.

The data generated by this technique is a product of nursing practice. Therefore, a healthcare professional does not have to request an informed consent to his colleagues to work with them during their usual interactions or to reflect clinical practice, since it is an inevitable consequence of teamwork.

However, a research permit was requested to the ED LRI nursing management team. This permit was granted because it was not considered that this project will involve an active observation, for which the informed consent of participants would be required.

### 5.5.3. Semistructured interviews

Using semi-structured interviews as a data gathering technique allows the introduction of nurses' experiences and values within the context in which they practice, promoting intersubjectivity and revealing human elements affecting the relationship between ethical, legal and professional nursing accountability factors.

Semi-structured interviews were conducted with nurses from the LRI ED who volunteer to be interviewed after being informed that interviews were being conducted for a study. Once the participant's interest was confirmed, an interview date and place (hospital, their home or any neutral place) was agreed between the researcher and the participant.

It was planned that interviews would last between 45 and 90 minutes, including 30 minutes to obtain an appropriate informed consent, but participants indicated that it was too long. Therefore, the participant information sheet was delivered by hand or by email to participants in order to ask the necessary questions before the interview and give informed consent just before the interview, reducing its time in 30 minutes, so each interview lasted between 30 and 45 minutes.

Before the interview, the researcher carried out a summary of its purpose and confirmed that the participant understood it, ensuring that the written informed consent was valid.

The interview's audio was recorded for later transcription and interpretation, which was erased after an anonymous interview transcript was created. After the interview, no follow-up was necessary, although a second interview could be arranged if the researcher and the participant believed that during the first one all the relevant information was not obtained.

### 5.6. Data processing: coding and triangulation

The same as data gathering techniques, data processing is too large to be classified within this chapter, so this brief mention will be extended in the correspondent chapter.

Data processing and analysis were parallel to its collection, so data from clinical policies and reflections on practice were studied at the same time, while the information from semi-structured interviews was analysed later.

To analyse data, it was coded separately first, then codes and categories from the three data gathering techniques were triangulated in search of a theory that explains the relationships between ethical, legal and professional nursing accountability factors.

# Chapter VI:
# Reflections on clinical practice

### 6.1. Contextualisation

Using reflections on clinical practice to generate information not only serves as a source of data on daily practice and its accountability but also as one point of view to be triangulated with other sources of data. The vast amount of data produced during clinical practice represents it in a complete way, with its rituals, customs and beliefs. However, it can also be too general, losing details in the search for patterns. That's why triangulation with other data sources is so important to represent reality in the most holistic way possible.

Reflections on clinical nursing practice in the LRI ED were carried out in the period 2014-2016, being completed in the full participant role with a critical design. When the researcher started working in the department, informants were unaware of this research and the informal entrance to the field was less hostile. The field role evolved from culture shock to the delicate balance between the roles of investigator and registered nurse.

The reflections on clinical practice process conducted since 2014 have undergone an evolution that has conditioned that part of it was not advertised. During the first year of data collection through reflections on clinical practice, the field diary was for personal use, so the other nurses did not know about its existence. It was this process of reflections on clinical practice that precipitated the creation of the thesis that is part of. Having been in a full participant position, the fact of obtaining data was an accidental result of practice, which made sense as an intentional action after the creation of this thesis.

After formalising reflections on clinical practice as a data source for an investigation, other nurses were informed about it, giving them the opportunity to have their contributions not included in the data collected even if this data collection technique does not affect their practice in any way and does not include personal data of any kind. Even though on the first day after the announcement they felt embarrassed, that feeling disappeared over time.

We have collected a large quantity of data, but after classification and coding only data that is directly or indirectly related to the objectives of the thesis will be mentioned. This is not intended to discriminate some data fragments in favour of others, but to avoid repetitions and distractions from the main issues, facilitating a comprehensive development of the relevant data.

### 6.2. Daily routine and dynamics in clinical practice

The first step to give meaning to data from the reflections on clinical practice is to place them in a specific context. This allows us to understand their causes and consequences, thereby extracting a more holistic relative truth.

There are several shifts according to their start time and duration. The shifts available are divided into short shifts (8 hours, 7.5 without break) and long shifts (12.5 hours, 11.5 hours without breaks). Therefore, shifts available are long day (7:30-20:00), early (7:30-15:30), late (12:00-20:00), short twilight (16:00-00:00), long twilight (13:30-2:00) and night (19:30-8:00). The most common shifts are long days and nights, although each nurse can choose short shifts if he prefers it. However, the monthly shift distribution does not follow any consistent pattern.

Not all shifts are equal. The most notable difference is that the day shift begins with a relatively low number of patients while the night shift starts in the middle of the high attendance period (between 16:00 and 00:00 hours). This dictates a higher clinical workload at the start of the night shift that decreases during the shift, while in the day shift the opposite occurs. Other variables to consider would be changing the sleep pattern at the beginning of night shifts, staff overlapping between short and long shifts, the time of year or staffing numbers.

However, a shift comparison based on time distribution is not appropriate to structure data because, even if there are differences among them, base performance in an ED at different times should be the same due to the continuous care demand characteristic of emergency services.

That is why the context of a standard shift and its variants will be structured based on patient flow. Therefore, various contexts are described to classify observed data in relation to one of the most determining variables in an ED. It has to be taken into account that data presented in this section is generalised to form part of the context in later sections, which focus on specific topics.

### 6.2.1. Standard shift

#### 6.2.1.1. First handover and personnel distribution

The variable patient flow in a standard shift is characterised by a moderate, continuous and constant flow of patients through the department, during which the staff numbers and their competencies are adequate. This day begins with the meeting in the seminar room before starting the shift. While the nurse in charge of the department (NIC) ensures that all checklists are done, each nurse is directed to a specific area where they will receive the handover from the previous shift:

- Assessment Bay: The new shift nurse coordinator allocates each nursing team (registered nurse and HCA) to a box while receiving the handover from the previous shift nurse coordinator. If there is a patient in the box where a nursing team has been assigned to they will relieve the previous shift's nursing team, allowing them to finish their checklist if it was not done.

- Majors: Nurses are divided into two teams, red and blue, and receive the handover of the patients that they will be accountable for, while the nurse coordinator receives a general handover, including area status and unsolved issues.

- Minors: The nurse coordinator receives a brief handover on the area situation by the emergency nurse practitioner (ENP) or the previous shift's nurse coordinator.

- Resus: Like in Majors, nurses receive handover of their allocated patients directly from the previous shift's nurse, while the nurse coordinator receives a general handover of the area status and problems to be solved.

- Children's ED: They do a complete team handover, where they discuss all patients and potential problems that must be solved. After the handover, the nurse coordinator allocated nurses in their respective zones within the Children's ED: Triage, Majors and Minors.

#### 6.2.1.2. Patient distribution

After the initial handover, patients continue to arrive to the department, following different routes depending on their age and the pathology that afflicts them:

- Older than 16 years old:
    - Urgent musculoskeletal or histological pathology: These patients are ambulatory, derived to Minors from outpatient services or from Urgent Care Centre (UCC) if they required diagnostic tests or treatment that they cannot do. Other patients, such as those afflicted with a possible deep venous thrombosis, can also be treated in Minors, but most Minors patients have problems in their musculoskeletal system. This allows rapid patient flow given the diagnosis and treatment efficiency in Minors.

After being treated, these patients can be discharged, referred to another service or transferred to a hospital ward, if necessary. However, if the patient has a disease that cannot be handled in Minors he will be transferred to Majors or Resus as appropriate, regardless of whether they also suffer a locomotive pathology.

Unlike the rest of the department, Minors is closed from 2 am to 8 am, so patients that should be treated there are examined in Assessment Bay and treated in Majors, who are labelled as Night Minors.

- Urgent physiological pathology: Any patient suffering an urgent physiological problem is received in one of the Assessment Bays, as they could be an ambulatory patient, from UCC or transferred by an ambulance. After nursing triage, he must decide which diagnostic tests are necessary at this time and perform some of them (cannulation, blood sampling, electrocardiogram, vital signs recording, etc.) in 15 minutes. There is also a practitioner present covering all Assessment Bays to intervene in complex cases.

After being triaged, patients are transferred to Majors or to Resus if an emergency condition has been discovered during triage and assessment. In Majors, patients will be assessed by a junior doctor supported by a senior doctor if necessary, while in Resus all patients are seen by a senior doctor. Patients with potentially contagious diseases that

are transferred to Majors are always allocated to the blue team, allowing appropriate barrier nursing. Following diagnosis and treatment, these patients can be discharged, referred to another service or transferred to a hospital ward, if necessary.

- Urgent mental illness: When managing patients with mental disorders, if they are not linked to a physiological problem, they are transferred from Assessment Bay to EDU for a mental health assessment by a psychiatrist or mental health practitioner. Nonetheless, if the patient also suffers a physiological problem, it must be treated before assessing his mental health, so he will follow the same process as patients with urgent physiological conditions.

Regarding the assessment of the patient decision-making capacity, this is evaluated by the nurse in the initial assessment, which is repeated for each relevant decision to be made.

- Emergency pathology: In these cases, paramedics report the patient's arrival in advance through a call to the "red phone" to give the multidisciplinary team some time to prepare. If an emergency pathology was discovered in a patient in another ED area, the patient would be transferred to Resus immediately in order to provide the advanced treatment and care necessary.

Once the patient has been assessed, treated and stabilised, he will be transferred to the appropriate ward, excluding the rare discharge home. However, if the patient cannot be stabilised or need treatment that cannot be offered in the department, multidisciplinary teams from other departments can come to support the ED team and transfer the patient from Resus to wherever is appropriate.

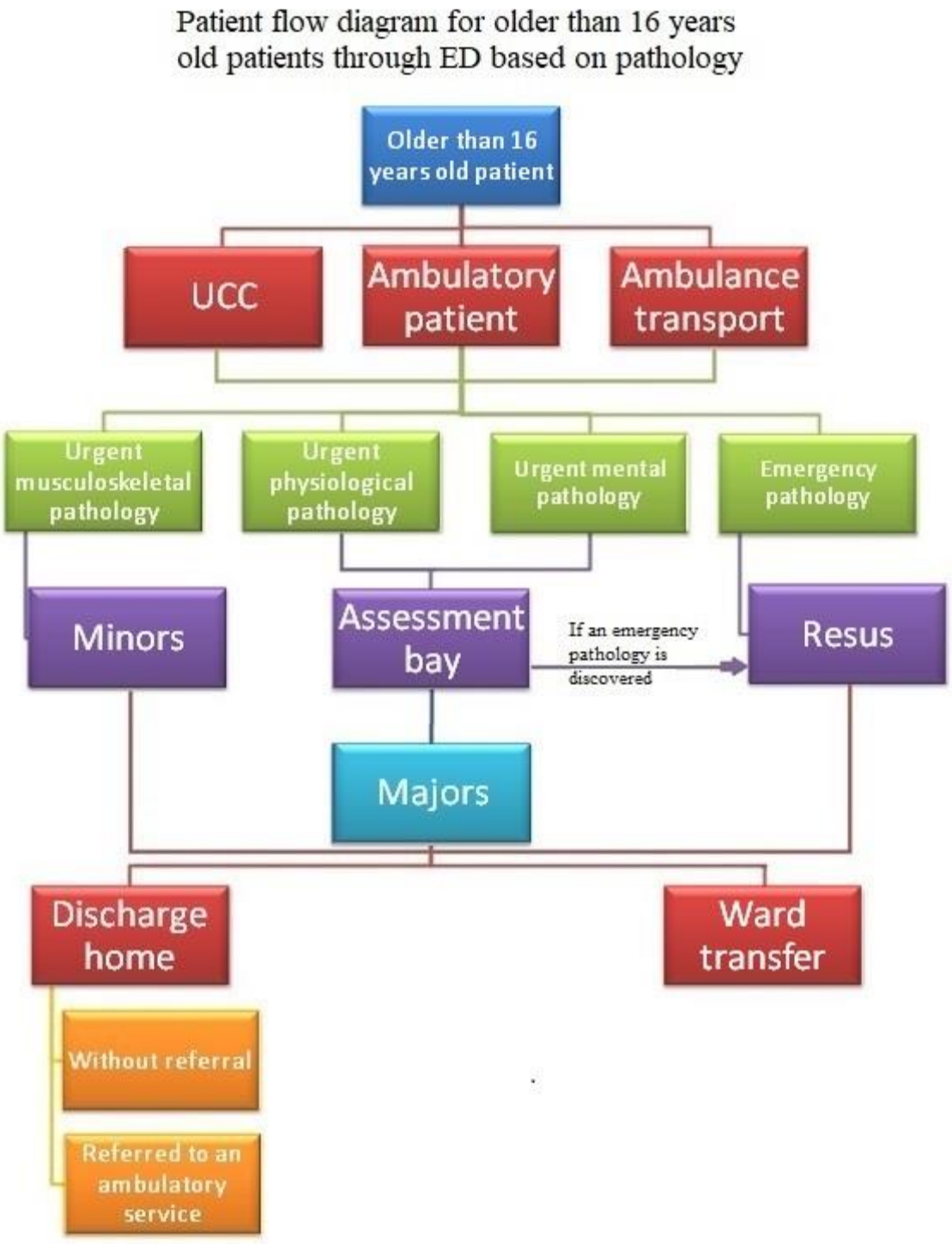
- Younger than 16 years old:
    - Urgent musculoskeletal or histological pathology: These patients are ambulatory or come from UCC or outpatient services, who are triaged and then sent to Paediatric Minors. From there they are usually discharged after diagnosis and treatment, although if the disease cannot be handled at home the patient will be hospitalised. Additionally, if the disease is not really urgent or can be fixed at the time, as a radial head subluxation in a 5 years old patient, he is discharged home from the triage box or is sent to UCC if he has not been assessed there.
    - Urgent physiological or mental pathology: Ambulatory patients and referrals from other services are triaged by a nurse and assessed in order of severity and arrival by a junior doctor, supported by a paediatrician in the Paediatric Majors zone. If the patient deteriorates or an emergency disease is discovered, that patient would be transferred to Resus immediately. Once a diagnosis has been obtained and, if necessary, initial treatment has been given, the patient is referred to the appropriate services, discharged home or admitted to the appropriate ward.

For patients with psychological or psychiatric disorders, Paediatric Majors zone also serves as a "safe place" to keep the patient until the paediatric psychiatrist arrives.

- Emergency pathology: These cases are handled in the same way as with adult patients, the only difference being the presence of a paediatric multidisciplinary team from Children's ED or another department to treat the patient.

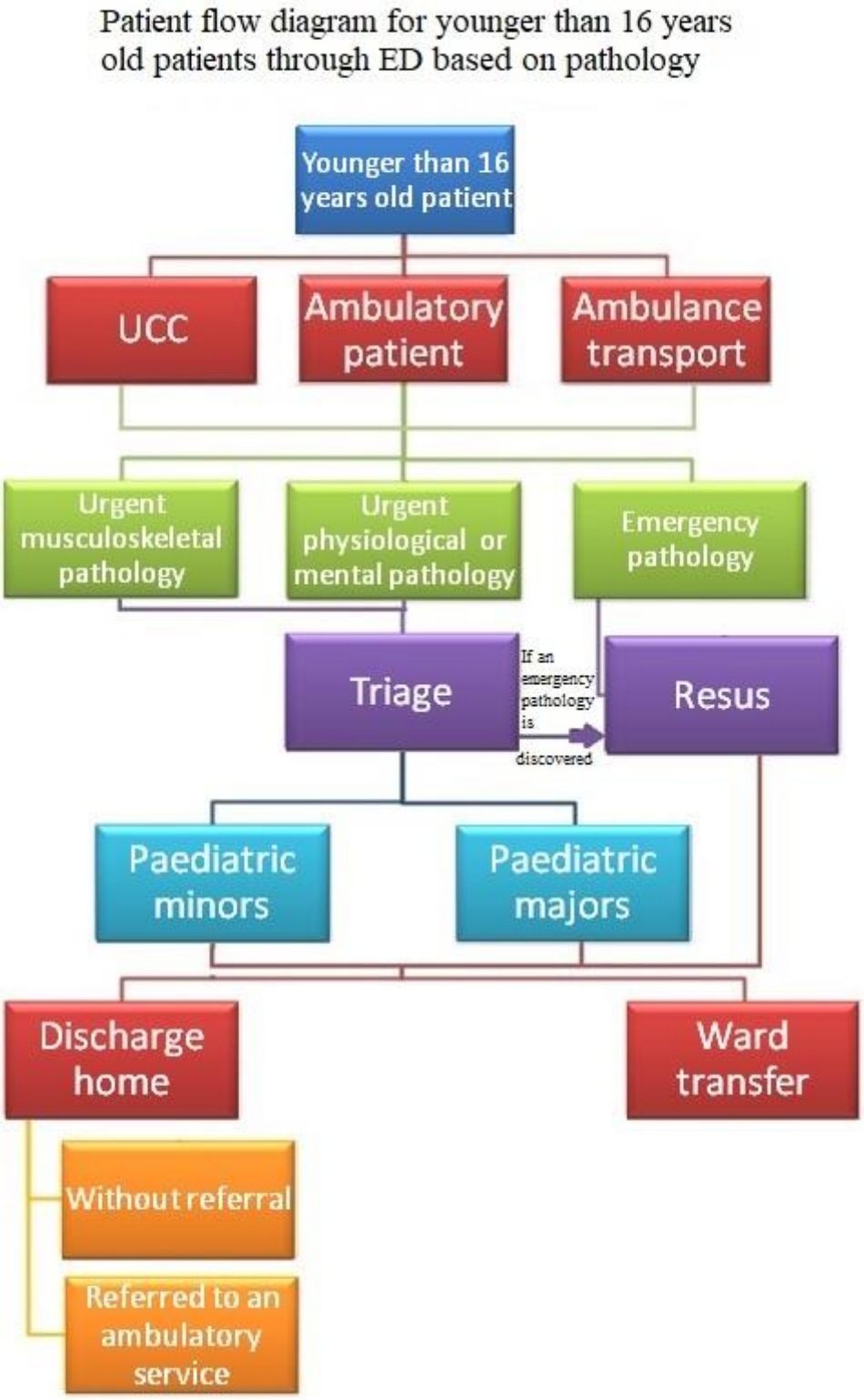
This process is simplified in diagrams 2 and 3:

**Diagram 2: Adult patient flow adult through ED**




Self-created content on the 20th of June 2016

**Diagram 3: Paediatric patient flow through ED**




Self-created content on the 20th of June 2016

#### 6.2.1.3. Responsibility and leadership

As they pass through the department, patients are placed under the care of a nurse. This ensures that they receive the care they need and that their interests are represented within the multidisciplinary team. However, each patient will receive care from different nurses during their passage through the department, forcing them to give multiple handovers (which will be discussed in depth separately). Patient responsibility is managed differently depending on the area and the severity of patients' illness, enabling efficient resource distribution in a standard shift:

- Assessment Bay: Firstly, if the handover has not been received by the Assessment Bay nurse coordinator, the patient is not considered in that area and no nurse is responsible for that patient. This happens with patients waiting in ambulances, which are paramedics' responsibility, and patients referred from UCC, which remain there until a handover has been made. For ambulatory patients, the receptionist calls a nurse who is triage-competent, who makes a quick triage and decide if they must be reviewed immediately or wait in time order. Once the nurse coordinator receives the handover from the paramedic, the UCC nurse or the nurse that triaged the ambulatory patients, he is responsible for those patients until they are assessed.

When is the patient's turn to be assessed, he is the assessment nurse responsibility until the nurse finishes his assessment and handovers that patient to another department or area (Majors, Resus or Minors).

- Majors: The patient who arrived at Majors from any other area should be assigned to a nurse by the Majors nurse coordinator. This nurse will receive the patient's handover and will be in charge of their care until he is transferred or discharged.

- Minors: Patients who come to Minors are the only ones who do not have a specific nurse responsible for their care. This happens because there is only a nurse in Minors, who coordinates, and all patients in Minors should be stable, so they should not need continuous care.

- Resus: Each patient is assigned to a box by the nurse coordinator and each nurse is assigned one or two boxes to cover. The nurse will escort the patient in any transfer until he gives the handover to another nurse from another area or department.

- Children's ED: Although is part of the same department, Children's ED works differently than adults in some aspects such as the patient's responsibility. Since patients are often accompanied by their legal guardians or relatives, they have someone with them responsible for their welfare. A nurse is assigned to be responsible for the patient only in the case of patients with very severe diseases or who have been transferred from Resus.

Nevertheless, this situation happens before the first assessment. Once the patient has been assessed by the triage nurse is his responsibility that the patient is treated faster if necessary, identifying possible severe pathologies. Moreover, it is the nurse coordinator's responsibility to know and control the status of all patients in his area, since he is responsible for managing the treatment and care that all patients need in the appropriate order.

The management of a department with a lengthy and continuous flow of patients need excellent leadership. To allow this, the distribution of English nursing hierarchy is used to assign the roles of nurse coordinator and NIC, being the nurse coordinators deputy sister/deputy charge nurse as a minimum and the NIC should be sister/charge nurse (both roles will be generalised as deputy sister and sister only to avoid confusion, but it is appreciated that these titles are feminine and that a male title for the same ranks exists). In the case of nurse coordinators, their roles are different depending on the area that they coordinate, adapting them to each area's needs:

- Assessment Bay: The nurse coordinator performs a quick triage to discern the order in which patients will be assessed. He also distributes the nursing teams in the boxes and chooses which patient goes to each box. Also, he chooses the breaks' order and ensures that no patients wait to be assessed outside the department.

- Majors: The Majors nurse coordinator's main role is to ensure that the 4-hours target is met. To do this, he distributes patients arriving from other areas among the nurses available, checks that diagnostic tests and treatments are done on time, brings together the multidisciplinary team every two hours to discuss the action plan of each patient and works with duty managers (managers in charge of patient transfers through the LRI and other hospitals, among others roles) and administrative staff to ensure that patients receive adequate care and treatment in less than four hours.

- Minors: Since the only nurse who is not an ENP is the nurse coordinator, his role is not to coordinate other nurses, but to ensure that patient flow is adequate. His roles include receiving clinical documents, performing the necessary techniques to treat patients, discussing action plans with the multidisciplinary team (mainly ENPs, doctors and physiotherapists) and ensuring that all patients are discharged or transferred in less than four hours.

- Resus: Patient and nurse distribution is not the only nurse coordinator's role. He also ensures that there are space and resources for potential new patients, receives "red phone" calls, creates action plans with the multidisciplinary team and serves as expert support in the treatment and care of critically ill patients.

- Children's ED: Since he must coordinate several small zones, the Children's ED nurse coordinator has slightly different roles than their peers in the adult areas. He discusses action plans for each patient with the multidisciplinary team, ensures that patients who need it are monitored and receive treatment and care, prevents that any patient waits more than four hours in the department and supports nurses in solving complex situations.

However, the Children's ED nurse coordinator usually focuses on the Paediatric Majors zone. This is because triage nurses have to be seniors and are usually independent, while in the Paediatric Minors doctors and advanced nurse practitioners (ANP) tend to work independently, asking for support to the nurse coordinator if they need it. Therefore, although there is only one nurse coordinator for the whole area of Children's ED his efforts are focused on the Paediatric Majors zone.

Excluding the specific role in each area, the nurse coordinator is the expert support for nurses, who will turn to him for advice in unusual situations or solve their doubts. Furthermore, the nurse coordinator is responsible for the efficient management of his area and is the main problem solver for any problems that may arise in the area. Therefore, if a nurse informs his nurse coordinator about a problem, this problem becomes the responsibility of both the nurse and the nurse coordinator. However, the nurse coordinator has more influence than the registered nurse, so he has a greater responsibility for whatever happens in his area.

For the NIC, he is the nursing team representative for the entire department, including adults, paediatrics and EDU. During a standard shift, his role is primarily to ensure that all nurse coordinators have everything under control, supporting them if necessary. He can change the physical layout of the department, move staff and patients where he sees fit and question the practice of any nurse, making decisions that can override the nurse's ones. Alongside the emergency practitioner in charge (EPIC), the NIC is ultimately responsible for whatever happens in the whole department, from patient complaints to interdepartmental discussions.

As sisters or deputy sisters, nurse coordinators and NICs have to handle administrative issues like shift planning, staff leadership or clinical audits. Therefore, although not physically present, the sisters' work is tangible every shift and are accountable for it to the matron and any relevant institutional body.

#### 6.2.1.4. Break's structure

A common action on all shifts is the existence of breaks. Nurses and HCAs have a 30-minute break on a short shift and two 30-minute breaks in a long shift. Moreover, there is an extra break lasting between 15 and 30 minutes called discretionary break, which was removed in 2015 and restored in 2016. Breaks do not count as time worked, but the discretionary break does.

All breaks must happen within a period of two hours, which is different depending on the shift type and the time period (it changed in 2016). Given the number of staff working in the department, breaks' management and distribution is something of great importance, these being the nurse coordinator's responsibility. Therefore, to maintain continuous and quality care nurses cover their colleagues' breaks. However, this process is done differently in each area:

- Assessment Bay: Nursing teams' breaks are not covered by another team, leaving a boxed unused until the nursing team comes back from their break. Also, depending on the number of teams their breaks have to be overlapped at 15 minutes intervals.

- Majors: Previously, breaks were assigned by the red and blue team leaders, but that role was removed between 2014 and 2015, forcing each nurse to be responsible for their patients. Due to the longevity of the old system of team leaders, many Majors nurse coordinators continue to depend on the most experienced nurse of each team to arrange breaks, even if is not their responsibility. This custom derives from a tradition in clinical practice and does not limit or eliminate the nurse coordinator's responsibility of arranging breaks, so if there are any disputes within the team is the nurse coordinator who has to act as an impartial person and solve them, including breaks' order.

- Minors: As there is only one nurse who is not an ENP in this area, nobody covers his break. One of the ENPs is informed of the general situation of the area and keeps it under control while assessing patients.

- Resus: In this case, breaks should not overlap given the high clinical workload that each patient represents. Nonetheless, it is impossible to meet the requirement of finishing all breaks in two hours if they are not overlapped, as four nurses and a nurse coordinator have to take their break in those two hours. This decision between infringing the "breaks in two hours" requirement or the "do not overlap breaks" one remains in the nurse coordinator hands, who must analyse the situation and make the right decision.

- Children's ED: Since staff distribution is usually more flexible, as the triage nurse can cover the nurse coordinator's break and vice versa, breaks managed by the nurse coordinator are not covered by a specific nurse because nursing roles can rotate to cover different needs in the area without overloading the clinical workload of one nurse.

A senior nurse working in the area, preferably a sister or deputy sister, will cover his nurse coordinator's break. If within that area no nurse is trained to cover him, the NIC will redeploy nurses as necessary or cover the break himself.

#### 6.2.1.5. Clinical practice general dynamics

One of the most important actions, or even the most important, is clinical practice itself. Due to its complexity, only a general description within a standard shift will be included in this section, deepening in the routines and relevant practice later. Although it is generalised, the expected practice in each area in a standard shift is standardised seeking maximum efficiency to be able to meet national objectives, showing significant differences between areas:

- Assessment Bay: In general, clinical practice in this area focuses on patients' assessment and the first diagnostic tests. Although it has undergone numerous modifications over the period 2014-2016, significant changes applied progressively during several months delimit two separate phases:
    - Phase 2014-2015: The first triage (performed by paramedics or the UCC nurse) was received by the receptionist, who used it to manage assessment order and priority. The nurse coordinator ensured that all patients were assessed as soon as possible, triaged ambulatory patients, organised nursing teams in the boxes and assessed patients when the clinical workload was high.

Regarding the nursing teams' practice, the nurse received the handover from the paramedic or the UCC nurse while the HCA was measuring the patient's vital signs. Upon completion of the handover, the nurse assessed the patient and performed the diagnostic tests and treatments that were urgently needed, documenting them on paper and in the EDIS software. Also, they were supported by doctors and ANPs to allow the care and treatment of complex or unstable patients.

After the assessment, the patient was transferred to another area, where the assessment nurse gave the patient's handover to the nurse in the new area. If there was no space in the area where the patient should be moved, he waited outside the Assessment Bay boxes while the nurse who assessed him examined another patient, who was responsible for both the patient being assessed and the one already assessed.

- Phase 2015-2016: The nurse coordinator receives all handovers and does a quick triage. After this, the patient is transferred to a box where he will be assessed by a nursing team, who has not received any oral handover, only the data written by the nurse coordinator.

The support of doctors and ANPs for complex cases continues, but also they start their own assessment if all nursing teams are busy and there is a free box, choosing what diagnostic tests and treatments nursing staff should do for them.

Once the assessment has been completed and documented, the nurse coordinator and the HCA that works with him are responsible for monitoring and caring for those patients if the patient cannot be transferred to another area, freeing nursing teams of any distractions while they assess other patients.

- Majors: The nurse receives the handover from patients assigned to him by the nurse coordinator (or the team leader, when they existed) and ensures that they receive the appropriate care and treatment, always trying to meet the 4-hours target.

To do so, the nurse monitors patient's vital signs hourly, maintains patients fed and hydrated, administers the necessary medication and engages with the multidisciplinary team to create an action plan which implementation is sustainable in less than four hours, documenting the whole process. When caring for dependent patients, nurses also feed the patients, keep them clean and change their posture if necessary. Moreover, each patient has specific needs that may or may not be included above and need to be covered by the nurse's care.

Each Majors team, red team and blue team, are usually formed by three nurses and an HCA who helps the nurses. However, nurses remain responsible for both their practice and the HCA's one with their patients.

Once the patient received the care and treatment that they need and is ready to be transferred, the nurse is responsible for ensuring that all documentation is in order and photocopied.

- Minors: The only nurse who is not an ENP in Minors has a dual role, registered nurse and nurse coordinator, as has been explained before.

- Resus: Each nurse, whose nurse coordinator assigned him two boxes, will receive handovers from paramedics, Assessment Bay, and occasionally UCC and ambulatory patients with life-threatening diseases. After receiving the handover, the nurse works alongside the doctor to assess and stabilise the patient. Following the patient's assessment, the nurse monitors the patient, administers medication, maintains patient hygiene and covers any reasonable need that the patient has, documenting every step of his care. It is also his responsibility to escort his patient in any transfer (radiology, another ward, another hospital, etc.) unless he hands over his patient to a trained healthcare professional like a paramedic or other nurse.

Clinical practice in Resus usually involves caring for critically ill patients and working within multidisciplinary teams of various specialities that move where the patient is. Therefore, the nurse and the doctor in Resus are the links between the basic needs of the patient and the specialised teams that can cover them, having to deal with teams that are not familiar with the area. The presence of critically ill patients also requires nurses to be competent and familiar with techniques such as advanced CPR or social skills like remaining calm during an emergency or maintaining composure while being empathetic when the death of a patient is communicated to his family.

- Children's ED: Due to the division of this area into zones, the practice in each of them is different. However, nursing practice is divided into triage and care, excluding the nurse coordinator.

The triage nurse focuses exclusively on it, receiving ambulatory patients and UCC patients (ambulance patients are received by the nurse coordinator). In Triage, he tries to make a quick assessment, measuring vital signs and documenting everything within the 15 minutes period. However, in Paediatric Triage no diagnostic tests are performed or complex treatments are administered, although quick treatments such as foreign body removal or radial head subluxation repositioning are performed, if necessary.

In the case of nurses dedicated to patient care, they follow the nurse coordinator's instructions to meet patients' basic needs, since there is no specific nurse responsible for any patient. These nurses have to measure vital signs hourly to every patient in the area, administer medications, keep patients calm and entertain them and escort them during ward transfers, documenting every action. Nevertheless, this area also has HCAs,

therefore they release part of the clinical workload connected to less technical tasks such as monitoring vital signs or entertaining distressed patients. If paediatric patients are in Paediatric Minors, the nurse is usually focused on performing Plasters of Paris, sutures and wound care, while in Paediatric Majors his main role is vital signs monitoring and medication administration.

If a patient younger than 16 years old suffers a serious condition and is transferred to Resus, a paediatric team consisting of a doctor and a nurse from Children's ED attend the patient in Resus. If that patient is pre-alerted when the ambulance is on its way, the paediatric team will be warned before the patient arrives and will prepare for his arrival.

When a nurse is caring for a paediatric patient in Resus he acquires the same roles as a Resus nurse, as previously described, until the patient is stabilised and transferred to another area or department. When the paediatric team goes to Resus children`s ED it loses a nurse, so a Resus nurse will be moved to children`s ED to cover the paediatric nurse while he is in Resus. However, the Resus nurse does not have to be trained in paediatric care or to know the layout of Children's ED.

#### 6.2.1.6. Checklists and last handover

One aspect of work routine that is related to clinical practice but is not directly part of it is the checklists. These are used to identify finished tasks like material stock replacement, cleaning (as cleaners only clean the floor, which must have been cleaned of any bodily fluids previously) or inspection of healthcare devices, among others.

At the beginning of 2014, their main function was checking the disposable material stock in Resus, although their use has spread to all ED areas to document that they are in good condition for the next shift. The checklists are done twice a day, one for the long day shift and one for the night shift.

Given the continued flow of patients, nurses must manage their time to perform the checklists' tasks in addition to their clinical practice, being penalised staying in the department until they are completed even if their shift has ended. These tasks, although

they revolve around department maintenance, they are different depending on the area, which is represented in the differences between each checklist:

- Assessment Bay: The checklist is divided into two parts, box checking and general area checking. Box checking includes:
    - Replenishment of the sharps container and the equipment trolley.
    - Box and curtains cleaning, when necessary.
    - Verifying the functioning of medical devices such as oxygen ports, suction, cardiac monitors or glucose meters.

These tasks are performed by the nursing team assigned to each box.

Regarding the general area checklist, which is done by all nurses and HCAs in the area together, contains various tasks that facilitate Assessment Bay's continued operation. Those tasks are:

- Restocking equipment in the material stack (two cabinets from where each team gets the material to replenish their equipment trolley).
- Replenishing documentation and gloves.
- Cleaning and supplying paper to the printers.
- Checking the inventory of glucose meters and ketone meters.
- Replacing the chlorine solution for disinfection if it is finished.
- Cleaning of public areas, laptops, portable toilets, blood sampling area and dirty room.

- Majors: This checklist is divided into three segments, one for the nurse coordinator, one for the red team and one for the blue team. The nurse coordinator does or supervises the following tasks:
    - Cleaning and dust removal from all work surfaces, laptops and photocopiers.
    - Restocking and cleaning the treatment room, the cannulation trolley and the urinary catheterization trolley.
    - Provision of clinical guidelines in paper, when necessary.
    - Review of emergency equipment, which should be documented in the pink book.

- Random hourly rounds' monitoring, which are part of the nursing documentation for each patient.

Unlike nurse coordinator's tasks, red and blue teams must perform similar tasks in their area as part of their checklist:

- Verifying the operation of medical devices in each box like oxygen ports, suction, cardiac monitors or glucose meters.
- Cleaning and dust removal in each box, changing the curtains if necessary.
- Replacing sharps containers.
- Verifying the operation of alcohol-based solution dispensers.
- Supplying the care cabinet and the intravenous fluids cabinet.

Nevertheless, the red team is solely responsible for reviewing the resuscitation backpack and replenishing sepsis and N-acetylcysteine administration packs, while the blue team is responsible for restocking the wound care cabinet and replenishing iliac fascia nerve block packs.

- Minors: Given the difference in clinical workload, Minors have different checklists for the day and night shifts, which are done by the nurse coordinator. There are several common tasks, although the day shift checklist includes checks that are not needed on the night shift. Common tasks are as follows:

  - Verification of the oxygen port and suction in each box.
  - Review of emergency equipment, which should be documented in the pink book.
  - Review of the tidiness, cleanliness and stock of the dirty room, the treatment room, the suturing room, the plastering room and the ocular assessment room.
  - Resupplying cabinets and sharps containers in each box.
  - Monitoring the absence of obstacles in front of the emergency exit.
  - Cleaning and testing of the cardiac monitors.

While during the night shift the previous tasks are the only ones included in its checklist, the day shift includes additional tasks:

- Restocking linen, medication, chlorine solution, crutches and entonox (50% $O_2$ 50% $N_2O$).
- Verifying the glucose meters and the medication fridge, including its temperature.
- Cleaning and stocking the nursing station.

- Resus: The Resus checklists are the longest ones of the department, resulting in different sub-checklists. These are the same on a day shift and in a night shift, only changing accordingly to the material that was used. The main checklist is divided into two parts, box tasks and general tasks. The box tasks are the following:

    - Verifying the operation of medical devices in each box like oxygen ports, suction, cardiac monitors or glucose meters.
    - Cleaning and dust removal, changing the curtains if necessary.
    - Replacing sharps containers, if necessary.
    - Material checking and replacement distributed in each box: top and bottom drawers, material hanging from the ventilator, defibrillator and equipment trolley.
    - Control the seal integrity of airway management trolleys (both adult and paediatric). If any of these has been opened, they must be restocked following the corresponding sub-checklist, after which they will be sealed.

The Resus general tasks checklist encompasses material and workspaces outside the boxes, which are equally important as the boxes themselves. These tasks are the following:

- Cleaning and dust removal from the nursing station, the equipment room and treatment room.
- Checking the operation of all glucose meters, ketone meters, infusion pumps and the fridge, the temperature has to be monitored and medication in it restocked.
- Restocking the urinary catheterisation trolley and the intravenous fluids shelves.
- Controlling the seals' integrity of transfer bags (both adult and paediatric) and specific procedure packs (general, adult and paediatric). If any of these

has been opened, they must be restocked and sealed according to the corresponding sub-checklist. However, these are reviewed once a month if they are not opened.

- Children's ED: In Children's ED, like in Minors, there are different checklists for the day and night shifts. However, the complete set of tasks is performed only on the night shift. This happens because the clinical workload rises at different times depending on the area, increasing in Children's ED during the afternoon once children leave school, which implies that the clinical workload will be lower overnight.

Starting with the day shift checklist, the included tasks are the following:

  - Restocking and cleaning the whole area: six rooms, seven boxes, a waiting room, two triage boxes, a treatment room, a cannulation trolley and a linen cupboard.
  - Verifying the operation of medical devices in each box like oxygen ports, suction, cardiac monitors and infusion pumps.
  - Examining the paediatric transport bags' seal integrity. If any of these has been opened, they should be replaced and sealed according to the relevant sub-checklist and inform Resus staff so they can include it in their checklist. However, these are reviewed once a month if they are not opened.
  - Checking that hourly rounds, controlled drugs usage and community referrals have been recorded appropriately.

While during the day shift the tasks above are the only ones included in its checklist, the night shift checklist includes additional tasks:

  - Verifying the operation of glucose meters, cardiac monitors and both fridges, the food fridge and the medication fridge.
  - Restocking and cleaning the cardiac arrest trolley (including the defibrillator check), the cannulation draw in room 4, the Entonox cylinders, the dirty room, the bandages trolley, the plastering trolley, the briefcases for specific pathologies and the nursing station.
  - Cleaning the stretchers' mattress and structure, the laptops and the scales.

When the next shift nurses start, they receive handover from the current shift nurses, therefore closing the cycle of continuous nursing care in an ED. The current shift's nurses and their nurse coordinators give an adequate handover, review that their checklist is completed and wait until the end of their shift is announced. While, the current shift's NIC and new shift's NIC review that all checklists have been finished, the controlled drugs' book is filled appropriately and any serious problems have either been solved or are in the process of being solved. To facilitate this, both NICs follow a list that enumerates the checks that have to be finished before shift change.

The completion of this list, if no complications occur, usually takes 15 to 30 minutes, ensuring that nurses finish their shift on time. Nonetheless, if problems arise no nurse or HCA is allowed to leave ED until the NIC announces it, regardless of whether they have finished their shift or not. To prevent this from happening, both shifts NICs follow their list, which allows them to solve common issues quickly and efficiently such as the lack of a signature in the controlled drugs' book or the absence of material resources in an area. In addition, they can move staff from the finishing shift to solve the problems that they encounter.

Nevertheless, even if not all checklists are completed, the shift finalisation is at the NIC's discretion. They are responsible for problems that may occur in unsigned sections of the checklists, whereas if a task has been signed on a checklist and it was not done the signatory nurse and the nurse coordinator will be responsible for any problems arising from such failure.

### 6.2.2. Shift with reduced patient inflow

A lower than normal patient inflow shift does not imply a drastic change in the department's functioning from a standard shift. However, depending on the patient flow coefficient (patient admissions per hour divided by discharges per hour) two situations can be distinguished.

If the patient flow coefficient is around 1, which means that few patients enter ED and few patients leave, the differences from a standard shift are minimal. The clinical workload is lower but constant, therefore maintaining the same performance as a

standard shift while time distribution per patient is more generous, allowing covering non-urgent needs.

On the other hand, if the patient flow coefficient is less than 1, which means that more patients leave than enter, a very low clinical workload situation is reached. In this context, nurses are able to complete their checklists and care for their patients in the most holistic way possible, but if the flow rate coefficient remains low nurses will have free time while caring for their patients, if there are any.

Nevertheless, NICs discipline nurses for sitting if they are not on their break and longer breaks are prohibited even if they are not doing anything. This encourages nurses to stand pretending to do something just to avoid reprisals after cleaning and restocking the whole department.

According to the senior nurses, there was a seasonal cycle during which the patient flow coefficient was lower than 1 in the summer and greater than 1 in the winter. Although the increased clinical workload in winter is a phenomenon that continues to happen, during the clinical practice period analysed shifts with a patient flow coefficient lower than 1 were scarce and randomly distributed, being more frequent during nights shifts in the summer of 2014 and virtually nonexistent since September 2015.

#### 6.2.3. Shift with increased patient inflow and standard or increased patient outflow

If the patient flow coefficient is around 1 in a specific point in time does not always imply that a shift could be considered a standard shift. Other factors such as staffing or patient arrival timing may create new problems even though there is no exit block.

The most common situation of this kind is when there is an increased patient inflow and an increased patient outflow. Understanding increased patient inflow as when patient admissions surpass ED's human resources, the problems arising from this type of shift focus on available human resources.

As admission efficiency depends on available resources, changes in staff numbers or their skills affect patient flow. Focusing on the nursing team, the number of nurses in

triage posts and their competencies influence how many patients can be assessed per hour, generating an entry block if there are not enough triage-competent nurses.

Even if the hospital tries to maintain an adequate number of staff with appropriate skills through temporary contracts and support from its nursing training team, various factors like rapid county population growth and low staff retention limit the amount of material and human resources available. Long-term measures have been proposed, such as building a larger ED and a greater investment in recruitment. However, while these measures are applied NICs have to deal with the entry block that could be generated by an increased patient inflow.

Various changes can be applied by the NIC to avoid or mitigate the entry block. These are often concentrated in triage areas, although all ED areas can modify their operation to avoid entry block.

- Assessment Bay: As main entrance area for ambulatory and ambulance adult patients, Assessment Bay is the first area to suffer an entry block when ED is under increased patient inflow. To prevent entry block, the NIC and the nurse coordinator may implement the following measures:
    - Increasing the number of triage teams, which is limited to the number of boxes.
    - Transferring patients from Assessment Bay to other areas prematurely, such as ambulatory patients with non-emergency conditions, who are referred to UCC, or patients transported by ambulance with non-emergency musculoskeletal injuries, who are referred to Minors.
    - Moving emergency patients to Resus to be treated there, if their clinical workload allows it.

Even though these measures accelerate patient flow, sometimes they are not enough and some patients have to wait to enter ED inside the ambulance that transferred them. These patients will be evaluated regularly by a nurse or doctor to prevent deterioration and to assign an appropriate assessment priority.

- Majors: Majors' operation does not resent in an entry block because they only receive patients referred from other areas. Also, if Majors' clinical workload is not

very high, nurses with triage skills can triage patients in Majors, mitigating the entry block in Assessment Bay.

- Minors: Given the pathologies treated in Minors, most patients can wait hours without any deterioration, so no measures are usually taken to solve the entry block for Minors. However, if the entry block persists over time, other non-blocked areas may take some patients from Minors.

- Resus: Resus entry block is the most dangerous of all because patients that need to be treated in Resus often suffer an emergency disease. To avoid this, the NIC prioritises patient flow in Resus through two main measures:

    - Any patient who arrives at Resus during an entry block is quickly evaluated by the Resus doctor in charge, and if is not an emergency the patient is transferred to Assessment Bay.

    - When an emergency patient's arrival is expected and there is no space available, the nurse coordinator moves the most stable patient from Resus to Majors to make room for the new critical patient.

- Children's ED: For paediatric patients, the current policy states that no patient should wait more than 15 minutes to be triaged. If there is any patient who has been waiting more than 30 minutes to be triaged, the NIC should be informed, who will provide an extra triage nurse if the entry block persists.

All these measures are useful when the right amount of staff with appropriate skills is available. If not, supporting triage areas is much more complex. Moreover, if the entry block is generalised resources are difficult to distribute, even though Resus is usually prioritised.

A generalised entry block usually overlaps with clinical workload peaks and does not persist in time, so it usually solves itself, except in major disasters. If it persist in time, it is a sign that the available resources do not cover patients' healthcare demand, so they should be increased. However, an entry block may persist if there is a standard or reduced patient outflow, resulting in an entry and exit block.

### 6.2.4. Shift with increased patient inflow and reduced patient outflow

The most common situation during 2015 and 2016 evenings and nights was a shift with patient flow coefficient greater than 1, in which the continuous patient inflow for several days had exceeded hospital resources; therefore there were not any empty hospital beds. This creates an exit block in ED because if patients need to be admitted there are no free ward beds to transferred them to, so they have to wait in the ED until a ward bed is freed and assigned to them.

Factors like staffing issues or major disasters can crowd the department on their own, but in most cases is the lack of hospital beds which causes an exit block. Furthermore, the lack of patient outflow generates an entry block if there is a standard or increased continuous patient inflow.

Entry and exit blocks bring new challenges to the ED's nursing team. The nurses available should provide integral care to more patients than they can cover, so task and time distribution is paramount. However, in those instances care is more inefficient and more time is lost due to various factors outside the nurse's control.

To prevent that patients deteriorate due to crowding, the NIC must implement changes to adapt the available resources to the current situation. These changes can be applied to any factor or person in the department, reaching the limit of what is legally and ethically correct to benefit patient flow.

Due to the discrepancy between the context of this shift and a standard shift, several differences in practice need to be covered in the following subsections.

#### 6.2.4.1. Patient distribution

- Older than 16 years old:
    - Urgent musculoskeletal or histological pathology: These patients are treated in Minors like in a standard shift, even if they have to wait several hours. If the wait stretches over four hours, the NIC should know why and act accordingly.

However, in practice few changes are applied to Minors, since they are non-emergency patients.

A common problem of this shift is that patients from other areas are referred to Minors erroneously, mainly due to clinical workload, and cannot be diverted back to Majors or Resus because they are full. This implies that the Minors nurse has to deal with emergency patients without the appropriate resources.

Another complication is that Minors is closed from 2 am to 8 am, so all patients who have been waiting for hours in Minors are put together with Majors patients at 2 am, increasing waiting times for both.

- Urgent physiological pathology: In this shift, patients coming by ambulance usually have to wait to enter Assessment Bay until there is a space, although in extreme cases they are aligned in the adjacent hallway. Those patients are triaged by a doctor or nurse assigned by the nurse coordinator to prioritise the entry of critically ill patients. For patients derived from UCC, they wait in UCC until the nurse coordinator deems appropriate.

After being examined, if there is no space in Majors (or Resus if an emergency pathology is discovered) the patient is treated in Assessment Bay. This entails that the nurse coordinator has to employ an HCA to monitor assessed patients' vital signs and assessments may take longer due to the provision of treatments and basic care usually given in Majors. If a patient is waiting for a long time, he can be examined by a doctor and be discharged from Assessment Bay, if human resources permit it.

Once the patient is transferred to Majors or Resus, he will receive appropriate treatment and care, even if he has to wait several hours to be evaluated by a doctor. If the patient is ready to be admitted but there is not any free bed on the ward he will wait indefinitely until a bed is freed or he requests the voluntary self-discharge.

- Urgent mental pathology: Once he is transferred to Assessment Bay, and if he does not have any physiological diseases, the patient is referred to EDU like in a standard shift. He may have to wait for a space in EDU, but EDU chairs are not usually used for a long period of time, so he could wait in Assessment Bay until he can go to EDU.

There is a possibility that EDU could not accept the patient, so he must follow the urgent physiological pathology patient process until he sees a psychiatrist in ED or until he can be transferred to EDU.

- Emergency pathology: Once the paramedics report the arrival of an emergency patient through the red phone, the nurse coordinator assigns and prepares a box for him. If there is no free box, the most stable patient will be transferred to Majors.

In the event that there is an exit block in both Resus and Majors, the NIC is responsible for making the necessary changes to allow emergency patients to be cared for in Resus. However, when all Resus patients are critically ill, Assessment Bay can receive some emergency patients to be assessed and stabilised. Once stabilised, patients can wait for a bed on a ward in Resus or Majors, according to the acuteness of his condition after receiving emergency treatment.

- Younger than 16 years old:
  - Urgent musculoskeletal or histological pathology: Given the nature of these diseases, patients wait to be seen as much as necessary once they have been triaged. If the nurse coordinator considers it appropriate, he can allocate more human resources to treat these patients faster.
  - Urgent physiological or mental pathology: If there are many patients with acute diseases without being triaged, the nurse coordinator can triage patients in one of the Paediatric Majors' rooms to relieve the entry block. If there is not enough space for these patients to be assessed or treated, they can be transferred to the Paediatric Minors' boxes, since they have most of the resources available in the Paediatric Majors' rooms.
  - Emergency pathology: The main difference from a standard shift in these patients is the importance of backfilling. Backfilling is a protocol in which a nurse from Resus covers the paediatric nurse who will care for the emergency paediatric patient in Resus. Although in a standard shift this does not cause any serious issues, in a shift with entry and exit block several weaknesses arise:

- The Resus paediatric nurse cares for paediatric patients only, who is usually one. As the standard Resus clinical workload is two patients per nurse, one of the nurses must be overloaded to compensate the fact that the paediatric nurse only cares for one patient.
- The Resus nurse is an adult nurse, who does not normally work with children and does not know Children's ED. This entails that he cannot be as efficient as a paediatric nurse would be, worsening the exit block further.

#### 6.2.4.2. Responsibility and leadership

Given the particularities of a shift with both an entry and an exit block, nursing responsibility in relation to their patients adapts to the situation in order to keep them safe while trying to restore patient flow. This involves allowing decisions and actions that would be prohibited or inadvisable in a standard shift.

Nursing accountability and patient safety are dependent on their situation, the area where they are and the area where they should be. That is why it is necessary to understand the decisions made in each area:

- Assessment Bay: If there are UCC patients, these are UCC's responsibility until they are called by the Assessment Bay nurse coordinator, so they are not included in the patients cared for Assessment Bay nurses. The nurse coordinator must consider if these patients have been waiting for too long, since is his responsibility that patients waiting in UCC are assessed as soon as possible. However, if the patient arrives at reception and sending him to UCC is not appropriate he would wait to be assessed by one of the triage nursing teams in Assessment Bay.

For patients waiting in an ambulance, even though their care is the paramedics' responsibility (even if the hospital is accountable for it), the nurse coordinator is accountable for patient deterioration and assessment prioritisation of patients in ambulances waiting to enter ED. Due to this, a nurse or doctor will be assigned to perform a quick triage to each patient waiting in an ambulance longer than 15 minutes.

Once they enter in Assessment Bay, every patient is the responsibility of the nurses in the area, especially the nurse coordinator. Although it is not a drastic change from a standard shift, this statement points out that independently of the number of patients in Assessment Bay, assessment and care excellence for all of them is expected.

When the patient is transferred to a box and assessed, if Majors is blocked the patient may be unable to leave Assessment Bay in several hours. Therefore, he has to receive treatment and care in Assessment Bay, which is the responsibility of the nurse who assessed the patient. Moreover, to avoid the boxes' prolonged blocking, the nurse coordinator is responsible for directing patient movement and the consequences of receiving more patients than allowed, if necessary.

Once the patient is transferred, the Assessment Bay nurse has to wait to handover to the Majors nurse, which can take as much as 15 minutes per patient depending on the nurse and his clinical workload.

- Majors: Every patient that arrives at Majors from any other area must be assigned to a nurse by the nurse coordinator, especially if they suffer exit block. To Majors nurses, their responsibility is the same as a standard shift, even with the increased clinical workload, higher pressure to discharge patients and increased need for ward-like hospital care (postural changes, nutrition control, hospital bed transfer, etc.).

- Minors: There is no noticeable change in the Minors nurse coordinator's responsibility, he only has to inform the NIC if patients are waiting more than four hours and why.

- Resus: The nurse coordinator must manage patient flow through Resus. However, if he cannot send patients to Majors because everyone is too ill or because Majors is full he has the option to transfer the new patient with the highest triage priority to Assessment Bay, where the first assessment will be done. This option is discarded in critical situations such as cardiac arrests or anaesthetised patients.

When the nurse coordinator does not have enough resources to treat and care for the patients in Resus he can ask the NIC for help, who will create space for new patients or refer them elsewhere.

The registered nurses' responsibility does not change if there is enough staff. However, if ED is understaffed they may have to take responsibility for more patients than they are able to care for.

- Children's ED: Being escorted by an adult, paediatric patients are the responsibility of both tutors and nurses are responsible for their care. However, during an exit block the nurse coordinator is primarily responsible for the order in which patients are examined by a doctor and receive nursing care.

If the nurse coordinator is unable to handle the exit block, the NIC will be informed and will try to allocate more resources to this area. However, the percentage of paediatric patients who are discharged home is higher than with adult patients, so an exit block is uncommon.

Regarding paediatric nurses, there are no significant changes in relation to a standard shift. Following the nurse coordinator's directions, they must care for different patients distributed throughout the area, but family support helps to avoid errors under high clinical workload.

If leadership is needed in a standard shift, during an entry or exit block it is mandatory to handle this situation in a safe and organised manner. Nurse coordinators and the NIC are the same, but their roles are expanded and rules are relaxed to adapt to the dire situation they face:

- Assessment Bay: In addition to receiving handovers, distributing patients and controlling breaks, the nurse coordinator must ensure that each patient in Assessment Bay is being assessed or will be assessed soon. In a standard shift, the assessed patient is transferred to another area, but if these areas are blocked the nurse coordinator should ensure that all patients who are waiting to be transferred are monitored and receive care and treatment.

- Majors: Although its primary role does not change, it becomes more complex. Prevent that patients stay more than four hours in an area with exit block is not always possible. This entails that the nurse coordinator has to work with duty managers to ensure that patients can be transferred elsewhere. Also, he must ensure

that patients that are waiting several hours in the department receive adequate care, even if is not commonly offered in Majors.

When the exit block is unsustainable, the NIC can open an extra area, called escalation area, to transfer stable patients who are waiting for a bed on a ward, freeing Majors boxes for new patients. This area will be staffed with a nurse and an HCA, wherein the Majors nurse coordinator will decide whose patients are suitable for this area. Once it is decided, he needs the approval of the NIC and the EPIC to move each patient, freeing a box for the next patient.

- Minors: The dual role of the Minors nurse coordinator does not change dramatically in an exit block. However, an entry block can increase clinical workload, which forces the nurse coordinator to care for patients while coordinating patient flow. This leads to coordinate inefficiently or to not perform all the techniques that he could, being the balance between the coordinator role and nurse role crucial to provide efficient and excellent care.

- Resus: Apart from managing patient flow through Resus, the nurse coordinator can provide clinical care if it is necessary and the situation permits it. This care helps to support and train junior nurses, thus maintaining excellent care despite a higher clinical workload. However, caring for patients is a secondary role of the nurse coordinator, who is not usually responsible for the care of specific patients to focus on resource management and patient flow.

Despite the above, if Resus nurses are junior or their abilities are unknown, the nurse coordinator must provide clinical care and leadership in emergency situations. Common examples include cardiac arrests or multiple traumas, which are led by the nurse coordinator and the doctor in charge of the area.

- Children's ED: As there is only one nurse coordinator for Triage, Paediatric Majors and Paediatric Minors, resources can be distributed easier in an exit block. While he maintains the same roles than in a standard shift, the nurse coordinator may adapt to cover zones with higher clinical workload, triaging patients if there is an entry block or delivering care if there is an exit block. However, as with all nurse coordinators,

his main role is resource management and patient flow, but to encourage patient flow and cover the lack of resources he has to provide expert treatment and care.

An ED under both an entry and exit block appears chaotic even if everything is under control. This environment stresses nurses and frightens patients, so one of the most important roles of the nurse coordinators is to stay calm. To do this, they show a serene look and keep both multidisciplinary teams and patients informed. Also, they are responsible for supporting nurses both clinically and emotionally to prevent that clinical workload exceeds them.

Independently of the context, if the nurse coordinators have to ignore policies or use unconventional solutions to complex problems they must consult the NIC. Within the ED regulations that the NIC can relax are the number of patients per nurse, the maximum number of patients in an area, use of corridors as a clinical area, patient transfers to other areas without receiving all treatment or break time allocation. Also, his vast experience and training allow him to support and guide both nurse coordinators and registered nurses.

Nonetheless, if the NIC decides to adapt a rule or policy to the situation to which it applies, he will be accountable for any consequences resulting from his decision. This entails that regulations are adapted only when they are the most reasonable solution to an extreme situation, not as routine practice.

#### 6.2.4.3. Breaks' structure

Breaks' structure and distribution should be the same regardless of the department's situation. However, in a shift with exit block is very difficult to start breaks because patients from a nurse must be distributed among those who remain working, even though they are not always cared for. Moreover, the discretionary break is usually eliminated or reduced, thereby increasing the nurses' fatigue under high clinical workload.

Breaks' management in this context is different depending on the area, since in some areas no change happens while in others additional factors has to be taken into account:

- Assessment Bay: Breaks are the same as in a standard shift, reducing the efficiency of the area temporarily but without implying any significant change. In the case of the nurse coordinator, several nurses in Assessment Bay can cover his break. In the unlikely event that none of the nurses are qualified to coordinate, the NIC will find someone to cover the nurse coordinator's break, even if it is himself.

- Majors: It is in this area where the breaks are less controlled and are poorly organised. As breaks have to be distributed by nurses in each team, factors such as lack of communication, clinical workload and stress hinder their management. Also, patients under the care of the nurse who is on break should be cared for by others nurses who receive a brief handover. However, nurses often prioritise their patients above the patients of nurses in their break, so the latter are not receiving any treatment or care in 30 minutes.

This results in delayed breaks, several untreated patients and lost handovers. Therefore, when the nurse comes back from his break he does not know how many patients he has, where they are or what happens to them. At the same time, another nurse wants to give his handover to go to his break, who will undergo the same process as the first nurse.

In regard to the nurse coordinator, the NIC will find someone to cover his break, even if it is himself.

- Minors: There is no difference between breaks in a standard shift and a shift with exit block, since nobody covers the nurse.

- Resus: In this area, breaks are led by the nurse coordinator, but are not fixed. The nurse coordinator must adapt to the resources that he has when he has them, since if he has sent nurses to escort patients to another area or ward he should not send another nurse on break. In extreme cases, where the type and number of patients do not allow the nurse coordinator to send nurses on their breaks, the NIC can use a nurse from another area to cover all Resus breaks.

- Children's ED: If staff is composed of paediatric nurses competent in paediatric triage, nurses can cover each other's breaks. However, in a shift with an exit block one of the paediatric nurses is usually in Resus, so the nurse covering him is an adult nurse. Furthermore, the lack of paediatric nurses is covered with agency nurses, who

neither triage nor coordinate. This entails that there have to be at least two paediatric nurses who can triage and coordinate or it is impossible to start breaks without compromising patient safety.

The NIC may place an adult nurse able to coordinate to coordinate or an adult nurse able to triage to triage, but being adults nurses they should not do it, thus this option is used only in extreme situations and when the adult nurse agrees. However, while able to cover basic roles, their efficiency is much lower than paediatric nurses who know the area and their patients, although it is more efficient than not covering the break. The NIC's break is covered by one of the senior nurse coordinators, usually the Majors one, as the last break to be covered.

#### 6.2.4.4. Clinical practice general dynamics

When there is a lack of resources or organisation, clinical practice is one of the elements that suffer the most. In a shift with an entry and exit block, despite the changes that coordinators may apply, several factors slow down and worsen nursing care in ED. These factors depend on the environment of each area, so it is necessary to mention them separately:

- Assessment Bay: Although practice changed during the period 2014-2016, the problems that arise in an exit and entry block shift are the same, these being what prompted changes from one period to another.

One of the most frequent consequences of entry and exit block is that patients have to be treated and cared for where they are because they could wait for hours until they can be transferred to another area. This situation involves practice that, even though it has normalised, is not acceptable.

When patients are waiting to enter Assessment Bay, they wait in an ambulance or at UCC. Those who wait in an ambulance are triaged by a nurse or a doctor, but once triaged they do not receive further assessment or treatment until entering the apartment, except in extreme cases such as sepsis. These patients are also the nurse coordinator's responsibility once they have been triaged, whether or not are inside the department.

Once the patient is inside one of the Assessment Bay boxes, he is assessed by a triage nurse and a doctor if the nurse deems it necessary. Afterwards, the nurse administers treatment and care in order to avoid any patient deterioration due to the transfer waiting time.

In the absence of a continuous flow, patients who need cardiac monitoring, oxygen or any other resource that is only in a box must remain in it. This situation results in blocked boxes, worsening the flow because all patients must be assessed inside a box. Moreover, there are limited spaces for patients waiting to be transferred to another area, forcing the nurse coordinator to not accept more patients than stipulated.

This situation forces nursing teams to care for patients who have already assessed while they assessed new patients. Although the HCA working with the nurse coordinator records the waiting patients' hourly vital signs, continuous care is provided by the nurse who assessed the patient and the nurse coordinator. Since both suffer a high clinical workload, the patient disease's progression in Assessment Bay is inadequate and can result in very serious consequences like cardiac arrest.

Assessment Bay is not an area for continuous care, but neither is prepared to deliver care to critically ill patients. When a nursing team assesses a patient with an emergency disease, transferred from Resus or not, if Resus is locked the patient is assessed and treated in Assessment Bay while he waits for a space in Resus. This assessment allows the multidisciplinary team (since the nursing team will search for a free doctor to confirm the emergency) to assess and treat the patient to prevent any deterioration. However, both material resources and the number of professionals available are much lower in Assessment Bay, so it can lead to a worse prognosis for the patient.

Once the patient can be transferred to Majors or Resus, the Assessment Bay nurse should hand over to the nurse that will receive the patient. However, due to the clinical workload that they suffer, nurses in the receiving area are often unavailable to receive the handover. While in Resus the handover is usually received quickly, since there are fewer patients per nurse, in Majors the nursing team from Assessment Bay can take between 2 and 15 minutes to find the nurse to hand over. This situation is mainly conditioned by the clinical workload and the teamwork in the nursing team that receives

the patient, since nurses with many tasks to perform or that do not identify with the global ED practice are usually less visible and less keen to receive the handover.

- Majors: In an exit block shift, the care delivered in Majors has to be fast and cover all the needs of patients who are waiting several hours there. This entails that in addition to providing the acute care and treatment characteristic of an ED, nurses have to offer ward-based care like the use of hospital beds or feeding support.

Since Majors nurses are used to prioritising urgent techniques and treatment in opposition to basic patient care, the latter is often relegated. Also, the lack of HCAs in Majors (one per team maximum, being increasingly scarce since 2015) hinders dependent patients' care. If we add that the team loses a nurse every time a patient should be transferred to radiology or a hospital ward with an escort, nursing care in Majors cannot cover all patient needs in a crowded area.

Teamwork is essential to provide excellent care, but when Majors is crowded teamwork is hindered. As each nurse has his assigned patients, he prioritises his patients in opposition to others, creating a conflict when a nurse needs help from another one, since they do not know if they will receive reciprocal support or they will temporarily abandon their patients to help his colleague.

The lack of communication in the multidisciplinary team, which is especially noticeable in a crowded department, impoverishes clinical practice quality. Taking into account that handovers are not always given to the right nurse, doctors do not always communicate when the patient needs treatment and patients do not remember their nurse, so each person asks help to the first professional that they encounter, regardless of who is responsible for the patient.

This situation may lead to some professionals asking others looking for the nurse responsible for a specific patient, who may be on break or escorting a patient without anyone knowing or remembering. The lack of communication also affects other aspects such as patient location, breaks' distribution or checklists.

To prevent the persistence of the exit block, the nurse coordinator asks his nurses who patients are suitable to be transferred to the escalation area. These patients should be stable, be diagnosed, treated and have an action plan. To allow this, both the NIC and

the EPIC must ensure that the transfer is safe. However, patients who are transferred to the escalation area are not always those who need less care, so the nurse who is responsible for 10 patients in the escalation area has to allocate time efficiently if he wants to cover the basic needs for their patients.

During an exit block, duty managers try to find the greatest possible number of hospital beds for patients who need them. This means that if dozens of patients are waiting for a ward bed and dozens of ward beds are freed at the same time nurses responsible for patients who can be transferred must do so as a priority. However, many nurses have a dilemma when they have to prioritise the transfer of patients in opposition to their care.

Given that the nurse coordinator, the NIC and the duty manager will be pushing to transfer patients to the wards, documentation, treatment and care errors occur as patients are transferred as fast as possible, especially with junior nurses.

- Minors: The nurse coordinator's practice does not change per se, the only difference is the clinical workload, which has to be balanced to allow him to coordinate and deliver care.

- Resus: Patient care in Resus is not affected by clinical workload given the limited number of boxes and the large number of nurses, one for every two boxes. However, patient flow intensifies if there is an entry block in Resus; therefore nurses are under a higher clinical workload. Furthermore, more than one critical patient (like a cardiac arrest) at the same time can use all Resus resources. Nonetheless, since patient arrival is alerted through the red phone resources can be managed between the nurse coordinator and the NIC before the patient arrives.

In the situation in which Resus does not suffer an exit block but Assessment Bay does, Resus can help with the assessment of patients at the discretion of the Resus nurse coordinator. He takes into account the exit block of other areas but he must also reserve space for possible emergencies.

- Children's ED: Since there is no other area with paediatric nurses to reinforce and exit blocks are very rare, no significant changes are implemented when this area is crowded. However, global practice is very sensitive to team composition, depending

on whether nurses are paediatric, permanent and competent in triage and coordination.

Only a paediatric nurse can give intravenous medication or take blood samples from paediatric patients, although rules relax with adolescents with adult weight and height. Moreover, only permanent nurses can triage and coordinate in Children`s ED. This entails that if there are not many paediatric nurses who can coordinate and triage clinical workload will be unbalanced against them, since other nurses may only be capable of recording vital signs and performing simple care and treatments.

If the multidisciplinary team's competencies are not adequate or clinical workload is too high, Paediatric Majors patients are usually prioritised in opposition to patients in Paediatric Minors, since the latter do not need hourly observations because they are presupposed stable and are accompanied by a tutor. Once the sickest patients have been assessed and treated, patients in Minors are treated at the same time than patients in Majors, usually allocating a doctor and a nurse or HCA for each zone.

In rare cases, patients between 15 and 16 years old can follow the adult path if the clinical workload is very high. However, this does not usually happen because the proportion of critically ill patients is much lower than in adults, so exit blocks are much rarer.

### 6.2.5. Emergency protocol activated shift

The NIC evaluates the overall safety of patients continuously. If the general situation of the department is out of control, usually through a prolonged exit block, the NIC (with the support of senior hospital managers) can declare a major incident and activate the emergency protocol that this declaration entails.

A major incident is defined as: "Any occurrence that presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organizations" (473).

Although a major incident can be related to a catastrophe like a natural disaster or an epidemic, the most common major incidents are caused by the inability of ED to provide the minimum healthcare standards, usually due to a prolonged exit block. This type of major incident, also called ED incident, only affects the emergency department, even though it can spread throughout the hospital and cause a hospital incident.

If he decides, after evaluating the situation and discussing it with the multidisciplinary team and corresponding management positions, to declare an ED incident, the emergency protocol indicates the process to follow (474):

- An ED incident requires the same management structure as a major incident: ED Clinical Business Unit (CBU) Lead, ED Lead Nurse or Matron and ED CBU Manager, who form the control team. The control team is located in the office next to the waiting room, from where they lead the department. Moreover, this management structure can be increased by the on-call UHL senior manager.
- All staff will wear tabards or cards to facilitate the identification of their role.
- The extended control team will assess the situation and redistribute additional resources (including additional medical and nursing staff, medical transport services, hospital managers and on-call staff) from the rest of the hospital, if necessary.

For nurses, their practice should be the same with or without an activated emergency protocol. However, they are under a different leadership and suffering a very high clinical workload in a chaotic department, so care quality is lower than in a standard shift.

The nurse coordinators and the NIC must follow the guidelines from the extended control team while they lead the nurses. Since the expanded control team may have different priorities than the nurse coordinators, communication errors and contradictory orders characteristic of a crowded department hinder a uniformed leadership, so parts of the extended control team support nurse coordinators if required.

Multidisciplinary expert leadership and extra available resources will be present until the provision of healthcare services has been normalised. At that time, the ED incident will be cancelled and will be evaluated later.

Declaring an ED incident is not an easy decision, as the NIC and the management team cannot accurately forecast patient inflow or number of discharges, although they can make estimates based on their experience and the assessment of the situation by the duty manager. In addition, the consequences of ED incident activation are severe enough to be considered only as a last resort.

When activating an ED incident, by definition, it is assumed that the department's resources are not sufficient to provide minimum healthcare services at the moment while normally they are adequate. That is why it is considered a departmental resource management failure until proven otherwise.

This entails that every time that an ED incident is declared the emergency department is fined and investigated for its causes, assuming the NIC is responsible for any serious failure in resource management or leadership in the department.

The investigation of an ED incident, or any major incident, can lead to fines, legal action and reforms to prevent another major incident.

## 6.3. Working environment evolution

Being a three years clinical practice period, various changes that show the evolution of the department against its challenges have been perceived within it. Although changes in the LRI ED are frequent, the visit from the Care Quality Commission (CQC) in 2015 triggered an unusual number of changes and reforms focused on meeting the requirements demanded by the CQC.

The changes imposed and their effectiveness are a sign of a steady increment in clinical workload and how administrative and managerial staff redistribute resources to support this higher demand. There are other changes that are not totally under control of corporate members, being staff turnover is one of the most important.

### 6.3.1. Changes in nursing staff turnover

In English nursing practice is very common that nurses move frequently from one job to another for different reasons, since the large quantity of job offers permits it. This enriches nurses' experience and helps them balance work with family and social life, even though it hinders staff retention. This is most evident in EDs, where the clinical workload and practice difficulties do not encourage nurses to stay in a permanent position, less even if there is no economic incentive to do so.

An ED offers the acquisition of a wide range of technical skills and experience with acute patients in a short period of time, making it attractive to junior nurses. However, once they obtained experience and core competencies, and having suffered the winter clinical workload, many of them prefer to opt for other job positions. This dynamic creates a steady stream of junior nurses entering and senior nurses leaving, which hinders team dynamics.

Although nurses' turnover through the emergency department has happened for years, according to senior nurses, junior nurses' input has slowed and senior nurses' output has increased progressively from 2014 to 2016. This phenomenon is distributed throughout the year, although it is in winter when most nurses are planning to go and start looking for another job, mainly motivated by the winter clinical workload and erratic shifts. The

imbalance in the turnover of permanent nurses was mitigated by international nursing recruitment, but in 2016 the NMC added the score of 7 in the IELTS exam as an admission requirement, which impaired overseas recruitment.

As the number of nurses who hold a permanent position in the LRI ED fluctuates, temporary nurses cover those positions while more nurses are recruited. These temporary nurses enjoy flexible working hours and higher salary that permanent nurses do not have, thus many of the permanent nurses reduce their hours or resign their permanent positions for temporary contracts.

During the period 2014-2016, the inclusion of temporary nurses, mainly agency nurses, has increased periodically to cover the lack of permanent nurses. The large number of temporary nurses per shift, which was between 25% and 50% of total nursing staff during various stages of 2016, entails an economic burden for the department and a lower quality care overall. However, since mid-2015 several agency nurses worked regularly in the LRI ED, during which they have integrated into the nursing team and are capable of offering similar standards of care as permanent nurses.

In addition to the progressive increase of agency nurses, other nurses with new roles have been introduced within the department, working in it or collaborating with ED professionals:

- Cardiology specialist nurses were already present in 2014, but their number was increased during 2015, distributed between LRI and GGH. Their presence is especially necessary due to the distribution of hospitals in Leicester, since the cardiology department is located only in the GGH, so they are the only cardiology specialists' professionals regularly present in ED.

- Primary care coordinators (PCCs) are a resource that is considered part of EDU but has been introduced in ED since 2014 as their referral was added to the ED nursing documentation in 2015. Since they are a group of nurses that works both in the hospital setting and in the community they are not considered part of the ED nursing team by other nurses.

- Research nurses are not part of the nursing team, since they only appear when there is an active research project. This was apparent during the HALT-IT and CRASH-3

research projects in 2014 and 2015, when they tried to implicate nurses for recruiting subjects but they did not respond appropriately. In 2016, due to the absence of active research projects implicating ED nurses no research nurse was assigned to the department on a regular basis.

- The sepsis specialist nurse was introduced in 2016 to improve detection statistics and treatment of sepsis and septic shock cases. This nurse works in ED to support the multidisciplinary team in relation to sepsis cases. However, the existence of this position derives solely from the requirements imposed by CQC, so this role could disappear in the future.

The existence of job positions for nurses to progress professionally allows losing nurses in a job post and relocating them in another within the same department. When nurses have 3 years of experience they usually opt for a deputy sister post, which gives them access to most nursing job roles. However, posts are limited, so it is common for nurses who cannot get a deputy sister position in the LRI ED to seek it in another ED.

To improve staff retention, each nurse who resigned his position in the department should fill a questionnaire explaining their reasons for doing so, which are usually flexible working hours, salary, career progression or burnout. Moreover, in the case of overseas English nursing practice, language and culture clash are often persistent reasons.

Conclusively, the flow of permanent nurses in and out of the department has being unbalanced progressively since 2014 and has had to be covered with temporary nurses. This entails that senior nurses are focused on team coordination positions and junior and agency nurses deliver clinical care.

### 6.3.2. Material resource distribution

Material resources or lack thereof is one of the main catalysts of nursing practice, since it must adapt to the available resources and use them appropriately. In a developed country, in which the basic materials resources are usually available, is the use of the department's area one of the most difficult resources to manage if the department is

usually crowded. To solve this, several changes have been implemented in the period 2014-2016 to make efficient use of space, which allows offering quality care to more people:

- The number of boxes has expanded gradually, changing the arrangement of the useful space in the building, either by creating new functional space or changing an existing usable space. In the period 2014-2016, Assessment Bay was expanded from 5 boxes to 7 (6 and a room for isolated patients), Majors had an extra box (from 15 to 16) by repurposing half of the seating area and Resus went from 6 to 8 boxes after several structural reforms. Minors and Children's ED had the same number of boxes because they did not needed more.
- During the first six months of 2014, seeing stretchers in Majors which were not in a box was unusual. However, after that period patients were placed in the middle area of Majors waiting for assessment, diagnosis or treatment. Since the patients who were placed in that middle area could not be reached and was unsafe, in 2015 this space was regulated into 5 demarcated stretcher parking areas. Furthermore, in 2016 4 boxes and 4 stretchers parking areas were fitted in a corridor, which could be isolated from the public, to endure the increased clinical workload.
- In 2014, all areas with patients were contained within the department. However, in 2016 ED was expanded and acquired the area from the deep venous thrombosis and the transient ischemic attack clinics, which were located next to the EDU corridor, to transfer Minors there and expand Majors where Minors used to be. During 2016 they were testing possible uses for the old Minors, starting as an escalation area, which later was staffed with a doctor and received the most stable patients for Majors, being renamed as Majors Yellow. In the last quarter of 2016, pilot tests were run in which an outpatient clinic was organized in Majors Yellow, but there was no established use for that area when the clinical practice reflection period ended.

The opening of the new ED building was planned by April 2017, which involved some changes. However, this event is located outside the clinical practice study period, so it will not be included in this section.

Regarding the single-use material resources, how they were organised was briefly explained through the checklists. These lists were expanded throughout the department during 2014, since previously they were only focused on Resus, according to senior nurses. Nonetheless, there are several details regarding material resources that have not been previously explained and put LRI ED nursing practice into context:

- Medication was stored mostly in medication automatic dispensers protected by fingerprint identification, which were located in Resus, Minors and Children's ED in 2014. Another one was added in Majors in 2015 to avoid wasting time getting medication from Resus. However, these dispensers cannot be used by nurses with temporary contracts, so they had to ask a permanent nurse for any medication.

There were also code locked cabinets in most areas containing the required medication and fridges in Resus and Children's ED for storing temperature-sensitive medication. At the last quarter of 2014, the Majors fridge was removed because it was not used.

Finally, there was medication that for various reasons must be inside a strictly monitored closed cabinet locked with two different keys, which are called controlled drugs. There was a controlled drugs cabinet in all areas apart from Assessment Bay.

- Sharps containers were present in each box in ED, excluding the Majors red team boxes and Paediatric Minors zone. In addition, there were portable small sharps containers throughout the department. Their use was not limited to sharp objects such as needles or empty blisters, but the sharps policy dictates that they should also be used to put syringes and intravenous lines.

- Using as a basis the specific procedure packs, between the last quarter of 2014 and the first quarter of 2015 packs for sepsis treatment, administration of N-acetylcysteine and iliac fascia nerve blocks were created. These were intended to manage various conditions more efficiently, although the only pack that was used frequently was the iliac fascia block, which was only used by doctors.

- To replace all fungible materials, ED had a stock deposit. It was closed under code lock during 2014, but other departments came down to ED and took material without following the appropriate procedures, hence ED could not reconcile their financial history. This was fixed in 2015, when they put a lock that only opened

using a chip, which was expensive to reproduce, so only nurse coordinators and support workers had it.

Regarding who managed and stocked material, since 2014 there was personnel responsible for managing material stocking, among other tasks. Additionally, support workers, which have among their tasks replenishing material in the department, were introduced in 2016.

- Non-fungible material like infusion pumps, cardiac monitors or portable ventilators could move with the patient when he was transferred to another area or hospital, even though it was the transfer nurse's responsibility to bring back any equipment. This situation created conflicts between the ED nurse and the ward nurse receiving the patient, since there could not be extra equipment available to swap it with the ED one.

  Therefore, during the 2014-2016 period ED had agreed policies with the different departments through which conflicts were avoided, so while in 2014 asking for an infusion pump back could create a conflict, in 2016 most departments that receive patients from ED knew the regulations regarding the equipment transferred with the patient.

### 6.3.3. Work dynamics evolution

The need to adapt to public demands and regulatory organisations' requisites implies that practice must constantly change to find the adequate way to care for patients in the context in which they are. Since the LRI ED has undergone progressively increased clinical workload in the period 2014-2016, many changes to try to mitigate its consequences were applied. These changes were more abrupt and definitive after the CQC visit in the last quarter of 2015 and its report in 2016, which demanded reforms in various aspects of clinical practice.

One of the earliest changes that were applied in the 2014-2016 period was to remove the team leader role in Majors and make each Majors nurse responsible for a number of patients. Before the change in 2014, Majors nursing teams were formed by a team

leader and two nurses per team, both coordinated by the nurse coordinator. The team leader was responsible for the patients in their team (red or blue) and for assigning tasks to the other two nurses to care for patients efficiently. In addition, he coordinated breaks and checklist implementation. However, due to the difficulties involved in managing human resources and clinical practice simultaneously a patient allocation model was implemented.

In the model implemented in 2014, the nurse coordinator assigned patients to a nurse in a team, trying to balance clinical workload evenly. Each nurse was responsible for his patients and their care, but he was also part of a team of three nurses working together when necessary. This change facilitated the identification of the nurse that was responsible for a patient and implemented a fairer clinical workload sharing system. Nevertheless, it also brought new problems such as the practical responsibility void during breaks or teamwork deterioration.

After the change, and until the end of the clinical practice study period, the Majors team leader figure still existed even though the role was discarded. Some nurse coordinators, especially the older ones, expected that the most experienced team member (who used to be the team leader) solved problems in his team even if they were not linked to his patients.

A common problem that nurse coordinators prioritised is discharges, which requires a minimum knowledge of the patient's condition and several minutes to complete and photocopy documentation. Therefore, the most experienced nurse in a Majors team is subjected to higher clinical workload than other nurses in their team, especially temporary nurses with no previous experience in the department, since he must care for his patients and cover his colleagues' main outstanding tasks. This fact, together with the monotony of Majors' practice, pushes senior nurses to avoid Majors if possible, so it is usually staffed by temporary nurses and junior nurses.

The area that has undergone more changes in its work dynamics in the period 2014-2016 has been Assessment Bay, mainly to avoid the bottleneck effect. Although changes were made gradually and have already been explained above, it is worth pointing out the constant addition of new policies in clinical practice. As changes

occurred regularly, not all nurses could adapt their practice to these changes, a fact that was more obvious just after the nurse coordinator role change in 2015.

As an entrance for patients to the hospital, ED is one of the most appropriate departments to implement policies and conduct research in acute patients. Therefore, various departments inside and outside the hospital designed policies and recruited subjects in ED. However, there was an evolution regarding nursing integration in these changes.

During 2014 and most of 2015, applicable policies and research did not involve nurses in an active way, and when they did they did not have in mind the clinical workload that they suffered. This led to most nurses ignoring them and not getting involved because it was not a main part of their clinical practice. However, during 2016, new policies for the management of sepsis, acute renal failure or confusion took into account nursing work dynamics using methods that were easily integrated into clinical practice, so they were more successful. It has to be considered that the implementation of multiple policies simultaneously over 2016 downplayed the success of most policies in favour of the sepsis six policy.

After the Minors location change during 2016, ED had an area of 10 boxes without any specific function. When the Majors Yellow test period started, patient flow from Assessment Bay changed, since stable ambulatory patients could be derived to that area, reducing Majors' clinical workload. Due to the high percentage of discharge patients from Majors Yellow, ambulatory patient flow accelerated, thereby reducing waiting time for these patients.

Nevertheless, a nurse, an HCA and a doctor were needed to allow the efficient function of Majors Yellow. Given the chronic lack of healthcare personnel, the staff redeployment that allowed the use of Majors Yellow extracted human resources from the rest of the department. This contributed to the use of that area between the function of Majors Yellow and an escalation area.

During the period 2014-2016, an increasing amount of documentation that nurses should fill was observed. In 2014 and 2015, nursing documentation was divided into different individual pages, facilitating losing them. To solve this, in 2016 the nursing

booklet was created, a compendium of the documentation commonly used by nurses. Although access to all nursing documentation together was provided, the number of forms to fill was also increased. Added forms recorded various topics such as the risk of falls, risk of contagious infection manifested through vomiting and diarrhoea or risk of developing pressure sores.

Not only forms were added, but the nursing booklet also contained a body map, the primary and secondary assessments, physiological and neurological observations, fluid balance, mental capacity assessment, hourly rounds, discharge checklist and general nursing documentation. Being an expected requirement for each nurse to complete the nursing booklet (although some parts may not apply to all patients), time spent on documentation increased, thus reducing the time spent on clinical practice.

At the same time, after the implementation of the nursing booklet, nursing documentation and completion of all its parts were more strictly controlled. Documentation checks were conducted every shift in Majors and twice a week throughout the department. This change in the firmness of the nursing booklet's completion is linked to several objectives imposed by CQC in the last quarter of 2015.

CQC was responsible for assessing UHL healthcare service quality, but they paid special attention to ED. Not only they made a surprise visit to ED before starting a formal evaluation of the hospital but also devoted more staff for longer to evaluate ED compared to other LRI departments. Changes, recommendations and objectives resulting from that evaluation were a turning point in ED clinical practice, which underwent several sudden changes:

- CQC indicated that patients took more than 15 minutes to be triaged, so handover reception was implemented after the patient entered Assessment Bay instead of waiting for the patient's triage turn. This involved that a skilled professional (nurse, doctor or paramedic) triaged the patient and gave him a priority, even if he had to wait to receive a secondary assessment. This process is much faster and allowed an increment of the percentage of patients triaged in 15 minutes, although the percentage of patients assessed in 15 minutes was the same.

- Children's ED patients were not being triaged in less than 15 minutes, but work dynamics and fewer nurses in Children's ED prevented that they could accomplish this goal. To solve this problem, a nurse was assigned from noon until midnight to triage all patients while they were admitted into the computer system by the administrator. Between midnight and noon the nurse coordinator was responsible for triaging patients, since the lower clinical workload allowed him to do so.

- According to the active version of the sepsis six policy in the last quarter of 2015, a high percentage of sepsis cases were not treated in the first hour in ED. This national standard was punctuated by CQC, which forced the corporate team to show statistics regarding the treatment of patients with sepsis each week so CQC could evaluate them. To address this situation, the treatment of sepsis patients under the sepsis six policy was prioritised, taking blood samples and administering medication in Assessment Bay. Furthermore, during the second half of 2016 the sepsis specialist nurse was implemented, who would help with the care and management of septic patients.

- The need to document hospital and community-acquired pressure ulcers through the body map to monitor them and send the result to CQC was reinforced. This implied that all patients who will score 2 or more in the Anderson/Andersen scale (475) (a tool aimed at predicting the risk of developing pressure ulcers, not to the evaluation of present pressure ulcers) should be assessed if they had or could develop pressure ulcers.

- During the surprise visit from CQC, inspectors noticed that breaks used to coincide with the busiest hours in some shifts. To avoid this, they proposed eliminating the discretionary breaks and forward the other breaks from 10 am to 12 and 3 pm to 5 pm.

Nonetheless, this change lasted only two months, since the elimination of a break and changing meal times worsened staff morale, reduced productivity and created discontent with management staff. After several discussions and meetings, breaks came back to the 2014-2015 model, but the discretionary break was given an educational use to through short talks on important issues.

- One of the problems for which CQC asked solutions for was the lack of skilled personnel in nurse coordination positions and inadequate distribution of competencies throughout the department. This problem was present since 2014, but was aggravated during the period 2014-2015 due to the greatest clinical workload and poor retention. To fix this, UHL increased funding to recruit nurses, more deputy sister jobs were offered and a group of agency nurses was created to cover staff shortages.

These reforms facilitated the efficient functioning of ED for a while but favoured the migration of the most competent professional to Assessment Bay and Resus while Majors was covered by junior or agency nurses who had not extensive experience in the department. Moreover, it made it difficult for senior nurses to gain experience in team management, coordinating areas only during breaks.

## 6.4. Customs and general routines

Clinical practice has always been led by a series of rituals that characterise it, some forged through custom and tradition, others implemented in the pursuit of efficiency. These define aspects of practice are not obvious to the naked eye, since they are dependent on the environment where they happen.

Several of these rituals reflect decisions that nurses have to do during their clinical practice and how they use different ethical, legal, professional and personal factors to create a solid foundation to justify their reasoning.

### 6.4.1. Patient handover and transfer

In the LRI ED, various types of handovers are performed, which involve several people in different situations. In addition, during the patient`s stay he can be moved to various hospital zones and transferred to a ward if the patient is not discharged home.

#### 6.4.1.1. First handover of the shift

Once nurses have been assigned to their working area, they go to take over from their previous shift's colleagues. In theory, handovers should be done in the same way in all areas: identify patients, offer a handover based in the communication model SBAR (situation, background, assessment and recommendations) and greet each patient to know them physically. In the case of nurse coordinators, they receive a handover of the whole area and any pending tasks, while the NIC receives a general handover from all areas.

Nonetheless, handovers are not usually like this. The communication model is individual, pointing out information that the nurse who ends his shift considers important and changing the handover according to the information needed by the new shift's nurse. Communication also depends on the relationship between the two nurses, their experience and the patient's clinical status. Moreover, this handover is different in

relation to the area in which is done, since each area presents different types of patients at different stages of their passage through ED:

- Assessment Bay: The new shift's nurse coordinator, after receiving his handover, he assigns each nursing team to a box. If within that box there is a patient being assessed by another team from the previous shift, the latter will give the handover to the new nursing team, which usually consists of a brief explanation of the patient's condition followed by the pending tasks in his assessment.

If the patient has already been assessed when the new team arrives, the handover is not usually done unless the previous shift's team believes there is a reason for it. Also, nursing teams try to transfer their patients to another area if they have completed the assessment, even if this difficult completing their shift on time.

- Majors: In order to receive patients, the nurses should present themselves as part of the new shift's red or blue team to receive patients from a previous shift on the same team. The handover is usually very general and it is not customary to greet patients, unless the nurse coordinator requires it or the department is crowded. This handover is carried out in the central area of Majors, so confidentiality can be violated accidentally during the handover.
- Minors: As the only nurse is the nurse coordinator, he receives only basic information about each patient and the area situation. Additionally, there is a handover between the day and night shifts, since Minors closes at 2 am.
- Resus: Every allocated nurse from the new shift follows both nurse coordinators and receives a general handover of each patient and his action plan, if there is any. After that, the nurse coordinator distributes patients among the available new shift's nurses, who go to each box to receive a more detailed handover by the previous shift's nurses. Since they received a handover inside the boxes and listen to the general one, all nurses saw their patients and received two handovers, one general one by the previous shift's nurse coordinator and a more detailed one by the nurse who was in charge of the patient.
- Children's ED: A general handover is shared with all nurses from the previous and the new shift, when the previous shift's nurse coordinator explains briefly the situation and the action plan for each patient.

In most handovers, regardless of the area, there is a special attention to detail when the patient suffered an accident in the department, being that a fall, wrong medication administration, attempted suicide, etc. Several nurses relate details from these situations with legal and professional repercussions derived from their Duty of Care.

Once the handover has been given, the previous shift's nurses have to ensure that the checklists are completed and wait for the NIC's announcement to finish their shift. This is the reason why the department has too much staff for 15 minutes, of whom half were engaged in talking to each other waiting for the end of their shift. This situation, misinterpreted by patients, generated complaints that end up forcing nurses to wait to the end of their shift in the hallway since 2016.

#### 6.4.1.2. Handover between nurses in different areas

During the patient journey through the department, several nurses take care of him in several areas. To facilitate the continuity of care, when the patient is moved from one area to another the nurse from the previous area handovers to the nurse from the receiving area. These handovers and their tasks are different depending on the areas involved, so it is necessary to explain them separately.

- Assessment Bay – Majors: The most frequent handover, it occurs once the Majors nurse coordinator decides who will care for the patient. After that, the patient is transferred to Majors and the Assessment Bay nurse looks for the allocated Majors nurse. According to various factors like clinical workload or predisposition to receive handovers, the Assessment Bay nurse can take between 5 and 20 minutes to finish his handover.

- Assessment Bay – Resus: Once the patient has been discussed with the Resus nurse coordinator and the Resus doctor in charge and both agree that the patient should be treated there, the Assessment Bay nurse moves the patient to the box assigned by the Resus nurse coordinator. After that, the Resus nurse chosen by his nurse coordinator will receive the handover after the patient is connected to the cardiac monitor. Moreover, depending on the patient acuteness and the resources in each area, both nurses can work together for a short period of time.

- Assessment bay – Minors: When a patient is identified valid for treatment in Minors, the Assessment Bay nurse describes the patient's clinical condition (by phone or in person) to the Minors nurse and ask if the Minors team is capable of caring for the patient. If he agrees, the patient will be transferred to Minors without any handover, since a suitable patient for Minors can wait without any health deterioration.

- Assessment bay – Majors Yellow: Since Majors Yellow was introduced, it has been used to accelerate the flow of stable ambulatory patients. Once the nurse or doctor identifies the patient as an ambulatory patient with a low severity disease, the process is the same as in Minors: Majors Yellow approval, after which the patient is transferred to the area without a subsequent handover.

- Majors – Resus: If a Majors patient deteriorates until it is considered an emergency, both the doctor and the nurse caring for the patient should discuss the patient's condition with the Resus nurse coordinator and the Resus doctor in charge. If the conclusion of that discussion is that the patient needs to be continuously monitored, he will be transferred to Resus, where the nurse who was responsible for the patient gives an exhaustive handover to the Resus nurse.

There are two exceptions to the responsibility transfer for the aforementioned patient. The first one is when the patient is only going to be sedated safely in Resus to reposition and immobilise a displaced fracture or dislocation. No nurse is usually responsible for the patient before the intervention is done (as he is stable), there is no handover and the nurse who assists the intervention is only responsible for the patient during and just after that intervention. Once the patient is conscious, he is transferred to radiology and to Minors after radiological tests.

The last exception applies to critical emergencies like cardiac arrest, status epilepticus or anaphylactic shock, in which timing is key for patient survival. In this case, senior doctors and nurses will manage the patient in Majors while another healthcare professional works with Resus staff to create a free space in Resus. When the patient has been transferred to Resus and is being treated, Majors doctor and nurse will hand over to their corresponding colleagues in Resus.

- Minors – Majors: This handover only occurs when a patient has been wrongly sent to Minors, either through reception or UCC. When a patient of this type is identified by one of the ENPs while he is assessed, the Minors nurse coordinator notifies the Majors nurse coordinator of the error and ask for a space in that area and a nurse who can be responsible for the patient. Once identified, the Majors nurse receives the handover from the Minors nurse coordinator or directly from the ENP.

- Minors – Resus: In extreme cases, patients who seemed stable have deteriorated while they waited their turn at Minors or the possibility of internal injuries was ignored when transferring the patient to Minors. This usually happens with ambulatory patients that are derived from reception to Minors, even though it also occurred with patients from UCC or Assessment Bay.

If the ENP believes that the patient who is assessing suffers an emergency pathology, he should contact the Resus nurse coordinator and the Resus doctor in charge and argue the reasons why he believes his patient's condition is an emergency. In the event that all agree that the patient needs immediate attention, he will be transferred to Resus and the ENP will give the handover to the assigned Resus nurse.

- Resus – Majors: Sometimes patients that do not suffer critical diseases are transferred to Resus. Usually, this happens because paramedics overestimate the seriousness of the situation or because the clinical workload in Assessment Bay is much higher than in Resus and the latter takes some patients to balance it and accelerate patient flow. Once the patient has been assessed and received initial treatment, if he is stable he can be transferred to Majors in order to make room for new patients.

To do so, the Resus nurse coordinator has to ask the Majors nurse coordinator for a free box, and once a box is freed the nurse responsible for the patient will hand over to the Majors nurse assigned by the Majors nurse coordinator. This handover is usually brief, since Resus nurses should not neglect their patients for long periods of time.

There is another reason why a patient is transferred from Resus to Majors, which is related to Resus limited capacity. When Resus has all its boxes occupied and receives an alert of an incoming critical patient, the nurse coordinator and the doctor in charge

should make the decision about which patient is "less acutely ill", so he is chosen to be transferred to Majors. In this situation, both the Majors nurse coordinator and the NIC should have been alerted when there was only one free box, so they have enough time to free a box in Majors. Once the "less acutely ill" patient is transferred to Majors, the Resus nurse gives an exhaustive handover to the allocated Majors nurse, since even the most stable Resus patient is still a patient suffering from a serious condition.

- Resus – Children's ED: Like with adult patients, paediatric patients can also go directly to Resus if their situation is critical. Once he is stabilised, the paediatric nurse and the paediatrician can transfer the patient to Children`s ED if they deem it appropriate. As a paediatric nurse escorts the patient and continues his care in Children's ED no handover is necessary, even though the Children's ED nurse coordinator is usually informed to avoid confusion.

- Children's ED – Resus: There are cases where parents underestimate the severity of the disease that afflicts their children, so if during triage an emergency pathology is detected, the patient should be transferred to Resus as soon as possible. While the Children's ED nurse coordinator discuss with the Resus nurse coordinator the release of a box for the new critical patient, the nurse who has triaged the patient (assisted by other doctors and nurses) attends the patient in room 4, which is equipped to deal with emergencies.

Once a box in Resus has been freed (normally box 1, since it has most of the paediatric equipment), a paediatric nurse and a paediatrician go with the patient to Resus. As both of them will care for and treat the patient, no handover is required.

- Paediatric Triage – Children's ED: Unlike with adult patients, there is no direct handover between the triage nurse and the other nurses, they leave the documentation on the corresponding shelf and the other nurses will review it when necessary. However, if the patient needs urgent treatment or diagnosis, the triage nurse notifies the nurse coordinator to prioritise these tasks.

Patient transfers from one area to another, especially when there are several transfers, break the continuity of care and stress the patient who does not understand why he is driven from one side to another. Adequate communication with the patient reduces

stress from the transfer, but the continuous handovers between different nurses can lead to information misinterpretation and clinical errors, adding more stress and insecurity to the patient. That is why the nurse takes into account both oral handover information and written documentation to contextualise patient care.

All handovers follow a structure based primarily on experience, even though there are some based on policies like Resus to Majors handovers. That is why most transfers between areas, particularly when ED is crowded, are resolved through discussion. In these discussions, the referring nurse tries to convince the nurse coordinator of the receiving area to accept the patient. Depending on the context, medical history, current condition, vital signs and diagnostic tests results can be used to argue transfer urgency.

These discussions are based on the nurse demanding the right area for his patient, since the nurse seeks the best treatment for his patient. In other words, the nurse transferred the patient "for his own good" based on the beneficence principle. However, the justice principle is above beneficence, since nurse coordinators must reason transfers based on all patients in ED, not only those in his area.

Despite the above, there are exceptions where patients are transferred to where they should not be for clinical reasons when there are other more important reasons. One of the most common situations is when Resus do not have free boxes and none of the patients there is stable enough to be transferred to Majors. In this case, patients suffering from serious diseases such as sepsis or stroke are assessed and treated in Assessment Bay, even though policies, and therefore the Law, say otherwise. It is the use of critical thinking based on experience which allows senior nurses and doctors to efficiently manage human and material resources, so more patients can be cared for meeting the highest quality standards. Nevertheless, this fact limits junior professionals' decision making, for which they have to rely on their colleagues' advice.

#### 6.4.1.3. Handover between nurses in the same area

In several situations during the course of a shift, nurses cannot receive the handover of their patients because they are not available. Although the most common cause for this is to be on their break, acts like patient transfers to the ward or the radiology department can also prevent a nurse to remain in his area for a period of time. Moreover, there is a disposition to receive the handover, which is individual and can be modified based on clinical workload, experience and nursing integration in the multidisciplinary team.

In theory, if the nurse who should receive the handover is not available, another nurse from the same area will receive it and give it back to the appropriate nurse when he is available. However, in practice it does not happen this way. A high percentage of handovers received by other nurses are not reported to the nurse responsible for the patient, and if so part of the message is usually lost. That's why the nurse, once he is available and observes on the computer system that he has a patient that he does not know, he often consults patient documentation before his colleagues for information about that patient.

Another example of a handover between nurses in the same area is when one of them has to go to his break, giving a temporal handover to his colleagues to care for their patients in his absence. However, not only there are very brief and general handovers, but the fact that a nurse handovers to a fellow nurse does not guarantee that his patients will be cared for. This concept is based solely on reciprocity, since the colleague will also need to go on his break and wants his patients to be cared for. This entails that when a nurse comes back from his break he has to discover what happened to his patients to resume his practice, either by fellow nurses or clinical documentation.

These situations present a problem not only in communication but also in balancing clinical workload and responsibility. It must take into account that while a nurse is not physically located in the department and has given a handover to a fellow nurse his patients are no longer his responsibility until he returns. However, the nurse who receives the handover doubles his clinical workload, thus he should prioritise the care he considers most important. What has been noticed is that most nurses ignore patients who are not assigned to them, even though this custom is less common in senior nurses or with critical patients and more common with agency nurses hired sporadically.

Despite the controversy, it may be that a percentage of patients do not receive care for a period of time, which in theory is legally and deontologically acceptable. The nurse who takes over is not able to care for all patients at the same time, so he prioritises tasks that he considers essential, which in most cases are only those of his patients.

Neither the NMC nor English Law can punish a nurse for not caring for more patients than he can cover, since that is the employer's fault, not the nurse's. Moreover, a nurse only has legal responsibility for patients who are assigned to him because break and transfer handovers are not usually documented.

Nevertheless, the most experienced nurses often organise their tasks according to their objective priority, not considering who his patient is and who is not. This, besides being a sign of fellowship and good practice, depends on the unintentional application of bioethical principles (non-maleficence, beneficence and justice) in clinical practice based on their previous experience.

An extension of the bioethical principles' unintentional application is the willingness to receive handovers, especially from other areas. All nurses know how patient flow through the department works and the consequences of keeping a nurse from another area waiting to hand over his patient. However, only some nurses are able to match the needs of their patients with those of others, realising that time employed by a nurse waiting for a handover is not utilised caring for his patients.

#### 6.4.1.4. Transfers outside ED

The LRI ED, even if it contains the necessary professionals and equipment commonly used in an emergency, cannot encompass all the equipment and professionals that each patient needs. Also, patients who have to be observed or cared for a long period of time should not stay in ED, since it would slow down patient flow. That is one of the reasons why patients can be temporarily or permanently transferred from the department. This in itself is not a problem, but if the patient needs an escort clinical workload distribution can be unbalanced and there is a potential risk to other patients.

A large percentage of patients who are transferred from ED are stable and have intact cognitive abilities, so they do not need an escort. In these cases, patients who are temporarily transferred can go only with the porter, while for permanent transfers the porter needs a handover written by the nurse with the photocopied clinical documentation. However, there are exceptions when the nurse should accompany the patient:

- Patient receiving oxygen
- Patient under spinal immobilisation
- Very long distances, over 15 minutes walking distance (maternity, gynaecology and oncology)
- Confused or unconscious patient
- Cardiac monitored patient
- Patient younger than 16 years old
- Unstable patient, commonly assessed by vital signs
- High risk past medical history or hyper-acute diagnosis

Although in some cases the patient may be accompanied by an HCA if one is available (as in the case of stable patients receiving oxygen or slightly confused patients), often is the nurse responsible for the patient who has to escort him. These transfers usually last between 15 and 60 minutes, during which the nurse has to hand over his patients to a colleague to devote exclusively to the transferred patient. Given that the amount of transfers that a nurse has to do is very variable depending on patient flow and the needs of his patients, clinical workload can be very unbalanced if a nurse does most of the transfers.

The dilemma that arises from this situation is that it is the nurse who decides, based on the exceptions noted above, if the patient needs to be escorted by him or not. Furthermore, it is the same nurse who must transfer the patient to the hospital bed, look for the nurse to hand over, hand over the patient and return to the department. Several nurses, especially agency nurses, benefit from their ability to choose who to escort, not only accompanying patients who could go alone but also taking breaks and excusing them as transfer time. This practice has been observed dozens of times by different

nurses, but due to transfers not being strictly monitored a solution to this problem has not been found.

The fact of using patient transfer policy improperly is convicted by most nurses, especially when clinical workload is high. These nurses understood through experience that is neither fair nor safe that a nurse dumps his clinical workload onto another one through continuous transfers. Therefore, the abuse of the transfer policy is unethical, since it conflicts with the principles of justice towards their colleagues and non-maleficence towards their patients, who are continually delegated to other nurses. Nonetheless, it is not against the Law or the *NMC Code* if the nurse is able to argue it adequately.

On the other hand, they have also been cases where the nurse had to argue with managers to delay a transfer because the patient was not stable enough to handle it safely. Since managers, despite having minimal clinical notions, are not usually healthcare professionals they tend to underestimate the risks involved in transferring patients. Because of this, the nurse should argue the reasons for the transfer delay against the manager.

Nevertheless, even if reasons to not transfer the patient are valid, several managers have used their hierarchical influence against the NIC to annul the decision taken by the registered nurse, thus transferring the patient despite the risks associated with it. This practice was reduced as crowding became a common phenomenon during 2015, mainly due to the consequences of transfer risks worsening the prognosis of several patients. That is why during 2016 an increased consistency in decisions made by nurses, especially senior ones, and a considerable decrease in the number of high-risk transfers was observed.

Given the structure of hospitals in UHL, sometimes a patient must be transferred to another hospital for treatment in the corresponding specialty. The most common destinations are the GGH and the LGH, even though severe traumas with multiple injuries are transferred to Queen's Medical Centre (QMC) in Nottingham and serious burns to Birmingham burns unit.

These patients are usually transferred by paramedics, technicians or ECAs, but rarely very unstable patients or those with special needs (non-invasive ventilation, intravenous medication through infusion pump, etc.) must also have a senior nurse escort. Once the nurse ends the transfer, he must return to the LRI in another ambulance or taxi, so a transfer can take several hours. That is why these nurse escorted transfers are very rare, and when they are needed they are usually carried out by one of the clinical duty managers (who usually have a nursing background) so the department does not lose a nurse for a long period of time.

### 6.4.2. Formal and informal meetings

To allow healthcare professionals to communicate with each other effectively, they usually meet in different situations to discuss various issues, avoiding the message degradation generated by passing it from one person to another. This ritual, though simple in theory, facilitates quick and effective multidisciplinary work and joint decisions, which are essential to maintaining patient flow through ED.

Nevertheless, not all nurse meetings are only related to current clinical practice, but there are sessions to discuss important issues for future practice, to consider problems that arise between different hierarchical scales and to share opinions and experiences, among others.

#### 6.4.2.1. First meeting of the shift

Before starting the shift, it is expected that nurses and HCAs meet in the seminar room. Once there, the new shift's NIC will pass a sheet with the staff distribution in the department for that shift, where professionals will tick next to their name, symbolising that are present. Meanwhile, the previous shift's NIC reads news from the Red Book.

The Red Book is a red file that contains important information that should be known by all healthcare professionals working at the LRI ED. This information usually comes from the sisters, matrons or medical consultants, although any professional who wants to communicate something relevant to everyone else can. Among the most frequent

topics there are common problems in practice, introduction of new policies or equipment, Datix (complaints) of the week and national or CQC and CQUIN statistics.

Once he has read Red Book's recent issues, the previous shift's NIC provides an overview of the department's situation: number of patients in each area, minutes to wait for medical examination and ward available capacity. After that, nurses and HCAs are directed to their assigned areas while both shifts NICs have a more detailed conversation about the state of the apartment, the most important events that have occurred in the previous shift and problems to be solved by the new shift. Also, at that time is when any error in staff distribution throughout the department is rectified.

#### 6.4.2.2. Multidisciplinary meetings

During daily practice, healthcare professionals have to work together to provide quality care. However, communication between healthcare professionals from different fields must overcome differences in knowledge, functions and objectives within the ED. To solve these issue, periodic multidisciplinary meetings were implemented in various areas between the last quarter of 2014 and the first quarter of 2015, even though they previously occurred sporadically if the nurse coordinator and the doctor in charge of the area considered it appropriate.

- Assessment Bay: Given the characteristic work dynamics in this area, multidisciplinary meetings, commonly between the doctor in charge of the area and the nurse coordinator, were reserved for entry block situations. In these cases, both argued about patient safety in the area, their care plans, distribution of personnel in the area, the severity of patients waiting in ambulances and possible solutions to restore patient flow.

- Majors: In this area it is where multidisciplinary meetings are more frequent and stricter. In theory, every two hours the Majors nurse coordinator and the Majors doctor in charge should meet with all the Majors doctors and nurses and discuss every care plan individually. However, this method consumes most of the human resources available for several minutes every two hours, so this rule was not followed strictly. Some nurse coordinators discussed only with the doctor in charge

of the area, while others carried only two to four multidisciplinary meetings every 12 hours.

Despite being considered multidisciplinary meetings, nursing participation declined gradually since the third quarter of 2015. The increase in clinical workload precipitated a decline in the interest of nurses in the progression of other patients who were not their responsibility, so the only nursing representation was the Majors nurse coordinator. This hampered handovers among Majors nurses and put more pressure on the nurse coordinator, who should monitor all care plans for all patients in his area.

- Minors: Since there is not a specific Minors doctor in charge, the nurse coordinator has no need for multidisciplinary meetings. Normally the ENPs assess patients and do not contribute to the management of the area, turning this task to the nurse coordinator. Nevertheless, he can bring the ENPs together to seek care plans and solutions to emergency issues, especially in entry or exit block.

- Resus: The communication between the Resus doctor in charge and the Resus nurse coordinator must be continuous in order to maintain patient flow, so multidisciplinary meetings are less common than in Majors. At these meetings all doctors and nurses, staff in charge of the area included, will discuss the care plan for each patient.

At least two meetings are held per shift, one when the new shift's nurses arrive and another when the new shift's doctors arrive. However, more can be organised if the area suffers increased patient flow or transferring patients to Majors has to be considered due to lack of capacity.

- Children's ED: When the nurse coordinator considers it appropriate, he brings all doctors and nurses together, except the triage nurse, to discuss care plans for all patients and solutions to emergency issues. These meetings occur at least once per shift during the first handover of the shift, even though they may happen more often if the nurse coordinator or the doctor in charge of the area deems it necessary.

Unlike other areas, Children's ED does not always have a senior doctor experienced in the field, in this case a paediatrician. Therefore, if there is no skilled practitioner present is usually the EPIC who oversees area management remotely working with the nurse

coordinator. However, multidisciplinary meetings do not include him, since he is responsible for the entire department.

Despite the rules imposed from 2015, the nurse coordinator and the doctor in charge of the area reserve the right to choose the meeting frequency depending on the state of the area and in favour of an appropriate use of human resources. While throughout 2015 this right was exercised rarely, from 2016 a tendency to restrict multidisciplinary meetings to dedicate more time to clinical practice was observed.

There are other situations in which a multidisciplinary team meets in the ED, but these are only connected with clinical practice indirectly. These meetings often require supervisors from various disciplines to address clinical management issues like complaints' handling, resolution of institutional problems or departmental resource organisation.

#### 6.4.2.3. Nurse coordinators' meetings

The nurses with advance responsibility roles that continue to be involved in clinical nursing practice are, except in isolated cases, only deputy sisters and sisters. They are in a privileged position, in which they can see the problems inside ED and have the knowledge, influence and rank necessary to solve them. Therefore, the adequate topic organisation and consensus on decisions taken as a group are essential to represent nurses adequately against managers from different hospital departments.

Among the measures taken to facilitate communication between them are the sisters' meetings, a weekly meeting between several sisters and deputy sisters that discuss and reach conclusions, which are then shared with the nursing team via internal e-mail. At these meetings discussion and brainstorming for solutions are promoted, even if some of them are dedicated to important or restricted information distribution.

#### 6.4.2.4. Occasional meetings during breaks

Although most nursing staff meetings are planned, or at least follow a pattern based on routine, others are sporadic. The most common example is informal gatherings in the staff room during breaks.

In these, nurses discuss personal and professional issues, offering emotional support in extreme situations, sharing experiences and professional knowledge, strengthening links within the nursing team and assessing different approaches in complex decision-making. Even if these gatherings are inconsistent over time and do not follow any predetermined structure, they can facilitate discussion and reflection on legal, ethical and bioethical clinical practice issues in an informal setting.

Nonetheless, despite the theoretical potential that these discussions can present, a high percentage of them are focused on releasing stress through destructive comments. This fact, together with social structure rigidity and physical and mental exhaustion, explains the low participation in informal conversations during breaks. Therefore, it is necessary to direct these conversations towards a more constructive approach to make them useful.

#### 6.4.2.5. Meetings outside the department

Professional and personal relationships among ED nurses not only occur within the department itself, since there are several contexts in which they often meet regularly or occasionally.

Various events throughout the year encourage nurses, along with other professionals, to meet, discuss ideas and expand their knowledge to apply it to clinical practice. These events include several conferences such as those organised by the RCN, Listening into action projects sessions and the Caring at its best awards.

Although other events can promote links between ED professionals and those in other departments, Listening into action projects are those which have demonstrated an ability to promote joint decision-making and reflective discussion on clinical decision-making. These projects have used professionals' experiences and dialogue between them to

improve clinical outcomes, reduce waiting lists, reduce mortality rates, improve staff morale, reduce sickness absence and change leadership style and culture, among others (476).

Not all Listening into action projects are equal, but they always involve staff in their methodology, commonly through surveys, chats or discussion groups. This concept transfers part of the responsibility for improving healthcare services to healthcare professionals, enabling them to make changes that promote improved patient care and better working conditions.

Social relationships among healthcare workers not only take place during working hours, but there also are several customs regarding meetings outside working hours. The most common and consistent are the payday parties, which were held in local pubs the night when the monthly salary was received, which was the last Thursday of each month. At these parties, healthcare professionals from different departments had the opportunity to meet and engage in social relations, which facilitated teamwork during clinical practice. However, this event also promoted an evening lifestyle linked to excessive alcohol consumption, an image that no healthcare professional should reflect.

To encourage the inclusion of new nurses to ED in an appropriate way, a deputy sister created a group called New Starters Support Group, which was intended to introduce nurses and HCAs who have recently joined to ED. This group held regular meetings to facilitate the adaptation process and dinners outside the department to enable social interactions between junior and senior staff in a secure environment. This group was created in 2013 and its activity was discontinued in 2015, when the deputy sister who led the group left the department and the people who were responsible for it afterwards stopped it.

### 6.4.3. Technical competencies

A common part of clinical practice in an ED is performing techniques such as peripheral venous cannulation, bladder catheterisation or taking blood samples. Even if several of these techniques are learned and practice by English nursing students, nurses are not considered legally and professionally prepared to perform them until the institution for which they work after graduating certifies it.

This process works differently in each hospital institution and for each profession, so this section will focus on the acquisition and practice of nursing technical competencies in the LRI ED.

#### 6.4.3.1. Training and recognition

The process of nursing technical competencies' training and recognition is the responsibility of the LRI ED nursing educational team, which monitor and update nurses' training to promote efficient and excellent care. One of their tasks is the place distribution for various types of courses through waiting lists, among which there are courses focused on various technical competencies.

Once the nurse interested in being competent in a specific technique communicates it to the nurse educator, or he deems it appropriate, the request is added to the waiting list. When it is the nurse's turn, a day and time are assigned for the course that will allow him to be competent in the relevant technique.

These courses differ in length and content, but their duration is longer than 8 hours only in exceptional cases such as advanced life support or physical restraint. Generally, these courses only offer a basic representation of the technique and the opportunity to practice it in a safe environment under the supervision of clinical instructors.

After completing the course, the nurse must perform a certain number of practices supervised by someone who has the appropriate technical expertise, a percentage of which must be supervised by a professional certified in the Leicester Clinical Assessment Tool (LCAT). The staff competent with LCAT must have extensive clinical experience and can only supervise the technical competencies that they possess. Once

the nurse has performed all the necessary supervised practices, one of the nurse educators will verify and validate the nurse as competent in the relevant technique.

Designed to expedite the acquisition of technical competencies by medical students (477), LCAT spread to most UHL healthcare professionals and helps the supervisor to certify the appropriate technique in a systematic and uniformed way throughout the hospital. Also, a technical competence certified through LCAT should be transferable to other hospitals.

In the case of personnel from other hospitals or countries, each case is studied individually, even though in theory if the nurse presents a certificate that validates his technical competence he should not go through the whole process again.

On the other hand, the reality experienced was less organised. The progressively quicker ED staff turnover slowed newly hired nurses from obtaining their essential technical competencies, which hampered their clinical practice during their first months. At the same time, the waiting list for the LCAT supervisor course was several years long, thus the lack of supervisors slowed technical competencies' verification in clinical practice.

Regarding the validation of competencies outside UHL, this was entirely subjective, since it was the nurse educator who decided which certificates were valid and which were not. Also, if the nurse had a valid certificate for one or more technical competencies, nurse educators could reduce the number of supervised practices necessary to facilitate the certification of technical competencies in UHL.

This created discontent among nurses against their nurse educators, who restructured the initial training of newly hired nurses in 2015 to expedite obtaining technical competencies. However, various factors, among which was the 50% cut in the East Midlands healthcare professionals training budget in 2016, obstructed the new training structure and denied any significant impact.

#### 6.4.3.2. Technical competencies' practice

Despite the long waiting lists, the longest period for many technical competencies' validation is the supervised practice phase. There were abundant opportunities to practice various techniques in ED, but the progressive increase in clinical workload and the lack of LCAT supervisors made difficult that nurses could validate their technical competencies and practice them without supervision.

This situation, more apparent during the late 2015 and 2016, hampered efficiency during clinical practice due to lack of nurses with diverse technical competencies and the use of two nurses for a technique if it had to be supervised.

Given the difficulties exposed, several measures were implemented to facilitate supervised practice of various techniques. An optional rotation in Minors was implemented, in which the nurse could obtain suturing and plastering competencies easier. Moreover, one of the nurse educators was assigned to provide supervision and support for nurses who needed supervised practice. However, the benefits of these measures were reduced by the rapid personnel turnover.

Once the nurse obtains the necessary technical competencies, he should be able to care for his patients independently within his team, but not all his team members necessarily have all these competencies too. This implied that his colleagues need help performing techniques to their patients or need to be supervised, which unbalances the clinical workload per nurse. If there was a reciprocal relationship within the team this should not be a problem, but during the clinical practice period analysed only newly hired permanent nurses routinely offered mutual support to the nurse performing techniques to his patients.

Moreover, a large proportion of temporary nurses do not use some of their technical competencies despite having them, since the validation of technical competencies between hospitals is not consistent and they do not want to risk a professional or legal retaliation if an error occurs. Consequently, it is this group who showed lower adherence to mutual support within the team, justifying themselves arguing that they are only temporary nurses, even though some have worked in the LRI ED regularly for years.

These two extremes on reciprocity within the nursing team are encapsulated inside the same legal context: a nurse is not required to perform a technique to a patient other than his if this entails neglecting the care of his patients, unless it is an order from a superior who delegates the care of his patients to another nurse until he finishes. Therefore, the fact that different nurses make different decisions in the same context entails that their experience and their individual values influence this decision.

It can be argued that permanent nurses have a stronger connection with the department, its operation and how teamwork influences in the care of all patients, not just theirs. Nonetheless, this could not be justified with newly hired nurses, so it is an incomplete argument. In this case it is necessary to analyse, at least superficially, the motivations of both permanent and temporary staff, which are radically different. While the main motivation for temporary nurses is their salary in a high percentage of cases, permanent nurses also seek to learn, advance professionally and improve the department in which they work.

This last paragraph is not intended to disqualify temporary nurses or their ability to provide excellent care, but it has to be understood that different motivations and values influence decision-making, including nurses' disposition to prioritise the most urgent care compared to their patients' care.

#### 6.4.3.3. Management of skill mix imbalance

One of the sisters' tasks is to distribute nurses and HCAs through the department according to their technical competencies and experience. This involves, for example, that only nurses who are triage competent can work in Assessment Bay. However, from mid-2015 until the end of the clinical practice period analysed, the percentage of nurses without specific technical competencies increased due to the loss of senior nurses, so achieving an appropriate staff distribution across the department was more difficult.

From that moment, the lack of staff relaxed regulations in favour of patient flow through the department and against safe clinical practice: nurses without triage training were allowed to triage patients in Assessment Bay, nurses were moved from their area to perform a technique to another patient in another area without appropriate care

coverage and technical competencies courses that were not essential in the department were cancelled if staff was needed.

The sisters who were responsible for nurses' distribution were aware that it was not ideal, but it was a short-term solution to the lack of human resources taking into account the loss of senior nurses, the slow acquisition of technical competencies and the reluctance of temporary nurses to perform various techniques.

Another short-term solution implemented was warning permanent nurses about shifts requiring staff through phone messaging, which allowed that nurses available for extra shifts could, among other things, increase the diversity of technical competencies in the nursing team.

### 6.4.4. Medication administration and management

Despite being, in theory, a technical competence, medication management and administration is a common transversal competence for all nurses in the UK. That competence is usually obtained as soon as the nurse is employed by a healthcare institution and is commonly used to differentiate among nurses and HCAs. Moreover, nurses manage or administer medication very frequently, so this technique occupies a large proportion of their time in ED.

One of the main characteristics of the British nurse is that they must be registered with the NMC to act as such. Registration certifies to the employer that the nurses' education is adequate, so they should manage and administer medication after a 7-hours course and several supervised practices.

Nonetheless, in practice medication management in ED constantly breaks the established policies without being corrected. This may mean that the practice should be corrected or that policies are inadequate, but a description of what was observed can give a more holistic approach to the situation.

#### 6.4.4.1. Medication administration and management in clinical practice

The UHL medication administration and management competency is divided into two parts: oral medication and intravenous medication. However, within the oral medication competency the non-parenteral routes are included (oral, topical, rectal, ophthalmic, sublingual, otic, intranasal, inhalation and vaginal) while the intravenous medication competency incorporates parenteral routes (intravenous, subcutaneous, intradermal and intramuscular). Despite being two medication competencies, they work differently.

For non-parenteral medication, the nurse can administer it independently if it is prescribed and documented. Additionally, there is the concept of patient group directions (PGD) (478), in which specific commonly used medication may be prescribed and administered by nurses, among other professionals, if this benefits the patient without compromising safety. In ED, analgesics such as paracetamol, ibuprofen or nitrous oxide may be prescribed and administered by nurses as PGDs.

To confirm that it is the right patient, the prescription should be verified through three pieces of patient-related data, which are usually full name, date of birth and address. For patients with reduced cognitive ability or unable to communicate, identity is verified through an individual wristband, which includes full name, date of birth and the hospital number.

On the other hand, parenteral medication follows different policies. Once the UHL intravenous medication competency is obtained, all parenteral medication requires two nurses (or other competent professionals) to verify that the process of medication preparation, management and administration is appropriate. Both nurses share the responsibility for any error that is committed and both must document their position in this process: medication administrator or second checker.

Nonetheless, the application of the parenteral medication policy in practice at the LRI ED involves a moral dilemma: to choose between following the policy, which defines excellence in clinical practice, or distribute human resources more efficiently, which allows more basic patient needs to be covered in the same amount of time. In the observed practice, this dilemma is solved intermediately: the medication administrator nurse checks with another nurse that he is going to administer the right medication at

the right amount, the appropriate concentration, the correct route and that the drug is in optimal conditions. However, the second checker does not follow the whole process, only when both nurses verify the medication and document it.

One could argue that medication errors occur because only a nurse follows the management and administration process, but 15% of British hospitals have policies that dictate that one nurse is sufficient for appropriate medication management and administration (479). Studies such as Keers et al. (480) show that this issue is very complex and must be assessed in relation to environmental and human factors, not only the number of nurses involved in medication management and administration.

Another detail that supports the inconsistency of the double verification of medication model is that medical professionals do not adhere to it. Even though in theory all UHL healthcare professionals should administer medication in pairs, doctors prescribe and administer medication without any second checker. However, no action has been implemented to encourage policy adherence by doctors. Given that the effect of environmental and human factors applies to all healthcare professionals, the absence of an increase in drug errors by doctors or in medication only administered by doctors reduces the theoretical credibility of the double verification of medication model.

Apart from not following the double verification of medication model strictly, in the period we analysed clinical practice several unprofessional behaviours were observed. Failures in identifying patients, the trivialization of calculations and medication management, inadequate aseptic technique during the administration of intravenous medication or lack of knowledge about medication and their side effects were among the most common malpractices. At the same time, in the LRI ED, unlike the rest of the hospital, drug prescriptions are still done on paper, leading to handwriting issues in both prescription and administration.

Environmental and human factors appear to affect ED nurses to a greater extent than nurses from a hospital ward. Among the environmental factors, the continuous patient flow and chronically high clinical workload condition an environment in which time management is divided into many tasks and the nurse cannot devote enough time to any of them. On the other hand, burnout, stress and excessive confidence in their abilities

(which conditions healthcare professionals to make mistakes) are more prevalent in nurses that are more stressed and more skilled than the standard English nurse.

One of the most significant differences in environmental and human factors between ED and ward practice is that there are no drug rounds in ED. In these rounds the nurse has assigned and protected time to administer medication to their patients, thus eliminating interruptions and minimising stress, reducing errors. However, given the number, severity and patient flow of an ED, medication has to be administered as soon as possible and in a frequency different for each patient.

This entails that even though it is known that medication management and administration in ED is under environmental and human factors, certain risk reduction measures designed for a ward, like drug rounds, cannot be applied.

Legal and professional consequences for committing a medication error vary according to its severity. If the error does not result in any harm to the patient, nurses should inform the patient of the error and they cannot administer more medication until their competence is evaluated again. When there is damage to the patient, the consequences depend on the context and the damage dealt, from removing the nurse from the NMC register to financial penalty and imprisonment. Given the potential impact of a drug error, legal and professional accountability is used to reduce malpractice while defensive practice is encouraged through fear.

Legal and professional accountability is shared between the medication administrator nurse and the second checker nurse, so both suffer the same consequences. However, each nurse has different skills, experience, stress, priorities and ethical values, therefore ethical accountability is individual even though legal accountability should be shared. This means that some nurses prioritise following the policy and safe medication administration while others focus on efficient time distribution and patient flow.

The ethical dilemma linked to the lack of resources, both material and human, under very high clinical workload is governed in a legal and professional manner through policies that criminalise both who decides to ignore their patients to administer medication according to the policy and who prioritises caring for the highest number of patient sacrificing medication management and administration quality. Therefore, since

both positions are professional and legally sanctionable, is through ethical decision-making how the nurse decides whether to follow the medication policies scrupulously or distribute his time between the multiple tasks and patients that are his responsibility.

Although it can be considered an ethical dilemma, two groups were formed based on their ethical decision-making regarding strict adherence to medication management and administration policies. The first group consisted of junior permanent nurses and temporary nurses, who followed policies strictly most of the time to achieve excellence in practice and avoid any legal and professional repercussions, according to them. However, most of them did not understand the characteristics and consequences of patient flow or not considered part of their role as a nurse worrying about other patients who were not his responsibility.

On the other hand, the second group was composed mainly of senior permanent nurses, both from LRI ED nurses and other ED nurses that were recently incorporated into the LRI ED. These nurses performed the medication double verification at a point in time and not during the whole process, but focused on the equitable and fair distribution of care among all patients, not just those assigned to them. They claimed that they knew the medication policies, but they felt that patients and the professional, legal and emotional consequences of their actions as nurses were more important than following the policy strictly.

#### 6.4.4.2. Exceptional medication management: controlled drugs and medication in emergencies

The LRI ED medication is diverse and covers a broad spectrum of possible pathologies, but a group of medication receives a more meticulous treatment than others: the controlled drugs. This medication includes various opioids, benzodiazepines and other drugs that can cause addiction and that the British government believes should be used with caution.

Controlled drugs are subject to specific storage, prescription, handling and administration policies. In practice, it means that all controlled drugs must be in a locked cabinet (usually with two locks locked with different keys) and any change in

the amount of medication must be documented in a specific book, which is reviewed by the Pharmacy Department. At the same time, any remaining unused medication must be deposited in a specific container, which is stored in the same cupboard as the controlled drugs. Finally, the importance of following parenteral medication policies, which are applicable, is pointed out.

Controlled drugs pose the same dilemma as other medication regarding their administration and management in ED, but broaden the scope of the problem because they are medications that need more time to be handled but simultaneously have the most dangerous consequences if they are not handled properly.

Another exception that occurs frequently in ED is the administration of medication in emergency situations, where some of the policies are ignored in favour of increasing the patient's survival probability. In those situations, the medication is prescribed only verbally and is not always verified, but when the situation normalises everything must be documented. However, various situations were observed during an emergency, from verifying medication for several minutes to medication errors due to lack of communication.

As discussed in other sections, ethical and legal accountability is flexible in emergencies, even though medication administration and management is a technique that influences patient survival greatly. When a death is considered suspicious, the coronel investigates how the emergency was managed, and if the cause of death was a medication error that could have very serious repercussions for the professionals involved.

It is in these emergencies when the ethical dilemma between technical quality and time management is accentuated by the severity of the context. To solve this problem, in the LRI ED a group of common medications in emergencies (adrenaline, atropine, calcium chloride, etc.) is administered in prefilled syringes to avoid errors and safe time verifying medication. However, only a small amount of medication is sold in prefilled syringes, which can also be administered incorrectly, even if this is unlikely to happen.

We also have to consider that this dilemma arises mainly in unexpected emergencies. Most emergencies are pre-alerted through the Resus red phone, so professionals in that

area can make preparations to receive the patient, including any medication that they may need.

### 6.4.5. Relationship between nurses and other healthcare professionals: responsibility hierarchy and presupposed and real influence hierarchy

The responsibility that each nurse has is mainly predisposed by their role within the multidisciplinary team and their job role. However, in order to carry out the necessary actions to meet those responsibilities he does not only need to possess the appropriate knowledge and skills but also being able to influence the decisions of others through his. It is this influence what allows the nurse to use material and human resources to fulfil his responsibilities.

In theory, every nurse has a base influence that is presupposed due to his position in the nursing hierarchy. This facilitates sisters and matrons to influence a broad group of healthcare professionals only through their hierarchical position, since it is assumed that to access that rank an advanced level of knowledge and resource management skills are needed. Moreover, these high levels of responsibility are accompanied by a greater decision-making power, through which they can influence or surpass the decisions of their subordinates in the hierarchy.

In order to monitor and improve the performance of a diverse multidisciplinary team, among other reasons, a direct stratification of people according to their job and their responsibilities is established in English practice, mostly in medical and nursing teams. In the medical community, career progression is directly related to the acquisition of knowledge in their field of expertise and responsibilities that support this knowledge. However, in the case of the nursing profession, career progression is not always directly related to the acquisition of nursing knowledge due to the variety of progression options, which entails that senior nurses have different responsibilities according to their job position.

These progression options define the nursing hierarchy in the LRI ED, which branches after registered nurse and can be simplified into three branches: supervisors and managers (sisters, matrons, head of nursing, etc.), nurse specialists and nurse

practitioners. Each of these branches interacts with registered nurses and patients in different ways, but all of them have a high level of influence.

In hospital wards, the separation between registered nurses and their superiors is evident, since the latter do not collaborate in clinical practice and even work in offices isolated from the ward. However, in the LRI ED, as in other specialised areas, the need for support and expert care precipitates that nurse coordinators work with registered nurses.

When a group of professionals works together for a long period of time they are able to recognise the strengths and weaknesses of their peers, which partially modifies the influence they may have on each other. This phenomenon precipitates a difference between the influence that a person should have according to their position in the nursing hierarchy (presupposed influence) and the influence that this person actually has according to the perception that each individual has of he (real influence), which is defined by his knowledge, his skills, his charisma and his decision-making, among others.

The real influence that a registered nurse has is needed when interacting with his superiors, to promote a smooth practice with his colleagues and even for training new colleagues and nursing students. However, this is often not effective against other departments or hospitals, where only policies and the presupposed influence affect interdepartmental discussions.

Therefore, there is a relationship between the responsibility that a nurse can handle and the personal resources that he has to fulfil his responsibilities, one of those resources being his presupposed and real influence. However, the interaction between the nurse and the different healthcare professionals is too complex to generalise it into a single group, so it must be fragmented into four general groups: colleagues in clinical practice, managers, pupils and other departments.

#### 6.4.5.1. Responsibility and influence between nurses and their colleagues in clinical practice

##### 6.4.5.1.1. Nurses

Registered nurses are aware that they are part of a multidisciplinary team that must work together to provide holistic care. However, diversity in the roles that each person represents obstructs homogeneous relationships between healthcare professionals and complicates teamwork by the simple fact of being multidisciplinary. This stems in part from the fact that nurses easily empathise with other nurses who share their caring role and Professional Ethics, while they struggle to empathise with professionals with different responsibilities.

Taking into account the previous indication one might assume that, by sharing the same role and Professional Ethics, the relationship between two registered nurses might seem simple. In practice, nursing decision-making is restricted within the parameters established by clinical policies, routine customs and current legislation, which homogenises practice and decision-making. Nevertheless, the relationship between two healthcare professionals not only depends on policies but also many individual factors that shape their personal values.

In the interaction between two nurses within the same area, a sense of camaraderie and joint decision-making was observed on issues affecting both nurses' patients and patients who needed more than one nurse. There were isolated cases in which one of the nurses refused to work in a team or two nurses made contrary decisions related to the same patient, creating a tense situation, but generally permanent nurses form good teams.

One of the factors precipitating both camaraderie and discussions between permanent nurses is the fact that they work together for a long period of time. Most nurses do 12.5 hours shifts several times a week for several years until they change roles or work, enough time to capture facets of their colleagues that are not easily identifiable. This means that nurses linked through their personal values form subgroups and others nurses with incompatible values avoid each other. However, this fact is masked by a

superficial cordial relationship imposed by the healthcare institution's professional etiquette, which facilitates that the public receives an impression of order and courtesy.

During practice, the nurse is responsible for a variable number of patients, who have to treat and care individually. Nonetheless, a nurse is not able to do his work alone, so he must interact with other nurses to cover his patients' basic needs. This forces him to ignore the negatives aspect that their relationship with other nurses may have to be able to care for his patient, using the teamwork pretence to influence them. If the relationship is between two nurses in different areas of the department, it is transformed into a flatter and direct relationship, which is focused almost exclusively to solve a specific problem.

There are delimiting factors that allow discerning key differences in the influence of some nurses to others. Even though all nurses have the same responsibilities, factors such as experience, nationality and type of contract are sufficient for a nurse to impose his decision onto another:

- Knowledge and training: Experienced nurses have a wide range of knowledge acquired both theoretically and practically, which is often used in ED. Junior nurses aspire to acquire such skills over time and turn to their senior fellow nurses to answer questions that arise during clinical practice.

This relationship similar to the mentor-student relationship is common in English Nursing given its structure of continuous acquisition of knowledge and competencies during and after graduation. However, this knowledge sharing relationship is based on the junior nurse's trust, who based his practice on other people's knowledge until he assimilates it as his own, thus the senior nurse is able to influence junior nurses' decision-making easily.

The problem that this phenomenon produces is that practice is based more on routine that evidence, since unless the junior nurse challenges the decision of his senior colleague and forces him to explain his reasoning he does not know what the basis of the senior nurse's decision-making process is. However, senior nurses do not tolerate junior nurses questioning their theoretical and practical knowledge, stating that their practice is based on their clinical experience.

- Skills and competencies: Senior nurses not only have knowledge that other nurses have not acquired yet but they are also able to perform various techniques that are necessary for ED daily patient care.

While junior nurses have not acquired their own skills they are dependent on their senior colleagues to perform specific techniques for them. This creates a dependent relationship that increases the senior nurses' influence, which could be abused by both parties. In most cases, the senior nurse is able to offer a fair task exchange so all patients receive the care they need.

The fact that senior nurses have a broader set of skills and competencies offers junior nurses a less abstract progression pathway, since it is easier to imagine themselves inserting a urinary catheter than creating a care plan, for example. Partly due to this, junior nurses project their future in the image of their senior colleagues, which includes a distorted perception of joint decision-making.

A common example of this phenomenon is the double verification of intravenous medication between a junior and a senior nurse. The senior nurse exposes the dilution he thinks correct and the junior nurse rarely questions it, verifying only the medication expiry date. This happens because the junior nurse perceives his senior colleague incapable of committing such a simple error like mixing powder for intravenous medication in the wrong solvent.

- Domain of routine activities: Junior nurses' training has prepared them for general practice, but once placed in a particular department they should familiarise themselves with it. This entails knowing the policies, handling the various forms and knowing the distribution of human and material resources throughout the department.

Knowledge about routine activities related to care is essential to provide quality care, being the easiest and fastest route to obtain it through the advice of his senior teammates, even though junior nurses can also learn through trial and error during practice.

Learning these routine activities is a common opportunity that senior nurses exploit to indirectly influence junior nurses in their subjective perception of care. They teach

junior nurses the care standards that they believe appropriate, inculcating a practice similar to theirs, so it is easier than both agree on the same decision in the future.

- Stress management in critical situations: Stress is a common element in nursing practice under clinical workload, even more when dealing with acute or critical patients. That is why stress management is vital in an ED, which can be a useful tool for keeping a nurse active or a burden that the nurse must endure until he burns out completely and leaves clinical practice.

Natural stress tolerance is an individual characteristic of each person, but stress management through coping techniques can facilitate working under stress regardless of tolerance. Each nurse claims to have his own technique to cope with stress, which is copied by other junior nurses in order to manage their own stress, usually with a low success rate.

Regardless of the techniques that each nurse use to manage stress, senior nurses suffer less stress than their junior peers given their greater understanding of the overall department situation, their advanced knowledge in emergency management and their desensitisation against traumatic events. However, these factors are not apparent to the naked eye, since the fact that there are nurses that remain calm in the most critical situations impresses junior nurses, creating a slight aura of respect and admiration for their senior colleagues that increases their influence.

- Affinity between nurses: A fundamental aspect of the relationship between two people is the affinity between them. In the specific case of the relationship between nurses, the affinity between them also applies even if it is hidden under the veil of professional etiquette.

All nurses treat their colleagues with respect and maintain a superficial and cordial conversation with them to avoid awkward silences, but the relationship between them does not progress further. However, in cases where personal values or hobbies are similar, the connection between them during practice is deeper, becoming friends outside the department. This connection results in the formation of subgroups within the nursing team who share values and ways of thinking.

This entails that both teamwork coordination and joint decision-making are much more fluid if both nurses are part of the same subgroup, since they trust each other more regardless of other factors. This also leads to a higher probability of error, since trust in members of the same subgroup reduces the verification required to make a decision or tolerate an unfamiliar decision.

In general, this phenomenon is largely positive despite the increase in errors during practice, since a small increase in error probability is compensated by improved teamwork fluidity, increased satisfaction at work, reduced stress levels and the creation of a social support network within the workplace, among others.

- Charisma and professional etiquette: LRI ED nurses have to maintain a professional etiquette in extreme situations, even in humiliating situations like verbal or physical aggression. The domain of professional etiquette is something that is achieved mainly with experience, since junior nurses used observed behaviour from their senior colleagues to base their own professional etiquette. However, even more important than professional etiquette is the nurse's charisma.

All nurses have a personal charisma independently of their job, but the application and adaptation of this quality into practice is vital to increase their influence over other nurses and to engage in a functional nurse-patient relationship.

Within the relationship between nurses, charisma is a catalytic element that enhances or decreases the effect of other factors (knowledge, skills, hierarchical position, affinity, etc.) in the influence between a nurse and another. This has derived into the perception of some junior nurses with greater influence than the rest, especially within their own group, and reduced influence of a group of senior nurses who had reduced social skills compared to the rest.

- Nurse's nationality: Although a high percentage of nurses are British, there are a group of permanent nurses who come from other nations, which are divided into two main groups: Southern Europe (Italy, Portugal, Spain, etc.) and South Asia (primarily India and the Philippines). Even though all of them are considered nurses, there is a difference in training and caring values in each country . These differences

are mitigated with the *NMC Code* mandatory compliance, but this involves a learning curve during practice.

Cultural and cognitive differences between English and foreign nurses hinder the relationship between them during the foreign nurse's learning curve. At this stage, the foreign nurse must adapt his language, practice and customs to the English ones while he validates his training and skills to English legislation. Due to this, foreign nurses start in a lower level of influence that the one they would have if they had been born and trained in England, so they seeking solace forming a subgroup.

If the foreign nurse is able to finish his adaptation to English customs and practice he could be accepted as part of a subgroup of English nurses, facilitating his influence on them. However, most foreign nurses refuse to replace their values and practice for the English ones, which derives in increased difficulty for a foreign nurse to influence an English nurse.

- Type of contract: When speaking of nurses in general we usually talk about nurses with a permanent contract, since they are the largest group of nurses in the hospital. Nonetheless, there are also nurses on temporary contracts, who even though are subject to the mentioned influence factors their employment relationship with the healthcare institution stigmatises them against permanent nurses.

The basis of this stigma is in the fact that, unlike permanent nurses or bank nurses, agency nurses are not hospital employees and are not protected by vicarious accountability. This results in a defensive and inefficient practice, to which is added the lack of support from their permanent colleagues and the ignorance of the resources available.

The prejudgement based on the stigma imposed by permanent nurses on temporary nurses, mainly agency nurses, is the sacrifice of care quality for greater financial rewards. To defend their prejudice, permanent nurses argue that temporary nurses are inefficient compared to the salary they receive, which is relatively true if the nurse does not regularly work in the department. This prejudice branches into two characteristic archetypes that permanent nurses use to classify temporary nurses: the "support nurse" and the "straw nurse."

The "support nurse" is usually a temporary nurse who regularly works in the department, who has managed to earn the respect of permanent nurses based on the quality and efficiency of his care. Because temporary nurses cannot have high responsibility roles, they often provide support to permanent nurses, offering their varied knowledge and skills. This makes them an appreciated resource by permanent nurses, even though they are not perceived as equals or are not included in their social group (although there are exceptional cases).

The "straw nurse" is a nurse who does the minimum work possible to finish his shift without committing an infraction. This archetype is characterised by a lack of teamwork, mediocre care and extensive documentation. In addition, if he works regularly in the department he uses the same policies to avoid unwanted tasks or extend his breaks.

These prejudices push agency nurses to form a subgroup among them, while the interaction with other nurses is minimum, a phenomenon more common with agency nurses of African origin. However, this prejudice is less relevant as more frequent the temporary nurse's presence is in the department. Although this only happens in particular cases, the temporary nurse can be accepted as part of the permanent nurses' group since the relationship between them is facilitated once his presence in the department is regular over an extended period of time.

The archetype in which the temporary nurse is classified is a limiting factor to their influence with the permanent nurses. The "support nurses" may have a moderate influence in different situations, while the "straw nurses" have minimal influence in most permanent nurses, regardless of context.

- Reputation and social position within the nursing team: All the factors mentioned above and other lesser factors (gender, age, physical appearance, etc.) make up the reputation of nurses within the ED nursing social structure. This social structure has as a skeleton the nursing hierarchical structure, but is diversified through the reputation that each nurse has. The reputation that each nurse has is important in English nursing practice because it serves to influence their colleagues more or less easily on decisions they have to make as a team.

As the hierarchical structure is the base for the nursing social structure, the nurse's position in the hierarchical structure is the most important factor to influence other nurses because it is an easy, simple and consistent factor rooted in English practice and policies. Based only on this, nurse coordinators can influence registered nurses, their subordinates in the hierarchy, directly and without discussion.

Nevertheless, the nurse's reputation can modify the influence of his position in the hierarchical structure positively or negatively, facilitating or hindering leadership and joint decision-making. Therefore, reputation and their influence is a factor to consider in relations between nurses at different levels in the hierarchy.

All these delimiting factors, alongside other more individual factors such as personal values and experiences, create a network of relationships of different categories according to the influence between some subjects and others. This network shows the direction in which the responsibility flows from some other nurses to others, usually from highest to lowest level of influence. However, while nurses receive or delegate responsibilities to other nurses, they are still responsible for their patients in addition to other team or delegated responsibilities. Even though one could argue that the network of relationships between nurses could lead to unfair accountability sharing against nurses with less influence, nurse coordinators should ensure that patients and the distribution of responsibilities are fair.

Finally, it is important to note that these delimiting factors can be applied to a greater or lesser extent to the relationship of nurses with other colleagues within the multidisciplinary team, but their weight depends on the type of relationship and the context in which they are applied.

#### 6.4.5.1.2. Nurses and healthcare assistants

LRI ED nurses do not care for their patients alone, since they have the help of HCAs, a collective very close to the nursing team. Their relationship with the nurse is based on delegation of patient care tasks and the responsibility that they involve.

The relationship created between a junior HCA and a nurse depends heavily on the influence that the nurse may have on the HCA, even if junior HCAs are usually willing to perform delegated activities, so the threshold of influence that nurses should have with a junior HCA to maintain a functional relationship is relatively low.

For junior HCAs, subordination to the nurse was evident, since they were dedicated exclusively to perform tasks delegated by nurses like measuring vital signs or maintaining patient hygiene and nutrition. However, since HCAs do not have their own responsibilities, the nurse should ensure that they performed the delegated tasks. This entails that if the nurse's influence on the HCA is not high enough he could ignore the tasks delegated by the nurse or perform them incorrectly without serious consequences, since the primary accountability lies with the nurse. It must be taken into account that after the implementation of the *Care Certificate* in April 2015 the HCA is partially responsible for the tasks delegated to him, even though this did not change practice drastically, since the nurse still maintains most of the accountability for the delegated task.

On the other hand, the relationship between a nurse and a senior HCA is more complex. In addition to having shared time together, so they know each other better, during his practice senior HCAs have obtained skills and competencies that allow them to practice semi-autonomously in different situations.

The initiative in individual decision-making that many senior HCAs have is based on the fact that their level of knowledge and skills is greater than the standard HCA, so they feel they should have a greater decision-making capacity. This fact is reinforced by the pay scale, through which the HCA can rise between the bands 2 and 4, differentiating between them. The band 2 HCAs are junior HCAs, since when they obtain their basic skills they can request access to band 3. In exceptional cases, assistant practitioner positions are offered, a band 4 post based on constant unsupervised technique execution.

Senior HCAs (bands 3 and 4) argue that they are able to make better decisions that junior nurses basing them solely on clinical experience, but they are aware that the final responsibility lies with the nurse. Nevertheless, a small group of these HCAs prioritises their decision-making over the nurse's one as they feel it is for the patient's good.

The problem that this creates is that the senior HCA can consider himself capable of making decisions without having the appropriate training or being accountable for it, shifting the accountability of their consequences on his nurse colleague. This commonly occurs in Assessment Bay, where the senior HCA tries to influence the nurse's decision-making during the patient's assessment, even though the primary responsibility lies with the nurse. If the nurse does not have enough influence on the senior HCA, refusal to follow the decision taken by the HCA can result in a verbal confrontation. Furthermore, in the event that the HCA influence on the nurse is very high, it may lead the nurse to make inadequate or even negligent decisions.

Situations when the relationship between the nurse and the HCA is inadequate, even if they offer a revealing perspective of the particular factors in the relationship between nurses and HCAs, are relatively infrequent. The common link between the HCA and the nurse is based on mutual respect and understanding of each person's roles, through which they can form a functional nursing team and provide quality care. The influence between the two groups is used to facilitate the delegation of tasks and to enable joint decision-making, especially in the case of senior HCAs, resulting in an equal relationship that attenuates the HCA's subordination perception.

#### 6.4.5.1.3. Nurses and doctors

The nurse-doctor relationship model present in the English healthcare system is based on the nurses' total subordination to the medical community and the choices they make, whether they are adequate or not. This is reflected in routine acts like when nurses taking notes for doctors, that doctors cannot be called unless it is an emergency or that nurses must adapt their work routines to the erratic distribution of doctor visits at the ward. Also, the joint decision-making is limited to exceptional cases between the ward nurse coordinator and the ward senior doctor, in which the nurse's contribution is only informative.

Nevertheless, the relationship between nurses and doctors in the LRI ED is radically different from the one commonly found in a hospital ward. This is due to various factors that are common only in ED or other specialties (ITU, Surgery, etc.):

- Lack of information: In a ward, patients are being cared for and treated according to the diagnosed illnesses that they suffer. Patients who come to ED suffer from an undetermined number of unstable diseases of any kind, so doctors rely on the information that nurses can provide them to facilitate each patient's triage, diagnosis and treatment.

- Severity of patients' diseases: Patients in a ward are in a controlled environment in which the severity of their situation and their progression can be predicted, which is not usually urgent. In ED, critically ill patients are constantly received in a crowded environment, in which doctors rely on nurses to monitor the sickest patients and distribute patients appropriately throughout the department.

- Knowledge level and skills of nurses and doctors: The registered nurses in a hospital ward have a set of basic knowledge and skills, which makes it easier for doctors to not take them into account in their decision-making. In ED, nurses have extended knowledge and skills that allow them to support doctors in their practice and judge it based on individual experience and theoretical knowledge. This allows the nurse and doctor to work together to accelerate and improve patient care, especially in critical situations.

- Contact frequency: Nurses do not usually talk to doctors frequently in a hospital ward because they are only there during the ward round or if nurses requested them to assess a patient. In ED, both doctors and nurses working in the same space, being more accessible to each other for clinical or non-clinical reasons. Moreover, even though doctors have their own staff room, most doctors spend their break in the nursing staff room given its location close to the department and the constant presence of different professionals to talk to.

- Accountability for negligent acts: The fact that a nurse challenges the decision of a doctor because he believes it is incorrect or negligent is very rare in a hospital ward, mainly driven by the taboo of nurses arguing against the medical decision and the aura of unquestionable authority projected by ward doctors.

  However, ED nurses are able to recognise the knowledge and skills of doctors regardless of their status as doctors, so they are able to challenge the doctors'

decision if they believe it is inappropriate, contacting the EPIC if necessary. This entails that doctors take into account nurses to avoid being accidentally negligent or to prevent a complaint that could lead to legal and professional consequences.

These factors, among others, generate a dependency relationship between doctors and nurses, where joint decision-making and teamwork is more common because their knowledge and skills are similar and complementary. This does not eliminate the fact that doctors and nurses are both aware of their role and their responsibilities, but in this case they are able to understand each other's decision-making process and judge it based on their knowledge and values.

The base influence doctors have in nurses is higher than the basic influence nurses have in doctors, but various delimiting factors can change the level of influence between each other, mainly due to the nurse or doctor hierarchical position. Furthermore, the time spent as part of the multidisciplinary team in ED allows them to work better as a part of it, since both require an adaptation period to eliminate bad habits obtained in ward practice.

##### 6.4.5.1.4. Nurses and nurse coordinators

Registered nurses are able to provide independent care as part of the multidisciplinary team but are unable to perform individual patient care while monitoring their area and the whole department. In addition, nurses are also employees of the hospital, who need a supervisor who handles administrative matters like shift distribution, sickness absence or career progression for each nurse.

These roles are covered by the sisters (and to a lesser extent by the deputy sisters), who are the nurses with the highest hierarchical rank that also have a regular clinical role. In practice, they are engaged in coordinating an area or the department, providing expert support to nurses who need it. However, they also have an administrative role, through which ensure that the nursing team is monitored.

The relationship between registered nurse and nurse coordinator is governed by the same delimiting factors that shape the relationship between two registered nurses. The

big difference is that there is a tangible difference in the hierarchical position of the registered nurse and the nurse coordinator, which gives the latter a considerable influence on the registered nurse. Moreover, apart from being their superiors in the nursing hierarchy, nurse coordinators are also registered nurses' line managers, which entails that nurses evade a hostile relationship with the nurse coordinators to avoid having professional or administrative implications.

In most situations, the registered nurse does not dispute the nurse coordinator's decision, since the nurse coordinator has overall control over the area or the department while the registered nurse only knows the specific situation of his patients. In cases where a discrepancy between registered nurse and nurse coordinator that cannot be resolved by a quick discussion arises, the nurse coordinator can use the influence that his position in the hierarchical structure gives him to force the registered nurse to accept his decision, even if this means that the nurse coordinator is accountable for that decision.

This resource is used by nurse coordinators in the few occasions when their influence or negotiation skills do not work, since forcing registered nurses to do something they do not consider right can hinder the relationship between the two, besides being neither professional nor ethical. Also, registered nurses know their patients better, so nurse coordinators try to respect the nurse's decisions on the basis that no competent nurse would take decisions against the welfare of their patients.

The maximum representation of this phenomenon is the relationship between a registered nurse and the NIC, who must be at least a sister. The NIC has the greatest influence of all clinical nurses in the department, since he is the representative for every nurse in the department and is indirectly accountable for their practice, so his decision can be discussed, but must always be followed. However, the NIC is the nurse that known less about individual patients, so he can be persuaded to change his mind if the registered nurse explains the patient's situation within the problem's context that the NIC wants to solve.

#### 6.4.5.1.5. Nurses and other colleagues within the multidisciplinary team

The nurse must work with different groups within the multidisciplinary team to provide holistic care. These groups work with nurses differently, but their relationship is not as characteristic or common as in the previous groups:

- Nurse practitioners: The nurse has a similar relationship with nurse practitioners and doctors, since their knowledge and their role in ED are very similar.

- Specialist nurses: The nurse and the doctor are able to require the support of a specialist nurse in a specific field, who will provide expert assessment and treatment. The influence of registered nurse on these specialist nurses is relatively low, since the latter are independent professionals who are devoted to a specific departmental visit.

Nonetheless, cardiac specialist nurses are the exception, since they work frequently in the department with registered nurses, thus applying the same delimiting factors as regular nurses but also taking into account their advanced knowledge and skills in cardiology.

- Physiotherapists and occupational therapists: These professionals work frequently in EDU where they assess the mobility of elderly patients and provide them the tools necessary to perform daily living activities for themselves.

The relationship with EDU nurses, although common, is reduced, since these professionals focus on their evaluations and check the clinical documentation for the information they need.

- Primary care coordinators (PCCs): These professionals are dedicated to distributing healthcare and social community resources to dependent patients, facilitating discharges and improving their quality of life in the community. Even though they have an office at EDU, the PCCs collaborate with ED nurses and doctors to find suitable candidates for community care.

The relationship between nurses and PCCs is simple and superficial, since they do not collaborate frequently or for extended periods of time. However, the influence of

registered nurses in the PCCs is remarkable, since only nurses or doctors require their services and enable them to find enough patients to meet their monthly targets.

- Administrative staff: The management of the large amounts of documentation that the department produces each day is the responsibility of various administrative roles present in the department. The registered nurses' relationship with administrative staff is routine and systematic, which is divided into three main interactions: clinical documentation print for new patients, stored documentation recovery for regular patients and incorrect patient data modification. In addition, administrative staff may ask a nurse if they believe an ambulatory patient needs an urgent assessment, since they do not have healthcare knowledge.

Moreover, there is a specialised administrative group dedicated to maintaining and monitoring patient flow in real time, the ED trackers, which have a closer relationship with the nurses. This is because the ED tracker facilitates patient transfers between areas, handles discharges with the duty managers and receives most outside calls, freeing time for the nurse and allowing the ED tracker to filter the right information to the corresponding nurse.

- Mental health team: A group of psychiatrists and mental health practitioners attend patients with acute mental disorders in the ED once a senior doctor has ruled out any physiological problem. These professionals specialise in suicide attempts, intentional overdoses and delivered self-harm. During their practice they maintain a minimum relationship with the nurses, speaking with them only when a patient is referred to them by telephone.

One of the main reasons for the isolation of these professionals within the multidisciplinary group is that they work in a separate environment from the rest, which is located in a room next to the EDU hallway.

- Security officers: Security officers have their office next to ED reception, so their response to any call is usually quick. Their presence is common in EDU, where they guard patients temporarily lacking decision-making mental capacity while they wait for the mental health team's assessment. They also guard these patients in other areas and detain aggressive or armed patients.

These security officers follow the orders of nurses and doctors without any objection if the nurse or doctor makes himself accountable for the possible consequences. Therefore, the nurses' influence towards the security officer is high, which allows the nurse to direct the security officer's actions, since tasks like adequate patient restraint should be monitored by healthcare personnel to avoid collateral damage such as joint dislocation or death by asphyxiation.

#### 6.4.5.2. Responsibility and influence between nurses and their managers

Nurses are part of an extensive institutional structure, which is led by a variety of managers who ensure the proper functioning of UHL through the monitoring and management of departments and hospitals. It should be borne in mind that registered nurses rarely talk to hospital managers, but there are specific situations that particularly affect nursing practice.

The most common case is with duty managers, who manage the distribution of patients throughout the hospital. Since a large percentage of patients enter the hospital through ED, duty managers ensure that there is room in the hospital wards to accommodate patients who need it, thus fulfilling the objectives set by the British government and avoiding unnecessary fines. Duty managers are divided into two main groups, which have a different relationship with nurses.

On the one hand, there are duty managers without healthcare training, who use discussion, intimidation and their status as managers to force nurses to make decisions that they believe convenient to maintain patient flow. However, since they do not have healthcare knowledge duty managers cannot override the nurse's decision even if it does not contribute to patient flow. Another resource used by duty managers is coercing nurse coordinators so they annul the registered nurse's decision, even though this could entail the transfer of unstable patients or inappropriate and disrespectful treatment to patients.

On the other hand, senior nurses are eligible to become duty managers, which enable them to make clinical decisions even if their goal is patient flow, not patient welfare. These clinical duty managers are allowed to make clinical decisions to improve patient

flow, nullifying the decisions made by the nurse and making themselves accountable for any consequences that their decision may cause. The registered nurse can be right clinically, legally and ethically, but the simple fact that he is a clinical duty manager allows him to ignore the nurse's good practice in favour of the movement of patients outside the department. The only nurse who can confront the clinical duty managers is the NIC, who is not always present in the area in which the clinical duty manager is interfering in the care and treatment of patients to increase patient flow.

Regarding managers who are also nurses, the top of the departmental nursing hierarchical structure is occupied by nurses who do not perform any clinical care, focusing on the management and representation of large groups of nurses. These nurse managers are the ED nursing team representatives for the rest of the hospital and for the general public, so they attend social events and are part of teams that create nursing practice policies. These include the matrons (departmental nursing team representatives) and the head of nursing with his deputy heads of nursing (nursing team representatives of a group of specialties).

The relationship between nurse managers and registered nurses is minimal, only common in major incidents (where they act as senior nurses in team leadership) and social events such as nurse recruitment fairs. In these cases, if nurse managers decide they need to be involved in clinical practice they can make clinical decisions that cannot be refuted by any nurse, since theoretically they are the nurses with the higher hierarchical rank of the department. However, occasions when nurse managers are involved in clinical care are rare and they tend to follow the advice of senior nurses from the department before making a decision.

The only ones above nurse managers in the hierarchical structure are the executive officers, who are led by the chief executive officer, the apex of hospital hierarchical structure. Executive officers are divided into four groups: chief operating officer, medical director, chief financial officer and chief nurse, who are the last representatives of their management area in front of the NHS and the British public. The relationship between any of the executive officers and registered nurses is zero (excluding promotional or advertising visits), since they share their decisions through their subordinates in the hierarchical structure.

#### 6.4.5.3. Responsibility and influence between nurses and their apprentices

English nursing training is partly theoretical and partly practical, so it is common to find inexperienced nurses in ED whose practical training is supported by a nurse who takes them as apprentices. These nurses are divided into nursing students, who have not obtained their nurse qualification yet, and nurses in their supernumerary period (with or without NMC PIN), who need to obtain the knowledge and skills necessary to practice in a specific department.

The relationship between mentors and apprentices nurses could be prejudged as the same as between junior and senior nurses, but there are three key differences that determine the mentor-mentee relationship:

- Active practical training: Unlike training among registered nurses, who learn from each other passively working together, training offered by a mentor to an apprentice should be active, which increases learning opportunities and promotes critical discussion of the theory and the practice. This means that the mentor should seek learning opportunities within his practice to meet the mentee's learning needs, creating fictional scenarios to complete practical training if necessary.

- Deliberate choice of the mentor's role: The primary purpose of the nursing profession is caring for people, so not all nurses are willing to share their knowledge or are able to train other nurses, since it is beyond their primary role. However, mentors have deliberately chosen to receive specific training to instruct other nurses and devote part of their clinical time to guide mentees.

It is to note that even though the choice of being a mentor is deliberate, being one is a mandatory requirement to advance professionally as a nurse, so not all mentors decide to become a mentor for their teaching vocation.

- Apprentice's inability to practice independently: Although junior nurses have limited knowledge, they are considered skilled nurses in independent patient care, both professionally and legally. On the other hand, apprentices are not considered able to practice independently, since they have not demonstrated the necessary knowledge and values yet or are awaiting their confirmation by the NMC.

These differences define a relationship in which the mentor should participate actively in the training of his apprentice subtracting clinical or break time for it, while the mentee attempts to apply the theory learned at university into the practice performed with his mentor. The mentor is responsible for both training the learner and his supervised practice, which confers him a continuous influence to his apprentice.

Although both apprentice groups (nursing students and nurses in their supernumerary period) have the same basic mentor-mentee relationship, there are variations between one group and another. For nursing students, the mentor has a very high base influence with his apprentice because it is he who decides whether his apprentice continues his training or failed his placement, with the consequent university sanction and delay in his training. However, since he did not finish his university training yet, the nursing student is considered neither professionally nor legally suitable to deliver independent patient care, thus the mentor is fully accountable for any act of the mentee during supervised clinical practice.

In a department under high clinical workload like ED, reducing time dedicated to care delivery to allow an adequate support for the nursing student assigned to the mentor can affect the mentor's efficiency and the quality of care he can provide. This entails that several aspects of the apprentice's training like documenting his training progress have been done during breaks or in leisure time.

On the other hand, nurses in their supernumerary period still need to learn knowledge and skills specific to their department, but the mentor-mentee relationship is different depending on whether they have already received their NMC PIN or not. When the apprentice has just graduated and has not received his NMC PIN yet he is not considered professionally and legally prepared for independent practice, so he is still behaving like a student towards his mentor even if he has finished his basic nursing training. However, the mentor have to monitor his apprentice less closely because the apprentice is aware that he cannot practice as a nurse without supervision and must perform HCA tasks while he is not with his mentor, since the apprentice nurse is responsible for any repercussions that may result from his practice if he is not under supervision.

In the case of nurses with NMC PIN in their supernumerary period, the mentor-mentee relationship depends on the mentee's experience, since the mentee may have recently received the NMC PIN or have years of experience and come from another department or hospital. This is because any new nurse that arrives at ED, regardless of his experience and training, is assigned a mentor for a temporary period dedicated to his adaptation. Therefore, even though the mentee could be a senior nurse he receives support from his mentor to adapt to the ED routine practice.

#### 6.4.5.4. Nurses' responsibility and influence in relation to other departments

LRI ED nurses work alongside different hospitals and departments in various fields to offer holistic treatment and care. Relationships between ED professionals and other departments or hospitals differ according to their function, even if they may be assembled into two main groups: specialist consultations in ED without hospitalisation and patient referral with hospitalisation. These relationships are structured in policies and are based on the presupposed influence of both parties.

There are other sporadic relationships between nurses from different departments, including equipment requests and during training courses. However, these are not common enough or have enough impact to change the influence between them.

Each hospital and each department have their own policies and their view regarding the role and relationship with ED in general and with ED nurses in particular.

##### 6.4.5.4.1. Leicester Royal Infirmary departments

In the LRI ED, patient stay is structured to be very short, referring patients to other departments if they need treatment or care for a longer period of time. This entails that ED personnel have to deal with staff from other departments to ensure care continuity.

The patients that after evaluation in ED need a prolonged hospital stay are generally transferred to the assessment units: AMU (ward 15 and 16) for medical evaluation,

AFU (ward 33) for gerontological assessment, SAU (ward 8) for surgical assessment and CAU (ward 9) for paediatric assessment. In these short-stay units, patients receive appropriate care and treatment for a few days until they are discharged home or transferred elsewhere.

Once the ED doctor has referred the patient to the doctor in the appropriate assessment unit and a bed has been assigned to the patient, the ED nurse must hand over to the assessment unit nurse. If the patient is considered stable (which is generally evaluated through his vital signs and the severity of his illness), the nurse can write a handover and transfer the patient without an escort with the help of the porter alongside the clinical documentation and written handover. Nonetheless, if the patient is unstable, the nurse must accompany the patient to ensure a safe transfer to the assessment unit.

The main interaction between the ED nurse and the assessment unit nurse is when the ED nurse gives the handover of an unstable patient after his transfer. The assessment unit nurse assumes the care received in ED is the same as the one he performs, so he prejudges the quality of the care offered by the ED nurse based on his subjective perception of quality care. On the other hand, the ED nurse prejudges the clinical workload faced by the assessment unit nurses and reacts in a non-constructive manner to the comments made by the assessment unit nurse.

This lack of empathy among professionals from different hospital wards and from ED is relatively common, since both of them work in different environments subject to different clinical workloads and different standards of care. This entails that their relationship is neutral, simple and functional, which is focused on adequate information transfer.

ED does not only transfer patient to assessment units but also uses the services of different specialties. The LRI has different specialties, but the most requested by ED without their own assessment unit are otolaryngology, plastic and maxillofacial surgery, orthopaedics and the stroke unit. Both the nurse and the doctor may request a patient review from professionals in those specialties, trying to avoid unnecessary hospital admissions.

Doctors and specialist nurses from other departments conduct a quick assessment of the patient and decide whether they can manage the patient in ED or he needs to be transferred to a ward in the relevant specialty. In cases where specialist professionals do not respond to the ED professional's call, the patient is admitted in the corresponding specialty for doctors and nurses to assess him there. Nevertheless, the stroke team always assess their patients in ED given the short period of time in which they can treat an ischemic cerebrovascular accident.

The nurses' relationship with these specialist doctors and nurses is focused on the moment when they request the specialist services, since the specialty team is responsible for patients that are referred to them and correspond to the patient profile treated in their department. After that, the relationship between the two is minimal and only focuses on whether the patient should be admitted to one specialty or another.

In the case of critical patients, they need specialised treatment and care for a long period of time, thus the ideal place for these patients to be treated long-term is not Resus. This is why the doctor can request support from an intensivist doctor and an ODP (operating department practitioner) when he manages critical patients. Both the intensivist and the ODP handle the airway and the anaesthesia during the patient stay in Resus until he is transferred to ITU (intensive therapy unit). The relationship between ED nurses and the ITU team is shallow but functional, through which the nurse serves as a connection to the ITU team with the resource and care distribution in Resus.

In cases where critical patients need emergency surgery, it is not appropriate to refer them to SAU because the operation would be delayed. Therefore, these patients go directly from Resus to the emergency operating theatre, where an entire surgical team waits for the patient. Since the nurse who escorts the patient to the operating theatre is aware of the current situation, he can give a quick handover to the surgical team if there been any changes during the transfer.

The relationship of nurses with other professionals from other departments is based primarily on their presupposed influence and the policies governing the movement of patients throughout the hospital. Since working with one another is rare, the relationship between them does not evolve beyond a cordial treatment.

#### 6.4.5.4.2. Departments in other hospitals

UHL is an NHS Trust formed mainly of three hospitals: LRI, GGH and LGH. Given the distribution of specialties through the three hospitals, patients requiring urologic, cardiac or respiratory specialist care must be transferred to another hospital. The main difference between these specialties and the ones present in the LRI is the need for patient transport by ambulance, which slows down the process and hinders the transport of unstable patients.

Regarding the LGH specialties, only urology and the second SAU present in the LGH receive patients regularly from ED. The nurse has no connection or influence in it, since is the doctor who hands over the patient to the LGH doctor.

In the case of GGH, patients with heart or lung problems must go through CDU before being distributed throughout GGH. However, there is a hostile relationship between the ED and CDU professionals due to the management of both departments.

CDU is an assessment unit of patients with heart and lung conditions, receiving patients from ED, GPs, ambulance services and other departments. Like any assessment unit, when CDU is at maximum capacity does not accept more patients. However, ED nurses feel that it is unfair that the department that allows access to acute specialised care does not suffer the clinical workload that ED suffers, while CDU nurses perceive that their ED colleagues underestimate them and do not they treat them as equals. This passive-aggressive conflict is not resolved because both groups of nurses only communicate by phone and none of them has worked regularly in the opposite environment.

Besides being part of UHL, the LRI is a trauma unit within the East Midlands trauma network, where the main trauma centre is Queens Medical Centre (QMC) in Nottingham. In cases of patients suffering from multiple fractures or needing neurosurgery, they must be transferred to QMC for specialised treatment. The only relationship between the LRI ED nurse and the QMC ED NIC is through the telephone handover done before the patient is transferred.

### 6.4.6. Interactions between the nurse and non-healthcare individuals

When working with people and for people, nurses must communicate and interact not only with colleagues but with all kinds of people. These people are the patients themselves, their families and friends, people connected with them in other ways and people without healthcare needs. Given the different roles and relationships that these people have, they cannot be understood as an indivisible group but as several subgroups.

#### 6.4.6.1. Nurse-patient relationship

The word patient is defined similarly in Spanish and English: "a person who is or will be medically assessed" (481) and "a person receiving or registered to receive medical treatment" (482) respectively. Although there is another definition in Spanish that could be applicable ("a person who suffers physically and corporally, and especially who is under medical care"), it should not apply to an ED, since in ED only emergencies should be managed, not anyone suffering from any disease or under medical care. Furthermore, this definition excludes mental and social care offered by ED for people with acute psychiatric problems or social issues.

Using the above definitions, the definition of patient applicable to this thesis is indicated, which is "a person registered in the LRI ED to be assessed by a practitioner and to receive medical treatment". The changes applied are linked to the human resources available in the department, in which not all practitioners are doctors (ANP, ENP, etc.). We take into account that not all treatment offered in an ED is prescribed or administered by a doctor, but the term "medical treatment" is used as a general concept that encompasses any healthcare treatment or intervention.

In order to comprehend the relationship between the patient and the nurse in an English ED, the change in the power balance that has occurred in recent years has to be understood. Since the revolution imposed by Bioethics and the birth of the social and legal defence against medical paternalism, United States of America led a change that empowered people and allowed them to decide which interventions and medical treatments they wanted to receive. However, when the United Kingdom decided to

adopt a system in which an autonomy concept similar to the American one was promoted in a public national health system through policies such as the *NHS Constitution*, several inconsistencies emerged:

- The application of a free demand system for healthcare services by NHS customers is neither fair nor economically feasible, since as it is publicly funded its distribution should be in accordance with the actual healthcare needs, not subjective needs not based on evidence.

- Healthcare professionals' training, according to several LRI nursing students and junior nurses, does not properly educate them to face a healthcare system highly legalised in which they must not only be excellent professionals but also they must meet the subjective customer needs and master legal and ethical concepts such as vicarious liability or autonomy.

- Differences between the point of view of healthcare professionals and hospital managers in the public funding and private management NHS model result in two different perspectives of the relationship between nurses and their patients: the classic nurse-patient relationship that remains in most healthcare institutions and the client-healthcare provider relationship that the hospital managers must establish to claim NHS funding. Nonetheless, both the interference of managers in clinical practice and the tendency of people to simplify healthcare based on their subjective demands has created a mixed relationship in which the nurse treat the client as a patient and the person who needs medical treatment treats the nurse as a care provider.

These incongruities, among others, demarcate a context in which two subjects, nurse and patient, have different perspectives on their relationship. Also, thanks to the legal and social protection linked to patient autonomy in recent decades, the power in the nurse-patient relationship has moved from the nurse to the patient, promoting defensive practice and unfair distribution of healthcare resources. This statement does not ignore the great advances that have been achieved by promoting patient autonomy, such as patient rights charts and control and criminalization of malpractice, but notes that these developments have led to negative side effects.

The client-care provider relationship is relatively new, so factors like age, education and social status influence it. Although the number of interactions and relationships between them is virtually infinite, we perceived some that repeated constantly, mainly due to the type of patients presenting to the LRI ED, patient flow, the ED environment and the characteristics of the treatment and care offered.

In the LRI ED, patients are assessed, treated and cared in a structured way, which is focused on urgent or emergency patient with mainly physiological needs. However, ED patients can have all kinds of needs: physiological, psychological and social. This fact significantly influences the relationship between the patient and the nurse, so it will be used as a divider factor of the following sub-sections.

##### 6.4.6.1.1. Patients with subjective urgent primarily physiological needs

Both policies and English EDs advertisements suggest that the priority of these departments is physiological emergencies. However, even though most patients treated in EDs suffer physiological illnesses, their wide diversity and complexity include a variety of different interactions.

One of the representative groups of any ED are patients that are not a medical emergency but come to ED looking for urgent treatment. This group goes to ED for several reasons, but two prevail due to their frequency: patients who are unaware of the seriousness of their situation or how ED works and patients seeking access to the services available in ED knowing that they do not suffer a medical emergency.

Despite advertising campaigns, a considerable part of the population treated in the LRI ED did not understand the role of EDs or lacked basic health knowledge. This led to patients with chronic diseases not under acute episodes or patients with non-urgent conditions to attend ED. A large proportion of them was referred directly to UCC, but a percentage of them entered the department through an ambulance or walking.

Once in ED, given the low severity of the patient's situation he waited hours for treatment because the sickest patients were prioritised ahead of him. When his turn

came, he tended to be frustrated but relieved because it was their turn. The nurse who assessed the patient, aware of his healthy state, performed a quick triage without any diagnostic tests, moving the patient to the next area of the department. In some cases, the nurse convinced the patient to discharge himself, even though triage-competent nurses are able to discharge patients. The interaction between the patient and the nurse in this context is conditioned by several factors:

- The patient who believes he is seriously ill does not usually trust the nurse assessment if it does not satisfy him, so he often claims a doctor's assessment. This leads to a longer stay in the department waiting for this medical assessment regardless of nursing triage.

- The routine for nurses who are not practitioners is to not discharge any patient even though they are able to do it, delegating this responsibility to the doctor or dialoguing with the patient until he self-discharges. The lack of practitioners in the assessment areas and the defensive practice conditioned by this routine facilitate many of these patients to continue their journey through ED without needing it.

- Adult patients or firstborn children make up the majority of this group, while seniors and young people often do not fall into this category due to their greater understanding of NHS processes and history and their superior health and education levels respectively. Therefore, triage nurses are more cautious in their assessments when the patient is not part of the latter groups.

All these factors, together with nurse's personal values and environmental factors like clinical workload, create a nurse-patient relationship based on miscommunication and respect for the applicable legislation.

This relationship is more obvious once the patient goes to areas like Majors or Minors. The nurse who receives the handover from a patient within this group has to distribute his time between this patient and others with more urgent needs, causing the nurse to only communicate with the patient when measuring his vital signs hourly, if needed. This creates a sense of abandonment in the patient, who believes he has been forgotten, which increases his fear and frustration. Nonetheless, the nurse knows that this type of

patient needs less care than the most urgent patients, so he considers that an hourly assessment is sufficient.

A large percentage of nurses tell their patients the estimated time to be assessed by a doctor and that one of the reasons why it is so long is that emergencies are a priority. Nevertheless, within this group the healthcare emergency perception is usually not appropriate, since they believe that they are suffering a healthcare emergency and they should be prioritised. This is accentuated if the patient has symptoms less common or unknown to him, even if they are not unusual for the nurse (temporary memory loss after traumatic head injury without prolonged loss of consciousness, red vomit after intoxication with red wine, mild oesophageal bleeding after tonsillectomy, etc.).

Once the patient has been assessed by the doctor, the health promotion offered by both the doctor and the nurse is poor or nonexistent, so reattendance is promoted. Due to this, the nurse-patient relationship deteriorates further, since nursing prejudice against the inappropriate use of ED services manifests in their attitude toward the patient. The only relationship maintained between the nurse and these patients is through the hourly observations, if required, and the questions that the nurse must perform to complete the mandatory forms within the nursing documentation.

On the other hand, there is another group that despite understanding that their situation is not an emergency decides to go to ED looking for quick healthcare services and expert diagnostic tests, treatment or evaluation. Even though each patient is individual and has his own reasons to behave in this manner, various factors precipitate that patients come to ED instead of the correct services:

- The fact that patients do not have to make an appointment to be seen in ED and it being open continuously suits the needs of any patient better than making an appointment at his general practice, even if their GP can offer urgent assessments. If it is considered that the LRI is a 15-minute walk from the city centre, this makes the LRI ED a convenient place to receive care for any pathology at any time.

- The LRI ED has access to various diagnostic tests and contains expert staff, so there are patients who believe they need diagnostic tests or a more expert assessment than their GP one, going to ED in search of this. However, GPs usually have more

experience than many ED doctors (excluding consultants and heads of service). Moreover, public perception regarding longer waiting times to see a doctor, a specialist or to be the subject of a diagnostic test promotes this practice even more.

- Patients with any disease or healthcare need that are not registered with a GP have no choice but to attend ED, since being registered in a general practice is the main way to access most NHS services.

The relationship forged between the patient and the nurse in this context depends primarily on the reasons why the patient has access ED without needing it being aware of it. In most cases, the patient feels powerless against their inability to get the treatment and care that he believes he needs, arguing that he is not aware that all that is offered in an ED is emergency care and they are desperate. This group has a similar relationship with the nurse as the previous group, with the same lack of communication and the same frustration.

Nonetheless, a segment of adolescent and young adult patients from this group is not satisfied with the nursing and medical assessments and demand diagnostic tests or treatments that they believe they need. Although this behaviour occurs at different rates in all patients and relatives groups, the greatest number of observed cases of people with this behaviour was patients without urgent or emergency needs and aware of the their disease's severity and the management of the department. In this case, the relationship between the nurse and the patient is different depending who describes it.

The standard nurse who works in the LRI ED focuses his relationship with his patient in the patient's direct or indirect basic needs that cannot cover himself, for which the nurse must assess his patients periodically. However, when a patient demands specific treatment or diagnostic tests he argues that he is a customer who has paid those services through his taxes. This entails a dialectical conflict between the nurse, who knows that the patient does not need what he demands, and the patient, who feels he does not get what he paid for.

This situation is not considered a legal problem, since the legislation and clinical policies support the professional to avoid unnecessary expenses to the NHS. However, the fear of making a misjudgement and the patient ease to sue the nurse create a tense

relationship, in which the defence of their own rights against others is the main goal instead of emergency care (since the patient does not need it).

If the patient is pressing enough in their demand for healthcare services, this will be acknowledged by the nurse coordinator, who will explain the current situation and revaluate the patient with the registered nurse. However, if a manager receives the patient's demand for services is more likely that this demand is met, since the manager seeks to avoid a complaint regardless of crowding and justice in resource distribution. Therefore, these patients require more time and resources that they should in theory need and most professionals do not want to be involved in their discharge to avoid possible legal problems.

This defines a patient-care provider bipolar relationship, in which the nurse and the patient maintain a passive-aggressive relationship that stops both the nurse to do his work efficiently and the patient to receive the services he claims. This patient-care provider relationship is maintained through different areas of the department and endures even when the patient has obtained the requested services, being characterised by dehumanised care, brief and infrequent communication and detailed written documentation of any discussion.

One of the main reasons for the existence of this dysfunctional relationship is the confrontation between nurse's Professional and Personal Ethics and patient's Personal Ethics. Most LRI ED nurses have been instilled in the importance of a fair distribution of human and material resources and to keep all patients safe. However, the same nurse depends on his job to survive, which could lose if patients sue him. From the patient's side, he defends his right to receive the healthcare services that he thinks necessary and which were paid through his taxes.

The risk that the nurse makes following his Professional Ethics is low, but the collective fear increases the insecurity of junior nurses, who tend to defend their personal subsistence above the values of their profession. This occurs to a lesser extent in senior nurses, who understand that if they follow adequate professional values (and the applicable legislation) they will rarely be punished.

In general, patients usually have community values, through which they understand that the best use of public resources is through the fair distribution of qualified professionals. Nonetheless, this small group of people put their personal values above community ones, especially the preservation of their subjective perception of their health, using methods such as discussion, coercion, deception or verbal and physical aggression.

Patients that prioritise their personal welfare above the civic use of public healthcare services for various reasons are usually classified by nurses as "second-class patients". This happens because ED nurses believe that in a service with limited resources they should be distributed among the people who need it and not to everyone without any distinction.

The problem that this segment of the population creates stigmatises all patients attending ED for subjective urgent needs, when most of them arrive due to ignorance or because they are not registered with a GP. This conditions nurses to react in a passive-aggressive manner to any patient that requires services that are not theoretically needed, moving the patient to the next area of the department or ignoring his requests in favour of more unstable patients.

##### 6.4.6.1.2. Patients with objective urgent primarily physiological needs

Once the characteristics of the patient group with physiological subjective needs have been distinguished, the largest group of patients presenting to the LRI ED can be discussed: patients who, after a triage, are identified with signs and symptoms that may be related to an urgent or emergency physiological pathology. As the largest group, ED and most of its policies are designed around this group of patients, so healthcare professionals are more accustomed to dealing with them. This statement does not mean that the nurse-patient relationship with these patients is not complex, but as it is the most common one the nurses feel more comfortable with it.

Overall, the nurse-patient relationship established in the LRI ED is based primarily on the coverage of needs that the patient cannot cover himself during an emergency.

Within these needs are basic needs such as nutrition, hygiene and sleep and more complex needs such as diagnosis or treatment of various diseases. Therefore, for the best possible nurse-patient relationship the patient must indicate his needs directly or indirectly to the nurse and the nurse should focus his practice in patient care through coverage of his respective needs (which should be reasonable and appropriate in an emergency situation).

The standard nurse-patient relationship would be between an expert nurse dedicated to his patients and an honest and kind patient. A frequent and cordial communication would remain between them, in which the nurse would be able to assess and meet the patient's changing needs through the description given by him, not only through his signs and symptoms.

The nurse would be able to provide holistic care covering not only physiological but also psychological, emotional or social needs, offering himself as an advocate for his patient within the English bureaucratic healthcare system. The patient would seek to be self-caring, depending on nursing care only for the needs that he could not cover himself, as he learns techniques and knowledge from the nurse to apply them in his future self-care. Unfortunately, many elements prevent the adequate nurse-patient relationship to be the prevalent one in the LRI ED, being the most important ones listed below:

- Clinical workload and crowding: The state of continuous crowding that was established in ED from mid-2015 onwards precipitated an increase in clinical workload so drastic that prevented to provision of holistic care to all patients. Therefore, nurses only had time to perform care and techniques to meet the most basic needs of all patients, thus maintaining a safe department and avoiding the deterioration of the patients' health.

Nevertheless, patients are not always aware of the severity of the situation, so they do not understand why they are not receiving the highest quality care as soon as possible. A common example is the patient's perception of being forgotten because he has been waiting for a long time, even after having explained him the triage process and the crowded state of the department. The patient's expectation is the planned order of a general practice, where turns are preset and consultations timed, but an ED cannot

provide estimated times given the dynamics within it (being Minors an exception, which works as a clinic but consultations are untimed).

Furthermore, since he has to prioritise care for the sickest patients, the nurse cannot always guarantee that every patient will have all his needs covered, so the relationship with the sickest patients is usually closer than with non-urgent patients. This does not mean that the nurse gives unfair priority to the sickest patients, but having to spend more time with those patient allows him to identify needs that would not be recognisable during the hourly vital sign monitoring done to non-urgent patients.

- Lack of human resources and imbalance in the distribution of technical competencies: Regardless of the clinical workload, the nurses leaving the department are not completely covered by the recruitment of new nurses, leading the department to rely on temporary nurses to fill the remaining places. If there are not enough nurses the patients per nurse ratio increases, allowing the nurse to spend less time per patient and exacerbating the consequences of the aforementioned crowding.

Nonetheless, even though the number of nurses established by the CQC after his visit was covered, the efficiency of permanent senior nurses is usually much higher than the efficiency of junior nurses and temporary nurses, since the latter are not able to perform different techniques or care due to lack of experience, knowledge or policy incompatibility between hospitals.

This affects both the nurse-patient relationship and clinical workload, since the lack of familiarity with the department and the inability to care for his patients independently subtracts time that should be devoted to strengthening the nurse-patient relationship through holistic care.

- Care continuity breach: The LRI ED is divided into areas, several of which must be traversed by the patient to be assessed, treated and cared for. Also, nurses are distributed through these areas, so care continuity is broken several times. At the same time, care continuity is also broken when a nurse performs a technique for a colleague who is not competent in it and when nurses cover each other during breaks and shift changes.

These interruptions between a nurse and another encourage other malpractices through communication failures, especially when the responsibility transfer in relation to a group of patients is temporary. It is in those moments when the patient feels he has no nurse, since he does not know him, so he asks the first nurse he encounters, who is likely to ignore him while he focuses on his patients.

The situation described implies that a patient could interact with the nurse who triaged him, the named nurse who cares for him while he is being treated, the nurse who performs the techniques in which the other nurse is not competent, the nurse covering the break of the named nurse and the nurse who takes over at the end of the shift. This not only hinders the nurse-patient relationship with a nurse in particular, but also reaffirms the sense of disarray that the patient feels in ED.

- Care division between nurse and HCA: In an ED, both nurses and HCAs are dedicated to patient care, being the nurses the only ones accountable for it. However, in the LRI ED it has been a trend towards HCA individuality, allowing them to engage in specific tasks unsupervised but fragmenting care between nurses and HCAs. This is because the nurse delegates tasks that the HCA is able to do so he can perform tasks that cannot be delegated to an HCA (medication administration, wound suturing, insertion of urinary catheters, etc.).

Public perception of the defining characteristics of a nurse makes it difficult to distinguish between a nurse and an HCA, since both can care for people and perform simple techniques. Therefore, the patient may try to establish a nurse-patient relationship with HCAs, maybe because they have more connection with him through hourly vital signs monitoring, maybe because he identifies them as nurses. This fact makes it difficult for the nurse to establish an adequate nurse-patient relationship, since he has less time to dedicate to basic care than the HCA and bears the accountability of both, which would not be a problem if the HCA was able to assess the patient's needs and communicate them to the nurse (a fact that only happens with sudden changes in vital signs).

The general context observed showed patients expressing their needs and concerns to HCAs, since they had more time to listen to every patient. However, they did not identify the patient's needs or concerns and communicated them to the nurse regularly.

Consequently, the patient had a camaraderie relationship with the HCA and a nursing technique receptor relationship with the nurse, which does not allow the nurse to provide holistic patient care.

- Long-term care in an ED: Both ED policies and ED personnel are adapted to treat and care for patients for a short period of time. However, one of the consequences of the recurrent exit block since 2015 is that patients are in ED for more than 4 hours regularly, which affects, among other things, the nurse-patient relationship.

The ED nurse has as a routine the delivery of basic care to cover the most urgent needs, delegating the rest to their colleagues in the wards, since patients are not in the department long enough for the nurse to analyse and meet all their needs. Even though all nurses should try to provide holistic care, time constraints have forged a punctual relationship between the nurse and the patient that ignores the non-urgent needs.

If patients cannot be transferred to another department, ED nurses should adapt their relationship with the patient. In this case, the nurse would have to create a care plan and search the physiological, psychological and emotional needs of the patient. Nonetheless, ED nurses are not comfortable with this relationship, in which the hospital institution and the patient expect holistic care but ED nurses have training, experience and specialised resources only linked to emergency care.

This means that many nurses despair when they must care for several seriously ill patients with multiple and complex needs for long periods of time, despair perceived as hostility or indifference by the patient.

- Dehumanisation of emergency care: Nurses have different methods of dealing with the stress of treating and caring for severely ill patients under high clinical workloads, one of the most common being the trivialisation of other people's suffering and dehumanisation of care. This is most obvious in senior nurses, when years filled with traumatic experiences have minimised their impact.

This view contrasts with the perspective of the average adult patient, who does not have advanced medical knowledge and overestimates the severity of his illness (this is less common in elderly patients). This entails that when the nurse and the patient begin to create a relationship between them, the nurse’s apathy contrasts with the patient's

anxiety, creating the illusion that they speak about two different situations. This relationship enhances the prejudices that nurses can have on the patient and the patient's insecurity on the nurse's competence.

Although the above statement does not apply to all nurses, dehumanisation of care is manifested in other aspects of care that affect a high percentage of nurses in the LRI ED. One of the most common aspects is the rejection of certain aspects of care (hygiene, nutrition, sleep, etc.) and the prioritisation of physical needs in favour of psychological or emotional needs.

Dehumanisation of nursing care in ED is primarily a result of the distribution of scarce human resources, which are dedicated to the care of patients in critical conditions, deliberately ignoring others. Therefore, the nurse who is only able to see his patient to give medication and measure vital signs is unable to create a functional nurse-patient relationship, so the patient does not receive the holistic care he deserves because nurses do not have time to analyse and meet his needs. However, as long as patient numbers are not reduced, nurse numbers are not increased or clinical practice is not changed there is no other viable alternative, since establishing an adequate nurse-patient relationship requires time and resources that if they are not distributed appropriately can derive into patient harm or death by negligence.

- Patient's lack of credibility in the nurse: The nursing social and professional status has evolved throughout its history, but in England the figure of Nightingale is still present in the nurses' public perception, so the public tends to underestimate the general knowledge and skills of a nurse.

Nonetheless, this proposition is partly based on reality. The range of knowledge, skills and competencies of a nurse changes drastically depending on the environment in which the nurse practices, since differences can be observed even among nurses in the same area. Therefore, the patient does not know what his nurse's capabilities are and presupposes a basic level if it is not proven otherwise. Being EDs an area of specialised practice, nurses have a set of specific knowledge and skills that are not generally known by the public.

When the patient comes to ED, he thinks his problem is an emergency, so he expects to be treated by a qualified and experienced professional, who is, in his view, the doctor. This is why, even though he does not have any doubt of the nurses' professionalism, he demands medical assessment as a solution to his alleged emergency.

The relationship worsened by this context is usually corrected when the nurse directly or indirectly demonstrates his knowledge and skills, so in a high percentage of cases the effect of this factor on the nurse-patient relationship is temporary. On the other hand, there are cases in which patients underestimate nurses' skills for various reasons that are more durable (bad past experiences, prejudices about Nursing as a collective, etc.).

In these particular cases is when the nurse-patient relationship is severely damaged. The nurse is offended as a professional and the patient believes that the nurse is the obstacle to overcome to access the doctor, so the care provided by nurses is deficient due to the lower nurses' willingness to care for the patient and the higher patient's reticence to receive nursing care.

- Excessive documentation: Nursing practice documentation is an essential part of it, which contributes to care continuity between nurses and within the multidisciplinary team over time. Another function is to be a professional and legal proof for the healthcare provider against a negligence accusation, thus protecting both the healthcare institution and the nurse.

To avoid missing any essential aspects of care and to provide the healthcare institution with evidence against any litigation in a systematic way, nursing documentation is structured in various forms to be filled. This requires time, which must be subtracted from the time spent on patient care.

The problem this poses is that inadequate clinical documentation is sanctioned both by senior nursing managers and by professional and legal institutions in case of litigation, while inadequate care is blamed to clinical workload and is not investigated in most cases. Therefore, many nurses prioritise documentation before care for fear of legal and professional consequences. This is more common in temporary nurses, who in the absence of support and confidence from the nursing team fear being blamed for any negligence even if they did not commit it.

This context encourages nurses to devote a considerable part of their time documenting their practice, which is observed by patients in most cases, since the nursing station is visible. If the fact that the patient feels neglected during periods of high clinical workload is taken into account, the situation worsens when he sees the nurse devoting so much time to documentation while focusing their discussions on closed questions to fill out nursing forms rather than meet what he believes that are the needs that cannot be covered by himself.

- Care protocolisation: Nurses are aware that they must follow policies in order to provide the care considered optimal by hospital standards. However, strict adherence to policies does not always guarantee the most excellent care, especially if the policy is outdated or generalises the practice of specific areas. On the other hand, another aspect that ensures that nurses follow policies regardless of their effectiveness in the context in which they apply is vicarious accountability, through which the healthcare institution protects the nurse legally and professionally only if he follows those policies strictly.

The effect these events have on the nurse-patient relationship is relative to the context, since only when policies do not meet patient needs these affect his relationship with the nurse. This happens because the nurse usually protects his professional and legal situation over an increment in the quality of patient care, which can degrade the patient's trust in the nurse.

A recurring example in the analysed time period is the generalised prioritisation of vital signs monitoring over other types of care, even if the patient does not need it. Faced with this situation, the patient is frustrated by having to endure hourly vital signs monitoring and by being unable to receive the care he believes he needs, while the nurse cannot devote time to strengthen the relationship with his patient if he must measure the vital signs of all his patients hourly.

The oddest thing about this example is that nurses are allowed according to the policy to measure vital signs at longer intervals of time if they think it is appropriate and they document it, but the pressure from nurse coordinators and the nurse’s reluctance to make decisions against the routine nursing practice precipitate that nurses prioritise vital

signs monitoring and medication administration over other facets of care that could be more important for the patient.

Another aspect of protocolised care is blind obedience to high-rank personnel in the hospital hierarchy. In some cases, managers have healthcare training and experience, so it is possible to discuss decisions affecting patients with them. However, there is a percentage of managers who only have business knowledge, who focus on the economic viability of the hospital. To facilitate it, they prioritise patient flow through the department over care quality, since more money is lost in the department for failing to meet national objectives that through patient complaints.

In an ideal situation, the nurse defends his patients' right to decent care, but the current hierarchy overrides the nurse's decision-making if it contradicts the manager's one. Consequently, it is difficult to create a nurse-patient relationship if the nurse feels unable to defend the interests of the patient and the patient feels abandoned by the healthcare system in general and the nurse who cares for him in particular.

- Nurse's individuality: Although nurses have similar training and must follow the same deontological code, other elements that constitute them as individuals equally influence on how they relate to their patients.

One of the most obvious factors in the analysed practice period was how different life experiences, whether are connected to practice or not, shape the way in which each nurse starts a nurse-patient relationship. Work experiences as a nurse or other jobs, socio-economic status or additional training are several aspects that change how a nurse can relate to his patients. However, the variability of the nurse-patient relationship is minimised by following the *NMC Code* and the healthcare institution code of conduct, resulting in an apparently cordial relationship between the nurse and the patient regardless of the nurse's life experiences.

Although applicable codes of conduct specify that the nurse should not make value judgments, these were common during the period analysed. Separating personal and professionals values during fast and consistent decision-making is very difficult, so much so that it is considered negative by many senior nurses because they could not use

their instinct in decision-making, which is based primarily on their previous experiences.

A common example is pain management in acute patients, which could be based only on signs and symptoms, but these are not sufficient to identify the patient's pain, so nurses have to apply value judgments based on previous experience to identify the existence of real pain. Therefore, even though the nurse-patient relationship is apparently cordial, beneath it there is a layer of prejudice that can improve or worsen the quality of care depending on the context.

Another particular factor in EDs is stress management. Clinical workload and patient severity create a situation of continuous stress that affects how nurses interact with patients and colleagues. If the nurse is not able to deal efficiently with stress he will burn out slowly, which impairs his ability to empathise with his patients, dehumanises his care and affects his quality of life inside and outside ED.

One element to consider is the nurse's integration in the department. Temporary nurses feel that their only role is to care for their patients, so they should be able to offer holistic care, but their lack of familiarity with the department promotes defensive practice and inadequate time distribution. This entails that, since they are not familiar with the procedures in the department and its policies, they will focus more on meeting the legal requirements of their work than establishing a relationship with their patients. However, the previous indication does not apply to temporary nurses who work regularly in the LRI ED. On the other hand, permanent nurses and regular temporary nurses are more aware of the general situation of the department, so they are capable of spending more time establishing a nurse-patient relationship.

A categorical factor concerning how nurses engage relationships with their patients is their job role and its linked accountability. In the case of registered nurses, they are only accountable for patients assigned to them, so they do not usually start a nurse-patient relationship with other patients. On the other hand, nurse coordinators and NICs are indirectly accountable for all patients in their area and department respectively, but it would be impossible to engage in a meaningful relationship with all those patients.

In conclusion, practice suggests that the nurses' contribution to their relationship with the patient is shaped by their Professional Ethics superficially, while their life experiences and values forged through them create their Personal Ethics, through which they build their practice and their relationship with patients.

- Patient's individuality: The diseases that patients may experience are very different, so that could be considered a defining aspect of their individuality. However, the reaction of each patient to his pathology also individualises him, since there are virtually infinite reactions to each condition; being the suppression of symptoms, the anxiety about the possibility of dying and the disease severity underestimation or overestimation the most common ones. These reactions may be modified by many elements, including their life experiences and their health knowledge, whether truthful or not. This enables those elements to modify their normal behaviour and reasoning, facilitating or hindering their relationship with the nurse depending on the context.

Regardless of how the patient perceives his illness, some of them are capable of altering the patient's consciousness from confusion or delirium to coma. Even though the nurse understands that the patient's consciousness is impaired, this hinders communication between them and stops the nurse from finding all patient's needs.

Not only nurses have individuality, but each patient is a different person from the rest. Nevertheless, unlike nurses, patients are not governed by any specific deontological or ethical code. In theory, every person in a developed country like England should follow a civic minimum Ethics, which allows the construction of a stable society. Even though civic Ethics exists and is a fundamental element of English society, it is only present superficially. It is during a period of vulnerability like being sick when personal values, part of personal maximum Ethics, matched or cancel civic Ethics in a considerable percentage of patients, especially in adult patients. This leads to a lack of empathy with the multidisciplinary team and other patients in favour of selfishness justified by their survival instinct.

The effect that this has on the nurse-patient relationship is very varied. Nurses are aware of the real severity of the disease and tend to react negatively to conscious and repeated acts of selfishness by a patient who is often prejudged along his journey through ED.

However, when the patient demands favourable treatment inappropriately he can obtain it under the threat to put a complaint or sue the nurse. This situation results in people who do not respect a minimum civic Ethics receiving better healthcare services than people who respect it, so selfishness and lack of civic values are accidentally promoted.

The pinnacle of this phenomenon is a subgroup of these patients who make regular visits to the apartment in search of different services that are not emergency care (food, shelter, conversation, friendly human contact, opiates, etc.). These know their rights as patients and the legal duties of nurses and healthcare institutions and argument their demands based on those duties. In these cases, the nurse-patient relationship is very negative, since nurses consider these patients as a waste of resources or a government failure, which should cover their needs appropriately.

In conclusion, each patient is different and their values and personality affect the relationship established with the nurse. However, there are common reactions to being ill that nurses are able to recognise, which can be interpreted positively or negatively, being one of the most common and negative lack of civility.

All these factors generate an infinite number of nurse-patient relationships different from the standard type, depending on the context and the different modifying factors. In the LRI ED, all of them create an environment in which the nurse-patient relationship is dehumanised and only can be maintained through a superficial cordial relationship that allows both the nurse and the patient to not break the Law, since both follow their personal values above professional and civic Ethics. This does not mean that there are no nurses and patients that take into account professional or civic Ethics, but the trend has been the defence of personal values and needs above the values and needs of others.

#### 6.4.6.1.3. Patients with primarily psychological or psychiatric urgent needs

The nurses' relationship with patients with mental health problems is conditioned by the same factors as patients with physiological problems, even though some of them are changed drastically. First and foremost is that LRI ED nurses do not have special training to treat and care for patients with mental health problems, solely an annual 7-

hours course in order to meet government requirements. This means that when they engage with these patients they are not trained for it, making it more difficult for a patient to trust his nurse, essential aspect to form a nurse-patient relationship. Furthermore, due to the lack mental health training, prejudices based on the stigma associated with mental health problems in England are frequent among nurses, who blame the patient for his illness.

One of the reasons that push patients with mental health problems to attend ED rather than a specialist mental health service is that EDs are considered a "safe place" for patients who cannot be transferred to another place. The lack of services for acute mental health disorders or their deficiencies affects ED, which has a 24-hour mental health practitioner to deal with these cases. However, this mental health practitioner only assesses patients without any physiological diseases, which must be proven by a doctor.

From the patient’s perspective, a high percentage of acute mental disorders or chronic mental disorders with acute episodes alter the patient’s consciousness or his perception of reality. This situation can make it difficult to express his needs, establish a relationship with someone or follow a basic civic behaviour, including the use of verbal or physical aggression. The nurse must ensure that his patients do not present a danger to themselves or other patients, so this kind of behaviour hinders care even more.

In extreme cases, the nurse or doctor may temporarily restrict the patient's freedom to protect him or the public. For this, the patient's mental capacity should be considered impaired, since the patient is considered unable to retain and process information. However, this process is very delicate, since if the nurse or doctor restricts patient freedom based on an erroneous assessment they are committing a criminal offence. Also, mental capacity is variable since it is assessed in every decision taken by the patient, which complicates the decision-making process further.

This case is a clear example of a phenomenon that occurs in the nurse-patient relationship, but is accentuated in aggressive patients: the interaction between nurses' clinical status and the patient’s legal rights. The nurse appeals to beneficence against the patient based on his clinical knowledge and the nurse’s presupposed social status, while the patient claims his rights through his status as British resident (temporary or

permanent). In this interaction there is not usually a person who is indisputably right, allowing a discussion to reach a solution that harms neither of them, in which the position of power moves from one person to the other repeatedly.

The nurse could surpass the patient's freedom without taken him into account if he considered necessary, but future malpractice professional and legal consequences in these cases are very serious, so it only happens in extreme cases. In the vast majority of cases, when the nurse-patient relationship becomes a seemingly endless conflict, experienced nurses and doctors are usually involved to prevent inappropriate actions from both the nurse and the patient.

For patients with mental health problems, this interaction is even more complex because it is not clear if their perception of reality is altered or not. Therefore, the nurse has to discern the patient's general mental state and engage him considering his perception of reality, trying to avoid more stress for the patient and creating a functional nurse-patient relationship. This does not prevent the nurse from protecting himself with specific room distribution or security personnel, which can be misinterpreted by the patient and break the relationship between the two, but the nurse believes that safety is more important than his relationship with the patient.

#### 6.4.6.1.4. People with primarily social urgent needs

There are people who come to the LRI ED looking for different services, who do not suffer any acute physiological or mental condition that can be considered an emergency. This phenomenon occurs because English EDs are designed to attend every person, so people looking for different services consider that the most efficient way to get them is in ED.

Although the operation of the department is not designed to address non-pathological needs, in specific situations it is common to attend various social needs. One of the most common is the protection of vulnerable people temporarily in cases of domestic violence, assault or different crimes that may have resulted in physical or mental harm. In these cases, the person is protected and cared for in the department until the police secure a place for that person or until he is transferred to a hospital ward.

Another very frequent case in EDs is people who suffer a non-urgent health problem or condition that is not adequately addressed in the community. Whether they know that their condition is not urgent or not, these people perceive EDs as the gateway to all hospital services that they believe they need. Therefore, they attend ED on the grounds that their condition is urgent or that their doctor does not offer the healthcare services they consider appropriate. These people suffer the consequences of financial cuts in healthcare services and are forced to resort to EDs as a last resort, even if a part of this group that consciously takes advantage of the speed and diversity of the services offered in ED to manage their non-urgent needs.

A pattern of attendance repeats for homeless individuals and people addicted to alcohol or other substances: the person is found unconscious during the night by a passer-by and is taken by ambulance to the nearest ED where he can be fed and rest until he is able to go on his own. Even though alcohol poisoning and reduced level of consciousness are considered physiological problems, nurses are aware of the social problems caused by this situation and the final purpose of their stay: food and shelter. Due to this, nurses prejudge that this person should not be in ED using resources that could be used in patients with urgent healthcare needs.

Within the group of patients addicted to various substances, there is a particular subgroup going to ED in search of substances which are not accessible legally but are commonly used in hospitals, being morphine the most common one. The conflict that these people present is that they often pretend to suffer an exacerbation of chronic pain, a relatively common condition in ED. Because of this, nurses have created an opiate abuse prejudice around patients suffering an exacerbation of chronic pain, especially if they are recurrent patients. This leads nurses to be unable to empathise with these patients and establish a functional nurse-patient relationship, even if they are not seeking opioids.

Another small but characteristic group is the people who come to ED seeking human contact, which is often masked as chronic physiological problems. It can be excused as accidental falls, alcohol abuse, chest pain or any symptoms with the potential to match an urgent disease, but after the relevant investigations nothing abnormal is found and the patient is discharged. These people regularly attend the department where they

receive care and attention until the doctor makes a diagnosis. If this situation is repeated over a long period of time, the ED consultant team and the patient's GP create an urgent care plan in which they specify in which situations that person will be considered an ED patient and what treatments and care he should receive.

Although different groups of people were mentioned, all of them have something in common: they suffer, at least apparently, no urgent physical or mental condition objectively or subjectively. Therefore, in theory they should not attend ED. At the beginning of the period analysed, when the clinical workload was not as high, the assistance of these people was prejudged but tolerated, resulting in them receiving similar care as other patients with a weak nurse-patient relationship. However, due to the continuous clinical workload growth at the end of 2015, nurses were forced to distribute their time between more patients and more tasks. This entailed that they spend less time with these people in favour of sicker patients, so the nurses' prejudice grew amongst them.

Despite the observed prejudgements, nurses assess care individually, so in some cases they could reinterpret policies to provide appropriate services to the people that needed them (providing shelter masquerading it as an observation period, performing theoretically unnecessary tests to prevent anxiety outbreaks, spending a few extra minutes to talk to the patient during his assessment even if the issue is not related to it, etc.). Nonetheless, as previously mentioned, the uncontrolled increase in clinical workload and the lack of material and human resources drastically reduced this practice in favour of a quicker and more dehumanised care.

#### 6.4.6.2. Nurse - patient's relative relationship

Patients attending ED, like anyone else, can have a social circle that cares for them. This implies that some of them can accompany the department or ask for him by phone. The relationship between the nurse and the patient's relative via telephone is minimal given the limited information that the nurse can reveal via telephone. However, if the patient's relative is with him, the interaction between him and the nurse is more extensive and complex.

Given that there are different types of social relationships that the patient may have with another person and that these relationships may involve different levels of confidence, the nurse has to take into account various factors to learn how to interact with the patient's relatives.

One of these factors is whether the family or friendship relationship translates into a positive social relationship with the patient. Nurses often assume that people who accompany patients do it with the intent to safeguard them in their temporary state of dependence, but this is not always the case. It is not a nursing task to solve the friends and family problems that the patient may have, but what the nurse does is protect vulnerable patients from possible harmful agents, even if they are friends or relatives. This occurs in extreme cases where domestic violence, assault, attempted murder, extortion or any other act involving a serious and immediate danger to the patient is presumed. In these extreme cases, the competent authorities and institutions will be notified in order to protect the patient regardless of the opinion of the possible aggressor.

A much more common factor than relative's maleficence is breaking patient confidentiality with his relative without the patient's authorisation. Nurses are used to assess, treat and care for patients with their relatives without asking who they are or if they are authorised to hear patient's private information. In most cases, a person accompanying a patient entails that he trusts him enough to want his support in times of weakness, but this does not always indicate that the patient agrees to share any personal information with his relative.

When the nurse believes that the information is especially delicate (illegal acts, mental health assessments, socially stigmatised diseases, etc.) he often asks the patient if his relatives can leave the box or invites said relatives out of the box. This behaviour, even if it strengthens the nurse-patient relationship and protects patient privacy, it also reduces confidence from the patient's relative and it may be the beginning of a conflict with the nurse. However, there is an opposite situation in which the patient does not trust the nurse or is unable to communicate with him and is the patient's relative who provides information to facilitate patient's assessment and care.

Just as there are a virtually infinite number of different patients, there are a virtually infinite number of different patient's friends and relatives, each one with his own personality, his goals and his attitude towards society in general and nurses in particular. Nonetheless, if we ignore the personal past experiences, the characteristics that define the relationship of most patient's relatives with the nurse depends directly or indirectly on the perception that the patient's relative has on the quality of care that the patient is receiving. Therefore, the patient's relative serves as a biased unskilled nursing care assessor and patient's rights advocate if he considers that the care provided is inadequate.

In most cases, the patient-patient's relative-nurse relationship is positive, since the relative does not only provides another perspective on the evaluation of the care offered but also is able to offer support in gathering patient information, patient stress management and other care needs. However, the relative is often not familiar with the operation of the department and does not usually have advanced healthcare knowledge, so the support offered can be harmful despite being well-intentioned.

One of the most common situations that demonstrate how the intervention of patient's relatives may indirectly impair patient care is when the relative's demands are made constantly or aggressively. This usually happens when the department is crowded and the relative has to wait for the patient to be assessed and treated, since the relative often perceived the patient's pathology is more urgent than it actually is compared to other patients in the same area. In these cases, the relative repeatedly asked how long the patient is going to wait to be assessed by the doctor or the nurse, which disrupts their practice. Furthermore, when he is informed of the estimated waiting time he might continue asking and try to coerce the nurse coordinator to prioritise his relative, usually without success.

ED staff is used to dealing with questions from patients and relatives, but continuous interruptions lead to accidental errors in practice and take time that could be used in patient care. In cases when the relative uses continued harassment or verbal aggression, nurses tend to avoid that person and the patient he accompanies unconsciously. This can be reduced with good communication between both sides, but this is not always enough to satisfy the anxiety produced by waiting with a sick patient.

Regarding the care that relatives can receive from nurses, as they are voluntary chaperones of the patient is assumed that they are independent and able to meet their basic needs independently, so the nurse should not worry about their health. However, there are exceptions like relatives of a deceased patient who need nursing emotional care to pass the first stage of bereavement in a healthy way.

If the relationship between the nurse and the patient's relative is generalised and simplified, it would be like a defender of an individual patient against an advocate for all patients in the department. In an ideal situation, both would work together to provide the highest quality care but under high clinical workload using time to strengthen the relationship with patient's relatives is secondary to patient care per se. Both Professional Ethics and Personal Ethics push the nurse to prioritise the patient above his relatives, since even if relatives can offer extra support patients are who need help and care.

#### 6.4.6.3. Relationship between nurses and other people involved with the patient

When a patient comes to the LRI ED is not accompanied by family or friends only, since there are other people who are not ED staff who interact with the patient regularly.

The most common example is ambulance transport personnel: paramedics, ambulance technicians and ECAs. They accompany the patient from their location to the hospital, stabilising him in various ways according to their rank and competencies, since the patient is their responsibility during the trip. Being a volunteer transport and thanks to early, individualised and on-site paramedic intervention, paramedic-patient relationship tends to be mostly positive.

On the other hand, the paramedic-nurse relationship can be conflicting, despite being cordial. This happens mainly because paramedics feel responsible for their patients until they hand over to hospital staff, whether they are in the hospital or not, which is a problem during periods of exit block. Is in those cases when paramedics must wait to hand over several minutes or hours caring for a potentially critically ill patient in an ambulance even if their shift is finished, which creates an accountability conflict

between the paramedic (capable only of providing short-term treatment with limited knowledge and resources) and the nurse coordinator (unable to introduce more patients within the department without compromising patient safety). Once inside the hospital, paramedics are able to access hospital resources even if they have to wait to give their handover, so the fact of waiting more does not increase the tension between the nurse and the paramedic.

In 2015, a computer system that monitored the paramedics' entrances and exits was introduced, which penalised the hospital if paramedics were waiting to hand over and penalised the paramedics who remained near the hospital once they handed over their patient. This worsened the relationship between paramedics and nurses for a few weeks, as they blamed each other for breaches recorded by the computer system. Nonetheless, this tension dissipated in two months and the relationship between ambulance transport personnel and nurses returned to be friendly.

During the handover, paramedic transmits patient information that may be useful to the nurse, which expects a minimum amount of information (personal data, weight, presumed urgent disease, past medical history, etc.). This handover is also an opportunity for the paramedic to review his documentation and to write any forgotten key information. On the other hand, the opposite process occurs when a nurse needs an ambulance to transfer one of his unstable patients to LGH or GGH.

Another group of people who interact with a large number of patients are British police forces. Police officers accompany many patients to protect them if there is a serious risk, escort arrested patients or get information from patients once they are treated in ED. In addition, their presence may be required if an offence is committed within the department.

Unlike ambulance transport personnel, police officers do not have advanced healthcare knowledge, so they do not have authority in decision-making regarding patients' health. Therefore, their roles are very different and the relationship between them and nurses is more distant than with paramedics.

There are common interactions between nurses and police officers, one of them being especially dangerous patient restrain. In these cases, the nurse is accountable for the

patient's health, even if this means to contradict the police officers' immobilisation method, since inadequate immobilisation can end in death by asphyxiation.

Another common interaction is obtaining patient information through the nurse, usually without the patient's consent. The nurse is usually reluctant to disclose private patient information without his consent, so it is usually through the NIC or a duty manager through whom the police officer has access to personal patient data. However, police officers know both legislation and various techniques for obtaining information subtly, so sometimes they are able to obtain private patient information through the nurse unconsciously. This leads to a general distrust among nurses when a police officer makes them any questions, even though they feel safe if the police officer is only intended to contain the patient, preventing a risk for the other patients.

There are other officers who guard patients from prison through the department while they are chained to them, the prison guards. The prison guards' relationship with the nurse is reduced, since they do not usually know any relevant patient information and the nurse does not need to report anything specific to the guards. However, as they are chained to the patient, the guards cannot cover all their needs by themselves, so it is usual that the nurse gives them water, food or a chair to sit if necessary.

In general, the nurses' relationship with these groups of people related to the patient is cordial and mutually beneficial. However, there is no obvious benefit for the nurse to deepen his relationship with these people, in contradistinction to patient's relatives.

#### 6.4.6.4. Relationship between nurses and people not linked to the patient

While it is considered that there could be people in ED who do not work in the department, are not patients and are not related to any patient; their number and frequency of appearance is so low that their interaction with nurses will not be studied in depth. The relationship between this group of people and nurses is cordial in general, even if it is different from each nurse.

Since this group of people do not need emergency nursing care or are entitled to receive any information from any patient, this type of social relations will be generalised as

standard individuals, without any associated role. In these cases, the nurse guides the person outside ED, since this person adds crowding to the department without needing any treatment or care.

Nevertheless, we must briefly mention two groups that are treated slightly differently than the general public without urgent healthcare needs. The first is famous visitors, which are subject to specific communication policies in which any communication with them that is not programmed by UHL is prohibited. The second would be journalists authorised by UHL, who can ask nurses about issues not related to personal information about patients if it does not entail nursing performance issues or care quality deterioration.

### 6.5. Customs and routines in specific areas

The LRI ED is divided into different areas, which even if they work in harmony their practices and customs are different from each other. There are in these details where has been perceived greater individuality in decision-making, which differs from one nurse to another in the same situation but follows a specific pattern. This may be due to factors such as nurses' Personal Ethics, their knowledge and skills or a biased perception of the situation, but each routine is delimited by different factors.

#### 6.5.1. Assessment Bay

Assessment Bay nurse's clinical practice revolves around the triage and primary and secondary assessment of ED patients. This process, although routine, is always different due to the patient's and the nurse's individuality and the relationship between them.

One of the problems in Assessment Bay's routine practice is the misreading of triage as primary and secondary survey. National targets mark all patients should be triaged in 15 minutes, relatively simple task if there is no entry or exit block. However, ED's routine direct nurses to perform additional tasks as part of the patient's assessment, which is nurse's responsibility:

- Paramedic handover's reception: The nurse must transfer, with the paramedic, the patient from the ambulance stretcher to the ED stretcher. Once transferred on an ED box, the nurse must receive and document the handover from the paramedic, which must contain at least: admission cause, related events to that cause, past medical history, medication administered by paramedics, weight, allergies, social situation and vital signs.

Meanwhile, the HCA measures the patient's vital signs to compare them with the ones from the handover and evaluate the patient's condition in real time.

- Primary and secondary survey: Once the paramedic has ended his handover, the nurse must perform a primary and secondary survey ensuring that no change happened since the paramedic made his evaluation and assessing the seriousness

linked to those changes. In the secondary assessment, the nurse should confirm any patient information received through the paramedic to avoid confusions or mistakes.

Based on this assessment, the nurse assigns a value within the dynamic priority score (DPS), which can change if the patient's condition improves or worsens. This scale is scored on vital signs and other patient values, which is distributed in DPS 3 (stable patients that can be assessed in order of arrival), DPS 2 (unstable patients that should be assessed in less than 30 minutes) and DPS 1 (emergency to be assessed and treated immediately).

- Expert assessment in case of doubt or critical condition: Although nurses are those who carry out most assessments, they can ask for support to the doctors or ANPs present if they consider that the patient would benefit from expert assessment or need that a doctor prescribes medication to their patient. Critical conditions such as septic shock are always assessed by a nurse and a doctor in order to make the best assessment possible.

- Diagnostic tests: Once the assessment has been performed, several diagnostic tests are often needed to diagnose and treat the patient's disease. Therefore, diagnostic tests such as blood tests and electrocardiograms are requested, conducted and analysed by the nurse and the HCA in Assessment Bay to avoid unnecessary delays in patient flow. In addition, doctors review urgent diagnostic tests to prevent that important details are ignored.

- Emergency medication management: When the nurse or the doctor considers that the patient needs medication immediately, it can be administered in Assessment Bay or can be handed over to the Majors nurse. However, if Majors is blocked Assessment Bay nurses should administer the medication to prevent any patient deterioration due to not receiving it in time.

There are also situations like patients with severe pain or septic patients that receive medication in Assessment Bay regardless of the situation of other areas.

- Handover to the next area: The nurse and the HCA must find and hand over the patient that they have assessed to the corresponding nurse in Majors, Resus, Minors

or EDU. This handover should be quick but complete, covering the relevant information for diagnosis, treatment and patient care.

This fact implies that to meet the triage time national targets imposed on Assessment Bay evaluations a hasty and incomplete assessment should be performed, since it is impossible to perform all tasks linked to an adequate patient evaluation in 15 minutes in most cases. This worsens if there is exit block, since the management of patient distribution across the area consumes time that should be devoted to assessing patients.

The solution applied by nurses to this dilemma is individual, since some prefer to perform all his tasks correctly taking longer and others decide to hasten their assessment to do it as fast as possible even if it is incomplete. This freedom of practice is allowed because all Assessment Bay nurses must be experienced nurses able to assess the patient's situation and manage time distribution, which should be tailored to each patient and the area's general situation. Therefore, each nurse is responsible for conducting a correct assessment to their patients, even if the nurse coordinator presses for quick assessments.

Assessment Bay nurses and their nurse coordinator are aware that if they make their assessment too quickly they are more likely to commit errors that may result in harm to the patient, but they rush their evaluations to avoid the consequences of an entry block.

If Assessment Bay is not able to accommodate more patients it is considered an entry block, since Assessment Bay is the main entrance for adult patients in ED. When this entry block occurs, the remaining patients must wait in the ambulance, which has several consequences like deterioration of critical patients, lack of control over the patients' health outside the department and Assessment Bay human resource distribution to monitor patients in ambulances. Moreover, the movement of patients from the waiting area to a box to be assessed is more complex, since the spaces to place a stretcher are limited but the capacity for ambulatory patients is much higher. This entails that when a patient on a stretcher has to be moved outside a box to assess an ambulatory patient there is no space to place the stretcher and the ambulatory patient cannot be assessed.

The consequences of entry block connect in a positive feedback loop, since as more patients are waiting for assessment or transfer to an area more difficult is to distribute, monitor and assess them, devoting more time to each patient only due to the lack of patient flow through Assessment Bay.

In the second half of 2015, during the clinical workload peak observed in this period, the primary and secondary surveys were separated to meet national targets by allocating the 15 minutes limit to only the primary survey. This primary survey consists on the handover from the paramedic to the nurse coordinator, during which he assigned the DPS and measured the patient's vital signs. Even though this fact balanced the NHS requirements with real practice, it also led to patients waiting hours to be assessed without any pressure from nurse coordinators or managers.

Another fundamental aspect of Assessment Bay nursing practice is teamwork between the HCA and the nurse. Each nurse works with an HCA throughout his shift, interpenetrating for an adequate and efficient assessment. However, teamwork between nurses and HCAs is often little or inexistent, trying to perform different tasks separately as independent professionals. This situation depends on each nurse and HCA, but there are two main factors that hinder teamwork between them:

- HCA's refusal to accept his role in Assessment Bay: The HCA's role in Assessment Bay is to measure vital signs and to perform diagnostic tests, since other tasks are performed by nurses. However, some HCAs refuse to perform their tasks continuously, arguing that the nurse should share the clinical workload. This is because patient assessment is a task that is underestimated by the HCA, who perceives patient assessment as the search for a cause of a problem and not the analysis of the patient's physical and mental condition.

- Nurse's exploitation of his influence on the HCA: Even though the HCA and the nurse work as a team, the nurse's decision prevails in the event of a discrepancy. Some nurses take advantage of this situation and delegate all possible tasks to the HCA even if they are not busy, thus promoting the imposed subordination of the HCA to the nurse.

Although teamwork between nurses and HCA is not common, when it occurs derives into a quick, complete and safe assessment thanks to the support between the two professionals.

To facilitate the correct assessment of various diseases, one of the consultants created some guidelines for diseases such as paracetamol overdose, gastrointestinal bleeding, cerebrovascular accidents or accidental falls. These guidelines provide standardised assessment of these patients and limit the use of medical assessments. A guideline of paramount importance in Assessment Bay and around the LRI is aimed at identifying patients with suspected sepsis, assigning a DPS 1 regardless of suspecting that is not septicaemia and that the symptoms are a result of another disease.

Assigning a DPS 1 to the alleged septic patients is an exceptional precaution to prevent septic shocks, but there are other situations where the DPS assigned to a patient does not reflect his real situation. The most common example is the allocation of a lower DPS by paramedics to leave the hospital sooner, regular behaviour if the paramedic has finished his shift and he is still waiting to hand over.

The problem continues when the nurse who assesses the patient does not change the DPS and the patient is transferred and treated as urgent but he is not, eliminating the role of triage, especially when every patient has a DPS 2. Even when used correctly, the DPS as triage scale promotes inadequate triage based on subjective factors such as pain or the perceived patient disease severity by the nurses.

All the facts mentioned create an environment that does not work efficiently under an exit block, which leads to an entry lock. The problem that arises when there are patients waiting to be transferred to another area is that they have no allocated nurse dedicated to their care actively. The nurse coordinator tries to monitor patients while performing other tasks, but it is not an active or effective monitoring. This entails that patients who are already assessed remain an indirect responsibility of the nurse that assessed them, regardless of whether they are able to devote time to their care, resulting in patients calling any nurse in their visual field with the consequent delay in patients' assessment.

### 6.5.2. Majors

Majors nursing practice follows a very specific routine, which is built around the stages of the patient's stay in the area:

- Patient reception: When the Majors nurse receives the handover from the patient is assigned to him. At this stage, the nurse identifies the patient and provides the treatment and care handed over from the previous area.

- Medical evaluation: The nurse must ensure that the patient receives a medical assessment when it is his turn and he has to communicate with the doctor for appropriate treatment and care corresponding to that assessment.

- Diagnosis and action plan: Once the doctor has determined a suspected or confirmed diagnosis, the Majors nurse should ensure that an action plan is created and that he and the doctor follow the same action plan.

- Discharge or transfer: When the action plan involves the patient's discharge, the nurse must perform the necessary tasks to allow a correct discharge, whereas if the patient should be admitted to a ward the nurse should prepare all relevant documentation for his transfer.

In addition to the specific tasks of each phase, the nurse must secure his patients' welfare and meet their needs through frequent care.

The distribution of patients within Majors is very fluid, since patients move in and out of the boxes to be assessed, treated or to do private activities. However, this fluidity means that it is very difficult for the nurse coordinator to monitor all patient movements in the computer system, especially if he is busy with other tasks such as assigning nurses to Assessment Bay patients.

This continuous movement of patients means that nurses do not always know where their patients are, especially if they are independent. If the patient in question has not been identified by the Majors nurse yet (which usually happens in the handover unless the patient is in radiology or another nurse has received the handover) finding him is a complex challenge. To do so, the nurse is forced to surmise which patients fit the age and sex of his patient and go asking their name one by one. In the case of missing

patients who are a risk to public or themselves due to their illness or their mental capacity, the nurse contacts the police, which will look for the missing patient.

Although the patient movements within Majors can be problematic, lack of patient movement into Majors is a much bigger problem. This occurs for two reasons: crowding, which prevents moving patients to free spaces, and blocked boxes by patients who need oxygen, cardiac monitoring, isolation, etc. This entails that patients take longer to be transferred to a box and be assessed, increasing the stay time and slowing down the assessment of other patients. Furthermore, maintaining the hygiene of dependent or incontinent patients should be handled privately, which is more difficult if there are no free boxes, leading to serious violations of patient privacy by junior nurses and HCAs.

To unlock the boxes and expedite patient movement within Majors, the area needs their patients to be discharged or admitted, so early patient transfer outside the department through admissions and discharges is one of the Majors nurse coordinator's main priorities. Nonetheless, the nurse coordinator is unable to manage all transfers and discharges in addition to his other tasks, so it delegates patient transfers and discharges to their corresponding nurses. The problem this entails is that the nurse coordinator requires the registered nurse to stop any activity that he was doing to organise the transfer or discharge.

When patients are waiting in ambulances and there are no hospital beds on the wards for the patients in Majors, the NIC may decide to open escalation areas, areas where patients are waiting to be admitted and stay under the supervision of a nurse and an HCA. The use of these escalation areas was very rare until the end of 2015, where their use was normalised. These areas are divided between the old Minors, the new Minors and the corridor, accommodating four patients per zone if it can be staffed by a nurse and an HCA.

The escalation areas are a temporary solution to Majors' crowding, which buys time until patients can be transferred to hospital wards and prevents that patients wait in ambulances. However, if the exit block continues the situation worsens, since the department attends more patients than it should with the same human resources. In addition, patients in the escalation areas are isolated from the rest of the department in

an environment that is not ready for dignifying patient care, so only the most stable and independent patients should be transferred to an escalation area.

For the registered nurse, the main priority is his patients and their welfare. The nurse recognises the need to maintain patient flow through the department, but is aware that this is secondary to the welfare of his patients. Therefore, when his nurse coordinator instructs him to perform an act against what he believes right for his patient two main reactions were observed:

- Adherence to the coordinator's orders: Based on the fair resource distribution and the welfare of all patients, the nurse follows the nurse coordinator's orders, which is responsible for the consequences of his orders. Moreover, social pressure, routine and the nurse coordinators' influence promote nurses' obedience as the characteristic practice in this area, but this does not protect the nurse of any legal complaints.

- Individual patient's welfare defence: Other nurses decide to accept the role of patient advocates and prioritise their time based on their patients' needs, not the needs of the area or department. Even though this option is the safest legally, it encourages social rejection by the nursing team, especially the nurse coordinators, if it is not accompanied by a convincing reasoning.

This dichotomy in nursing decision-making is common throughout the department, but more frequent and prevalent in Majors.

Another decision that the nurse must make is whether their patients are receiving the treatment and care that they need in Majors. The main action that the nurse can do, besides providing specialised treatment and care, is pointing out the impending severity of the disease suffered by the patient and argument why he should be treated in Resus. These transfers are rare and can occur only after a decision between Majors and Resus multidisciplinary teams. However, the Majors nurse is responsible for providing treatment and ongoing care to his critically ill patients until they are transferred to Resus, even if this reduces the time spent with other patients.

It was previously acknowledged that documentation is an essential aspect of nursing practice, but it is in Majors where the nurse coordinator puts special emphasis on its

importance and its professional and legal consequences. This is reinforced through the documentation checking rounds done by the Majors nurse coordinator once per shift, who questions the corresponding nurse if he did not fill in all the documentation related to patient care.

A crucial part of nursing documentation is the record of vital signs and patient care performed, so it has become an hourly routine. Even though this routine prevents patients to not being assessed for long periods of time, nurses follow this routine strictly, evaluating patients hourly even if they do not need it. This entails that a considerable period of time is devoted only to the collection and documentation of vital signs from all patients, at least hourly.

A small percentage of senior nurses were able to relax their routine and measure patient's vital signs in an interval corresponding to their current situation and the risk associated with their pathology. However, the pressure of nurse coordinators and managers to have a record of hourly vital signs implies that most nurses give in to the constant pressure and resigned to devote part of their time to measure vital signs of stable patients.

Majors' routine is the most rigid one in the department, being the Majors coordinator the most involved in the care offered by each registered nurse. One reason for this is that Majors is the area in which junior nurses and temporary nurses are concentrated, preventing the appearance of innovations in practice and encouraging a routine in that area. The distribution of these nurses in Majors is derived from the department's needs, as both Assessment Bay as Resus need senior nurses, Minors only need a nurse and paediatric nurses do not usually work in adult areas. Therefore, the less dangerous area for inexperienced nurse or nurses who do not know the department is Majors.

Although it is the most logical staff distribution, the fact that most junior or temporary nurses are assigned to Majors carries its disadvantages. Compared to other areas, teamwork is rare, nurses lack basic skills and they need recurrent support from their nurse coordinator to do their job properly. This is most evident when a senior nurse is assigned to Majors, since the efficiency and quality of care offered are much higher.

### 6.5.3. Minors

The nurse assigned to Minors has a dual role as registered nurse and nurse coordinator, and it is this dual role that defines his contribution to the multidisciplinary team. However, a registered nurse and a nurse coordinator have different responsibilities, goals and ranks, so when both roles converge in the same person creates a dilemma for the nurses in Minors: prioritise their responsibility as a nurse or as a nurse coordinator?

When clinical workload is not high this fact is not a dilemma, since the nurse can coordinate the ENPs and doctors while offering them the help they need, since patients in Minors should be independent in covering their basic needs. However, when the clinical workload increases human resource coordination and healthcare technique performance are necessary to maintain patient flow throughout the area.

Most nurses preferred to focus on the technical support, feeling that they would be more useful to the area that way, delegating area coordination to the practitioners. This led to lack of control of the area's general situation and the neglect of some patients by the practitioners. On the other hand, when nurses committed to their coordination role patient flow slowed and practitioners reacted hostilely to the nurses' refusal to perform techniques for them.

One reason why a nurse is assigned to Minors is because he requested a temporary stay working in that area to obtain the suturing and plastering competencies. These temporary stays assure the nurse that he will be assigned to Minors for several weeks and he could make significant progress in obtaining those skills. However, this fact conditions the nurse in his dual role, so he often chooses to perform skills related to the competencies he wants to obtain rather than area coordination.

This model of competence acquisition could be considered inappropriate, but at least ensures that Minors will have a nurse, since it does not always have one. This is because, unlike other areas, it is not considered essential to have a nurse in Minors, since ENPs are independent professional practitioners. Due to this fact, the Minors nurse can be relocated to other areas without breaking any policy or significantly affecting Minors' performance. Given this, it could be debated whether there is a real

need for a nurse assigned to Minors, but both nursing managers and the CQC claim they are needed.

A situation that was increasing its frequency through the period analysed was inadequate patient referrals to Minors. These referrals were mainly from UCC and Assessment Bay, through which patients suffering emergency pathologies were transferred to Minors. When the department is not crowded the patient is transferred to the appropriate area, but if there's no space for that patient in the appropriate area he has to be treated in Minors until a space in created. Given the limited human and material resources in Minors, practitioners are reluctant to accept any patient whose history might indicate an emergency disease, but once the patient is in the area they are forced to assess him even if it is outside their specialty. It is in these situations when the presence of an emergency nurse is more useful, since he is able to assess, care for and treat acute or critical patients.

Excluding the exceptional management of emergency patients in Minors, the dual role of the nurse is routine because coordination of the assessment order and performing wound care and fracture immobilisations are tasks that in Minors can be repetitive.

#### 6.5.4. Resus

The clinical workload in Resus is significantly more random than in the rest of the department, since its capacity is smaller and the reception of patients is dependent on how many emergencies need to be managed. These healthcare emergencies are often pre-alerted through the red phone, even though some are derived from Assessment Bay or UCC.

In order for the area to function adequately, strong multidisciplinary leadership is necessary to ensure that only emergency patients are admitted to Resus, since both the nurse coordinator and the doctor in charge of the area should prevent that Resus resources are used inappropriately. This is because when Resus has a lower clinical workload than the rest of the department the NIC and the EPIC can lead patients from Assessment Bay or Minors to Resus to be assessed and after transferred to the

corresponding area. However, if Majors is blocked Resus would be filled with non-emergency patients that limit or block the space available for new emergencies.

The pre-alert and the arrival of Resus patients can be cumulative, so the nurse coordinator may receive two to five consecutive calls, more even in multiple accidents, with only a few minutes for their arrival to Resus. This limits the preparation that the Resus team can arrange for these patients, including the creation of free boxes. If this occurs while Majors is locked Resus patients cannot move anywhere else, so receiving non-emergency patients in Resus is avoided.

In a situation in which Resus is full of critically ill patients but has received more pre-alerts, the multidisciplinary team decides who are the patients whose situation is less critical and transfer them to Majors. In the event that there were no free boxes in Majors, the priority for the Majors nurse coordinator is to create a free box to transfer Resus patients, since the whole department is aware of the fatal consequences of delaying the treatment of a critically ill patient. These patients from Resus should be frequently monitored even when they are in Majors, since the same standards of care and treatment are expected for them even though human resources are scarcer in Majors than in Resus. Therefore, the Majors nurse who takes care of patients from Resus is forced to prioritise the care of said patients over the rest in order to avoid their deterioration, even if this entails to minimise the care offered to the rest of his patients.

Moreover, in specific cases the situation of a patient in any area of the department may deteriorate until it becomes an emergency, so he is moved to Resus. Since these transfers cannot be alerted prematurely, a nurse from Resus should transfer a patient to Majors while another assess and treat the new Resus patient with a doctor.

There is an exception to the rule of not deriving non-emergency patients to Resus: patients from Minors who need sedation to manipulate a dislocation or fracture. Given the risk involved when sedating a patient, it must be done in a controlled environment, so it is only safe to do it in Resus. However, critically ill patients have priority over patients needing sedation, so this exception is not considered a misuse of Resus resources.

The red phone is usually answered by the nurse coordinator, even though a senior nurse or doctor can answer it if the nurse coordinator is not present at the time. After receiving the handover by telephone, the nurse coordinator and doctor in charge of the area discuss which box and resources should be prepared for the patient's arrival. Nonetheless, if the nurse coordinator and the doctor in charge of the area decide that the pre-alert does not indicate that the patient suffers an emergency disease they will perform a quick primary assessment when the patient arrives, deciding there whether the patient should be admitted to Resus or transferred to Assessment Bay. The primary survey is performed by both, but is the doctor's responsibility to refer the patient to the appropriate area, so he has to be cautious when transferring patients to Assessment Bay.

To distribute patients fairly and safely, a continuous communication between Resus and Assessment Bay nurse coordinators is maintained in the event that a patient needs to be moved from one area to another. This routine is neither mandatory nor part of the policies, but is considered a courtesy necessary to enable the nurse coordinator of the receiving area to prepare for an unexpected patient.

Each patient transferred to Resus is assigned to a nurse who assesses and cares for two patients at most. If Resus do not have enough nurses to meet the ratio of two patients per nurse the necessary boxes are closed to maintain that ratio. However, this action is not sufficient to maintain a sustainable clinical workload in Resus.

During 2015 and 2016, an increase in the presence of junior nurses in Resus was detected, not only due to the lack of senior nurses but also as a result of complaints made by junior nurses about their isolation in Majors and the effect it had on their training and career progression. Therefore, even if Resus has the appropriate number of nurses, these nurses may not be prepared to treat and care for critically ill patients.

The effect that junior nurses can have on patient safety in Resus is remarkable. Several of these nurses have no training or experience in patient triage and assessment, so they are not allowed to practice in Assessment Bay but are encouraged to assess patients in Resus. It is true that all patients in Resus are assessed by a doctor in a short period of time, but a junior nurse may underestimate the severity of a patient's illness in his assessment, delaying patient care with the possible consequences that this entails.

Another consequence of the proliferation of junior nurses in Resus is the uneven distribution of clinical workload. Resus is an area where patient care commonly requires technical competencies like intravenous medication administration and intravenous cannulation, among others. If a nurse is not competent in any of these techniques he depends on another nurse to provide care to his patients, unbalancing the distribution of clinical workload. Moreover, if a junior nurse must respond to an emergency, his lack of knowledge and technical competencies devalues his efficiency as part of the multidisciplinary team. Even though it is an inevitable phenomenon, since English nurses learn during practice, the nurse coordinator is aware that new nurses should not be concentrated in Resus, which will be transmitted to the NIC so only a small percentage of nurses in Resus are junior.

The difference in experience is not the only factor that unbalances the clinical workload among nurses, since each patient's care differ individually, which is most evident in Resus. While each nurse cares for two patients, the range of their dependence is wide. For example, a patient stabilised or sedated does not need the same clinical care that a critically ill unstable patient. This fact was noted when junior and temporary nurses were assigned to stable patients while senior nurses cared for the most unstable patients, managing human resources correctly but ignoring nurses' clinical workload.

Resus nurses, like all the professionals in the department, have a break every six hours. Patients assigned to these nurses are handed over to another nurse during his break, but what was experienced in practice was that this handover is symbolic, since no one cares for patients during his nurse' handover. This is because most nurses prioritise tasks related to their patients against the tasks related to other patients, so if their patients are very dependent they will not devote any time to their colleague's patients.

Inadequate break coverage is a widespread custom in the department, but in Resus is where it has major consequences and where it is more contradictory. To prevent unsustainable clinical workload in Resus the open boxes in Resus are limited, but 30 minutes breaks that can lead to the abandonment of unstable patients are not covered. This fact, even if all patients are monitored, may cause a delay in treatment and care that facilitates the deterioration of critically ill patients.

To mitigate the clinical workload imbalance and inadequate break coverage, some Resus nurse coordinators decide to support their team of registered nurses, thus preventing a nurse to deal with four possible emergencies at once. For this, they performed specific care and techniques to reduce the clinical workload of the busiest nurses. However, the nurse coordinator's primary responsibility is the management of the area, not the care of individual patients, so he is forced to not fully involve himself in patient care, thus avoiding losing the perception of the general situation in the area.

The perception of registered nurses and nurse coordinators of the fact that the nurse coordinator is actively involved in patient care is controversial, since registered nurses believe that the nurse coordinator should support them more, but the nurse coordinator is aware that if he engages fully in patient care he could ignore the problems that as nurse coordinator should solve (keep patient flow, dealing with specialists, support nurses who need it, lead the nursing team in an emergency, distribute breaks, etc.). However, this controversy only happens in Resus, since in the rest of the department the role of the nurse coordinator is not discussed.

Healthcare professionals in Resus are usually able to deal with most situations, but there are exceptions where the difficulty or severity of the situation requires more human resources imminently. In these cases, there are protocols for urgent specialised support in different situations (trauma, gynaecological emergencies, newborns, stroke, etc.). When one of these protocols is activated, a considerable amount of specialised professionals appear, for which ED nurses can be the link between them and ED's resources.

Although there is a specialised protocol for cardiac arrest support, the Resus multidisciplinary team is usually prepared to deal with them, so they usually do not activate it. This may affect the care of other patients, since cardiac arrests need several nurses, usually the most experienced ones. Nevertheless, in specific cases where there are no human resources or several cardiac arrests need to be managed at the same time the corresponding protocol will be activated to obtain more human resources and increase the likelihood of patient's survival.

Because healthcare emergencies are managed in Resus, most patients who die in the department do it in Resus. Therefore, nurses working in Resus are exposed to the suffering and death of a small percentage of patients who are assigned to them.

The reaction to suffering and death evolves as nurses gain experience in the department, from shock and uncontrollable sadness to no apparent reaction, being the most common reaction a sense of respect for the deceased accompanied by an aura of silence. However, the nurses' reaction to death in paediatric patients or pregnant women is more emotional than in the case of elderly or palliative patients.

Nurses, especially junior ones, feel uncomfortable with the care of dying patients if the patient does not have a do not attempt resuscitation (DNAR) order. However, once the DNAR order is formalised, no nurse has shown any inconvenience caring for dying patients. This happens because the nurses perceive that if the dying patient has a DNAR order they may not be blamed for his death, whether is his fault or not. This conception of legislation is based on the healthcare personnel's perception that if a patient dies is only related to their actions, which is not always true.

Each nurse understands death differently depending on their values and beliefs, but most proved to be able to adapt their practice to the patient's and the relative's customs to provide a dignified death and facilitate the grieving to the family. The dehumanisation of care characteristic of senior nurses was not present when dealing with relatives of deceased patients, with who they spent all the time and resources they considered necessary.

#### 6.5.5. Children's ED

Paediatric nurses are distributed by the nurse coordinator between Paediatric Majors, Paediatric Minors and Paediatric Triage. However, unlike other areas, in Children's ED there is a fluidity routine between different zones, through which nurses and HCAs work together to balance the clinical workload of all zones between the whole team, supported by the nurse coordinator's guidance. Even though this fluidity is limited by the skills and experience of each nurse and HCA, this routine demonstrates a continuous and stable team dynamic.

The main reason why group dynamics in Children's ED are more fluid is because their nurses are considered part of a smaller subgroup, in which they know each other and maintain a generally positive relationship. Paediatric nurses and HCAs assigned to Children's ED are part of this sub-group, who practice almost exclusively in that area.

From this fact could be inferred that Children's ED is an isolated ED rather than an area within it, so it should not fall within the scope of this study. Nonetheless, there are several aspects that stipulate the area status of Children's ED for practical purposes:

- Subordination to the ED NIC: Although children's ED has its own nurse coordinator who monitors all zones, he is still subordinated to the ED NIC. This facilitates the nurse coordinator to get expert support in key situations, in addition to expert supervision in the case that the nurse coordinator makes a mistake unconsciously. Moreover, Children's ED sisters can also play the role of NIC, further reinforcing the single cohesive department perception.

- Resus area sharing: All ED areas can refer patients to Resus if necessary. Children's ED can not only refer patients to Resus but can transfer one of his nurses there to care for paediatric critical patients, who has access to Resus resources.

- Differentiated but shared management: Although Children's ED sisters are the supervisors for paediatric nurses and HCAs, they share the same management team with the rest of the ED sisters in areas such as personnel distribution, handling complaints or enforcement of departmental projects. Furthermore, paediatric nurses share the same training and professional development team, personal assistant, staff room, seminar room and sister's office with the rest of the department.

- Resource transfer from one area to another: When under the supervision of the NIC, Children's ED may request human resources from other areas if necessary, the same as human resources from Children's ED can be transferred to other ED areas temporarily in exceptional cases.

Although Children's ED is part of the LRI ED, it has a number of advantages over other areas. The most common is the fact that paediatric nurses are rarely transferred to other areas, while it is common for nurses from other areas to be transferred to Children's ED as unspecialised support. This stems from the lack of paediatric nurses in Children's

ED, since only a paediatric nurse is legally authorised to perform the advance care and techniques that paediatric patients need.

On the other hand, when a paediatric patient should be cared by a paediatric nurse in Resus the paediatric nurse is transferred to Resus to care for that patient only and an adult nurse from Resus is temporarily moved to the Children's ED to cover the paediatric nurse's clinical workload. This process, called backfilling, destabilises the balance of clinical workload in Resus and in Children's ED, but it ensures that critical paediatric patients receive the best treatment and care possible.

Another advantage of Children's ED is that they cannot use too many temporary nurses, since unless these are paediatric nurses they should not cover paediatric nurses positions with adult nurses. However, when there are not enough paediatric nurses, the nurses assigned usually to Children's ED are adult experienced nurses, permanent or temporary.

When the clinical workload increases considerably from one area compared to other areas, the NIC often send nurses from areas with the lowest clinical workload to the busiest areas. However, Children's ED is an exception, since paediatric nurses are rarely transferred to another area even if they do not have any patients. This is because, in theory, paediatric nurses are not professionally or legally trained to care for adult patients, so they refuse to do so.

On the contrary, adult nurses could refuse to care for paediatric patients, but the nurse coordinators' pressure and the task simplicity (measuring vital signs, administering oral medication, patient entertainment, etc.) encourage most of them to agree to be transferred to Children's ED, ignoring the professional and legal consequences that negligence could have in these circumstances.

Paediatric patient flow through the department is separate from adult patient flow, reuniting only with critically ill patients in Resus. This entails that, even if the number of patients in the Children's ED is lower compared to other areas, patients needing hospitalisation can only do so through CAU, which capacity is lower than SAU, AMU, AFU, CDU and other adult assessment units combined. Therefore, paediatric nurses

have to deal with CAU to negotiate each patient's transfer, who is always accompanied by a nurse.

CAU has limited capacity, so when they cannot receive more patients Children's ED saturates with patients waiting for hospital admission. If this saturation is such that no boxes are free in Paediatric Majors, the nurse coordinator can restructure the box distribution in Paediatric Minors, transforming half of them in improvised Majors boxes where a paediatric nurse is assigned to offer care similar to CAU's care.

One of the main characteristics of paediatric patients is the fact that their young age modifies all stages of treatment and care compared to an adult patient: their triage is more cryptic, their behaviour does not follow an established civic pattern, they are not able to understand their situation and make decisions for themselves, etc. This entails that paediatric nurses and HCAs should soothe and entertain patients as part of the care they provide, thus mitigating the trauma that their stay in Children's ED could cause them.

Another consequence of his young age is the presence of one or more patient's tutors or relatives with him at all times. The lack of health knowledge of patient's relatives can create a sense of unease and urgency among them, which is made worse when they have to wait for triage and medical evaluation. One of the key capabilities of Paediatric Triage nurses is to explain to the patient's close relatives that he does not suffer a serious pathology and the symptoms suffered are temporal when they are so, avoiding recurrent visits with the same symptoms. Nevertheless, despite the health education that paediatric nurses can provide to the patient and his family, they do not always agree with the actual diagnosis, being relatives' verbal complaints more common than in other areas.

## 6.6. Bioethical principles application in practice

Bioethical principles are present in all aspects of nursing practice to a greater or lesser extent, but their relationship with specific nurses' behaviours can facilitate understanding nursing decision-making.

Most decision-making observed from registered nurses followed departmental or hospital policies or ED routines without much variation, regardless of the context of the decision. However, a small group of senior nurses demonstrated the ability to challenge the policies and routines of each area to offer a safe and excellent care for their patients and other patients in the department.

The registered nurses unconsciously apply bioethical principles in their decision-making process individually, mainly due to the impact of their Professional and Personal Ethics. However, the relationship between community values, Professional and Personal Ethics in LRI ED nursing practice may be concentrated in a variety of behavioural phenomena anchored to bioethical principles.

### 6.6.1. Nonmaleficence and tolerance to others' suffering

All nurses, including ED nurses, are aware that nonmaleficence is a fundamental principle to be applied in their daily practice. However, during the period 2014-2016 it was noted that several nurses consented that patients suffered physical, mental and emotional deterioration. This behaviour was widespread among LRI ED nurses for two main reasons: the perception of the patient as their responsibility and the dehumanisation of care.

Nurses are aware of the existence of patients in ED, but not all patients are perceived as their responsibility. This stems from the allocation of a certain number of patients to each nurse, who is legally and professionally responsible for his patients.

This would not be a problem if each patient had a nurse constantly assigned to him, but a nurse can be between 2 and 6 patients under his care at any time, a number that can grow if we take into account nurses' breaks and ED crowding. Therefore, if a patient needs something and his nurse is not available, he will ask for help to any nurse who

enters his field of vision. However, nurses ignore most patients who have not been assigned to them, independently of the patient's request.

Nurses believe that they would be more efficient and fair this way, offering all their time to their patients as other nurses do with theirs, pretending to practice individually. However, this dehumanised behaviour may result in urgent treatment delays or patient's deterioration. Such behaviour is not only a violation of the Duty of Care and the *NMC Code*, but it demonstrates a total disregard for the health of patients around them, which can lead to negligence by omission.

Nurses working in ED gain experience in handling emergencies, which can be traumatic situations for both the patient and the nurse. One of the effects of being subjected to other people's suffering for long periods of time is that nurses are desensitised against the perception of other people's suffering in the future. If ED care technification and protocolisation are considered, the dehumanisation of care from ED nurses is relatively common.

This dehumanisation of care means that the nurse separates his role as a nurse from patient care, perceiving their professional role as executing a series of technical and disjointed tasks, which are planned in policies or are performed routinely. This care dehumanisation facilitates that the nurse excuses himself in different ways in malpractice cases, separating his responsibilities from his patient's needs:

- Bureaucracy: Caring for patients in the LRI ED is anchored to various policies and documentation that nurses can follow. These policies are built around generalised situations to cover most patients applicable to each of them, so it is specified that clinical reasoning should be applied when using these policies.

Nevertheless, there is a generalised fear in the nursing team around challenging a policy, even if they know that their application in a specific context for a specific patient is not adequate. This fear is based on the perception of the policy as legislation and the professional and legal consequences of deviating from a policy.

Another aspect that allows them to excuse malpractice is the complexity of the bureaucracy imposed on various tasks. Access to medication from other departments or hospital pharmacy, request for medical equipment or demand for engineers to fix

various devices are several tasks that involve a long and tedious process, so the responsible nurse ends up ignoring the problem because he considers them an administrative problem, not a nursing one. However, the consequences linked to ignoring these tasks can lead to a direct or indirect harm to the patient, since not having any intravenous infusion pumps available or being unable to analyse blood samples urgently because the whole blood analysis equipment is blocked can lead to delays in emergency situations.

- Colleagues' malpractice: Most nurses learn through observation and joint practice with their co-workers, but only a small percentage of them base their practice on evidence. This entails that the senior nurses' malpractice in transferred to their junior colleagues, who conceive senior nursing practice as the ideal practice without questioning it.

Common malpractice in ED (perception of the lack of communication with their patients as an efficient use of their time, inappropriate verification of intravenous medication, prejudice to different groups of patients, etc.) shifts from one nurse to another as appropriate practice, leading to widespread malpractice throughout ED.

- Inadequate routines: The multidisciplinary team has different ways to enable communication and practice among its members, which transform into routine acts for several years. However, even though they continue to use several of these routines, they are obsolete in the current context of nursing practice. Indisputable obedience to senior medical decisions, preferential treatment for patients who present formal complaints, poor patient care during breaks, nurses' reluctance to enter a box when a doctor is assessing a patient and patient transfer through an area without modifying his location in the computer system can be included within these routines.

- Documentation: The documentation is an essential part of nursing practice, but in the LRI ED its importance becomes greater than patient care at times. This stems from managerial pressures and nurses' fear of possible professional or legal problems.

The problem this poses is that negligence by omission is a more serious ethical, legal and professional problem that incomplete documentation. Therefore, the argument that many nurses use, "what has not been written has not been done", is counterproductive if to document a patient's care they have to ignore the needs of another patient.

Clinical documentation in the LRI ED remains on paper, which facilitates that it can be temporarily lost through the department. This is a common excuse to ignore the care of a patient, since most care and tasks should be documented after being performed, since documentation is legally binding in areas such as medication administration.

- Orders from his managers: The influence of nurse coordinators and supervisors in registered nurses is very strong, so it is a challenge for them to confront their bosses' decisions even if they lead to patient harm.

Therefore, registered nurses follow the orders of their superiors without question in most cases, even if a rational discussion could find an intermediate solution. However, this behaviour is more common in junior nurses, leading to a lower rate of strict subordination by senior nurses.

Using these arguments to excuse their malpractice allow them to have no remorse for their practice, since they argue that they have offered the best care possible under dire circumstances. This may be acceptable in professional and legal field sometimes, especially if a person with superior responsibility forces the nurse to commit malpractice, but almost on no occasion it would be ethically excusable.

Nursing practice in the LRI ED is set in a challenging context under high clinical workload and complex critically ill patients, but even in this situation they never should ignore one of the minimum standards of care: prevent patients from deteriorating. Even though it may be considered an obvious concept in the legal, professional and ethical fields, the bureaucracy surrounding these aspects of nursing practice hinders the understanding of its importance by LRI ED nurses.

Although it could be deduced otherwise, the malpractice observed did not have a devastating effect on patient care or group dynamics. This is due to malpractice limiting systems that have been added to ED's practice to correct its effect without correcting malpractice per se. These limiting systems are the presence of nursing coordinators,

policies, assigning each patient to a nurse at all times and the joint assessment from the multidisciplinary team.

Malpractice avoidance systems work by making a specific nurse accountable for the welfare of a patient and restraining malpractice that nurses could make through monitoring and expert guidance. This means that is futile that the nurse excuses his malpractice because the patient's welfare is his primary responsibility and he has expert support available in case of doubt.

### 6.6.2. Beneficence and defensive practice

Being able to provide excellent care is one of the objectives of any nurse, but the circumstances in which each nurse practices delimit the extent to which this nurse is able to perform excellent care. In the LRI ED, nurses care for their patients under particular circumstances, but they are able to provide minimal care in most cases despite the adverse conditions in which they work.

Nevertheless, there is a difference between minimal care, simply focused on avoiding patient deterioration, and excellent care, through which the nurse can analyse and cover all the basic needs that the patient can not cover by himself.

During 2014, it was perceived that the quality of care was taken into account by nurses and coordinators, while during 2015 and 2016 there was a generalised progressive mentality change where minimal care was promoted as the only standard to consider. This change is mainly due to the progressive increase in clinical workload, to which nurses reacted by promoting the safety of all patients against the benefit of a few. However, this regression in care standards was maintained regardless of the clinical workload from 2015 onwards because ED nurses felt that offering holistic care was not possible in a few hours and, therefore, was not part of their role.

A side effect of clinical workload is decreased likelihood of achieving the care and documentation necessary on the estimated time due to reduced time available for patient care. Also, inadequate documentation not only hinders continuity of care and

communication between multidisciplinary team members but also limits the nurse' defence when facing malpractice or negligence allegations.

This context facilitates the proliferation of defensive practice, in which the nurse performs the minimal care required by UHL policies and applicable regulations to devote a considerable percentage of his time to documentation. Nurses who practice defensively usually argue that they will not risk their profession and their way of life to benefit a patient who does not appreciate the care he receives, an argument that comes from the change in public perception of healthcare services.

Due to changes in patients' rights and service accessibility, patients are empowered to demand excellent care in any aspect, regardless of the objective importance of their demands. This entails that nurses can be blamed for the claims of these patients, which could derive into them losing their NMC registration and their license to practice as nurses. Even though the NMC only removes nurses from its registry for very serious or repeated infringements, nurses prefer not to risk it and focus on documenting extensively the minimal care they provide.

This phenomenon shows how one of the collateral consequences of the rebellion against medical paternalism is the legalisation of care, being the Law, not clinical judgment, which sets care quality standards. This entails that healthcare professionals should care for their patients based on the complaints they can make and the legal basis for such claims, which is not always known.

Another group of nurses argued that they want to provide the best care possible, but care bureaucratisation prevents it, mainly through pressure from nurse supervisors. This is due to the dual role of nurse supervisors as nurses and managers, for who quality care is the one correctly documented in order to foster audit results.

Defensive practice, even if it limits beneficence in care, should ensure nonmaleficence through strict legislation and policy monitoring. However, maleficent acts were observed in the strict implementation of policies, especially when retaining patients against their will. In these cases, medical personnel retained the patient based on his inability to make decisions only because that patient allegedly suffering an urgent pathology, so the medical staff wanted to make sure the patient was healthy prior to

discharge. This was not done to prevent deterioration or death of the patient per se, but to avoid legal and professionals consequences, curtailing his freedom for it.

In situations where defensive practice entails a detriment to the patient, malpractice limiting systems can be applied, effectively preventing the maleficence that is linked to defensive practice. However, these systems do not promote beneficence in care, so if laws, policies and nurses' perception of care excellence are not changed the trend of offering mediocre care is likely is continue.

### 6.6.3. Autonomy and the self-care paradox

One technique that the LRI has been promoting during the period 2014-2016 has been the early discharge of patients under community support, thereby facilitating the recovery of their independence and improving their self-care. To this end, ward multidisciplinary teams supposedly foster the independence and self-care of their patients with health education. However, in the LRI ED a paradoxical phenomenon linked to patient autonomy was observed.

Elderly patients who were treated in ED indicated their displeasure when they realised they would be admitted into hospital, arguing that every time they spent a period of time in bed they lose some of their independence. However, adult patients wanted to be admitted for reasons relatively easy to treat in the community, but they felt more secure being cared for at the hospital. This is the self-care paradox, in which patients unable to meet their basic needs reject professional support while independent patients demand that others cover needs that they could cover.

Nurses are forced to document several aspects of care (nutrition, elimination, hygiene, etc.) regardless of their patient's degree of independence, so it is common to cover needs that the patient can cover itself. This self-care disparagement is stimulated by complaints from patient's relatives who perceive that their loved one needs more support than they actually required.

Another reason why there is a self-care paradox is the apparent decline in the level of basic health knowledge in adult patients compared to elderly patients. A large

percentage of patients attending ED without suffering an urgent pathology are in their adulthood, while elderly patients rarely visit ED without suffering a health emergency. Nevertheless, it must be taken into account that this is not derived not only from the level of health knowledge but also from the patient's subjective perception of an emergency, the greater number of comorbidities in elderly patients and the ease to access ED by foot, among others.

Self-care in ED is perceived as positive by registered nurses, allowing them to perform fewer tasks per patient, but for managers is negative, since patients and relatives do not perceive that they are being cared for. Patients' opinion is able to change clinical practice through complaints and suggestions, which is mainly used by patients who do not have advanced medical knowledge. Therefore, since patients do not know hospital team dynamics and what is important to maintain them, their requests are based on their personal perception of care.

This means that UHL, like any private business, suits the demands of its clients and change its procedures around these demands. Such demands favour unnecessary patient dependence in healthcare professionals, which cover needs that patients are able to cover. For example, a complaint from a patient's relative precipitated the establishment of hourly rounds where food and drink were offered to all patients and their relatives. Even though it is an idea that can keep patients and relatives fed, a large percentage of them was able to obtain food and drink on their own. However, the perception of nursing subservience remains latent in English society, so patients and relatives who observe nurses and HCAs offering hot drinks perceive that they are performing tangible care, even if the use of these professionals in other roles is more clinically appropriate

It should be borne in mind that, unlike most private companies, UHL is a publicly funded NHS Trust, so the inappropriate use of public resources should be illegal. Nonetheless, since it is the public who decides the priorities in their care, this is not considered an inappropriate use of resources, even if it may be misinformed.

The patient perception of their own autonomy and their self-care ability is individual, but a general fact is that patient autonomy and independence decrease during hospitalisation. Given this argument only, it would be understood that hospital

admissions were limited to promote patient self-care. However, what happens is that the medical team admits independent patients for non-clinical reasons.

Although most of these patients are admitted because they need more observation time, more diagnostic tests, more intravenous medication, more social support or more time to make a diagnosis, a subset of these patients are admitted by strict adherence to policies or the pressure imposed on the multidisciplinary team by patients or their relatives. This behaviour is common in junior doctors who do not trust their clinical skills or fear legal reprisals. Nurses do not consider that this decision is part of their role, so they do not challenge admissions even though they know that they are unnecessary and even harmful to patients predisposed to losing their independence (elderly patients, patients with chronic diseases, sedentary people, etc.).

Actions taken by ED nurses to increase patient autonomy are minimal, since they feel that they have no time for non-urgent care, blaming the lack of community resources and family support for the loss of autonomy in recurrent patients. Nonetheless, it is common that nurses try to teach aspects of health education to patients who are discharged from ED, even if the nurses' low influence in the public limits the effectiveness of the limited health education that they can offer.

#### 6.6.4. Justice and subjective distribution of human resources

The resources available in the LRI ED are limited, so their appropriate use and distribution are essential for the department's operation. ED materials resources are accessible by most members of the multidisciplinary team, but human resources are handled only by doctors and nurses with enough influence, usually professional with a high rank in their hierarchical structure.

Before the visit of CQC, nursing supervisors distributed human resources in advance as each supervisor considered appropriate. However, after its visit CQC imposed structuring the distribution of personnel across all ED areas, indicating the appropriate staff numbers, skills and expertise in each area. In addition, CQC demanded a weekly report about the staff assigned to each ED area in every shift, monitoring that the CQC objectives were met.

Although the CQC's imposition intended to increase nurses per shift, it did not have the expected effect. This is because, according to several supervisors, the number of nurses assigned to one shift was the same before and after the CQC visit, but different unpredictable factors (sickness absence, shifts cancelled without notice, etc.) did not allow them to maintain an appropriate number of nurses regularly. However, they also pointed out that after pressure from CQC they were able to obtain more temporary nurses to cover the lack of permanent staff.

The NIC is able to modify the distribution of personnel in real time to adapt to the situation of the department. This allows nurses to move to Assessment Bay to fix an entry block or to Resus if several emergencies arrived simultaneously. Nevertheless, the distribution of human resources by the NIC is subjective, depending on the objectives' prioritisation order (patient flow, quality of care, patient safety, staff safety, fines and complaints avoidance, etc.). Each NIC pursues different goals in different situations, but during and after the CQC visit the prevalence of patient flow and the avoidance of fines and complaints on top of other objectives were observed on most NICs.

When human resources are limited in some areas more than others, nurses distribute their time in the way they consider most fair for both patients and for them. However, the lack of nurses in various areas in favour of others limits their options, since at least they should avoid that no patient deteriorates or dies. Therefore, when the patients per nurse ratio increases considerably nurses have to distribute their time among all patients similarly to provide minimal care, even though there are several exceptions depending on different factors:

- Severity of the disease suffered: Patients suffering an emergency disease are usually prioritised by nurses against patients suffering non-urgent diseases or not suffering any disease.

- Dependence level: Nurses will spend less time meeting needs that patients can cover themselves and more with patients who need support to meet their basic needs.

- Maintaining patient flow: Many nurses are aware of the importance of patient flow, either through personal knowledge or by the nurse coordinator's pressure.

Therefore, time could be monopolised by a particular patient to prepare his discharge or transfer, which allows patient flow to remain active.

- Documentation: The registered nurses, especially those who habitually practice defensively, coordinate their practice around taking hourly vital sign monitoring and mandatory forms filling. This means that new patients would be prioritised in favour of patients whose assessment and care has been documented.

- Nurse coordinators' orders: Sometimes nurse coordinators give specific orders to the nurses without a context that justifies it. Even though the nurse considers that his time should be spent with his patients, the influence of the nurse coordinator rules that the first priority for the nurse is the tasks entrusted by the nurse coordinator. This gives complete freedom to the nurse coordinators and the NIC to distribute human resources in their areas of influence as they see fit, but limits the nurse's ability to distribute his time the way he considers fairer.

- Complaints from patients and relatives: Complaints made by patients or patient's relatives increased gradually in the period 2014-2016, especially during crowding phases. When these complaints are made verbally and with a cordial tone, nurses take into account the suggestions but not drastically change their work plan. However, if these complaints are made to the nurse coordinators or managers their effectiveness is much greater, especially if they threaten to put a formal written complaint.

On the other hand, if complaints are accompanied by insistent verbal or physical assault nurses tend to prioritise the demands of these patients to prevent further attacks on both healthcare workers and the other patients. In cases where the attacks do not stop once the aggressor's demands are fulfilled, security officers may be requested to prevent further violence.

These exceptions underline the possible subjectivity in the allocation of human resources, both in large groups like nurse coordinators and individually like registered nurses. Therefore, different contexts may lead to unfair distributions of human resources, especially when staff changes are made based on non-clinical arguments.

### 6.7. Reflections on clinical practice as a data collection technique

The reflections on clinical practice conducted between 2014 and 2016 allowed obtaining a large amount of information directly from the LRI ED nursing practice, but it can be argued that the method of participant observation might be too absorbent and others' perspective can be lost. However, reflections on clinical practice are ideal for this research, since they allow experimenting nursing accountability directly and observing the behaviours of other nurses without disturbing them.

It should be borne in mind that we had to obtain data for a long period of time, at the beginning of which the research project had not been proposed. This is because the researcher is a nurse in the LRI ED, so he had access to clinical areas since January 2014, when he started taking notes for his own use during his clinical practice before the research project's proposal was made to the University of Murcia.

To start collecting data before submitting the research project could be considered unethical or could be accused of violating hospital policies, but this did not happen. All data from the process of reflections on clinical practice as a full participant were taken passively as part of the standardised nursing role in the LRI ED, which is within the policies established by UHL. This practice is similar to critical practice reflections that the NMC registration requires to revalidate every three years. Therefore, no personal data was recorded and nobody in clinical practice was involved other than the observer during the period 2014-6.

The fact that conditioned the inclusion of data from a period before the adoption of the research proposal is that the time estimate for doctoral studies is four years, so it is very difficult to include a 3 years clinical practice period, data analysis and the necessary bureaucracy within the estimated four years. On the other hand, reducing the period of clinical practice to only take into account the stage after the research project approval was considered, but due to administrative problems that rejected its early approval this stage would be of one year and three months, which would significantly reduce data quality and ignore most of the changes implemented in the period 2014-6.

Another issue would be the use of a presumed consent for the nurses linked to the reflections on clinical practice, since if the process of reflections on clinical practice is

performed in the role of full participant the data obtained is a clinical practice passive by-product, so an explicit consent was not needed. Reflections based on the observed experience are one of the bases of nursing training, besides being used regularly in audits.

Furthermore, obtaining and monitoring the informed consent of more than 180 nurses who worked in the 2014/16 period would have been a very laborious task, mainly due to the rapid nurse turnover and data origin differentiation during clinical practice.

During practice, nurses are aware that they may be being watched by their colleagues, patients, their families and anyone else who is in the area. This fact was exploited by CQC members and other regulatory bodies to assess various aspects of the department, for which they did not obtain the explicit consent of any nurse, only a general institutional consent from UHL. That is why UHL in general and the LRI ED in particular were informed through UHL sponsorship and its research department that nursing practice in their department would be analysed, thus obtaining a general institutional consent.

Even if it was not necessary based on current regulations, nurses were also informed that this investigation was underway once it was approved and they were allowed to withdraw their consent even though we did not obtain data from any nurse in particular, but from nursing practice in general. However, no nurse contacted the investigator to withdraw his consent.

Although both ED nursing management as LRI ED nurses knew we were gathering information for an investigation, the participant observation part of the reflections on clinical practice was less intrusive and more fluid because data gathering was done by one of their nursing colleagues. The self-consciousness of the first day dissipated, after which the nurses interacted with the researcher in the same way they did before starting the research project. Moreover, the reflections on clinical practice involved no behavioural change by the researcher, since taking field notes can be interpreted as part of the nursing documentation and the interactions between the researcher and the rest of the nurses are the inevitable by-product of the researcher as part of the nursing team

As all research projects, the possibility of a conflict of interest should be indicated. In this case, this investigation did not produce any individual benefit beyond the possibility of obtaining a doctoral degree. The researcher is an UHL employee, but this research was not funded by UHL or the NHS. Therefore, it can be concluded that there was no conflict of interests.

The full participant modality could be questionable in some respects. One of these arguments indicates that if the participant was out of clinical practice we could capture more data, but has been perceived to be during clinical practice when we could analyse other nurses' practice in a specific context, whereas isolated observation would struggle to connect nurses' actions with their decision-making process in a rational coherent connection.

Another argument might be that when the researcher participates in practice alongside other nurses there is a possibility to influence the practice that he wants to analyse. It should be borne in mind that all nurses interact during practice and affect each other, so if the researcher acts as another nurse his effect on the rest of nurses is no different than the effect that any other nurse may have. Additionally, the interaction with other nurses provides key information to the researcher that would be impossible to obtain through passive observation.

The continuous process of reflections on clinical practice as a full participant for an extended period of time increases the risk that the researcher "becoming native" (introduced in the society and culture of the study participants so much that the researcher identifies himself as part of them), which would skew the data he collects. However, the researcher was never included in any of the nurses' social subgroups or treated as an equal by them. He was perceived, in the words of several native nurses, as a "worthwhile token" (the symbol that foreign nurses can be as capable as native ones). Likewise, the researcher was never considered by the nurses as an equal to admit in their social group or more than a human resource that facilitates the operation of the department. This means that throughout the clinical practice analysed period the researcher was not assimilated into the prevailing culture in the department and could remain receptive to any information without skewing it.

This section focuses on how the LRI ED building change in April 2017 may affect the validity of the observation made in the period 2014-6. Since the researcher continues to work as a permanent nurse in ED as of May 2018, we can confirm that, despite changes in area distribution, the department's capacity and the absorption of UCC, nursing accountability remains the same, even if factors that can influence it may have changed.

The evolving nature of EDs to adapt their resources to the demand for emergency care obstruct obtaining contemporary results that require deep analysis, since during data analysis clinical practice routines and policies may change. In this research, moving from one building to another has not directly affected nursing practice because ED areas, nurse's role in each area and multidisciplinary relationships have not changed drastically. However, it must be taken into account several aspects of this transfer that influence factors affecting nursing accountability:

- ED's higher capacity: All areas increased their capacity, but staff was not increased proportionally, which led to increased patients per nurse ratio. Also, as ward capacity was not increased, ED had to retain more patients for longer, increasing the clinical workload.
- UCC absorption: The new ED building absorbed UCC's roles and staff, for which an entry for ambulatory patients, a separate triage queue from Assessment Bay and an area with GP was added. This led to the supervision of GPs' to be added to the Minors nurse roles, who was forced to challenge GPs if they did not assess more than one patient per hour.
- New space distribution: The new building has the same areas as the old one plus UCC, but these are distributed with more free space between them, giving the perception of calmness even if the department is crowded. In addition, the possibility of leaving patients out of the boxes was removed, so when ED cannot accommodate more patients these are assessed and treated in the ambulance.
- Change in handover style: To increase the efficiency of triage teams, they opted for a written handover model between different ED areas, even though they continued to maintain oral handovers for critically ill patients. This led to the receiving nurse being accountable for a patient without knowing it and to losing more information in the handover due to poor documentation and illegible handwriting.

Reflections on clinical practice is a technique that requires much time and constant attention to produce sufficient data, but its quality and complexity produce multidimensional results, enabling the holistic analysis of the study phenomenon. Therefore, it was an appropriate technique to obtain data on the complexity of nursing accountability for a long period of time.

# Chapter VII:
# Ethical analysis of clinical policies applicable to nursing practice

## 7.1. Conceptual analysis

UHL clinical policies are built to be followed exactly as they are written, penalising unauthorised interpretations if any problems arise during the relevant practical. However, the clinical practice that these policies regulate is also tied to the English nursing practice values, which are represented by the *NMC Code*. Therefore, it is important that the clinical policies that nurses have to apply do not contradict the values that are imposed to them as members of their profession.

While it may be arguable if the values proposed by the NMC Code can be considered ethical or not, examination of their presence or contradiction in various policies shows not only if there is an inclusion of nursing values in the multidisciplinary policies but also the representation of the nursing profession in decision-making related to hospital policy creation.

In order to analyse the representativeness of the British nursing values in UHL clinical policies, they have been divided into four main groups: clinical techniques and competencies, general clinical practice, nursing resource management and nursing documentation.

### 7.1.1. Clinical techniques and competencies policies

Unlike other countries, clinical procedures in England are not always assigned to different professionals based on their training or practical knowledge but based on their ability to perform a technique or procedure satisfactorily. This entails that many of the techniques that do not require complex processes can be carried out by various disciplines, which have to follow the same policies regardless of the discipline.

The multidisciplinary nature of these policies facilitates the generalisation of any professional value from any discipline to allow their application to different healthcare professionals. However, it can be seen that almost all policies in this group were created by a team containing at least one representative of the nursing profession, the only exception being the policies that deal exclusively with medication, which were created by pharmacists.

Despite this, most policies do not regulate the appropriate management of confidential data (declaration 5 of the *NMC Code*) or informed consent (statement 4.2 of the *NMC Code*), so the inclusion of a nursing representative does not ensure that the values representing his profession are going to be reflected.

The fact that these policies deal only with clinical techniques and competencies eliminates the theoretical need to imprint values in which healthcare professionals can support themselves, since their main function is to isolate the technique or competency from its complexity in clinical practice to simplify its performance in a series of instructions or a flowchart, ensuring that professionals from various disciplines can perform a wide range of techniques commonly used in clinical practice.

### 7.1.2. General clinical practice policies

Policies from this group cover a wide range of topics within clinical practice, some being multidisciplinary while others are only aimed at nurses. Most analysed policies have nursing representation, with two exceptions. The first one is the policy for management of violence, aggression and disruptive behaviour, which was created under a cooperation of the police and hospital security officers. The last exception encompasses two related policies, which were created solely by doctors and corporate professionals: the informed consent policy and the delegated consent policy.

While handling violent and aggressive patients is usually supported by security personnel, so the absence of medical and nursing personnel when creating the policy could be excused (even though nurses and doctors are the ones leading the restraining techniques to avoid side effects), nurses should obtain informed consent from their patients to be able to care for them, so the absence of nursing representation in the policy's creation is questionable.

Although it is specified in the declaration 4.2 of the *NMC Code*, the policy does not encourage verbal informed consent in regular nursing practice but it focuses on obtaining a written informed consent for certain high-risk practices. It also does not indicate the need for specific training for verbal informed consent, requiring only specific training for doctors and researchers who obtain written informed consent

regularly (UHL Consent training). Other healthcare professionals, including nurses, have the option to do an online training module on basic consent. However, within the same policy there is a contradiction, since the importance of obtaining informed consent to perform and evaluate clinical techniques it is also indicated, which are carried out by several professionals, including nurses.

In the subgroup of policies with nursing influence on their creation, such influence is not perceived clearly in them, even though it is particularly notable that most of them (all but one) do not infringe *NMC Code* statements consistently. This could be because these policies have to be purged of any particular professional value to make them multidisciplinary or because nursing representatives in policymaker teams have a corporate role, which means that they are not involved in clinical practice a large percentage of their shift or they do not have a clinical role.

The policy that infringes *NMC Code* statements is the uniform and dress code policy, which does not meet the statements 1 and 16. Statement 1, which says "treat people as individuals and uphold their dignity", highlighting within it the statement 1.3 (avoid making assumptions and recognize diversity and individual choice) contrasts with the dress code applied to nurses, who are people but their diversity and individual choice is not always respected.

Aesthetic decisions that do not affect infection prevention such as hair colour, tattoos' content or socks' colour are imposed to healthcare professionals, while dress choices that could increase the infection risks (turbans or headscarves that may come into contact with the patient's environment) are maintained to respect the right to creed. Furthermore, nurses are strongly criticised by their superiors if they do not follow these rules strictly, unlike other healthcare professionals that consider dress code superfluous. This nursing hierarchy reaction against the clothing of his subordinates comes from the customs established by modern English Nursing during and after Nightingale's time, which are still part of current clinical practice.

Regarding statement 16, this indicates the need to act if there is a risk to patient safety or public safety, which could be violated by cleaning the uniform at home. Although it is to be noted that there is evidence that uniform washing at home is not a risk per se (483-4), since washing and ironing at the appropriate temperature is sufficient to

remove most of the pathogenic microorganisms, these articles do not consider the journey of the uniform since the shift finishes until it is washed and the nurses' adherence to the appropriate policy. Recent evidence (485-6) points out that some healthcare professionals do not always follow the policy's instructions, either through ignorance or indifference, which entails a risk of spreading diseases inside and outside the hospital.

The possible violation of the declaration 16 may be the result of a lack of evidence to confirm or deny the need to wash uniforms in the hospital, but if future research follows the same direction as shown in the articles above allowing dirty uniforms to be washed in the workers' homes could be considered a risk to public health, and therefore would violate declaration 16.

### 7.1.3. Nursing resource management policies

All policies mentioned in this group relate to the management of nurses as a human resource, which have been detached from the values and ideas that characterise nursing practice, regardless of the constant nursing presence in the policymakers' team. This is partly because human resources distribution is not identified as part of clinical practice (even if it actually is), which facilitates collaboration with members of the management teams and allows control of healthcare workers ratios by the corporate team.

Since they do not represent any specific values or ideals, these policies do not violate any *NMC Code* statement but they also do not show the representative values of English Nursing. In the case of ED SOPs, these are just a set of rigid rules and guidelines that indicate what healthcare professionals should do during clinical practice, regardless of experience, context or multidisciplinary team composition. On the other hand, policies that deal with Trust-wide permanent or temporary staffing are very general guidelines for the appropriate professional to take appropriate decisions using the policy as a guide, not a command to follow.

Excluding a few exceptions mentioned in the preceding paragraphs, most policies analysed in all groups show a neutral connotation and an apparent disconnection to the professions that they regulate. They rarely infringe an *NMC Code* statement but also

infrequently represent concepts inherent to Contemporary Nursing. This strengthens the image that the LRI ED have of policies and the nursing representation in them: "bureaucracy that protects the healthcare institution's interests at the expense of care quality, produced by corporate staff that exercised a healthcare profession in the past but does not represent the ideals and interests of their previous clinical profession beyond the interest of the corporate group".

Even if there was a perfect policy network to regulate all clinical practice under the newest scientific evidence, if healthcare professionals are not motivated to learn about these policies they only serve as an institutional legal defence to avoid vicarious liability if a problem arises. That is why, despite the great utility of clinical policies, their main use as a legal document and their poor implementation in clinical practice violates statements 6 (always practise in line with the best available evidence) and 19 (be aware of, and reduce as far as possible, any potential for harm associated with your practice) of the *NMC Code*.

#### 7.1.4. Nursing documentation

Nursing documentation is not part of a group of policies, but their inclusion in this section is motivated because they are the only documents used daily by nurses, so they should reflect their practice. In ED, the nursing documentation is included in the purple book and blue book used in daily clinical practice, but it is appropriate to mention that most departments and specialties have their own nursing documentation that should be adapted to the patient's needs and the type of care offered.

Both documents are divided into sections that allow the nurse to document or locate information quickly through boxes that he just has to tick. They also have several pages devoted to free documentation of any information not included in the above forms. This documentation model represents the speed with which ED nurses document in order to maintain a sustainable work pace that allows them to provide emergency care as soon as possible.

However, this nursing documentation model follows the maxim "if it is not documented, it has not happened," so the purple book contains 19 pages that include

any common clinical practice details. These forms are not always applicable to every situation, but their completion is mandatory, since there are part of the legal defence of both the nurse and the healthcare institution against any complaint or litigation. This documentation aspect is so important that these documents are monitored by the matron twice a week to ensure that they are completed correctly.

The ethical problem arising from the use of this documentation is not in the documentation per se, which although limited provides a place to document care, but using it as a tool for defensive practice rather than to maintain care continuity. This entails that, even though they do not violate any *NMC Code* statement directly, using clinical documentation for legal defence limits the useful information from it and modify the intention with which the nurse documents.

Finally, if the nurse's purpose when he documents is to protect himself from his clinical practice' legal consequences care excellence is pushed to the background, resulting in mediocre care, a passive-aggressive nurse-patient relationship and an unsafe work atmosphere. The basis of this behaviour is rooted in the nursing hierarchy, which is linked to the fear of being deregistered by the NMC being transmitted from senior to junior nurses and the firmness with which the corporate group distrusts the nurses' professionalism, forcing them to follow specific forms while other professionals are free to document as they see fit. Due to this, a change in the perception of policies and nursing documentation that would point out their condition as an indispensable tool for excellent practice and care continuity would require a collective effort of professional unions and training, healthcare, legal and governmental institutions to reduce care legalisation, defensive practice and the "culture of fear" that prevails in current English Nursing practice.

### 7.2. Formal analysis

The provision of care is often accompanied by ethical problems that could cause a negative effect on the person receiving such care. From medication administration to patronising decision-making, ethical problems that are not tackled could have a significant impact on the health of the patient in particular and society in general.

However, there is an obvious contrast between the management of ethical issues in clinical practice and in research studies.

In England, in order to provide treatment as part of a research project, even if such treatment is commonly used in other contexts, the principal investigator must meet strict guidelines and policies from the Health Research Authority (HRA) (487), the Medicines and Healthcare products Regulatory Agency (MHRA) (488) or the host institution's REC. In order to follow these policies, the research project's documentation must include an adequate informed consent for each participant, information about any adverse event or reaction and an explanation of any suspicion against the transparency of the research project or the researchers' credibility. All documentation must be stored under specific conditions to maintain data confidentiality and should only be accessed by researchers of that project and inspectors representing different institutions (489).

The approval process of a research project could be considered tedious due to the restrictions imposed by various policies, but the society's protection provided against malicious researchers ensures that all clinical research projects authorised in England are not only protected from any researcher's ulterior motives but are also convenient for the English population in general, not only for the participant. However, despite the potential benefits of a strictly supervised national structure, clinical policies do not follow the same standards as research protocols.

Clinical policies and guidelines control various aspects of clinical practice, including individual care and treatment, resource management and healthcare professionals' etiquette. These are produced and controlled by hospitals or Trusts that apply them to ensure safe clinical practice, which results in the creation of one or several policies for each clinical problem in each Trust, theoretically obstructing a standardised national practice.

On the other hand, people who create and update these policies need to be experts in the field in which the clinical policy applies, but is not required for them to have any knowledge about Ethics or how ethical issues may arise or be handled. In addition, clinical policies and guidelines are not always approved by a CEC, but by a policies and guidelines committee, who are not required to conduct an ethical analysis. This context facilitates some ethical concepts like informed consent, patient autonomy and

professional integrity to be ignored, which can have negative consequences for the patient.

To facilitate a structured ethical evaluation process of clinical decision-making the CECs apply the Ethox Structured Approach, but this tool is useful when a particular case needs time to be examined and analysed. In most clinical situations, clinical policies are considered the standard for quality, thus assessing and fixing the policies before they are applied is essential to ensure safe and ethically valid clinical practice.

After an exhaustive bibliographic search, no tool that could be used to analyse the ethical validity of clinical policies was found, information that is necessary to deliver solid results and an adequate triangulation for this thesis. Therefore, a new tool was created to perform standardised clinical policy ethical analysis, CliPEAT (see annex 2).

CliPEAT, the acronym for Clinical Policy Ethics Assessment Tool is a tool for the ethical analysis of clinical policies that was created with the intention of analysing the relevant policies to this thesis but can be used by CECs, policies and guidelines committees and any other relevant institution or group. CliPEAT follows the structure of the Roberts Research Ethics Protocol Assessment Tool (REPEAT), which is considered by Li et al. (490) the only relevant tool to assess the ethical elements of a clinical research protocol.

Before designing CliPEAT, a literature search was conducted to find a suitable tool that could analyse the ethical validity of clinical policies or find similar tools that could form the basis of a new tool. Such literature search was conducted in PubMed, SciELO, CUIDEN and Cochrane Library in the period between 1995 and 2017, with the following search terms: [1] Clinical [All Fields] AND ethics [All Fields] AND protocol [All Fields] AND tool [All Fields] and [2] clinical [All Fields] AND policy [All Fields] AND ethics [All Fields] AND assessment [All Fields], both in Spanish and English.

After that search, no clinical policy ethical analysis tool was found, but only one analysis tool for research protocols that could be modified to analyse the ethical validity of clinical policies was identified: RePEAT, created by Laura Weiss Roberts (491).

To adapt a tool that analyses research protocols to another that examines clinical policies all items had to be modified or deleted to adapt the tool to the clinical practice

context. Similarly, additional items related to professional accountability, legal accountability and various clinical situations were added to allow the evaluator to include legal and professional aspects that are connected with the policy's ethical validity.

The result was CliPEAT, a 25 items tool simple enough for use by any committee but complex enough to include most ethical problems that may arise in the relevant clinical practice.

### 7.2.1. CliPEAT conceptual basis

Roberts followed the principles of the Belmont Report (492) when she created RePEAT, but society in general and bioethical principles in particular have evolved over the past 20 years. Respect and justice are embedded in most developed countries' societies as something obvious that needs to be valued. Regarding the principle of beneficence, it has been divided into nonmaleficence and beneficence, partly due to the prejudice about beneficence and medical paternalism.

Similarly, current clinical practice is not only more advanced but also more legalised. Concepts such as professional accountability or informed consent are ethical clinical issues that have been legalised to ensure safe and efficient practice, so ignoring the interactions between Law and Ethics in clinical practice could reduce CliPEAT's usability and validity as a tool for ethical analysis.

Taking all this into account, this tool was created based on its ability to identify ethical problems that could influence clinical practice and legal and professions issues that are connected to those ethical issues. All items are organized into different areas that evaluate a different ethical aspect of clinical practice.

#### 7.2.1.1. Design issues (items 1-2)

The first concept to discuss is the policy design itself and if it is capable of being identified as a solid clinical policy. Before discussing the possible ethical incongruities that the policy could have, it must be applicable to one aspect of clinical practice.

In England, almost any action or process related to clinical practice has a policy that regulates it, from clinical care and treatment to professional behaviour and resource management. If the policy does not regulate an aspect related to clinical practice, continuing its assessment is unnecessary. This statement may seem obvious, but introducing this security question as the first item prevents any tool misuse and ensures that the examiner comprehends what he is assessing.

Regardless of its simplicity, item 2 is vital for a policy to be applicable in real clinical practice. Being able to situate appropriate rules and behaviours in a context should be a policy's primary purpose; hence its ability to describe the clinical practice it represents is vital for its functionality. A policy's ethical analysis that is not based on actual clinical practice may be misleading due to inconsistent unrealistic demands or proposals. For example, if the venous access policy does not include or quote central venous access and generalises venous access as peripheral, the policy assessor may underestimate the technique's risks and benefits, wrongly validating that the risks and benefits of using any venous catheter are the same.

#### 7.2.1.2. Expertise, commitment and integrity issues (items 3-7)

The main purpose of this section is to assess the policymakers' capabilities to produce an ethically valid clinical policy before the policy itself is evaluated, trying to avoid malicious bureaucratic machinations that could be very difficult to find otherwise.

The creation of a clinical policy is a long and complex process, similar in theory to the design of a research project. Both need to be generated by a group of renowned and trustworthy experts to avoid conflicts of interest, ulterior motives, any abuse of the policy by third parties and adequate representation of the relevant context in the policy.

However, clinical policy monitoring is laxer than in research protocols, hence the integrity of the policymakers' team needs to be reaffirmed even more.

Ethical principles such as justice or nonmaleficence must be applied in decisions made by the policymakers' team, ensuring that the policy is safe and fair. The most common way to do this is to anticipate any suspicion that any committee may have and explain any possible conflict of interests during the policy's evaluation or within it. Nonetheless, this is not always enough.

Policymakers' teams must be able to prove not only their experience in the relevant clinical field but also their reputation and integrity to clarify any allegations that might be directed at them. Furthermore, they must have access to the necessary resources to design a clinical policy without the support of third suspicious parties, which should not be complicated if the policymakers are employed by the institution that will apply the policy, like in NHS Trusts.

Ignoring the experience, integrity and commitment of policymakers' team is to assume that all of them will follow the relevant ethical principles above their personal interests, which does not always happen. The consequences of ignoring these items in the policy's ethical evaluation could be disastrous: from a poorly structured policy that could not be implemented effectively in clinical practice to a malicious policy that benefits a few taking advantage of patients and healthcare professionals, disrupting the fair provision of services by the healthcare institution.

A real example was the Colchester General Hospital Research Foundation NHS Trust investigation by the CQC due to faulty data on cancer care waiting lists (493). At first, Colchester General Hospital NHS Foundation Trust was accused of manipulating waiting list times for cancer patients to meet government targets, but CQC confirmed that the cause was "serious mismanagement" (494). However, if the documentation policy and the whistleblowing policy had been created by an expert team free of third-party influences this problem could have been managed better or could have been avoided entirely, preventing harm to patients who were waiting for their cancer treatment.

#### 7.2.1.3. Risks and benefits (items 8-11)

Ensuring that clinical practice is beneficial to their recipients and that risks are minimised is one of the classic goals of clinical policies. They should use the available evidence to confirm that the care offered to any individual has its advantages boosted and risks reduced, which should certify that healthcare services are provided for the patient's benefit.

If risk assessment is not carried out correctly, people could receive any advantageous treatment regardless of its harmful consequences, so a specific technique could be performed even if the collateral damage is greater than its theoretical benefits. Due to this, risk assessment is useful not only as part of an efficient cost-benefit analysis but also as an assessment of the situations in which the provision of a specific treatment could be considered ethically questionable. Moreover, risk assessment facilitates appropriate patient's decision-making, since he can compare different treatments for the same disease with different risks and benefits, giving him the opportunity to make an informed consent.

When there are symptoms that frequently arise when performing treatment or care, the policy should prevent those symptoms to avoid further damage. Unlike research projects, in a large percentage of clinical policies the possible side effects are known through scientific evidence and previous experience, so it is even less excusable that there is no plan to control the occurrence of known side effects.

For these reasons, CliPEAT reinforces the need to minimise any risks and maximise the benefits of clinical practice for patients, communities and society in general. It also accepts that not all risks can be always eliminated, ensuring that any emerging symptoms can be detected and controlled.

#### 7.2.1.4. Confidentiality (item 12)

The concept of confidentiality is part of English legislation and is embedded in clinical practice through policies and routines. This is also one of the key parts of an ethically established clinical practice, which obtains information only to allow patient care and

keeps that information secure to prevent any misuse of personal data. Even though sensitive data control is widespread in British healthcare institutions, some policies may ignore how important confidentiality is.

It is socially established that personal address or past medical history must be treated confidentially, but not all policies treat the obtained sensitive information confidentially. This entails that the lesser known sensitive data like diagnostic test results or refusal to receive treatment can have serious consequences if it is not kept confidential. For example, keeping the refusal to receive treatment confidential ensures that the patient is able to make a decision about his health and maintain it without suffering social pressure from family or friends. Another common example in United States of America would be health insurance, which rises in price if the insurer gets information (even if it should be confidential) that might indicate a high risk of illness.

Confidential data management encourages each individual to control the use of their information and prevent the fact that trusting sensitive information to institutions and healthcare professionals could be detrimental in the medium or long term. If clinical policies would not ensure confidential data handling, the patient would be forced to disclose only the information that will not harm him under the control of a third party, which would break the healthcare professional-patient relationship. Given that the relationship between healthcare professional and patient is vital for excellent care, correct confidential data handling is as important as obtaining it.

#### 7.2.1.5. Informed consent and decisional capacity (items 13-14)

Since the birth of Bioethics and the patient rights movement in the twentieth century, informed consent and decisional capacity have been relevant both in Bioethics and clinical practice as a combination of individual autonomy and fair care. Clinical practice has consequences that can be beneficial and harmful at the same time, thus being able to make an informed consent (when the individual does not have his capacity to make decisions impaired) is vital to maintain patient autonomy and to avoid medical paternalism.

Nonetheless, current clinical practice is very different from the environments built for research. Healthcare professionals are not so skilled in obtaining informed consent as research personnel, so they do not consider applying informed consent in routine techniques like administering oxygen or peripheral venous access. Similarly, the use of oral consent is common when care is given in a busy environment, which would be unusual in medication investigations. However, this context does not prevent healthcare professionals to obtain a high-quality informed consent from their patients, since the only change is how that consent is obtained.

Items in this area are very similar to those items in RePEAT because both assess informed consent quality built in or around a policy. The key difference, besides the oral consent, is the recognition that the resources available are limited and how this affects informed consent in clinical practice.

A research project must have a planned budget that would encapsulate all the necessary resources for such research or it would never be sponsored by any respectable institution, while during clinical practice the available resources are not always sufficient to meet the needs of each individual. This concept is reflected in item 13e, in which the possibility of a presumed consent or ignoring informed consent could be discussed. Obtaining presumed consent of an unconscious patient in an emergency is an accepted custom in emergency care given the lack of other valid options, but the situations where decisions made by an individual about their own health are ignored might be more controversial.

Even if it is only used with extreme caution, the invalidation of the patient's decision is necessary for certain situations to ensure that resources are distributed fairly in a public health system. The most common example is in cardiopulmonary resuscitation, in which making the decision to start it or stop it is the doctor's responsibility, not the patient or his representative (495). However, there are more circumstances in which a healthcare professional has no viable option but to decide on the patient`s behalf, two of the most common cases being the fair distribution of available resources and the protection of the patient and society. Examples of these exceptions would be rejecting the provision of inappropriate or unnecessary treatment even if it is the patient's decision (e.g. intravenous antibiotics for an uncomplicated sore throat) or the retention of a patient

against his will because he carries a highly contagious deadly disease that could endanger the entire population.

Restricting or denying informed consent could be considered illegal, unethical and a violation of human rights. Consequently, CliPEAT considers it only in extreme situations and only in the benefit of the individual, the community and society.

#### 7.2.1.6. Professional accountability (items 15-17)

Clinical practice is always changing to adapt to the latest evidence, so healthcare professionals must continually learn to be able to provide excellent care. Policies should facilitate safe and updated practice, thus they must encourage evidence-based practice and should establish the necessary training and experience to perform the relevant practice. If a clinical policy does not include these features it could not only allow unsafe and malicious practice but also prevent the healthcare personnel's knowledge update and promote the harassment of junior healthcare professionals who do not feel capable of working outside their scope of practice.

Healthcare professionals do not only follow basic civic norms and their own moral but also represent their profession and is expected from them to understand, share and practice behaviours connected to their occupation. In England, these behaviours are represented by the regulatory institutions' codes of conduct (e.g. *GMC Code of Conduct* (496) or *NMC Code of Conduct* (80)), which are considered a mandatory requirement to practice for most healthcare professionals.

If a clinical policy contradicted one of these codes of conduct, the healthcare professional would be in an ethical dilemma: to follow his professional values and violate a clinical policy (which is prohibited indirectly in most codes of conduct) or to respect the clinical policy and break the professional code (which is prohibited directly in several clinical policies and in the employment contract). The healthcare professional may be accountable for any consequences of his clinical practice if he did not follow all relevant policies and codes of conduct regardless of their inconsistencies. If clinical policies and codes of conduct contradict each other, healthcare professionals, especially junior ones, would be incapable of practising safely.

#### 7.2.1.7. Legal accountability (items 18-19)

CliPEAT's function is ethical analysis, but Ethics and Law are often interconnected. In this case, ensure that a clinical policy complies with the applicable regulations avoids the ethical dilemma created when we have to choose between breaking a law and violating a clinical policy (which may also be illegal in some cases).

Given the devastating impact that breaking a law during clinical practice could have (even if it is accidentally, without malice and without negative consequences for the patient), the policy must prevent the professional to accidentally violate a law. This not only makes it easier to keep healthcare professionals in their job practising carefree but will also prevent the healthcare institution to lose funds that should be used in treatment and care for its patients.

After pointing out the basic monitoring of current legislation, clarifying when vicarious accountability applies allows the healthcare professional to make an informed decision about when to follow a policy and its consequences. Senior staff are especially known for being able to consider a fluid interpretation of clinical policies to maximise the patient benefit in every situation, but if there is no concrete explanation of when a non-strict interpretation of the policy could be inappropriate or illegal very few would jeopardise their professional career only to slightly improve a particular aspect of clinical practice, thus reducing critical thinking and care improvements until the policy is updated or deleted.

#### 7.2.1.8. Other issues (items 20-25)

It is important to evaluate how a clinical policy establishes how the relevant practice is documented, thus ensuring that the healthcare professional can be accountable for his practice and to facilitate future policy upgrades or enhancements, if needed. Therefore, for these improvements to be carried out they must be programmed policy revisions, forcing both the sponsoring institution and the policymakers' team to implement the newest evidence-based practice within it regularly.

The last three items present an opportunity for the evaluating committee to discuss any identified problem that could not be included in the previous items. This is because CliPEAT is a complement to policy ethical analysis, but in no case replaces the assessment of any of the evaluation committee members or the reflexive discussion between them to reach a multidisciplinary conclusion. That is why CliPEAT serves as a structure for policy ethical analysis, thus preventing that important issues are ignored during it, but is open to debate and is flexible to the inclusion of any ethical issue.

The last two statements, which are not listed because they are not items, sentence the committee's verdict regarding the policy's ethical validity. Also, the second statement adds a critical hint that research and clinical practice share: not all policies are equal and therefore, even if they may be ethically viable some policies need closer supervision than others. This may be reflected in periodic audits or more frequent updates, which ensure that the more complex, dangerous and controversial aspects of clinical practice can be handled correctly without restricting practice per se.

### 7.2.2. Clinical policy evaluation with CliPEAT

CliPEAT was used to evaluate 54 policies and guidelines applicable directly or indirectly to Nursing in the LRI ED twice at an interval of 14 days between one evaluation and the other. These policies and guidelines were divided into three groups: clinical techniques and competencies, general clinical practice and nursing resource management (see annex 3). This division was designed to structure the evaluation and establish the scope that an ethical analysis with CliPEAT may have.

When comparing both assessments, the general mean agreement item by item was 86.4%. The mean agreement item by item for each policy group was varied: 91.2% in clinical techniques and competencies policies, 87.7% in general clinical practice policies and 79.4% in nursing resource management policies. Item by item agreement on individual policies stood between 71.7% and 100%.

After using CliPEAT with the aforementioned 54 policies and guidelines, all nursing resource management policies met the minimum requirements to be ethically viable. However, 85.7% of clinical techniques and competencies policies (12 of 14) and 10% of

general clinical practice policies (3 of 30) did not meet the minimum ethical requirements established by CliPEAT.

The items that were not acceptable are measured as the number of clinical policies rated as "unacceptable" divided by the total number of policies in the corresponding group, while the data in brackets shows the number of clinical policies rated as "unacceptable" divided by the total number of policies analysed:

**Table 1: Percentage of "unacceptable" items in general clinical practice policies**

| **Percentage of "unacceptable" items in general clinical practice policies** | | | |
|---|---|---|---|
| Item 12 | Item 15 | Item 16 | Item 19 |
| 6.6%<br>(3.7%) | 10%<br>(5.5%) | 6.6%<br>(3.7%) | 3.3%<br>(1.8%) |

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**Table 2: Percentage of "unacceptable" items in clinical techniques and competencies policies**

| **Percentage of "unacceptable" items in clinical techniques and competencies policies** | | | | | | |
|---|---|---|---|---|---|---|
| Item 9 | Item 10b | Item 10c | Item 12 | Item 13a | Item 13b | Item 13c |
| 7.1%<br>(1.8%) | 25%<br>(5.5%) | 25%<br>(5.5%) | 78.5%<br>(20.3%) | 85.7%<br>(22.2%) | 85.7%<br>(22.2%) | 85.7%<br>(22.2%) |
| Item 13d | Item 13e | Item 14a | Item 14b | Item 14c1 | Item 14c2 | Item 21 |
| 85.7%<br>(22.2%) | 85.7%<br>(22.2%) | 85.7%<br>(22.2%) | 85.7%<br>(22.2%) | 85.7%<br>(22.2%) | 85.7%<br>(22.2%) | 7.1%<br>(1.8%) |

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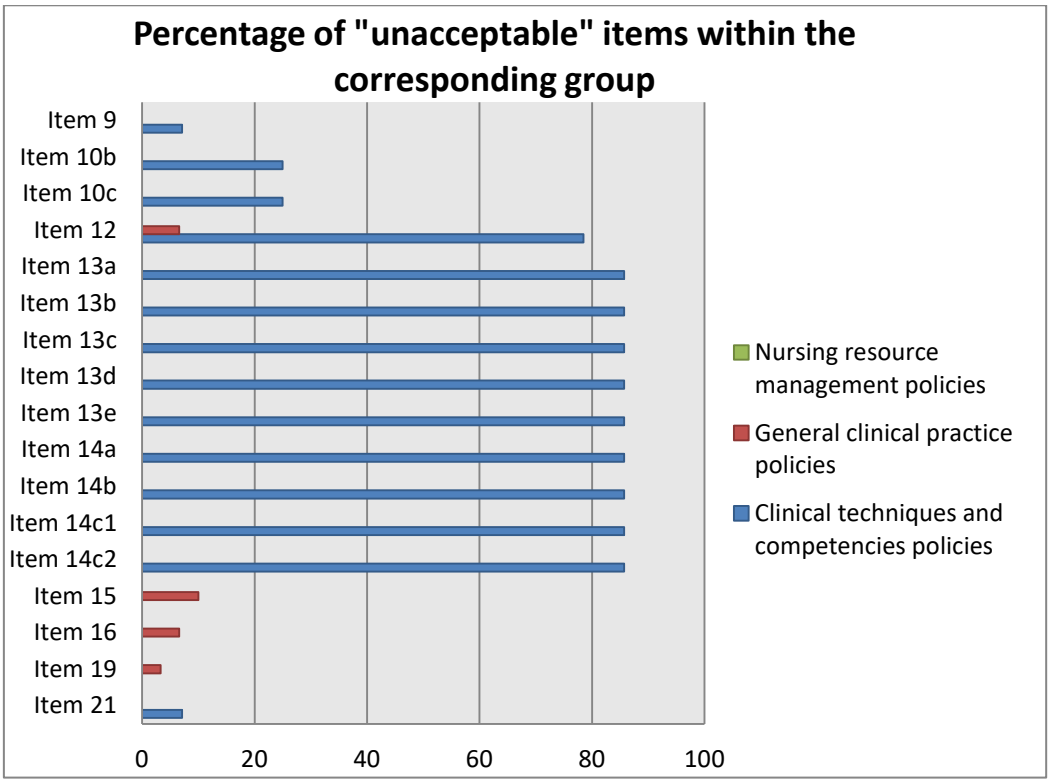
**Graph 1: Percentage of "unacceptable" items within the corresponding group**

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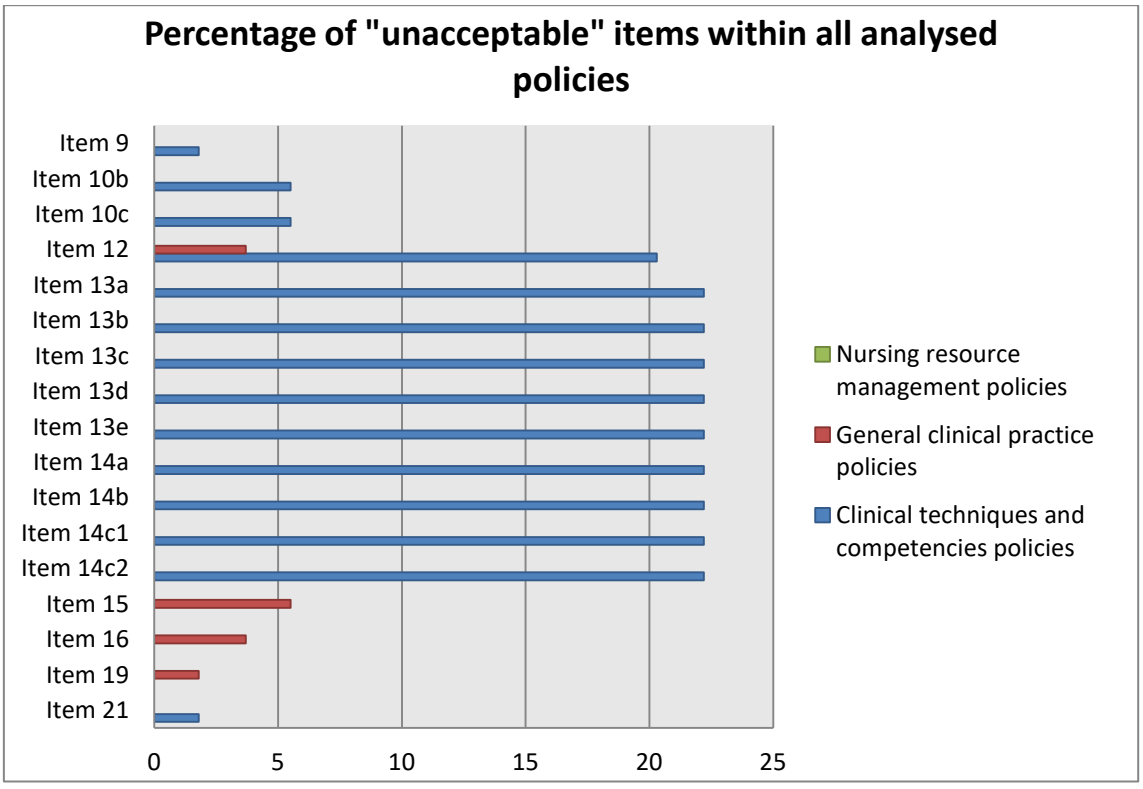
**Graph 2: Percentage of "unacceptable" items within all analysed policies**




Self-created content on the 20th of June 2017

Furthermore, it is also interesting to measure the use frequency of the term "not applicable" to estimate the accuracy and applicability of CliPEAT in different types of policies, measuring the number that clinical policies that were classified as "not applicable" (N/A) divided by the total number of policies in the corresponding group, while the number the data in parenthesis determines the number of clinical policies rated as "not applicable" divided by the total number of policies analysed:

**Table 3: Percentage of "not applicable" items in general clinical practice policies**

| **Percentage of "not applicable" items in general clinical practice policies** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Item 10a | Item 10b | Item 10c | Item 12 | Item 13a | Item 13b | Item 13c | Item 13d |
| 70% (38.8%) | 70% (38.8%) | 70% (38.8%) | 63% (35.1%) | 73.3% (40.7%) | 73.3% (40.7%) | 73.3% (40.7%) | 73.3% (40.7%) |
| Item 13e | Item 14a | Item 14b | Item 14c1 | Item 14c2 | Item 16 | Item 19 | Item 20 |
| 73.3% (40.7%) | 73.3% (40.7%) | 73.3% (40.7%) | 73.3% (40.7%) | 73.3% (40.7%) | 10% (5.5%) | 3.3% (1.8%) | 30% (16.6%) |

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**Table 4: Percentage of "not applicable" items in clinical techniques and competencies policies**

| **Percentage of "not applicable" items in clinical techniques and competencies policies** | | | | |
|---|---|---|---|---|
| Item 13b | Item 13c | Item 13d | Item 14a | Item 14b |
| 7.1% (1.8%) | 7.1% (1.8%) | 7.1% (1.8%) | 7.1% (1.8%) | 14,2% (3.7%) |

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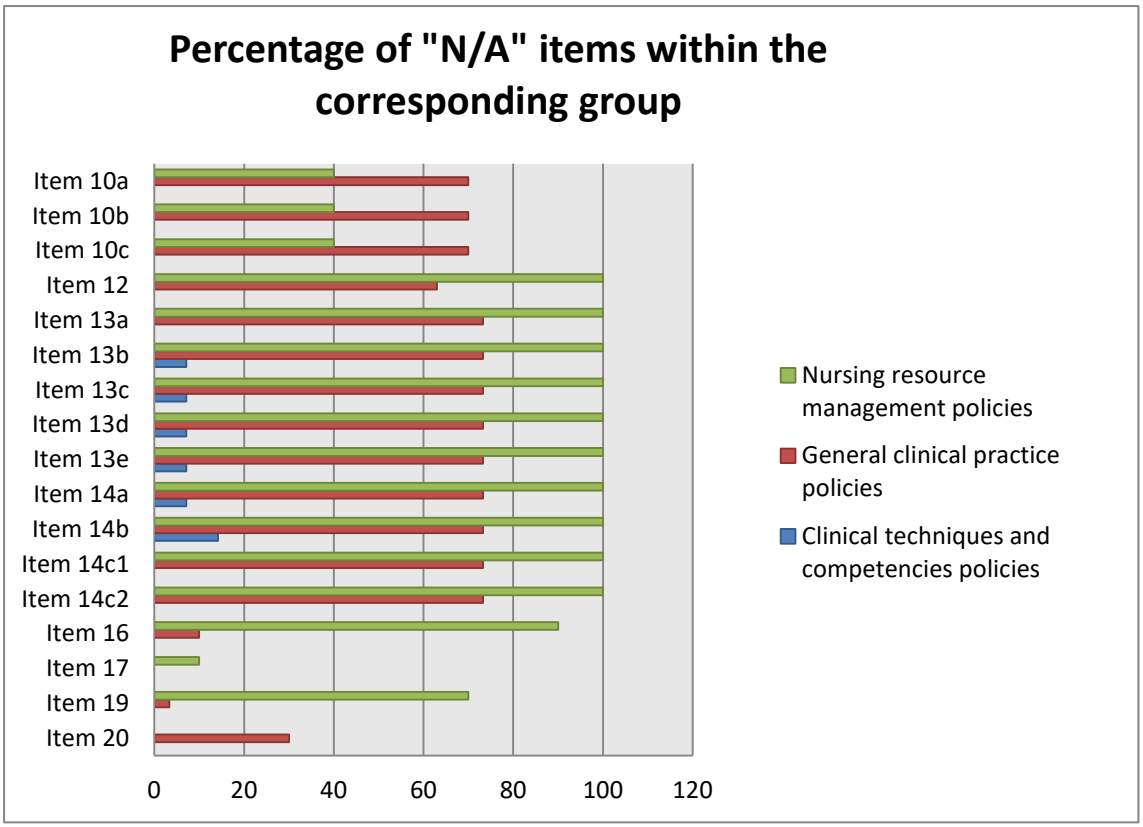
**Table 5: Percentage of "not applicable" items in nursing resource management policies**

| Percentage of "not applicable" items in nursing resource management policies | | | | | | | |
|---|---|---|---|---|---|---|---|
| Item 10a | Item 10b | Item 10c | Item 12 | Item 13a | Item 13b | Item 13c | Item 13d |
| 40% (7.4%) | 40% (7.4%) | 40% (7.4%) | 100% (18.5%) | 100% (18.5%) | 100% (18.5%) | 100% (18.5%) | 100% (18.5%) |
| Item 13e | Item 14a | Item 14b | Item 14c1 | Item 14c2 | Item 16 | Item 17 | Item 19 |
| 100% (18.5%) | 100% (18.5%) | 100% (18.5%) | 100% (18.5%) | 100% (18.5%) | 90% (16.6%) | 10% (1.8%) | 70% (12.9%) |

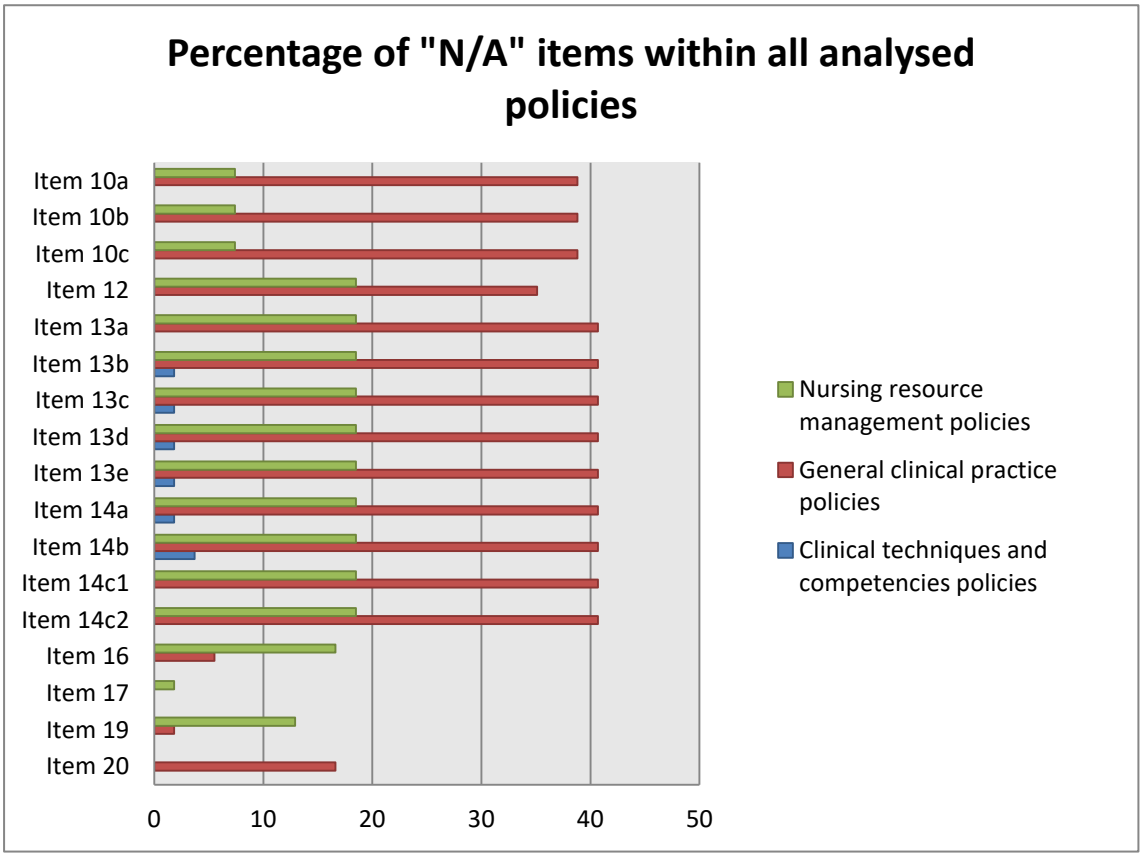
Self-created content on the 20th of June 2017

**Graph 3: Percentage of "N/A" items within the corresponding group**




Self-created content on the 20th of June 2017

**Graph 4: Percentage of "N/A" items within all analysed policies**

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### 7.3. Ethical analysis of clinical policies applicable to clinical nursing practice as a data collection technique

Understanding the theoretical nursing accountability in the LRI ED is essential to contextualise nursing practice. To do this, we chose to examine LRI ED's clinical policies, which represent what activities should be performed by which group of professionals and under what circumstances, in line with current regulations and institutional guidelines.

A conceptual and formal analysis was performed to take into account both what clinical policies represent and how policies regulate clinical practice and nursing accountability. In relation to the conceptual analysis, it is able to frame different policies within the *NMC Code* and reveal the incongruity of many of these policies in an ED.

This incongruity is focused on the fact that hospital policies and the *NMC Code* contradict several times, creating an ethical dilemma: follow the policy and expose yourself to professional sanction or ignore the policy and jeopardize your job?

This problem is easily avoidable if hospital policies followed a regulated and mandatory ethical analysis before being approved, but the evaluation of a policy by a CEC is not a mandatory requirement.

Another finding through conceptual analysis is the lack of contextualisation of hospital policies in ED. This happens because hospital ward environment and ED atmosphere are very different, so applying the same policies in both places causes that they do not translate appropriately into practice and create an ethical dilemma: follow the policy and provide low-quality care or ignore the policy and expose yourself to a legal or professional sanction?

To avoid this problem, the healthcare institution could produce some policies able to adapt to different types of situations, like the crowding policy, which implies that different individuals perform different tasks depending on the level of crowding in order to fix it as soon as possible.

In regards to formal analysis, it focuses on how clinical policies are structured and if they meet the minimum elements that prevent negligent and malicious practice. To do

so, we had to create a tool for ethical analysis of clinical policies, since none was found during the literature search. The main problem this entails is that it is very complex to set a standard on how CliPEAT should work, with which policies should be applied and the accuracy of its results.

Because it is based on RePEAT, CliPEAT might have some conceptual limitations. This is mainly due to the differences between a controlled research environment and a clinical area. However, new items (13d, 13e, 15-19, 21 and 23) were added to adapt the tool to a clinical area where British healthcare professionals do not always know all policies and their function but are should be familiar with their legal and professional accountability.

The results shown may have a different meaning depending on if CliPEAT is deemed precise enough to analyse all clinical policies or if it should only be applied to policies involving direct patient interaction. If CliPEAT was considered appropriate for the ethical analysis of any clinical policy, including standard operating procedures (SOPs), this would imply that only nursing resource management policies meet the minimum ethical criteria established consistently. On the other hand, if the absence of errors in nursing resource management policies is considered as the result of CliPEAT's possible limitations, only the results of clinical policies involving human patients could be considered objective.

CliPEAT can be flexible and adapted to an extensive range of policies, but its use in this thesis revealed that might not be suitable for analysing nursing resource management policies given the extensive use of the non-applicable response and the apparent lack of ethical problems found in these specific policies. This does not mean that the use of the "not applicable" response is inadequate, since it allows CliPEAT to adapt to a wide range of policies, but its overuse can be an indicator that a specific policy should not be analysed with CliPEAT.

Regardless of the range of analysable policies with CliPEAT, its results are relevant. The most common problems are related to items 12, 13 and 14, which are connected to confidentiality, informed consent and the delegated consent. If the analysed policies were connected with the confidential data handling, consent to treatment and delegated consent policies through a summary in the ethically invalid policy it would not need

further adjustments. This is possible because a new policy has to be taken into account as part of the hundreds of policies present in each healthcare institution, so it is essential that each policy is part of a policy network to avoid duplication or confusion.

Nonetheless, if the clinical policy's ethical problems are ignored because other policies could avoid them another problem is created: conflicting policies. Healthcare professionals should be able to interpret policies to promote safe and fair care, but when two policies contradict each other avoidable problems arise. For example, if the oxygen administration policy does not mention that the patient's consent is necessary to giving him oxygen, this contradicts the consent for treatment policy. It could be argued that it is unreasonable to force someone to receive oxygen, but the healthcare professional who is not familiar with the concept of informed consent could argue that the treatment needs to be imposed on the patient regardless of his opinion to help him recover from his illness.

To avoid these ethical problems, CliPEAT should be used not only with a policy in mind but with a group of policies that regulate an aspect of clinical practice. For example, the three policies and guidelines that regulate a specific technique (venous access in adults and children policy and procedures, guideline for obtaining venous blood samples from an adult and guideline for the insertion, care of and removal of a peripheral cannula in adults) should be evaluated together.

Another aspect that could be discussed is the apparent lack of impact of the results from the ethical analysis of policies through CliPEAT in coding and triangulation. However, this arises because what are triangulated are the concepts that these results represent, not the quantitative results per se. For example, two of the most representative concepts are inadequate routines handling confidential information and obtaining informed consent, arising from the high rate of failure of the clinical techniques and competencies policies in items 12, 13 and 14 and the institutionalisation of professional and legal accountability, which is represented by a reduced number of failures in items 15, 16, 17, 18 and 19 in all policies.

CliPEAT has the potential to be used as a guide for policymakers and committees evaluators to ensure that clinical policies meet minimum ethical criteria. Because of this, it needs to be tested with different clinical policies from several institutions to

confirm that it can be used with all clinical policies or only a specific group of them. However, the accuracy shown with clinical policies involving the patient (clinical techniques and competencies policies and general clinical practice policies) indicates that CliPEAT is ready to be applied in those groups of policies.

Nevertheless, regardless of the potential that may have CliPEAT outside the context of this thesis, in this research it serves as a base structure to document comprehensive policy ethical analysis in a clear and orderly manner. This entails that many of the ethical problems were found before applying CliPEAT, but its use accelerated their analysis and avoided major flaws in it.

# Chapter VIII:

# Semi-structured interviews

## 8.1. Main characteristics

### 8.1.1. Recruitment process

To triangulate reflections on clinical practice with data from other nurses, 34 semi-structured interviews were done to LRI ED nurses. The method followed for making these interviews is described in Chapter VI.

Since all nurses with enough experience that worked regularly in the LRI ED were possible candidates, all of them were informed about this research project through advertisements in the staff room and during the first meeting of the shift in the ED seminar room. However, no nurse volunteered during the first two weeks.

It was after those two weeks when someone asked about the research project in the staff room and we started to receive more questions from nurses about what was the purpose of this research. Most of them mentioned that they often ignore messages during the beginning of their shift and did not see the advertisement in the staff room, but the fact that a nursing research project was carried out was interesting for them and the first person who asked introduced that information within the conversation topics in the staff room.

This reaction from nurses led to a slight adaptation of the participant recruitment techniques. If during breaks there was a potential participant who might not know the research project, a casual conversation with that person would establish if the situation was convenient, during which he will be informed about the research project's content and purpose. At the end of the conversation, the potential participant was offered the opportunity to be interviewed, but he had to confirm it later, giving him time to make an informed decision and avoiding any kind of coercion derived from the relationship between the researcher and the potential participant. The researcher could only ask once a month (three times maximum) to the same person, so only if the nurse was interested he would contact the researcher again to arrange the interview.

Consequently, between May and August 2017 we contacted all nurses who met all the inclusion criteria and did not fall within any exclusion criteria during those months, being these 128 of the 180 nurses employed permanently during that period.

The high number of nurses excluded is due to two main causes:

- UCC merge with ED in May 2017: When UCC was taken over by the LRI ED, it also absorbed its nurses. Therefore, theoretically these nurses did not have more than 6 months of experience in the department, so the 14 UCC nurses did not meet the inclusion criteria.
- Accelerated staff turnover: Given the high ED permanent staff turnover, 38 nurses had less than 6 months of experience in the department during the interviewing stage.

Of the 128 nurses informed, there were 34 who agreed to be interviewed. The main reasons why the other nurses did not contact the researchers to be interviewed can be grouped into three categories.

- Lack of interest: Nurse practitioners (ENPs and ANPs) and specialist nurses did not perceive their daily work as nursing practice, so only two showed interest in being interviewed. In regards to other nurses, many of them were not interested in nursing research in general or in this particular research project, which led them to consider it a worthless use of their time.
- Lack of time: Due to family responsibilities, extra shifts or living away from the hospital, several nurses argued that they did not have the necessary time to be interviewed. Since the Directorate of Emergency and Specialist Medicine banned conducting interviews during working hours, coordinating interviewee's and interviewer's free shifts was a challenge. However, this problem was partially solved when we did interviews just after finishing the interviewee's shift.
- Lack of trust: Since the interviews included issues related to professional accountability, professional registration safety and clinical error management, several nurses were not comfortable dealing with such controversial issues with an interviewer. Several arguments were received, being the most common the possible hospital and NMC reprisals if the interviewer detected malpractice that should be reported (trust on the interviewer) and the inability to provide relevant information during the interview (trust on himself).

### 8.1.2. Interviews' execution

Once the interview was organized, the potential participant had data from the participant information sheet (PIS) (see annex 4) to be able to consent being interviewed before he met with the interviewer. This led to the period of the pre-record interview (greeting) to be divided into a casual introduction to facilitate a smooth and relaxed conversation, a summary of the research project reinforcing the information from the PIS to the participant and obtaining the participant's informed consent to conduct the interview, which was documented on the informed consent form (see annex 5).

After obtaining informed consent, the audio recorder was turned on and the main section of the interview started: the semi-structured questions. This period was characterised by several factors that define the data from these interviews, being the most influential ones described below:

- Questions' flexible structure: All interviews followed prefixed semi-structured questions that guided the conversation and facilitated the researcher to obtain similar information from all participants. However, the participants were not always able to answer direct questions regarding their values or the legislation to which they were subjected to, so more general questions were offered as an alternative. Those alternative questions were becoming the standard questions when we encountered a widespread problem when answering direct questions about Ethics and healthcare legislation.

- Perception of the interview's purpose: Although in both the PIS and the pre-recording period the purpose of the interview and the research project was explained, each participant interpreted its purpose differently, focusing his responses in relation to his understanding of this research.

  In some cases, this facilitated more elaborate answers to specific questions, while in others it limited the data obtainable from other questions, interrupting the investigator on several occasions. The interviewer was responsible for directing the interview to encourage complex responses and promoting that all relevant questions were answered without limiting the freedom of the participant's answers, collecting as much varied and relevant data as possible.

- Interview schedule: Both the interviewer and the participants worked in the LRI ED, so finding a day off together was difficult. While some interviews were conducted on a day off, before a shift, before or after a course or after an interview, 52.94% of the participants (18 of 34) were interviewed after a shift of at least 8 hours. This allowed the participant to link questions with his clinical practice more fluidly but also slowed the pace of the interview in isolated cases.

- Intention to please the interviewer: All participants knew the interviewer, some for several years. Even though he did not maintain a non-professional relationship with any of the participants, the interviewer's influence toward them encouraged some of them to perceive their participation as a way to thank him for his support during clinical practice. This fact was discovered during interviews when specific participants started seeking the interviewer's approval after an answer.

  Although this could be considered negative, since the interviewer could influence the responses and produce biased data, he always indicated that there was no right answer and that the participant should respond without thinking about the validity of his answer. In addition, participants who were trying to please the interviewer were more open and developed their answers more than the more neutral participants, evidence that the former put more trust on the interviewer.

After finishing the round of semi-structured questions, the farewell took place. At the beginning of it, the recorder was turned off and the member check was done, a technique to increase data validity and transferability. In this research project, the member check consisted in providing a summary of the interview's information to the participant to clarify concepts with him and verify that the information from the interview was truthful.

The member check was made right after the interview but was not recorded, so the participant could discuss controversial concepts without the pressure of being recorded, clarifying any issues that have been avoided for that reason.

After the member check, the interviewer encouraged the participant to ask any questions that he deemed appropriate. After those questions, a short informal conversation was started to relax the participant and switch from an interviewer-interviewee relationship

to a working colleagues relationship. Finally, both interview members said farewell informally.

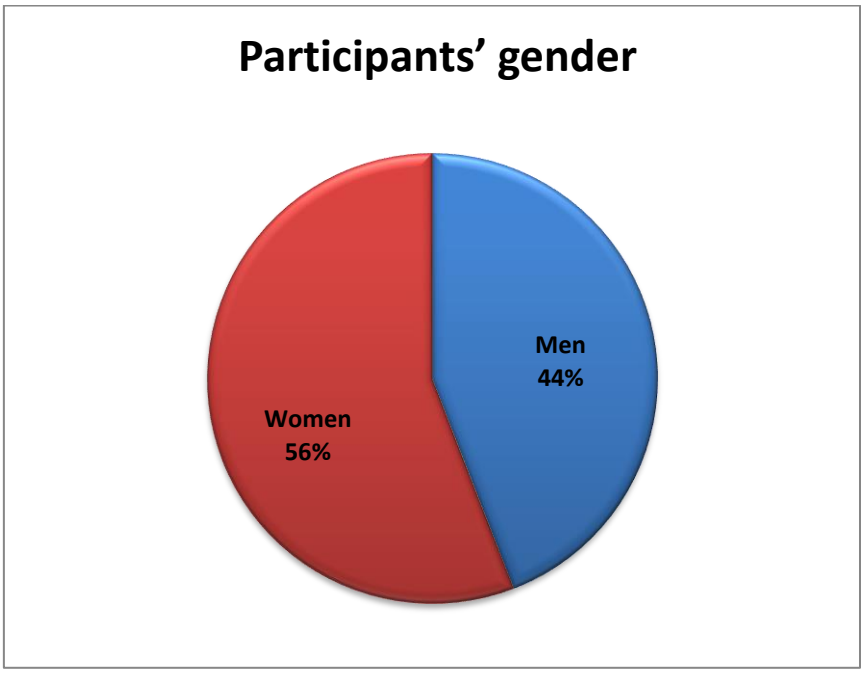
### 8.1.3. Participants' demographic description

The 34 participants who were interviewed can be grouped differently, even though the most appropriate groups to contextualise the interview results are gender, professional role, experience and professional culture.

#### 8.1.3.1. Gender

19 women (55.88%) and 15 men (44.12%) were interviewed (Graph 5).

**Graph 5: Participants' gender**




Self-created content on the 17th of October 2017

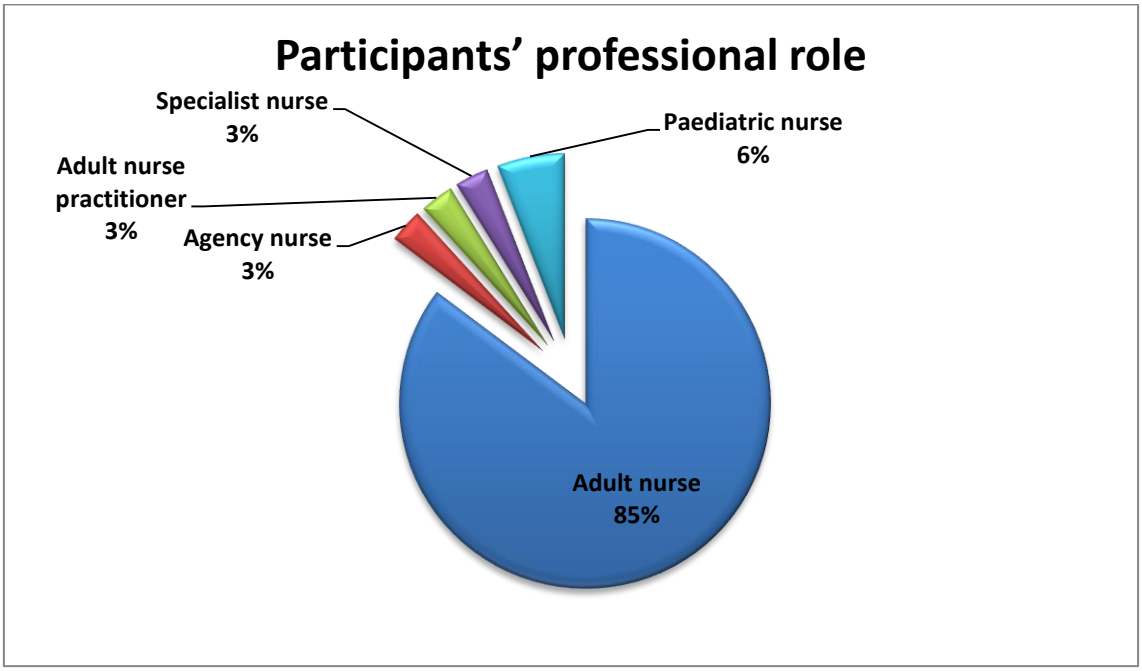
The proportion of women is lower in the sample (55.88%) than the total number of permanent nurses in the LRI ED (82.3%). This is due to several factors, among which there are the increased workload of women outside their job role and the lack of confidence in a male interviewer.

### 8.1.3.2. Professional role

Clinical responsibility differs depending on the role that each nurse has in ED, so it is important to know with nursing roles are represented in the sample.

The main role of the participants nurses is adult nurse (29; 85.29%), followed by paediatric nurse (2; 5.88%), agency nurse (1; 2.94%), specialist nurse (1, 2.94%) and adult nurse practitioner (1; 2.94%) (Graph 6).

**Graph 6: Participants' professional role**




Self-created content on the 17th of October 2017

The sample contains at least one nurse for each role, but most of them were adult nurses. The lack of interest from specialist nurses and nurse practitioners since they do not feel that their practice can be classified as nursing practice, the defensive relationship of agency nurses with permanent staff and the small percentage of paediatric nurses in regards to adult nurses (only 24 nurses of the 180 permanent nurses were paediatric, a 13.3%) are the main reasons for the sample distribution regarding professional role.

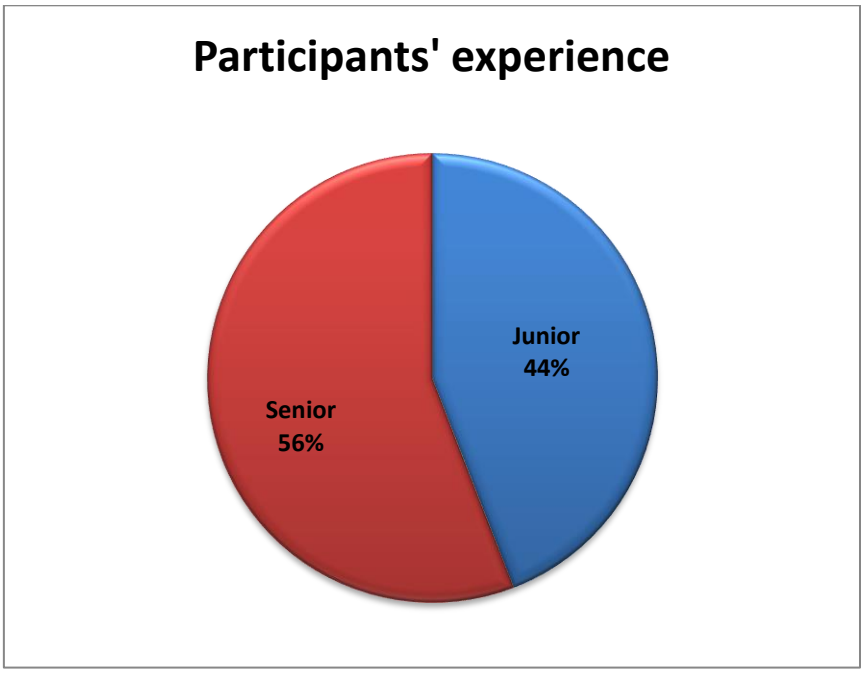
#### 8.1.3.3. Experience

The sample has been divided into junior and senior nurses, being the turning point between one and another established by the LRI ED:

- More than two years of experience in the department.
- Competent in daily practice basic techniques (intravenous medication, cannulation, venous blood, bladder catheterisation, etc.).
- Capable of coordinating nursing teams sporadically or under supervision.

19 senior (55.88%) and 15 junior (44.12%) nurses were interviewed (Graph 7).

**Graph 7: Participants' experience**




Self-created content on the 17th of October 2017

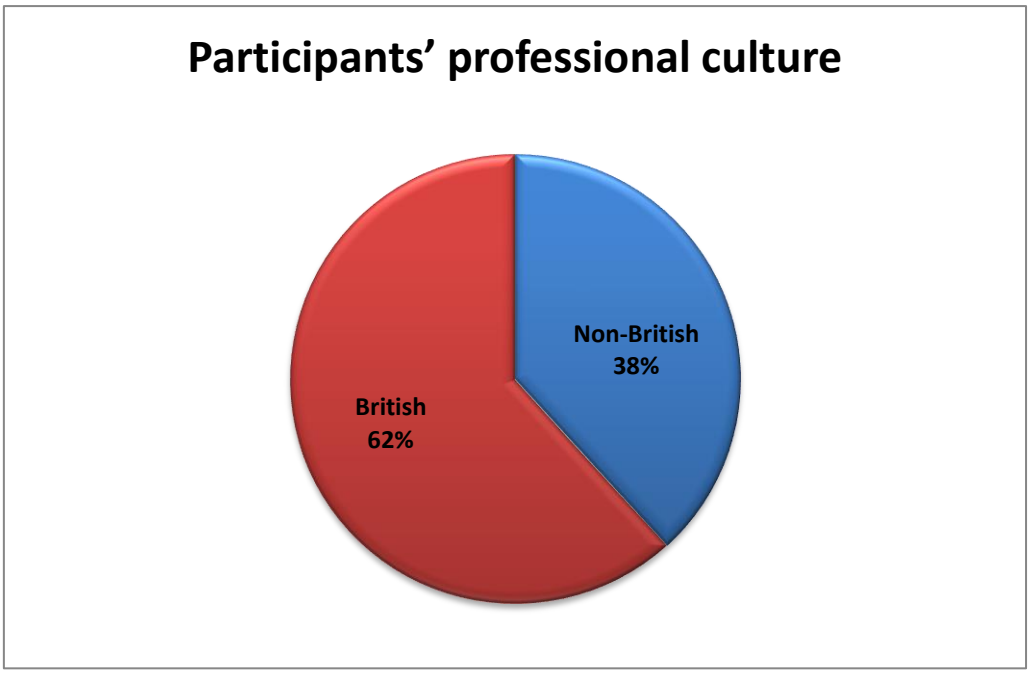
The junior-senior ratio is very similar in the sample (44% - 56%) and in the total amount of permanent nurses in the department (42.23% - 57.77%).

#### 8.1.3.4. Professional culture

The concept of professional culture defines the fact that nurses from different countries or different cultures have different perceptions of what constitutes a nurse, nursing training, care and clinical practice.

Due to the participants' confidential data management, the culture of origin cannot be specified if it is a minority. Therefore, participants are classified according to their professional culture in British (21; 61.76%) or non-British (13; 38.24%) (Graph 8), considering the nurse British if he obtained his Nursing degree in Great Britain or has worked over 10 years in Britain uninterruptedly as a nurse.

**Graph 8: Participants' professional culture**




Self-created content on the 17th of October 2017

The proportion of culturally British nurses is lower in the sample (61.76%) than in the total number of permanent nurses in the department (77.7%). This is because the vast majority of nurse practitioners have extensive experience working as nurses in Britain, so the fact that only 1 of the 37 participated reduces the percentage of interviewed British nurses.

## 8.2. Recurrent themes

### 8.2.1. Care and the nurse-patient relationship

Care is a central concept in nursing practice, the most known of the nursing paradigms. Participants considered it one of their priorities with patient safety, mentioning the need for a holistic, fair and quick care.

Although participants mentioned various details regarding patient care, they can be grouped into two main groups: assessment and treatment in nursing practice and nurse-patient relationship.

#### 8.2.1.1. Assessment and treatment in nursing practice

The practical care of acute patients in ED can be classified into assessment and treatment, considering these two concepts within a holistic practice. Therefore, both concepts refer not only to physical but also mental, emotional and spiritual care.

Starting with the assessment, it is continuously performed in ED from patient triage to the last assessment before discharge:

> P (participant) 9: I think identifying what patient's needs are, one of the main things that all nurses in ED or any other area need to do because that is what we are here for, basically. We need to identify what is the clinical presentation, what have been done for the patient, what investigation needs to be done, what we are waiting for […].

> P13: I want to do my first assessment and then leave everything done, so I want to see their face and ask them my questions. I know they [Assessment Bay nurses] already asked them, but I want to know who I'm dealing with and I want to know what happened on that occasion. […]. I know they [the patient] already told other doctors and nurses 4 or 5 times and they are tired about it, but I want to know what's wrong because if something happens everybody comes to me, not to the doctor, to me because the patient may not being seen by the doctor yet and I am the only one who knows about that patient.

However, no assessment is performed based on the patient alone, since it also considers his relationship to other patients and the resources available:

> P12: So I will attend first to the patient that it might be under the impression to be unwell or it might have the potential to deteriorate more. That's the priority of keeping everyone safe, look at EWSs, eyeball all patients and physically have contact with patients because sometimes the patients might not be scoring but the patient might not actually look that well.

Moreover, drug treatment provision in acute patients is considered a priority over other types of care:

> P1: So, although I think we always stick with [clinical] priorities and what is more important clinically for that patient I think we will slack in all those other things that are not a priority, which can be quite upsetting for the patients.

> P16: So, the most important things first, any treatment, and then any care than needs doing, and then anything else that needs doing to keep the patient comfortable.

Several factors directly affect the quality of the assessment and treatment performed by LRI ED nurses, being the most mentioned clinical workload, patient flow, staff shortages, staff training and clinical practice routines.

A high clinical workload requires nurses to prioritise critical care on top of holistic care, focusing on the avoidance of patient deterioration or death in opposition to the quality of care offered. Nurses are aware that the care they provide is not excellent care, which they find frustrating, but they recognise that it is the only option they have in high clinical workload situations:

> P16: Because we are such a busy department the little things get missed out or they get delayed to make way to more important things, which isn't great for the patient but has to be done. I think in Majors when it gets busy having six patients does cause some of the comfort things no to be done as quick as they could be, mainly because is so much going on that you need to spend time looking over all patients and checking that everything is seen to.

> P23: Ok, especially when it's really, really busy I feel like I can't look after all the patients and makes me depressed because I can't…I'm not able to do the job that I wanted to do since I became a nurse, which is look after people. […]
>
> Sometimes, due to the nature of ED you don't get to look after everyone because some people slip by you without even receiving proper nursing care. I think when you're getting that constantly, day in and day out, it wears you down and makes you feel a bit depressed about the job because you think "I'm not a very good nurse, I can't do this nursing job, I can't look after everyone".
>
> I did feel like, especially during the winter crisis, I feel like is a bit of burnout almost because you get used to be really really busy you get used to not to do certain things of patients care, the little things like giving the patient a cup of tea when they are upset or tired or actually having time to sit down and talk to patients about what's going on.

Participants also mentioned the apparent difference in clinical workload between ED and hospital wards, since even though they have fewer patients than their ward colleagues ED nurses care for many more patients a day with commonly more urgent pathologies.

> P21: It's a hard corner because most of the time you need like one nurse to four [patients], in a ward is one [nurse] to eight [patients], but ward nursing and ED nursing it's very very different.
>
> P29: In this department there are a lot of pressures from times and obviously is an ED, so puts you in a different stress perspective than on the wards, although on the wards sometimes we have to double check and it doesn't happen either, but is easier to work by the book on the wards than is in here, as least from my experience in both places.

The workload is inversely related to patient flow, since when patients are not transferred to another place they accumulate in ED, increasing the patients per nurse ratio. Nurses are aware of this phenomenon, which they mainly blame to the lack of beds in wards:

> P4: The amount of pressure we are put down here needs to be the same amount

> of pressure put in patients that they are medically fit for discharge upon the wards. They need to have a team of people going around and recognizing patients what they are almost ready to be discharged and get the ball rolling that end too to free up the bed space that does impact us down here.
>
> It is nothing worse that went you work a shift here [ED] and there is such a long delay for patients having beds and that causes more problems down here. We need better patient flow throughout the hospital, not only the emergency department.
>
> P34: So, this is one of the points that I'm seeing more in this department, that is very overcrowded and that affect patients, myself and the whole system because it does not work well. If there is no system that organize itself so patients receive the care that they need, everything will be affected.

Healthcare professional staffing, or lack thereof, is a factor that affects clinical workload, patient flow and assessment and treatment as part of patient care. This, together with staff training, was the factor most often mentioned by participants when asked what they would change in the LRI ED. Participant nurses indicated that there is not enough healthcare staff, which directly affects patient safety, quality of care and staff morale, amongst others:

> P4: All the things that I have been taught about how to care for my patients I have not been able to put it into practice all the time because when we [the ED nurses] are short of staff and it is just me. Let's say, for example, providing personal care, which is all at the forefront, sometimes I am not able to change my patients until I've got a member of staff to help me so it is a delay.
>
> P7: The delays are not often due to nursing care but due to this external factor, but I think if we had flow all the time and lots of staff you would be able to care of your patients as you want to, meet targets and follow procedures.
>
> P23: More staff will be lovely, that's not going to happen. If you look it realistically, a nursing ratio of 1 to 4 would be perfect, that would give you time to see each of your patients every hour, make sure that they're safe, they're comfortable, they have something to drink and eat, they are warm enough, give

them blankets and a pillow, that would mean that you could do that. I think that would make us feel better knowing that we delivered better care. I know of nurses that have been in tears working in Majors just because they feel that they are not doing enough for their patients and that's really hard to see.

The lack of staff and the fast turnover of personnel facilitate a large percentage of junior nurses, so appropriate training is essential to maintain quality standards. However, all participants mentioned problems related to staff training and how it affects care provision, either through lack of skills or poor theoretical and practical knowledge:

P7: I think we need to change how we train people and I think it will be really helpful if we had a nurse that was just dedicated to work alongside people, mostly newly qualified nurses, they often want to stick to the rules and they do not find a way to think away from them.

P15: We need people up to skilled level. The main thing is keeping people up to skilled level because if you have good people, a good number of people that could do Assessment Bay and walking you're not going to have 40 people waiting to be assessed in walking.

In relation to training and professional practice, another way to learn how to perform different tasks in clinical practice is basing them on the routines of other more experienced professionals. However, this entails that junior nurses base their care on the subjective experience of other professionals, not on scientific evidence.

A high percentage of junior and senior nurses are aware that they follow not evidence-based routines, but different factors such as the influence of senior staff or the presumption that practice based on policies is not adequate perpetuate their conscious and constant application.

P4: Also, it can get sort of…laziness, but it is not fair to say that some nurses are lazy but sometimes they can let their practice, not follow [an adequate] practice. For example, slide sheets, I know that a lot of the time do not use slide sheets and that is just because it is a practice kind of left aside. They [nurses] do it rather the quick way, which is grab the sheet and pull, they do not want to cause harm by it but is just bad practice that is being going on for so long. I try to

remind people to do it how they should be done. […]

Especially if you are watching how other people, more experience staff, do things that aren't how you've been taught; and not having the confidence to challenge them and say "actually, I was taught this is the way to do it", has an impact, a bad impact.

P15: Any procedures that I need to do to a patient, the catheters, the cannulas, I am not thinking of following them, I don't even know, I don't even know the protocols for those. I do it the way I was taught and the way I think it's correct and the best for the patient.

Holistic patient care is a complex concept dependent on many factors, but participants noted how clinical workload, patient flow, lack of healthcare personnel, delays in training and routine malpractice had a negative effect on their ability to care for their patients under the quality standards set by the NHS and by themselves, even though they feel discouraged because they cannot care for their patients meeting their personal standards.

#### 8.2.1.2. Nurse-patient relationship

Creating and maintaining a temporal relationship between the nurse and the patient is essential to provide care that meets the patient's needs. If the relationship is constructive, it promotes trust between them, provides psychological support for the patient, allows the nurse to care for his patient holistically and empower the nurse so he can be the patient's advocate. However, if the relationship is defensive or destructive it can lead to poor care, stress and even negligent acts.

One of the most common and harmful prejudices for the nurse-patient relationship is the patient's lack of basic health education. Participants did not expect patients to have medical training, but they thought that people will use healthcare services appropriately rather than attend ED as their first choice:

P17: I think there needs to be a lot of education outside the hospital [burst laughing], that should make it easier for people because if you didn't get people

> coming into hospital that didn't necessarily need acute hospital services, then movement through ED would be smoother and you would not have patients there for 11 hours already on their second dose of medications.
>
> P31: So, I think our problem is a whole cultural thing in the UK is the people that are seeking care in ED. […] So, I would probably invest back to the community and educate the young people to visit their GPs and to seek health education themselves rather than "oh, let's go to ED because it's always open, it's always there". It's an age problem, you're never going to fix it.

Part of the prejudice concerning the lack of health education comes from poor self-care in independent patients and repeated use of ED due to this deficiency. Within this group are patients under the influence of alcohol, with low adherence to medication treatments or overprotective parents:

> P25: I didn't see this child's finger, but what I was told is that it was so incredibly minor, but some people want your advice, some people take your advice, some people will take the advice leaflet and throw it away as soon as they leave or draw on it or whatever.
>
> P32: I probably try to improve the way that we treat self-inflicted sort of alcohol, drugs, that sort of stuff…pathway on arrival. Have greater control of… they put themselves into that state, that means they don't need to be in ED, but in another…sort of…facility, like a drunk tank or something. By then, us taking our time with someone that we should be looking after, someone who's actually ill unless they've got injuries or illnesses that could impact them. If there's just generally intoxicated, it's nothing wrong, ED it's not the place.

The general public's apparent lack of health education in regards to the available healthcare services matches their expectations, which are not always realistic, according to the participants. The most common resource used by the participants is to keep patients informed of the department's real situation, expecting that the patient empathises with them and the lack of resources with which they have to deal with:

> P29: Sometimes it's very difficult to manage that kind of thing, the abuse that we receive from the patients, the demands for things that probably are entitled

> to, we just can't give it on a timely manner on in the way that they expect. In their eyes, is fully our responsibility, in my eyes is not just my responsibility, is a generalised department factor that can't be totally managed by me, but is difficult.
>
> P31: I think is hard when we are working at a [high seniority] level because the priority is often shifted by other people towards the Trust as a whole, but mine we'll always be that patient and keeping as many people informed around that patient as to what's going to happen to make their expectation realistic.

Nevertheless, the public still chooses EDs compared to other healthcare services. The presence of skilled healthcare personnel, the 24-hour service without appointment and the access to other resources from the hospital promote that EDs are used by the public for non-urgent conditions, according to the participants:

> P31: People are always going to be killed in car crashes, but that's what ED should be about, it shouldn't be people that had a headache for 6 months who lost the trust on their GP because they can't get an appointment. […] If I was a GP and it was a Friday afternoon and I thought "oh, Ms Jones is unwell in her nursing home, I just going to go and see her and make a plan for the weekend" because often the problem is that out-of-hours services don't know the patient and is it was our GMC number we probably send the patients as well because they haven't got plans in place for, you know, when a 98-year-old develops a chest infection. That's a natural progression of life and being in ED at the end of your life is not good, is not often where people want to be.

Since ED resources do not always meet public expectations, patient satisfaction should be a problem. However, according to the participants, patient satisfaction depends primarily on meeting patients' needs while they wait, not on the time they wait for diagnosis, treatment or transfer:

> P22: I think people tolerate long waits, I think people don't mind waiting for a long time, but people mind waiting for a long time when it's uncomfortable, if they're cold, if they're hungry, if they're thirsty. If you can sort out and they have to wait long periods of time, they would not care so much.

> P26: It's stupid but tonight they [patients] were concerned because they waited hours and hours and you have to reassure them…and save their life when needed.

Regardless of patient satisfaction, participants' priorities were focused on the assessment, diagnosis and treatment of acute or life-threatening pathologies, leaving patient satisfaction in the background:

> P14: So, then the live-saving stuff is done and the treatments are done, we move to make the patient comfortable and any little things, but because we are such a busy department the little things get missed out or they get delayed to make way to more important things, which isn't great for the patient but has to be done.

> P23: My priorities lay on what's going to have an immediate detrimental effect in the patient's health rather than what's more comfortable for them. So, as much as I want to do things to make the patient comfortable, when it's busy I focus more on what's immediately concerning their health, sort of speak, if that make sense.

The participants' vision of the nurse-patient relationship has been divided into two main approaches. The first one considers that nurses should behave naturally with the patient to establish a relationship based on mutual trust:

> P17: Even this past week I came across two or three patients with their relatives [in the same situation] and you cannot help but bringing…I'm not saying I'll give them my life story, but I share experience with people and that's how we build relationships and that's the public will remember the most, more than the NMC code says that I have to do this, this and this. It makes me more human, it makes the interaction more personal.

> P23: I think sometimes is good to be how you are with the patient because you might experience patients like a character, whereas if someone is neutral and doesn't have anything about them patients find it very difficult to warm to that person, they think "do they care about me? Do they want to be near me?" but if you were yourself that patient can accept that you are that person. Obviously, to a point that you don't disrespect them or anything, you still treat them with

> respect, treat them… I would say treat them as I want to be treated but does not always work because everyone is different.
>
> Treat them in a way that you're only trying to look after them, that you're trying to care for them, so I think being neutral always causes more contact because you distance yourself from the patient if you're been neutral, whereas if you've been yourself it shown that you feel comfortable with the patient, that you are there to help, that you're not starring from a distance, that you are there for them.

The second approach focuses on treating patients as a neutral subject to avoid offending their personal ideals or influencing their decisions:

> P22: I know there're definitely times when a patient's beliefs system have clashed with what we feel is the best practice and what we feel we should be doing, that's when it becomes very difficult, I think. Particularly, one of the thinks was with an end of life care and the relatives were very very keen for us to give antibiotics, cannulation, you know, very invasive procedures for someone who was evidently dying. This was obvious to anyone looking after them and that was very very difficult because someone can argue that is my belief system that this patient should be allowed to die.
>
> P32: I think we should be neutral, but obviously if the patient has the same beliefs as you it's good because they find that they can talk to you. I think that we should be neutral and every patient has the right to make a decision either if we agree or not agree, so we should be quite neutral.
>
> P34: I think that we need to be neutral in most of the situations because your personality could clash with the patient, you would have patients with a personality totally opposite to yours and to respect the patient you have to be neutral. You have to be neutral respectfully.

The latter approach is based not only on respecting the patient and making decisions free of coercion but also in the nurse's defence against the threat of being sued by the patient.

> P9: If the patient does not want to be treated by a nurse not because of the race or religion, but because the patient does not like the nurse I do not mind, there are enough nurses to change. Because, at the end, I can be blamed for something only because she does not like me.

Both sides of the nurse-patient relationship apply to the nurse-patient's relative relationship, even though the situation is even more complex due to confidentiality and possible problems between the patient and their relatives:

> P10: So yesterday I was talking to a nurse that said he was dragged to court because she gave an antibiotic, the patient wasn't allergic but the patient doesn't supposed to receive antibiotics because he was a cancer patient end stage. The family members said "yes, we want treatment" and he have the antibiotic with the family members right there and the patient arrested and died. So [the nurse] was dragged by the court by the same [emphasis on same] family member that was there, so I said to him "you could lost your PIN".

### 8.2.2. Staff social interactions

Relationships between healthcare staff members are continuous, fluctuating and complex, as in any group of people with different knowledge, goals and ideals.

In order to classify the nurses' social interactions between each other and with other healthcare professionals, we opted to use several concepts from social psychology, which are explained in manuals like the one written by Edwin P. Hollander (497). However, this does not imply that data is going to be analysed using techniques from social psychology, since the psychosocial analysis of healthcare personnel interactions in the ED LRI is a theme of great complexity that deserves a thesis by itself.

#### 8.2.2.1. Person-person interactions

Individual interactions between staff members were diverse, but the ones mentioned continuously by participants were related to communication between two colleagues, or lack thereof.

One of the most mentioned communication problems by participants was the lack of an adequate handover when the patient moved from one area or department to another:

> P5: Also, when patients are moved from Assessment Bay to Majors without handover because the patient is stable…I heard a lot of nurses that complain about one of their patients needed treatments or anything else and they did not know because they forgot to look the back page of the notes because simply they need to always look, is something to do that is not being handovered.

> P8: A patient was across to the Glenfield [hospital] with a chest drain that wasn't attached or in situ. An incident form was done but looks like the doctor knew, have discussed with the Glenfield reg [registrar] and no one communicated to me.

> P16: Other thing that caused a lot of stress is that we will have patient sent around and we will not be notified that they've being sent around, let alone have a handover unless the patient is acutely sick.

Nevertheless, the lack of communication is not only limited to handovers, since participants mentioned several situations where the lack of communication entailed clinical errors or unnecessary conflicts:

> P4: There are things like, if we just communicate a little bit more or if we are busy, if that treatment is very important like antibiotics in a sepsis, so just make sure that someone can give it straight away and not only prescribe it and leave the prescription chart back in the draw.

> P5: It happened to me that the coordinator told me to send a patient to x-ray, I thought that it was done but he told me to send him. We sent him again, so our colleagues in x-ray told us that he had his x-ray already.

> P11: There was a situation when we have a patient who was aggressive and confused and needed to be restrained because he wanted to enter the children's department as an adult patient under the influence of [illegal] drugs and things. People call security for help but they didn't use the appropriate method, they used the tannoy rather than the walkie-talkie system that we use now, so that meant that we didn't have the help we needed when we needed it.

Another factor affecting human-human interaction that was pointed out by the participants was hierarchy. In addition, several interviews specified how it affects on how professional reputation is used by a professional to influence another. For example, HCAs are below nurses in the professional hierarchy, so sometimes the latter use their reputation to treat HCAs contemptuously:

> P10: We need to make them happy because sometimes people talk to them like they are nothing, people talk down on them and people disrespect them. I've seen many many cases, some of them even medical students. I've met a few in the old department, three of them, if they don't tell you'll never know. We need to respect them because what they are doing is helping out, if they weren't there I have to do all obs alone, all changes alone, you see.

Furthermore, senior nurses have more reputation than junior ones, so they feel able to treat junior nurses regularly in a condescending manner. This prevents junior nurses from being respected and maintains senior ones in a privileged position within the department:

> P30: What else would I change? I also change, I know is hard, but I would also change the attitude of some people that are more senior because, not all the time, but sometimes they can be quite patronising. For example, I started one of my first shifts in Resus, she was "why are you doing that? You should not do that". I was told that I was putting ECG leads on wrong, even in the stickers were in this place [pointing onto my chest around my left pectoral area] because I could miss an inferior MI [myocardial infarction]. This was said in front of two doctors, two paramedics, the patient and the patient's wife.

All this entails that the vertical social interactions (which are held between two professionals in different hierarchy levels) are considered primarily destructive by the participants. This is exemplified most clearly by the interaction between nurses and managers.

Junior nurses have a subservient relationship with managers, since nurses follow orders that they consider inappropriate without discussing them even though they are capable of rationalising that the order that they are going to follow is not the most appropriate solution to the problem. Managers argue that their experience is the most appropriate source of knowledge to solve issues in clinical practice, an explanation that junior nurses use to quell their doubts about the consequences of their blind obedience.

> P10: With that, it makes you…because we need to obey our managers too, so it puts you in a tight corner that can move you away for working by evidence-based practice or following the NMC Code because this is your manager telling you "I am more experience than you, I am been here more years than you and I am telling you to do this and do this", it's hard to rebel, so…You're forced to do it [discharge the patient] and you are not happy, you know…That's the thing, sometimes you do not know what to do, you just have to obey, so sometimes I feel that patient is not safe.

On the other hand, senior nurses have their own professional background, so they feel able to challenge managers if patient safety is involved. However, unless they have compelling evidence that their argument is valid, they rarely disobey their managers to avoid major conflicts:

> P3: (IR) – If one of the senior nurses tells you to do something that you know or feel is not right, how you will approach that situation?
>
> (IE) – If I do not think is right I would not do it, I will question it giving the reason why I do not think is right. If they still encourage me to the wrong way, I will probably are going to seek a second opinion from somebody more senior to them. It's difficult to do because you do not want to feel like you are stepping on their toes or whatever.

> P6: Again, I think when that happens if I am not happy with a specific practice because if a manager says "you need to do this, this is how is done", if I do not agree and I have valid reasons for that explain these valid reasons "this is the article that says this and I agree with this".

> P17: I also think I'm quite a vocal person that I would say "actually, I'm not comfortable doing that". Again, you have a lot of junior staff here and you also have quite a lot of domineering seniors who would say "you have to get on with it" and I think that would be a situation that could occur.

#### 8.2.2.2. Person-group interactions

When a nurse interrelates with a group of professionals, being them part of ED or other departments, two main interactions were perceived by the participants: leadership and compliance.

In theory, nurses should act as leaders of their peers who are below them in the hierarchy:

> P9: As a nurse you have your enrolled nurse [nursing associate] who can do some stuff, and your HCA, and you lead them. You have to know when you have a bay so you have to decide who has to do what. So, you are responsible for the care. […] Some HCAs do not understand this and they do not behave that way but you are the leader and you should act like one.

However, in most cases mentioned by participants only senior nurses acted as leaders regularly since junior nurses did not feel prepared to deal with that responsibility:

> P34: For example, that someone like me is placed to coordinate an area or the department when I don't have enough experience and I am forced to coordinate an area and tell people with 10 years of experience what they need to do…it does not make any sense to me.

In a large department as the LRI ED, healthcare workers' leadership is essential to ensure safe, efficient and high-quality care. However, leadership as an interaction between a person and a group can be constructive or destructive.

According to the participants, constructive leadership allows staff to adapt to the needs of the department and to receive any kind of support when necessary, in which the leader treats his subordinates respectfully to facilitate teamwork and reduce conflicts:

> P10: It's our responsibility to build a good rapport and working relationship with them because if there's tension; number one: you cannot find them in the shop floor to help you with something, they disappear. So I always make sure that I build a good rapport.

> P11: I am very fortunate that as soon as I called for help, I got so much support because I know for well that the doctors that they were in Resus at that time were thinking the same, they weren't trained or experienced enough to deal with that. So for the team that was in that area and me, those responsibilities felt out of my area very quickly, but I was very lucky that you can escalate it and ask for help.

On the other hand, destructive leadership is based on abuse of power and lack of respect for the subordinated professionals:

> P10: If you don't listen to your manager, they cannot back you, when there's a problem they cannot back you, but sometimes you listen to them and you know that what they are saying does not add up, you know. It doesn't make sense and you still have to go by it.

> P30: I had someone said to me to change a flip-flop on a urinary catheter and I said "sorry, what's that?" and she said "that's why you should have a ward placement before you come here, shouldn't you?" in front of people, and I went "ok" and I thought "that's a joke", do you know what I mean? and kept looking at me very seriously and I thought "ok then".

One reason for the lack of adequate leadership is the clinical workload and the lack of time devoted to team management. Without the time needed to create constructive

interactions with the team and build a reputation that will allow him to influence their subordinates positively, senior nurses tend toward destructive leadership.

> P31: No, I think I would staff, I would have…[sigh] maybe allow more time for leadership. So, obviously we're understaffed constantly, that impacts on everything, we're all tired, but there is a reason why work there, so retention is a massive problem in any ED anywhere. Rightly so, if you're not cut out for working in that environment you're going to burn out, you're not going to be happy; but allowing some positive leadership and everybody else that junior nurses are looking up to lead by example because they've got the facilities, the beds, the inflow, all the other things that we moan about.
>
> If we can be happy and skilful in our work, the next set of fantastic ED nurses will be able to come through and say "I remember when Alfonso was in charge, he was really good, he knew this, he knew that", but I think often you don't have any time to learn because you're fighting fire all the time, you're just making sure that you've done the bare minimum, so you can't be empowered and enthusiastic about where you work because is so "hardcore".

On the leadership's opposite side, compliance is when a person is influenced by a group. Nurses without team management responsibilities tend to be influenced by the department and its leaders, so they are considered conformists.

The participants mentioned permanent nurses' conformity briefly, especially in relation to their interaction with managers. However, the main conformist group that was continuously mentioned was temporary nurses, who risk patient safety and service efficiency to not commit an offence or to follow the instructions ordered by the coordinators.

> P9: So, as an agency nurse you need to be very careful with everyone. If they find that as an agency nurse you are not allowed to do this, this and this, even if you can do it, you don't do it, you don't do it. Even if you can save a life, there still some people in the ward that can do it [the lifesaving procedure].

> P13: Once, I was working with an agency nurse, I was covering Resus coordinator's break. The agency nurse said, despite working here 4 years already, "[IE name], what I have to do? You are the boss now".

According to the participants, the main reason that temporary nurses, especially agency ones, are so conformist is because they feel vulnerable to the consequences that a confrontation with permanent staff or the infringement of an unknown policy may have:

> P9: Yeah, male catheters. You're trained, you can do it but now you need to consider "can you do it in this Trust or not? Blood transfusion, can you do it or not?" I know that many agency nurses do not do blood transfusions at all, even if they can do it, because the Trust does not allow them. In some Trusts, especially in our ED, there was a time when agency nurses could not do it [blood transfusion] as a pair of agency nurses. Then, of course, one day can, one day can't, depends of the nurse in charge as well.
>
> […]
>
> (IR) – So, do you feel that part of the reasons that agency nurses are scared of losing their PIN is that hospitals do not protect them legally?
>
> (IE) – Yes, because they do not protect you at all. It's better for them to get rid of the agency nurse…
>
> P11: I have done agency work in another ED and I am probably more worried about my PIN number in those departments that I have been in this department.

Therefore, temporary nurses tend to use reasoning, defensive practice and cautious obedience to the permanent staff to avoid legal or professional consequences:

> P9: I can tell you that most agency nurses use their common sense, especially me; I've never worked for the NHS [permanently employed]. I manage with my common sense and things I learn along the way.

#### 8.2.2.3. Group-group interactions

The formation of subgroups within healthcare workers in a department is very common. Being groups created based on professional role, experience, self-interests or relationships outside the workplace, all individuals tend to cluster in search of an individual or mutual benefit. The participants did not directly mention the formation of subgroups but spoke of two common interactions in these groups: conflict and cooperation.

Conflicts between two groups are relatively common, with conflicts between groups of nurses (horizontal conflicts) described differently than conflicts between groups with different professional roles (vertical conflicts). According to the participants, the horizontal conflicts are less frequent than vertical ones.

For nurses' groups, conflicts between them are usually due to inappropriate clinical workload distribution, a common phenomenon that creates conflicts between junior and senior nurses.

> P10: Do not forget, I have my own 4 or 5 patients to look after. So they chase me "can you do bloods for me? Can you cannulate my patient? Can you give my IV's?" That puts a lot of weight on my shoulders, what's the department doing to ensure that they get quick training? So, that weight come of us, it's too much. I have a lot of nurses complaining that you are in a team; you have just you and another two nurses that they cannot give IV's.

On the other hand, vertical conflicts have other causes. One of the most common is the abuse of power by some doctors, through which they are able to ignore policies and make decisions without consulting the other professional groups involved with no apparent retaliation:

> P16: I know that's being part of the design of the department by one of the doctors [laughs], I feel that the nursing staff weren't consulted on that.

> P10: I have seen doctors giving drugs and not checking with anyone, they just give it and they sign both boxes. Because the patient is under your name as well, if anything goes wrong you will definitely be dragged in a court case, you see.

> I've question a few doctors about "why did you give this" and they said "it was an emergency" but we also have the duty of care to check the expiry date, check the dosage before administering; but you will get some consultants or registrars that ran to the cupboard, get it [the medication], run quickly and just give it.

Another common vertical conflict is related to the stratified practice in professional roles (nurses, doctors, HCAs or other healthcare professionals), which does not hinder teamwork among professionals with the same role but makes working together as a multidisciplinary team very difficult:

> P22: Between nursing [shared responsibility] tends to be very positive. I think for a doctor delegating to a nurse, I think there's a case of "I told the nurse to do it" as oppose to a combined approach to the patient, and sometimes the medical staff, which I know there's busy as well, but noticing that "hang on a minute, the nurse was not able to do this, let me do it, let me…" They very much say "I wrote it down and it's not done" and there very much kind of push out responsibility there.
>
> Equally, that works like this for the HCAs, I've seen some nurses saying "the HCA doesn't done the obs". The HCA is not responsible for the patient, they are not ultimately responsible, the nurse is, the patient is under the nurse's care not the HCAs'.

Cooperative interactions between two groups in any hospital area are essential for its correct operation. These can be divided into vertical and horizontal cooperation.

Vertical cooperation, or when two or more groups in different hierarchical scales work together for the same goal, was often referred to by the participants, both positively and negatively. The most discussed case of vertical cooperation was among nurses and managers, through which managers provide nurses with the necessary resources to provide care:

> P6: If there is something in a policy that does not match a patient's situation, the policy says something that it needs to happen but is not in the best interest of the patient, when I will discuss it with the nurse in charge or the duty manager and

communicate to the MDT so the protocols, laws, norms or whatever can be changed to benefit the patient.

P10: For instance, the patient had hypothermia, I was quite new on the department and I didn't know exactly what to do and everything was out of my hand, but this patient was handover to me; and there was a manager there, he came to me and said "do this, do that, do that". That really helped because that was a practical teaching [session] for me and since then is stuck in.

However, lack of training or experience in some nurses with high responsibility positions implies that such cooperation is not always as efficient as it should be, which entails that nurses do not feel supported by their managers:

P1: Yes, recently I have been feeling that I have certain responsibilities, which I am happy to take, but I have not been given the right tools or support to do them. This is really the first time in my career that I experience that, I have been working for [many] years. I am feeling that right now.

P24: I would say, I sometimes fell, and certainly when I first started being put as a coordinator in Resus and I was calling the band 7 to come and help, she never arrived. And then, when it all went really wrong, I was calling nice and early, and when it went really wrong she arrived and told me off because it went really wrong. So, I feel sometimes there's not enough support or structured development maybe, some roles should be started with the support of a band 6 so they can push you in the right direction, really, so you develop your skills to deal with those situations more effectively.

On the other hand, the participants also discussed vertical cooperation between different members of the multidisciplinary team, and how this is beneficial for patient treatment, care and satisfaction:

P13: How can ED go on without nurses? Cannot. Without HCAs, impossible. Without doctors, impossible. We need HCAs, nurses and doctors.

P21: Because you have the Swiss cheese thing, so if the doctor miss something and the nurse miss something and the HCA miss something harm comes to the

patient; but hopefully at some point along there it be picked up that there was a mistake or there's something going wrong and interventions can take place.

P31: No time together as doctor and nurse or nurse and physio [physiotherapist] or nurse and HCA is wasted because there is so much to do you can always plan and keep you patient informed when you are together.

Regarding horizontal cooperation, different nursing groups work in search of the same goal, which usually is holistic patient care:

P3: I definitely think that we are part of a team and I think that is important for the patients because if we work as a team we will provide the best patient care. Everybody has their own experiences and everyone has different levels of knowledge because I think we come from different backgrounds, so one person could add something that maybe the other person might not though off.

P23: It's always good to be able to share that with other nurses because you can discuss the care, is not about who knows more, it's about discussing it, and the more you discuss patient care the better you can work it out for them.

Furthermore, horizontal cooperation is a support mechanism among different nursing groups to reduce stress and distribute clinical workload fairly:

P3: We help each other as well when one of us is feeling stressed or upset about something, even if it is physical, if someone has a bad shoulder or something, we go and help each other to make everyone's job role a little bit easier.

P28: Again, I say that I, at the time, if I had patients and they needed IVs it was my responsibility to make sure that my patient was getting the treatment that they needed, so I had to be sure that if I asked one of my colleagues to do that treatment for my patient I was helping my colleague in another way so the patient was getting the treatment that they needed.

### 8.2.3. Legal and professional accountability

Clinical accountability is a key factor in this thesis, but when asked about accountability participants responded based on their professional and legal accountability, ignoring their ethical accountability. This does not mean that information about ethical accountability cannot be extracted from the interviews, but it lies within the contextualised answers' analysis, not the raw answers. Because of this, answers related to legal and professional accountability will be discussed in this section, while ethical accountability and the different ethical theories will be expanded in a subsequent section.

The division performed by the participants, which was partly guided by the semi-structured script, was based on the individual, group and organisation that were accountable for the subject matter. This led to accountability being divided into individual, shared and institutional consistently during the interviews.

#### 8.2.3.1. Individual accountability

When participants were asked about accountability during practice, most responded that every professional should be accountable for their actions and their consequences:

> P7: I think nurses and doctors should be held accountable for their own actions and how fast they work.

> P28: We are responsible for our patients, we are accountable towards our patients, we are accountable for everything we do in the department and, as nurses, we are accountable towards our Code of Conduct as well.

> P29: Basically, we are responsible for everything that ended up happening because we are working, so to a degree it's always our responsibility.

Nevertheless, during the course of the interview the participants indicated factors that imply that they do not consider themselves fully accountable for the consequences of their actions.

Patient safety is, alongside care, the participants' main priority. This is considered a minimum standard for patient care, since if the patient is not safe and stable he may deteriorate to an irreversible state:

> P10: My priority is…making sure that the patient is safe. So, normally I have a few priorities in mind, so safety is my first concern.
>
> P14: My priority is patient safety.
>
> P16: My priorities are keeping the patient safe, healthy.
>
> P22: My priority is keeping the patient safe. I think it needs to be the overwriting priority.
>
> P23: My priorities are mainly, especially if it's busy, it's patient safety.

While a registered nurse is accountable for the safety of his patients, senior nurses who coordinate an area or the whole department are indirectly accountable for the safety of all patients in their area:

> P18: My priorities are, obviously, my priorities are the department as a whole. […] Obviously, the risks are potentially patient safety and staff safety. They will be the main key ones.
>
> P31: My priority is always the patient. I think is hard when we are working at a [high seniority] level because the priority is often shifted by other people towards the Trust as a whole, but mine we'll always be that patient and keeping as many people informed around that patient as to what's going to happen to make their expectations realistic.

However, the nurse coordinators' accountability is not limited to patient safety and care in their area. Unlike their purely clinical colleagues, part of their role is to manage resources, being those human or material. Therefore, the resource provision and distribution across the area and the department is the nurse coordinators' and the NIC's responsibility:

> P15: My main responsibility is to support my nurses and keep patient safety. That's the most important, support your nurses and patient safety. If you support your nurses, it should be a lot safer, that's what I think.

> P18: As a nurse in charge I need I have to have an overview of the amount of patients of each area and what the waits are, any issues with anything in the area, any security issues, any staffing issues.

Another aspect of nurse coordinators' practice that they are responsible for is linking the top of the hierarchy and registered nurses. This is done in several ways, but the one that was mentioned by the participants consistently was the objectives defined by the Trust:

> P18: Then there are the responsibilities as the Trust targets, so if I'm on the shop floor it's the 4-hour breach or the 15-minutes ambulance breach, how many patients are on ambulances.

Everyone is capable of making mistakes; LRI ED nurses are not exempt from this fact. They are aware of the possibility of making a mistake and how various factors like clinical workload or departmental objectives may increase the likelihood of error during practice:

> P5: Also, there can be other types of errors because we are exposed to certain pressures in regards to the time. Those things can lead to a medication error in which you can mix patients and give the wrong medication, the doctor asks for something and you make a mistake or send a patient [upstairs] that maybe needed an x-ray.

> P7: I supposed that because we look after so sick people in such a busy environment things get forgotten and missed because you are always worrying about the next patient that you've got.

> P22: I think one of the biggest risks of nursing is making a mistake. It happens, you know, if you did not prove the necessary question and you miss something, a patient perhaps can come to harm or they don't get the right treatment in time.

The participants were also aware of the possible consequences of their mistakes in patients' lives:

> P8: You learn, you eventually learn, but that's one of the risks of being a nurse, that you can kill someone by your omissions, really.

> P11: There is the risk that you probably missed something or that you're going to do the wrong test or whatever, if you request blood [tests] you need to request the right ones, you're going to miss something out that's going to be very important for that patient, if we make a mistake it can have a massive impact in someone's life.

On the other hand, the participants knew the consequences that an error may have on their careers and life in general, even though they focused on the legal and professional convictions:

> P12: If you're short of staff and if you're doing too many things at one time you wonder if you're going to make a mistake that will take your PIN away. So that's present in my mind as well.

> Unfortunately I have to say that many times I might be at risk of that happening [losing his PIN], not because I've done anything wrong but there is the potential that I do something wrong because of the sheer amount of work we have in our hands.

> P21: Because of this incident, even having some prison time or stuff like that, previous nurses that have gone to prison just for accidents, not purposely hurting people, but they kind of miss something or done something because they were told to or they misunderstood or the prescription was written wrong and they gave the wrong prescription and then end up in prison for it.

One of the most talked risks by participants was the risk of being deregistered by the NMC, the risk of losing the NMC PIN (Nursing and Midwifery Council Personal Identification Number). Even though it is a real risk, its perception is distorted from university education to clinical practice, increasing the fear of losing the NMC PIN:

P5: I think that yes, we have a bit of fear, we are a bit afraid, here we talk about the PIN a lot, that your PIN is at risk.

P7: At university is drilled into you that your registration is at stake every time you do anything, you always have to think about your registration when you see any patient. I think is drilled into you from university.

P22: I know that there are certain things in the media recently when nurses are been pull to the NMC for things that for some of us are things that we would do. I know a case when there was a nurse that decided not to do chest compression to someone that she felt to that was obviously passed away quite a few hours before, but because there was no DNAR in place, the NMC felt that this was caution worthy offence, a caution for not starting chest compression on someone that was clearly dead.

However, risk perception is different in different groups of nurses. Taking into account their experience, junior participants understood their professional registration differently than their senior peers:

P17: I think is that…maybe the group of nurses that we have that are qualified only a little bit of time because when you are a student you are constantly aware that your PIN is at risk because you're told by your tutors and etcetera etcetera; and then you get when you know sort of what you're doing and you maybe become a little bit complacent so you don't become aware of it as you become more experienced and you are aware of what's going on you can see more than your patient, you can see the whole environment, you can see how risky ED can become.

For junior participants, some rely on their senior colleagues' support to protect them and prevent that both of them are removed from the NMC registry. Even though they care about their professional registration, consider that their colleagues' support is enough to protect their PIN:

P6: I think in ED we are a bit more protected and that is my understanding.

> P11: I think we have a good team in this department particularly, that's why I do not have to worry about my PIN number as much as in other department where the teamwork is poorly and scary.

On the other hand, when junior nurses obtain some experience they realize that their colleagues cannot always protect them, so many of the senior participants use rationalised practice and correct use of policies to avoid problems related to their NMC PIN:

> P8: The way I balanced that in my mind is "can I stand in a court of Law and explain my actions and my reasoning with the knowledge I have at that moment in time to make the best care, the best decisions for those patients?" And that's…you know, when you look to court cases and people lost their PIN numbers. I'd like to think I wouldn't because I can justify my actions and I can go through piece by piece why I make that decision.

> P24: If you start going off the local area policies, you're not longer covered by the local area policies, so losing your PIN becomes a more realistic…thing because you're not working within what UHL had laid out.

Another division that differentiates professional registration perception is the professional culture. Nurses whose professional culture is not British tend to give less importance to the NMC PIN, even ignoring its possible loss during clinical practice:

> P13: So, stop thinking about the bad things, start working and stop…if you are going to give meropenem do not think "if the patient is allergic to penicillin and has an anaphylactic reaction I can lose my PIN", no, do not think in your PIN, think about the patient that can have a serious reaction and die, that's the problem and not losing your PIN. If you lose your PIN is not a problem, you still alive, he's not alive anymore.

> P14: I never ever thought about my PIN number since I came here. Our colleagues they are always talking about protecting our PIN number, doing all the documentation, but I never thought about it, it's true.

The perception of their nursing registrations' fragility makes participants link risks and errors in clinical practice with the possibility of losing their PIN NMC. However, even facing the possibility of losing their way of life, some participants prioritise patient care and safety before the safety of their professional registry, since they feel that if patient care or safety is poor they will also lose their NMC PIN:

> P3: I think you are just very aware of it as a nurse that one mistake can have you stork off the [NMC] registration, you can go to coronel cases and that kind of thing. Is not like I am constantly thinking "I do not want to do that because my PIN number", patient's safety comes first to me but if patient's safety is put at risk so also my PIN number be.

> P18: If potentially a patient does not receive a treatment when it should be given, treatment delayed or not given at all, which can also result in injury to the patient, or I suppose on the worst, death to the patient. That can lead to issues resulting in coroners and the uppermost, I suppose, which it lead to your job and your PIN number.

On the other hand, some participants choose to protect their professional registry more actively, documenting all facts that could be challenged:

> P5: They talk a lot about how important is to keep your PIN safe, that you have to document everything or your PIN is at stake. I think that there is some fear in the air although I'm lucky and I never had any problems, but people talk about it and that fear exist. Sometimes I have it too, like when the doctor tell me "no, don't do it that way", you keep thinking about it and document everything just in case you need to be covered.

> P21: You have your NMC registration, who's kind of always there and you know in your head that you have to make sure that you document everything, which is a pain to get that sorted because it kind of takes away the time to deliver the care because you're busy documenting the care you already delivered.

When personal interests' active protection, including professional registration, stands and takes precedence over patient care, it is a case of defensive practice. Some participants recognised that they use part of their time only to avoid future legal or professional retaliation, so they practised defensively.

> P9: So many years of training and to get the license and you do not want to throw it away. […] So, those notes [written nursing notes] are done for no reason at all, just for when we are sued or blamed.

> P30: I think is some cases it's a defensive mechanism in the sense that I did say to that person…you know, it's human nature. If someone say "you did this", you get slightly defensive and you think "actually, no". […] I always cover myself writing as much as I can and if I don't give something late I'd say "I wasn't made aware, however patient didn't come to harm, the antibiotics were given 10 minutes late, but patient has no ill effect from this and was given at whatever time" [laughs].

A group that has been identified by most participants for committing defensive practice constantly are temporary nurses, especially agency nurses. The fact that they are not always protected under the hospital's vicarious accountability makes temporary nurses feel vulnerable, so they feel forced to practice defensively:

> P9: There was a bay on ladies on [another city] that they were speaking about me, that I was too pushy, too strict. Since then, I didn't go back not because I didn't want to care for them but because I didn't want further problems. I am sure that they didn't mean it, but I needed to protect myself, not them

> P13: I think that sometimes we do more things that we should do. Then we have bank staff that come from other wards, they are scared and they start to complete everything, even the diarrhoea and vomiting pathway for a patient with a collapse query cause. They prefer to complete everything even if they waste time.

#### 8.2.3.2. Shared accountability

According to the participants, in the LRI ED there is a teamwork and multidisciplinary discussion routine in the patient's benefit. However, when the clinical workload is shared the accountability attached to it is also shared.

The risk involved in shared accountability is that it facilitates conflicts between professionals, since if a problem occurs they might try to blame one another so one gets away while the other professional burdens with all the penalties. Participants felt that shared accountability increases patient safety, while cases of conflict related to it were rare but possible:

> P11: I can say how it could be seen as an opportunity to move the blame to someday else because if you have a group of people sharing responsibility is easy to point out fingers and say "I did my job, but they didn't do theirs", but they may did not communicate it. I think generally working as a team and having that shared responsibility makes for a safer department, definitely.
>
> P24: Shared responsibility means, realistically, that patients are safer because I can pick up something that you don't or I might pick up something that the doctor doesn't.
>
> However, there are individuals with who lead to finger-pointing or if you're not writing it down is like "well, I did that, why you did not do that". You would hope that working as a team would improve patient safety because it gives you, even discuss things, you can have somebody else's opinion on something, but sometimes individuals make it problematic, that will be my answer to that [laughs].

Although shared accountability was perceived as positive in general, the participants noted differences depending on which professionals were involved. They mentioned the need to work together with all professionals in the department, but they share accountability more often with other nurses, doctors and HCAs.

Nurses share patients and tasks regularly since it is an essential requirement to ensure adequate and continuous patient care. Despite the variety of tasks and responsibilities

shared, the most frequent example was double verification to administer intravenous medications:

> P23: Second checking, without a doubt, I think definitely improves patient safety. There are plenty of times when you're going to second check something and you go "what's not what is says" and the other one says "oh, oh, I know that's not what it says", but because they are in such a rush you grab the bag of fluids, being normal saline or Hartmann's [ringer lactate solution] and you go to second check it and you meant to grab saline but you grabbed Hartmann's in that rush. Second checker, absolutely, as much as it becomes a hinder sometimes. I think definitely improves patient care and maintains patient safety.

> P26: Actually, in my experience it just helps to improve patient safety. […] For example, a doctor could not see the weight of the patient and the doctor prescribe paracetamol 1 gram, but the patient is less than 50 kilos, so if is IV and you have to double check, the second person could be helpful to you because if you don't notice it "are you sure that is more than 50 kilos? Are you sure that he or she needs one gram?"

Double verification to administer intravenous medication is a task that can create conflict based on shared accountability, since it is exposed to confirmation bias, as several participants pointed out:

> P22: I think that there is something to be said about double checking. That said, I think that there's some research around almost a "confirmation bias", where actually by checking with another person assume that the other person will check thoroughly and maybe if you're not with it that day, if you're not paying enough attention and the other person isn't either, the both of you will just miss it because you think the other person will pick it up and I think in that case you kind of…it will be very easy to go "they did not check it either", when you actually just take a shared responsibility for it.

> P27: We are used to double check, we are used to rely on others, but sometimes is just for commodity because it's easier. Sometimes we don't really considerate the real implications of the choices we make or the decisions we make when the

responsibility is shared. I think, at the end of the day, if things go wrong, we try to shift the blame to someone else.

Nevertheless, despite the potential problems caused by confirmation bias, the participant nurses tend to solve them and not try to blame each other:

P22: I was lucky that I was in case of exactly that. Locking some [drugs] on the CD [controlled drug] cupboard coming from pharmacy, myself and the nurse were very busy at the time and the CD arrived so we just needed to get it book it. We booked it in with more drugs, wasn't' just [that drug] alone, we just put it in, count how many they were and sign the book. Was only later on when the wrong dose of [that drug] was delivered instead of what have been requested and actually if that [drug] have been given as the normal way we give [the drug] it could be very detrimental; and who's to say that when it went in use that double checking don't happen because we always think that someone else will pick it up and actually this is quite dangerous. Thankfully, in that situation both raised our hands and said "we did not check it properly", there was no baling there, but that's probably because we were of a similar level nursing, we get along and we were a very good team.

On the other hand, shared accountability between nurses and other professionals is not always handled correctly. When they talked about doctors, nurses consider them an equal part of the team:

P12: If they were outstanding circumstances, then I would make that clear to the doctor than I expect support from them to do that. So, in those situation I think is fair to have share responsibilities because we work as a team, and that applies to most things not just drug rounds, but it's also very important that everyone knows their role and what they are expected [to do] when they are looking after patients, really.

P15: If it's like giving meds prescribed and signed with the doctor and the meds turned out to not being given or something else being given, both should be responsible, more the doctor because he is the prescriber but the nurse should be caring a bit of…the…[responsibility], yeah. I do not agree with that, with

> blaming the nurse, we should share the responsibility, especially with the doctor should be a shared thing [responsibility].

Nonetheless, this perception is not reciprocal, since doctors often blame the nurses if a problem has arisen that both could be accountable for, minimising the importance of their own mistakes:

> P20: Obviously, this prescribing thing, the amount of, every day, the same with you, every single day, you have to take a prescription back to the doctor and say "that's not the right one" and they're like "never mind", it doesn't matter.

> P22: I think for a doctor delegating to a nurse, I think there's a case of "I told the nurse to do it" as oppose to a combined approach to the patient, and sometimes the medical staff, which I know there's busy as well, but noticing that "hang on a minute, the nurse was not able to do this, let me do it, let me…" They very much say "I wrote it down and it's not done" and there very much kind of push out responsibility there.

> P25: The query comes then when one of my colleagues had to do a learning log for a drug error because a doctor gave a child some ibuprofen and paracetamol, but because they've just [the doctor] giving it, they didn't prescribe it. She [the nurse] went to do this child's temperature later and it was still high and because it wasn't written on the drug chart on the back she went and gave the same drug, legitimately so because she could do PGDs, but then found that actually this child had another dose previously. […] She was really crossed because she had to do a learning log and the doctor didn't and it's like "that's much as the doctor's error as the nurse". In fact, it was more the doctor's error because if they had written it in, she would just looked on the back and go "oh, so and so had some ibuprofen a couple of hours ago, I would not give anymore, we just have to go with the temperature".

Regarding the shared accountability between nurses and HCAs, a similar phenomenon to that of nurses and doctors occurs: nurses consider HCAs part of their multidisciplinary team, but not as equals. This fact is confirmed when the participants mentioned that they do not share their accountability with HCAs, but they delegate

tasks to them even though they still are accountable for them. However, nurses tend to exaggerate the importance of their mistakes rather than minimise it.

> P17: Obviously, with an HCA, if you ask them to do something I think is your responsibility, is your responsibility. We delegate it, but we are the person with the professional status who is responsible for that patient.

> P21: Nurses are kind of smack in the middle with the whole patient care because you have your HCAs, but the nurses still responsible for the HCAs actions. […] If your patient is scoring 8, 9 or 12 in the EWS [early warning score], becomes acutely unwell and the HCA didn't tell the nurse, the nurse [mumbling] "I was never told".

> P33: I delegate to a HCA because you get so busy with treatments, if I delegate a job to a HCA is my responsibility to [check] because I'm still accountable for the care of the patient. I know that they have being trained to do obs as well, but it's my responsibility to chase it up and if it's not being done I need to chase it up and do the action, do the job.

#### 8.2.3.3. Institutional accountability

The hospitals' corporate team, as representatives of an NHS Trust, have a number of responsibilities. However, the responsibilities mentioned by participants can be classified into two main groups: responsibilities towards the public and responsibilities towards its employees.

The raison d'etre of a hospital is to provide healthcare to the public, so its priority is to maintain the care standards that the public requires. These standards are measured by the NHS based on various targets to ensure that the care offered in a public hospital meets the minimum requirements claimed by the population and the British government.

Although there are dozens of targets that measure healthcare performance and quality in the LRI, those mentioned by the participants were the 15-minutes target to triage and, above all, the 4-hours target.

P6: Obviously thinking in the department's situation, which is the 4-hours target, all the targets that we need to achieve so within these 4-hours so the patient has all the care they need to either be transfer to the appropriate area, either other specialty or other hospital or if the patient is safe to be discharged home to their GP.

P18: Then there are the responsibilities as the Trust targets, so if I'm on the shop floor it's the 4-hours breach or the 15-minutes ambulance breach, how many patients are on ambulances.

P19: I'm going to take a quote from one of the medical directors "the 4-hour target is actually not an ED target, it's looking at the services surrounding ED, so it's actually a failure of everyone else if the 4-hours target isn't necessarily met".

In order to meet departmental objectives, managers frequently go to ED demanding actions to meet the targets even if they are not suitable for patient safety or satisfaction:

P4: In the emergency department where we have bed managers coming out to as saying "right, move this patient, this patient needs to move, it's going to breach [the 4-hours target]".

P5: So, when you try to give all the care that your patient needs and try to keep him comfortable, but "this patient needs to go now, forget about anything that you're doing and try to do it" and that are situations where you're doing something and the coordinator ask you in a hurry, like saying "that should be more urgent" and you say "I cannot multiply…uff…" but they say "no, no, no he's going to breach".

Managers' pressure can trigger problems if inadequate decisions are made under such pressure. This is more serious in the case of managers without clinical experience, since they are unaware of the risks that imposing their orders over the registered nurses' argument may have. Therefore, nurse coordinators, and sometimes clinical duty managers, support registered nurses against the constant harassment of some managers:

> P8: As a manager I believe I become my staff's advocate to an extent. I am their protector, I am their buffer against anyone more senior coming down, bullying and telling them what to do.
>
> That's my responsibility, to act in the best interest of the patient and the staff. I'd like to say that the patients are the most vulnerable group, but not always, sometimes is the staff, so that's how I see myself anyway.
>
> P31: I think the fear that I have is if something happen and I was involved in it and I didn't make the right decision, escalate it to a clinical person rather than a non-clinical manager, who may have other interests in making that decision. They may want to clear Resus so we don't have a long ambulance wait, but clinically that would not be the right decision to make.

The hospital does not only ensure that patients receive adequate treatment through departmental objectives but also has a set of policies that protect its employees physically and legally.

Regarding employees' physical safety, despite the application of several policies, nurses suffer verbal and physical abuse, as well as stress and other psychological problems:

> P15: First thing, being assaulted, me and my nurses being assaulted, either verbally or physically; there is a very high risk of getting a contagious disease I'm afraid because you never know what's going on, you never know what this patient has in their blood and it's quite risky.
>
> P25: Clinically risk-wise physical injury, perhaps mental ill health, maybe, in the form of stress and anxiety if you're exposed to certain conditions too frequently or you're exposed to conditions you're not completely comfortable with, if you've been exposed to that situation in the past and you had an adverse event towards that situation, then yeah.
>
> [Counting with their fingers] Physical injury, mental health issues and violence and aggression, I think they are the main risks that we deal with. And litigation.

Like departmental objectives, policies that legally protect healthcare professionals are not always applied correctly by the hierarchical apex:

> P18: I don't think I…I can challenge it, but it is comes from the chief executive I don't think I can challenge it, but then he very much said that it's within certain guidelines that we are opening this area [the corridor not big enough to put patients in] and as long as those guidelines are followed…

However, in most cases they provide a basis for nurses to feel legally safe during clinical practice:

> P18: I think they're guidelines for us to follow and I think they back us up, they create that added level of safety for us, so as long as we follow those, because they are set by the hospital.

> P21: The policies and procedures are there to cover the nursing staff back and make it safer to the patient, so if you follow the policies and procedures and something goes wrong, at least the trust will have your back, which they weren't in you straight away from those policies.

The employees' legal safety is fairly stable, since no participant commented any legal issue affecting nurses in the department. This is related to the link that legal nursing accountability and institutional accountability has through vicarious accountability.

As an employer, the hospital is obliged to protect its employees and create a secure environment with set limits. Since employees' negligent acts can affect the hospital through vicarious accountability, policies provide a legal basis for the protection of the nurse and the hospital, as mentioned above.

To ensure that the hospital is able to defend itself against possible litigation, it implements and enforces specific policies and documentation, thus clinical practice is overloaded and nurses are forced to choose between clinical practice and protecting the hospital and themselves.

> P13: In the nursing notes, if you have a patient with a collapse query cause you should complete the diarrhoea and vomiting pathway because you have to fill all purple [nursing] notes even if the patient came with a collapse query cause. If I end up in the coronel, I do not know, if something happen, they can ask you "why you did not complete the diarrhoea and vomiting pathway?"

P27: To give an example, the most common thing that the Trust asks us to do is to document. It's very important because either give us some data to rely on, but at the same time is for me as a nurse to protect myself and for the Trust itself. That said, it takes time that I could spend to do something more practical for the patient that, even in that case, if I'm not writing, not recording what I'm done, for the Trust and for the public is like I'm not done anything at all, but in real practice I'm doing something for the patient but we don't have any proof of it.

P33: Documentation-wise, how can you document something while you're stuck with a poorly patient? So, how can you back up yourself? If they pick it up, if they Datix it, you can't back yourself up, can you? That's the problem.

### 8.2.4. Decision-making process

During clinical practice, any nurse has to make hundreds of decisions a day to perform his role correctly. Some of these decisions are obvious and others need time for meditation, but all take into account several key factors in ED practice to a greater or lesser extent.

Among these factors, there are some that are part of the decision-making process in all decisions made by the participants directly or indirectly, which are considered basic, while others are mainly related to the general operation of the department.

#### 8.2.4.1. Basic factors in clinical decision-making

Decisions made by nurses in the exercise of their professional role may involve several factors, which differ according to what and who is involved in that decision. However, in clinical decisions (these being decisions directly related to patient assessment, treatment or care) the participants regularly mentioned three factors: clinical knowledge, hospital policies and clinical intuition.

Clinical knowledge is a combination of evidence-based theoretical knowledge and practical knowledge based on professional experience. However, even though they work

together in decision-making, their origin and applicability are different. While theoretical knowledge is more objective and is more prevalent during the firsts years of practice, practical knowledge is gained over the years and tends to replace theoretical knowledge:

> P27: That means that some nurse that might not be at the same level [of knowledge] that others will not have to take dangerous decisions like some other nurses may do all the time with less…taking risks, but low risk because following their knowledge and their instinct they can reduce that risk; but not all the nurses have that because some nurses are inexperienced and they have less [practical] knowledge.

The problem this entails is that practical knowledge progressively displaces theoretical knowledge, strengthening routines obtained during observed practice or their own practice, which are not always adequate to maintain optimal care standards. In addition, obtaining theoretical knowledge after university education is not reinforced, so it is rarely updated:

> P4: I personally came across people that they have been doing it [nursing practice] their way for so long that is more difficult for them to change. Either they do not want to change because they believe that is nothing wrong with their practice in the first place, so they will carry on doing it, or they just find it difficult. […] Also, it can get sort of…laziness, but it is not fair to say that some nurses are lazy but sometimes they can let their practice, not follow [an adequate] practice.

On the other hand, theoretical knowledge is used especially in solving clinical discussions, when two professionals have come to different conclusions from the same problem:

> P6: For me to say "I do not agree with this" I need to be very fundamental and I have valid reasons for that like evidence-based practice and people that may have thought about the same things and explain why this is not a good practice.

Therefore, clinical knowledge is essential for clinical decision-making, even though to apply it correctly it should have a balanced distribution of theoretical and practical knowledge.

Clinical intuition is a factor based on the subconscious reasoning of situations based on knowledge and past experiences, so it can be considered more subjective than clinical knowledge:

> P8: Intuition, you talked about intuition. Intuition for me, there's no such thing, I think your intuition is the back of your mind, your knowledge and your past experiences are there and you balance it. You call it intuition but actually is based on something.

Although it is a subconscious process not based on verified information, intuition is often used by the participants and is built into several policies:

> P11: I was coordinating ambulance assessment and I have five patients coming up literally at the same time and I need to pick up from who I take the handover for first, so it's just a visual "which one I go to first". I picked the guy who was quiet, lying there, very still, just because for me, my gut feeling told me that he looked the most unwell. I took the handover and as soon as the paramedics gave the handover to me I took him straight into Resus because I thought he has some sort of pelvis fracture. To be fair, he did it in the end and got transferred to Queens, and that was gut feeling 100%, I could take his handover the last and he could stay there poorly.

> P13: So…I think the gut feeling in paeds is needed because you don't have other [choice], they don't speak, they're just babies, you need the gut feeling.

> P25: I think gut feeling is brilliant. […] On the POPS score we have a gut feeling bit in that that's integral.

Nevertheless, the difficulty in arguing decisions based on clinical intuition could hinder the nurse's legal defence if the decision results in a possible negligent act.

Protocols, clinical guidelines and hospital policies are the most objective factor of the three basic factors. They are based on evidence-based practice and on the consensus of

experts in the field in question that draft a framework to be applied in general situations. These provide nurses with a professional and legal basis for decision-making:

> P4: I do find that they are a neat structure, it does provide us an structure. It is like a skeletal system for practice. Also, these things [policies] are reviewed regularly anyway, so if something is not working they can always amended, just in case is not fit for practice.

> P8: I think…no protocol has been developed without the need for it. They all come from something, there's been a mistake or someone who's died or suffered so that's why you put a protocol in. I think they are very good guidelines, protocols for drug checking, things like that. They are reasons for it [the creation of the protocols], there are good safe procedures that they should be adhere to.

Nevertheless, despite the advantages offered, decision-making through policies also exhibits several flaws. The first is that if nurses do not know the policies they cannot apply them. This entails that even though the participants could have benefited from using various policies, not knowing their existence or their content made them useless in the decision-making process:

> P3: Yes, I think they do help to improve our practice but I think I do not know many people's routine of getting a policy out in the middle of the ward and read through it.

> P9: It will be good if something change and we move to a new department they tell us "you do this, this and this, and find things there; and this is the protocols for this and for this" because you do not have the time to go through all the protocols, if something change, you don't know. The only thing you hear is when you are downstairs in the handover, but that's not enough.

> P13: In 20% of cases is going to make your job slower because if I have six patients, or seven, and they say "[IE name], use this pathway", I have no time. I have to give medications, I have to do this, I have to do this and now I have to spend 5 minutes on the pathway to see what happened. Sometimes, it's not good enough.

> P16: One thing I would like to do is read a lot more of the policies because at the moment I don't have time, especially when I'm on shift, but most of the policies are on Insite [intranet], which we cannot access at home. If I'm honest, nobody wants to come in a day off to read policies and things like that. So, it will be helpful to know all the policies, but…

Another hospital policies' drawback is their rigidity. Since they should serve as legal support and be applicable to different situations in different hospital departments, policy regulations are usually very rigid:

> P20: I think is one of those things, it can be quite obstructive, but I think the…idea is a good one, I don't think anyone is putting in up to be obstructive, so I think the intention is good, but does not necessarily correlate to a good way of working.

> P26: Sometimes, I really think that they are not helpful. Not that they are not helpful, they are helpful in certain aspects because they suggest you what to do next, but sometimes I think they are just too strict.

This stiffness obstructs many policies from being adapted to the situation of a specific patient, so following them strictly could be harmful to the patient in specific situations, since they do not take into account other factors:

> P20: I think is getting to the point where you can't use your common sense, you know, doctors and nurses, everything is very prescribed and you're not allowed to use your common sense with things.

> P22: The problem with policies and procedures is that you cannot have one for every eventuality.

Moreover, since they pretend that all departments follow the same standards, policies not demand realistic results. According to the participants, this could be due to the disconnection between policymakers and clinical practice:

> P16: Yeah, I think it's very difficult to follow a policy just for the nature of what happens in the ED, it's a difficult area to work in.

> P21: I know is there for a reason, but some of the policies seem written by people that aren't actually working in those situations, there're like doing a tabletop exercise "what's the best way of doing this, with this situation?", so they sit down around the table and they say "we do this, we do this, we do this" and that's it. […]
>
> P22: It will be useful if the policymakers came to work with us, so they see what the reality of the shop floor is sometimes and how some things that they put in place are basically unachievable.

The relationship and the use of the basic factors in clinical decision-making are slightly different for each participant, but they follow a very similar pattern to the one exposed by Benner in her work *From novice to expert* (498). However, there are significant differences related to the acquisition of new responsibilities within the department.

For junior nurses, since they do not have experience or have developed their clinical intuition yet, they use the theoretical knowledge gained at university and the practical knowledge from senior colleagues' advice to make decisions:

> P13: When I started I was not working with that criteria, I only did what I was ask first to do. I was crazy back then because, yeah, I was bringing water to a patient when someone was screaming in pain, it makes no sense.
>
> P16: When I started I was thinking more along what my training taught me and what other people taught me.
>
> P30: I'm finding that my judgement is increased and I can rely on that a bit more and rely on my gut feeling a bit more because when you start you have to do everything right by the book.
>
> P33: If I'm unsure, I liaise with a band 6 or a more senior nurse who's more…knows more than me.

Furthermore, junior nurses also rely on the few policies that they know, usually through past experiences or hospital training:

> P16: I think that was my first missing persons…problem. However, initially I've done what I thought it was my instinct to do and that was alright, and after that I learned about the missing person preform, so I worked through that, I already worked some of the steps and went to the ones I didn't do. Next time I will go straight into the preform.

> P22: Policy is there for a reason, I hope that in most cases is being drawn by best practice and what research will tell us is the best thing to do in that situation. I think for a lot of things that's the reason they're in place.

Once nurses start to obtain their firsts years of experience, their confidence in their practical knowledge increases and their theoretical knowledge start to be outdated, so routines are created during practice which do not need to be based on scientific evidence:

> P4: I personally came across people that they have been doing it [nursing practice] their way for so long that is more difficult for them to change. Either they do not want to change because they believe that is nothing wrong with their practice in the first place, so they will carry on doing it, or they just find it difficult. […] Especially if you are watching how other people, more experienced staff, do things that aren't how you've been taught…

> P15: Any procedures that I need to do to a patient, the catheters, the cannulas, I am not thinking of following them, I don't even know, I don't even know the protocols for those. I do it the way I was taught and the way I think it's correct and the best for the patient.

> P24: I mean, you need book learning, but maybe clinical experience and learning the new job as you're going along is; possibly more…has more importance because you're seeing it. It's good to know what to do theoretically but may not necessarily be able to apply it in their everyday life.

Moreover, with that experience the nurse develops his clinical intuition and considers its use in decision-making:

> P13: I follow my clinical knowledge, which will go always with my gut feeling. So, for me clinical knowledge and gut feeling it's always together and, if I have a doubt, I will follow them. I rather ignore my protocol than ignore my gut feeling or my clinical knowledge, I rather be sure with my clinical knowledge. If they are both together, great, but if the protocols say something and my gut feeling says another I would go with my gut feeling.
>
> P22: Policies and procedures are there for a reason and we should follow it, but most of the time gut feeling, which I think is intrinsically linked to your experience.
>
> P27: So, I think having a pool of nurses with an average knowledge, instinct is the most important thing. That said, we know that all nurses are not at the same level, some nurses are more knowledgeable and some nurse have less knowledge. So, to have instinct you have to have knowledge, to express your instinct, to be effective with your decisions following your instinct you have to have knowledge, if you didn't have knowledge, you cannot have instinct because instincts are based on knowledge, I think.

On the other hand, since they had to deal with different kinds of problems they are aware of the clinical practice risks, the different policies to be implemented and how they can use them to work safely:

> P31: We don't all know policies of by heart, but I think we you are a bit more experience you know where to find them, you know who to ask, you know who can back you up in your evidence to say "it's something wrong here and I'm not happy with it".
>
> P34: Obviously, I think that we need to apply our knowledge to those policies. Without knowledge no policy would exist and if you don't have the knowledge you don't know how to follow the policy. You need to do it 50-50, but putting knowledge first because if you don't' have clinical knowledge you don't know what the policy is talking about, I think.

In the case of the more senior nurses, they have developed a clinical intuition that links to their practical knowledge automatically, enabling them to make complex decisions holistically in a short period of time:

> P17: I would like to think that I use my [laughs] clinical knowledge and experience… [15 seconds pause], but I definitely that gut feeling on something is a huge...I mean, it's even coming in a lot of children guidelines and policies what the parent's think.

> P21: But there's not kind of a substitute, really, for time, experience and with that comes that gut feeling you just say, just to kind of you can look at someone and go "their obs are ok, they're talking to me, but something is not right or something is going to happened" because you kind of see things before and that feeling that you can't…something is wrong here.

> P32: I suppose they should be balanced, but usually more gut feeling that sort of takes over, but then you need a bit of evidence to sort of proof that your gut feeling is right.

Similarly, these expert nurses are able to detect policy limitations and act safely without following them strictly to benefit the patient and the department:

> P12: I think you always have to be aware of the policies in place and adhere to them as much as possible. If you disagree with the policy I feel confident to raise that to my seniors and challenge that to see if we can change the policy in some way, but I would say that if the policy is in place you have to adhere to it.
>
> That being said, there will be situations where you have to not follow the policy thinking about the patient's best interests. So, the patients' best interests always are the overwriting factor. I know I will not follow the policy, but if I can justify that I am doing that because is in the patient's best interests and then I'm confident in doing so.

> P23: We had a patient who was in a wheelchair and the policy was that the relatives could not park in the ambulance bays and we wanted to transfer this patient across to CDU, but they needed a paramedic to go across to CDU and the

> patient's wheelchair could not go into the ambulance and the patient could not go out of the wheelchair and lie flat because it was too painful for him. We had to do some bending of the rules with the nurse in charge to get this patient into their own accessible car but have a paramedic go with the patient in the car with all the right equipment to go to CDU with an ambulance following behind them. That's a really good example of fitting the policy to the patient so they didn't come to any more distress.

Until this point, the evolution of basic factors in clinical decision making has followed the structure documented by Bennet, but according to the participants this changes once experienced nurses get more responsibilities.

Given the rapid ED staff turnover, the ED nursing hierarchical apex encourages registered nurses to undertake more responsibilities as nurse coordinators without having been promoted to a higher position with established greater responsibility. This entails that, even though in theory their position and their role is that of a registered nurse, they feel forced to coordinate teams without any additional training:

> P33: I know we have a Minors study day, but I think that was not enough in a way to manage blue zone and to coordinate primary care and injuries, and especially I never coordinated, before that experience I never shadowed anybody and nobody show me how to coordinate and how to manage primary care and injuries together because it's quite complicated.
>
> P34: That's very shocking for me, is like "why I have to tell someone with 10 years of experience what they need to do?" when that person could be in that position [coordinating] or force people to coordinate area when they don't want based on the fact that a lot of staff left the department. Then, they force you a little bit and is not what the department needs, but the punctual requirements of the department.

The fact that some senior registered nurses are more engaged in coordinating teams than patient care makes them lose some of their clinical skills due to lack of practice. Also, they are accountable for all patients and the performance in their area, with all the

additional factors that this involves, so they start to actively use policies again to support their decisions:

> P19: I think when I, for example, I had it where there was 175 patients in the department. Again, as long as follow the procedures, so I would go out and say "look, we've got this waiting time, you're allowed to go home". There are some things that you can do to ease the burden a bit, if you like.
>
> As long as you follow everything, there's not a lot more than you can do.
>
> P31: I think you should always, always, fall back on policy to back up your gut decision. However, as a nurse ultimately, not a manager, the patient is my priority. So your gut feeling should overarch everything, then back up with clinical presentation and then you can say "no, because the policy says a, b and c and that's where this patient should be going or that's what we need to do with this patient".

#### 8.2.4.2. Human factor

The three basic factors follow an established evolution based on the nurse's experience when all interviews are analysed together, but none of them explains why two nurses make different choices if they have the same theoretical and practical knowledge, know the same policies and have a similar intuition based on their experience.

This is because when the interviews are analysed together an extra factor dissipates between the other factors' patterns since it is not distributed in a particular pattern. This extra factor is the human factor, which represents the nurse as an individual with his values, desires, ideas and feelings.

Since personal values are so diverse, it is unlikely that two people have the same ones. However, this does not imply that this factor is not important, since it can affect decision-making at any hierarchical level.

Nurses know that there is a human factor, which is repudiated by healthcare institutions because they cannot avoid the effect that it has, sometimes unconsciously, in decision-making:

> P21: Your biases and beliefs I think you should try to keep them at best you can. I mean it's difficult because it's part of who you are, but should try to keep those out of patient care.

> P29: So, that's something I discussed with my friends since nursing school. They expect us to not have an opinion, basically a nurse shouldn't be expressing an opinion, that's personal. I should say, based on my clinical knowledge, I'll say this, but as a person I might say something completely different because that's my beliefs and they expect that us nurses are that neutral person that's there. Although, I agree that people could see us as human if we bring our opinion forward, in the ideal idea of a nurse I think they expect us to be that neutral being that has no beliefs and no opinion and is there only for the patient.

Nonetheless, even though the human factor's effect is inevitable, nurses can decide whether to apply their values in their clinical practice actively and consciously or limit their effect as much as possible.

The participants who apply their personal values and experiences in their usual nursing activity argue that they help them to connect with their patient, since showing their personality allows them to express to the patient that they care about him:

> P17: It makes me more human, it makes the interaction more personal when you can have those conversations and again, they're all linked, your gut instinct, your clinical experience and things like that; but that's what makes us human because we're human.

> P23: I think sometimes is good to be how you are with the patient because you might experience patients like a character, whereas if someone is neutral and doesn't have anything about them patients find it very difficult to warm to that person, they think "do they care about me? Do they want to be near me?" but if you were yourself that patient can accept that you are that person.

> P26: I think you have to be yourself because it allows you to build empathy with the patient. I think being yourself just going to make them understand that you're human and you're not there just to do what you have to do. Yes, because I think if you're neutral they can just think "they are just here because they have to, but they don't really care or they don't mind about me and my needs" so I think that personality could help, and helps in this case.

> P31: So I think there are some…prejudices is always seen as a negative word, but there are some "things" that are evidence-based that are still within my personal beliefs. For example, I have quite a passion for older people and I worked a lot with older people and I like to think that I know who is worth taking a little more time with to facilitate a discharge for. So, for me, I would always justify a patient breaching if that means that patient is going to go home instead of going into the hospital because we know that older people don't always do very well when they come into hospital.

In addition, expressing their values and ideas without strict limitations allows nurses to practice more motivated:

> P6: I think values are important for us to create an idea of what nursing mean to us as well, so for some reason people might think that nursing is a way of having money at the end of the month and they've done their work and they finish and that's it. Some people are nurses because they have passion about caring for patients and making sure that they can contribute for a better world and a healthier living for people, supporting another areas like end of life and stuff like that.

On the other hand, the group of participants that preferred to limit the human factor in their decision-making commented that the patient might misinterpret the expression of their own ideas and feel offended:

> P21: Yeah, I mean, if you're bringing your kind of biases into any situation there's always that risk that the person you're dealing with, being patient or staff or member of the public, doesn't have that same kind of bias, the same kind of outlook on situations.

> Wherever that be through upbringing, through religion, or wherever it be just kind of personality because I think a lot of ED nurses and critical care nurses have a kind of darker humour to situations, which is not always appreciated by the general public or the patients or anything like that.
>
> P26: That's why I try to deal with my character and trying to deal with it because obviously I have to be polite and I'm always polite with every patient, but sometimes just answer them and give them answers that don't make them happy can be not dangerous but put you at risk in ED.
>
> P30: That's the same with putting your feelings onto a patient. I went with a doctor to tell to the relatives that the patient passed away and for me it's…I'm an emotional person, so I was trying to keep my face because it's not my grief. I a nurse was crying when they were telling me that my relative died I would be "why are you crying? that's not right, it's not your grief".

Another argument in favour of limiting human factors is the fact that they accidentally interfere with the patient's decision-making process and can restrict the patient's informed consent or influence it for the nurse's benefit:

> P11: People have religious values. Not that I am, but if I was a Jehovah witness for example, it will be wrong for me to encourage patient not to give a group and safe because I think transfusions are wrong, because that's my values. Maybe they're not Jehovah witness and it will be very unfair to discourage that, but as a Jehovah witness I may think, you know…
>
> P32: I think we should be neutral, but obviously if the patient has the same beliefs as you it's good because they find that they can talk to you. I think that we should be neutral and every patient has the right to make a decision either if we agree or not agree, so we should be quite neutral.
>
> P33: (IE) – Respect their beliefs, respect what they want and obviously you need to…if the patient, for example, if they've got the capacity you cannot enforce what you're religion is or what treatment. For example, the Jehovah's Witness are the ones that they don't want any blood, aren't they?

(IR) – Yes, they are.

(IE) – So, you can't push yourself, that's following the policy. So you have to make sure that the right things are followed, making sure that they have the capacity, making sure that the disciplinary team agrees that that's the decision that benefits the patient. So, you cannot force on what you believe to other people because everybody is different.

#### 8.2.4.3. Environmental factors

The environment in which the participants work affects many of their decisions, especially when those decisions affect more than one patient or they are in charge of the operation of an area or the department as a whole. Clinical workload and patient flow through the department were the two environmental factors mentioned consistently by the participants due to the continuous problems with them and their effect in daily practice.

When patient flow is discussed, this concept represents the movement of patients within and through ED. The consequences of an inadequate patient flow, like crowding, affect the speed at which the patient can receive appropriate treatment and care:

> P34: The risks are, at least from what I see, that there is overcrowding in ED and that affect patient care that, obviously, is not their fault that the department is like that and their care could be delayed, which entails a risk for the patient and for me because I'm responsible for providing care for that patient.

According to the participants, if patient flow is slowed patients have to wait longer for treatment and to be moved elsewhere. This means that patients have to wait several hours in ED to be transferred to their destination, sometimes by ambulance:

> P2: I believe that what happens in ED is the uncertainty because they [the patients] spend most of the time waiting, bless them.

> P17: Movement through ED would be smoother and you would not have patients there for 11 hours already on their second dose of medications.

The main cause of the patient flow slowdown is the lack of beds in hospital wards, since a large proportion of patients who expect to be transferred to a ward occupy a box that could be used by a new patient, which is even a bigger problem when patients are waiting in ambulances:

> P7: If we have outflow to the wards there isn't any issues.
>
> P8: What would I change? Oh, have beds [wards spaces] in the hospital, lots and lots of beds, so there is outflow.
>
> P15: Also, what I would do is probably open another medical admission ward upstairs. If not a medical admission, another medical ward upstairs, and hire the nurses and people to work there as well because one of the main problems is flow, is flow. So if were blocked upstairs [wards], were doomed downstairs [ED].

In order to avoid crowding in ED and meet departmental objectives, managers put pressure on nurses to move the patients who have been assigned a bed in a hospital ward as soon as possible, even if this means inadequate care or an unsafe transfer:

> P9: Other stuff that I hated... Even if the patient comes and his bed is ready, I do not like to be pushed to send the patient away when the treatments are not being given and nothing is being done from my side [nursing care].
>
> P10: For instance, if a patient is breaching and you get all of these managers on your back to get them [the patients] out of the department, you feel they are not safe.
>
> P19: Obviously, you have individuals, and is not their fault, I've been in their shoes as well, they see that the board is turned green, that's the reference that the bed is allocated and ready; but we're not ready in the department to necessarily move them on, there are some aspects that we're not necessarily done.

On the other hand, several participants presented cases when, since there were beds in hospital wards, the patient passed so quickly through the department that nurses did not have time to provide basic patient care:

> P23: Sometimes, due to the nature of ED you don't get to look after everyone because some people slip by you without even receiving proper nursing care. […] When patients leave the department feeling like no one's [short pause] been into do the things they want, then I feel responsible for that, yeah.

In other contexts, clinical workload is usually measured by the number of patients that a nurse cares for during a day or through the patients per nurse ratio. However, according to the participants the clinical workload that they suffer depends on the patients per nurse ratio, patient flow and patient needs:

> P5: What happens is that in Majors we have more patients per nurse than before, I think, because before we had maximum 5 and now we have sometimes 6 [patients]. What happens is that is someone is on break you have to cover your patient and hers and that is an important workload. You can be lucky and maybe her patients do not need anything, but if they start to need treatment there's a moment when you're overwhelmed, there's a moment when you cannot manage.

> P6: In Majors you used to have 4 patients per nurse and now you have at least 6 on a bad day, and sometimes some nurses have 7, and is a very fast movement.

> P16: I mean, like I said earlier on having 6 patients in Majors can be very challenging, especially if several of them are acutely unwell or they have dementia and they like to wonder.

When nurses have to deal with high clinical workload, which happens often, they are forced to prioritise the most urgent care in search of "efficient" care, denying less urgent aspects of care to avoid any patient deterioration:

> P14: I think it depends if we are in a rush or not because sometimes I work with the same colleagues and I see them do things in a rush, they do not have time to talk with the patient. Sometimes, when we only have two or three patients we have time to talk more with the patient, to give…not more care but to give better care when we are not in a rush, so that depends on if we are full or not, depends on that.

P16: Because we are such a busy department the little things get missed out or they get delayed to make way to more important things, which isn't great for the patient but has to be done. I think in Majors when it gets busy having six patients does cause some of the comfort things no to be done as quickly as they could be, mainly because is so much going on that you need to spend time looking over all patients and checking that everything is seen to.

P23: I did feel like, especially during the winter crisis, I feel like is a bit of burnout almost because you get used to be really really busy that you get used to not to do certain things of patients care, the little things like giving the patient a cup of tea when they are upset or tired or actually having time to sit down and talk to patients about what's going on.

However, caring for potentially critically ill patients is very risky, since while the nurse devotes extra time to a patient another one may deteriorate. Nurses are aware of the dangers of providing immediate care to critically ill patients, facilitating the occurrence of errors or omissions:

P4: If you are constantly working under pressure, like every single day, that takes a toll on you physically, you know? It will take its toll under a long period of time and that's when more mistakes can happen, drug errors and…you know?

P5: For example, in the typical case of sepsis we need to give the antibiotics before the hour, so that's something important to recognize and treat it on time, although you could have five or six more patients and the doctors tell you "this patient needs antibiotics now because it's important and could be sepsis". Also, there can be other types of errors because we are exposed to certain pressures in regards to the time.

P7: What else puts you at risk? I supposed that because we look after so sick people in such a busy environment things get forgotten and missed because you are always worrying about the next patient that you've got.

P21: So, if you've got, as we usually have in Majors, like 7 or 8 patients, at least usually six, you're writing about the care delivered to your first two patients when something is happening to the other 4 who you didn't have a chance to get

around to. So that's always a concern if something happens while you documenting or something happens to your patient and you don't have a chance to document it because you're busy with another patient when…yes, there's always a risk that that come back.

P27: In those circumstances I think I can't manage and I'm not safeguarding myself, and doing so sometimes I'm putting patients at risk because I'm doing too many things at the same time and it's dangerous. I made mistakes, I admit, doing that.

In order to address this risk, nurses work in groups to balance their clinical workload and ensure the safety of all patients in the area. However, staff shortages and poor training hinder teamwork and unbalance the division of labour towards senior nurses:

P4: We work in a very busy department and there is not always enough "help" [emphasis on the word help], so if you are struggling or you are on your own trying to help someone and you try to perform personal care.

P30: The more staffing you have… [sentence omitted for confidentiality reasons] the newest people are still behind and some of them are ahead of some the nurses that came before them.

This implies that senior nurses are overworked while junior nurses feel useless against their inability to help their colleagues:

P10: Another thing is that when we come to this department, you will agree with me, there are so many nurses when I start the shift…I do IV's, I take bloods, I cannulate and I have 4 or 5 nurses around me who cannot none of these things.

Do not forget, I have my own 4 or 5 patients to look after. So they chase me "can you do bloods for me? Can you cannulate my patient? Can you give my IV's?" That puts a lot of weight on my shoulders, what's the department doing to ensure that they get quick training? So, that weight come of us, it's too much.

Another aspect that is relegated to favour emergency care is the departmental objectives, which are constantly broken during periods of high clinical workload:

> P4: I also noticed that sometimes if you are very busy and you are providing care on top on that, giving treatments, a lot of times you are not meeting those targets of checking observations every 45 minutes, and that can have an impact as well because it looks like you are not doing your job properly.

Both patient flow and clinical workload are inversely proportional in both directions. This entails that if patient flow slows down clinical workload will progressively increase and vice versa, whereas if the clinical workload increases patient flow will be reduced and vice versa. This relationship is known by several participants, but they are aware that as registered nurses they do not have much control over environmental factors:

> P7: […] if we have outflow to the wards there isn't any issues. The delays are not often due to nursing care but due to this external factor, but I think if we had flow all the time and lots of staff you would be able to care of your patients as you want to, meet targets and follow procedures.

> P19: It is a top-down approach and it's an approach that requires, mainly for safety, as capacity and flow because don't forget that if you don't have capacity and you don't have flow you can't be safety either because as much as you have a responsibility with the patient you're looking after […] there still a wither responsibility with the other attendees that are not necessarily getting the same level of care that your patient is getting as well because you're not necessarily focus on the problem at hand.

#### 8.2.4.4. Material and human resources

In order to provide healthcare, an institution needs to have an amount of specific resources, which must be distributed optimally to maximise the quality of care offered and its efficiency.

Management of human and material resources across a healthcare institution in the medium and long-term is the responsibility of the institution's hierarchical apex, while short-term resource management is usually delegated to the EPIC and the NIC, who

manoeuvre the available resources within their department, leaving interdepartmental resource management to the duty managers. This implies that the EPIC and the NIC are often not able to obtain more resources when they need them if they do not drain resources from other areas or departments, so management of the available resources is key to provide basic care.

Nurse coordinators are only involved in managing resources in the area they control, while registered nurses are not allowed to distribute resources without informing their nurse coordinators. However, even if they do not have decision-making power in their distribution and do not affect the decision-making process per se, the available resources affect registered nurses' decision-making massively, limiting the available options and forcing them to consider new options that in an ideal situation would never be mentioned.

Regarding material resources, it has to be taken into account that the interviews were conducted in a period of transition between two different buildings, since the new ED opened on the 26th of April 2017 (499). Therefore, participants still remembered the problems associated with the old building:

> P6: I remember when I started in ED and Assessment Bay being a completely different Assessment Bay, there was nothing, there were no trolleys, you would have trays to pick up things and go to the patient, nothing like the Assessment Bay with cubicles, with trolleys, with everything you need, with a monitor, so that is nice and before it wasn't like that.
>
> P9: Ok, the old department, they didn't have stuff [equipment] to deliver the best care. We missed the ECG machine in the old department, so if you needed to do an ECG you have to wait an hour to find it and that was frustrating, very frustrating.
>
> P19: The example that I will give you is that I was in the old Assessment Bay, where you didn't have enough room to move for two people.

Moreover, they noted how the new ED's material resources helped to solve several problems that frequently had to manage in the old building:

P3: So, I think in the new department is a lot better, we have the bigger cubicles, we have all the facilities we need, there is a lot calmer. It [the bays] has glass doors, so you discuss confidential situations a lot better.

P8: I like the individual rooms where you can provide decent patient care.

P18: In the new department, it's like Majors, for example, I think it's a great area to look after patients, you know, the patient stay in that bay, they're not middle bays, there's no middle ground for trolleys to be lodged.

Nevertheless, while acknowledging that the change was beneficial overall, the participants also realised the failure or lack of material resources in the new building, which got worse after opening:

P5: The... the treatment room in Resus is a little small, if you have to fit two nurses to prepare treatment like NAC [n-acetylcysteine] or treatment for potassium [hypo or hyperkalaemia] you need to set up a few infusion pumps, so it is a little small for that.

P11: Maybe new equipment, slightly better equipment. We have a LUCAS that it's like 10 years out of date, you know? [laugh]. If you spend 20000 pounds in a monitor you can spend a few quid on a new LUCAS.

P16: For example, in the new department there are a few things that I looked at and I thought "why they designed like this?" In Majors, the sluice door has no window in it, but here're cupboards directly behind it, so you can open that heavy door and slam it against someone behind and that's sound as an accident waiting to happen. The room opposite, the treatment room, has a sliding door, so if we had a sliding door in the sluice that'll immediately solve the problem.

P26: I can't complain about the equipment right now because is quite good, well, there is always something that is faulty and is not working and you have to deal with it, but I think that quite normal.

Unlike material resources, which can be replaced with relative ease, managing human resources in an ED is so complex that significantly affects the quality of care offered, among many other factors.

Human resources were the most frequently mentioned topic by participants, even though there was not a semistructured question focused on this particular issue. Also, staff shortages were an issue that was discussed in every interview, while the lack of training was reported in 32 of the 34 interviews. This reinforces how important human resources are for nurses, even if they have no control over them.

The lack of healthcare workers is a problem that not only affects the LRI ED but most hospitals in the UK. The participants indicated that human resources are not sufficient for the demand endured by the department, even citing ideal patients per nurse ratios or minimum staffing levels set by the hospital itself (500):

> P8: Patient care, I think if we've got the right staffing levels, and I do not believe we've have the right staffing levels, I think the department should be staffed as it was originally, which it was two qualified nurses and two HCAs for 6 or 8 cubicles, something like that.
>
> P18: What I would do, personally, it has to be more nurses, doesn't it? So, there is a patient to nurse ratio and needs to be a lot less. [...] I think 1 to 6 [bay numbers] it's quite tough with the nurses. In an ideal world, 1 to 3 would be great, 1 to 4 even, it would be a lot better. So, it always has to be more nurses.
>
> P19: Ok, I want to flip that slightly and not look at it from my practice but from the benefit of the patient per se. The reason is that if you tell you're going to give me unlimited resources in regards to my practice, I would simply say quite easily that you could just have increased the staffing to the minimum requirements settled up in the business plan, that I'm aware, and I'm sure you are as well, we're not even close to that, not even vaguely close; both from support, nursing, allied healthcare professionals, doctors, medics, portering, everything else. That's your core requirement, without people, you cannot do your role effectively. It doesn't matter how good I am as an individual, I'm only as good as everyone that is available with me at the time. If there is nobody there, there is nothing that can be done about it.

Staffing issues affect the operation of the department in various ways. The participants mentioned some of those interactions, which are the ones that most frequently affected them during their clinical practice.

It was mentioned above how patient flow deceleration through the department can increase clinical workload, but the participants also mentioned that the lack of nurses increased clinical workload directly since they have to distribute more patients per nurse:

> P16: We, as far as I'm been in ED, very rarely have the staff to have one-to-one carers for the patients. It's very challenging dealing with some people that wonder or are acutely confused.

> P24: I would probably full staff the department because at least you would have enough nurses to your patients.

When the clinical workload increases, nurses are forced to prioritise the most urgent care, so they have to reduce their care standards to prevent patients from deteriorating. The participants indicated that sometimes they had to offer sub-optimal care because they had no choice:

> P3: I think staffing levels, again, I think were a lot better that we were, and I know that will never happened but in an ideal world I think it would be lovely to have more staff because you can give your patients more of your time and make them feel more valued.

> P4: All the things that I have been taught about how to care for my patients I have not been able to put it into practice all the time because when we [the ED nurses] are short of staff and it is just me. Let's say, for example, providing personal care, which is all at the forefront, sometimes I am not able to change my patients until I've got a member of staff to help me so it is a delay.

> P22: You either need to lower your standards, which I don't think is preferable to anybody, or you need to increase staffing to meet the standards that are in place; and at the moment the level of staffing that we have…I think this is not an

isolated ED problem, this is an NHS wide issue, I didn't think that the level of standards that have been set are achievable on the current staffing.

Since the speed at which the patient can pass through the department also depends on the number of patients that can be cared for at the same time, staffing issues affect patient flow, slowing it down if there are not enough nurses or doctors:

P15: So, if they are teams in the walking assessment doing stuff together as they do in Assessment Bay flow would be improved a lot more.

P11: I mean, obviously, more nurses, more doctors, more support staff, you know, the waiting time to be seen by a doctor sometimes is too long and then that slows the flow out of the department. They thought that moving to this new department will fix things, then… it's just a nice environment. It makes a nice environment, which is great but doesn't change the fact that patients still need to wait 8 hours to see a doctor.

Since the lack of personnel increases clinical workload, it also increases the likelihood of errors and omissions, so it facilitates unsafe practice for both the patient and the nurse:

P12: The staffing levels, the fact that we are so short in many occasions it's really one of the limitations we have, not only because do not have enough people to look after the patients per adequate ratio, but because when you are covering holes in looking after patients that don't have proper cover, then you're not focusing on other thing that could improve patient care and you are more prompt to risks. So, staffing is major major problem.

P20: So, obviously you have a fear that something is going to happen to one of the children, but certainly when I'm coordinating…I coordinated some shifts with I'm the only children nurse and I've got someone very experience, you know, like [a nurse] that's being in children's for a while, but she isn't a paediatric nurse, and she is in assessment with only an agency nurse. So I had nobody, we had around 25 children and I had the duty managers up, I had everybody up because at the end of the day I'm in charge of that unit and it wasn't safe.

The participants also discussed the possibility of redistributing part of the clinical workload in community, social and mental health services when necessary. However, they also recognised that these services also suffer financial problems, so patients who cannot be cared for in the community are part of the patients treated in ED:

> P25: You could extrapolate that through all social care and it will be brilliant because it will be no bed blocking because there will be enough funds for people to be discharged into the appropriate care settings and palliate care areas or home packages being sorted out because the training and teaching side of things would adequately prepare these people to feel confident in providing appropriate patient care in the appropriate setting.
>
> P31: The other thing that I would do is to take a whole load of money and putting in back into the community care for older people because I think the problem is with increased frailty in England and increasing age, patients are not being looked after at home, they're not talking about death and dying and cares who are going to see them get like 6 minutes to give somebody a wash and their breakfast, it's ridiculous. So, if Ms Jones again, she keeps coming up, if nobody checks that she drank her cup of tea and she don't drink her cup of tea for a week, she is going to get dehydrated and she will have to come into hospital; when actually she don't want to come back to hospital.
>
> I think other thing that I would do, in the meantime I'm Prime Minister, is look up at mental health services because that's a thing that really demoralizes me, that a lot of people don't get the help they need and that's why they re-attend and escalate their behaviour, they don't get the follow-up they require, they don't get the support they require. […] It's hard though. People are always going to be killed in car crashes, but that's what ED should be about, it shouldn't be people that had a headache for 6 months who lost the trust on their GP because they can't get an appointment, so we probably need to put the money out of the department and back into the world.

In the hypothetical case when there was the ideal number of nurses, this would not be sufficient to ensure adequate human resources, since these nurses must be trained and have to obtain the necessary competencies to perform tasks related to patient care. The

participants indicated that poor training is a major problem that promotes malpractice and clinical errors:

> P14: We know what we have to do, but if we had more training like trauma courses, advanced life support, it's going to improve our care because we have a lot of nurses that are leaving, mostly experienced nurses, and we have a lot of new recruited nurses. I think that we need to have more training to improve our care and to improve patient safety as well.
>
> P24: So, it's doing a realistic amount [of work] with the people that have the appropriate skills to be sure that it's safe.
>
> P25: Training. I would get everybody trained up with all the prerequisite ED skills. I think, even if you did it form a bottom-up approach, it will be more viable than the approach that we've seen to have at the minute, which is typically top-down in regards to courses. When the paeds cannulation process was brought into peads and Training and Development said "ok, we would get the band 8s, the paediatric matrons on it first" and I was like "no, we need to do it the other way around, we need to do it so all the little…maybe the senior band 5s do it first because I worked with them".

One of the causes for the nurses' poor training is the lack of funding for it. This entails that courses are less frequent and do not cover staff turnover, so those most affected are junior nurses, who must wait several months to receive the basic training that allows them to perform their professional duties:

> P11: More staff development, you know? You ask to be put in training courses and you're told that there is no funding, so more funding for training and development.
>
> P14: Yes, it's true because at the moment I heard from some colleagues that we don't have enough funds [for training]. Especially in ED, there are a lot of trainings that we need to have and we're not having at the moment. That [training] will do improve our care, of course, at least when we work in Resus because we've got a lot of fresh-recruited nurses.

> P23: One of the things that I was going to suggest is, perhaps, training and development for newly qualified staff. To change anything in the UK would be…for example nurses in the UK when they qualify they aren't able to do IVs, they aren't able to do cannulas, they aren't able to do bloods and they aren't able to give medication. That means that when they qualify they are a nurse, but they can give medication, they can't do cannulas, they can't do catheters, they are not able to do the most essential things that nurses are expected to do.

One of the most prevalent reasons for training nurses is to empower them with new skills that enable them to provide more efficient and holistic care. However, the lack of training has a direct impact on obtaining competencies:

> P8: I would insist that the skill mix was set so they have to be a certain amount of nurses on shift that have all the ED nursing skills: suture, plaster, triage, coordinate areas. There has to be minimum number of those, doesn't it? You always have nurses that are learning, always, but I would make sure that there is a proper skill mix.

> P10: Another thing is that when we come to this department, you will agree with me, there are so many nurses when I start the shift…I do IV's, I take bloods, I cannulate and I have 4 or 5 nurses around me who cannot none of these things.

> P13: About the training…First if you're going to apply for a job you're a nurse you're able to give IV's, so before you start working you should have the basic training like IV and oral medication, just to start. I waited several months to have IV training. Why? I would like to change it so as soon as you come to ED you have your IV training because our educators are allowed to teach IV training, we do not need anyone else.

The consequences of the lack of competent nurses in a variety of tasks essential to patient care are varied, but the most mentioned by participants are the obstruction of human resource distribution through the department and the reduced standards of care offered:

> P15: The main thing is keeping people up to skilled level because if you have good people, a good number of people that could do Assessment Bay and walking you're not going to have 40 people waiting to be assessed in walking.
>
> P16: Sometimes, it can be difficult in my situation because I can't give intravenous medication and other skills at the moment, so it's difficult to get other people to do that, mainly because they are busy, not because they are not willing.
>
> P24: Also, going back to coordinating, if you're coordinating and you have 4 staff nurses, 2 can't bleed or cannulate, 1 that cannot give IVs , someone that cannot get into the Medi 365 [electronic medication cupboard], as a I did for a shift, how can you taking a step back and not doing any sort of coordinating? You don't, you finish up relevant patient care when it would not be [necessary] if I had staff that could bleed and cannulate or give IVs.

If the appropriate amount of staff with their training and competencies updated was obtained, the problem involving staff retention still needs to be solved. According to the participants, a key staff factor in staff retention is employee satisfaction, which would increase productivity and slow staff turnover if maintained high.

In relation to healthcare workers' satisfaction, the participants mentioned three elements that affect their satisfaction with their work: stress, the need for social approval and salary.

The stress that participants say they or their colleagues suffer, which was indicated directly by 28 participants, comes from many factors previously mentioned like excessive clinical workload, lack of staff and training, poor job security and non-compliance with care standards, among others:

> P6: There have been many situations where I felt unsafe, I felt "I do not know what is happening", I felt "if something goes wrong, I am going wrong with it".
>
> P10: No one listen to nurses who have been in the department for long, what we face, because when I come to work and you put two nurses and they cannot do IVs, straight away, form the first minute I start working I'm angry, I'm

> frustrated because definitely I have to carry those two [nurses] on my shoulder as well. And that's very frustrating, something must be done.
>
> P14: Just stress, sometimes you are very stressed and sometimes we do things that we keep thinking if we did the correct thing or not. Sometimes we come home thinking about one specific situation, like a patient who was really unwell, and we can keep thinking about it for 2, 3, 4 hours.
>
> P22: I know of nurses that have been in tears working in Majors just because they feel that they are not doing enough for their patients and that's really hard to see.
>
> P23: Ok, especially when it's really, really busy I feel like I can't look after all the patients and makes me depressed because I can't…I'm not able to do the job that I wanted to do since I became a nurse, which is look after people.

Another element related to staff satisfaction is the need for social approval, to feel appreciated by their peers and superiors. Several participants said they did not feel valued by their colleagues due to their interactions with them or based on the fact that they do not feel rewarded for their effort:

> P10: Because it's a hard job, really really hard mentally and physically, really challenging, but if someone isn't appreciated they will go somewhere else when they are appreciated. […] I was waiting to be registered [somewhere], this is from last year, count all the months, all the emails I've sent, trying, telling people, managers personally, sending emails, I have the proof there, nothing done. Absolutely nothing. So, if I need to take some bloods I need to go and ask somebody, you see? Then, I see HCAs [registered]…so I said to myself "Am I valued? Do you understand? Am I valued?
>
> P11: Maybe we are wear down because we don't have enough staff, people feel undervalued.

The third element mentioned by the participants regarding staff satisfaction was the salary. They said they would welcome a raise, but that is not as important for their

personal satisfaction as receiving adequate training or working in a department with the appropriate number of healthcare personnel:

> P6: I am not saying about pay rise because I do not have anything to do with budget. Obviously I need to be paid to have a house, to have food, eat and survive.

> P10: I think that is hard to talk about payment levels because what I've said to people is that if we demand more pay to ED staff, the ITU staff will come and demand more, the surgical ward…because they are all nurses so it's a very grey area. Most people talk about money but cannot pay a set on band 5s more than the other, creates a lot of tension and conflict. I do not think it's an area to toll.

> P22: I'm happy to be paid what I'm paid, but not for the amount of problems that we have with the lack of staffing, and that would be the thing [staff] that I would definitely want more of.

However, even though they recognise that it is not a decisive element for them, they mentioned that it would be an appropriate strategy to increase nursing recruitment in ED:

> P20: I think if I had unlimited money, I'm not sure if is the same in Portugal and Spain, but I spoke to somebody than in a lot of places in Europe, if you work in an emergency department or intensive care your salary is higher than in a ward-based area, therefore these are high demanded jobs. […] I think I you rewarded people financially for wanting to work here, people would want to work in ED.

> P21: I think better wages for the staff, just for moral training. I think…not necessarily more money, some people are struggling, look at the news and something like [nurses using] food banks, so the ways that reflect our responsibility in our role, so kind of like the pressures that we get as nurses.

Given these three elements, the satisfaction of healthcare workers has a significant effect on nursing retention. However, according to the participants, it also affects the quality of care, since unmotivated nurses do not feel able to provide holistic care or do not care about their care quality standards:

> P8: It's the stress, if the stress builds up with the little things, you know, I think it's not taking care of your patients as well as you should.
>
> P21: Some people these days are just so dishearten with it all and just don't care [emphasis in just, don't and care] about their environment and things like that, which has an impact on patient care.

A classic linked to the elements related to nursing satisfaction, such as stress and anxiety, is *A Case-Study in the Functioning of Social Systems as a Defence against Anxiety* (501), an article by Isabel Menzies.

Besides showing aspects of English clinical practice present today like responsibility social redistribution, reduction on the weight of decision-making based on monitoring lists and protocols or the delegation to superiors; Menzies also presents sources of stress and anxiety as the dehumanisation of care, the idealisation of the career progression possibilities or the deprivation of personal satisfaction, which show a very similar scenario to the one described by the participants.

Therefore, several elements related to nurses' stress and satisfaction remain the same since 1960, which continue to be a problem in many hospitals across England.

One reason why several of these elements remain without any apparent solution is the positive feedback loop between staff satisfaction and workforce quantity. According to the participants, if nurses are dissatisfied with the amount of staff in the department, and everything that entails, they will go to another department in search of better working conditions. This situation results in losing more staff, which will be more dissatisfied based on the reduction of healthcare personnel:

> P1: I will say that those nurses always have an alternative, if they think that the care they provide is not up to standards, which is to leave and find another job elsewhere.
>
> P4: I can understand why a lot of ED nurses think "why am I putting myself through this extra stress when I could get paid exactly the same working in a clinic, 9 to 5, doing the odd blood pressure?", none of the stresses of ED life.

This is a cycle that would maintain high staff retention if employee satisfaction and the quantity of healthcare personnel was increased to optimum levels.

If by modifying several or all the elements mentioned in this section appropriate human and material resources were obtained and maintained, according to the participants this would entail improving various aspects of the clinical practice:

- Improved patient flow.
- Controlled clinical workload.
- Adequate use of policies.
- Holistic care promotion under high care quality standards, increasing patient satisfaction and reducing morbidity and mortality.
- Increased staff satisfaction, reducing stress, sickness absence and expenditure on temporary staff and improving workforce retention and staff happiness.

#### 8.2.5. Ethics and values

Ethics in healthcare professions is a vital aspect of them, which transcends practice and legality to allow, in the case of Nursing, the care for all individuals, groups and communities, be it through health promotion, illness prevention or care provision. However, nurses do not always follow the values of their profession blindly, since the institution that hires them and them as individuals have particular values that can significantly defer the perception of ethical accountability and the different values to apply to their clinical practice.

To capture the participants' values in relation to their clinical practice was an arduous task, especially since many of them confused religious beliefs with values or were not able to understand the scope of ethical values as a concept. However, the participants expressed their values indirectly in other answers, allowing that their values could be contextualised based on their actions.

#### 8.2.5.1. Professional, institutional and personal values

During clinical practice, nurses apply a set of values that can come from various sources. In England, the NMC sets some values that all nurses must assimilate and demonstrate during their clinical practice through the *NMC Code*. The participants commented that they and the rest of their colleagues are aware that they must follow the values set by the NMC:

> P1: Then I will have the *NMC Code of Conduct* that tells us about how to behave from a professional point of view.

> P10: Having the *NMC Code of Conduct* in mind when I am going to work is very important.

Junior participants assimilated the *NMC Code* in their clinical practice consciously or unconsciously:

> P2: In my case [codes of conduct] are only something that we end up absorbing and integrating in our way of working. The [code of conduct] it used like a filter that we have to filter all the information that we receive from a patient or from when we are working, to know what we can do, what we cannot do, what you can say and what you cannot.

> P5: I know the *NMC Code*, I apply some things, more or less we try to apply everything but there's always something that can be passed through.

In contrast, senior participants replaced the values stipulated by the *NMC Code* for personal values forged during clinical practice:

> P3: I think that there are some people that they do not follow them [her nursing values], most of us do purely from our own morals and the fact that we want to do things right, not because we are following it because it is a rule [spontaneous laugh].

> P7: Yes, I think loosely following the rules set by the NMC but more… obviously the longer you've been qualified the more experience you get

following your gut and I feel that when you fell something is not right normally isn't.

P16: However, you have to be cold to be kind and that can conflict with the NMC Code of Conduct. For example, if someone is doing something inherently bad, like taking illegal drugs, sometimes you need to be blunt and say "if you're keep doing this, you're going to die" and maybe that's the wakeup call they need, but if you say particularly bluntly it could be seen against some of the values of the NMC.

The participants who confessed that they did not strictly follow the *NMC Code* recognised that its values cannot adapt to all situations or all patients, so they do not allow a holistic and humanised care:

P17: (IR) – Ok, so for me to clarify it because I think I know what you're trying to say. You think we interpret the Code, we [interrupted]

(IE) – Yes, we interpret it.

(IR) – And we add our personal experience to our care to try to make it more human.

(IE) –Yes, yes, absolutely.

P22: Now, if that goes back of that I said, we should not do harm. Actually, desecrating a corpse, which is in my opinion what that is, is doing harm; and I think sometimes the NMC don't hold us to the right standards, they hold us to a standard that is disconnected to the reality of practice.

On the other hand, an NHS Trust also represents various values, which can be considered ethical in a healthcare context. Several participants commented that the UHL NHS Trust represents several common values in the nursing discipline, so they frequently apply them:

P3: I think a lot of it is just your general rules, your general morals, isn't it? And ethics and, you know, you treat people with dignity and respect naturally anyway, at least you would hope that you are going to nursing to do that. I mean, I think is

> one of the UHL values as well but one of my morals with nursing is treat people how I want to be treated and how my family want to be treated.

However, another group of participants indicated that those institutional values are a way to establish an appropriate etiquette instead of holistic care, so they chose to prioritise the latter:

> P17: The Trust would like me to say is Trust's values and [laughs] do what the Trust tells me to do, what I do, but…as a nurse and someone who's in a care profession I want to provide care, the right care for the right patient at the right time. That's very individual for every patient that I've come across.

The set of values more varied and difficult to classify are personal values, since there are as many possible combinations as individuals in the population to study. Although there are countless variables to analyse nurses' personal values, one stands out for its multifactorial effect and high frequency of mention in interviews: professional culture.

Professional culture states that nurses from different countries or cultures have different perceptions of what constitutes a nurse, nurse training, care and clinical practice. This is more prevalent when the nurse trained or worked in other countries before practising in England, since values are very diverse in different cultures. For example, participants from other cultures forged an ethical responsibility after their university training or during their clinical practice, through which they feel responsible for fulfilling the values that their nursing culture represents:

> P1: First and foremost I did not qualify in the UK, so I qualify back in my country, and so when you finish qualifying you have to take a vow to the equivalent to the NMC, so I am accountable to them despite not being register with them but ethically I see myself accountable because I have taken a vow by the end of my nursing studies. Then, I always have a responsibility ethically towards all patients, which always guide my actions [looking after patients] as I was looking for friends or relatives of mine with the highest standard I could come up with.

> P13: So, stop thinking about the bad things, start working and stop…if you are going to give meropenem do not think "if the patient is allergic to penicillin and has an anaphylactic reaction I can lose my PIN", no, do not think in your PIN, think

about the patient that can have a serious reaction and die, that's the problem and not losing your PIN. If you lose your PIN is not a problem, you still alive, he's not alive anymore.

On the other hand, acts related to legal accountability like defensive practice are more common in British participants, through which they focus more on blaming someone for a problem, so they are not accountable for it, than on fixing it:

P1: That happens a lot of times where people are more concern about not doing anything that might put them at risk of taking professional or even criminal responsibilities. I think that is also a very cultural issue, as I think is quite cultural finding who is guilty of mistakes that happen rather than preventing these mistakes from happening in the first place.

P12: Perhaps it's a cultural thing here but it's in everyone's heads [the risk of losing the PIN] I believe, especially when you work in a challenging environment when you think you don't always have the right means to carry out your nursing work.

Another aspect of clinical practice affected by the professional culture is the hierarchy's complexity. While in British practice accountability decentralisation is facilitated through the hierarchy, in other cultures the nurse is more autonomous, forcing him to be individually accountable for his actions:

P2: Or it´s me, that sometimes I think I´m stupid and I can´t manage some things that are relatively simple, but that´s [the quantity of seniors to escalate] disorients me a lot, which slows my pace and makes that many times I do not know what to do, where to go or to who I have to speak to.

P6: First of all, my nursing background is not an English nursing background, so that makes a massive difference because it is a cultural shock, nursing in UK is different than other countries. So, I think there is always a cultural shock, there is always the idea of "in my country I do this or is done this way" and in UK is done in a different way. I am not saying that is wrong or right, it's just different things or more autonomy for nurses on some countries that UK does not have, is given to doctors as a responsibility.

> P27: So, yes, I think the responsibilities should be much more focused on the single professional. […] I would reduce any unnecessary staff. I understand that the NHS is much different from what I'm used to and also it's a different background, but I think that the NHS, as a whole, is like a very big family, but some members of that family are not doing much. If we want to obtain better results, we need to focus on what is most important.

This is reinforced when double medication verification is considered. While the British participants believe that verify medication with someone is safer, many foreign participants think it is not necessary if the nurse is accountable for his practice:

> P2: I am pleased that we need to double check, especially in ED working so fast, but from there to the point that some people will check [medication] and follows you is like "I feel you don´t trust me", I think we have to take into account that we are nurses and nobody is going to try to kill someone or giving another medication than the prescribed one, even if it's one of those controlled drugs. I hate that part, when they follow you to see what you do, if you dispose the morphine it´s left.

Other values that change according to professional culture are the ones related to following orders and rules, since while the British participants are accustomed to following policies and instructions, overseas participants tend to ignore policies based on what they believe will be beneficial for the patient:

> P3: I'm not going to send the patient to the ward without giving him his insulin, or with pain, I don't care that he has to go somewhere else, I'm going to give him his medication first.

> P26: Also, if you think that you could do it quicker or having a better result, you have to follow them because they are procedures, so obviously we follow them, but sometimes I think we could…not avoid it [using policies] but they're not very helpful.

> P27: I would connect my thoughts with the ED policies that we have. They help to give a safer care in a wider range, generally speaking, but at the single professional [level] they don't teach you how to think, they make you soft,

> basically, because if something is written you have to follow it blindly you stop thinking, you just do things in order like a protocol. Instead, if you had different options and you start to think by yourself, this will improve your personal knowledge, it would make you a better professional and, of course, it means to give you more responsibilities, but there is no improvement without responsibilities.

However, one of the features that most participants shared is that in emergencies they ignore their values and enter a trance state, in which they dehumanised the patient and their care in a number of tasks to maximise efficiency and avoid the patient's death:

> P11: If you have a cardiac arrest, your values are out of the window, everything is task-focus, you need to be very channelled in your thought process, so there is fast, efficient, that's what is needed for that situation.

As shown in these interviews, personal values are the ones mainly used in practice, since institutional and professional values are often applied only if they are compatible with the nurse's personal values:

> P3: I think that we follow the Code [NMC Code], like if you ask me to read anything from it I do not think I could because I think a lot of it is just your general rules, your general morals, isn't it? And ethics and, you know, you treat people with dignity and respect naturally anyway, at least you would hope that you are going to nursing to do that.

> P17: We're not robots that… we should follow that the Code says and we do follow that the Code says [whispering], but if you ask people to question it they will not be able to, would they? We are…we know it's there and we know what's stand for, but we don't…maybe I'm saying the wrong thing here [whispering], but we don't, do we? We're humans, humans who care and that's all we do and that human factor is what makes us individuals and able to take care of people individually.

On the other hand, if some professional or institutional values are frequently used in clinical practice, they are assimilated as part of the nurse's personal values, both inside and outside his clinical role:

> P22: That, that, that is my personal feeling on it, but when we drew the line when is my feeling and when is my professional feeling? And I'm not really sure I can separate the two because my personal beliefs are driven by my professional work, this is all I do, this is all I ever done.

#### 8.2.5.2. Ethical accountability

During nurses' training and practice, the consequences of malpractice and benefits of holistic care are inculcated and learned. This entails that nurses not only weigh the consequences of their actions based on the legal and professional implications they may have for them but also in relation to how the ramifications of their actions may conflict with their values, as shown in the previous section. Therefore, ethical accountability is important not only as the foundation of holistic care but also as protection for the nurse's moral integrity.

The main aspect of ethical accountability obtained during these interviews is its evolution between the junior and the senior nurse and the dissociation of ethical accountability and clinical practice during this process. This begins with the junior nurse, who connects practice with his personal moral looking for a holistic care that satisfies him as a professional. However, the limitations of real practice, which are not usually included in clinical simulations, generate frustration that decreases the nurse's satisfaction with his work:

> P2: I think a lot of the time you do not have the staff; you do not have the equipment, and you have to escalate to whoever is in charge in that area to try and get the help. I do not know…I do not want to go off track but things like staffing and staff, sometimes do you have to just make what you have to and just try to get the job done with the limited staff or the limited facilities.

> P27: So yes, some days like that are unmanageable because we don't have staff, too many patients, but this is not a surprise, we know that is always like this, but what can you do? I do the best as I can, sometimes is not the best for the patient, is not the best for me, definitely.

During this early stage, junior nurses perceive the dehumanisation of the care provided by their senior colleagues and the healthcare institution, but they feel unable to promote change towards a more humanised care:

> P13: So, stop thinking about the bad things, start working and stop… […] If you lose your PIN is not a problem, you still alive, he's not alive anymore.

> P23: I mean, but some people get annoyed with other colleagues when they go "I'm doing my writing, I'm doing my documentation" and they think "I just need a hand". Like, for example, if somebody comes to "can you help me with a slide, sliding this patient up?" and the other nurse is doing some writing and it goes "I'm doing some writing, just give me 5 minutes, or give me 2 minutes" and by the time they have finished writing the nurse that asked for help manage to do it by themselves anyway.

When they gain experience, elements like constant high clinical workload, continued exposure to other people's suffering, unsafe work environment and senior nurses' social influence start to slowly dissociate the nurse`s personal values from his clinical practice, so his values do not change but he ceases to apply them to his practice:

> P4: It will take its toll under a long period of time and that's when more mistakes can happen, drug errors and…you know? […] I think the responsibilities… there is a lot of pressure and I find it that can be very overwhelming.

> P8: To me, personally the risks are emotional because if I go home having made a mistake, everyone makes mistakes in their nursing career, it's having to live with yourself and dealing with the consequences of your actions.

> P10: We need to obey our managers too, so it puts you in a tight corner.

> P28: Sometimes you cannot follow your personal beliefs, there is no time, there is not…it's impossible. Sometimes you may feel sorry for a patient when giving [devastating] news or… to make some decisions that for the patient are hard to accept, but sometimes you have to because…we also have to think about other patients.

> P29: Sometimes it's very difficult to manage that kind of thing, the abuse that we receive from the patients, the demands for things that probably are entitled to, we just can't give it on a timely manner on in the way that they expect. In their eyes, is fully our responsibility, in my eyes is not just my responsibility, it's a generalised department factor that can't be totally managed by me, but is difficult.

This process is accelerated when nurses start coordinating teams, since the managers' pressure and influence based on the departmental objectives justify an immoral practice in specific patients to protect all of them:

> P4: That made me realize that, actually, I think I will be put in that situation [coordinate areas] quite soon and that is an overwhelming feeling as your responsibility grown, but it's just the way it is.

> P15: If I have to do obs and take handover, they will come after me because I didn't meet the 15-minute target, but to meet the 15-minute target I cannot do obs and patients could be more than an hour without any obs. So, yeah, that's quite worrying.

Nonetheless, in some exceptions nurses are able to keep their values intact and defend them against external influences, even if this means frequent conflicts with managers or other professionals that they always lose since their influence and hierarchical rank is lower. This leads to more frustration and stress, which precipitate that ED nurses that follow their ethical accountability tend to move to another department or leave the nursing profession entirely:

> P25: Perhaps disagreement between nursing and medical, so if you're advocating for the child with a deformed arm that is "vascularly" intact, has a pulse and such like; and the orthopaedic doctors would like to come and manipulate that child's arm without anaesthesia, the risk of getting a complaint against you because you seem to be defying somebody specialist, but equally if you're advocating for the child…that your job, that's what you supposed to do.

> P31: My priority is always the patient. I think is hard when we are working at a [high seniority] level because the priority is often shifted by other people

> towards the Trust as a whole, but mine we'll always be that patient and keeping as many people informed around that patient as to what's going to happen to make their expectations realistic.

The result of this process is that a large percentage of senior nurses continue to maintain appropriate values for clinical practice, but since they are dissociated for their practice they do not feel accountable if they violate those values. This precipitates decentralisation and dissipation of ethical accountability, since nurses blame the institution and its hierarchical apex for hampering the quality of the care that they provide through the orders that they must follow:

> P5: There are other situations that are out of your control but it isn't your fault.
>
> P15: If I have to challenge a doctor "I've not done that before, are you sure about doing that?", if the decision is made by someone higher rank than me I will make a note in the patient's notes saying that I suggested that and the nurse above me when to that…to cover me.
>
> P22: That's a very tricky one, I think. I think is something that we struggle with, not only nurses but the healthcare profession as a whole. I think there are times when your own beliefs stand in the way of the care that should be delivered or the care that you've being told to deliver, anyway.

This blind obedience is more common in junior nurses, which entails that they violate their values consciously but they do not feel accountable for it because they followed orders. This fact closes the ethical accountability decentralisation and dissipation cycle, which goes from junior to senior nurses, from senior nurses to managers and the hierarchical apex and from the latter dissipates throughout the whole healthcare institution in the form of objectives unfulfilled, internal incidents or patient complaints.

#### 8.2.5.3. Ethical theories

In the semi-structured interviews, two main ethical theories were found in relation to the values that various people or entities represented: a Kantian interpretation of the patient as an individual, who is an end in itself and not as the means through which the NHS is

maintained, and a utilitarian perception of the population as a whole, which allows healthcare resources to be distributed to more people even if these people lose their individuality in the process.

The Kantian theory that the participants mentioned comes partly from their university education and their deontological basis, which are reflected in institutional documents like the *NMC Code* or the *NHS Constitution* to specify the rights of each individual as a patient. Also, that fact that institutional and personal values related to holistic care match the Kantian theory that was indicated, promoting the patient's comprehension as a complex being by himself:

> P3: You treat people with dignity and respect naturally anyway, at least you would hope that you are going to nursing to do that. I mean, I think is one of the UHL values as well but one of my morals with nursing is treat people how I want to be treated and how my family want to be treated.
>
> P13: (IE) – Do you remember the 14 Henderson needs?
>
> (IR) – Yes, the Henderson needs [interrupted]
>
> (IE) – I think we have a responsibility to cover all those needs, from the first one to the last one, and know checking all those needs is automatic for me.

On the other hand, the participants indirectly indicated that the main representation of the utilitarian theory during their practice was UHL itself through departmental objectives and their managers, who were more concerned with serving the majority of potential patients than with the quality of the service they offered:

> P5: Something that´s typical at the beginning, that here is followed to the letter: the 4-hour objective. So, when you try to give all the care that your patient needs and try to keep him comfortable, but "this patient needs to go now, forget about anything that you're doing and try to do it" and that are situations where you're doing something and the coordinator ask you in a hurry, like saying "that should be more urgent" and you say "I cannot multiply…uff…" but they say "no, no, no he's going to breach".

> P10: For instance, if a patient is breaching and you get all of these managers on your back to get them [the patients] out of the department, you feel they are not safe.

This fact shows how the acts attributed to UHL do meet neither the institutional values it promotes and defends nor the values protected by the NHS in its constitution. This promotes the dehumanisation of care and focuses patient care around departmental objectives as if each patient was considered as a disease to be cured inside a recipient that does not matter:

> P31: So, what I think that happened in Stafford, in their ED, which the Francis report came afterwards, they had a lot of managerial decisions made like coding patients like they didn't look like they breach or coding patients out when they didn't leave the department.

The contradiction between institutional values and the healthcare institution's actions is due to the lack of ethical accountability by the healthcare institution, since its members are the ones who share a collective ethical accountability. However, when large numbers of patients are managed they are deprived of their individuality, so members of the hierarchical apex do not feel ethically accountable for the consequences of their decisions.

This would not be such a problem if the nurse coordinators conceived the patient as a holistic being and could defend him against institutional decisions, but the hierarchical structure and the managers' influence weakens the protection that nurse coordinators can offer to their patients:

> P18: As a nurse in charge I need I have to have an overview of the amount of patients of each area and what the waits are, any issues with anything in the area, any security issues, any staffing issues.

> P23: I think [a nursing responsibility/nursing care] is more managing flow of patients, making sure that they have everything done that needs be, so they can…go upstairs to a bed and keep the flow moving in the department sort of speak.

This difference in ethical theories force patients to fight for their rights that in theory are protected by the *NHS Constitution*, which weakens the nurse-patient relationship and creates an unfair distribution of healthcare, in which patients who complain receive better care than those who remain silent:

> P29: Sometimes it's very difficult to manage that kind of thing, the abuse that we receive from the patients, the demands for things that probably are entitled to, we just can't give it on a timely manner on in the way that they expect. In their eyes, is fully our responsibility, in my eyes is not just my responsibility, is a generalized department factor that can't be totally managed by me, but is difficult.

#### 8.2.5.4. Bioethics principles

Bioethical principles, as they were defined by Beauchamp and Childress, are present in the participants' clinical practice, even though some were not aware of it. Therefore, references to nonmaleficence, beneficence, autonomy and justice were frequent during the interviews.

Regarding nonmaleficence, the participants understood that to not harm the patient intentionally is one of the foundations of their practice:

> P9: Do the best as I can, do not harm the patient in any way and help [the patient] to get the best care.

> P22: I think one of our responsibilities is making sure that we deliver safe care. Firstly, we shouldn't harm our patients and I think that can be looked at in a couple of respects. Obviously, we shouldn't harm them and we shouldn't give anything that's going to be detrimental for their health.

Besides knowing the concept of nonmaleficence and applying it in their clinical practice, some participants considered their practice's limits and when it may be considered excessive, causing unnecessary suffering to the patient:

> P22: In an ordinary well patient, that's very easy, I think that perhaps there are some cases when doing no harm is actually looking when interventions that we do are actually appropriate. I think there are definitely occasions when we overtreat, and I think that's quite difficult as a nurse like you're really advocating for your patient if you're doing things that you don't feel that there are in their genuine best interests. […] Particularly, one of the things was with an end of life care [patient] and the relatives were very very keen for us to give antibiotics, cannulation, you know, very invasive procedures for someone who was evidently dying. This was obvious to anyone looking after them and that was very very difficult because someone can argue that is my belief system that this patient should be allowed to die.

> P29: We should do it if you based yourself on the "do not harm, put the patient interest first"; and that's a very grey area to stand on, it's so difficult.

If we refer to beneficence, the participants also considered the patient's benefit an integral part of their clinical practice:

> P29: So, my main priority always is patient care and the patient's interests and, obviously, doing the best practice I can within my knowledge. Those are my main concerns when I work.

> P34: Also, working with the team, respect the patient and the team and work together in the best interest of the patient.

Within the application of beneficence, the participants mentioned how it should be prioritised in favour of policies and departmental objectives in order to protect the patient from managers' decisions based on other priorities:

> P1: I do feel that people are quite mindful of it and that is a shame because sometimes patients will benefit from clinical staff to make decisions that are in their best interest rather than following what is standardized.

> P12: That being said, there will be situations where you have to not follow the policy thinking about the patient's best interests. So, the patients' best interests always are the overwriting factor. I know I will not follow the policy, but if I can

justify that I am doing that because is in the patient's best interests and then I'm confident in doing so.

P23: (IR) – So, my responsibility is making sure that patient understands what's happening to them and they're comfortable with it, you know, they're not in pain and they're looked after, sort of speak, as well.

(IR) – Ok, only for me to understand the concept, do you consider that you consider your responsibility being the advocate for the patient?

(IE) – Basically.

Regarding justice, the participants focused on the fair distribution of resources, especially in time distribution:

P3: In an ideal world I think it would be lovely to have more staff because you can give your patients more of your time and make them feel more valued. Like, the other day I was lying at bed at 11 o'clock at night and I was thinking "Oh my god, I forgot to give this lady a cup of tea" because you try to do too much at once. I know that is silly little thing but something we are pushed with time so we only can do like the basics.

P6: Making sure that I am able to identify all the patient's needs, so I know that care they need, obviously depending on the area. If I am in Resus or Majors I'll identify my patients and prioritize according to the time available, managing the time accordingly.

P23: When you start not worry about things that you should worry about, having the time to sit down and hold the lady with dementia's hand and reassure her that's ok or, you know, rather than just look after everyone else, if that makes any sense at all.

Furthermore, senior nurses discussed the need to allocate resources fairly across the department in high clinical workload situations or under an acute lack of resources:

P18: I think when I, for example, I had it where there was 175 patients in the department. Again, as long as follow the procedures, so I would go out and say

"look, we've got this waiting time, you're allowed to go home". There are some things that you can do to ease the burden a bit, if you like.

Finally, autonomy was conceived by participants from various angles. On the one hand, several of them mentioned the overuse of emergency services due to frequent patient self-care neglect:

P32: I probably try to improve the way that we treat self-inflicted sort of alcohol, drugs, that sort of stuff…pathway on arrival. Have greater control of… they put themselves into that state, that means they don't need to be in ED, but in another…sort of…facility, like a drunk tank or something. By then, us taking our time with someone that we should be looking after, someone who's actually ill unless they've got injuries or illnesses that could impact them. If there's just generally intoxicated, it's nothing wrong, ED it's not the place. [elongated pause].

On the other hand, other participants emphasised the healthcare system's predisposition to hospitalise dependent patients even if it is not beneficial for them:

P31: So, if Ms Jones again, she keeps coming up, if nobody checks that she drank her cup of tea and she don't drink her cup of tea for a week, she is going to get dehydrated and she will have to come into hospital; when actually she don't want to come back to hospital.[…] If I was a GP and it was a Friday afternoon and I thought "oh, Ms Jones is unwell in her nursing home, I just going to go and see her and make a plan for the weekend" because often the problem is that out-of-hours services don't know the patient and is it was our GMC number we probably send the patients as well because they haven't got plans in place for, you know, when a 98-year-old develops a chest infection. That's a natural progression of life and being in ED at the end of your life is not good, is not often where people want to be.

Another perspective described during the interviews was the limited nursing practice autonomy in relation to their competencies, which affects the quality of the care provided and the responsibilities they can take:

P25: I think, even if you did it form a bottom-up approach, it will be more viable than the approach that we've seen to have at the minute, which is typically top-

down in regards to courses. […] Then, if a child came and needed cannulating, the likelihood is that would be someone on shift that could do it and assess them so we promote autonomy and increase their skill set more quickly.

### 8.3. Semi-structured interviews as a data collection technique

Considering that nurses' perception of their own accountability is necessary to understand it holistically, the perspective of different nurses should be compared to gather faithful data to study this phenomenon.

The technique used to obtain nursing accountability information from different perspectives was semi-structured interviews, which allowed nurses to describe their experiences related to their accountability without the constraints or pressures that are linked to a public conversation. Through this technique we obtained different testimonies that represent nursing accountability in clinical practice through experiences that the researcher may not have perceived or lived.

During the research project, it was also planned to conduct focus groups to supplement the information from semi-structured interviews and encourage debate among nurses, but 94.1% of the candidates refused to participate in a focus group. This general rejection of the focus groups is mainly due to their consideration of clinical responsibility as an issue too personal to be discussed in a group, since they would feel embarrassed if they were forced to do so. Several of them argued that decisions about their nursing accountability could be prejudiced by their colleagues and that such prejudice could affect them during their usual practice, so no participants were recruited for focus groups after the second month of recruitment because the taboo around nursing accountability would have biased the data from focus groups, variable that was not raised in the research project.

Nonetheless, after their interview several participants volunteered to participate in a focus group, even after explaining the possible consequences that might have for their clinical practice. This would have facilitated the realisation of a focus group if it were not for the fact that it was impossible to find a day that everyone was available in 3 months, which was the result of random shift allocation and the healthcare institution' refusal to offer participants time off to attend a focus group.

Semi-structured interviews extracted a lot of varied and relevant information for this thesis, so the focus groups neither were necessary to find key data nor affected the

quality of the results, even though they would be able to offer a constructive debate related to nursing accountability.

The decision to establish the final sample size as 34 participants is based on several reasons:

- The main reason to set the sample size at 34 was the fact that data saturation in all the semi-structured questions and all the study factors was reached with 26 interviews, even though it was continued until 34 to confirm that saturation with more data. Therefore, following the definition of Fusch and Ness (502), from the twenty-seventh interview there was enough information to replicate the study, no new information was obtained and additional coding was not necessary.

  This means that increasing the sample size would have not increased the data diversity or its validity; it only would have been an unproductive use of additional resources.

- The 100% of possible participants who met the inclusion criteria and did not meet the exclusion criteria were informed, but of the 128 possible candidates only 34 agreed to participate, mainly due to lack of interest, time or confidence in the researcher.

- Participants' recruitment was limited by restrictions set by the various evaluation committees to avoid coercion during recruitment. To avoid violating those restrictions, the researcher had to be very careful when announcing his research to not coerce anyone to participate, depending mainly on the transmission between different nurses to recruit more participants. Moreover, to avoid unintentionally pressuring candidates who volunteered to participate, those candidates had to contact the researcher to plan the interview's place and time, unless the candidates would specifically ask the researcher to organize it.

  Due to this, recruitment was a process that required a high level of caution, limiting any researcher's possible effect in an indecisive candidate.

Another aspect that deserves to be mentioned is what could have been the possible effect of the ED building's change in the semi-structured interviews. The continuing

evolution of EDs and the derived administrative problems of conducting research in an English hospital linked to Spanish doctoral training obstructed the coordination of the three data gathering techniques in the same period of time, which delayed the execution of the semi-structured interviews until May 2017, when the change to the new ED building was done.

Although the change to a new department led to some incidents, as explained in previous sections, the patient care process and the ethical and legal issues related to patient care in the new ED building are the same as in the old one, so there were no significant changes in nursing practice that could fundamentally affect their accountability in the period in which the interviews were completed (from May to August 2017).

Furthermore, in order to meet the inclusion criteria candidates must have worked in the old department. Therefore, even if the change of department could be considered a significant change in practice, candidates have more experience in the old ED building than in the new one, which predisposes them to describe their clinical practice based on the old department.

We also need to mention the researcher's possible influence on the participants' responses, being it positive or negative. In order to evaluate this influence is necessary to examine the researcher's influence within the nursing team and the measures taken to avoid influencing the candidates.

The researcher was promoted to deputy charge nurse at the end of January 2017, which entails that such change should only be taken into account in relation to the semi-structured interviews. In theory, this promotion implies a position of power in relation to the registered nurses, but in order to minimise its effect various measures were taken:

- Non-coercive advertisements
- Passive recruitment to avoid recruiting candidates using social pressure
- Informal interviews
- Avoid interviewing nurses with less than 6 months of experience, who can be more influenceable

- Focus the researcher's non-clinical projects in his role as deputy charge nurse in nurses who do not meet the inclusion criteria

As part of the nursing team since 2014, the researcher had a good reputation within that team. This led participants to trust the researcher more, opening more in the interview, being honest and revealing more personal information, which allowed the gathering of complex and high-quality information. The positive effect of the researcher's reputation is very difficult to control since it depends on other nurses' perception and how their perception is shared by the nursing team.

Finally, we have to clarify that the interview fragments quoted are anonymised to protect the participant's confidentiality and are transcribed literally (including spelling and grammar mistakes) to extract the context of their message from how they talked and to avoid any unnecessary data modification.

# Chapter IX:

# Results

The results of this thesis should not be comprehended outside the analysis process, since this will damage its reliability and validity preventing that the same analysis could be replicated in future studies. Therefore, coding and triangulation will be presented as part of this chapter before the final results.

The data analysis process has been partially structured following the steps established by Altheide for ECA, but those also rely heavily on the qualitative content analysis (QCA) process. Therefore, each stage's progress will be explained to clarify any intersection between the two methods and facilitate this research's replicability.

To analyse data diversity in a consistent manner that suits the research questions, various sources of methodological information were consulted, being the main ones Margrit Schreier's *Qualitative Content Analysis in Practice* (503), Johnny Saldana's *The coding manual for qualitative researchers* (504), David Altheide's *Qualitative Media Analysis* (505) and Klaus Krippendorff's *Content analysis: An Introduction to its methodology* (506).

### 9.1. Raw data preparation and transcript sampling

In order to analyse data correctly, it must be transcribed and classified to facilitate data coding and triangulation. During this process, the field notes taken during clinical practice, the reflections on practice, the result of the ethical analysis of clinical policies, the policies analysed and the semi-structured interviews were transcribed, anonymising sensitive data. Transcripts were literal, including misspellings and grammar mistakes, if they were any.

After completion of the transcription process, the resulting transcripts were transferred to the software Nvivo® 11 (version 11.4.1.1064) for storage and classification according to their physical origin distinction: reflections on clinical practice, clinical policies with their ethical analysis and semi-structured interviews. However, no automated computerised method was used to code or triangulate data automatically.

Transcript sampling was unnecessary since all of them were analysed. This was due to the sample diversity and the complexity of the interactions between the different subcategories, even though data was saturated in the three sources during their individual compilation. In the beginning, a stratified transcript sampling with a limiting factor was conceived, but during the transcription process several limiting factors were identified, so using one of them to draw a sample from all the transcripts would impair the analysis of other factors.

Before performing data analysis, the coder attended several training courses in qualitative methodology and its methods, performed a literature search around the ECA method and the coding and triangulation processes and practised his skills codifying various transcripts not connected to this research. In addition, the coder was the same person that collected the data and knows the context in which the transcripts are located. In this way, it is ensured that the coder’s skills and knowledge are not a limiting factor for data analysis.

### 9.2. Coding

The coding process in an ECA, like in a QCA, should start by creating a coding frame. This allows focusing the data analysis on the research questions and guides coding based on a structure, even though in ECA this structure can be changed when new data is obtained.

Categories, also called dimensions by Schreier, are the thematic centre of coding, since they symbolise the possible answers to the research question. The definition of categories and their subsequent subcategories is included in the final results, but without these results it can be argued that the inclusion of personal factors, professional factors and decision-making was necessary since they are an intrinsic part of the relation between clinical accountability's ethical and legal factors and their application in nursing care.

Once categories were established, subcategories were created inductively and deductively using both transcripts' information and knowledge of the context and the environment in which the data is situated, using the techniques of descriptive coding and subcoding described by Saldaña, thus structuring categories without deleting data through excessive abstraction, which could limit data validity and reliability before triangulation.

This facilitated a subcategories' hierarchy that represents the relation between the factors that the research question aims to discover. However, the coding frame of each data source (policies, interviews and clinical reflections) was created separately, since they would be coded individually before being combined during triangulation.

Coding frames for each data source had a distribution of different subcategories, being the interviews' frame the most complex and the policies' frame the simplest. However, they all shared several subcategories. Once the coding frames for the transcripts of the three data sources were created, such transcripts were divided into units of coding based on a thematic criterion, which means that the division between a unit of code and another is delimited by a change of topic. This transcripts' division was performed before executing the pilot coding phase, ensuring consistent units of coding.

Before the coding frame could be used to categorise units of coding, it must be tested during the pilot phase, thus preventing that errors in the coding frame are found after coding all transcripts, which would require starting coding from the beginning with the new version of the coding frame.

For the pilot phase, 25% of transcripts from each data source were selected randomly (enumerating the transcripts and selecting them with a random number generator). The amount and complexity of the selected transcripts allowed the use of the three coding frames in their entirety.

After 13 days, the pilot phase's transcripts were coded using the same coding frames to check their coherence. Minor adjustments were applied, mainly to some subcategories' definitions, but the coding frame structure and units of coding assigned to each category and subcategories were the same, so another pilot phase was not necessary.

To evaluate the coding frames, the requirements for coding frames described by Schreier were utilised, which were evaluated and accomplished to an adequate degree in all the coding frames that were tested in the coding pilot phase. These requirements are:

- Unidimensionality: Each category represents only one aspect of the material.
- Mutual exclusiveness: A unit of coding represents one subcategory only.
- Exhaustiveness: Every unit of coding is assigned to at least one subcategory.
- Saturation: All subcategories contain at least one unit of coding.
- Reliability: The coding frames were applied twice to the same transcripts by the same person two weeks apart, allowing a comparison across two points in time with a coefficient of agreement amongst all subcategories of 96.5% (clinical policies), 96.7% (reflections on clinical practice) and 93.4% (semi-structured interviews) respectively. The coefficient of agreement was high enough to consider that the coding frames' internal reliability is adequate and therefore they are consistent.
- Validity:
    - Face validity: In none of the coding frames there were abstract categories that ignored vital information, residual categories with a high number of units of coding or subcategories that contain a high percentage of units of coding compared to other subcategories.

- Content validity: Assuming that the researchers are experts in their field, content validity is based on reliability, which is in an appropriate range, as mentioned above.

Once the coding frames were checked in the pilot phase, they were used to code the transcripts from the corresponding data sources. Units of coding were established before, so the same ones were used for the main coding, including those that were part of the pilot phase.

Eleven days after the first main codification of all units of coding, a second main coding phase was performed to check the results of both and compare their coherence. The definition of several subcategories had to be adjusted, merging some dealing with similar themes and modifying others that partially overlapped their units of coding. However, the coding frame structure remained mostly intact and the units of coding were classified in the same categories and subcategories both in the first and second main coding phases, the only difference between them was the subcategories that had to be modified.

To evaluate the coding quality we used the coding requirements described by Schreier, as we did in the pilot phase. The unidimensionality, mutual exclusiveness, exhaustiveness, saturation, face validity, content validity and reliability requirements were met; the latter was based on the transcripts coefficient of agreement of the three data sources (clinical policies 100%, reflections on clinical practice 93.4% and semi-structured interviews 97.7%).

It can be perceived that the coefficient of agreement between the first and second main coding phases of the reflections on clinical practice transcripts is lower than in the other two data sources, even though it is at acceptable levels, which is mainly due to how transcripts are structured. While each interview and each policy follow a relatively similar structure, so their coding frames were easier to adapt to all their corresponding units of coding, various parts of the reflections on clinical practice transcript mention different issues in different fragments, being necessary to expand, merge or modify some subcategories to encompass all units of coding that were not included in the pilot phase.

After this process, three coding frames with their categories and subcategories were obtained, which facilitated that data was triangulated correctly. However, coding was relatively simple with a low level of abstraction, allowing all relevant data to be available during the triangulation process.

The decision to perform two stages of coding, an individual one for each data source and another united one for triangulation, resulted in more time invested in data analysis, since the raw data obtained through the different data gathering techniques was so apparently disparate that coding without triangulation would have been much harder and more prone to error.

The three data collection techniques extracted information from the same context from different points of view, so it was predicted that they should be related, but the relation was not apparent in the raw data given the disparity between the three techniques. This happens because each data source has its structure, semantics and jargon that must be taken into account for correct coding.

Therefore, it was only after the coding phase when the resulting categories and subcategories allowed the triangulation of the three data sources, since their abstraction allowed that they could be interrelated to explain the study phenomenon.

### 9.3. Triangulation

Triangulation is a technique that allows the analysis of a phenomenon from different perspectives in order to increase the available knowledge about it, facilitating a deeper analysis. In this study, data triangulation was used, which uses different data sources to build a more holistic analysis, since it includes different forms in which the phenomenon can manifest and be measured.

Triangulation can also be used to increase the validity of a study comparing the similarities between different data sources, but this is not the main purpose of triangulation in this study, since finding patterns between different data sources is intended to expand the analysis' scope and describe how some factors are linked to others.

The fact that data from different sources have been classified into codes using the same techniques allows the triangulation of theoretically disparate sources. Furthermore, the three data sources share a context, which can link them all.

While coding was focused on classifying data without abstracting a general meaning, triangulation is intended to find relations and coincidences amongst data from different sources, trying to abstract common consistent results within the context in which data was collected.

To analyse data with their context reflexively, as is characteristic in ECA, information from individual coding has to be used to abstract the factors linked to ethical and legal accountability and their relations.

Triangulation began with the creation of a triangulation frame that included all transcripts from all data sources within one frame. For its creation, a procedure similar to individual main coding was followed but using the pattern coding and simultaneous coding techniques described by Saldana, facilitating linking information from various data sources and finding relation patterns between the different categories and subcategories. This allowed finding relations between categories and subcategories that share units of coding and abstracting a large number of categories in fewer categories that are more inclusive.

Since the interviews were delayed compared to other data sources due to administrative problems, we decided to create a triangulation frame with the coded transcripts of ethical policy analysis and reflections on clinical practice, which was applied to 25% of the ethical policy analysis and reflections on clinical practice transcripts, which were chosen randomly.

After 34 days, when the coding of the interviews' transcriptions was completed, the triangulation frame was applied to 25% of the transcripts from all data sources, which were chosen randomly. However, since the interviews were not taken into account in the creation of the first triangulation frame, it could not be used correctly with the full set of transcripts, requiring major structural changes and giving a coefficient of agreement of 52.6%. Therefore, it was decided to eliminate that triangulation frame and create a new one taking into account all the coded transcripts. This fact stressed the need to triangulate all data sources to represent the study phenomenon in the most reliable way possible.

The new triangulation frame was tested with another 25% of randomly selected transcripts. After 10 days, it was tested again with the same transcripts, meeting the requirements of unidimensionality, exhaustiveness, saturation, face validity, content validity and reliability (coefficient of agreement 100%). However, the requirement for mutual exclusiveness was not fulfilled, since in order to analyse the relations between the different categories and subcategories simultaneous coding was used, which was applied using more than one subcategory per unit of coding to find patterns among different clinical accountability factors.

After the successful validation of the triangulation frame in its pilot phase, that frame was used in the triangulation of all units of coding from all transcripts. Nine days later, a second application of the triangulation frame was carried out, which only showed the need to amend the definition of two subcategories to add items not previously covered. Therefore, the requirements of unidimensionality, exhaustiveness, saturation, face validity, content validity and reliability (coefficient of agreement 96.7%) were verified.

Due to the use of simultaneous coding, the mutual exclusiveness requirement was not met, like in the pilot phase. However, this does not affect triangulation's reliability or validity, since the breach of mutual exclusiveness is the result of the search for patterns

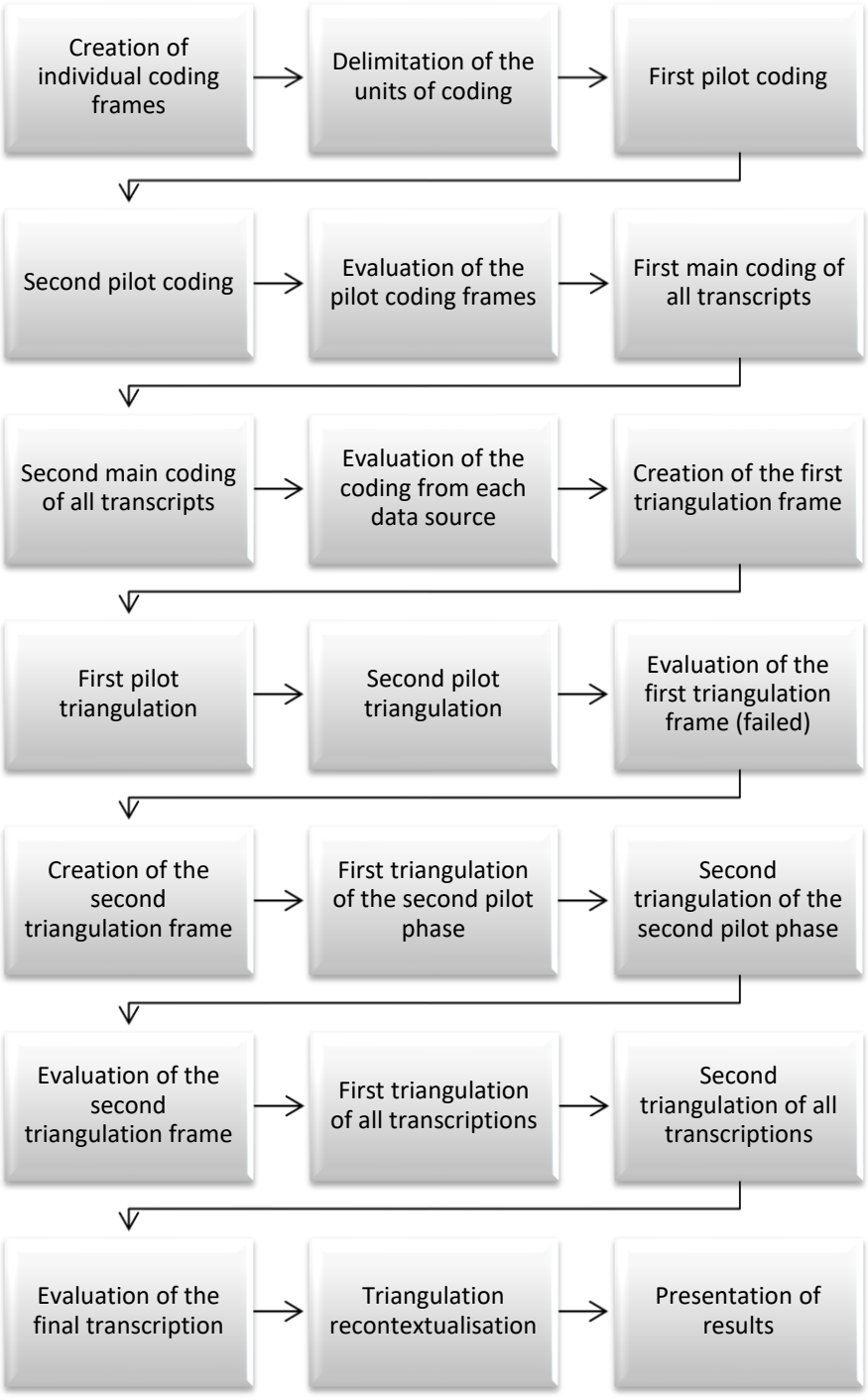
among different subcategories. Furthermore, the possibility that the failure of meeting mutual exclusiveness is the result of the incapability to choose only one subcategory per unit of coding is discarded because in the coding phase that requirement was verified with the same units of coding.

After the main codification, there were three different coding frames, one for each data gathering technique, so triangulation had to transform three coding frames in a uniformed triangulation frame that represented both the information from all data sources and the study phenomenon. To that end, three coding frames with different assigned units of coding representing similar categories in different coding frames had to be superimposed, which ensures that all coding frames are represented during triangulation and allows pattern analysis through simultaneous coding of several subcategories in the same unit of coding, even if mutual exclusiveness had to be sacrificed during triangulation.

In order to present the final results in a cohesive manner with the context in which they were located, a triangulation recontextualisation was done, in which the relations amongst the subcategories were connected with relevant secondary information that enabled a clear explanation of the causes and consequences of those relations.

Finally, a diagram of the coding and triangulation processes is presented to summarise it and facilitate its reproduction in future studies:

**Diagram 4: Coding and triangulation process**




Self-created content on the 7th of December 2017

## 9.4. Final results

Clinical accountability is a very complex phenomenon, so to allow the analysis of the factors that interact within it and facilitate their understanding we chose to present the clinical nursing accountability cycle and the factors connecting the two themes within it separately.

It has to be indicated that both processes are part of the same phenomenon during decision-making and the accountability linked to the consequences of those decisions, but their extension difficult their understanding in the same model. This is because the clinical nursing accountability cycle explains punctual decision-making and its consequences, while the relations amongst clinical nursing accountability factors reveal the interactions of different aspects of healthcare provision and how these affect nursing accountability, the health institution's accountability and the decision itself at the moment when the decision is made. However, once both models are considered they must be rationalised as a whole, since both discuss nursing accountability, even though the former analyses the consequences of a particular decision and the latter explores the factors that impact on the decision-making process and its derived consequences.

### 9.4.1. Clinical nursing accountability cycle

Every nurse suitable for clinical practice should be able to make decisions and be accountable for them, including omissions that he decides to commit. However, the nurse is not the only entity that participates in the decision-making process concerning his practice. Either directly or indirectly, the healthcare institution which employs the nurse influences him as much as himself in the decisions he makes and their consequences.

To understand how accountability flows between both entities, which are the main themes in the theory of clinical accountability that will be presented, they must be defined in the clinical nursing accountability cycle that unites them.

- Nurse: The nurse is conceived as a holistic being, who can be analysed from the different roles that define his clinical practice, even though these roles interact together forming a single entity.

    - Nurse as a legal entity (legal factor): As a resident of a country, the nurse should be governed by that country's laws. In addition, there is specific legislation that applies to nurses based on the representative knowledge and values of the nursing profession, being a classic example the Duty of Care extension applicable to healthcare professionals.

    - Nurse as a care agent (professional factor): As part of a profession which purpose is caring, the nurse must have specific knowledge and skills that enable him to meet the needs of patients under his care, which are obtained during his training and clinical experience.

    - Nurse as a member of the community (ethical factor): Anyone who lives in a community for a period of time acquires part of its representing values, independently of them being considered positive or negative. Therefore, as any human being, the nurse tends to acquire behaviours and values from his immediate surroundings, including the hospital environment. Also, as a member of the nursing community, there are values and behaviours promoted by various associations (NMC, RCN, etc.) that specifically target the nursing profession and are reinforced during clinical practice.

    - Nurse as an individual (personal factor): Like every person, nurses have their individual values, goals and desires, which can conflict with their Professional Ethics as nurses when they make a decision in a concrete case in clinical practice. In these situations, that personal factor is which weighs the hierarchy of values (which are those of Professional Ethics) regarding the case circumstances. Possible conflicts between values or principles and between them and legal issues could arise, being the personal factor the determinant of the decisions taken by the nurse and the accountability derived from them.

- Healthcare institution: Although when we mention a healthcare institution can be any healthcare provider, for this research the healthcare institution was UHL, an NHS Trust. Being an organisation formed of several individuals instead of one, healthcare institutions are governed by other legal, professional, ethical and personal factors.

    - Healthcare institution as a legal entity (legal factor): In addition to the legislation applicable to any member of the healthcare institution, there is legislation governing the activity of public healthcare institutions. This entails a higher level of scrutiny of their activities when dealing with vulnerable people.

      Moreover, as an employer it is accountable for the safety and welfare of its employees and the consequences of their actions if these have not been controlled or planned by the healthcare institution.

      On the other hand, the healthcare institution is also accountable for the safety and welfare of its clients, but this is a factor delegated on its employees, so the healthcare institution is not directly accountable for its clients if it allows its employees to work in the correct conditions to protect them.

    - Healthcare institution as a healthcare provider (professional factor): The public healthcare institution's main function is the provision of healthcare to clients that need it. For it, it has different resources that are managed to offer the best service based on pre-set targets.

    - Healthcare institution as a public institution (ethical factor): The NHS is a reflection of British society values, so it is expected that a public healthcare institution meets the values preached by documents such as the *NHS Constitution* (271).

      On the other hand, each NHS Trust publicises specific values that should be reflected in its decisions as an organisation and the decisions of its employees as part of the institution.

- Healthcare institution as a group of individuals (personal factor): The inclusion of a directive board in the hierarchical apex rather than one person limits the personal factor, since it encompasses the consensus of a group of people, not the values and desires of an individual. However, the influence among members of the directive board may end up leading its decisions in favour of the intentions of a particular individual or group of individuals.

The themes' definition will be expanded later in the analysis of relations between the factors from these themes. However, the definition presented allows the contextualisation of the issues within the clinical nursing accountability cycle without introducing extra information that is not relevant in this section of the results, avoiding complicating this section excessively.

The clinical nursing accountability cycle starts with a problem relative to a patient, whose solution could be based on one of several possible options. In order to decide which option is the right one, both the nurse and the healthcare institution participant in the decision-making process directly and/or indirectly in a different way:

- Nurse: The nurse as a healthcare professional is able to make decisions and influence the decisions of others. For that, he uses two main methods to choose the right option based on his own reasoning.

    - Clinical intuition: Also known as hunches, clinical intuition is an essential element in clinical decision-making, especially for senior nurses. This was rated as essential by a large percentage of the participants in the semi-structured interviews.

Clinical intuition in nursing practice was described by classics like *From novice to expert* (497), where Benner links clinical intuition with progression to expert practice, and in more modern articles, as those published by Gobet and Chassy (507) or Payne (508), which describe alternative models to define clinical intuition in Nursing. Also, clinical intuition's usefulness during practice promotes its applicability in university nursing education, as argued by Robert, Tilley and Petersen (509).

Clinical intuition is an unconscious process in which previous experiences allow establishing patterns that identify different situations. This allows the nurse to make a

decision based on what he feels is right, but it is really based on similar previous situations, the decisions he made and if they were successful or not. Moreover, the process of unconscious rationalisation characteristic of clinical intuition enables faster decision-making, ideal in emergency situations.

Nonetheless, clinical intuition works based on the nurse's experience, so it cannot be used by junior nurses correctly. On the other hand, being based on patterns of past experiences, it only works in nurses who practised in a specific field for a long period of time, during which they unconsciously analysed the decisions they made and their consequences.

- Subjective beneficent knowledge: The theoretical and practical knowledge that a nurse obtains during his career is immense, even though its use is very subjective. To explain the use of the nurse's knowledge in decision-making, not only the knowledge that he possesses per se must be taken into account but also how such knowledge is selected to be rationalised and implemented.

The concept of subjective beneficent knowledge explains how nurses apply their knowledge to clinical practice consciously. To do so, the nurse considers both his theoretical training and his professional experience to choose the pieces of information that he thinks are relevant and discern what decision is most beneficial for the patient, even if he does not always consider the patient's opinion. This phenomenon was observed both in clinical practice and in the semi-structured interviews.

The nurse's personal values can interfere with what he considers beneficial for the patient and can lead to paternalistic actions or conflicts of interest. However, expert nurses are able to maintain the patient's benefit as a priority using their theoretical and practical knowledge against different entities that have other interests, allowing the nurse to defend patients from different threats that cannot fight for themselves due to their temporal vulnerability.

Although theoretical and practical knowledge is obtained mainly in the first few years as a nurse, rational use of such knowledge to benefit the patient is a continuous process that requires familiarity with the healthcare system in which the nurse practises and with

all the consequences that the decision chosen would entail, including the theoretically unexpected or irrational ones.

- Healthcare institution: Since it is unable to care for its clients itself, the healthcare institution delegates those decisions on its employees. However, to ensure that such decisions are taken following the healthcare institution's vision, it usually intervenes in two ways:

    - Policies: The guidelines that the healthcare institution wants to establish in its employees are reflected in the policies it produces. Being a mixture of evidence-based clinical guidelines, legal protection, institutional values and personal decisions, policies are the essential tool that allows the healthcare institution to communicate how it wants all aspects of care to be performed.

Policies can standardise care provision and maintain adequate standards of care. They also have the potential to reduce human error and be a guide for junior professionals. However, their use as clinical support is usually secondary, since they are prioritised as legal documents which purpose is to shift the accountability for any incident that violates the healthcare institution's guidelines to the employee.

The policies' scope is not only limited to the provision of care, since the healthcare institution can also mould the nurses' behaviour to be subservient to clients, imposing compliance with the healthcare institution's prefixed etiquette. This etiquette is based on client satisfaction and the status that the healthcare institution wants to project through its employees, but it also affects decision-making during care provision, since nurses must apply policies literally even if they are not based on evidence or they are not beneficial for the client.

On the other hand, the policies' ethical analysis revealed several consistent failures in most policies, especially on issues like informed consent and confidentiality, which are key elements in care provision. Moreover, the lack of cohesion between different policies was evident. These results reveal that policies do not always correspond to the most appropriate decision in all the situations that can be applied to, which may encourage nurses to make the wrong decision based on what the healthcare institution tells them that it is the right choice.

An extreme situation that policies facilitate, especially when they are not linked to each other in an appropriate manner, is the moral dilemma that constitutes the contradiction between a policy and a legal or professional regulation. This entails that the nurse has to choose between breaking an order from his employer or a guideline from his professional code of conduct, being the result of either of them a sanction for the nurse.

Even if the healthcare institution hypothetically had a perfectly connected policy network, these policies must be interpreted and applied by nurses with different personal backgrounds. This entails that even though policies are built to avoid second interpretations, the nurse can choose to apply the part which he believes is relevant to the situation he is managing.

- Resources: Providing healthcare without consistent material and human resources is a theoretically impossible task. Therefore, the healthcare institution affects decision-making indirectly based on resource distribution.

According to the reflections on clinical practice and the semi-structured interviews, the most common way in which resources affect decision-making is in relation to human resources, either on the number of professionals or their knowledge and skills. This happens because the nurse divides his time among his patients based on the clinical workload and the needs of each patient, so if there are not enough human resources or most of them do not have the necessary knowledge and skills the nurse will make different decisions regarding the care he provides and will reduce its quality to be able to offer basic care for all his patients.

Similarly, the decisions made by nurses are not only based on the resources that the healthcare institution can provide by itself but also on the resources from accessible external services. The most common examples are referring patients to their GPs, receiving support from mental health teams in the management and treatment of patients with psychiatric disorders or obtaining support from pre-hospital teams when patients have to wait in ambulances.

On the other hand, material resources also affect the nursing decision-making process, especially adequate space distribution for patient care and provision of equipment and single-use material.

When both the nurse and the healthcare institution have provided the relevant information to make a decision, it will have positive and negative consequences for both parties, which will modify the factors that apply to their decision-making process, improving the solution of future problems. For example, if a decision resulted in negative consequences for the patient that affected both the nurse and the healthcare institution because the nurse did not know the treatment for the patient's pathology, the policy was obsolete and there was no senior staff to ask for advice, the nurse will learn about this disease and the healthcare institution will change its policies and employ more senior nurses. However, this will only happen if one or both parties perceive the negative consequences of their decision, this being more common when the decision involves some type of penalty or conflicts with their values.

Both the nurse and the healthcare institution must be accountable for the consequences of the decisions that they make together, not only as an educational tool but also to compensate their decisions' negative consequences. However, since two entities are involved in the same decision both try to blame the opposite party in order to escape unpunished, since none of the parties perceives that their input in the decision-making process was what precipitated the negative consequences of the decision made.

This cyclic incrimination process is regulated by two factors, preventing both sides to accuse one another indefinitely, which would deny any kind of resolution to the individual affected. These factors are:

- Vicarious hierarchical accountability: The nurse is considered a healthcare institution's employee, who performs the care that the institution provides. Therefore, they are legally bound as employer and employee and the legal concept of vicarious liability can be applied, through which the healthcare institution protects its employee.

Vicarious liability follows three main consecutive rules in English Law, which determine if it is applicable, as exposed by Dimond (510):

  - Someone was negligent or was liable for a civil wrong.
  - That someone was an employee.

- Said employee was acting in the course of his employment.

Nevertheless, vicarious liability applies only in cases in which the consequences of the decision made result in a legal dispute, which happens rarely. Also, to prevent being involved, the healthcare institution produces a large number of policies that clearly specify what treatments, techniques and behaviours are approved by it, and therefore which ones offer legal protection to the nurse under vicarious liability. This entails that any decisions that nurses made outside the limits established by the applicable policies are their responsibility and they will be the only ones accountable for it.

Nevertheless, given that there is a low proportion of legal disputes based on decisions with negative consequences made within a healthcare institution, since each of the nurse's acts and omissions involves a decision with positive and negative consequences, most of these situations are not solved using classical vicarious liability but with vicarious hierarchical accountability.

The vicarious hierarchical accountability consists in the dispersion of accountability for the decision taken through the hierarchical structure, involving employees with more influence than the nurse but without affecting the healthcare institution per se. A representative example of this phenomenon is when the nurse coordinator or the NIC takes responsibility for the consequences of a decision made by a registered nurse, reducing the patient's stress while they talk to an authority figure and allowing the nurse coordinator to satisfy the patient in relation to the negative consequences of the decision made by the registered nurse.

The training and experience in conflict resolution that employees with high influence received allowed them to relax the patient and minimise the importance's perception of the negative consequences that he has suffered. More serious situations may involve any employee, including consultants, duty managers or executive officers, but the healthcare institution is not involved per se, thus avoiding a legal process.

- Subjective contractual individual accountability: Being an employee of a public healthcare institution carries following the clauses of the employment contract like in any company, but there is also a subjective factor in how the nurse feels part of the healthcare institution for which he works for.

Employees of English public healthcare institutions feel proud to be part of the NHS, which is an essential part of English modern history and culture. Also, employees tend to feel part of a group with a purpose within their department, so they establish an accountability relation not only with patients or his colleagues but also with the department per se. This results in them having a subjective perception of their individual accountability as employees, which is represented in the concept of subjective contractual individual accountability.

The subjective contractual individual accountability exposes the phenomenon in which the nurse feels accountable for his decisions not only in relation to the accountability established in his employment contract or in applicable legal and professional regulations but also depending on what he feels that should be his responsibility. Therefore, the nurse may feel accountable for the consequences of actions that he has not done or are beyond his control. He will work overtime, shorten his breaks, bear higher clinical workload or carry out actions that displease him if he believes that it is his responsibility as a nurse employed by a public institution or if he feels that his patients need him.

That nurses strive more in extreme situations is something that is expected of them, but they are not legally or professionally forced to increase their clinical workload voluntarily. However, since the nurse believes it is his responsibility to strive beyond his contractual duties regularly, the healthcare institution will assume this level of extra effort as the nurse's normal level of performance, demanding increased efficiency in order to cover more clients with the same employees. This promotes the stress and high staff turnover typical of English EDs.

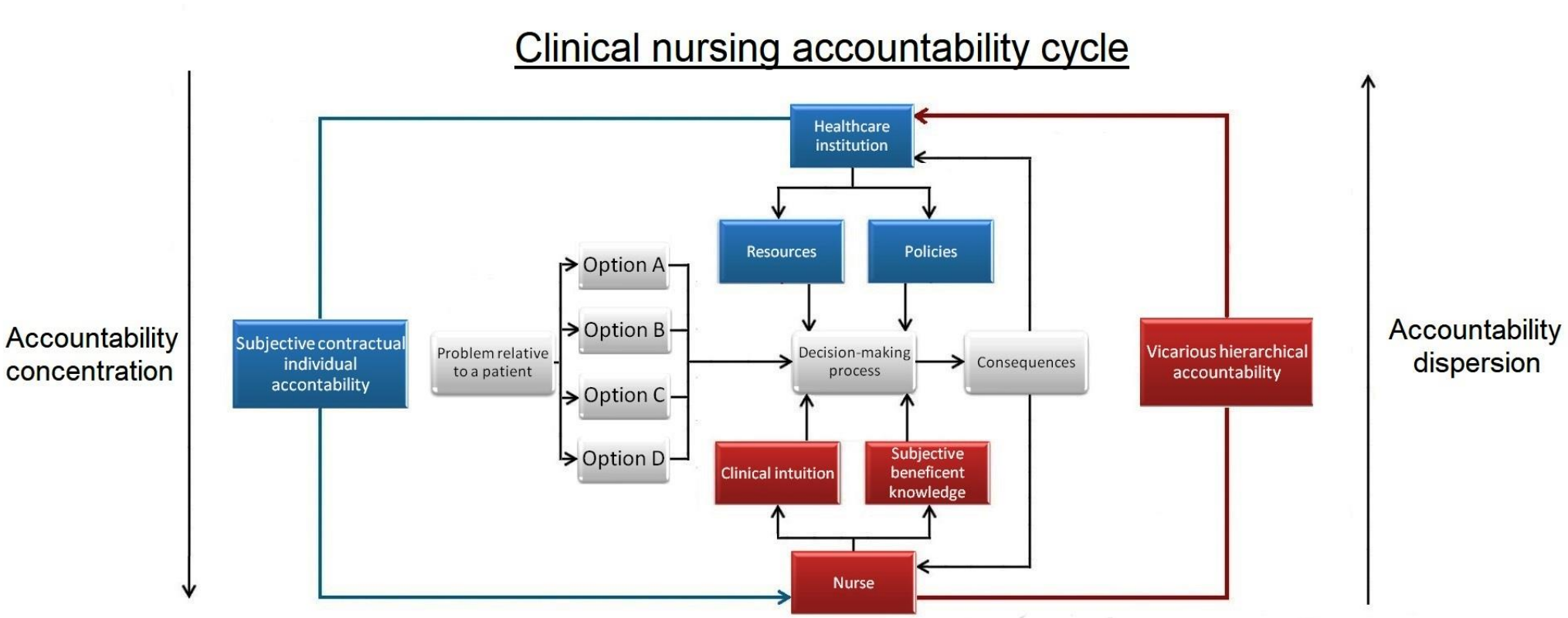
Another manifestation of subjective contractual individual accountability is when the healthcare institution makes the nurse feel accountable for the decisions made by it to make him feel guilty, indoctrinating him to follow its goals. The most common case is departmental objectives, when the healthcare institution's influence branches through the hierarchical structure towards duty managers or nurse coordinators, who shift the responsibility for departmental objectives' compliance to the registered nurses. This can be done using active or passive pressure: aggressively prompting the nurse to be accountable for something or making him feel guilty about the consequences of

someone else's actions, so he decides that he is accountable even if he was not involved in the decision-making process.

The subjective contractual individual accountability depends primarily on the nurse's ethical values and personal background when he is not involved in litigation, so its effect on accountability regulation between nurses and the healthcare institution is very variable. This entails that there are nurses that feel only accountable for what is stipulated in his contract, nurses that continually sacrifice themselves for the benefit of the healthcare institution and nurses in any situation between these two extremes.

To visualise the clinical nursing accountability cycle completely and ease its understanding, a diagram describing it is presented:

**Diagram 5: Clinical nursing accountability cycle**

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### 9.4.2. Relations amongst clinical nursing accountability factors

The clinical nursing accountability cycle explained in the previous section indicates which are the main factors affecting such accountably during and after the decision-making process, but is unable to describe which factors interact when a decision is made and how. To clarify this, the relations between the nurse and the healthcare institution have to be considered holistically.

Nevertheless, two connectors have to be considered in order to connect the legal, professional, ethical and personal factors from both themes. Said connectors do not originate from the nurse or the healthcare institution only, since they are key factors that define how both entities interact with each other.

- Clinical workload: Clinical workload is defined as the movement of patients into and through the emergency department and can be measured by the patients per nurse ratio, the number of admissions or the patient flow coefficient; but as a concept it represents both the physical, mental and emotional stress that the nurse is subjected to during clinical practice and the hospital capability to meet the healthcare demand of its clients with the resources it manages.

A high clinical workload does not affect the decision-making process per se, but it influences many of the factors that are involved in it. One of the best-known consequences of a continuous high level of clinical workload in an emergency department is crowding, which directly affects aspects like quality of care (511), patient satisfaction (512) or short-term mortality (513).

Another interpretation of clinical workload is as an efficiency measurement for the entire system, so the healthcare institution can sense changes in its staff if clinical workload rises sporadically even if they have enough resources to manage the number of clients present, while the nurse can discern the lack of resources if clinical workload increases without any changes in routine practice.

Nonetheless, even if it is good measuring if something is wrong within the system, the network of factors affecting clinical workload is so complex that without delving into the source of the problem a long-term solution cannot be found. This precipitates that both the healthcare institution and the nurse prejudges each other, blaming the opposite side for the clinical workload's rise.

- Protocolisation: The protocolisation does not refer only to the creation and update of policies but also to their use to control the healthcare institution's employee based on its values and objectives.

Aspects such as the provision of care, employee relationships or behaviour towards clients represent the healthcare institution, so it marks strict behavioural rules which application is demanded to its employees to promote safe, efficient and complaisant practice. This allows the healthcare institution to communicate with all employees at the same time and impart behaviour as it considers appropriate.

Furthermore, protocolisation has to be contextualised within an institution with hundreds or thousands of employees, each with his own ideas. If it does not standardise clinical practice, the healthcare institution exposes itself to employees that could apply obsolete knowledge to patient care, even allowing negligent or malicious acts.

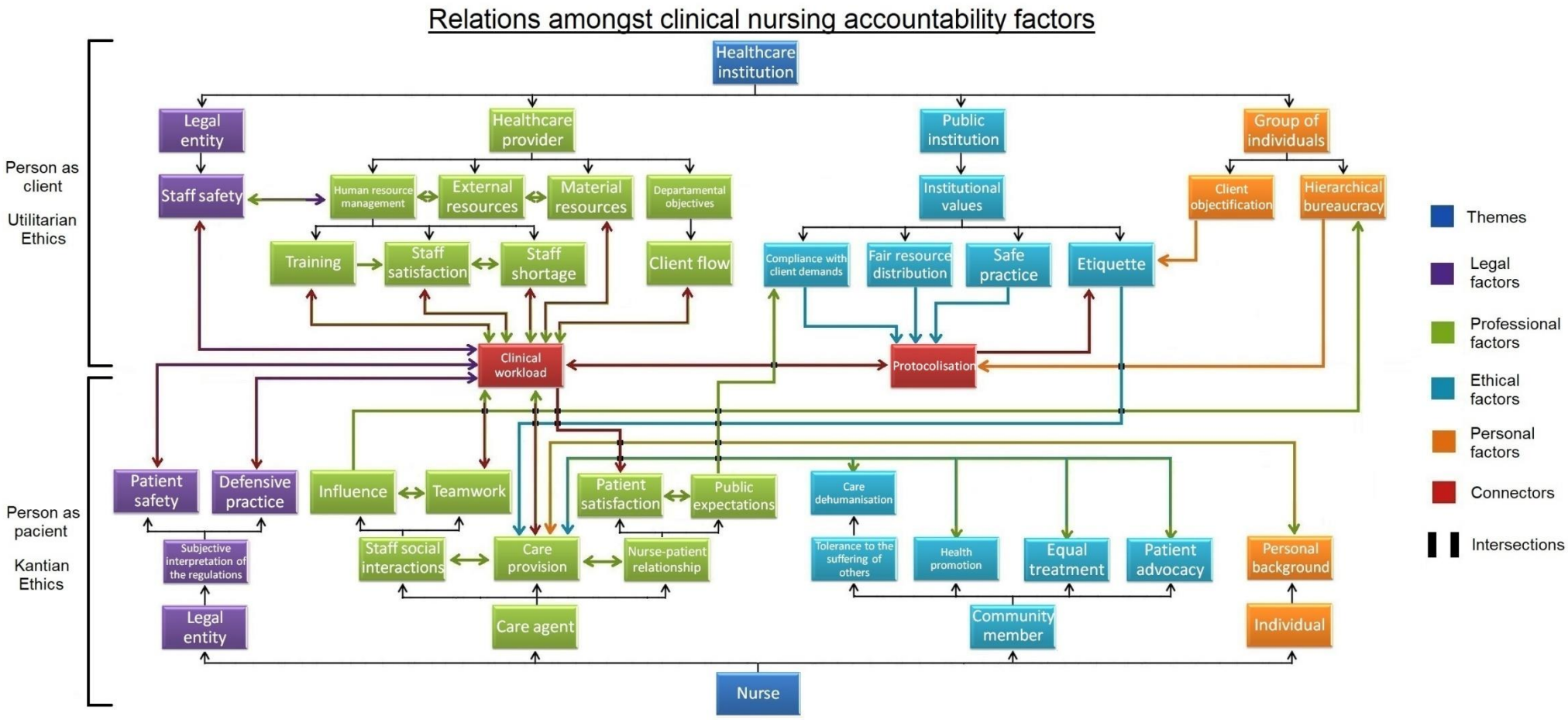
A feature of protocolisation is healthcare standardisation, which allows standard base care but limits creativity and flexibility in different situations. Therefore, the nurse will be able to provide minimal care based on the healthcare institution's guidelines, but the protocolisation of practice will limit the employee's response to unusual situations and hinder a holistic approach to care. Moreover, if the protocolised standards are not adequate or are not updated they may promote malpractice, the violation of vulnerable people's rights or theoretically illegal acts, which is pointed out in the conducted policy ethical analysis.

These connectors are linked to many factors from both the nurse and the healthcare institution, but they also relate to each other. This relation is based on the need for the healthcare institution to control clinical workload's negative effects, so it protocolises clinical workload in levels, each one with its characteristics actions.

On the other hand, clinical workload also affects protocolisation, since when it is too high the nurse tends to not follow all policies strictly, allowing him to prioritise what he believes is important. This stems from the nurses' perception of the connection between the lack of resources and increased clinical workload, which predisposes the nurse to replace protocolised practice with prioritised attention to the patient's vital needs.

Before starting to explain the relations between the different factors from both the nurse and the healthcare institution, a diagram of said factors with all their relations is presented, thus facilitating the comprehension of the results and the monitoring of the various interactions.

**Diagram 6: Relations amongst clinical nursing accountability factors**

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#### 9.4.2.1. Nurse

##### 9.4.2.1.1. Nurse as a legal entity

The nurse knows that he must follow both the law applicable to every English citizen and the professional and legal nursing regulations. However, the nurse usually does not know the details related to his legal accountability, since he is confident that if he follows the applicable policies and deontological code he will avoid any legal problems.

This perception of his legal accountability strengthens the influence of deontological codes and hospital policies during clinical practice, but only the fragments that nurses remember or consider important. In the semi-structured interviews, it was indicated that both deontological codes and policies are implemented in nursing practice when the nurse considers it necessary, which is determined by his past experiences in relation to the current situation. That is why the nurse does not make decisions based on his theoretical legal accountability, but on the subjective interpretation of the relevant regulations in force, being this reflected in laws, policies or deontological codes.

The subjective interpretation of the regulations is dependent on the experience and values of each nurse, leading to some following the rules literally in most cases while others apply them only in unusual cases. However, all nurses apply the rules that they know to protect two individuals: the patient and themselves. Therefore, we have to distinguish between patient safety and defensive practice.

- Patient safety: Patient safety not only refers to protect the patient from external risks, being these caused by unsafe environments or third parties, but also to protect the patient for the disease he is suffering, promoting recovery and avoiding the deterioration of his health. This entails that patient safety is the first priority for the nurse, a fact that was apparent in the observed practice and in the interview responses.

The aspect of nursing practice related to patient safety that concerns nurses the most is committing errors. These errors can be precipitated by many factors depending on the situation (training, experience, resources, stress, multidisciplinary communication, etc.), but according to the interviewed nurses they are much more common during high clinical workload periods.

Clinical workload is not only a sign of system failure, which can be caused by several of the factors that precipitate committing errors but also indicates the amount of work that nurses must do. If the nurse is not able to prevent patients from deteriorating, since he cannot care for them when he should, he tries to do tasks faster in order to protect all his patients. However, this beneficent measure predisposes the nurse to ignore the rules and to skip the clinical safety measures in place to prevent errors in the attempt to save time and be able to provide vital care to his patients.

Although high clinical workload derives in deficient patient safety, an increase in patient safety also raises clinical workload. This happens because, in order to provide safe care according to the standards set by the healthcare institution, nurses have to perform various routines that are not directly related to patient care like double verification in the administration of intravenous medication, checklists or hourly rounds.

The direct relation in one direction and inverse in the other between patient safety and clinical workload balances patient safety level and clinical workload, reason why clinical workload can be used to measure departmental patient safety.

- Defensive practice: Defensive practice does not have positive or negative connotations out of context, since it relates to nurse's protection against possible future problems using comprehensive documentation of their practice and strict adherence to the rules. However, during periods of high clinical workload it may conflict with patient safety.

Time is a limited resource, and its rational use is an essential skill in an emergency department. During periods of low clinical workload, the nurse may be able to maintain patient safety and his simultaneously, so a defensive practice would be considered adequate, since it promotes appropriate registration of nursing practice and strict policy application.

Nonetheless, in periods of high clinical workload the nurse must distribute his time amongst a larger number of tasks. This entails that the nurse must choose between spending more time protecting the patient and ignoring his own protection or prioritising his protection and relegating patients to inadequate care. Therefore, the

patient's possible deterioration under high clinical workload when the nurse prioritises his protection is the reason behind the stigma of defensive practice, since it goes against the characteristic complaisant and self-sacrificing nursing image.

One of the most common arguments observed in nursing practice in favour of defensive practice is the fact that if the nurse does not protect himself, he loses his PIN NMC and with it his license to practice as a nurse, so the healthcare institution loses human resources and clinical workload will be further increased. This is based on the fact that the only care taken into account is the care that nurses document, not the care they actually provide, so if they do not utilise time to document their care and follow policies step-by-step they risk not being able to defend themselves against litigation in the future.

Defensive practice increases clinical workload, since it absorbs time that could be spent on patient care, so the time available to care for the same group of patients is reduced. On the other hand, clinical workload also increases defensive practice, since the rise in clinical errors and the lack of control precipitate the nurse to feel insecure and to protect himself against future problems. This direct relation in both directions between the two factors creates a positive feedback loop, which facilitates that the nurse tends to protect himself first, progressively reducing the time devoted to patient care, which increases clinical workload.

The two subcategories of subjective interpretation of the regulations, patient safety and defensive practice, are not connected to each other if they are analysed within the nurse's legal factors. However, if clinical workload factor is considered a connector between them an inverse relation is observed.

In situations with low clinical workload, the nurse will be able to provide optimal care and protect himself from future litigations at the same time, since he has enough time for it, so there is no obvious connection between the two. However, if the clinical workload is high both factors tussle for the nurse's available time, so if the defensive practice increases patient safety decreases and vice versa. Therefore, the inverse relation between patient safety and defensive practice only occurs during periods of high clinical workload.

This may seem counterintuitive, since if the nurse uses his time to increase patient safety he should not worry about his legal safety, since if the patient is safe the nurse should not be blamed for anything serious. However, we have to consider the fact that if the nurse spends more time in patient safety the possibility of problems or errors is reduced, but not eliminated, and even if the nurse focuses completely in caring for the patient if it is not documented he cannot prove what he has done.

This entails that for patient safety to reduce defensive practice by itself, the nurse should conceive that there is no risk that might affect him in the future, which is highly unlikely, even more so in periods of increased clinical workload.

#### 9.4.2.1.2. Nurse as a care agent

The primary role of the registered nurse in an ED is the provision of patient care to meet the needs they cannot cover themselves. The care performed by a registered nurse is linked to all aspects of his practice, since care is the end of nursing practice. However, in this section only factors related to nursing accountability will be considered.

The three main factors of the nurse's accountability as a care agent are staff social interactions, care provision and the nurse-patient relationship, which are connected with each other but are presented separately to describe in detail their subcategories and the relations between these and other factors.

- Staff social interactions: Humans are social beings, so social interactions are common in any group. The LRI ED multidisciplinary team is no exception, since in order to meet all patient needs several professionals from different disciplines must communicate and work together.

Social interactions between the nurse and the rest of his colleagues are not only a product of their social needs but are also crucial for their practice, since human resource coordination through adequate communication in an ED is vital for its efficient operation.

This was repeatedly mentioned during the interviews, since it is impossible that the nurse can meet all the needs of his patients alone, so if the multidisciplinary team'

members are able to interact with each other the quality of the care that patients will receive will be higher. On the other hand, if the patient needs' amount and complexity are greater, more interactions among multidisciplinary team members will be needed to meet those needs, so there is a direct relation between care provision and staff social interactions.

Nevertheless, the fact that multidisciplinary team members interact with each other does not mean they treated each other as equals, so it is necessary to divide these interactions between the social hierarchy that regulate their social interactions (influence) and the joint activities that they perform (teamwork).

- Influence: Defined as the power and authority of someone to another or others, influence allows the nurse to encourage another person to agree with his decision or to do the action commanded by him. The influence among different individuals is inevitable in groups long-term, but in a multidisciplinary team this influence focuses on decision-making.

The main reason why the nurse should be able to influence other multidisciplinary team members is conflict resolution. Some conflicts can be solved following policies or the available evidence, but if the nurse is able to influence his colleague is able to stop the conflict immediately. This is very important for nurse coordinators, since the ability to solve conflicts with their decisions or just with their presence facilitates regulating the activity of many healthcare professionals at the same time.

One of the reasons why nurse coordinators are able to use their influence regularly is their hierarchical position. This happens because, even though influence is an individual factor and the personality of each person affects how they can be influenced, the hierarchical structure is embedded as a class system that allows people in a higher hierarchical position to impose their decision against any professional in a lower hierarchical position. Therefore, it does not matter if the decision is appropriate or not, but the hierarchical position of those involved in the dispute.

Another class system related to influence is the professional role of the person to whom the nurse wants to influence or who is trying to influence the nurse. Although they have different hierarchical structures, doctors feel at a higher level than nurses, while nurses

feel the same with HCAs. Moreover, the coordinators, both nurses and doctors, have a greater influence on the purely clinical healthcare professionals, while duty managers and executive directors can influence any professional who does not have a management position.

The nurse's experience is also an important factor to influence other people, especially other nurses. The senior nurse's presupposed knowledge facilitates that he incites his junior colleagues to follow his decisions. However, experience only increases the nurse's influence if he is a permanent member of the multidisciplinary team, since temporary nurses suffer multiple handicaps because they are not integrated into the social structure of the department, including reduced ability to influence their peers as they are unfamiliar with their experience, knowledge and reliability.

Influence is a concept that is part of the operation of any institution formed by more than one individual, so it is vital to promote efficient teamwork. If the nurse is able to positively influence his colleagues, they will be more willing to work with him and work dynamics will be more fluid. Also, if the nurse works frequently with the same group of professionals both tend to influence each other more easily because of the link created between them.

- Teamwork: The dynamics of working in a multidisciplinary team are vital to provide holistic care, so the understanding of teamwork as social interaction is necessary to understand the distribution of accountability through a multidisciplinary team.

One of the foundations of nursing practice is the support among nurses in an area to cover their deficits and balance clinical workload in order to provide holistic and equal care for all patients. This also involves task sharing based on the nurses' experience and skills, which may be uneven if the nursing team does not have an adequate distribution of senior nurses. Each nurse is accountable for a number of patients, but is also accountable for the care and techniques that he performs, either to his patients or to his colleagues' patients. This entails that shared accountability is a common phenomenon among nurses in the same area, since the lack of senior nurses leads to team deficiencies in the knowledge and skills necessary for holistic care.

In the case of nurse coordinators, they are able to help registered nurses not only through their expert advice and practice but also distributing human resources as appropriate. The position of responsibility of a nurse coordinator entails that he also shares accountability with any nurse on his team, especially if the latter has asked him for help.

On the other hand, nurses also work with other professionals, who some of them are not involved in healthcare. These professionals serve patient needs from different perspectives, allowing individualised care. However, only registered healthcare professionals can be accountable for a patient's care directly. These professionals are aware of the role they have to perform and the patient needs they must cover, but in the case of overlapping the multidisciplinary team is able to treat the patient according to the abilities of each team member, sharing the accountability between them.

Multidisciplinary teamwork also applies to coordinators, both nurses and doctors. These can create uniform and functional multidisciplinary teams, providing expert solutions to complex problems and enabling suitable working dynamics.

The most important factor in any healthcare team is communication among its members. Miscommunication results in inefficient and negligent practice, so frequent exchange of ideas between team members is promoted, especially during handover. However, clinical workload reduces the time devoted to communication and its effectiveness, since the nurse must perform more tasks at the same time under stress.

On the other hand, if teamwork is poor, being this due to inadequate communication or other relevant factors, clinical workload will increase. This phenomenon is based on an inability for the nurse to care for an acute care patient alone, so failures in group dynamics will directly affect team efficiency, needing more time to meet basic the patient's needs. Consequently, if more time is needed to care for each patient they will stay longer in ED, catalysing crowding and increasing clinical workload.

- Nurse-patient relationship: Considering the patient as the central entity of care, the relation between the nurse and the patient is a crucial factor to provide holistic care. This entails that an appropriate connection between the nurse and the patient is a way to discern and meet patient needs, facilitating holistic care provision.

On the other hand, the nurse's care changes his relation with the patient positively or negatively depending on the patient's reaction to that care, allowing nurses to strengthen the bond with the patient based on the care offered. However, this also means that when the nurse performs care that is negatively interpreted by the patient, especially when he is not aware of its cause, he could prejudge the nurse as an enemy, drifting into a passive-aggressive or actively hostile relationship.

Given the wide variety of patients who are treated in an ED, each nurse-patient relationship is different, even if there are patterns in how both parties behave. These patterns are based on two main factors, patient satisfaction and public expectations.

- Patient satisfaction: Being measured at local, regional and national levels, patient satisfaction is very important both in relation to a particular patient and in the quality assessment of a service provided by a healthcare institution. Regarding the nurse-patient relationship, patient satisfaction is an indicator not only of the quality of the care offered but also of a positive relationship with the professionals who attended him.

Since the nurse can influence his colleagues, he can also change the perception of the patient's experience. If the nurse is able to establish a positive relationship with his patient, he could discover all the patient's needs and focus his practice on them, which entails that the patient is not only being cared for adequately but also feels like someone is caring for him. Moreover, if the nurse has created a bond with his patient he can support the patient psychologically if a factor has caused him distress or discomfort.

Furthermore, the relation between the nurse and the patient's relatives also influences the satisfaction of said patient. When the nurse is identified by the patient's relatives as a friendly individual the nurse-patient relationship is improved, since the patient usually trusts his relatives to protect him when he feels vulnerable. This entails that the patient will feel more comfortable with the nurse and next to his family and friends, which increases general satisfaction with the care offered.

Although the nurse may influence patient satisfaction, his potential impact is far less strong than the effect of clinical workload. The combination of long waits, low-quality care and crowding characteristic during high clinical workload periods precipitates that

the patient is unhappy with the overall service, even if nursing care was the best possible within the constraints imposed by the context in which it is performed.

- Public expectations: The public, referring to English population in general, go to EDs with preconceived ideas regarding its operation, efficiency and the services they offer. These preconceptions may come from different sources: official documents like the *NHS Constitution*, press, television, previous visits to the same or other EDs, friends and family, etc.

Another source of preconceived ideas regarding the use of English EDs comes from the public's health education. Individuals with first aid, English healthcare system or health emergency basic knowledge tend to go less and have more realistic expectations about the services offered in an ED.

If the patient expects to be attended immediately regardless of his condition's severity, common preconception in young and middle-age patients, he will be more dissatisfied with the healthcare service offered than if he was not influenced by his preconceived ideas. Therefore, if the individual's expectations are higher he will feel more dissatisfied in relation to the care received.

Furthermore, if the patient has been treated in the same ED several times, his experiences will modulate his preconceived ideas. This leads to situations in which if the patient had an exceptional experience in ED his expectations will increase for an upcoming visit, whereas if the patient suffered a terrible incident he will not expect excellent care on his next visit.

- Care provision: The main role of registered nurses in an ED is the provision of acute care, so it is indirectly related to most factors related to clinical accountability. However, there are direct links to certain factors that explain the subjectivity of nursing accountability perception in regard to the care they provide.

The most common tasks within care provision are patient assessment and medication administration, even if more basic care like maintaining patient hygiene or psychological support are also part of the nurse's routine. This entails that when tasks need to be prioritised nurses concentrate on identifying potentially harmful diseases and treating them, thus preventing the patient from deteriorating at the time.

The focus on constant assessment and immediate management of critically ill patients increases the number of patients per nurse who can be kept stable, but technifies the care they receive. Care technification is a common phenomenon in EDs, where immediate care to all patients is valued over providing a holistic high-quality care.

Another aspect of care that suffers due to the regular operation of an ED is its continuity. The patient is moved through different areas within the department, so he is attended by various professionals in each area. This makes it difficult to engage in a functional nurse-patient relationship and facilitates miscommunication errors, since the several handovers and the lack of interaction with the patient separate the patient and his allocated nurse.

Although the base functioning of the department is stable, continuous changes are made both in the department's structure and in care provision to meet the needs of future patients. The nurse's ability to adapt to a process of constant change is a common requirement of his job, but this adaptation takes time, leading to mistakes and lower quality care while he adapts to those changes.

All the care provision features mentioned are linked to the department's clinical workload. Efficient assessment and treatment will reduce clinical workload but will result in technificated care, while breaking care continuity and the constant changes in clinical practice decelerate the nurse, whose consequence is increased clinical workload. That is why clinical workload alone is a good measurement of minimal care provision, but it does not measure care quality adequately.

Furthermore, a nurse under high clinical workload is able to offer a small amount of vital care to each patient, therefore the quantity and the quality of the care offered decreases. The predisposition to errors, stress and other factors commonly associated with high clinical workload periods must also be considered, since they deteriorate the care performed by nurses even further.

#### 9.4.2.1.3. Nurse as a community member

Every physically and mentally healthy person follow a set of common values in the communities where they live, learning how to interact with the world around him through the collective knowledge of these communities and the experiences within them. Possible communities with which the nurse relates are his close family circle, his friends, his co-workers and even the population of his country.

All this entails that in clinical practice nurses unconsciously apply the community values obtained during their lives, which are constantly modified inside and outside his role as a nurse.

Although these values are varied and depend on the communities with which the nurse is associated, according to data from interviews and clinical practice there are four common behaviours in all ED LRI, which are linked to the Bioethics of Beauchamp and Childress (8):

- Tolerance to the sufferings of others: One of the values promoted by both the English society and the nursing community is nonmaleficence, the evasion of the act if it were to result in harm to another individual. This principle is engraved both in training and in nursing practice, promoting a safe and humane care. However, for ED nonmaleficence promotes the evolution of another phenomenon: the tolerance to the suffering of others.

Humans are able to develop tolerance to most nonlethal stimuli if they are exposed to such stimuli a number of times over a period of time. In the case of ED nurses, they are in contact with people with acute pathologies constantly, many of whom suffer physically, mentally and emotionally because of these diseases.

The nurse is able to provide care to mitigate the patient’s suffering, but if he does not have the knowledge, skills, influence and resources to do it he is forced to see the patient suffer helplessly, since caring for patients outside the nurse`s scope of practice could be detrimental for both.

Given the continuous clinical workload nurses suffer in their daily practice, the occasions when a nurse is not able to alleviate the patient's suffering in a short period of

time are frequent. If this fact is combined with the quick flow of patients through the department in low clinical workload periods, the exposure to patient suffering is very common.

This frequent exposure to other people's suffering creates a tolerance to it that takes different periods of time to manifest, even though it is very rare in junior nurses and consistent in most senior nurses. Suffering tolerance is not a bad thing per se, since it allows the nurse to think clearly how to help the patient while he is suffering, but this leads to a phenomenon that corrupts the purpose of nursing practice: care dehumanisation.

- Care dehumanisation: One of the main features of nursing care is that the patient is treated holistically, considering not only his physical health but also his mental and emotional state. However, tolerance to the suffering of the patient facilitates that he is cared for only based on his vital signs and pathology. Nonetheless, in order to deepen into care dehumanisation in ED we must first distinguish between it and care technification.

Care technification is based on the rejection of holistic care and the division of patient needs into tasks in favour of maximum efficiency in emergency situations, even if quality is sacrificed. This entails that physical needs are prioritised over others, but mental and emotional needs are being met once the patient is physically stable.

On the other hand, care dehumanisation implied that the patient is not considered a person with needs, but a set of organs and tissues that do not work correctly and must be repaired. This leads to a dehumanised care in which the nurse does not need to consider the opinion, feelings or suffering of the patient, since his sole purpose is to treat the physical pathology and fix irregularities that can be diagnosed through clinical tests.

The main difference between the care dehumanisation and care technification is that the latter considers all patient needs, even if they are divided and the physical needs are promoted above the rest, while dehumanised care do not conceive the patient as a rational individual or even as being alive. Therefore, even though care technification can result in dehumanised care, this may be acceptable in specific emergency situations (dying patients, catastrophes, etc.); while when a nurse offers dehumanised care to their

patients is not excusable, since it corrupts one of the fundamental pillars of the nursing discipline.

Care dehumanisation is directly related to the provision of such care since it changes the perception of patient needs, discarding anything other than strictly physical needs based on signs, symptoms or diagnostic tests. Even though this behaviour was favoured in some nurses by factors like stress or stereotypes based on prejudices, the tolerance to the suffering of others was the precipitating factor of care dehumanisation throughout the sample.

Moreover, care dehumanisation is the product of care provision in adverse situations, since it proceeds from the tolerance to the suffering of others. As the nurse begins to integrate the relief of patient suffering as an integral part of his practice, patient's misery starts to progressively become background noise, like monitor alarms or colleagues' conversations, since he is continually unable to alleviate that suffering. The continuous frustration that this entails encourages nurses who do not develop a suffering tolerance early to move to another department, while those who remain will eventually believe that suffering is something natural in an ED.

Consequently, once they interpreted that their only important role is to avoid that the patient dies, nurses will provide care based solely on the stabilisation of vital signs, devoid of empathy or human contact, since the nurses' perception isolates the pathology from the individual who suffers it.

- Health promotion: Nursing roles are not limited to the care of sick patients, since there are other equally important roles, amongst which health promotion is included.

In an ED, healthcare professionals observe daily their patients' apparent lack of health education, which leads them to make unwise decisions regarding their health. The characteristic environment of these departments hinders health promotion, but even with this handicap nurses understand its importance and try to advise their patients against present and future health problems.

The common argument that participants gave in their interviews to justify health promotion in an ED is trying to reduce frequent attendances by the same patient and promoting a more judicious use of public health resources. Although health promotion

reduces the inappropriate use of healthcare resources, the fact that there are no allocated time, training or specific policies for nursing health promotion in the LRI ED (apart from Minors' leaflets), together with the poor environment for health education, hinders any significant effect on the population that could be observed.

Nevertheless, health education in an ED is also important for another reason: increasing patient autonomy. If the patient has basic health knowledge on their present or future illness he will be able to assess the risks and benefits of the treatments and care available and make an informed decision. A person can go to an ED for common cold and he will be treated like any other patient, even though triage staff should advise him to discharge himself, but if this person knew that he could wait several hours to see a GP who will discharged him home without offering any curative treatment (since it is not necessary) he could decide if waiting is an appropriate use of his time and public healthcare resources.

Health promotion is key prior to discharge a patient to allow him to understand the risks of various conducts, even if that does not avoid him to make unwise decisions. One of the frequent cases of health promotion before discharge is accidental overdose of paracetamol, when is confirmed to the patient that taking a higher dose of paracetamol does not increase its analgesic effect. Also, the patient is worn about the risks of paracetamol overdose, since even if it is sold in supermarkets and can be considered a safe drug a paracetamol overdose can lead to liver failure and an agonising death if it is not treated promptly.

Due to all of this, health promotion influences the care that nurses perform since it allows them to empower the patient's decision-making about his health inside and outside ED. If the nurse does not offer a minimum health education to their patients, he would be curtailing their autonomy indirectly by limiting the information available before they choose which treatment or care they want.

The care that the nurse has performed affects the health education that will be necessary for the patient to maintain his autonomy outside the hospital. Common examples are the maintenance of a urinary catheter, symptoms to observe after a head injury or wound care after closing it with staples or sutures. Similarly, the nurse has pamphlets to offer to

patients with common problems in order to strengthen the health education they have received and reinforce it in future occasions when the patient revises the pamphlet.

- Equal treatment: English population diversity, which is particularly reflected in Leicester, promotes equality between different groups, whether through community values or their application in legislation. In the LRI ED, patients of different race, culture, gender, creed, age and socioeconomic status are cared for, each with his personal history, so the diversity of patients in ED concords with the diverse community to which it provides healthcare. However, even though the concept of equality is theoretically present in English society, its application in personal relationships and in healthcare is poor on some occasions.

English nurses working in an ED are trained and registered to manage physical pathologies, giving priority to the patient's survival and physical wellbeing. This entails that patients suffering acute mental illness or an urgent social need could not be triaged correctly and be discriminated based on said triage. The groups most affected by this phenomenon are alcohol intoxicated patients, vagrants, recurrent patients and patients suffering an acute episode of a chronic mental illness.

Nonetheless, even if many of the nurses are aware of these biases, even being themselves who promote them, they tend to provide neutral care to minimise any kind of discrimination. This behaviour is linked to the nurse's values as healthcare professional, within which is non-discrimination, since they try to apply the values of their profession over their personal values, but fail to completely suppress the latter. Senior nurses are often able to suppress their prejudices better as they know their implications and how they affect their practice.

Although the nurse tries to promote a fair and equal practice, even against his own personal ideals, external factors can prevent a fair distribution of the care that nurses provide. Being some of them high clinical workload, hierarchical orders or healthcare etiquette, different factors affecting care provision indirectly impact the nurses' ability to provide equal treatment to all patients.

When the nurse gains experience during his clinical practice, he starts to realise that his patients are not the only ones in the department, understanding the injustices that he

would commit if he would prioritise his patients above the rest. Therefore, senior nurses, especially if they regularly coordinate areas, tend to consider all patients that may be affected by their actions, whether they are under their care or not, promoting equal treatment throughout the department.

- Patient advocacy: When a person suffers a serious disease, he can be placed in a vulnerable position against other entities with conflicting interests. Given the privileged status of the nurse as the registered healthcare professional who interacts more often and for longer with the patient, he has a duty to ensure his welfare.

Using beneficence as a principle for patient advocacy is usually interpreted as something negative, symbol of the medical paternalism that was fought since the 70s. However, there are a percentage of patients whose health is so impaired that they cannot protect themselves, so the only way to protect them against third parties' negligent decisions or actions is through other people, who could be their relatives or healthcare personnel.

The role of the nurse as patient advocate is most evident when the patient has previously documented the treatments and care he wants to receive in an emergency situation, being the most common example the do not attempt resuscitation (DNAR) order. On the occasions where the patient has not previously communicated his wishes, the family or the doctor are the ones who make the final decisions regarding the patient, since the nurse cannot be the legal representative of the patient. However, the nurse liaises between the patient and the various parties involved in making decisions concerning the patient, ensuring that the patients' rights are protected and that the decision made is the most beneficial for the patient.

A high percentage of vulnerable patients are able to communicate their wishes regarding the care they want to receive, but they are unable to defend their wishes against others. In these cases, the nurse adapts not only the care he does but all the care the patient receives through communication with the multidisciplinary team to ensure that the patient's wishes are considered, even if this is only possible is these are reasonable requests within the resources available and the patient is able to make decisions coherently.

The nurse may be involved with the patient, the multidisciplinary team, patient's relatives and other third parties as his patient's advocate, but the most common interaction based on patient advocacy is with patient flow supervisors, both nurse coordinators and duty managers. This happens because the premature transfers of unstable patients are a common problem that affects patients' welfare regularly, which are the result of patient flow between different areas and departments. In these cases, both the nurse and the doctor may oppose to the patient being transferred due to the danger that the transfer carries, but the constant presence of the nurse encourages him to be the main intermediary between patients' wellbeing and their flow through the department.

The struggle for patient welfare is a principle directly related to care provision, since it is one of its objectives. Due to this, the nurse is able to integrate patient advocacy as part of care and justify the resources used in it, covering patient needs indirectly by preventing them to arise.

Care provision is essential for patient advocacy, not only through disease treatment but also as a method to identify patient vulnerabilities and prevent other individuals to exploit them for their own benefit. To do so, the nurse uses common resources in care provision like the nurse-patient relationship, assessment of basic needs or multidisciplinary team support to ensure that the care received by the patient focuses on his welfare as a holistic being.

#### 9.4.2.1.4. Nurse as an individual

The analysis of a professional group's accountability could focus solely on their activity and professional values, but ignoring the fact that each of these professionals is a unique individual with his own goals, wishes and values would derive in incomplete results and erroneous conclusions. This happens because the nurses' individuality affects all decisions made inside and outside their professional practice, so ignoring it would lead to attributing individual decisions to collective factors.

During the presentation of the semi-structured interviews, the concept of professional culture was used to explain one aspect of the sample distribution, but the nurse's

individuality goes beyond the perception of its role based on his cultural heritage. In order to address such a broad concept as human individuality in a simple way, the concept of personal background will be used to symbolise the set of past experiences and learning derived from them as an intrinsic part of the human being, which shape the values, wishes and personal ideas of each individual.

The nurse's personal background affects different factors in different individuals. For example, if a nurse has had a negative experience with a specific group of patients within or outside his professional practice, he might not be able to empathise with patients belonging to this group, while the nurse that has experienced a similar situation to that of his patient would be able to empathise with him easily. Also, an ambitious nurse would tend to please his superiors over his patients, an insecure nurse would practice defensively more frequently or a nurse of a particular religion will try to adapt his practice to his religion's prefixed values.

Nevertheless, even though most relations of personal background with other clinical nursing accountability factors are dependent on each individual, reason why various patterns of connection between them were not identified at the beginning of the data analysis phase, there is a factor that relates directly and constantly with the nurse's personal background: care provision.

The nurse is aware that both the healthcare institution (etiquette) and the NMC (neutrality) indicate him that he should provide generalised care for each patient without relying on value judgments. However, each nurse thinks he knows in which occasions it is appropriate to apply value judgments based on his personal background in order to increase quality of care. This is the main argument used by senior nurses to explain why their practice does not always follow clinical policies, since their extensive professional and life experience allows them to adapt their practice to the patient based on the results of previous situations.

Nevertheless, the effect of personal background in care provision is not always positive. There is a possibility that even if the nurses' intention is good, applying their experiences in the care of others results in paternalistic care or clinical errors. If the nurse bases his care on his personal values continuously he may indirectly impose them onto the patient, curtailing his autonomy by providing care that only matches the values

that the nurse professes; whereas if the nurse provides care in an unorthodox way just because it worked previously he could increase the chance of clinical errors in future situations.

Care provision in an experience in itself, which permanently marks the nurse's life in and out of professional practice. ED nurses learn concepts through the continued provision of care like stress management, task prioritisation, dignified death, the prudent use of public resources, teamwork, the plurality of personal values, the complexity of human beings as holistic individuals and conscious control of his feelings, among many others.

When a person identifies himself as a nurse, he does not consider it only as his training or profession but as a central part of what defines him as an individual. Once a nurse has practised clinically for several years, his perception of the world around him is not the same even if he does not practice clinically anymore, since the experiences derived from care provision become a permanent part of the life experiences that will build his future decisions.

#### 9.4.2.2. Healthcare institution

##### 9.4.2.2.1. Healthcare institution as a legal entity

When considering a public organisation that provides services to a given population, a healthcare institution is governed by the applicable English Law due to both its status as a legal entity and to the activities and services offered as such. Compliance with those regulations is essential not only to avoid punishment but also to maintain public confidence and governmental funding.

The primary responsibility of any service provider is with its clients, and healthcare institutions are no exception. Therefore, the healthcare institution should focus its corporate strategy in short, medium and long-term healthcare provision. However, it is not able to provide any services itself, so it employs various professionals to perform diagnostics, treatment and care on its behalf.

When the healthcare institution delegates the care of its patients to its employees, it also delegates their safety based on the policies established by it. This does not eliminate the accountability that it has with all the patients seen in its facilities, but allows a more comprehensive and individual patient safety control if employees follow set guidelines correctly.

The healthcare institution is also the employer of its healthcare professionals, so it must ensure that its employees are able to care for and be cared for safely. Legally, this happens because the healthcare institution has a Duty of Care with its client and its employees that must meet to maintain a legal activity, but maintaining the safety of its employees is essential so they can provide adequate care for the clients, regardless of the legal consequences.

Healthcare workers have the same rights as any English public employee (working less than 40 hours a week, holidays, breaks, training, practice free of aggression or coercion, etc.), which must be protected by their healthcare institution, but it also has to protect its employees based on its potential vicarious accountability, enabling them to perform the activity for which they have been hired for. If a nurse makes a mistake or a negligent act because the policies were not updated, he did not have sufficient resources or he was in a dangerous situation the health institution is legally accountable for the consequences of the employee's actions, so protecting its employees is an indirect way to protect itself.

There are many known dangers in English ED practice (aggression, stress, accidents, cross infections, etc.), but all are linked to the clinical workload suffered by the staff. Therefore, one of the most effective ways to protect healthcare personnel is to maintain a sustainable level of clinical workload, having an efficient contingency plan during periods of high clinical workload so they are resolved as soon as possible. If the healthcare institution is able to control the clinical workload of all employees constantly it would be able to offer basic healthcare to its clients, reduce errors, stress, conflict and staff resignations and avoid potential legal problems based on its vicarious accountability.

Maintaining a safe environment for each employee often requires resources, which come mainly from the department in which those employees work. This entails that

clinical workload is indirectly increased short-term when staff safety is increased, since both compete for the same resources.

A common example is the established policies to prevent cross infections, like isolating any patient who has had vomiting or diarrhoea in the last 48 hours or cleaning rooms and boxes between patients. These policies reduce the chances that a nurse contracts a cross infection, but to do so it must use some of his time entering and exiting the isolated area (with the relevant hand hygiene and fungible personal protective equipment) and cleaning each box from which a patient is moved.

Nonetheless, even though the effect of measures based on staff safety can lead to a short-term increase in clinical workload, sickness leave resulting from cross infections might increase clinical workload more in the medium and long-term due to staff shortages. Therefore, even if implementing methods to increase staff safety could raise clinical workload short-term, their effects are able to reduce clinical workload medium and long-term.

#### 9.4.2.2.2. Healthcare institution as a healthcare provider

As introduced in the previous section, the product that a healthcare institution offers to its clients is the provision of healthcare. This entails that their primary role as a company is the management of human and material resources to produce care that meets its clients' expectations both in quantity and quality.

For EDs, the irregular demand for urgent and non-urgent healthcare hinders an accurate determination of the resources necessary to cover it, so appropriate management of the available resources is imperative to provide basic healthcare services to all clients that require it.

The NHS has limited resources, so it has to impose rules and objectives to ensure that the public funds given to each healthcare institution are designated to the provision of universal high-quality healthcare. Therefore, the NHS promotes comprehensive control of human and material resources inside and outside every healthcare institution.

- Human resource management: The control of employees' distribution and their activities allow the adaption of the professionals allocated to each area according to the clients' needs in that area. This control can be performed passively through policies or actively through team coordination based on the hierarchical structure. Therefore, to manage healthcare professionals both their status as an employee and the tasks they are able to perform have to be considered, so the healthcare institution has to monitor their safety and their skills.

To deploy staff in areas where they are able to practice safely, have the necessary skills to perform their tasks without leaving their scope of practice and are supported by expert staff is essential to protect them from possible errors, stress or coercions. Also, identifying recurrent conflicts between staff members and fixing them before they result in physical, psychological or emotional consequences is another way to protect employees through staff management, in this case outside the clinical area.

On the other hand, when healthcare professionals work in a safe environment free from hazards and coercions their management is more fluid, since they are comfortable abiding by their coordinators' guidelines. A recurring example is the nurses' allocation to a triage area after obtaining the corresponding competence, since a high percentage of junior nurses do not feel comfortable assessing patients on their own after observing other nurses evaluate patients only for 5 shifts (of which only 3 were in the adult ED). Due to this, security measures like support from senior nurses and doctors, allocation of junior nurses with senior HCAs as a nursing team, assignment of non-critical patients to junior nurses or pre-triage control of conflicting patients were implemented.

Human resource management is not only based on the number of professionals in each area but also has to take into account the skills and experience of said professionals to enable the provision of adequate care for all clients. However, even if all hired professionals have the necessary skills to do their job, if they are not satisfied with it they will look for another one, thus losing a professional and the experience he has acquired. Therefore, in order to plan the real capacity of healthcare provision medium and long-term three factors must be considered: training, staff satisfaction and staff shortage.

- Training: Nurses, as registered professionals, must receive specific training before they can enter the NMC registry and be considered nurses legally. However, that training is not enough to educate nurses as care agents in an ED. That is why it is established that the healthcare institution will provide further training to the nurse so he can care for his patients adequately.

Even though the healthcare institution offers basic training in various aspects of care (dignified death, safeguarding adults and children, dementia, equality and diversity, etc.), ED nurses' training, especially in their early years of practice, focuses on obtaining basic skills such as medication administration, blood sampling or cardiopulmonary resuscitation. The healthcare institution has to ensure that a minimum percentage of nurses per shift are proficient in these techniques, since without skilled nurses is impossible to provide minimal care to the clients who attend ED.

The theoretical-practical approach to continuous education allows that junior nurses are able to perform patient care independently in a short period of time, since when they lack this basic skills nurses have to rely on their colleagues to care for their patients, a fact that causes embarrassment and frustration to those unskilled nurses. Furthermore, when a nurse is unable to perform a task he needs to find a qualified co-worker who is not busy to help him and explain the context in which the task should be performed to him, so more time is spent executing the task than if he was able to do it alone.

For a nurse who just finished his nursing degree, the training necessary to obtain the skills needed in an ED takes longer than in a hospital ward. In addition, the entry of junior nurses is also higher, since retention is lower compared to a long stay hospital ward. Therefore, the training demand from ED nurses is relatively high in proportion to other departments, so its funding must be controlled to avoid that ED monopolises the healthcare institution's limited training resources.

In order to manage the training resources allocated to ED fairly, any course must be assigned through the nurse educators, who distribute the available places based on waiting lists. This prevents abusive competition among ED nurses to attend a course and avoids that ED nurses monopolise the courses that belong to other departments. Nonetheless, given the seriousness and complexity of the clients attended in an ED, training its nurses can be prioritised by the healthcare institution if a large percentage of

the nursing workforce does not have the basic skills, even though this would entail an exception that must be authorised by the nursing hierarchical apex.

Continuous nursing education has a theoretical part, which is represented by the training offered by the healthcare institution, but it also has a practical part to obtain skills and develop holistic care in each of its facets. This practical training is developed through simulations, supervised practice and senior nurses' support during clinical practice.

Practical training requires that nurses are supervised or trained by a senior nurse, who combines his clinical responsibilities with the educational support of his junior colleagues. However, in periods of high clinical workload the senior nurse should prioritise his patients' needs over his colleagues' education, so if clinical workload periods are prolonged and frequent junior nurses will not be able to obtain the competencies and skills needed to care for their patients.

If there is a shift with a high percentage of junior nurses who lack the theoretical or practical training necessary to practice independently, the small number of senior nurses will not be able to support all junior nurses, so the nursing team's efficiency will be lower and clinical workload will be increased progressively.

A common example of this relation is when only one nurse can manage intravenous medication in Majors. This situation results in intravenous treatments being administered one by one, so patients would wait longer for intravenous treatment in the department and they could deteriorate, which would add further pressure to the nursing team.

This positive feedback relation between nursing training and clinical workload propitiates deficient nursing training and higher clinical workload, so the healthcare institution has to use resources to reverse the cycle, in which a trained team will reduce clinical workload, which will facilitate the training of future junior nurses.

- Staff satisfaction: Nursing in England is a profession driven by vocation, since the high demand for nurses throughout the country and the different options for nonclinical career progression facilitates nurses who are not happy with their working environment to find another job, clinical or not.

Therefore, nursing staff satisfaction is vital for managing human resources in any English ED medium and long-term.

One factor affecting staff satisfaction is the stress to which they are subjected. Mainly caused by clinical workload, according to the interviews, the constant stress that nurses can suffer in an ED directly affects their satisfaction with their work, since not only the working conditions are worse than in other departments but they also feel frustrated as they are not able to care for their patients meeting their personal quality standards. Therefore, if nurses in an ED are more likely to be under continuous stress due to frequent periods of high clinical workload, their satisfaction should be lower and junior staff retention should be lower than in other departments.

If nurses are not motivated or feel dissatisfied with aspects of their work their performance will be lower. This stems from the disconnection generated between the dissatisfied nurse and his practice' purpose, since if his practice does not cause him excitement or happiness the unsatisfied nurse will tend to perform the minimal tasks required of him as an employee, limiting any extra effort. Consequently, dissatisfied nurses indirectly increase clinical workload because their lack of motivation limits their performance to the lowest tolerated by their superiors. However, the stress linked to clinical workload is not the only factor that regulates nurses' satisfaction.

Clinical teamwork and the emotional support that the nursing team's colleagues offered among them are paramount to adequate decision-making, overcoming traumatic events and creating a pleasant working environment. Consequently, staff shortages limit the size of these groups and the support offered in them, so they promote nurses' dissatisfaction with an environment in which neither can engage in healthy relationships with their colleagues nor receive help from them. Moreover, if there are not enough nurses to create adequate nursing teams, more nurses will decide to move to another department in search of better working conditions, which creates a positive feedback cycle that alone would end up dispiriting all the nurses in the department.

There is another factor that increases patient satisfaction, especially with junior nurses: training. LRI ED nurses feel motivated when they learn new things and are able to apply them to improve the quality of the care they provide to their patients, either through courses or supervised practice. Furthermore, obtaining knowledge and skills

increases nurses' efficiency and influence, which boost their professional pride and their satisfaction with it. Consequently, if the nurse does not receive the training that he thinks he needs, his satisfaction will decrease because he believes his clinical effort is not valued by his superiors when they deny him such training.

I can be argued that the salary could be a motivating factor due to the loss of nurses' purchasing power over the past 5 years, but this argument was constantly refuted by the interviewed nurses. Although they mentioned that a raise would be appreciated, they also indicated that they prefer to solve other problems like staff shortages or poor staff training, factors that directly affect their working environment and the quality of their practice. In addition, nurses considered the potential conflicts that an irregular salary scale for NHS nurses in different departments could lead, further dividing the nursing community.

- Staff shortage: For the healthcare institution to manage human resources, it must first have enough employees from various professions to create functional multidisciplinary teams that allow efficient client treatment and care. Because of this, the lack of personnel is the most important factor in long-term human resource management.

The NHS has suffered from nurses' shortage during most of its history, so the lack of nursing staff is not a new phenomenon. However, the recent increment of the patients per nurse ratio in pursuit of cost-benefit efficiency has worsened the impact of unfilled vacancies.

Staff shortages not only include the nursing profession, but affect all professionals that are part of the multidisciplinary team to a greater or lesser extent. This entails that if there are not enough doctors, HCAs, porters, radiology technicians, administrative staff or members of any other professional group directly or indirectly related with clinical practice the operation of the multidisciplinary team will be affected, which also influences nurses as part of that team.

The efficiency reduction resulting from a staff shortage in the multidisciplinary team exponentially increases clinical workload, not only due to the lack of manpower but also due to its inadequate distribution. For example, if the healthcare institution wanted

to cover the lack of nurses with more doctors, which is theoretically possible, they do not have any experience caring for people, so their efficiency would be much lower and the clinical workload would increase proportionally to the number of nursing posts covered by doctors.

Another more realistic example is when the healthcare institution allocates HCAs to cover nursing shortages. Although HCAs are more familiar with care and the nurses' main roles, their lack of relevant training and skills forces HCAs to overload nurses with the care they cannot perform, slowing care provision to all clients in the area.

If this lack of personnel is recurrent and clinical workload is persistently high due in part to this, clinical workload effects like stress, unsafe practice and dissatisfaction will encourage an increase in the number of sickness absences and their duration, which will worsen the staff shortage even more. If only the relation between these two factors was considered, they would create a positive feedback loop in which the lack of staff would be so severe that it would force the healthcare institution to close the department.

- External services: The NHS is diversified into a network of services that are designed to cover the majority of the population's healthcare demands. Given the specialisation of such services, collaboration between different departments and healthcare institutions is not an isolated event, but its overuse can result in medium and long-term financial and efficiency problems.

The most common use of external services is resorting to other departments within the same healthcare institution. This is a recurring process in the LRI ED, since when clients need to be admitted to wards other than general medicine or geriatrics (AMU and AFU are part of ED financially) they have to be transferred to other departments. The same happens when clients are transferred to the GGH or the LGH, either because they need specialised care or due to the lack of space in LRI wards.

Teamwork between different departments within the same healthcare institution is required to offer each client personalised care, so there are managers in the directive board who are able to make decisions for the benefit of the institution, even if those would undermine the financial stability of a particular department. However, although there is a hierarchical apex that directs the institution, they are unable to control all daily

conflicts between different departments, which affect the efficiency and quality of the services provided.

A healthcare institution has to interact with other NHS institutions to offer quality services due to public healthcare service diversification. In regards to the LRI ED, it depends on NHS ambulance services to receive their non-ambulatory clients, GPs to refer non-urgent clients and monitor them after they are treated in ED, community services to maintain an adequate level of care and avoid failed discharges and mental health teams to provide specialised care to clients with psychological or psychiatric problems, among others. There are also conflicts between different NHS services, but since they are part of different directives the policies that link them are usually more difficult to create and require inter-institutional collaboration.

Finally, there are also private external services hired by public healthcare institutions to cover deficiencies short and medium-term. In the LRI ED there are two significant cases: private ambulance services and temporary staff recruitment agencies.

Since UHL NHS Trust is distributed in three hospitals (LRI, GGH and LGH), transfers between departments may incur an inter-hospital transfer that requires the use of ambulances for non-urgent transfers, for which it has to resort to private companies such as Arriva Transport Solutions Ltd. This solves the inter-hospital short and medium-term transfers, but the time, quality and cost-benefit inefficiency involved in the division of the only ED in Leicester and specialised services like cardiology or pneumology requires long-term measures to reduce the frequency of inter-hospital transfers.

The chronic staff shortages of both nurses and doctors are used by recruitment agencies to provide temporary staff services for a much higher price than the salary offered to permanent employees. Excluding the reduced cost-benefit efficiency of agency staff, their disconnection with the environment in which they will work predisposes them to a more defensive, less efficient and lower quality practice than permanent staff. Therefore, the use of agency staff is excusable only as a short-term measure, since its utilisation in the medium and long-term indicates a failure in recruitment, retention and human resource management by the healthcare institution.

- Material resources: Human resources are essential for the provision of healthcare, but without adequate material resources it is impossible for these professionals to care for their patients following the minimum standards of a developed country. Material resources, both fungible and non-fungible, allow the healthcare institution to offer higher quality and aesthetically pleasing care.

Fungible (single-use) instruments have been a breakthrough for global health, since their use significantly reduces the transmission of pathogens and allows mass production of sterile material for performing invasive techniques. However, the fact that an instrument is considered fungible depends on the cost of its reconstitution, since instruments like laryngoscopes or the ones included in the suture packs (needle holder, flat scissors, flat forceps and toothed forceps) are discarded despite they could be reused, mainly because the healthcare institution considers that buying new disposable instruments is cheaper than sterilising used ones.

Fungible material resources are a constant investment that is part of the healthcare institution's budget, but the most significant periodic costs are often related to non-fungible material resources, whether it is reusable equipment, medical machinery or ED's building infrastructure. These materials allow the creation of an organised environment in which healthcare professionals are able to assess, treat and care for clients beyond the limitations of human senses and appendages. However, the financial investment and installation time necessary for the improvement of non-fungible material resources limit their short-term implementation and forces the healthcare institution to plan long-term, especially in relation to the department's infrastructure.

All these material resources allow healthcare provision, so their shortage directly affects clinical workload. If the infrastructure of an ED is not able to accommodate all its clients, they will have to wait because there would be enough private spaces to accommodate them all at the same time, creating crowding and client assessment, treatment and discharge delays, with its corresponding clinical workload increment. Furthermore, if there were no needles to draw blood or all electrocardiographs were broken many clients could not be evaluated and treated appropriately until such materials are replenished, which also would result in crowding and delays.

Nonetheless, that the lack of material resources precipitates an increase in clinical workload does not imply that an exorbitant increase in material resources would reduce it. Following the previous example, if a department can accommodate 1,000 clients but has staff to care for 50, the fact that the department is bigger does not reduce its clinical workload. It may even be at risk of accommodating so many patients that the staff cannot cope with minimum care provision, which increases clinical workload and jeopardises both clients and employees.

When an ED suffers high clinical workload continuously its use of material resources increases proportionally. Since it provides services to more clients per hour and day, its facilities suffer greater wear, machinery tends to break more often and larger amounts of fungible equipment are needed. This is the main reason why the checklists were implemented, since if material resources availability is not monitored frequently these may not be available in an emergency, thus reducing clients' survival rate.

- Departmental objectives: As part of the NHS, all English public healthcare institutions must follow the objectives set by the British government. The objectives that the government demands are varied and depend on the type of healthcare institution and the services it offers, but these can be divided into three main groups: clinical efficiency objectives, client experience objectives and client security objectives.

These objectives can be measured in different ways depending on the services offered and the department to which they apply, even though the number and rating of the Friends and Family questionnaire or failed discharge ratios are often recurrent objectives in most acute Trust's departments. Following departmental objectives literally does not ensure an improvement on the healthcare services' quality and efficiency offered by each department, but allows the government to require a minimum level of safety and quality to its funded institutions.

In addition, there are also specific objectives for EDs that affect clinical efficiency, client experience and client security: the objectives related to client flow.

- Client flow: An ED, like any hospital department, will not be ready to receive the number of clients per hour expected if it does not discharge the same number of clients, since it has limited resources. However, the movement of clients through an ED must be faster than any other hospital department, since the available resources are calculated based on the argument that EDs are an emergency stop in which the client is stabilised and transferred to another place. In addition, EDs cannot turn away clients just because they are crowded, so their capacity is virtually infinite even if this results in crowding.

This entails that if client flow slows down because there are not enough discharges or because clients are not attended fast enough several problems would arise, which the fact of following the applicable departmental objectives is trying to avoid.

The main objective related to client flow, which is the main focus of the healthcare institution's efforts in ED, is the total time in ED target (4 hours). However, there are also targets for triage time (15 minutes), treatment time (60 minutes), patients who leave without being seen (maximum 5%) and senior medical review. These objectives can be categorised into the three groups, since when client flow slows down increases both clinical workload and crowding, reducing staff efficiency, client safety and his satisfaction with the service received.

In order to meet the government objectives, the healthcare institution must force a global response, since the main reason that slows client flow is exit block. Such block cannot be controlled by ED, but by other departments that receive clients transferred from ED.

Although the healthcare institution intends to standardise client flow through monitoring the departmental objectives set by the government, this is not always possible. Exit blocks, material or human resource shortages, clients with complex requirements or assistance spikes can slow client flow, which will increase the number of clients who require healthcare while increasing clinical workload.

Increased clinical workload will slow down client flow even more by reducing staff efficiency, increasing the error rate and decreasing client and employee safety. This

bilateral relation between client flow and clinical workload create by itself a positive feedback loop that results in a chronically crowded department, even if the control measures established by the healthcare institution prevent crowding to evolve into a total admission blockade for even critically ill patients.

#### 9.4.2.2.3. Healthcare institution as a public institution

Healthcare institutions within the NHS should not only provide the services that people need within its range of established services, but these services must follow specific values, which are part of both official documents and the population's collective knowledge. These institutional values allow clients to understand in advance what the healthcare institution's intentions are and what expectations they should have about the care they will receive.

- Institutional values: Each NHS Trust publicises the values that it adopts as a public healthcare institution and undertakes to abide them through the actions of their employees and the institution per se. These values are often illustrated by abstract phrases that represent a statement of intent.

For UHL, five values embody the institution, which are a reflection of the characteristics of the services offered and its staff's behaviour:

- We treat people how we would like to be treated: Empathy, dignity and friendliness.
- We do what we say we are going to do: Clear and truthful communication.
- We focus on what matters most: Responsible decision-making and client participation in his care.
- We are a team and we are best when we work together: Professionalism and teamwork.
- We are passionate and creative in our work: Creativity and inventiveness.

Nonetheless, although the UHL values are essential to the efficient functioning of any healthcare institution, their application is based on the clients' perception of those values and their consequences, not the assimilation of those values in practice.

This entails that the values UHL applies as an institution are based on the client's subjective perception of the service he received, promoting the satisfaction that comes from feeling that he is a priority for others who protect him and care for him.

In the LRI ED, this phenomenon is represented through the values applied by the healthcare institution that have been analysed during both clinical practice and semi-structured interviews: compliance with client demands, fair resource distribution, safe practice and etiquette.

- Compliance with client demands: As any service provider, the healthcare institution has to meet its clients' demands for his business to continue to receive clients and remain economically viable. However, in the case of EDs client demands have to be compatible with its operation.

ED clients expect prompt attention to their urgent illnesses, for which they demand early pain management and appropriate care and treatment according to their needs. In addition, the healthcare institution ensures that client needs can be assessed and met as a routine part of clinical practice, promoting the use of Friends and Family questionnaires to assess its services and adapt them to its clients.

The healthcare institution's focus on client flow allows almost immediate attention and avoids chronic crowding, two recurrent client demands, but the clients' self-perception of their disease's urgency is subjective, so their needs cannot always be or should be completely covered by the healthcare institution.

Whether for lack of health education, lack of knowledge about NHS services or convenience, there are clients who attend ED demanding to ignore the triage system to be assessed earlier and receive more care. Although the healthcare institution understands that violating client demands can lead to complaints or lawsuits, it also understands that to maintain a safe and efficient department it has to ignore a client's demands to benefit the majority of its clients. This technique can be argued not only based on the provision of minimum care and its Duty of Care but also under a business

perspective, in which pleasing most clients upsetting some of them reduces the total number of complaints and increases satisfaction rates.

Client demands, whether reasonable or irrational, are based on the expectations that these clients have of the services that the healthcare institution can offer. Due to this, previous experiences in similar departments and information about the healthcare institution from secondary sources will affect how clients perceive the urgency of their condition within the ED environment and the healthcare services they deserve.

To ensure that most client demands are met, the healthcare institution protocolises recurrent demands to ensure that its employees cover them. This facilitates that client suggestions are implemented, like changing metal bins for plastic bins to avoid unnecessary noise or setting hourly rounds to keep clients fed and hydrated. However, this also entails that most complaints that result in a lawsuit would be protocolised, even if they do not improve any services, like changing the name of the Minors area to Yellow Zone and later to Injuries because clients complained that their illness was urgent and not "minor", even if it was considered so after being triage by a healthcare professional.

- Fair resource distribution: The appropriate management of available resources is one of the most important roles of any healthcare institution, so how those resources are managed reveals the values that influence their decisions. In the case of the LRI ED, it frequently emphasises fair resource distribution among its clients, but what is considered "fair" to the healthcare institution is relative.

ED resources are distributed mainly based on the assessment of the client disease's severity, either through the first triage or consequent evaluations. This method reduces health deterioration of the most critical clients, which saves resources, and prioritises basic needs over subjective demands.

Nevertheless, there are exceptions for resource allocation based on the severity of the client's disease. The most common exception is distributing extra resources to avoid breaching departmental targets, even if this means that more critical clients or clients who have waited longer have to receive care later. Although this measure may seem

unfair and immoral by the healthcare institution, this is its response to the sanction model established by the government.

The healthcare institution's reasoning is that if it violates departmental objectives regularly the economic fines would limit the available funding to attend future clients, which would increase objective infringements, creating a positive feedback loop that would bankrupt the healthcare institution. Therefore, the healthcare institution considers that the resource allocation based on sanction evasion is fair if its long-term effects are considered.

However, although resource allocation based on long-term economic efficiency can be considered fair by the healthcare institution, its employees do not believe so, since their value system addresses the needs of their patients above their employer's long-term economic stability. Since the healthcare institution is aware of its employees' value system, it protocolises ED practice around its departmental objectives to ensure that they follow its values.

Examples of this protocolisation are measuring the client's length of stay compared to the 4-hours target, pressure from managers and nurse coordinators to meet departmental objectives, managers transferring clients against the nurse's decision, multidisciplinary meetings looking for a plan to discharge clients or the specialty review policy (if the doctor of a particular specialty has not assessed the client 30 minutes after his referral, the client will be transferred to the corresponding ward for the specialist doctor to assess him there).

- Safe practice: As a healthcare provider for vulnerable clients, the healthcare institution should ensure that it protects them from the dangers of its employees' clinical practice, standardising a minimum safety and quality level to avoid malefic or negligent behaviour.

The healthcare institution is able to analyse both the scientific evidence and its clients' past experiences to recognise the rules that it must impose on its employees to promote safe practice. In this way, it prevents recurrent issues and predicts any malpractice that might occur in different situations, controlling that its employees only provide the safest care that the context allows.

The expression of the value of nonmaleficence through safe practice makes sense when a public institution is conceived as a provider of care through its employees, since it cannot care for its patients alone. This entails that to protect its clients from negligent acts it must establish rules to prevent such acts before they occur. However, the public institution not only promotes safe practice to follow the values set by the NHS but also to avoid any legal and economic consequences.

When treating vulnerable clients, the public institution has a Duty of Care to those clients, which must comply if it does not want to suffer serious legal consequences. Moreover, if it does not regulate its employees' practice, they may resort to vicarious accountability to blame the healthcare institution for any negligence that has not been considered in its clinical policies.

Regarding the economic perspective, a safe practice does not only prevent the institution to pay fines derived from malpractice but also increase staff retention and reduces sickness absence due to stress. Allowing employees to work in a controlled environment where they feel their practice is safe reduces defensive practice and the anxiety resulting from the possible consequences of their mistakes, since they can base their decisions on the healthcare institution's policies.

The most effective way in which the healthcare institution can establish safe practice in all departments is with practice protocolisation through clinical policies. The healthcare institution creates clinical policies for any pathology, technique, care or decision that may be performed by its employees, thus reducing the chances that they commit negligent acts during their clinical practice. In addition, these policies allow employees to standardise their practice and make it safer and more efficient.

- Etiquette: The employees' conduct in a healthcare institution can be as varied as the number of employees that institution contains. However, the healthcare institution's corporate image is transmitted through the behaviour of its employees, so it must control them to display a specific behaviour approved by the institution: etiquette.

Etiquette consists of influencing staff so they follow a uniformed socially accepted behaviour based on arbitrary rules that please the client and represent the healthcare

institution's image. Given the variety of clients received, the etiquette promotes neutral client care to avoid offending them, even if this impairs the employee-client relationship and the quality of psychological and emotional support.

In the case of the nursing profession, the etiquette also implies the nurse's subservience to the client, behaviour characteristic from the classical role of women as nurses. This conduct is promoted through the enforced coverage of clients' needs that they can cover themselves, since they are entrusted to the nurse because he is subservient to the client. Moreover, nurses are forced to have a specific appearance based only on aesthetic reasons and to suppress any emotion, manufacturing the perfect servant.

Neutrality and servility modulate the nurse's etiquette to create the illusion that the nurse cares about the client, even though this does not need to be true. The healthcare institution cannot control that all its employees genuinely worry about its clients' wellbeing, but through etiquette it can convince clients that someone cares about them and their welfare. However, establishing a neutral etiquette obstructs healthcare professionals' empathy with clients, so fewer employees will be able to establish a real relationship with clients and genuinely worry about them.

This phenomenon exemplifies the goal of healthcare etiquette: healthcare service marketing through the promotion of acceptable behaviours by their employees, which are disconnected from both the client and the employee, which dehumanises them.

In a healthcare institution, policies are not always based on scientific evidence. On some occasions, policies come from past experiences that the institution wants to avoid or social customs that it wants to maintain. Due to this, the application of non-evidence-based policies transforms into etiquette, since the main difference between etiquette and evidence is that, even if both modify behaviours, one is based on scientific research and the other on anecdotal information.

The effect of etiquette on the nursing profession is perceived mainly in care provision, but influences all aspects of their practice. This effect is not only due to policy interpretation based on anecdotal information but also to the information transfer from senior employees to junior ones, which is strongly linked to the etiquette present when senior professionals began working as healthcare professionals. This entails that any

conduct not based on evidence transmitted to junior professionals will affect their practice, since it is transmitted without being updated, because senior professionals argue that their vast experience authorise them to decide which behaviours are appropriate and which are not.

#### 9.4.2.2.4. Healthcare institution as a group of individuals

Even if healthcare institutions are usually considered a neutral and impassive body that makes decisions on behalf of the global good based on the available data, those decisions are actually made by a group of individuals who constitute the hierarchical apex: the healthcare institution's directive board (formed by the executive officers). Since they make decisions by consensus, the personal contribution of each member is reduced, but this does not eliminate that each one of them has his values, ideals, goals and wishes, which could influence his decisions as part of the healthcare institution.

Managing a large healthcare institution like an NHS Trust carries monitoring at least thousands of employees and tens of thousands of clients, which makes it impossible for the healthcare institutions' directives to be able to engage with every problem individually. Moreover, the decision-making structure based on the directives' consensus promotes lobbying among the various members in the search for personal gains given the limited number of members and the confidentiality of their meetings. This context can be described by two phenomena: client objectification and hierarchical bureaucracy.

- Client objectification: The perception of a being or an event is directly related to the information that the subject can obtain from it and the past experiences to which that information can be related to. In the case of the healthcare institution, its directives only have access to processed and biased information that other individuals provide them, which limits their perception of the client.

A directive makes decisions that directly or indirectly affect thousands of clients simultaneously, but he is not aware of their situations. Due to this, to enable the healthcare institution to make decisions, directives uses information from their analysts that is summarised and structured to facilitate the assimilation of large amounts of data.

Nonetheless, quantitative data analysis removes the context from which the data was obtained from, limiting the understanding of the decisions' consequences made daily by the healthcare institution's directives. In addition, presenting some data and erasing the rest biases the information that the healthcare institution will consider when making decisions. The result of this lack of context is client objectification, which is to consider the client only as inert data, either financial or legal.

The difference between care dehumanisation and client objectification is that the nurse is forced to interact with the patient as part of his daily activity, so even though he could not consider the client as a human should be able to perceive that he is alive, while the directive rarely interact with a client, so the pressure that comes with making decisions that affect human lives does not exist. This facilitates not only making emotionally challenging decisions without causing remorse but also allows unfair and immoral decisions to be made because the directives do not have to bear any moral accountability for the consequences of their actions.

Client objectification exemplifies a change in the Ethics theory predicated on the NHS. The Ethics applied by nurses and promoted by patient advocacy documents like *NHS Constitution* treat the client from a Kantian perspective, in which the clients is an end in itself, which is reflected through the holistic care that considers the client as a complex being, not as the sum of his parts. However, the lack of contact with the client that promotes client objectification facilitates that the healthcare institution adopts Utilitarian Ethics, in which the individual client is only a means through which to finance the resources necessary to provide equal healthcare to the entire population.

The fact that client objectification can lead to unfair or immoral decisions does not mean that healthcare institution directives are necessarily immoral, but is the result of the lack of context and remorse characteristic of decisions influenced by it. Also, directives are unable to engage with every client, so to limit the effect of client objectification they rely on their employees and the Law to defend the client against unfair decisions based solely on decontextualised data.

Another effect of client objectification is the generalisation of their demands and needs, since their opinions are analysed in the search for patterns and employees are forced to change their etiquette relative to these patterns. An example would be the clients'

recurrent complaint about not knowing the name of the nurse who cared for him, for which the healthcare institution established the mandatory order to wear identification badges at chest height for any client to identify his nurse. However, patients still complain that they do not know their nurse, since the problem is not that nurses cannot be identified but that they are not able to establish an appropriate nurse-patient relationship for several reasons.

- Hierarchical bureaucracy: The group of individuals who have a hierarchical position that allows them to make final decisions affecting the entirety of the healthcare institution represent it. Typically, these people are members of the directive board, who have high responsibility job roles. However, their job role does not exempt them from having their own ideals and goals to pursue as anyone else.

People with the necessary influence to represent the healthcare institution might be able to make egotistical choices, but there are several measures to prevent it. The main measure is that decisions affecting the institution as a whole are decided by consensus among several people with similar influence, being a common example decisions made by the directive board. Furthermore, people with a high level of responsibility and influence also receive comparable benefits to their status (economic, social significance, working conditions) to limit the benefit that making a selfish decision on the healthcare institution's behalf would have.

Nevertheless, even with these measures, there is a possibility that some of these people may decide to make a decision to benefit themselves that affects the operation of the healthcare institution. There would have to lobby for support from other individuals, seeking common interests with them. Even if they get enough support for the decision to be approved by a majority, their intentions may be identified by those affected by it, whether employees with less influence or clients. To prevent this lobby from being discovered, they use the method of hierarchical bureaucracy.

Hierarchical bureaucracy is a technique that consists of introducing a specific decision within the complex bureaucracy of an institution to mask it like a routine change or justified it based on the presupposed influence of the deciding group's hierarchical position. Examples that occurred in England are the Colchester General Hospital NHS Foundation Trust case, in which the directive board was accused of manipulating cancer

patients' waiting lists to receive an economic incentive, or The Mid Staffordshire NHS Foundation Trust Public Inquiry, in which managers altered information to keep their job and avoid fines for the healthcare institution.

The influence of the individual who wants to apply hierarchical bureaucracy to his ends is essential to achieve the consensus of his peers and to remove any doubts that may arise about his decision. This does not mean that people with less influence, like managers, cannot use hierarchical bureaucracy, but they will have to convince more influential individuals to support them.

Once they have obtained the necessary support, for the consensus decision to go unnoticed it must be integrated into the policies' entangled network, either through an official document or a clinical policy. This clears doubts about its legitimacy and enables the group of individuals to argue their reasons, whether they are true or not, to implement their decision in a policy. It also allows the decision made to have long-term effects that are difficult to rectify if its consequences were not identified before implementing it.

The dangers of using hierarchical bureaucracy as a selfish tool have been mentioned, but it also can be used to implement disinterested decisions that are controversial or complex without creating social hysteria. A hypothetical example would be a consensus among emergency services and pre-hospital care services to not transfer alcohol intoxicated patients to ED. Although it could be a disinterested decision that could benefit both institutions, it could be misconstrued as discrimination against alcohol intoxicated patients by the media, which could lead to distrust of healthcare services, public protests and conflicts between healthcare institutions and their clients.

# Chapter X: Discussion

## 10.1. Results discussion

### 10.1.1. Discussion in relation to the objectives

The study of the ethical and legal factors that affect clinical nursing accountability in the LRI ED is the main objective for this thesis' research project, but the results showed that in order to fully understand this phenomenon several factors must be analysed in addition to ethical and legal factors.

The nurse is a human being, so he perceives the world around him through the subjective decryption of the theoretical and practical information he collects. This indicates that each nurse will understand his accountability differently based on different factors, so even if the Law and the institutionalised nursing values can be considered objective their application in clinical practice is always subjective. Ignoring the subjectivity of nursing accountability in an attempt to generalise its consequences limits its understanding, a fact that is reinforced when all the factors affecting the subjective nursing accountability are considered.

Nursing accountability is modulated by legal, professional, ethical, and personal factors, as shown in the results. However, these factors do not only describe how different variables affect decision-making and its consequences but also represent how professional duty affects ED nurses, which is based on three main concepts:

- Professional Ethics: Subjective values shared by a professional group that are not officially documented and are transmitted through practice. Their compliance is not regularised, so there is only an obligation in conscience.

- Professional deontology: Set of duties that have been institutionalised through professional organisations like nursing colleges. Those duties are documented and non-compliance is penalised within the professional group, even though if they are not legalised they do not carry legal penalties.

- Legal regulations: Mandatory codes of conduct for all society. Sometimes, part of the deontological duties may be part of the applicable legislation if it is considered that their compliance is mandatory for the maintenance of a just and civilised society.

Ethical, professional and legal factors identified in the results coincide with the concepts of Professional Ethics, professional deontology and legal regulations respectively. However, that does not explain the existence of personal factors, which may lead to decisions against professional duty.

These personal factors represent the moral judgment that the nurse should make when a conflict between professional values or principles and between them and legal aspects arises, which can lead the nurse to make a decision against his professional duty in a concrete case.

Apart from the consideration that the nurse works within a multidisciplinary team, which is dependent on his individual efficiency, the healthcare institution and its relationship with the nurse must be considered to analyse the accountability of both in the clinical practice performed by the nurse. Both the healthcare institution and the nurse need each other to provide care that meets the quality standards of a developed country, so they constantly interact with each other to provide such care, even if each one follows their particular goals. It would be unfair to blame one nurse for not closing a wound if he does not have suturing equipment or to sentence a healthcare institution for the nurse's malicious care consequences, so establishing the shared factors of both entities that affect clinical accountability is fundamental to encourage both parties to carry out their role based on the appropriate legal, ethical and professional standards.

Nursing accountability's temporal perception must also be taken into account. Typically, the clinical nursing accountability cycle considers factors affecting decision-making at the time when the decision is taken, facilitating its analysis and simplifying the search for a possible culprit of its consequences. However, the factors that affect decision-making have been previously influenced by other factors (which are represented in the relations between clinical nursing accountability factors), so the latter should also be taken into account during the nursing decision-making analysis.

The retrospective understanding of the factors regulating nursing accountability is essential to promote that both the nurse and the healthcare institution make themselves accountable not only for the direct consequences of their actions but also the indirect consequences of past decisions. This would promote prudence in decision-making and increase error reporting, thus facilitating a safer practice and a more consistent

healthcare provision. For example, in this way the nurse would be protected if the healthcare institution decided to cut staff and he made a mistake mainly because he could not cope with the number of patients assigned to him and the healthcare institution would be defended from the negligence caused by the malicious influence of a nurse that has encouraged malpractice in the nursing team.

Although the retrospective analysis of nursing accountability is much more complex than its punctual analysis, its benefits justify its realisation, especially when future issues can be avoided through interventions in the primary factor that triggered the problem, which are more effective than modifying the final factor in which the issue manifests itself.

We emphasise that during the analysis of the clinical nursing accountability factors a dichotomy between the nurse's and the healthcare institution's Ethics applied to decision-making was exposed, since the nurse usually treat the care recipient as an individual patient and the healthcare institution perceives him like every other client. This leads to the fact that the nurse tends to apply Kantian Ethics, considering the patient as an end in himself and final goal of care, while the healthcare institution objectifies all its customers to distribute healthcare evenly through measurable factors like vital signs or suspected pathology.

This dichotomy in Clinical Ethics originates from the goals that each entity has established, which involve a different perception of the care recipient. The reason for the nurse to do his job is to care for people, so his patients become the purpose of his practice; while the healthcare institution is focused on generating profits and cut costs, for which clients are the means through which it obtains funding, a utilitarian practice that clash against the Kantian orientation of nursing practice.

This difference in objectives may face the nurse and the healthcare institution in decision-making, especially in the use of human and material resources. Those confrontations are detrimental to both parties, so a constructive debate would enable the two parties to have a shared vision of care. That vision should be the one defended by NHS patient advocacy documents, which promote Kantian Ethics through the defence of the holistic patient as the final purpose of healthcare, but the current NHS institutional structure promotes aggressive competitiveness that prevents this vision to

be implemented. Each Trust must demonstrate an improvement in cost-benefit efficiency for senior management to receive incentives or keep their job, regardless of whether the quality of healthcare suffers, so the NHS indirectly encourages English healthcare institutions not to follow the values it promotes.

The specific relationships between clinical nursing accountability factors are explained in detail in the previous chapter, but it has to be mentioned how safe healthcare can be provided even taking into account the positive feedback loops present among several factors.

The healthcare institution is required to maintain a safe environment and provide minimal care to its customers, so it will take extraordinary measures to achieve this, the most common being the indiscriminate exploitation of human resources. This works short-term because under induced stress the nurse will work faster and will be able to care for more patients, but the resulting exhaustion of human resources will be negative medium and long-term.

Another reason why care that meets the minimum standards can be provided under inadequate conditions is the tendency for nurses to strive beyond their limits to care for all their patients. This behaviour is based on the values of nurses both individually and as a collective, which pushes them to increase their performance to their limit, even if they sacrifice patient safety or their own welfare to ensure that all their patients receive the minimal care they need. This conduct can increase short-term efficiency, but increases the risk of errors, stress and accidents.

Nevertheless, the effectiveness of both behaviours is unpredictable and depends largely on the individuals who apply them and the situation in which they are applied. In addition, their medium and long-term consequences will worsen the aforementioned problem, so even though they are plausible short-term emergency solutions their regular use is strongly discouraged if medium and long-term healthcare provision needs to be maintained.

Clinical policies related to professional accountability in the LRI ED were analysed to obtain information of theoretical nursing accountability as part of the first secondary objective, but during that analysis their consistency within the NMC deontological

framework was also analysed. In addition, an indirect result of this analysis was the revision of policy applicability, which was confirmed during the reflections on clinical practice.

The nursing practice observed was strongly influenced by clinical policies because each technique or task that the nurse has to perform as part of the provision of care was directly or indirectly regulated through a policy. Therefore, understanding clinical policies was necessary to discern the theoretical limits of nursing practice in an emergency department.

The results of the ethical analysis of the UHL clinical policies applicable to the LRI ED revealed that some aspects, like informed consent, were ignored in most clinical policies. This was reflected in nursing practice, in which the use of adequate informed consent for conducting invasive nursing techniques was practically zero. However, the influence of policies in clinical practice occurs not only by their teaching role as a clinical guideline but also by the protection they offer to nurses when performing a task in a specific way without being coerced or pressured.

In periods of increased clinical workload, the healthcare institution can force nurses to provide care quicker sacrificing quality, but if such care is regulated by a clinical policy they cannot be rushed by managers without violating a clinical policy created by the same institution that they represent. This fact highlights the importance of policy ethical validity, since not only direct the nurses towards better practice but also protects them when their practice may be affected by external factors.

Most policies analysed show a generalised failure regulating an adequate informed consent, even though one of the analysed policies focused only on informed consent, which was a solid and well-written policy. However, neither the concept of informed consent nor the informed consent policy are mentioned in other policies involving invasive practices.

The apparent lack of connection between policies hinders their use by nurses, since only a small percentage of senior nurses dominate all policies applicable to their clinical practice, even if most nurses vaguely know some of them. Therefore, to promote good practice, especially in adequate informed consent, the healthcare institution should train

its staff in its clinical policies and link all policies in an intuitive network easily accessible for any healthcare professional.

The connection of interrelated clinical policies could be solved by mentioning the related policies at the end of each one, as some of the analysed protocols did, even though none mentioned the informed consent policy. However, that solution would not be effective if it is not consistent and does not allow access to the cited policies, so policies related to each other should also be linked on the healthcare institution's intranet, enabling that nurses accessing the latest version of the policy are also aware of the policies related to that one and how to access them.

Nurses working in the LRI ED told the investigator their experiences as nurses during clinical practice and in their interviews as part of the second secondary objective. These experiences focused on different topics related to their accountability as nurses, but they mentioned stories of all types, which shared common themes.

The main issue that most registered nurses mentioned was the chronic impotence they felt when they were unable to provide the standards of care their patients deserved and they are capable of offering, since their care provision is limited by the hospital institution's resources. They tell frustrated that even if they tried to work more efficiently, even skipping their breaks or without going to the bathroom during the entire shift, they were not able to meet the care demand of their patients. Some indicated that finishing shifts crying and feeling guilty for not being able to care for people suffering is a routine event during the first months in the department, after which the frustration remains latent but can be controlled.

This frustration environment encourages junior nurses to leave the department, while the nurses who remain tend progressively towards a perception of care dominated by techniques, which creates the feeling that they do their best to care for their patients and reduce the suffering caused by the violation of their professional values.

The increased clinical workload that afflicts registered nurses during their clinical practice not only frustrates them but also raises questions about the stability of their job and their profession. Nurses indicated that when forced to work under high levels of clinical workload and stress care they felt that their professional registration was in

danger, and with it their job and their lifestyle. Therefore, senior nurses, who claimed to be aware of the risks of their practice for both patients and for them, face an ethical dilemma: focus on patient care without documenting and risk losing their NMC registration or focus on documentation and relegate care?

Even knowing the risks, some registered nurses preferred to follow the values of Professional Ethics and prioritise patients above themselves, even if this creates a feeling of uncertainty that predisposes them to engage problems defensively. This attitude hinders that nurses document their own clinical issues, afraid of their consequences, even if those issues were predisposed by the actions of another person or institution.

Another common experience among nurses was the perception of the progressive loss of personnel and training opportunities, which are denied by the healthcare institution. The considerable increment in capacity, patient flow and the number of patients per hour without a proportional staff increment angers nurses, especially due to the effect it has on their practice and the healthcare institution's refusal to recognise the problem. Furthermore, the nursing training budget cuts and the strict control of ED staff's courses limit the competencies that nurses can obtain, curtailing the development of nurses towards providing holistic care.

This situation fuels the nurses' disappointment regarding the healthcare institution's veracity and its intentions, perceiving their employer as a selfish and evil entity with which they have to life in order to perform their work and be paid for it.

Another fact that supports the nurses' negative perception of the healthcare institution is the different objectives between the two. Since the healthcare institution's main purpose is cost-benefit efficiency, it must promote an objectified treatment of its clients to meet its goals.

On the other hand, the nurse promotes holistic care and tries to protect his patients from the healthcare institution's objectification, although their lack of influence leaves them powerless against the decisions made by healthcare institution representatives. The impotence suffered by the nurse feeds the negative perception of the healthcare

institution for which he works, since he does not understand or share cost-benefit efficiency prioritisation in favour of quality of patient care.

According to the nurses, nursing practice in the LRI ED involves many disadvantages, but most of them love to practice as a nurse in ED, as many of them directly mentioned. The accelerated work pace, the critical situations and the impact of the care they provide to their patients have encouraged them to continue working in that department despite the many drawbacks that this entails compared to a ward.

They claim that to work in an ED someone must have a certain personality, without which it is impossible to bear the job disadvantages. The personality type that they describe is a curious and energetic person with an impervious willpower, able to withstand the ED environment for the knowledge and satisfaction that comes with helping to save lives regularly.

### 10.1.2. Discussion in relation to the hypothesis

The hypothesis that states that legal factors' influence is greater than ethical factors' influence in professional accountability and nursing decision-making in the LRI ED seems inconsistent with decisions based on professional duty, in which ethical factors prevail over legal ones. However, to understand this phenomenon we need to deepen into the values hierarchy in the moral judgment of the concrete case.

Any professional frequently prioritises Professional Ethics against professional deontology, and the latter against the applicable legal regulations, when he makes a moral judgment that results in a certain decision. However, there are concrete cases when there are conflicts between values or principles and between them and legal aspects, which are resolved differently depending on how values are hierarchised and which conclusion is individual depending on the context in which the nurses work, their previous experiences and their theoretical and practical knowledge of their legal, ethical and professional accountability, among many other factors.

In order to illustrate the complexity of the nursing accountability factors' interactions in the moral judgment of the concrete case in a simple way, two extreme examples will be

presented. The first would be a permanent senior nurse extensively trained in his department's policies and practices who has never been sanctioned working in a quiet shift, while the second would be an agency nurse without any experience in ED in a high clinical workload shift who is not familiar with the department's policies or practice and has already been sanctioned once by the NMC.

The first nurse would be more influenced by professional and ethical factors, since he feels safe undertaking his usual practice in a controlled environment in which he can provide adequate care to all his patients. Also, being a senior nurse in the department allows him to understand that most problems are solved in the department itself and only a small percentage of them result in litigation, most of which can be avoided through the use of his influence and the vicarious accountability that protects him as a permanent member of staff.

On the other hand, the second nurse would be more influenced by legal and professional factors, since he is in an unfamiliar hostile environment and he knows the consequences of making a mistake that results in harm to the patient. Moreover, he does not feel protected by the healthcare institution's vicarious accountability, which facilitates that he could be used as a scapegoat by it. This context favours that the nurse tends to practice defensive and protect his own interests above patients' interests because he feels vulnerable.

If nursing decision-making within the LRI ED is contextualised, we know that it is a department with a high percentage of junior and agency nurses, clinical workload is consistently high, there is a fear culture about losing the NMC PIN, nurses are dissatisfied with the care they provide and registered nurses do not have all the skills necessary to perform their role efficiently. This context facilitates that in the resolution of a conflict between values, principles and legal aspects nurses regularly hierarchise legal aspects above the rest to protect their profession, their way of life and their liberty from possible litigation, as evidenced by the decisions taken by nurses during 2014-2016.

The LRI ED context predisposes the hierarchisation of legal factors above the rest, but every moral judgment is unique. To accept that nursing accountability should be studied individually in relation to the nurse, the healthcare institution and the context that unites them is primordial to understanding the decision-making process retrospectively and how the entity accountable for it may be the nurse, the healthcare institution or both.

## 10.2. Limitations

Like any research project, this thesis has several limitations derived from its methodology, its study phenomenon and the implementation of an English research project for a thesis directed by a Spanish university. Discovering these limitations was essential to reduce the effect they might have on the results' validity and reliability through the implemented precautionary measures, which have been explained in previous sections. However, even after identifying them, there are limitations that could not be eliminated completely, so they must be taken into account when considering the results.

Nursing accountability as subjective concept is a complex phenomenon, being perceived differently by each professional. This situation entails that any data gathering technique could only obtain partial information about nursing accountability, which could skew the data collected. In addition, the nursing accountability's perception variability is virtually infinite, since every nurse conceives his responsibility in relation to his own personality and the context in which he is located.

To avoid that the study phenomenon's complexity affects the results, it had to be examined from several perspectives through three different data gathering techniques: reflections on clinical practice, ethical analysis of clinical policies and semistructured interviews. This decision was based on that each of these techniques analyses the study phenomenon from a different perspective, which can be triangulated to create a holistic view of it.

Specifically, the reflections on clinical practice included a deep practical individual analysis, the policy analysis encompassed a theoretical analysis and the interviews involved a practical multiple analysis. To triangulate the information from these three techniques, we considered the nursing accountability perceived for three years and its similarities and differences with the subjective nursing accountability of 34 other nurses through the theoretical context in which they practice, thus creating a short, medium and long-term theoretical and practical holistic image of nursing accountability.

Nevertheless, data triangulation is not performed to discover a single general perception of nursing accountability, since being a subjective concept its variability is virtually

infinite and will lose most of their individual meaning if it was generalised. The purpose of this research in general and data triangulation in particular is discovering different factors that influence nursing accountability perception through common patterns in the different data sources, allowing the prediction and correction of problems related to nursing accountability and understanding individual nursing decision-making through a general cognitive structure.

Another possible limitation would be that the research was only conducted in the LRI ED, which could lead to not consider it applicable in other British or foreign hospitals. LRI training, clinical practice, regulations, values and policies are very similar to those of other English hospitals, so we can deduce that the factors that define nursing accountability are the same ones. However, since practice is not standardised across the NHS it cannot be indisputably confirmed that the results of this research can be applied to other English EDs without further research in other hospitals, or at least a pilot project.

Considering overseas EDs, other similar research projects located in other countries should be carried out before applying the results of this study in these countries given the cultural, legislative, educational and nursing practice differences. The realization of these international research projects would also reveal if culture, training and practice influence nursing accountability perception or the globalisation of contemporary nursing practice unifies the factors affecting it.

Applying the results to departments that are not EDs, whether British or in another country, without further research into those departments would not be recommended. Differences in nursing practice are considerable, so confirming that nursing accountability perception is the same in other departments would entail another investigation in another hospital department to compare the results of both.

It should be considered that the administrative problems arising from carrying out a research project in an English hospital as part of a thesis directed in Spain delayed the interviews over other data gathering techniques. This delay had the potential to put the interviews in a slightly different context of 6 months apart, which could skew triangulation results.

However, the researcher maintained his regular presence in the department, recording if significant changes related to nursing accountability occurred in both clinical policies and nursing practice. By staying in the field of study we can confirm that several changes occurred, which have been explained in previous sections, but none of them affected the LRI ED nursing team's subjective perception of nursing accountability.

There is also a language limitation due to the nature of both the English and Spanish language on the use of singular pronouns in gender-neutral sentences. Since the thesis was created in Spanish and translated into English, we had to consider the use of "he" as a gender-neutral pronoun as the best option for this thesis.

We contacted representatives of the RAE and the Spanish General Nursing Council for advice about which pronoun to use. Both agreed that in Spanish the gender-neutral pronouns are the masculine ones, so we used those. However, when the thesis was translated into English, it also could be misinterpreted as sexist due to the use of the masculine gender in writing as gender neutral in context.

To avoid any sexist connotations, the use of the singular "they" was trialled, but it was frequently mistaken by the plural "they". This situation severely affected the fluency and comprehension of the text, so the only option that would fit an academic text without clouding its meaning was the use of masculine as gender-neutral. Despite it could be considered outdated, this use of "he" as gender-neutral is considered acceptable in the English language.

This does not entail that this thesis or any of its creators do not consider women as part of the nursing community, since the highest percentage of nurses are female and the nursing history is closely linked to women, but due to the nature of gender-neutral language it could not be clearly represented in writing. Therefore, to clarify any misleading understandings of this thesis, we confirm that both genders were represented as the masculine gender throughout this thesis.

## 10.3. Theoretical and practical impact

Nursing accountability is a fundamental concept in the study of Ethics and Law applied to Nursing, so any progress in the understanding of this concept will advance the discipline and will increase its theoretical background.

Regarding the factors related to nursing accountability identified in this thesis, they can be related to other theoretical concepts to strengthen other hypotheses like the inverse relationship between clinical workload and quality of care, which manifests in the results through the inverse relationship between clinical workload and patient satisfaction or between clinical workload and patient safety. However, despite presenting a theoretical potential, the results of this research are intended for practical use to improve nursing practice directly or indirectly.

One application of understanding the factors regulating nursing accountability is the development and implementation of codes affecting nurses, being those either national law, professional deontology or hospital policies. By understanding the nursing decision-making process, not just in the moment in which it was made but the factors that have affected it retrospectively, legislators can create fairer rules that take into account the context in which the decision was made and specific inquiry and judgement methods for nursing accountability. If the applicable regulations would change to take into account those factors, intervention in all factors affecting nursing accountability in each case might be encouraged through economic or criminal sanctions, avoiding future problems.

Likewise, if the NMC implanted nursing accountability factors within its regulations it would facilitate a fair trial in relation to the nurse's charges, since all factors would be analysed within the possible infringement's context, even those outside his control. In this way, the public would be protected from malpractice derived from negligent nursing practice and the healthcare institution's negligent management, avoiding always blaming the nurse and providing a solution to that problem and similar future ones.

Understanding the concept of subjective nursing accountability and the factors that describe it is significant in the adequate human resource management and the provision of safe and efficient care, so its application in clinical policies and institutional

regulations by healthcare institutions would entail many advantages. Conceiving nursing accountability within a context and affected by a number of factors allows the healthcare institution to solve problems at their root and implement control risks measures related to these factors, empowering it to solve several common problems of ED nursing practice:

- Increased staff retention and reduced job stress and clinical errors through incremented training opportunities and higher staff numbers.
- Teamwork control through the distribution of nurses based on their influence on the team.
- Deconstruction of the clinical workload's increment causes, facilitating its control and avoiding medium and long-term departmental crowding.
- Quality of care control through the factors that affect it.
- Reduction of defensive practice and its consequences through clinical workload control and fair judgement of errors based on the retrospective effect of nursing accountability factors in practice.
- Increased percentage of errors reported by eliminating the guilt culture and replacing it with an accurate understanding of their actions' consequences and the effect that other factors may have on them, so more mistakes would be investigated and more future errors would be avoided.

The nurse's comprehension of his accountability and how his own decisions and their consequences may be influenced by other factors is essential, since he could defend his practice while providing excellent care. The implementation of the subjective nursing accountability concept in British higher education institutions at undergraduate and postgraduate levels would prepare nurses to consider the indivisible relationship between the nurse and the healthcare institution in contemporary nursing practice and how the dynamics between the two affect nursing clinical practice.

Nurses with this knowledge would be able to identify external factors that negatively affect both their patient and themselves, so they can fix them, defend against them or at least report them to the appropriate agency so that the problem can be solved. Also, if

these nurses ascend to managerial or directive positions they will be able to understand and analyse their nursing employees' decision-making and modify factors under the healthcare institution's control to positively transform aspects of their employees' practice.

One of the most important and complex applications of the results is the comprehension of the healthcare provision's ethical dichotomy. This dichotomy creates a rivalry between the nurses' objectives and the healthcare institution's ones, limiting their efficiency and impacting on the quality of care provided to the patient. If the NHS would change its competitive model of public funding distribution based on cost-benefit efficiency to another one based on the quality of care provided, both parties would agree on their vision of healthcare and fulfil the English public's demands represented through the *NHS Constitution*.

Nonetheless, this unification in the values that drive healthcare services is incredibly complex and would require a change in the NHS structure and the English population's personal values that could take decades. To do so, it would not be enough with training nurses to defend their professional values against the healthcare institution's corporate values, but the English public should also state their opinion of the values expressed by NHS healthcare institutions through democratic means.

Finally, although this research's results are applicable presently, they also have the potential to be the basis for future research that expands the knowledge about nursing accountability during practice, which could follow two main routes: extend the concept of subjective nursing accountability and its factors in other contexts or focus and expand the relationship between two nursing accountability factors.

This research was conducted in the LRI ED, so other researchers could verify if they obtain the same results in other EDs, British or overseas, or other British or overseas departments. If the same results were confirmed in other healthcare settings, the relations amongst nursing accountability factors model could be applied to solve problems in those contexts, even generalising them in contemporary nursing practice if the results are consistent across different departments and countries.

On the other hand, since this study focus in finding all the relations between different nursing accountability factors, we could not delve into each relation between two different factors, but several of these relationships are so complex that could be the foundation of several research projects. Relations between factors like clinical workload and staff satisfaction or influence and teamwork have a considerable effect on nursing and multidisciplinary practice, so an extensive study of these relations could reveal how to influence them better, which would have theoretical and practical applications.

## 10.4. Practice improvement proposal

The translation of research findings into clinical practice is a complex task, regardless of their theoretical and practical potential. The gap between scientific evidence and clinical care can only be closed if these results are translated into a language that can be understood by nursing management teams and applied in clinical practice.

To facilitate that this research results in substantial improvements in nursing team management, individual decision-making and care quality in an emergency department, a list of recommendations was created (see annex 7). These recommendations are structured based on the results obtained, describing the necessary changes in various factors to improve nursing practice in an emergency department.

As part of the agreement with UHL, the results of this thesis and its recommendations will be distributed to all nurses in the LRI ED, including registered nurses, nurse educators, line managers and ED's nursing management. In addition, they will also be shared with the UHL research and innovation department so they can inform any UHL member that could implement the proposed recommendations. Therefore, their possible effect is maximised, since nurses and managers are aware of the importance of evidence-based recommendations, even if they are not legally binding.

# Chapter XI: Conclusions

With the results obtained we expose the following conclusions:

1. We verify that the applicable legislation takes precedence over professional ethical principles in professional accountability and nursing decision-making at the Leicester Royal Infirmary Emergency Department.

2. In clinical practice, nursing accountability is a subjective concept. The clinical nursing accountability cycle depends on four groups of factors: legal, professional, ethical and personal. These can be extended in thirty-two interconnected variables.

3. More than a quarter of the policies analysed conflict directly or indirectly with the values described in the *NMC Code*. 85.7% of the clinical policies that regulate nursing techniques and 10% of the policies related to general practice in the Leicester Royal Infirmary Emergency Department do not contemplate informed consent, encouraging the involuntary violation of patient rights' during the provision of invasive and non-invasive care.

4. 82.35% of the LRI ED nurses interviewed indicated that they suffer from stress due to the continuously increased clinical workload or the uncertainty that causes them to feel that their professional registration is at risk.

5. The LRI ED nurses' requests to their healthcare institution focus on improving their working conditions and the practice for which they are accountable for, not on obtaining personal benefits. The ethical perspective of care manifests itself as an ethical conflict between the nurses' Kantian deontological care and the healthcare institution's utilitarian interests.

6. The demand for emergency healthcare services rose progressively over the duration of the investigation without the proportional increment of human resources, which led to a generalised increased clinical workload.

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# Annexes

**Annex 1. NMC Code**

The Code: Professional standards of practice and behaviour for nurses and midwives (80):

Prioritise people

1. Treat people as individuals and uphold their dignity. To achieve this, you must

    1.1. treat people with kindness, respect and compassion

    1.2. make sure you deliver the fundamentals of care effectively

    1.3. avoid making assumptions and recognize diversity and individual choice

    1.4. make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay, and

    1.5. respect and uphold people's human rights.

2. Listen to people and respond to their preferences and concerns. To achieve this, you must:

    2.1. work in partnership with people to make sure you deliver care effectively

    2.2. recognise and respect the contribution that people can make to their own health and wellbeing

    2.3. encourage and empower people to share decisions about their treatment and care

    2.4. respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care

    2.5. respect, support and document a person's right to accept or refuse care and treatment, and

    2.6. recognise when people are anxious or in distress and respond compassionately and politely.

3. Make sure that people's physical, social and psychological needs are assessed and responded to. To achieve this, you must:

    3.1. pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

    3.2. recognise and respond compassionately to the needs of those who are in the last few days and hours of life

    3.3. act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it, and

    3.4. act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care.

4. Act in the best interests of people at all times. To achieve this, you must:

    4.1. balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

    4.2. make sure that you get properly informed consent and document it before carrying out any action

    4.3. keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process, and

    4.4. tell colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care (you can only make a conscientious objection in limited circumstances).

5. Respect people's right to privacy and confidentiality. To achieve this, you must:

    5.1. respect a person's right to privacy in all aspects of their care

    5.2. make sure that people are informed about how and why information is used and shared by those who will be providing care

5.3. respect that a person's right to privacy and confidentiality continues after they have died

5.4. share necessary information with other healthcare professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality, and

5.5. share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand.

Practise effectively:

6. Always practise in line with the best available evidence. To achieve this, you must:

6.1. make sure that any information or advice given is evidence-based, including information relating to using any healthcare products or services, and

6.2. maintain the knowledge and skills you need for safe and effective practice.

7. Communicate clearly. To achieve this, you must:

7.1. use terms that people in your care, colleagues and the public can understand

7.2. take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs

7.3. use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs

7.4. check people's understanding from time to time to keep misunderstanding or mistakes to a minimum, and

7.5. be able to communicate clearly and effectively in English.

8. Work cooperatively. To achieve this, you must:

    8.1. respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

    8.2. maintain effective communication with colleagues

    8.3. keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff

    8.4. work with colleagues to evaluate the quality of your work and that of the team

    8.5. work with colleagues to preserve the safety of those receiving care

    8.6. share information to identify and reduce risk, and

    8.7. be supportive of colleagues who are encountering health or performance problems. However, this support must never compromise or be at the expense of patient or public safety.

9. Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues. To achieve this, you must:

    9.1. provide honest, accurate and constructive feedback to colleagues

    9.2. gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

    9.3. deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times, and

    9.4. support students' and colleagues' learning to help them develop their professional competence and confidence.

10. Keep clear and accurate records relevant to your practice. This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice. To achieve this, you must:

10.1. complete all records at the time or as soon as possible after an event, recording if the notes are written sometime after the event

10.2. identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3. complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.4. attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

10.5. take all steps to make sure that all records are kept securely, and

10.6. collect, treat and store all data and research findings appropriately.

11. Be accountable for your decisions to delegate tasks and duties to other people. To achieve this, you must:

11.1. only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

11.2. make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care, and

11.3. confirm that the outcome of any task you have delegated to someone else meets the required standard.

12. Have in place an indemnity arrangement which provides appropriate cover for any practice you take on as a nurse or midwife in the United Kingdom. To achieve this, you must:

12.1. make sure that you have an appropriate indemnity arrangement in place relevant to your scope of practice.

Preserve safety:

13. Recognise and work within the limits of your competence. To achieve this, you must:

    13.1. accurately assess signs of normal or worsening physical and mental health in the person receiving care

    13.2. make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment

    13.3. ask for help from a suitably qualified and experienced healthcare professional to carry out any action or procedure that is beyond the limits of your competence

    13.4. take account of your own personal safety as well as the safety of people in your care, and

    13.5. complete the necessary training before carrying out a new role.

14. Be open and candid with all service users about all aspects of care and treatment, including when mistakes or harm have taken place. To achieve this, you must:

    14.1. act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

    14.2. explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers, and

    14.3. document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly.

15. Always offer help if an emergency arises in your practise setting or anywhere else. To achieve this, you must:

    15.1. only act in an emergency within the limits of your knowledge and competence

15.2. arrange, wherever possible, for emergency care to be accessed and provided promptly, and

15.3. take account of your own safety, the safety of others and the availability of other options for providing care.

16. Act without delay if you believe that there is a risk to patient safety or public protection. To achieve this, you must:

16.1. raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other healthcare setting and use the channels available to you in line with our guidance and your local working practices

16.2. raise your concerns immediately if you are being asked to practise beyond your role, experience and training

16.3. tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can.

16.4. acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

16.5. not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern, and

16.6. protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised.

17. Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection. To achieve this, you must:

17.1. take all reasonable steps to protect people who are vulnerable or at risk of harm, neglect or abuse

17.2. share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information, and

17.3. have knowledge of and keep the relevant laws and policies about protecting and caring for vulnerable people.

18. Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations. To achieve this, you must

18.1. prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

18.2. keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

18.3. make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

18.4. take all steps to keep medicines stored securely, and

18.5. wherever possible, avoid prescribing for yourself or for anyone with whom you have a close personal relationship.

19. Be aware of, and reduce as far as possible, any potential for harm associated with your practice. To achieve this, you must:

19.1. take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

19.2. take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures

19.3. keep to and promote recommended practice in relation to controlling and preventing infection, and

19.4. take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public.

Promote professionalism and trust:

20. Uphold the reputation of your profession at all times. To achieve this, you must:

20.1. keep to and uphold the standards and values set out in the Code

20.2. act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.3. be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.4. keep to the laws of the country in which you are practising

20.5. treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.6. stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

20.7. make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way

20.8. act as a role model of professional behaviour for students and newly qualified nurses and midwives to aspire to

20.9. maintain the level of health you need to carry out your professional role, and

20.10. use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times.

21. Uphold your position as a registered nurse or midwife. To achieve this, you must:

    21.1. refuse all but the most trivial gifts, favours or hospitality as accepting them could be interpreted as an attempt to gain preferential treatment

    21.2. never ask for or accept loans from anyone in your care or anyone close to them

    21.3. act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care

    21.4. make sure that any advertisements, publications or published material you produce or have produced for your professional services are accurate, responsible, ethical, do not mislead or exploit vulnerabilities and accurately reflect your relevant skills, experience and qualifications

    21.5. never use your professional status to promote causes that are not related to health, and

    21.6. cooperate with the media only when it is appropriate to do so, and then always protecting the confidentiality and dignity of people receiving treatment or care.

22. Fulfil all registration requirements. To achieve this, you must:

    22.1. meet any reasonable requests so we can oversee the registration process

    22.2. keep to our prescribed hours of practice and carry out continuing professional development activities, and

    22.3. keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance.

23. Cooperate with all investigations and audits. This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register. To achieve this, you must:

    23.1. cooperate with any audits of training records, registration records or other relevant audits that we may want to carry out to make sure you are still fit to practice

    23.2. tell both us and any employers as soon as you can about any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction)

    23.3. tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body

    23.4. tell us and your employers at the first reasonable opportunity if you are or have been disciplined by any regulatory or licensing organisation, including those who operate outside of the professional healthcare environment, and

    23.5. give your NMC Pin when any reasonable request for it is made (when telling your employers, this includes telling (i) any person, body or organisation you are employed by, or intend to be employed by, as a nurse or midwife; and (ii) any person, body or organisation with whom you have an arrangement to provide services as a nurse or midwife).

24. Respond to any complaints made against you professionally. To achieve this, you must:

    24.1. never allow someone's complaint to affect the care that is provided to them, and

    24.2. use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice.

25. Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the healthcare system. To achieve this, you must:

    25.1. identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first, and

    25.2. support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken.

## Annex 2. Clinical Policy Ethics Assessment Tool

| Clinical Policy Ethics Assessment Tool (CliPEAT) [a] | | | | |
|---|---|---|---|---|
| | Acceptable | | Unacceptable | |
| **Design issues** | | | | |
| 1. Does the policy content manages a clinical field or is connected to an aspect of clinical practice? | Yes | Not applicable | Requires Clarification | No |
| 2. Does the policy design appropriately describe the clinical practice that it represents? | Yes | Not applicable | Requires Clarification | No |
| **Expertise, commitment and integrity issues** | | | | |
| 3. Does the team that created the policy have sufficient expertise to successfully create and update the policy? | Yes | Not applicable | Requires Clarification | No |
| 4. Does the team that created the policy have sufficient commitment, resources and support from the institution to successfully create and update the policy? | Yes | Not applicable | Requires Clarification | No |
| 5. Are the members of the team that created the policy experts in regards to the relevant clinical field and in good standing within the professional communities? | Yes | Not applicable | Requires Clarification | No |
| 6. Does evidence exist of past misconduct by members of the team that created the policy, individually or collectively? | No | Not applicable | Requires Clarification | Yes |
| 7. Do the financial, institutional, or other arrangements related to the policy pose any threat to the integrity of members of the team that created the policy, individually or collectively (e.g., significant "conflicts of interests")? | No | Not applicable | Requires Clarification | Yes |
| **Risks and benefits** | | | | |
| 8. Are risks associated with the relevant clinical practice minimised by the policy design? | Yes | Not applicable | Requires Clarification | No |
| 9. Does the policy pose excessive risk or other burdens to individual patients, the community or society? | No | Not applicable | Requires Clarification | Yes |
| 10. If patients are likely to have emerging symptoms (e.g. new symptoms or worsening existing symptoms) as a result of or during relevant clinical practice: | | | | |
| a. has an appropriate mechanism for identifying and following symptom progression been built into the policy? | Yes | Not applicable | Requires Clarification | No |
| b. has an appropriate mechanism for identifying when to discontinue the relevant clinical practice in order to begin standard treatment for emerging symptoms that pose safety risks or enduring distress been built into the policy? | Yes | Not applicable | Requires Clarification | No |
| c. has an appropriate referral mechanism to provide patients with standard treatment for emerging symptoms that pose safety risks or enduring distress been built into the policy? | Yes | Not applicable | Requires Clarification | No |
| 11. Are benefits in association with the relevant clinical practice optimised by the policy design for individuals and society? | Yes | Not applicable | Requires Clarification | No |
| **Confidentiality** | | | | |
| 12. Do the policy design and plans for data use adequately protect patient confidentiality? | Yes | Not applicable | Requires Clarification | No |

| | Acceptable | | Unacceptable | |
|---|---|---|---|---|
| **Informed consent and decisional capacity** | | | | |
| 13. Does the policy design define an appropriate informed consent process including:<br>- the policy´s purpose?<br>- who is responsible for the relevant clinical practice? | Yes | Not applicable | Requires Clarification | No |
| a. disclosure of information regarding:<br>- why may the individual be eligible as a receptor of the relevant clinical practice?<br>- the nature of the illness (or the relevant phenomenon)?<br>- the proposed intervention?<br>- the associated risks and benefits associated and their relative likelihood?<br>- alternatives to participation? | Yes | Not applicable | Requires Clarification | No |
| b. reasonable assurance of adequate decisional capacity of patients with respect to the ability to understand, rationally analyse and appreciate the meaning of their decision in regards to relevant clinical practice, **OR** reasonable assurance of adequately meeting all criteria under item 14 below? | Yes | Not applicable | Requires Clarification | No |
| c. reasonable assurance that individuals will not experience coercive pressure to be receptors of the relevant clinical practice (e.g. enough time obtaining the consent so all individuals can consider in detail their decision and seek the advice of other people, explicit recognition that participation is voluntary and that individuals can reject or withdraw their decision to be part of the relevant clinical practice without adverse consequences, provision of the right to refuse to be the receptor of the relevant clinical practice to individuals unable to give an informed consent)? | Yes | Not applicable | Requires Clarification | No |
| d. a concise, readable, accurate and understandable consent form, adapted to the relevant population **OR** an oral informed consent obtained in a conversation that includes all the criteria listed previously under items 13, 13a, 13b and 13c? | Yes | Not applicable | Requires Clarification | No |
| e. the context, if there are any, in which the lack of time and/or resources (emergency, crowding, major incident, etc.) allow the healthcare professional to obtain a presumed consent and/or to not obtain an informed consent for the benefit of the clinical practice receptor, the community and/or society? | Yes | Not applicable | Requires Clarification | No |

| | Acceptable | | Unacceptable | |
|---|---|---|---|---|
| 14. If individuals are likely to experience diminished decisional capacity during relevant clinical practice (including when they give their informed consent): | | | | |
| a. has an appropriate mechanism for identifying, following and documenting the level of diminished decisional capacity of the clinical practice receptor been built into the policy? | Yes | Not applicable | Requires Clarification | No |
| b. when possible, has an appropriate mechanism for enhancing or restoring the decisional capacity of the clinical practice receptor been built into the policy? | Yes | Not applicable | Requires Clarification | No |
| c. If a period of diminished decisional capacity may be necessary because of the nature of the relevant clinical practice (e.g. surgery under general anaesthesia, medication with neurological side effects, etc.), does the policy include: | | | | |
| 1) an appropriate mechanism for advance decision-making by the clinical practice receptor or for identifying an alternative decision-maker for the clinical practice receptor? | Yes | Not applicable | Requires Clarification | No |
| 2) an appropriate mechanism for implementing advance decisions or for preparing and utilising the alternative decision-maker when necessary? | Yes | Not applicable | Requires Clarification | No |
| **Professional accountability** | | | | |
| 15. Do the professionals authorised by the policy to perform the relevant clinical practice have enough training and/or experience to perform it, supervise it and/or evaluate it? | Yes | Not applicable | Requires Clarification | No |
| 16. Is the policy updated in accordance with the latest evidence-based practice? | Yes | Not applicable | Requires Clarification | No |
| 17. Does the policy follow the codes of conduct of the regulatory bodies of the healthcare professional involved in the relevant clinical practice (GMC, NMC, etc.)? | Yes | Not applicable | Requires Clarification | No |
| **Legal accountability** | | | | |
| 18. Does the policy follow the applicable legislation without any discrepancies? | Yes | Not applicable | Requires Clarification | No |
| 19. Does the policy specify in which situations, if there are any, healthcare professionals are not covered by the vicarious liability of the institution for which they practice? | Yes | Not applicable | Requires Clarification | No |

| | Acceptable | | Unacceptable | |
|---|---|---|---|---|
| **Other issues** | | | | |
| 20. Are documentation practices adequate to monitor policy procedures and healthcare professionals' accountability? | Yes | Not applicable | Requires Clarification | No |
| 21. Are future revisions of the policy programmed? | Yes | Not applicable | Requires Clarification | No |
| 22. Are other ethical problems apparent in this policy? If "yes", describe: | No | Not applicable | Requires Clarification | Yes |
| 23. Are other legal problems apparent in this policy? If "yes", describe: | No | Not applicable | Requires Clarification | Yes |
| 24. Are there other issues that interfere with policy approval? If "yes", describe: | No | Not applicable | Requires Clarification | Yes |
| 25. Prior to its approval, does the policy require additional review by others with more specialised expertise or by others with especially relevant interest and experience to assess its ethical or legal validity? | No | Not applicable | Requires Clarification | Yes |
| Does the policy, in its present form, meet minimal criteria for being ethically sound [b]? | Yes | | No | |
| Does the policy, in its present form, require a more rigorous level of monitoring than is customary? | No | | Yes | |

Comments:

[a] For use in the assessment of ethical aspects of clinical policies involving human participants.

[b] All evaluative criteria (items 1-25) must receive an acceptable response for the policy to be minimally acceptable on legal and ethical grounds. Problems, as indicated by responses in either of the second two columns, should be addressed formally and should undergo re-review prior to policy approval.

## Annex 3. Analysed policies and guidelines

| Policies and guidelines analysed with CliPEAT | |
|---|---|
| **Clinical techniques and competencies** | |
| Blood transfusion policy B16/2003 V4.0 | CPR UHL / LPT / LLR policy E4/2015 V2 |
| Oxygen therapy policy B27/2010 V2 | Urethral catheterisation policy B29/2007 |
| Administration of medicines to adult patients who cannot swallow tablets Guidelines for practice B31/2008 | Guideline for the insertion, care of and removal of a peripheral cannula in adults B33/2010 |
| IV UHL Policy B25/2010 V3 | Leicestershire medicines code policy B60/2011 V6 |
| Policy for the documentation of medication allergies B2/2013 V3 | Self-administration of medicines by adult patients or their relatives/carers [policy] B13/2004 V4 |
| Patient group directions policy B43/2005 V5.0 | Management of medication errors policy B45/2008 V2 |
| Procedure for obtaining venous blood samples from an adult [guideline] B16/2010 | Venous access in adults and children policy and procedures B13/2010 V3 |
| **General clinical practice** | |
| Adult patient transfer and escort policy and guidelines B30/2004 V3 | Healthcare environment cleaning policy and procedures B36/2010 |
| Aggressive parents in ED SOP C207/2016 | Policy for clinical handover B18/2013 V2 |
| Guidelines for the supervision and management of adult patients with agitated/challenging behaviours B6/2012 | Management of violence, aggression and disruptive behaviour policy B11/2005 V4 |
| Bed rail policy E2/2015 V7 | Aseptic non touch techniques guidelines B20/2013 |
| Policy for delegated consent B10/2013 V2 | Policy for consent to examination or treatment A16/2002 V10 |
| Fall management policy for adult-in-patients B15/2014 V2 | Good practice for patient-side nursing handover [guideline] |
| UHL policy for assessment and care management of patients at risk of wandering in hospital B25/2008 V4 | Guideline for the completion and escalation of Early Warning Scoring (EWS) monitoring system in adult patients B25/2011 |
| Policy for managing fluid balance and hydration in adult patients B38/2016 V1 | Mentorship policy for nursing and midwifery staff B24/2010 V2 |
| Hand hygiene policy and procedures B32/2003 | Infection prevention policy B4/2005 V3 |

| | |
|---|---|
| Hospital linen infection prevention principles [policy] B14/2012 | Guidance for the care of patients in the last days of life [guidelines] B1/2014 |
| Mental Capacity Act policy B23/2007 V4 | Missing patients policy – adults B15/2005 V3.1 |
| Policy for documenting in patients' health records B30/2006 V2 | Prevention and management of pressure ulcers in adults and children policy and guidance B23/2014 V2 |
| Patient identification band policy B43/2007 V3 | Managing pre-alert calls SOP C176/2016 V1.0 |
| Safeguarding adults – alerting and referring SOP C181/2016 V7 | UHL policy on safety standards for invasive procedures B31/2016 V1 |
| Sharps management policy B8/2013 V2 | Uniform and dress code policy B30/2010 V2 |
| **Nursing resource management** | |
| Cohorting of ambulance patients within the ED SOP V1.0 | Managing Assessment Bay at full capacity SOP V2.0 |
| Assessment bay operations and escalation SOP V3.0 | Majors standard operating procedures manual SOP V1 |
| The assessment of administration of medicines by nurses and midwives policy and procedures B13/2009 V2 | Policy for the support of staff involved in incidents, inquests, complaints and claims B28/2007 V3.0 |
| Work experience policy E4/2010 V2 | Initial assessment & dynamic priority scoring C174/2016 V3 |
| Temporary staffing policy and procedure B58/2011 V5.0 | Temporary nurse staffing operational policy B35/2016 V1.0 |

## Annex 4. Patient Information Sheet


University Hospitals of Leicester NHS
NHS Trust

**Ethical and legal accountability in nursing clinical practice: analysis of protocols and clinical activity in an English emergency department.**

**Participant Information Sheet (PIS)**

We would like to invite you to take part in a research study asking you some questions in an interview and/or a focus group. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

The first part of the Participant Information Sheet tells you the purpose of the study and what will happen to you if you take part.

Then we give you more detailed information about the conduct of the study.

Do ask if anything is unclear.

**Purpose of the Study**

The relationship between ethics and law and accountability in clinical nursing practice may seem obvious, but the current literature in the specific area of emergency care is very limited. In the case of England, emergency departments undergo an overcrowding stage that relaxes the limits of liability to which the nurse is subjected, who must deal with the subjectivity of the presumption of emergency and the rigidity of the NMC Code. That is why factors affecting the decision-making process are decisive to improve the quality of care and to understand what influences the care agent to work in one way or another.

To understand the accountability of the emergency department (ED) nurse, ethical and legal factors affecting professional responsibility in nursing practice in an emergency department will be studied. This requires a ternary ethnographic qualitative study that will consider the protocols of the department and the experiences of their nurses using protocol analysis, reflections on practice and individual and group interviews.

As a nurse working in the Emergency Department at the Leicester Royal Infirmary for more than six months, you are eligible to be interviewed as part of the individual or group interviews. This study will end when enough participants are interviewed and data form their interview reaches data saturation.

**Taking part in the Study**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form.

If you decide to take part you are still free to withdraw at any time and without giving a reason.

**Description of the Study**

This study is a PhD student research project, which is undertaken to obtain a PhD award. It has three sources of data, protocol analysis, reflections on practice and individual interviews / focus groups, however you will only be involved in an individual interview and/or a focus group. You can participate either in an individual interview, a focus group or both.

The interviews and the focus groups are semi-structured, so they have open questions but they are focused around a theme. The interviews will be individual, but the focus groups will be formed with between 4 and 8 participants. Your interview or focus group will last around 45-90 minutes, but you can stop it at any time if you need to.

The interview will be done in a place which will be agreed between the interviewer and the interviewee, which could be in the hospital or outside, but it cannot be done in any clinical area. These areas include a room in the hospital not located in a clinical area, the interviewee´s house or any neutral location that does not create any mayor distraction, compromise the interviewee´s privacy or coerce the interviewee in any way.

The focus groups will be arranged in a non-clinical room in the hospital. The specific time of each focus group will be set according to the interviewees' availability, being the

non-clinical hospital room booked after the day and time is agreed between interviewer and interviewees.

The interview and/or the focus group that you could participate in will be done in your spare time, so I will be very grateful if you decide to spend a few minutes of your precious time to allow this research to happen.

The audio from your interview will be recorded to be anonymised and analysed by the researcher using ethnographic content analysis. No follow-up to this interview is required.

When all interviews are finished, data will be catalogued and compared with the reflexions on practice and the protocol analysis.

**Potential Benefits**

There are no results which will benefit you specifically, but there could be benefits your practice as a nurse and your care as part of the public. Some of the possible consequences of this study and its influence are:

- Defining accountability standards to which nurses are subjected, reducing burnout and increasing permanent staff.
- Indicating ethical and legal factors related to nursing clinical practice in emergency departments, shaping policies and protocols around them.
- Identifying common legal infractions and immoral behaviours which nurses suffer or commit, finding the root of them and how to reduce them, thereby increasing patient satisfaction and quality of care.
- Analysing the relationship between ethical and legal factors could avoid contradictions between them, resulting in a reduction of excessive documentation and a safer and more independent practice.

**Potential disadvantages**

The only disadvantage is the risk of finding serious concerns of poor practice, like matters of Fitness to practice, breaches of the Code of Conduct or of Duty of Care. These must be reported to the participant´s employing authority (your line manager) and, if appropriate, their regulatory body (NMC) as appointed by UHL procedures.

We can discuss this issue further before you giving consent so you feel confident that only cases of severe and unmanaged malpractice are reported, which will be treated with strict confidentiality. If after explaining this to you do not feel comfortable participating in the study, you are welcome to withdraw the study without any consequences.

**Voluntary Participation and Discontinuation**

Your participation in this study is voluntary. If you agree to take part and then change your mind and wish to withdraw you may do so at any time. Any data collected from participants that withdrawn for the study will be excluded from analysis and destroyed, only the reason for withdrawal could be recorded. Your legal rights will not be affected by your giving consent to participate.

**Confidentiality and Participants´ Rights**

If you agree to take part in the study you will need to sign and date an Informed Consent Form. All information, which is collected, about you during the course of the research will be treated as strictly confidential. Please initial the consent form to indicate you are happy for us to do this. Your legal rights will not be affected by agreeing to take part in or withdrawing from the study. You are free to withdraw from the study at any time without giving a reason.

You will be given an ID code which will be used instead of your name. Any identifiable information will be removed and anonymised. Any direct quotes used will be anonymised, however it may be that something you say may be recognised by others. Procedures for handling, processing, storage and destruction of study data meet the requirements of the Data Protection Act 1998.

The trial master file and all printed and written documents with any contact details and copies of consent form will be held in a participant file identified by a number code only and stored in a locked cabinet at the Leicester Royal Infirmary. All names and identifying information will be removed from the interview and focus group transcripts, using only pseudonyms to identify the participants.

The computerized data will be anonymized and analysed in UHL and DMU facilities. However, all data will be anonymized from the audio files before it is computerized. All computerized data will be locked under a password and a security copy will be created in another drive in the same computer to avoid data loss in case of hard drive failure.

All data from the trial master file, all printed, written data and computerized data relevant to this research will be held 5 years after the end of the study before being shredded or deleted, following UHL policies.

You should also be aware that I may be duty bound to pass on information that you provide that reveals harm has occurred to a child or other vulnerable individual.

In focus groups I cannot promise confidentiality as that duty cannot be imposed on all participants in that kind of interview but all data that I collate will be anonymised.

**What if I am harmed by the study?**

It is very unlikely that you would be harmed by taking part in this type of research study. However, if you wish to complain or have any concerns about the way you have been approached or treated in connection with the study, you should ask to speak to the Chief Investigator of this research (details below) who will do their best to answer your questions. If you remain unhappy and wish to address your concerns or complaints on a formal basis, you should contact Patient Information & Liaison Service at pils.complaints.compliments@uhl-tr.nhs.uk.

The Firs, c/o Glenfield Hospital

Groby Road, Leicester LE3 9QP

Freephone: 0808 1788337

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against University of Leicester but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate).

**Results of the Study**

At the end of the study the information collected will be analysed and published in recognised journals. Your department will be informed of any publications and you will be able to obtain a copy of these publications on request. The identity of the participants will remain confidential.

**Organisation and funding of the study**

The research study is being sponsor by the University Hospitals of Leicester. The research is self-funded.

**Time to Consider**

You can take as much time as you need to decide if you wish to take part, been the minimum 30 minutes. I will give you this before the interview date so you can read it and consider it. At the interview day I will go through it in detail with you explaining all sections and answering your questions. After that, you have to give your informed consent before we start the interview.

**Who Should You Contact with Questions?**

You will be given a copy of this information sheet and the signed consent form to keep if you decide to take part on the study. If you have any problems or questions you should contact the Chief Investigator:

Alfonso Rubio Navarro

Work email: alfonso.navarro@hotmail.com

Personal email: pocho_r.navarro@hotmail.com

Personal phone number (for urgent enquiries): 07926642498

We would like to thank you for reading the Patient information sheet and for considering taking part in this study. If you have any further questions please talk to the researcher before considering participation into this study.

## Annex 5. Consent form

RESEARCH & INNOVATION

University Hospitals of Leicester NHS
NHS Trust

Study Number: 215141

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: Ethical and legal accountability in nursing clinical practice: analysis of protocols and clinical activity in an English emergency department.

Name of Researcher: Alfonso Rubio Navarro

**Please initial all boxes if you agree**

1. I confirm that I have read and understand the information sheet dated 12/04/17 (version 1.3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. ☐
3. I understand that data collected during the study, may be looked at by academic supervisors, individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission to the supervisor to have access to my data. ☐
4. I understand that any serious concerns related to poor practice identified in this study must be reported to the appropriate parties. ☐
5. I agree to the interview being digitally audio recorded, and to the use of non-identifiable quotes in articles, thesis or conference presentations. ☐
6. I understand that data will not be analysed in a NHS site after being collected and will not be stored on NHS computers. ☐
7. I agree to take part in the above study. ☐

| Name of Participant | Date | Signature |
|---|---|---|
| Name of Person taking consent. | Date | Signature |

Consent form date of issue: 12/05/2017
Consent form version number: 1.3

Page 1 of 1

**Annex 6. Semi-structured interviews' basic guidance**

I. Opening

[Shake hands] My name is Alfonso, and as a member of the research team I think it would be a good idea to interview you so that I can gain knowledge from your experiences as a nurse.

I would like to ask you some questions about nursing ethical and legal accountability in order to learn more about how these topics interact in clinical practice.

II. Body

[Basic topics to guide the interview/focus group, to be changed or expanded according to each participant's responses]:

- What are your priorities at work?
- Tell me about your responsibilities as a nurse.
- What do you think nursing responsibilities should be?
- What are the risks of being a nurse?
- Did you ever feel at risk of losing your PIN/NMC registration? Why? That was though in university or you learn it in practice?
- Which values or codes do you follow to make a decision in practice? And your colleagues?
- Did you ever feel that you were not able to manage what you were responsible for? Why? What happened?
- Can you explain to me what are you accountable for? (when the participant is receptive)
- Do you know any protocol that applies to your practice? Can they improve your practice or they only are an obstacle to care for your patients?
- If you could make any changes to your practice, which ones would you implement?

III. Closing

[Perform member check if applicable].

I should have all the information I need. Thanks again. If you have any questions or concerns related to this interview do not hesitate to contact me.

## Annex 7. Recommendations

| Ref no. | Theme | Recommendations |
|---|---|---|
| **Care provision** | | |
| 1 | Holistic care | Care provision should consider every patient holistically to meet high standards of care. Holistic nursing care is challenging in an emergency department mainly due to high clinical workload, so it has to be controlled to allow humanised individualised care. |
| 2 | Nurse-patient relationship | Appropriate nurse-patient relationships should reduce patient distress and improve patient satisfaction with the service, since they have to be focused on the provision of holistic care.<br>The quality of the nurse-patient relationship should be measured with patients' opinions using tools like an expanded Friends and Family questionnaire and should be included as a care quality indicator. |
| 3 | Dehumanised care | Dehumanised care is a common phenomenon in emergency departments, which can affect care quality, patient safety and staff morale. The main method to avoid it is clinical workload control, but including physical, psychological, emotional and spiritual care within clinical guidelines and policies should be considered to ensure that nurses are able to provide holistic care and are not punished for it. |
| 4 | Health promotion | The incorporation and protection of health promotion as a role in emergency nursing practice should be implemented due to its several benefits, since nurses interact with a large percentage of the population:<br>Recurrent attendances avoidance<br>Quality of life and self-caring capabilities increase<br>Patient autonomy empowerment |
| 5 | Equal treatment | Equal treatment is paramount to ensure that resources are shared fairly and no patients are discriminated. Training should limit prejudgments, but senior role modelling should be encouraged to reduce accidental and purposeful discrimination. |

| Ref no. | Theme | Recommendations |
|---|---|---|
| 6 | Patient advocacy | Nurses should act as patient advocates, primarily with dependant and vulnerable patients. To empower them, healthcare institutions should implement patient advocacy as a main nursing role, reinforcing decisional capacity to facilitate that the nurse's ability to protect the patient is not nullified or coerced by third parties without a compelling argument. |
| 7 | Individual decision-making | How their personal background affects nurses' decisions is inherent and individual to every nurse, but if the healthcare institution prevents ethical dilemmas in which nurses are forced to make decisions against their own professional values they will not have a negative effect on the care provided. Those ethical dilemmas should be avoided if the healthcare institution provided:<br>Controlled clinical workload<br>Consistent staff safety levels<br>Reliable institutional legal support<br>Adequate staff satisfaction |
| 8 | Oral informed consent | Appropriate oral informed consent should be obtained before providing care that involves an interaction with the patient, including techniques and basic care. It should be incorporated into nursing training, both pre and post-registration.<br>In addition, it should be reminded and reinforced in technical teaching to both nurses and healthcare assistants. |
| 9 | Confidentiality | Adequate confidentiality management, both for oral and written information, should be incorporated into clinical practice and policies to protect patients' privacy. |
| 10 | Teamwork | Multidisciplinary teamwork should be promoted at all levels of the hospital hierarchy, avoiding that a professional or a group of professionals monopolise clinical decision-making. Nursing and multidisciplinary teamwork should be encouraged through various methods:<br>Multidisciplinary staff meetings, including team building activities in clinical areas and outside them<br>Institutionalised team accountability sharing<br>Effective communication techniques<br>Senior support and role modelling |

| Ref no. | Theme | Recommendations |
|---|---|---|
| **Nursing staff management** | | |
| 11 | Pre-registration training | To be able to provide holistic care in a variety of settings to a changing population with complex needs, pre-registration training should adapt to global contemporary nursing practice. To allow this, a 3-years generalist nursing training should be implemented, after which a one-year mandatory adult, paediatric, mental health or mental disabilities specialisation should be implemented to not disrupt the actual division of nursing practice.<br>Nursing care plans, NANDA nursing diagnoses, Applied Nursing Ethics, physiological and pathological fundamentals and nursing technical competencies should be included as an integral part of the generalist nursing degree, preparing the nurse to be ready to practice independently and as part of a team after finishing the degree. |
| 12 | Post-registration training | Continuous professional development training allows nurses to obtain more skills and knowledge to improve patient care and coordinate teams efficiently.<br>To allow nurses to deliver high-quality care, the number, length and diversity of nursing courses should be increased to match the complexity of their patients' needs. This need should be reflected in an increment of the mandatory training hours for NMC revalidation. |
| 13 | Supervised practice | Supervised practice for both recently trained nurses and nurses obtaining practical competencies should be protected, since both the learner and the mentor should focus on the learner's training to create an adequate teaching experience. This supervised practice should also include one-to-one support in team coordination and patient triage. |
| 14 | National training standards | Post-registration training standards, courses and modules should be unified nationally, so they can be interchangeable between Trusts and meet the same quality standards. |
| 15 | Course cancellation | Training courses should not be cancellable due to high clinical workload, since the lack of nursing training should increase clinical workload in the future. |

| Ref no. | Theme | Recommendations |
|---|---|---|
| 16 | Evidence-based practice | Evidence-based practice should be promoted and routine practice based on anecdotal evidence should be actively avoided. To encourage that, nursing research should be promoted and nurses should have protected allocated time to update their practice through new research and policies. |
| 17 | Etiquette | Nursing etiquette hinders care quality and furthers stereotypes that damage public opinion of both the nursing profession and the healthcare institution. It should be changed to an ethical-based behaviour system that uses research evidence to provide excellent care. |
| 18 | Aesthetic restrictions | Any aesthetic restrictions that are not based on infection prevention evidence (e.g. hair colour, tattoos, socks' colour, etc.) should be eliminated, avoiding any unnecessary violations of nurses' right of self-expression. |
| 19 | Professional responsibility culture | A culture of professional responsibility should be reinforced, in which nurses want to learn and care for their patients to ensure that the care they provide meet the highest standards possible because they feel responsible for their patients' care. To allow this, the current culture of subservience should be discouraged, in which nurses are encouraged to follow orders without questioning if they could be detrimental to the patient, the service or their practice. |
| 20 | Recruitment and retention | The chronic nursing shortage affects all English hospitals, so nursing recruitment and retention is a prime priority for every NHS Trust. To increase recruitment, nursing training should be funded by the NHS until nurses' working conditions match other degree-trained professions. The main action to increase retention should be boosting staff satisfaction. |
| 21 | Staff satisfaction | Staff satisfaction is key to increase retention, productivity and to encourage more people to become nurses. To increase it, working conditions should be improved in different areas:<br>Safe patients per nurse ratios<br>Training and development opportunities<br>Salary progression<br>Eradication of vertical and horizontal bullying<br>Furthermore, holistic care provision should be supported and staff satisfaction with their practice should be promoted to avoid that their values dissociate from their practice due to care dehumanisation. |

| Ref no. | Theme | Recommendations |
|---|---|---|
| 22 | Patients per nurse ratio | Safe patients per nurse ratios in ED and in other departments should be calculated around holistic care provision, not minimum service provision. Regular patient needs and break and transfer coverage should be taken into account when calculating safe patient per nurse ratios.<br>Moreover, these ratios should be legally binding to avoid errors, negligent acts and deficient care, amongst others. |
| 23 | Staff safety | Staff safety should be protected actively not only to ensure low absence rates and high retention rates but also to reduced clinical errors and avoid vicarious legal repercussions. This protection should include:<br>Verbal and physical abuse risk control<br>Institutional legal support<br>Periodic staff stress assessments<br>Continuous senior clinical support<br>Structured shift patterns and flexible shift planning |
| 24 | Defensive practice | Defensive practice should be minimised through active and passive actions in practice:<br>Clinical workload control<br>Appropriate patient to nurse ratio<br>Adequate time management<br>Staff legal protection<br>Risk avoidance measures |
| 25 | NMC fear culture | The Nursing and Midwifery Council fear culture should be eradicated locally and nationally to avoid defensive practice and reduce stress in clinical practice. To allow this, several changes should be implemented:<br>NMC fitness to practice proceedings should be restructured.<br>A safe registration culture should be encouraged.<br>The NMC code should be rewritten to fix its discrepancies with other applicable legislation and codes of Ethics. |

| Ref no. | Theme | Recommendations |
|---|---|---|
| **Public expectations** | | |
| 26 | NHS Trust actions | Public expectations should be modelled by honest statements to encourage transparency and fair distribution of public services. At an NHS Trust level, several changes should be implemented:<br>Waiting times should be displayed in real time to the public at all times.<br>Patients should not be prioritised by non-clinical reasons (e.g. to avoid complaints).<br>Patient feedback should be a mandatory requirement for every patient discharged home. |
| 27 | Government actions | NHS' public expectations are also a responsibility of the local and national government, which should action applying two main policies:<br>A clear description of the healthcare services capacity should be made easily accessible to the public.<br>Basic health education should be taught to children in their schools and adults in their workplaces. |
| 28 | Self-care | Self-care should be encouraged to boost the autonomy of the public and promote the responsible use of healthcare services. As part of this recommendation, healthcare services should only cover the needs that patients cannot cover by themselves, facilitating their independence inside and outside the hospital. |
| **Resource distribution** | | |
| 29 | Department location | All areas to which an emergency department frequently transfers patient to should be in the same hospital as the aforementioned emergency department. This recommendation should avoid frequent hospital transfers, which are more cost-efficient since less private ambulance services will be needed, and should reduce dangerous ambulance transfers of critical patients. |
| 30 | Stock replacement | Clinical stock replacement should be embedded into nursing practice with protected time or there should be specialised staff dedicated to it, since using nursing staff clinical time for it leads to inconsistent stocking and inferior nursing care. |

| Ref no. | Theme | Recommendations |
|---|---|---|
| 31 | Distribution priority | Resource distribution in an emergency department is very complex, since the service demand increases progressively. Available resources should be distributed based on patient needs to avoid any health deterioration, even though national care quality objectives should also be considered. |
| **Clinical workload** | | |
| 32 | Clinical workload control | Clinical workload is the manifestation of systematic problems related to clinical practice. Due to this, it can be improved through many changes. However, to ensure long-term clinical workload stability three factors should be improved:<br>Nursing ratios and training<br>Patient and staff safety<br>Multidisciplinary teamwork |
| 33 | General patient safety indicator | Clinical workload should be considered institutionally not only as a performance indicator but also as a measurement of general patient safety, since they balance each other constantly. |
| **Patient flow** | | |
| 34 | Patient flow contextualisation | Patient flow should be measured in context with different parameters to facilitate long-term planning:<br>Clinical workload progression<br>Population growth trends<br>Ward capacity and discharge rates<br>Patient factors<br>Re-attendance rates<br>Nursing ratios and skills |

| Ref no. | Theme | Recommendations |
|---|---|---|
| **Protocolisation** | | |
| 35 | Protocolisation foundation | Protocolisation enables indirect practice, safety and staff monitoring and support, which standardises it throughout the department. However, protocols and policies should be based on research evidence and community values to avoid any individual or group malicious influence. |
| 36 | Protocolised safe practice | Safe practice has to be encouraged by the healthcare institution to standardise patient safety and clinical efficiency by creating updated evidenced-based policies and implementing them to the context in which the patient is cared for. |
| 37 | Policy network | Policies should be connected together in a network by both citing them in the related policy and connecting them on the intranet, allowing an adequate use of the policy itself and facilitating the use of policies as support in clinical practice. |
| 38 | Policy and practice | To facilitate that policies are connected to practice and can be achievable in it, policymakers should be at least partially active in the practice they are regulating and/or policies should go through a consultation by the clinical professionals that would be ruled by it. |
| 39 | Sensible use of policies | Clinical reasoning should be encouraged and policy use should be reserved to basic knowledge, routine practice and conflict resolution. |
| 40 | Hierarchical bureaucracy control | Hierarchical bureaucracy should be controlled through transparency, monitored corporate decision making and appropriate accountability for their decisions, including their indirect effects. |

## Annex 8. Timeline

| | 2014 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Activities** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** |
| **Reflexions on practice** | | | | | | | | | | | | |
| **Literature search** | | | | | | | | | | | | |
| **Theoretical framework** | | | | | | | | | | | | |
| **Methodology** | | | | | | | | | | | | |
| **Policy ethical analysis** | | | | | | | | | | | | |
| **Interviews** | | | | | | | | | | | | |
| **Codification** | | | | | | | | | | | | |
| **Triangulation** | | | | | | | | | | | | |
| **Results** | | | | | | | | | | | | |
| **Discussion and conclusions** | | | | | | | | | | | | |
| **Final revision and translation to English** | | | | | | | | | | | | |
| **Thesis presentation expected date** | | | | | | | | | | | | |

| | 2015 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Activities** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** |
| **Reflexions on practice** | | | | | | | | | | | | |
| **Literature search** | | | | | | | | | | | | |
| **Theoretical framework** | | | | | | | | | | | | |
| **Methodology** | | | | | | | | | | | | |
| **Policy ethical analysis** | | | | | | | | | | | | |
| **Interviews** | | | | | | | | | | | | |
| **Codification** | | | | | | | | | | | | |
| **Triangulation** | | | | | | | | | | | | |
| **Results** | | | | | | | | | | | | |
| **Discussion and conclusions** | | | | | | | | | | | | |
| **Final revision and translation to English** | | | | | | | | | | | | |
| **Thesis presentation expected date** | | | | | | | | | | | | |

| | 2016 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Activities** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** |
| **Reflexions on practice** | | | | | | | | | | | | |
| **Literature search** | | | | | | | | | | | | |
| **Theoretical framework** | | | | | | | | | | | | |
| **Methodology** | | | | | | | | | | | | |
| **Policy ethical analysis** | | | | | | | | | | | | |
| **Interviews** | | | | | | | | | | | | |
| **Codification** | | | | | | | | | | | | |
| **Triangulation** | | | | | | | | | | | | |
| **Results** | | | | | | | | | | | | |
| **Discussion and conclusions** | | | | | | | | | | | | |
| **Final revision and translation to English** | | | | | | | | | | | | |
| **Thesis presentation expected date** | | | | | | | | | | | | |

| | 2017 | | | | | | | | | | | |
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| **Activities** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** |
| **Reflexions on practice** | | | | | | | | | | | | |
| **Literature search** | | | | | | | | | | | | |
| **Theoretical framework** | | | | | | | | | | | | |
| **Methodology** | | | | | | | | | | | | |
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| **Interviews** | | | | | | | | | | | | |
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| **Discussion and conclusions** | | | | | | | | | | | | |
| **Final revision and translation to English** | | | | | | | | | | | | |
| **Thesis presentation expected date** | | | | | | | | | | | | |

| | 2018 | | | | | | | | | | | |
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| **Activities** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** |
| **Reflexions on practice** | | | | | | | | | | | | |
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