

# Thinking about the emotional labour of nursing – supporting nurses to care

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## Abstract

**Purpose** – The aim of this article is to report some of the work undertaken by a nursing “think tank”, focussed on examining the causes of poor nursing care in hospitals, and potential solutions.

**Design/methodology/approach** – A “think tank” was convened which incorporated widespread discussion with national, regional and local stakeholders, a critical literature review, and a focus group of senior nurses.

**Findings** – It was found that there are no widespread systems of staff support that help nurses working in hospitals to cope with the emotional component of their work. This is one element that contributes to nurses providing poor care. A number of approaches to staff support have been developed that warrant further study.

**Practical implications** – If episodes of poor care are to be prevented it is necessary for hospital boards to recognise the importance of supporting nurses in managing the emotional labour of caring. The introduction of routine systems of staff support should be considered.

**Originality/value** – In addition to highlighting and condemning poor care, it is important to seek solutions. This article offers a new perspective on an enduring problem and identifies approaches that can be part of the solution.

**Keywords** - Emotional labour, Care, Staff support, Hospitals, Nurses, Nursing, Patient care, Management stress

## **Paper type - Viewpoint**

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## **Introduction**

How can we ensure patients are treated with compassion in hospitals? Nurses work in a healthcare system that, although complex, is highly regulated. Despite this, there have been several recent high-profile reports that record a litany of failure to provide dignified, competent, nursing care, particularly in the English National Health Service (NHS) (Francis, 2010; Abraham, 2011; Care Quality Commission, 2011). Complaints about poor care are not new, and date back to the 1960s and beyond (Walshe and Higgins, 2002); however, there has been an increase in negative stories about hospital care of late, which is also of growing international concern (Ojwang et al., 2010; Darbyshire, 2011). Despite the formulaic response to such episodes, which has been to investigate, and/or hold an inquiry, then produce a number of recommendations for change, the problems persist (Commission on Dignity in Care, 2012). This begs the question: what else can be done? This paper reports some of the work undertaken by a “nursing think tank” that focused on examining the key challenges and identifying potential solutions.

## **Background**

Whilst nursing has always been a difficult job, it may have been made more so, albeit unknowingly, by the removal of routines that in the past helped nurses manage the anxieties associated with care (Menzies, 1960). In addition, greater patient acuity, increased pressure on beds, the imperative of performance targets, and meeting the requirements of numerous external and regulatory bodies have all had an impact on the environment of care. Indeed, the development of a performance culture may have affected nursing disproportionately, because it is hard to measure compassionate care. In an environment that has often been characterised as “what matters is what’s measured” (Bevan and Hood, 2006), nursing may be deemed unimportant until cases of poor care emerge, resulting in investigations, disciplinary action and blame. This situation has been exacerbated by media reports vilifying nurses (Phillips, 2011; Marrin, 2009) rather than considering the wider organisational issues. For example, an

analysis of the factors contributing to quality failures found that they are systemic and not specific to the nursing profession (Walshe and Higgins, 2002). To explore this further, the authors engaged in discussions with key stakeholders at local, regional and national levels in the NHS, and conducted a critical literature review (see below) and two focus group meetings of nine Executive Nurses from acute hospitals (see Sawbridge and Hewison, 2011). The work considered the environment of care, and education and development; however, the focus in this paper is on the need to support nurses in managing the emotional labour of caring.

### **Nursing and emotional care – a brief review of the literature**

The role of the nurse involves supporting people when they are distressed, suffering and dying. Nurses provide 24-hour continuous care for patients, all year round and feel the full, immediate, and concentrated impact of the stresses arising from patient care (Menzies, 1960). Their “work involves carrying out tasks which, by ordinary standards, are distasteful, disgusting and frightening” (Menzies, 1960, p. 97). However despite the evidence linking staff well-being and improved patient care (McKee, 2010; West and Dawson, 2011), there is no system of routine staff support for nurses. Hochschild’s (2003) concept of emotional labour is relevant here. Originally developed in a study of flight attendants, later work drew on it to demonstrate how the emotional component of nursing is rendered invisible and so is not managed (Smith, 1992; Gray and Smith, 2009). The dissonance arising from the constant suppression of powerful emotions can result in “burnout” (Smith, 1992; Gray and Smith, 2009). In the past a task-centred approach to care provided some level of emotional distance and protection for nurses (Menzies, 1960), and whilst recognising that task allocation was not the best way to organise care, Menzies (1960) identified its value in enabling nurses to cope with the stress of caring. The dismantling of the rituals and routines, as an outcome of efforts to delineate nursing’s contribution as a professional discipline (Allen, 2001), has removed other “defence mechanisms”. For example, the individualised care at the heart of the nursing process was intended to engender a more systematic holistic approach to care, summarised as: “It’s more thinking of the patient as a whole as opposed to one nurse being responsible for bedpans etc” (Smith, 1992, p. 39). This makes emotional demands on individual practitioners, making them more vulnerable to distress. Other supportive organisational arrangements have also been eroded. Changes to shift patterns resulting in shorter handover periods, some taking place at the bedside rather than in an office, have removed an opportunity for nurses to express concerns about their work in private and alleviate stress by sharing “vocabularies of complaint” (Turner, 1987). Similarly, the closure of hospital laundries

means that most nursing staff do not remove their uniforms before leaving work, and so do not have the opportunity to symbolically divest their work concerns along with their uniform before leaving the hospital. These were important, if unacknowledged, processes for managing the “emotional labour” of nursing work, and nurses now have fewer sources of informal support available to ameliorate the pressures of delivering compassionate care, day in and day out. This is not to advocate a return to task-based approaches to care, or to argue that care was always better in the past; rather, it is to surface the issues and identify the need to recognise the effect these changes have had on nurses. A balanced approach to changing working practices is needed to ensure the impact on staff does not translate into potentially negative effects on patient care. Although the high emotional cost of caring is identified in the literature, it is rarely discussed in the media, and the reality of what is involved is overlooked in trusts. In order to convey what a typical day was like, Benner and Wrubel (1989) described a personal nursing experience (see Appendix 1). Although drawn from work in the USA, it reflects the relentless stresses of a “routine” working day that nurses worldwide would recognise. It shows how sustained exposure to such pressures can result in burnout manifested as emotional exhaustion, depersonalisation, and a reduced sense of personal accomplishment (Leiter and Maslach, 1988). If not addressed, burnout can result in a shift in attitude from positive and caring to negative and uncaring on the part of the nurse (Vaughan and Pillmoor, 1989). This conclusion is as relevant now as it was in the 1980s.

### **Exploring the emotional labour of nursing care: from theory to practice**

When reflecting on our literature review with the senior nurses in the focus group, they accepted that nursing care is emotionally difficult, yet felt supporting nurses in their role and embedding systems to do this were problematic. Although the literature suggests this is worthwhile, the senior nurses identified significant barriers preventing the provision of systematic support for nurses. For example they reported that clinical supervision, based on a model of reflective practice recommended by the UK Central Council for Nursing and Midwifery in the 1990s (United Kingdom Central Council for Nursing and Midwifery, 1995) had failed. They also felt the costs of introducing a support system for staff were prohibitive and acknowledged that apart from counselling services for staff diagnosed with stress there was no provision. However, they did identify other ways of supporting staff, for example one had implemented a coaching programme to support leaders in bringing about cultural change in the trust and it was argued that support for staff with the emotional component of their work may occur as a fortunate by-product. Another initiative was the change to 12-hour

shifts. In the participants' hospitals the nurses had welcomed the opportunity to work fewer days and have more time away from work. This arose out of the desire to manage the staff resource more effectively rather than to address the issue of emotional labour, and although welcomed by the staff, decisions seem to have been taken without recourse to the literature, which reports the problems associated with longer shifts. These include increased fatigue, which is negatively correlated with performance, increased incidence of needlestick injury, and reduced standards in hand washing ( Josten et al., 2003; Barker and Nussbaum, 2011). This demonstrates how actions taken to address one problem can cause others in the form of unanticipated consequences, so although the nurse directors and their staff had implemented 12-hour shifts, the longer-term impact on care is less clear, particularly with regard to emotional labour.

Whilst these organisational approaches may bring about some changes in the nursing experience, they neglect the fundamental issue of emotional labour, which needs to be discussed openly and addressed by organisations (Benner and Wrubel, 1989; Smith, 1992). In light of this, what can be done? There are some models available that could be further developed and introduced in a wider range of care settings to support nurses and help them manage their emotional labour.

As part of its Point of Care programme, the King's Fund commissioned an evaluation of Schwartz Centre Rounds (Goodrich, 2011), which had been piloted in two UK hospitals. The rounds involve multi-disciplinary discussion about the impact of a case on the team, and provide space for group reflection and acknowledgement of the emotional labour of care. They were found to have a positive impact on supporting staff to improve patient care and organisational culture, reducing isolation (Goodrich, 2011), which suggests this model may be beneficial in other settings.

In a similar vein, a system of clinical supervision support for health visitors was introduced to combat low morale in a health visiting service. Prior to its introduction, the stress levels of the staff were measured and 33 per cent were found to have levels of stress higher than ambulance workers who had been asked to reflect on a recent traumatic episode and 23 per cent had higher scores than soldiers removing deceased colleagues from the battlefield. However following a programme of "restorative supervision", burnout was reduced by 36 per cent in most participants, and stress by 59 per cent. The staff valued the supervision, feeling it restored their ability to think clearly and make decisions (Wallbank and Preece, 2010).

This suggests that, if managed well and funded adequately, systems of staff support can be effective. Another approach that could be applied has been developed by the Samaritans organisation (see Appendix 2). Before working for the Samaritans volunteers are given training and guidance so they are able to provide the emotional

support callers need. The emotional distress experienced by callers is often severe, with some making contact whilst in the act of suicide. Clearly this is an extremely difficult task and in recognition of this the Samaritans provide a structured support system. It has much to offer nurses in terms of helping them manage the emotional labour inherent in their role.

## **Conclusion – learning to labour**

The emotional labour of nursing is “real”, and needs to be acknowledged and managed in hospitals (Benner and Wrubel, 1989; Smith, 1992). In addition there are significant financial savings to be made from reducing sickness through appropriate staff support (Department of Health, 2009). This suggests that trust boards should recognise the emotional labour of nursing and establish a systematic approach to supporting nurses, potentially by adopting one of the models reported in this paper. Their application should then be evaluated to assess their impact on nurses as carers and the subsequent outcomes for patients. It is assumed that “kindness and compassion costs nothing” (Williams, 2011), in economic terms perhaps, yet the emotional cost can be high. Staff do not need more blame and condemnation; they need active, sustained supervision and support (Cornwell, 2011), and this will only occur if urgent management action is taken in health organisations.

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### **Appendix 1. Coping with care giving (Benner and Wrubel, 1989)**

I am in charge tonight with five nurses and 30 patients. Two of my nurses have never been on the floor; one will be an hour late, so I will have to cover her patients. Our medical-surgical patients have diagnoses (including) kidney failure, stroke, diabetes, cancer, sickle-cell disease, hepatitis, AIDS, pneumonia and Alzheimer's disease. The average age of our patients is 79. We have five fresh post-operative patients and one going to surgery in two hours. As I come out of report one of our stable patients transferred from the Coronary Care Unit yesterday, is having chest pain. There is a doctor on the telephone waiting to give admission orders and the anaesthetist for our pre-operative patient wants the old chart, now. Down the hall an elderly confused patient has just crawled over the side rails and fallen. Two of our post-op patients are vomiting as a side effect of the anaesthesia, (and) their families are very tense and need reassuring. One of the patients I am caring for has just pulled out his IV; another wants something for pain; another needed the bed pan and I got there too late. The lab has called with a critical low haemoglobin level on the patient who pulled out his IV; he'll be getting a few units of blood as soon as possible (emphasis in the original).

### **Appendix 2. The Samaritans**

Samaritans aims to benefit society by improving people's emotional health in order to create a greater sense of well being. Apart from being a 24-hour source of support on the telephone, by e-mail, by letter or face to face, we also work in the local community. Support system Each volunteer undergoes training before taking calls. Each shift is between 3-5 hours, and volunteers work in pairs. The callers are often greatly distressed, and volunteers are actively encouraged to share their last call with their partner in the "down times" between calls. If the volunteer needs longer to debrief, the telephones are turned off. This is rarely necessary as most debriefs are completed in a few minutes. It is recognised that that if the volunteers are not cared for they will be unable to support the callers, and the "switch off" option demonstrates this commitment to the volunteers. At the end of each shift, the volunteer "offloads" to the shift leader by summarising the types of calls taken and how the volunteer is feeling. The leader makes a judgement about the emotional health of the volunteer, and if the volunteer was particularly affected, she/he will be contacted the next day to see how they are.

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