

'Poppets and parcels': the links between staff experience of work and acutely ill older peoples' experience of hospital care

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Background. Few empirical studies have directly examined the relationship between staff experiences of providing healthcare and patient experience. Present concerns over the care of older people in UK acute hospitals – and the reported attitudes of staff in such settings – highlight an important area of study.

Aims and objectives. To examine the links between staff experience of work and patient experience of care in a 'Medicine for Older People' (MfOP) service in England.

Methods. A mixed methods case study undertaken over 8 months incorporating a 149-item staff survey (66/192 – 34% response rate), a 48-item patient survey (26/111 – 23%), 18 staff interviews, 18 patient and carer interviews and 41 hours of non-participant observation.

Results. Variation in patient experience is significantly influenced by staff work experiences. A high-demand/low-control work environment, poor staffing, ward leadership and co-worker relationships can each add to the inherent difficulties staff face when caring for acutely ill older people. Staff seek to alleviate the impact of such difficulties by finding personal satisfaction from caring for 'the poppets'; those

patients they enjoy caring for and for whom they feel able to ‘make a difference’. Other patients – noting dehumanising aspects of their care – felt like ‘parcels’. Patients are aware of being seen by staff as ‘difficult’ or ‘demanding’ and seek to manage their relationships with nursing staff accordingly.

Conclusions. The work experiences of staff in a MfOP service impacted directly on patient care experience. Poor ward and patient care climates often lead staff to seek job satisfaction through caring for ‘poppets’, leaving less favoured – and often more complex patients – to receive less personalised care.

Implications for practice. Investment in staff well-being and ward climate is essential for the consistent delivery of high-quality care for older people in acute settings.

Key words: acute care, nursing care quality, older people, patient experience, staff well-being, team climate, unpopular patient

Introduction

Against a background of continuing unease about the values of patient care in hospitals (Goodrich & Cornwell, 2008; Maben, 2008) and the policy drive for efficiency, productivity and ‘throughput’, the care experience of older patients is coming under increasing scrutiny (CQC, 2011; Patients Association, 2011; Patterson *et al.*, 2011; Tadd *et al.*, 2011). Older patients’ and their relatives’ experience of good hospital care highlights relational care issues as being of primary importance (Bridges *et al.*, 2009) but Iles (2011) describes show ‘transactional’ models of care (where the individual is cared *for*) often eclipse ‘relational’ models of care (where patients are cared *about*). Tadd *et al.* (2011) suggests wide variation in the experience of older people in acute settings, with some patients receiving dignified care and others not, and the Patients Association helpline hears of ‘bad’ care on an almost daily basis (Patients Association, 2011).

Despite these reported deficiencies in care, the majority of NHS staff are motivated by ideals of altruism and making a difference to people’s lives (Becker & Geer, 1958; Maben *et al.*, 2007) and strive to offer dignified and high-quality care (Department of Health, 2007). However, these aspirations are often tempered through early nursing careers as staff realise the limits of their work or their workplace (Maben *et al.*, 2006, 2007). Iles (2011) suggests ‘the vast majority of people working with the NHS are good people: not saints, but competent people who have good intentions who are behaving rationally within the situations they face’ (p. 4). However, as staff feel increasingly unable to care for patients appropriately, they may experience moral distress (Corley, 2002) along with degrees of ‘burnout’ accompanied by felt

alienation and emotional distancing from their work or from patients (Maben *et al.*, 2007).

To date, few empirical studies have directly examined the relationship between staff experiences of work and patient experiences of care. The purpose of this study is to examine the links between staff experience of work and patient experience of care in a ‘Medicine for Older People’ (MfOP) service. This mixed methods study aims to highlight firstly, the demands of the work; the inherent features of providing care to acutely ill older people that present challenges to staff and, secondly, specific contextual factors shaping staff experience and impact on the quality of patient care.

Research setting

This study draws on selected findings from a 3 year, mixed methods, national study that examined the relationship between staff well-being, motivation and affect (observable expression of emotion) and patient experience of care (Maben *et al.*, 2012).

One element of this wider study was a series of in-depth case studies in eight different services (four acute and four community). One of these case studies was a MfOP department, a dedicated service for older people situated in a large acute teaching hospital in England within an NHS trust with an established reputation for good organisational performance and high patient satisfaction. Hospital managers, interviewed in Phase 1 of the overall study, perceived this service as one with poor patient experience, low staff morale and an absence of ‘team spirit’ in an otherwise high-performing organisation. The other three acute case studies provide comparison data for the case study presented in this article and were identified and selected as a high-performing

haemato-oncology service in the same hospital as the MfOP service and a high-performing maternity service and lower performing emergency admissions unit (EAU) in a different NHS Trust (performance based on either or both patient experience or staff well-being).

The MfOP service comprised six wards including general older people's care wards; acute care wards and a ward specialising in patients with delirium and dementia. Many patients admitted through the service arrived with some degree of confusion, dementia or delirium along with high physical care needs. All wards had similar physical environments; each with 27 beds; 4 × 6-bedded bays and three side rooms. There were two senior clinical nurses (one new in post) and six medical consultants plus one locum consultant working across the service. Junior medical staff cover as well as allied health staff had been recently reduced across the service. On each ward, there was a ward manager (band 7) and 4–6 junior ward managers (band 6), with a team comprising Registered Nurses (band 5) and healthcare assistants (HCAs; bands 2–3¹).

Methods

The fieldwork was undertaken between January and August 2010 and comprised a 148-item staff survey; 48-item patient survey; patient, carer and staff semi-structured interviews and non-participant observation of staff and patient care interactions. A favourable ethical opinion for this research was granted in October 2009.

Staff survey

Health care staff ($n = 192$) were invited to complete a staff survey and 66 returned completed questionnaires (34% response rate). The survey used validated scales to explore a variety of self-reported dimensions of staff motivation, affect and well-being as well as patient care performance. The survey also included scales of organisational and local climate (for patient care) (Schneider *et al.*, 1998), affective patient orientation (adapted Peccei & Rosenthal, 1997), work dedication (Schaufeli *et al.*, 2006) and job skills and competence (Peccei & Rosenthal, 2001), job demands (Caplan *et al.*, 1980), job control (Wall *et al.*, 1995), and as well as for perceived organisational support (Eisenberger *et al.*, 1986), supervisor support (from national NHS surveys which

is based on the Michigan supportive and participative leadership scale), job clarity and co-worker support (Price *et al.*, 1992) (See Maben *et al.*, 2012).

Patient survey

All patients discharged over a 2-month period were invited to complete a 48-item patient survey ($n = 111$) and 26 did so (23% response rate).

This questionnaire employed Williamson and Kristjanson's (2008) 'Patient Evaluation of Emotional Care During Hospitalisation' (PEECH) instrument (21 items) to capture staff behaviours as experienced by patients (i.e. the relational aspects of care). This instrument has four components or subscales; levels of security, knowing, personal value and connection. We also used the 15-item short-form Picker instrument (Jenkinson *et al.*, 2002) and an additional 12 items from the longer UK NHS national patient survey that gauge patient experience in relation to courtesy, respect and dignity; confidence and trust; nurse staffing levels; involvement in care; help with meals; how well doctors and nurses work together; wanting to complain; rating of care received and willingness to recommend the service to family and friends.

Qualitative fieldwork

One-to-one semi-structured interviews ($n = 18$) were undertaken with staff across the MfOP service. These included HCAs ($n = 4$), Registered Nurses ($n = 4$), senior clinical nurses ($n = 2$), a student nurse ($n = 1$), operational manager ($n = 1$) and doctors ($n = 6$), which included four consultants. Staff were asked to talk about what it was like to work in the department; any stressors in their job; whether they felt 'cared for' and their perception of patient experience in their ward. Qualitative data on patient experiences of care in this service were collected from patients ($n = 13$) and their relatives or carers ($n = 5$) either by one-to-one semi-structured interviews (30 minutes to 1 hour) or by less formal conversations with patients and family members during fieldwork (varying from 10 to 45 minutes). Patients and carers were prompted by a topic guide to talk about their recent experiences of care; their relationships with staff; what constitutes 'good' and 'bad' care; and what they thought it was like for staff to work in the service. Qualitative data collection also included 41 hours of unstructured non-participant observation of routine day-to-day interactions across three of the six wards. Observation was led by two of the research team with clinical nursing backgrounds (JM and MA) and was undertaken for whole or half shifts during which one researcher shadowed

¹In the UK all staff (except Doctors) are employed on the same pay scales which range from bands 1 to 8, with band 1 the lowest band, with the least pay. Registered nurses upon qualification start at band 5.

staff (Registered Nurses, HCAs and student nurses) for varying periods of time, ranging from 30 minutes to 5 hours, median 2–3 hours. These observations focused on staff's formal and informal interactions with patients, carers and colleagues as well as their expressed feelings about this. The observation work also included organisational loitering, when the wider and often rapidly changing work environments and contexts of patient care and staff well-being were explored. For example, researchers also sat observing care for a group of patients; sat in on staff breaks; on ward handovers; and in ward meetings.

Data analysis

Staff and patient surveys

Summary statistics (means, standard deviations) were calculated for each case study. We compared across the eight case studies (four acute and four community) using analysis of variance. We built variability into the design so we would expect some differences. The small number of case studies ($n = 8$) placed limits on what could be performed statistically at that level in terms of comparisons between patient experience and staffing variables.

Qualitative fieldwork

All interviews were audio-taped and transcribed and field notes were written up as soon as possible or were 'spoken' into an audio recorder for later transcription and analysis. Thematic analysis of interview and field observation transcripts were undertaken through a series of general and focused readings by two researchers to identify emergent categories and open codes (Rapley, 2011). For example, codes relating to staff well-being included support; leadership; team cohesion and family at work; job demands; poor staffing levels; the intensity of the work; satisfaction and patient recognition. Codes relating to patient experience included low patient expectations; importance of relational care; the 'favoured and unfavoured patient'; and patient emotional labour. Subsequent focused coding included the identification of exception events and the search for negative evidence (Hammersley & Atkinson, 2007). In tandem, we cross-checked the qualitative analysis with the survey data findings. After team discussion of these emergent codes, the relevant data (and exemplar quotations) were mapped onto tables, for within and cross case analysis.

Results

Patient experience varied in MfOP with some patients satisfied (i.e. reporting a good experience relative to their

expectations) and others much less so. Many staff were committed and motivated to do their best for patients and really cared about older people but they were also 'all very tired'. Below, we present the inherent realities of nursing work in a MfOP service before exploring specific contextual factors shaping staff experience. Finally, we report patient experiences of care in terms of how these relate to the staff's experiences of work, focusing on the variation in patient experience using 'poppets' and 'parcels' as signifying examples.

Staff experience of work

The inherent demands of nursing work in MfOP

Our observational fieldwork identified particular inherent challenges of nursing care in the MfOP service. These included the complex needs and high dependency of the acutely unwell older patient; the unpredictability and repetitive nature of essential patient care tasks; and the length of time taken to explain, undertake and complete such tasks for frail or confused older people. We also observed the ongoing compromises in care delivery that staff were obliged to make; staff frequently had to 'double up' to care for patients with high and unpredictable physical care needs – inevitably taking one member of staff away from their planned care with other patients. This often meant staff having to choose between, for example, meeting the toileting needs of one patient or supporting another with feeding. At times staff had to compromise the dignity of a patient to ensure that they met their physical care needs quickly and safely. For example, without the time or availability of two care staff to help a patient to walk to the toilet or move out of bed, a nurse or care assistant would resort to a commode at the bedside or a bedpan in bed. Such alternatives, as nursing and medical staff noted, impacted poorly on patient dignity and privacy and on the wards' or services' reputation for care. Similarly, qualified staff – with inadequate staff cover – found themselves 'torn' between the completion of 'drug rounds' and meeting an unexpected and pressing physical care need of a patient. Staff recognised such dilemmas and spoke of patient's care demands yet sometimes saw these same patients as 'demanding', presenting different, but overlapping ideas that were apparently indistinguishable for staff at times. Many staff highlighted that the care they wished to give was not only physical care but psychological care, to get to know people and to have time to chat to them as well as attend to their most intimate and basic needs, yet felt this was not possible.

All staff noted the distinctive demands of older people's acute nursing care work (i.e. the complexity of acute care

needs combined with requirements for personal and psychological care). Older patients were reported as increasingly more dependent on nursing staff for care: 'we're getting a very much more complex, frailer, older patient, ... compared to ten years ago, we regularly have 100 year olds on our wards, and the majority are in their late 80s or 90s' (Doctor 1).

Whilst the staff survey showed that work dedication was the highest in the MfOP service (4.36 mean) compared with the other three acute services we studied, nurses frequently noted the inadequacy of care provided to their patients: 'some people wait a long time to get any help.....(and the) buzzers might be going off for quite a while' (HCA 1).

Registered Nurses and medical consultants noted the contradictions between the Trust's promise to ensure 'excellence in patient care', their personal and professional aspirations for delivering good patient care and the reality of the workplace. Frontline staff felt senior managers – whilst appearing supportive – did not really want to listen to the complexity of the problems staff encountered on a daily basis. Whilst some staff felt that their patients received a 'fair service... hopefully' (HCA 1), most nurses expressed feelings of guilt, low morale and frustration because of their felt inability to offer good patient care to patients, particularly those without urgent care needs. A manager who had previously worked as a nurse in the MfOP department recalled the stress of working in this high work demand service where she spent most of her day saying to patients, 'I'll be with you in a minute' only to realise 'Oh my God, Mr So and So has been sitting on the commode for half an hour because I haven't got back to him.' (Manager 1).

Several qualified nurses also described the challenges of recruiting staff to a service area often regarded as 'basic', 'dead end' or 'low esteem' by colleagues elsewhere in the Trust; 'Lots of people don't want to work in MfOP because it's heavy and mentally quite taxing' (Manager 1). Related to this, 64% ($n = 44$) of MfOP staff survey respondents reported experiences of physical violence from patients in the previous year which was higher than found in other three acute services (1%, 13% and 58%); direct care staff often noted the stressful and demoralising effects of attempting to care for confused and aggressive patients. One HCA described the experience of taking 'quite a beating every morning... I've been punched, I've been spat at, I've been kicked. The men are very strong' (HCA 2 in field notes).

Our findings indicate that staff may manage these work challenges through discretionary care; that is, to not simply favour some patients but by extension to offer good care selectively to them, which enhanced staff satisfaction in an

otherwise unsatisfying work environment. Staff job satisfaction in the MfOP department was second lowest (3.89 mean) of the four acute services, with EAU the lowest. However, on those wards with poorer work and patient care climates, we noted episodes of very tender and attentive patient care, often delivered by unqualified staff or students who felt marginalised from their co-workers and ward teams. On a 'difficult ward', as two young HCAs explained, it was possible to find personal satisfaction from caring for 'the poppets', those patients who they enjoyed being with and for whom they could 'make a difference'. Sometimes such good care was undertaken at the expense of time and attention owing to less favoured patients with less rewarding direct care needs (this is explored further below).

Contextual factors shaping staff experience

Our fieldwork identified two broad contextual factors that made an already challenging job more difficult:

- A high-demand/low-control work environment.
- The local work climate.

Demanding work: high-demand work with little control

Human organisation studies note that staff who work in high-demand settings – such as the MfOP service under study – require high levels of felt control over their work to support their well-being (Karasek, 1979). Demands – also called 'role overload' or 'time pressure' (Caplan *et al.*, 1980) – refer to the amount of work that employees have to complete in a limited time (Karasek, 1979; Warr, 1987) and job control refers to the degree of discretion and autonomy employees have in making job-related decisions (Karasek, 1979; Hackman & Oldham, 1980).

Compared with the other three acute services we studied, job demand for MfOP was the second highest (mean 4.17) in the staff survey. Self-reported data suggested that job control was also high, the highest across the four acute case studies (mean 2.96) (Haematology lowest at 2.63). However, in those wards with a poor work climate, we observed acutely ill dependent patients creating a very high-demand environment and staff lacking control in a number of ways. Our qualitative data indicated that three key factors exacerbated the felt control of nursing care work, including:

- Inadequate or unpredictable staffing levels.
- The movement of staff at short notice into other staff-depleted service areas.
- The felt lack or inadequacy of training in specialist care skills (e.g. dementia and delirium) for nursing staff.

Staff nurses and HCAs emphasised that patients received inadequate care because of the shortage of direct care staff on wards. An experienced HCA described how 'you need [staff]

numbers to keep your patients safe because of the risk of falls and wandering' (HCA 2), whilst a staff nurse described the impact of reduced staff numbers on the emotional and physical care of patients with less immediate or obvious care needs: 'The patients are innocent, they don't want to disturb you, I feel so sorry for them. You ask them, 'Did you open your bowels?' and they say, 'No, I felt I wanted to this morning but you were so busy' [Staff nurse 3]. Twenty-seven per cent of patient survey respondents felt that there were sometimes enough nurses on duty to care for them and 8% felt there rarely were. Medical staff interviewed agreed there were insufficient nurses: For ...5 or 6 years, most doctors in the department have not felt that we have had sufficient nurses' resulting in 'a significant deterioration in the nursing care of our patients' (Consultant 1) which meant patients 'don't have a good experience'. Another consultant felt it was 'Definitely more stressful.... things are definitely worse than they were a year and a half ago' (Consultant 2).

The inherent demands of working in an MfOP service were further exacerbated by a Trust policy of moving nursing staff from their own wards to more depleted areas of the service or organisation. Many HCAs described how this practice undermined their morale – reminding them of their 'disposability', leading them to question their personal investment in ward tasks and in establishing relationships with patients and other staff. They also recognised its impact on patient care: 'you get quite a nice relationship going with your patient, and they get continuity because they see you most of the week. If you're moved somewhere else, somebody else is coming in that they don't know, they don't understand them (..) it must have an impact' (HCA 1).

Direct care staff also identified their need for more 'hands on' training to enable them to care effectively and sympathetically for patients with confusion, dementia and delirium: 'we get a lot of confused patients, dementia patients (..); it can be a bit stressful if they're aggressive. I don't think we have enough training to deal with that, really' (HCA 1). Our observations of such 'ward level' training indicated it could be rushed and piecemeal when delivered on wards lacking sufficient capacity to release staff and without ward-based structures and processes (including enough good role modelling) to facilitate the ongoing dissemination and support of good practice. In essence, most direct care staff therefore continued to manage the particular challenges of caring for patients with complex emotional and psychological needs by 'drawing on [their] own experience' (HCA 3).

In all, our quantitative and qualitative findings indicated a service in which nursing staff are constantly involved in high-demand work with limited felt control over their work demands.

A family at work: local work climate

Our data allowed in-depth comparison of staff work experience across the six wards in the MfOP service and suggest that whilst organisational climate has a role to play in staff well-being, it is the local work climate that is key. Analysis shows two key facets of local work/ward climate – ward leadership and co-worker relationships – were important in explaining variations in staff work experience. Where ward leadership and co-worker relationships were good this alleviated a difficult job; where they were not they further added to the inherent difficulties of the work.

Ward leadership

Ward leadership was an important factor in determining the felt level of discretion and autonomy available to ward nursing staff in making decisions at work (cf. Hackman & Oldham, 1976; Karasek, 1979). In the MfOP service, nursing staff were polarised in their opinions of ward managers: some were often openly critical of their managers, whilst others were very positive, depending upon their evaluation of them in terms of supporting the team to deliver good patient care. Nurses appreciated ward managers who performed some immediate patient care, had presence in ward areas and were felt to be accessible: 'our manager's very good; she's hands on; she'll get on the ward and help out with the patients' (HCA 4). In addition, these managers were appreciated by their colleagues because they were seen to be knowledgeable and able to facilitate effective patient care. In contrast, staff identified autocratic, arrogant and unsupportive leaders as unhelpful, creating a poor work environment for staff well-being. Many staff spoke of a senior clinical nurse who: 'caused a lot of trouble (..) s/he'd come on the ward and order you to do something whether you were busy (..) or not. You immediately dropped everything to do their bidding' (HCA 1). This senior nurse was equally unsupportive of ward managers: 'S/he hasn't supported them when they've needed it, but s/he has gone over the top on small points when they've been really not in the mood for it' (Manager 1).

Changes in Trust policy also influenced the felt level of discretion and autonomy amongst different ward leaders, particularly in terms of their capacity to personally recruit their own staff and so 'hand pick a team'. A senior manager reflected on the situation in one of the wards: 'to have lost 80% of her staff and have them replaced and never chosen one of them, not one of them herself, it's not surprising that there are problems'. On another ward, there was a very different situation 'she was able to choose her staffshe got the opportunity to build, to construct a proper team and then do lots of team building work with them; And we do get

fewer complaints, fewer incidents, lower sickness, lower turnover, and it is down to good leadership and building your own team' (Manager 1).

Co-worker relationships

Our staff survey findings showed that across the MfOP service co-worker support items scored lower for this service (mean 3.83) than for the other three acute services included in our national study (highest-maternity mean 4.21). However, further data analysis revealed significant variations in these items across the six wards (ranging from means 3.50 to 4.42). This variation correlated with the reported quality of ward leadership on the six wards (highlighted during staff interviews and observations) as well as staff-perceived variations in patient experience (as reported by service managers, ward managers and other staff).

We identified three particular fissures in co-worker relationships on wards where poorer local work climates and patient care climates were indicated by the staff survey findings. This resulted in a sense of family at work being lost. These fissures were between:

- Qualified staff (registered nurses) and unqualified staff (HCAs);
- Staff from different cultural or ethnic backgrounds;
- Staff who practised or experienced incivility and bullying.

The division between qualified and unqualified staff centred on the difficulties of understanding one another's work roles and responsibilities. Several HCAs criticised qualified staff who avoided 'dirty' direct care work (Hughes, 1984), in preference for 'paperwork', whilst several staff nurses lamented their lack of opportunity for 'hands on care' and worried that patient care relied on unqualified staff. Such mistrust sometimes undermined the exchange of important information on patient care and support for each other in delivering patient care.

The MfOP service had problems recruiting staff and whilst it had a long history of overseas recruitment of registered nurses, the challenges of multi-ethnic or multi-cultural team working came to the fore in those wards with poorer local work climates. In such situations, misunderstandings around communication, language or cultural norms – which were often noted by the older patients we talked to – were less likely to be managed well by the nursing or healthcare teams. For staff, there was a reported lack of shared identity and lack of cohesion as a team; in some wards, staff from the same ethnic group coalesced into working together to the exclusion of other team members. One healthcare assistant suggested that a sense of 'family' had been lost: 'Well, it used to be more of a family affair. We used to go out. We used to enjoy – not the same things – but we used to be able to go out

and chat. These days, we don't do any of that. We don't seem to be held together' (HCA 2).

Incivility between nurses at work was often observed on those wards with less respected ward leadership, poorer co-worker relationships and poorer reputations for patient experience. Several staff noted that an 'undercurrent of bullying' in the workplace caused tense atmospheres on the ward that could be felt by patients; such atmospheres compromised patient care and experience as staff felt unable to challenge the poor behaviour and attitudes of colleagues. This meant for some staff an unsupportive workplace where nurses in particular could not rely on colleagues to help them with their work. On two wards as well as direct bullying, many staff highlighted harassment, incivility and a generally unsupportive and tense atmosphere: 'There was a lot of back-biting' (HCA 4) and 'eye rolling' when certain members of the team spoke in ward meetings; 'There's a fair amount of, I'd say, bullying, if you like, goes on on the ward, depending what staff you're working with. (It's) not outward. (..) There is an undercurrent of bullying' (HCA 1). Thus, local work climate was perceived in some settings to undermine any sense of a 'family at work', which impacted upon patient experiences of care.

Patient experiences of care

From the patient survey, patients appeared relatively satisfied – with 85% rating the care they received as either excellent or very good and only one patient stating they were not treated with dignity and respect. Yet 12% were unlikely to recommend the service to their family or friends, 27% stated nurses and 31% doctors mostly or always talked in front of them as if they were not there (highest in the four acute services) and almost a fifth (19%) did not get the help they needed from staff to eat their meals. It is notable that, of the four acute services we studied, the greatest disparity between staff self-reported care performance and patient rated care performance occurred in the MfOP service; staff consistently rated the patient care they provided much higher than the ratings of the patients themselves. MfOP patient survey results revealed the second lowest ratings of the four acute services we studied and PEECH 'connection' levels were particularly low suggesting staff were not creating meaningful relationships with patients – failing to get to know patients as people.

Our qualitative data revealed a vulnerable patient group with low expectations and little desire to complain, for fear of becoming unpopular with staff or care worsening as a result. Whilst patients and relatives expressed satisfaction with overall care in the MfOP service, and some reported very positive patient experiences, there was often a marked

difference between care experiences reported in public accounts (in questionnaires) and those reported in personal accounts (during one-to-one interview). These differences were explained by one patient: 'I didn't want people to think, 'Oh, she's always complaining,' you know, take that sort of attitude' (Patient 1).

As significant for patient experience was the care that participants saw other patients receive. Patients tended to note, and reflect upon, the witnessed care of patients who they felt to be more vulnerable than themselves: 'I saw people sat in the chair, who didn't complain, without any slippers on their feet and it was quite chilly (..) and there were a number of quite sick older people, (..) who could not feed themselves (..) and I would see their meal placed on their bed table and left there and no one appeared to come along except to take it away again, which I felt should not have happened' (Patient 2).

Our qualitative data identified three dimensions of care experience that were particularly important to older patients with acute care needs. These were:

- Timeliness of care, particularly around toileting needs;
- Relational aspects of care; interest in the person, kindness, compassion and attending to the 'little things';
- The consistency and reliability of good nursing care and caring behaviours (both between individual nurses and between ward shifts).

Our analysis also showed that many patients reflected on the observed difficulties of nursing work and sometimes assessed the quality of care they received not only in relation to their expectations but also in relation to what they felt was possible for nurses within the context of this particular MfOP service: 'everybody in that ward was very ill and they spent so much time looking after them. They could spend an hour changing someone's dressing or giving them a bed bath or something' (Patient 1). This also often meant patients did not always ask for help when needed because 'staff were so busy'.

Variations in patient experience: poppets, parcels and 'being a nuisance'

Fieldwork observations and informal conversations with patients indicate that patients experienced more varied and unpredictable nursing care on those wards with a poor local work climate for staff. We observed how on one of these wards staff tended to negotiate their work tasks with reference to bed numbers rather than patient names; patients on this ward were also less likely to be greeted by nurses who cared for them and there was frequently little personalisation of care. Our observations indicate that these dehumanising aspects of care were not lost on the majority of patients one

of whom said 'in the end, I feel like I'm being moved around like a parcel, I'm being moved like a parcel from chair to commode to bed. I feel like a parcel and not a person anymore' (Patient 3). This echoes findings from interviews with other older people in acute care where patients experienced being moved around the hospital: 'One patient talked about feeling like a parcel and a consultant talked of patients as 'pushed around like a piece of packaging' (Goodrich & Cornwell, 2008, p. 10).

Conversely, several nursing staff reflected on the inevitability of having particular patients for whom they preferred to care – the poppets. These patients were often those for whom staff felt particular sympathy, those with no frequent visitors or who reminded them of a close relative: '(they've) got something that just endears to you and you just feel, 'Oh, she's gorgeous.' You just click with them as well' (HCA 3). Staff were aware of the difficulties this presented and tried not to show favouritism or get too close to patients but said they often 'could not help it'. Concurrently, staff also discussed the challenges of caring for patients who were more demanding, difficult or 'hard to please'. 'There's somebody who I go into see, nothing is ever right really, no matter what you do. Nothing is ever right' (Student nurse 1). Observation of staff caring for this patient revealed the care the patient received to be: 'quite brisk and businesslike ... staff didn't really have any affection for the patient there was no warmth or real greeting in their dealings with her' (field notes 070710). As we have noted staff may not simply favour some patients but through 'discretionary care' offer good care selectively to them enhancing staff satisfaction in an otherwise unsatisfying work environment. Such good care was undertaken at the expense of time and attention owing to less favoured patients with less rewarding direct care needs.

Patients reported inconsistencies in the care practices and behaviours of different staff, particularly at night. One patient recalled how she had to renegotiate her request for a commode by her bedside on a nightly basis 'according to the sort of mood of the night worker' so that each evening she 'dreaded whether she would get one or not' (Patient 4). Other patients and their carers also reported a felt lack of investment in them and their care. Patients reported staff did not or were not able to take the time to get to know them and their circumstances, and others reported rough handling: 'I said 'you've hurt me (..) it's still sore (..) she was rough, not only with me (..) a couple of people make it a bit awkward, being rough and tone of voice'. This patient did not use the analogy of a 'parcel' but as a research team we felt rough handling and an uncaring tone was another feature of this category. Seeing other patients treated as 'parcels' also had an impact as this patient went on to explain: 'You get one or two

of the old hands do a bit of bullying. The other night one couldn't get her own way with one of the ladies and had her crying. I felt sorry. I suppose I was a bit of coward I should have said I didn't like what I heard' (Patient 6, field notes 070710).

We also found that, in a high demand patient care environment, patients are cognisant of their vulnerability to becoming seen by staff as 'difficult or demanding patients' and seek to manage their relationships with nursing staff (in particular) accordingly. We saw patients being extremely polite and grateful to staff, offering treats and almost 'courting' staff favour – both potentially as a way of giving back to staff and perhaps trying to manage the relationships to gain good or better care for themselves. On the whole, the patients we spoke to did not wish to complain for fear of care worsening, yet one patient noted that 'making a nuisance' could be used as a strategy to improve care delivery: 'there's always one that doesn't want to work and turns away, and unless you make them do it by being a nuisance, it doesn't get done (...) none of them really helped me [get back into bed] and I said 'I'm sorry you think I'm a nuisance' and then he was alright' (Patient 7, field notes 100710). In effect, our findings suggest that the emotional labour involved in being a patient is greater in poor care climates where the quality of care is unpredictable and patient experience variable; patients need to 'manage' relationships with a plethora of staff as well as their own responses so as not to be seen as a nuisance or a 'problem' patient.

Discussion

The tendency of nursing staff to identify difficulty in the care of older patients in hospital has been noted and examined in previous studies (Melanson & Downe-Wamboldt, 1985; English & Morse, 1988; Patterson *et al.*, 2011; Tadd *et al.*, 2011). Drawing from Stockwell's (1972) seminal study that identifies 'patients whom the nursing team enjoys to care for less than others' (p 11) subsequent studies observe the important distinction between 'difficult' and 'difficult to nurse', based on notions of patient volition, and how these notions are shaped not only by nurse-patient interactions but also by wider contexts of care and care demands (Johnson, 1995). Our observations and conversations with direct care staff indicated that across the MfOP service staff often lacked the capacity to either examine, understand or seek to address the reasons for patient's apparently 'demanding' behaviours.

Patients themselves also work hard to shape these relationships, demonstrating empathy towards nurses and feeling concerned for the busy, time-pushed, emotionally exhausted nurses. Gull (2011) – examining compassionate nursing care

with cancer patients – notes that patients often feel the need to 'to give something back' emotionally or in token gifts to 'replenish' and value nurses and describe the emotional connection as 'circular' and a 'two-way street'; making patients active participants in the nursing care relationship by being 'good patients' and helping the nurse to help them. Being a 'good patient' can result in a lack of complaint and a satisfaction with care based on low expectations which manifest in relatively high patient experience scores on NHS patients surveys of older people's experiences. Our data suggest that most insight is gained from specific survey questions (re 'staff talking over you'; help with food etc.) or from one-to-one narratives or interviews.

Our findings highlight the inherent relational care challenges faced by both older people and the nursing staff who care for them. They also suggest a clear relationship between staff well-being and patient experience of care. Eighty per cent of over 11 000 NHS staff surveyed for a review in 2009 felt that their health and wellbeing impacts upon patient care, and virtually none disagreed (Boorman, 2009). Across our four acute services where there were poor local work climates, poor leadership and where staff well-being was low – patient experience was also poor and conversely where staff well-being was high so too was patient experience (Maben *et al.*, 2012). This supports Nolan's senses framework, particularly the idea that if staff were to create a culture in which older people experienced the six senses of security; belonging; continuity; purpose; achievement and significance, then staff also had to experience them in their day-to-day work (Nolan *et al.*, 2006). Where this was possible, the environment for care was said to be enriched and where staff and patients do not experience the senses an impoverished environment is said to exist (Nolan *et al.*, 2001).

From our work, we suggest that there are particular organisational, service and ward-based factors that either support or undermine the efforts of nursing teams to 'keep the show on the road' (Staff Nurse 3). In particular, our data suggest as Patterson *et al.* (2011) note these include *firstly* the pace-complexity continuum (Williams *et al.*, 2009) – where the pace of care is being prioritised at the expense of quality with an ever increasing focus on tasks and technology. *Secondly*, the importance of a strong and visible ward leader exerting important influence on the caring and work culture (Ballatt & Campling, 2011). Smith (2012) suggests that 'patients and nurses are sensitive to ward atmospheres and social relations created by ward sisters', and that when nurses are appreciated and emotionally supported by these same ward sisters they had both role models for emotionally explicit care and also felt better able to care for patients in

this way (Smith, 2012, p. 194). *Thirdly*, the importance of the immediate team environment and the crucial role of ward leadership in shaping this (Patterson *et al.*, 2011). Ballatt and Campling (2011) argue persuasively that ‘in general, the NHS gives little thought to group dynamics and how to get the best out of its teams. Too often structure and culture impede rather than enable good team working’ (p. 81). *Finally*, our data suggest the need for staff to be emotionally supported themselves (Firth-Cozens & Cornwell, 2009) to be able to have staff support structures such as clinical supervision (Ashburner *et al.*, 2004) and to be encouraged to talk about their feelings and their own emotional needs (Youngsen, 2008).

There is an extensive literature suggesting excessive work demands leads to poorer well-being. Nursing teams on older people’s wards report having fewer resources to meet the needs of their patients and evidence suggests a significant association between having too much to do and feeling motivated (Patterson *et al.*, 2011). High levels of social support from supervisors, co-workers and the organisation has a positive effect on well-being in that it helps to reduce exhaustion, whilst also enhancing satisfaction and relative positive affect at work (Maben *et al.*, 2012). Work experiences directly contribute to the satisfaction of important individual needs at work, such as autonomy, support, belonging. Our data suggest that these experiences also have strong links to patient experience.

Our findings suggest that without good local work and patient care climate staff sometimes seek job satisfaction in care of ‘poppets’; potentially leaving less favoured and more complex patients to receive rushed and less personalised care – leaving them to feel like ‘parcels’. In this way, the work experiences of staff impact directly on patient care experience.

Conclusion

Through a mixed methods case study in one MfOP service, we have been able to describe the experiences of care for older people in acute hospital settings as well as to begin to understand the significance of the work experiences of staff for the quality of patient care. Gordon (2005) argues that care environments that are inadequate for meeting the emotional needs of patients will inevitably foster nurses who avoid attempting to meet such needs. Being unable to engage with patients in a meaningful way dehumanises nurses themselves (Austin, 2011). ‘The emotional work of health-care teams deserves to be prioritised’ (Ballatt & Campling, 2011, p. 82). Our research identifies the tendencies of demoralised and inexperienced staff to resist this process by

offering selective care that brought rewards to themselves and a few favoured patients.

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Contributions

Study design: JM, MA, RP, TM, GR; data collection and analysis: JM, MA, RP, TM, GR and manuscript preparation: JM, MA, RP, TM, GR.

Implications for practice

Senior managers and leaders need to invest in staff work environments to ensure quality patient care:

- *Review quality of patient experience:* Use different approaches (not only patient surveys); what does ‘demanding’ mean for staff- and for patients; educate staff to recognise the ‘unpopular patient’; discuss the quality of care received by all patients in the ward – ‘poppets’ and ‘parcels’ and how might this be the case in all wards.
- *Resilience building and renewal for staff:* Create support and supervision for staff to reflect on the emotional and physical challenges of caring for older people, for example, regular opportunities to discuss ‘difficult patients’ and how these might be managed; Schwartz Rounds² are one way to create space to talk about the emotional aspects of care work in the multi-disciplinary team.

²Schwartz rounds have been brought to the UK by the King’s Fund Point of Care programme from Boston Massachusetts where they originated. The rounds take place in 195 sites in the USA and currently 10 in the UK with expansion planned. The rounds (usually 1 hour each month) provide space for ‘renewal’ by practitioners and recognition, re-inforcement and support from colleagues and managers. http://www.kingsfund.org.uk/applications/site_search/index.rm?instance%5Fid=0&filtering=0&keywordsweight=1%2E5&old%5Finstance%5Fid=0&old%5Fterm=&searchrefferer%5Fid=0&categories=&term=Point%20of%20care%20Schwartz&include%5Fdocuments=YES&debug=0&similarpagesto=&filter=&titleweight=1%2E5&isajax=0&skip=10&count=10&subject=0&summaryweight=1%2E5&contentweight=1%2E0&id=0&sort=relevance&searchrefferer%5Furl=%2F404%2Erm

- **Leadership and support:** Invest in unit level leadership and supervisor support (i.e. ward sister level in acute services) and empower these leaders to manage staff and budgets, to create well functioning teams and to understand the links between ward climate and staff wellbeing and patient experience.
- **Teamwork:** Recognise the importance of good local teamwork and encourage co-worker support and a sense of 'family at work' – create positive space (e.g. ward teas) to get to know colleagues and places to talk about challenges or fissures in ward teams before they become embedded.
- **Adequate staffing:** Use tools of acuity and dependency to argue for sufficient staff for the high needs of the patient population.

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