

# Content analysis of 'Patient Opinion' website stories about nurse attitudes and behaviours



THE  
Evidence  
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# Key points

## Scope

The Royal College of Nursing (RCN) has undertaken much work to understand professionalism in nursing, including literature reviews, surveys with nurses, media analyses and roundtable discussions. Work is also underway to understand patient experience of nursing care but less was known about **what patients think** of nurse attitudes and behaviours, so the RCN wanted to address this.

Feedback from people using health services provides insight into what is working well and potential areas for improvement. There are many ways to collect patient feedback, including surveys, focus groups and ad hoc comments. A more novel approach is to use online tools, such as websites where patients leave comments or ratings, blogs and Facebook and Twitter posts. There is an increasing interest in gaining insights from social media, so the RCN wanted to examine how one online forum, the '*Patient Opinion*' website, could be used to understand patient experiences of nurse attitudes and behaviours.

*Patient Opinion* collects stories from patients and carers about their experiences of care; positive or negative. People are invited to share their stories anonymously online via the *Patient Opinion* website directly or through *NHS Choices* or individual hospital websites. There is a **selection bias**, because only certain people have access to the internet and feel motivated to share their experiences online. None-the-less, with more than 45,000 stories from throughout the UK being added to daily, the RCN wanted to **explore whether analysing these stories held any value** for understanding how patients perceive nurse attitudes and behaviours.

## Approach

An independent organisation, The Evidence Centre, undertook a content analysis of stories submitted to *Patient Opinion* between October 2012 and January 2013. In total, **1,182 stories** mentioned nurses or nursing during this period; three quarters of which were submitted by patients and one quarter by family members and friends. These stories were read and coded by two analysts, to check the validity of the process. **Qualitative and quantitative analysis** techniques were used. Codes were developed using a 'grounded theory' approach, whereby the themes emerged from the wording used by people themselves. Illustrative quotes were extracted as examples of core themes. The topics mentioned in stories were compared with frameworks used by the RCN, such as the *Principles of Nursing Practice* and the *Influence Map*, which examines systematic influences on attitudes and behaviours.

The analysis was undertaken for **internal use**, to spark discussion among RCN workstreams. It is important to be clear throughout that the content analysis does not provide insight into what patients think more generally. The majority of stories about nurses were from England (94%), with only 6% from Northern Ireland, Scotland or Wales. Where it was possible to discern age and gender, women and older people were slightly more likely to be represented, but in nine out of ten cases full demographic details were uncertain. The stories do not provide 'accurate' reflections of care, but rather the perspectives of those reporting on it. Negative feedback may be more likely in this context. The aim of the analysis was to ascertain what could be gleaned from *Patient Opinion*, but this is not necessarily a reflection of what most patients or members of the public in the UK think.

## Attitudes and behaviours

The analysis defined ‘attitudes’ as the values nurses may hold, such as their thoughts and feelings about their role, patients or their working environment. Attitudes can be difficult to observe, but may manifest in ‘behaviours’: the things that nurses do and say. Stories on *Patient Opinion* did not tend to differentiate well between attitudes and behaviours, and instead focused on how specific nurse behaviours affected patients’ experience of care.

Of the 1,182 stories analysed, 17% contained no information about nurse attitudes or behaviours, 20% contained a positive comment with no specific details, 2% contained a negative comment with no specific details and 61% contained positive or negative comments about specific nurse attitudes or behaviours. This illustrates the extent to which *Patient Opinion* contained information that was relevant to the RCN’s objectives for the analysis. In other words, **six out of ten stories contained relevant content** that could be analysed in more depth.

### **Less than 1% of the stories contained a positive comment about nurse attitudes.**

These stories described how nurses had a ‘caring attitude’ in general terms. Often such statements were made alongside comments about linked positive behaviours.

### **5% of stories contained a negative comment about nurse attitudes.**

Here, patients and carers described nurses that they felt had a negative attitude towards patients, for example saying uncomplimentary things about patients or families or appearing to see patients or families as an inconvenience. A small number also mentioned nurses who seemed disillusioned with their roles or the environment in which they worked.

A far greater number of stories included comments about nurse behaviours. **37% of the stories contained one or more specific positive comments about nurse behaviours and 26% contained one or more negative comments about nurse behaviours.** It is important to highlight that positive comments outweighed the negatives. However, often positive comments were along the lines of ‘the nurse was friendly’, whereas negative comments were much richer in length and detail.

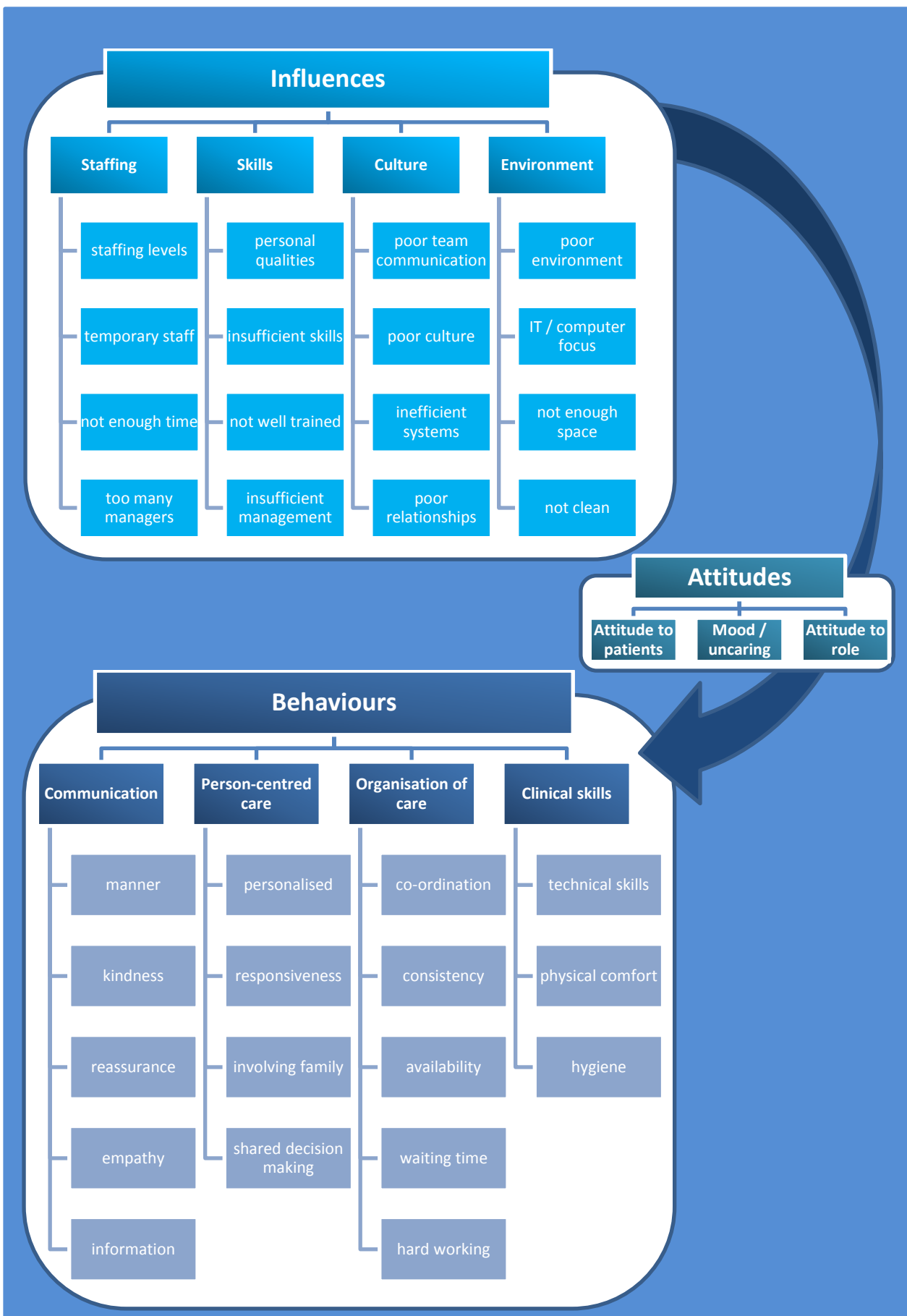
Whether reporting positively or negatively, the four key categories of behaviour described were the same:

- communication and information (850 comments)
- person-centred care and support (211 comments)
- organisation of care (200 comments)
- clinical skills (165 comments)

This highlights that the things most commented on were **non-technical skills** such as communication, bedside manner and information provision rather than clinical skills or patient safety or hygiene. In fact, **the issue that people most commonly commented about was nurses’ overall manner**, such as being friendly and smiling versus appearing rude and brusque.

Figure 1 provides an overview of the key themes emerging from the content analysis.

Figure 1: Core themes about nurse attitudes and behaviours highlighted in 'Patient Opinion' stories



## Influences

Patients and carers did not tend to comment in *Patient Opinion* stories about what they thought influenced nurse attitudes or behaviours. However, about one out of ten stories did suggest some potential causes of the negative nurse behaviours they reportedly experienced (12%). Here there were four key themes:

- staffing levels and skill mix (79 stories)
- skills and training (60 stories)
- culture and communication (54 stories)
- facilities / physical environment (13 stories)

People suggested a mix of individual, organisational and higher-level potential causes for perceived poor nursing behaviours. Concerns about **inadequate staffing** were the most common, with half of all stories about potential influences mentioning this (49% of comments about influences). Poor personal qualities among nurses (such as being rude and uncaring); poor communication between and within teams and working in an environment with a challenging culture or unrealistic expectations were also noted. One in ten comments about potential influences mentioned insufficient skills and training generally (10%), with a similar proportion mentioning insufficient communication skills (9%) or clinical skills (4%).

Stories did not delve into the complex relationships between attitudes and behaviours. For example, there may be a direct link between what nurses think and feel and the way they behave. On the other hand, there may be tensions, with nurses having a positive attitude towards their role and patients, but demonstrating negative behaviours as a result of the culture and environment in which they work. *Patient Opinion* stories are a relatively 'blunt instrument' and did not draw out these more complex relationships.

## Implications

The content analysis suggests that novel feedback mechanisms such as *Patient Opinion* can provide a wealth of information at a surface level. It is clear that the stories are from a select group and cannot be used to represent the wider patient population and that complex relationships are difficult to analyse, but the sheer quantity of material available and the richness of stories means there is much to learn from this source.

There are a number of caveats, however. The focus of *Patient Opinion* stories is on experiences of care rather than the underlying influences or the complexities of nurse attitudes and behaviours. The stories do not allow differentiation between types of nurses, and people may even **mistake healthcare assistants or other staff for nurses**. People may also be more likely to feel strongly about negative happenings and provide greater details about these. The proportion of positive and negative comments cannot be taken to represent care in general. In fact, **there are more positive comments in the dataset than negative ones**, but this may be overlooked.

Despite these issues, the analysis has a number of implications for RCN workstreams. The top three implications are:

- novel approaches to collecting feedback can be a **source of rich information** and may be worth exploring further, as long as the caveats are acknowledged;
- people providing stories on *Patient Opinion* have much to say about nurse behaviours, and the **focus is on non-technical skills** such as communication, patient-centred care and continuity;
- some people recognise that **cultural and organisational factors** may influence nursing behaviours. There are some overlaps with the RCN's *Principles of Nursing Practice* and *Influence Map*, but additional themes are also important to patients, such as staffing levels.

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# Background

## Context

The Royal College of Nursing (RCN) represents nurses and nursing, promotes excellence in practice and helps to shape health policies. The RCN has acted as a professional union for almost 100 years and currently has more than 400,000 members. The organisation pioneers professional standards, education and working conditions throughout the four countries of the UK.

The RCN's *'This is Nursing'* initiative has seven workstreams, comprising professional attitudes and behaviours; education; quality and the principles of nursing practice; leadership; paperwork and administration; safe staffing and the training and regulation of healthcare assistants. As part of the **professional attitudes and behaviours workstream**, the RCN is seeking to understand how the values nurses hold and the things they do affect patient care and the underlying reasons behind nurse attitudes and behaviours.

Activities completed for this workstream include a review of relevant literature; a survey about the attitudes and behaviours of nurses and how professionalism in nursing compares with other healthcare professions; focus groups at the 2012 RCN Congress; analysis of how nursing is presented in the media; feedback from RCN region and country directors about professional issues and an invited roundtable discussion. The RCN identified patient feedback about nurse attitudes and behaviours as a gap in existing knowledge and wanted to explore the value of novel sources of information in this regard. As one component of this, this report outlines a content analysis of stories submitted to the *'Patient Opinion'* website, conducted by an independent organisation.

Much research is available about nurses' attitudes towards issues such as professionalism, quality and working with specific patients.<sup>1,2,3</sup> Similarly, much has been written about how nurses behave, in terms of their interactions with patients and carers, colleagues and managers.<sup>4,5,6</sup> Information is also available about what patients think of nurse attitudes and behaviours, particularly in terms of how these may impact on the care that patients receive.<sup>7,8,9,10</sup> Other detailed work is underway through the RCN Research Institute at the University of Warwick.<sup>11</sup>

The people using health and social care services are ideally placed to provide feedback about their experiences. If well used, such feedback can help to further develop the professionals, structures and processes underpinning healthcare. There are many mechanisms for collecting people's views, such as questionnaires and patient involvement groups.<sup>12</sup> However, formal research can be resource intensive, selective in the types of questions asked and the types of people who respond, and may take time to analyse and act upon. **Newer techniques** are being tested to add to traditional ways of understanding the opinions and experience of patients and family members. Social media, such as Twitter, Facebook, blogs, online forums and websites that encourage patients to share their views are increasingly popular.<sup>13</sup>

*"The advent of social media and new technology potentially opens a door to insights into care (both positive and negative) unfiltered by traditional methods of healthcare data capture and analysis. For the first time, the voice of the patient may be heard with clarity and immediacy."<sup>14</sup>*

## *'Patient Opinion' website*

The *Patient Opinion* website is one such mechanism for encouraging patients and family members to share their views. It is part of a wider trend for using online information to understand people's views and predict trends that is sometimes known as the 'Big Data' revolution.<sup>15</sup> For example, analysis of social media posts and online content has been used to predict popular movies,<sup>16</sup> election results,<sup>17</sup> financial issues<sup>18</sup> and for disease surveillance.<sup>19,20,21,22</sup>

More and more people are using the internet as a platform to describe their care in the UK.<sup>23</sup> Similarly, in the US, more than eight out of ten adults are using the internet regularly and of these, half report looking at social networking sites daily.<sup>24</sup> One third say they have read about someone else's health experience online and more than one in ten have viewed online reviews of health services.<sup>25</sup> Corresponding figures are not available for the UK, but these statistics suggest that websites may be an increasingly important way for people to gain information about healthcare and to provide feedback of their own.

Research also suggests that online hospital ratings by patients or more qualitative stories on the internet can provide a good indication of the quality of health services, as measured by mortality and patient safety rates.<sup>26,27</sup> Thus examining these websites in conjunction with other information may provide important indicators of the overall quality of care.

*Patient Opinion* is a UK website that encourages people to provide feedback about the healthcare they receive. It is a social enterprise and has been running since 2005. Feedback takes the form of short anonymous stories. More than 45,000 stories have been submitted to *Patient Opinion* or via a linked portal on the *NHS Choices* website. *Patient Opinion* publishes the stories online, contacts the relevant health organisation about the feedback and allows organisations to make a response online if they wish.

The feedback comprises both positive and negative experiences and includes the geographic region and the name of the organisation involved.

The website has been acknowledged in the **Francis Report** as a potentially useful tool for improving the quality of care.

*"Publication of comments online, good and bad, is a powerful tool for patient choice and in forcing providers to address, in public, criticisms made. Encouragement should be offered to impressive contributions made in this field by organisations such as Patient Opinion."*<sup>28</sup>

The RCN has access to this database of patient stories and wanted to explore how this may be used as a source of information about people's views of nursing.

During March 2013, the RCN worked with The Evidence Centre to undertake a content analysis of material from the *Patient Opinion* database. **The analysis was undertaken independently** in that the RCN did not guide the methodology, the codes and frameworks used or the analysis process. This document outlines the key themes emerging from the analysis.



# Approach

## Objectives

The core objectives of the content analysis were to:

- use data from *Patient Opinion* to explore how patients and family members view **nurse attitudes and behaviours**, both positive and negative;
- understand the impact of behavioural and **non-technical nursing skills** on how patients and carers view nursing practice;
- consider how patient reported data fits with or challenges the **key themes** outlined in the *Principles of Nursing Practice* and *Influence Map* documents;
- consider the **value of this dataset** and its practicality for further use.

Each of these objectives is considered in a separate section overleaf.

## Definitions

For the purposes of the analysis, simple definitions of attitudes and behaviours were used.

**Attitudes** were defined as the values nurses hold. Put another way, attitudes relate to how nurses think and feel about things. Attitudes may take the form of an expression of favour or disfavour toward a person, place, thing or event.

**Behaviours** were defined as the things that nurses do or say.

The analysis looked at perceptions of both nurse attitudes and behaviours but it is difficult to distinguish issues regarding attitudes, as the things nurses think (or are presumed to think and feel) are perhaps less tangible than the things nurses do. Thus, most of the comments people made in *Patient Opinion* stories focused on nurse behaviours, rather than attitudes. Although some comments were made about 'poor attitude' this tended to manifest in behaviours such as rudeness and lack of compassion so the **division between attitudes and behaviours may be slightly spurious** from the point of view of patient feedback.

Behaviour may be a manifestation of nurse attitudes in some instances, but in other cases the relationship may be more complex. For example, nurses may have a positive attitude towards patients, but their behaviour may not necessarily reflect this (due to environmental pressures). Patients experience nurse behaviour, rather than the underlying attitude. There may be a degree of tension between attitude versus behaviour, but *Patient Opinion* does not illustrate these tensions or allow for in-depth exploration.

## Selecting stories

The RCN provided The Evidence Centre with several years' worth of data from *Patient Opinion*. A search was run to identify all stories that mentioned nurses or nursing anywhere in the title or story text. One of the goals was to see how many of the stories identified in this way actually contained useful information about nurse attitudes and behaviours.

The analysis used the categorisation of 'nurse' as outlined by those providing feedback. In other words, if a story attributed attitudes or behaviours to a nurse, the analysts did not attempt to critique whether **patients may in fact have been referring to a healthcare assistant, doctor or other staff member**. Patients and family members may not always be able to differentiate nurses from other staff so behaviours attributed to nurses may actually be linked to healthcare assistants, doctors or others. The stories should be seen as relating broadly to the 'nursing family' rather than specific types of nurses.

**The analysis approach had to balance methodological rigour and independence from the RCN alongside being realistic about what could be achieved within the budget and timeframe available.** It was decided that up to 1,000 stories would be examined, working backwards from the most up to date material. At the time of provision, the most recent stories in the dataset had been submitted in January 2013. Working back from this, 1,000 stories covered all of January 2013 and the final quarter of 2012. This means that the analysis included stories submitted between October 2012 and January 2013.

This has the benefit of providing an analysis of very up-to-date material, but the disadvantage is that there was not scope to track any changes over time or to 'over-sample' stories from regions or demographic groups that may have been less likely to be represented.

## Analysis process

The analysis used a mix of qualitative and quantitative methods. A multistage process was used that involved:

- reading all of the comments and **identifying key themes** using grounded theory;
- **quantifying** the frequency of key themes using a set of numerical codes;
- drawing out **quotes** as illustrative examples of the main themes;
- **comparing** the emerging themes with the RCN's *Principles of Nursing Practice* and *Influence Map* to explore overlaps and gaps.

All stories submitted to *Patient Opinion* between October 2012 and January 2013 that contained the text 'nursing' or 'nurses' were read by two analysts, and numerical codes were used as shorthand to summarise any comments made about nurse attitudes or behaviours.

The list of codes was developed based on '**grounded theory**'.<sup>29,30</sup> This means that the themes emerged from the stories themselves, based on the phrases and concepts identified by participants. New codes were added to the list as the analysts read through the stories. Pilot testing with all of the stories from 2013 helped to generate a list of codes which was then used for the rest of the stories. However, new codes continued to be added if further themes were identified.

Each story was allocated a line in an Excel database, and demographic details about the story were inserted (where available) along with all the codes about attitudes and behaviours mentioned in that particular story. This allowed quantification of the key themes to explore how frequently people made comments about various perceived attitudes and behaviours.

In tandem with this, excerpts from stories were compiled as **verbatim quotes** to provide illustrations of some of the key themes. In line with the RCN's mandate of working across all four countries of the UK, care was taken to draw illustrative examples from different countries and to reflect both positive and negative perceptions. The quotes do not purport to represent the views of all who submitted stories, but rather provide a flavour of the richness of the material and the type of content included most frequently.

Some of the quotes in the report are quite long. These extracts were reproduced because one of the goals of the analysis was to **give a flavour of the content** of *Patient Opinion* stories. Demonstrating the length and scope of stories through quotes was a key part of this. Although this may make the report somewhat difficult to read, this presentation style was chosen to stay true to the content of the stories and to illustrate the variation in content and the level of depth contained. Cutting down individual stories would not only detract from the messages being expressed but would also give a limited picture of what the dataset actually looks like.

The final stage in the process was to compare the themes identified from the stories with those highlighted in RCN documents such as the *Principles of Nursing Practice* and *Influence Map*. Starting from the data and working back to such documents helped to reduce bias and ensured that the key themes emerged first and foremost from the data itself rather than from preconceived frameworks.

Throughout the process the analysts kept notes about the pros and cons of the *Patient Opinion* dataset, to feed into debriefing with the RCN.

## Validation

Three key strategies were used to validate the analysis:

- **two analysts** independently coded all of the stories, to double check agreement about the main themes. Any discrepancies were resolved by discussion, and a third analyst was available if required. However, this was not needed, as inter-rater agreement was high (approaching 100%);
- the list of codes used to categorise the stories was **pilot tested** with more than 200 stories, to ensure that it was capturing the main themes. Saturation point was reached early on, which means that after the first few hundred stories, no new codes were being added;
- emerging themes were discussed with the RCN and compared with existing **frameworks**, to identify overlaps and gaps.

Despite these strategies, it is important to emphasise that the process of coding stories was subjective.

The aim of the content analysis was to explore the potential value of *Patient Opinion* stories and to draw out some of the core themes that patients and family members were highlighting for use by RCN workstreams. The aim was not to undertake a replicable academic analysis or to develop theory based on the material.

Another group of analysts may code the stories in a slightly different way – so the numbers referred to throughout should merely be used as an indication of whether comments occurred frequently or not, rather than taken as quantitative indicators of story content.

# Caveats

## *Representativeness*

It is important to be clear from the outset about what the content analysis can and cannot provide. The Approach section has highlighted caveats in terms of the simplistic definitions of attitudes and behaviours used, the selection of stories and the subjective nature of categorising themes. Three other caveats are worth noting: the extent to which the content is generalisable, the scope of what can be discerned from *Patient Opinion*, and the level of detail available for analysis.

In any analysis of internet content, **selection bias** is likely because the people who choose to write about their care online may not be representative of all those using health services. Research suggests that those who provide feedback on healthcare rating websites and via social media tend to be younger and from higher socio-economic groups.<sup>31,32</sup> Furthermore, services supporting some geographic areas or certain population groups may receive less attention on social media than others.

*Patient Opinion* stories cannot be seen as representing the views of all or most patients and carers. The demographics of those who submit stories to this website have not been collected, and even if demographic characteristics were comparable, people who have received particularly good or particularly poor care may feel more motivated to express their views online.

Therefore it is essential not to attempt to generalise the analysis to the wider population. The analysis provides information about what those giving feedback to *Patient Opinion* are writing about – nothing more.

## *Detail*

The stories vary greatly in length and detail. Although both positive and negative feedback is provided, much of the richness of the information lies in the negative feedback. In other words, **people tend to provide more detail about negative experiences** and this is reflected in the quotes used throughout the report. This is not to suggest that negative experiences are more important, but quotes have been inserted to provide a flavour of the content and thus reflect that many of the more detailed stories are negative.

It may be difficult to read some of these negative experiences and it is important not to lose sight of three key points. Firstly, there are many accounts of positive experiences and these should not be overshadowed, even if there is a lack of detail. Secondly, the stories provide one perspective; that of the patient or carer. They are not necessarily factual and there may be many mitigating factors. Finally, the aim is to learn from the feedback rather than to be defensive or disbelieving. Individual stories are perhaps less of a priority than the overall trends they help to illustrate.

## *Scope*

Whilst there is a wealth of information in the stories, there are issues with the scope. It is usually not possible to differentiate the care provided by various **types of nurses**, and patients may even mistake healthcare assistants or other staff for nurses when reporting about the care they received. Also, the focus tends to be on behaviours rather than the complex relationships between attitudes and behaviours or potential causes. This does not mean that these issues are not important, just that they are not covered within the patient stories submitted.

# Story characteristics

In total, **1,182 unique stories** that included the terms 'nurse' or 'nursing' were submitted to *Patient Opinion* between October 2012 and January 2013. Duplicated stories or those that fell into multiple categories were analysed only once so are not included in this number. This section describes the characteristics of these stories.

Overall, 23% of the stories analysed were submitted in 2013 and 73% were submitted in the final quarter of 2012.

## Geographic distribution

The services being reported on were based in:

- NHS Scotland (5%)
- NHS Northern Ireland (<1%)
- NHS Wales (<1%)
- NHS East Midlands (8%)
- NHS East of England (7%)
- NHS London (13%)
- NHS North East (7%)
- NHS North West (15%)
- NHS South Central (5%)
- NHS South East Coast (9%)
- NHS South West (8%)
- NHS West Midlands (10%)
- NHS Yorkshire and the Humber (8%)
- Independent sector (4%)

To some extent this distribution reflects broader population demographics, such as high population densities in London and the South East of England. However, the proportion of stories submitted from different parts of the UK does not represent population numbers. **About 1% of the stories came from Northern Ireland and Wales combined and 5% were about services in Scotland**, so these countries are under-represented.

In England, the highest proportion of stories came from the North West region. This does not reflect population figures so may instead be due to the extent of promotion or awareness about patient feedback websites or similar improvement initiatives in some areas.

In six out of ten stories the services being commented upon appeared to be in a built-up **urban area** (59%). One in five were located in smaller towns (20%) and 1% were in much more rural or isolated areas. In one out of five cases it was not possible for the analysts to easily identify the size of the area without referring to other sources (20%).

It is important to note that differentiations of urban versus rural areas may not be particularly helpful, because they refer to the location of the services rather than where the person telling the story was from. Furthermore, judgements about larger versus smaller areas were based on the analysts' knowledge and may not be accurate. For the purpose of this analysis these broad categorisations suffice, because they illustrate that most stories were about services in larger areas such as London, Manchester, Edinburgh and so on, rather than more remote towns.

The analysts did not identify any research breaking down internet usage more generally by geographic region in the UK so it is not possible to state whether usage of the *Patient Opinion* website for posting stories about nursing is similar to regional internet usage more generally. Nor did the analysis examine whether stories about nursing were more or less likely to come from certain regions compared to other (non-nursing) stories on *Patient Opinion*.

## Demographic details

**Three quarters of stories were submitted by a person talking about their own experiences as a patient (72%) and one quarter were speaking as a family member or friend (27%).**

Often these family members had accompanied patients to health services or had visited people in hospital and were writing about their own observations. In 1% of cases it was not possible to be sure if the story was from a patient or from a family member.

It was not always possible to discern the demographic characteristics of those submitting stories because this information is not routinely collected by *Patient Opinion*. However, in some cases this information was described within the stories. For example, women submitted 28% of stories, men submitted 7% and the gender was not stated in 65% of cases.

Age was even more difficult to ascertain, with 1% of stories coming from those younger than 30 years, 1% submitted by 30-60 year olds, 3% submitted by those aged 61 or older and 95% submitted by those of unknown age. Many stories submitted by family and friends were talking about the care provided to very elderly people. Whilst the stories were perhaps about an older person, it was the age of the person submitting the story rather than the subject of the story that was captured. The analysts did not attempt to guess the age or gender of participants. This was only noted where it was clear from the story.

## Service types

*Patient Opinion* encourages stories about any health service, whether run by the NHS or by the independent sector. However, only 4% of stories were identified as being about the **independent sector** – and upon further investigation, many of these were actually NHS services or services run in conjunction with the NHS and carrying NHS branding. This means it is not possible to make robust comparisons about NHS versus non-NHS services from this dataset.

The majority of feedback related to **nurses working hospitals**, rather than those in primary care or mental health services. More specifically, the type of nursing care that people provided stories about included:

- hospital inpatient / day case (56%)
- A&E / minor injuries / walk-in (19%)
- outpatient treatment (17%)
- primary care (2%)
- mental health (2%)
- district nursing (1%)
- community hospital (1%)



In eight out of ten stories it was possible to distinguish the conditions or broad reasons for which people were using health services. The two most common conditions covered by stories were surgery and unplanned care. A number of comments also related to maternity and gynaecology services.

The full list of conditions that people submitting stories were using health services for included:

- accidents / acute issues (21%)
- surgery (21%)
- maternity / gynaecology (7%)
- tests (6%)
- general medicine (4%)
- cancer (3%)
- cardiac care (3%)
- geriatric medicine (3%)
- stroke (2%)
- end of life care (2%)
- mental health (2%)
- children's services (1%)
- dermatology (1%)
- ear, nose and throat services (1%)
- eye services (1%)
- urology (1%)
- dental services (<1%)
- fractures (<1%)
- nephrology (<1%)
- neurology (<1%)
- orthopaedics (<1%)
- unknown (23%)

Each of these background pieces of information, such as geographical location, gender, and type of nursing care, was used in the analysis to compare any differences between groups in perceived nurse attitudes and behaviours. The findings from these analyses are reported in the sections overleaf. Where differences are reported, they are **statistically significant at the 95% level of confidence ( $p < 0.05$  using t-tests)**. This means that in 95% of cases we can be certain that any differences reported between groups is real rather than happening by chance in our sample.

The analysis did not examine the overall number of stories submitted to *Patient Opinion* between October 2012 and January 2013, or the location or types of services that these stories commented on. Only stories pertaining to nursing were analysed. This means that conclusions cannot be drawn about whether stories about nursing are more or less likely to come from some regions or whether stories about nursing are more or less likely to be positive or negative than other stories submitted to *Patient Opinion*. Furthermore the analysis did not compare the demographics of those who wrote about nursing versus those who wrote about other issues. This once again reinforces that the analysis can only describe what a select group of patients felt motivated to write about, and that the analysis is not of all stories, but rather those specific to nursing attitudes and behaviours.

# Attitudes and behaviours

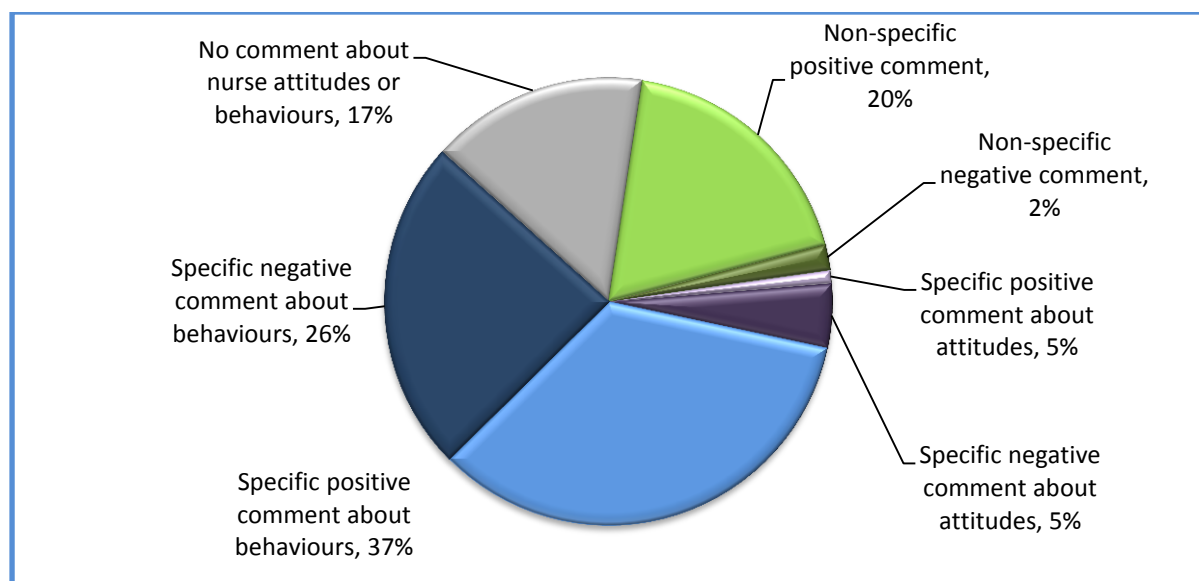
Of the 1,182 stories analysed, about three fifths contained specific comments about nurse attitudes or behaviours; one fifth contained general comments about nurse attitudes or behaviours with no details; and one fifth contained no comments about nurse attitudes or behaviours (see Figure 2).

One out of five stories contained an overall positive comment about nurse attitudes or behaviours, but without any specific details or with feedback inextricably linked to other professions (20%). For example, people sometimes said that all the doctors and nurses were very good, and this would be categorised as ‘overall positive, but not specific to nurse attitudes or behaviours.’ Similarly 2% made an overall negative comment about nursing attitudes or behaviours, but did not report the specifics of what this might entail.

Six out of ten stories contained a specific comment about nursing attitudes, behaviours or influences and these were analysed in more depth (61%; 721 stories).

It is important to emphasise that overall, **six out of ten stories (58%) contained positive comments about nursing attitudes or behaviours (whether specific or general) and three out of ten stories (33%) contained negative comments about nursing attitudes or behaviours.** Stories could simultaneously contain positive and negative feedback. Whilst more detail was provided about negative perceptions, the overall quantity of comments favoured positive feedback. In fact, there were double the number of positive comments compared to negative comments, though negative comments tended to be much longer and more specific and detailed.

Figure 2: Proportion of stories with comments about nurse attitudes or behaviours



Note: Percentages add to slightly more than 100% because a small proportion of stories contained specific comments about both attitudes and behaviours.



## Nurse attitudes

Out of all the stories analysed, **5% made comments about perceived nurse attitudes** (55 stories).

There were three positive comments about specific attitudes of nurses (<1% of stories) and 57 negative comments about the attitudes of nurses (5% of stories). Stories could include more than one comment about attitudes and could include both positive and negative comments concurrently.

Comments about positive attitudes tended to be broad and cite a 'caring attitude' (4% of people who commented about attitudes).

*"I liked the fact that, although the government are absolutely destroying the NHS and should be absolutely ashamed of themselves, the attitude of the nursing staff was excellent. With staff shortages, a continuous pay freeze, a recruitment freeze and the fact that there are far too many managers probably earning double a nurses wage, I want to commend the hard working, stressed and harshly treated frontline nurses for their commitment."* (hospital inpatient, NHS North West, 2012)

Reports about negative attitudes were slightly more common.

*"Several ... visits have been in the early hours and at these times the noise from the nurses has been intolerable. You could liken their shrieks, shouting and laughter to a teenage sleep-over. Several of the patients in have been frightened and many are elderly. This behaviour is immature and unprofessional. I have recently had three attacks in two days and on the last two occasions the nurse who took over from paramedics has rolled her eyes at my return as if I have some choice in it. Her attitude has been contemptable! She and another nurse were also blatantly passing comment about me when I was in the waiting room!"* (A&E patient, NHS North East, 2013)

Comments about perceived negative attitudes focused on the following issues:

- nurses having a **negative attitude towards patients**, for example saying uncomplimentary things about patients or families or appearing to see patients or families as an inconvenience (75% of people who made comments about attitudes);
- nurses looked like they were in a bad mood / seemed **uncaring** (17% of stories about attitudes);
- nurses appeared to have **negative values about being a nurse** / their role / environment (7% of stories about attitudes);
- **racism** (2% of people who commented about attitudes; equating to just one story).

## *Attitudes towards patients*

Comments about nurse attitudes most commonly described perceived attitudes towards patients. In fact, three quarters of comments about negative nurse attitudes fell into this category (75%).

Some reported that nurses appeared to see patients and family members as troublesome or inconvenient.

*"[I was] shocked by the arrogance bordering on aggressive attitude by one ward sister/nurse on the ward. It's as though we the visitors and patient also were the enemy and were an inconvenience."* (family member of inpatient, NHS West Midlands, 2013)

This was more likely in stories about the care of older people.

Some people commented in detail about the behaviour they had experienced and how they felt this was linked to the underlying attitudes of the nurses caring for them. Such comments often contained a great deal of background information.

*"I was taken round to A&E where I was extremely rudely barked some questions at by a triage nurse. I was feeling very unwell and was having difficulty answering the questions as quickly as they wanted. I was asked if I had problems with the lights. I was covering my eyes and I told the nurse I found it extremely bright in that room. The nurse said something like "well you're not wearing sunglasses, are you? Have you come in in sunglasses? No, so you can't be that bad." I couldn't quite believe what I was hearing. I was wheeled through to another section and the nurse walked off without saying a word to me, leaving me facing a wall. After about an hour with no one having spoken to me at all I became quite distressed. Two nurses came over to me and spoke to each other over me and then moved me into a cubicle... After more than five hours, feeling very unwell I just wanted to leave but I couldn't get anyone's attention to take the bars down from the trolley. I became increasingly upset and frightened... I have no complaints about the cleanliness of the hospital or my treatment on the ward, but the attitude of the majority of the nursing staff I came into contact with in A&E was disgusting. I felt that most of the ones I saw were rude, unfriendly, unsmiling, unsympathetic, unprofessional and I felt they thought I was just there to annoy them. Might I suggest if they really dislike dealing with sick and vulnerable people so much, perhaps they shouldn't be employed in what is supposed to be a caring profession."* (A&E patient, NHS South East Coast, 2013)

## Overall uncaring attitudes

Others linked poor nurse attitudes and behaviours to nurses being in a 'bad mood' or having an overall uncaring attitude (17% of comments about attitudes). The quotes below demonstrate how such comments were often linked to feedback about nurse behaviours and how nurses spoke about individual patients.

*"After birth of baby ... once upstairs in ward the staff seemed unresponsive towards me. I felt one nurse even blanked me when I looked at her which I thought was unbelievable. I had a normal delivery but this second baby left me in a great deal of pain. I asked for a heat pad and found that even when I was asking for help from some staff, their attitude was uncaring. My baby had to go to special care unit and I had to make trips downstairs all the time to see her because I had to wait until a bed was available for me in the unit. I asked for a wheelchair and help to be taken down by staff and no one was available. I was in shock because my baby was ill."* (hospital inpatient, NHS Greater Glasgow and Clyde, 2013)

*"Needs to be less laziness and more work on basic needs. Poor team work with disagreements over treatment plans. Trashing of doctor's plan by a moody and unpleasant nurse. Excessive lengthy personal chit chats going on at nurses' stations, disrupting to sleep with some confidential discussions about individual patients (inclusive of sarcasm and dislikes of certain patients) overheard as no awareness by the nurses that with open room doors loud voices are very clearly overheard... If so much laziness is possible on the ward when there are so many staff doing nothing, then there are too many staff."* (hospital inpatient, NHS East of England, 2012)

Similar feedback came from family members of patients. Usually people made reference to poor 'nurse attitudes' and then detailed some of the behaviours they felt illustrated an uncaring attitude.

*"My mum is ... too scared to comment about the care that herself and others on her ward are receiving, which she feels is disgraceful. I have witnessed some of the attitudes of some of the nurses who I feel sadly bring down the name of nurses who do care. I have been consoling my mum for the past three days and have well and truly had enough but cannot do anything as I fear she will be treated even worse. Things like: her cannula popping out of her arm and being left for four hours, as the nurse reported being too busy; painkillers prescribed first thing in the morning by the doctor, yet waiting ten hours because again they are too busy; being given insulin when she is not supposed to have it; not getting her diabetes injection all day as there simply isn't time, then getting told she can't leave because sugars and blood is unable to stabilise; being told off as mum asked for breathing apparatus, then it being plugging in high above her, forcing mum to ask for assistance. At this point the nurse stretched the wire whilst mum had to manoeuvre herself in a contorted manner, then the whole thing blew up in her face. The nurse laughed and walked off. Disabled and elderly with compounding health concerns - no wonder she cries on the phone to me at night. I have witnessed this treatment with others on the ward also - help these poor old age pensioners to have dignity, to be listened to."* (family member of hospital inpatient, NHS East Midlands, 2012)

## *Attitudes towards jobs*

Finally, around one in ten comments about nurse attitudes focused on perceived nurse dissatisfaction with their roles or the environment in which they worked (7%).

*“While I was travelling through the hospital, waiting in different areas, I could hear the staff - being porters, receptionist and nurses. They all had the same theme in their conversations, which was how badly they were being dealt and how bad their working conditions were. Whilst the initial care was good, I found that the atmosphere in the whole hospital was bad. I understand that people can be unhappy about their work but discretion is needed and they should voice opinions in private and not in front of the public. May be a little more nurse training is needed.”* (A&E patient, NHS Yorkshire and the Humber, 2013)

People commenting in this way believed that nurses should take care not to speak about their dissatisfaction in public areas or to let this affect the care provided.

*“I felt that, although the nursing staff worked well as a team, they could have been more discreet about the fact that they were understaffed. Discussions about who was covering what job was openly talked about in front of patients. The following conversation took place right in front of me: ‘why can't the doctors do the consent forms? There's not enough of us as it is.’ ‘I know, that's what X said’.”* (hospital inpatient, NHS East of England, 2012)

## *Differences between groups*

As with all of the feedback, these comments about nurse attitudes describe the perspective of patients, often at an emotional or stressful point in their lives, and do not necessarily provide the ‘whole story’ or take into account the complexities and challenges faced by nursing staff or the many things that may have led up to patients’ experiences. The comments provide a flavour of the things that people submitting stories to *Patient Opinion* felt strongly about – and they also illustrate that most comments about attitudes were interspersed with comments about related behaviours.

There were too few comments about nurse attitudes to draw conclusions about whether there were differences in the submissions of people from different geographic regions, age groups or genders or from those using certain types of services. Nor was it possible to suggest whether some types of nurses were more likely to have negative attitudes reported than others. Tests for differences between groups were not statistically significant. This does not mean that there were no differences between what patients versus carers or those from various regions, countries or demographic groups reported, just that the number of stories submitted about attitudes was not sufficient to draw conclusions about this.

## Nurse behaviours

In terms of behaviours, out of all the stories analysed, **six out of ten commented about a specific behaviour of nurses** (60%; 703 stories).

In total, 442 stories (37%) made one or more positive comments about specific nursing behaviours and 311 stories (26%) made one or more specific comments about negative behaviours of nurses. People could comment about both positive and negative behaviours within the same story.

There was a wide mix of comments, with some being very complimentary:

*“The staff have been truly amazing on all wards and in the theatre unit... The ward staff were empathic, encouraging and caring about everyone and had time for everyone. They made us all feel special and important and on a difficult unit this is an exceptional workforce we are talking about.”* (hospital inpatient, NHS East Midlands, 2013)

Others felt strongly that the behaviours of nurses had not been up to scratch, and these comments tended to be more detailed:

*“An experience I want to forget. The nursing care was non-existing. [I was] left for days without being washed. Food and drink left out of reach even though I couldn't feed myself. I wasn't turned or toileted for 30 hours and then because of that I had to be catheterised. I wasn't given a call bell even though I couldn't move at the time. A relative told a nurse I needed to urinate but no one came. A porter had to put me into bed a few days later as I had been left for hours hanging over a chair as I couldn't support myself. They had asked a nurse himself two hours previously but when they came back they saw I was still there so did it themselves. Nursing staff did not interact with patients but was told they were always on the computer doing what? What could they be inputting when they did not talk to their patients. An elderly lady was vomiting next to me and crying. I asked a student nurse who was a mature third year student could they see if she was ok. Their reply was "well she's not choking so don't worry" They showed no care or compassion and they are a future registered nurse. At the time they were making a bed laughing and chatting to someone... We expressed our concerns to staff and I was then whispered about at subsequent handovers. Care and mistakes got worse. The elderly and those who weren't self caring bore the brunt of the neglect. I am determined to do something about it and to protect others who can't speak for themselves.”* (hospital inpatient, NHS East of England, 2013)

There were four categories that patients and family members reported on in terms of nurse behaviours:

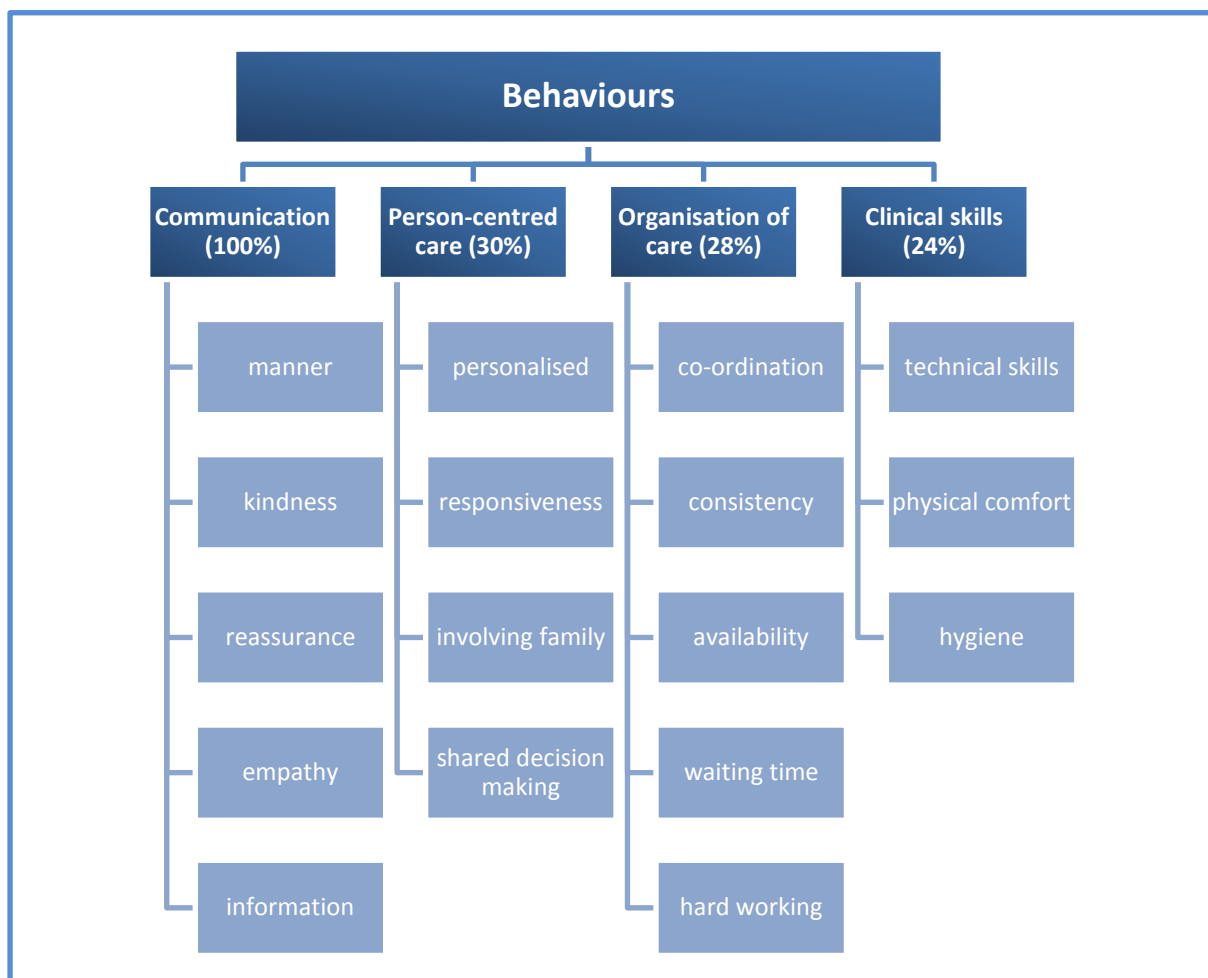
- **Communication** and information (850 comments);
- **Person-centred care** and support (211 comments);
- **Organisation of care** (200 comments);
- **Clinical skills** (165 comments).

Each of these categories had a multitude of subcategories, as detailed in Table 1 and Figure 3.

Further details are provided about the types of feedback in each category overleaf.

**The most common thing that people commented about was nurses' overall manner, such as being friendly and smiling versus appearing rude and brusque.**

Figure 3: Key themes in comments about nurse behaviours



Note: Percentages relate to the proportion of all 703 stories about behaviours that focused on a certain category. Percentages add to more than 100% because each story could contain more than one comment about behaviours. The aim is to illustrate the most common topics mentioned by people who commented about behaviours. It would not be relevant to base the percentages on the total of all stories, because one-fifth of stories provided no feedback about nurse attitudes or behaviours and one-fifth provided non-specific feedback. Including these numbers would not show what people were most commonly commenting about.



Table 1: Proportion of comments about positive and negative nurse behaviours

Positive behaviours	Negative behaviours
<b>Communication and information</b>	
Positive manner / pleasant / smiling / friendly / good bedside manner (25%)	Negative manner / rude / unfriendly (14%)
Kindness / consideration / courtesy / caring / respect (16%)	Lack of kindness / respect / dignity (7%)
Providing reassurance / hope / put at ease (11%)	Not alleviating fears (1%)
Clear communication / information / knowledgeable (10%)	Unclear communication / information (2%)
Regular communication / knew what was going on (6%)	No regular communication / did not know what was going on (6%)
Compassion / empathy / sympathy (6%)	Lack of compassion or empathy (6%)
Using humour (3%)	
Patient-centred communication / listening (2%)	Not listening (1%)
Supporting psychosocial needs (1%)	Not supporting psychosocial needs (<1%)
High quality and honest information (1%)	Not accurate or honest information (3%)
Apologies given (1%)	Apologies not given (<1%)
	Not speaking English well (<1%)
<b>Person-centred care and support</b>	
Good personalised care (6%)	Not personalised / treated as a number (3%)
Responsiveness to people's needs (4%)	Not responsive / changing to meet needs (3%)
Involving family and friends (4%)	Not involving family and friends (3%)
Supporting shared decision-making (1%)	Not supporting shared decision-making (<1%)
Supporting family and friends (1%)	Not supporting family and friends (1%)
	Noisy talking or laughing by nurses (4%)
Good relationship between patient and nurse (<1%)	Poor relationship between patient and nurse (<1%)
Dealt with problematic patients well (<1%)	
<b>Organisation of care</b>	
Co-ordination / integration / efficiency (5%)	Lack of co-ordination or efficiency (4%)
Hard working (2%)	Not hard working / lazy (3%)
Good availability / quantity of nurses (1%)	Lack of availability of nurses (3%)
Not kept waiting / keeping appointments (1%)	Keeping people waiting / not keeping appointments (7%)
Not made to feel rushed (1%)	Made to feel rushed (<1%)
Leadership / showing authority (1%)	Not showing authority / poor leadership (<1%)
Continuity / consistency (<1%)	Lack of continuity or consistency (1%)
<b>Clinical skills / practical issues</b>	
Good clinical skills eg treating wounds (2%)	Poor clinical skills eg medical errors (8%)
Supporting physical comfort (1%)	Poor support of physical comfort eg not enough pain relief / not offering refreshments (8%)
Good hygiene (<1%)	Poor hygiene (3%)
	Scruffy appearance (<1%)

Note: The percentages are calculated based on the total number of stories with comments about behaviours (703 stories). Percentages add to more than 100% because stories could report more than one nurse behaviour. Percentages are not calculated based on the total number of stories in the dataset because 17% of stories contained no comments about nursing attitudes or behaviours and 22% contained non-specific comments so it would not be appropriate to include those stories in the calculations.

## Communication

### Positive bedside manner

There were many positive comments about how nurses were friendly, smiling, good natured and had a good bedside manner. In fact, **one quarter of all comments about nurse behaviours mentioned nurses having a positive manner (25%).**

*“The technical aspects of support were obviously important, but the manner in which it was provided - by clearly dedicated, understanding and caring staff - leaves a lasting impression.”*  
(hospital inpatient, NHS East Midlands, 2013)

These comments tended to be short and contained little detail, but it is important that they are not overshadowed by longer negative comments which may be more detailed, but were also fewer in number.

### Caring and reassuring

In total, 16% of comments about behaviours described how nurses were kind, courteous, respectful and caring and 11% outlined how nurses provided reassurance to scared or anxious patients or family members.

*“The professionalism, support, and kindness shown by all of these staff was extremely reassuring. I was very anxious about the procedure but the staff made time to speak with me and explain things. They listened to my concerns and questions. They were extremely sensitive and caring. With the time pressures you are all operating under, it is extremely reassuring to know that the 'caring' profession is still able to be exactly that!”* (outpatient, NHS East of England, 2012)

### Using humour

A small proportion of comments about nurse behaviour emphasised the importance of using humour to diffuse tension and put patients and family members at ease (3%).

*“They say laughter is the best medicine. I may not have been laughing a lot but there were opportunities to have a joke about the number of times I had been to x-ray and the plaster room, which I found helped make the situation, for me anyway, easier.”* (A&E patient, NHS South East Coast, 2012)

Often humour was mentioned alongside many other positive behaviours, in the context of a working environment that appeared happy and well co-ordinated.

*“The nursing was of the highest quality... the kindness and consideration was exceptional. In three weeks not once was I made to feel uncomfortable or unhappy. All of the ward staff created an amazing atmosphere. Despite being desperately ill, there was even time for laughter. Nothing was too much trouble, I was never made to wait. It surpassed nursing; it was caring of the highest quality. Not once did I hear a moan or a sigh of discontent. They are an amazing team of the most respectable nursing and doctors I have ever encountered... Dignity was kept at all times, they were fast and efficient, but humane.”* (hospital inpatient, NHS South East Coast, 2013)



## Negative manner

However, not all stories were as positive. In fact, **14% of stories about nurse behaviours described staff that were felt to have been rude or unfriendly and 7% said that nurses had been unkind or disrespectful.**

*“The triage nurse stood at door calling patients as if she was at a vets. No smile, eye contact or ‘how are you’ to patients.” (family member of A&E patient, NHS Greater Glasgow and Clyde, 2013)*

*“I went into A&E as I was advised to do so by the out of hours practice to see a doctor about a bout of shingles that I have picked up. I found the triage nurse to be very rude and she frankly offended me with regards to her lack of diligence or care. She made it very clear that I was wasting her time and I should [have seen] a GP. I tried to explain that both my GP and the out of hours practice were unable to offer me an appointment to see a doctor but she was in no way interested in what I had had to say and basically called me a fool for coming in to the department. I totally understand that my condition was not a medical emergency and I ... said I was more than happy to go away and wait for an appointment to see my GP. I understand that the A&E department is an extremely busy and a stressful environment but I think that I could have been dealt with like I was not some time wasting idiot and an actual human. I must stress that I was very polite towards this nurse and was completely respectful and polite.” (A&E patient, NHS South West, 2013)*

6% of stories about nurse behaviours talked about a **lack of compassion** demonstrated by nurses.

*“I was in the worst pain I have ever been in (this was quite apparent as I was distressed and in tears) but I was not offered any help/kindness/glass of water/pain relief - not even a smile ... the appalling attitude and lack of care by the reception staff and triage nurse that I first encountered was extremely upsetting. As a nurse myself I am aware of the frustrations of working in a high pressure job and I know that people can have bad days as a result of this pressure. However, I would be ashamed of myself if I were to conduct myself in such an unprofessional way. It is deeply concerning that such frontline staff lack the ability to show compassion to someone who seeks help and support.” (A&E patient, NHS London, 2013)*

Patients also wrote passionately about how perceived problems with communication were linked to nurse attitudes and poor clinical behaviours, such as a lack of hygiene or medical errors. A small portion described what they believed were long-lasting serious impacts from poor nurse care, and nurse manner was just as important as perceived inappropriate clinical care in these instances. This suggests that some patients sharing their stories are linking communication and non-technical skills inextricably with good clinical care.

*“The nurse assigned to me was rude and uncaring. I'd been nil by mouth all day but no food was offered. I was told to wait until dinner time. I had to insist that a sandwich and coffee be brought. She failed to notice my drip was blocked for three hours and in spite of my pain and dehydration refused to change it. ‘Drink water’ she barked. I heard her hooting with laughter as I protested. I was so dehydrated my mouth had stuck together. Eventually I was comfortable enough to go to sleep and imagined that my ordeal was over. I woke up in the middle of the night in agony. My catheter valve had been closed off so it couldn't drain into the bag. The upper chamber was full and everything was backing up into me. It was excruciating ...The bed was filthy, full of blood and when I asked to for soap and water to clean myself it was refused. Again, I had to insist. The next day I went home but felt worse day by day. I was finally diagnosed with a kidney infection. I was treated by my GP but rang the hospital to report the infection to the specialist nurse. When I came for my follow-up appointment two months later nothing about the catheter error or the infection had been recorded in my notes. I discovered I had been given a shot of antibiotic in the op but no follow-up tablets. Had they done so my kidney infection would have been cleared up much sooner. I am temporarily disabled as the different antibiotics I was eventually given by my own GP have had devastating side effects. If the team ... had done their jobs properly this would never have had to happen. The domino effect of the appalling post-surgical care goes on even now, six months later. But the experience of being there, the humiliation, the pain, the dirt and the brutish atmosphere will stay with me a long time.” (hospital inpatient, NHS London, 2012)*

### *Information provision*

Another key aspect of communication was the provision of clear and regular information. One in ten people commenting about nurse behaviours mentioned that they had been pleased with the clarity of information provided or how **knowledgeable** nurses were (10%).

*“I attended the nurse-led anaemia clinic and was very impressed with the way in which I received person-centred care from the nurse specialist. I was given information about my blood results and had the opportunity to discuss the next steps to establish the cause of my anaemia... I'm a great advocate for nurse-led services and find that nurses spend more time explaining your condition to you.” (outpatient, NHS North West, 2012)*

Being **kept informed** of what was happening was important, particularly in an A&E or ward context (6%). Some patients and carers also spoke positively about feeling listened to (2%).

*“Following a visit to my GP I found myself having to attend the rapid access chest pain clinic at the hospital. The nurse was excellent, very professional and informative. I felt they listened to all my concerns, explained all the tests and reasons for them and explained the results. The nurse made me feel that they were genuinely interested in my health and gave good advice. A very caring individual who deserves to be recognised for the fantastic service provided.” (rapid access clinic patient, NHS North West, 2012)*

However, not all feedback about information provision was positive. Approximately equal numbers of people as made positive comments about information provision made negative comments about a perceived lack of regular information (6%), clarity (2%) and listening (1%). A small number linked communication problems with nurses not speaking English well (<1%).

*“Patients are people and I feel NHS employees should understand this. I’m not a wimp and have been through a lot in my life but on being blue-lighted into a hospital, I was scared and I needed reassurance. I think someone should have done this and neither myself or my girlfriend got any detailed or realistic information on what was happening or my condition. Hospital staff bustled around us, seemingly too busy to speak to us as we waited about three hours for a bed - were we waiting for a bed? We didn’t know as no one told us. All it would have taken was a doctor, nurse or new patient liaison to sit down for five minutes with us and explain calmly and clearly what was happening... I found the nurses that cared for me not only uncaring but also very difficult to communicate with. The whole time I was in there I did not meet a single nurse that spoke good English (I assumed very few were English). I often found it difficult to make myself understood and I witnessed a lot of other patients being misunderstood.”* (hospital inpatient, NHS London, 2013)

## Person-centred care

Around one-third of comments about behaviour contained feedback about person-centred care (30%). About half of the comments were positive and half were negative. Person-centred care could be seen as a component of communication and information provision, but was analysed as a separate category because there were some specific themes about being treated as an individual. This re-emphasises the subjective nature of the coding process. The themes and categorisations used by one set of coders may differ from those used by another group.

### Treated as a friend

Some patients wrote about how they had been treated like a friend by the nurses caring for them.

*“I had a totally positive experience ... whilst in for a mastectomy. The nursing care was wonderful and the surroundings lovely. From cleaner to consultant, everyone was really helpful and friendly. The nurses gave me big hugs when I was leaving - they felt like friends.”* (hospital inpatient, NHS Greater Glasgow and Clyde, 2013)

*“[Nurse] is a caring incontinence nurse - She makes me feel relaxed. When I am worried, she always reassures me. A 100% nurse - always making me feel like a friend. She explains everything really well when I am not sure - She’s one good person!”* (patient using independent sector, area not specified, 2012)

Women were more likely to make these sorts of comments than men. This may be because this type of support was more important to women, or more likely to be offered to women.

## *Treated as an individual*

Similarly, patients talked about how they were treated as an individual rather than a number (6%).

*“The nurses ... treat you as an individual with a name and feelings. You are not just another patient going for treatment, you are a real person. They were kind, reassuring and pleasant. My treatment was routine for them but very scary for me. I never felt in the way or left out of how my treatment was going.”* (hospital inpatient, NHS East Midlands, 2013)

*“The nurses are absolutely excellent. They looked after myself and other patients. They treated me and others like humans and not like just a number like at other hospitals, even though they were rushed of their feet. Very kind and caring.”* (hospital inpatient, NHS North West, 2013)

Being **responsive to individual needs** was a key nurse behaviour in this regard.

*“There are rules in place for a reason, but it's also important to change them when they are inappropriate. Had they not allowed me to have someone with me I simply would not have coped. It's hard to express the extent of my gratitude to them. They were beacons of brilliance.”* (hospital inpatient, NHS East Midlands, 2013)

Some people reported how nurses had gone out of their way to treat them humanely and with dignity and compassion; sometimes bending the rules to attend to individual needs or going ‘beyond the call of duty.’

*“I was admitted a couple of weeks ago late at night through A&E. When I came to be discharged the following evening I got a bit teary when I realised I only had my pyjamas and a coat (I hadn't been in much of a fit state to bring anything with me the night before as I was in so much pain). I didn't have my purse. I had no money. My phone had run out of battery and to top it off there was no-one available to come and pick me up. [The nurse] could see I was in a bit of a state and still feeling quite poorly and lent me the money. I don't think she expected to get it back but I was able to return later that evening with her money. I'd just like to say thank you. You could have left me to my own devices or left me to block a bed until someone could pick me up. You could have just said it wasn't your problem but you didn't and it made a world of difference to me after a long, painful and rather emotional 24 hours. You went above and beyond and it was much appreciated.”* (hospital inpatient, NHS London, 2012)

There were a number of positive comments about how nurses working with **children** and their families adapted to meet individual needs.

*“My son was treated with the utmost care... The nurses were very caring and always made sure we knew what was going on at all times. He most enjoyed in the playroom with the play team. They were fantastic and always gave him plenty to do. They took time to find out more about him to provide him with things he liked doing. They made him feel very safe and cared for especially when he went down for his op and in the treatment room. Knowing he didn't feel as scared made life more bearable for us.”* (family member of patient, NHS East Midlands, 2012)

Nurses working in **mental health services** were also singled out for praise regarding responding to individual needs and adapting to provide more person-centred care.

*“I find [my community psychiatric nurse] encouraging; thoughtful and considerate; realistic. Her comments demonstrate that she takes the time to consider how she would feel if she were in my shoes. It may seem a small thing but often emotional, psychosocial support is offered by professionals but often practical support is also at times needed. This is the first time I have experienced not only support in the form of positive encouragement and events and responses put into perspective but also in practical ways too.”* (mental health service user, NHS East Midlands, 2012)

### *Supporting shared decisions*

Another component of person-centred care is supporting shared decision-making. Only small numbers of people mentioned this in their stories, with about equal numbers reporting on positive (1%) or negative (<1%) nurse behaviours in this regard. Often, positive comments about helping people to be involved in their care were made outside acute hospitals, in community services or primary care.

*“I attended the clinic to get information about going on the contraceptive pill. The nurse who saw me was very friendly and welcoming, and made me feel at ease and relaxed for the entire appointment. I was given full and clear information and the nurse helped me choose which decision was best for me.”* (independent sector community clinic patient, area not specified, 2012)

### *Not supporting person-centred care*

However, there was also negative feedback about the extent of person-centred care. Some people reported that they felt overlooked by nurses or that nurses did not concentrate on them when providing care.

*“The nurse kept referring to me as ‘love’ and when taking blood it was in some sort of a store room where the nurse taking the blood and another nurse had a long discussion about how unhappy they were regarding overtime payments. Just like I wasn't there. Not paying attention to taking to blood, reading the paperwork - not just rude but dangerous.”* (hospital inpatient, NHS North West, 2012)

Others said that nurses had an air of 'knowing best' and did not listen to the concerns or needs of patients.

*"Am fed up with this department ... time and time again they do not listen to a word I say and I am just fobbed off as the nurses have no interest in their jobs here and even less interest in trying to help. Through no fault of my own, I have poor hearing and have no option, other than to use this department - 10 years on and I am still having the same constant battles, with the staff telling me they know my hearing better than I do and that the moulds they take of my ears "fit perfectly" when they are enormous, very uncomfortable and the last pair I had done do not even fit!!"*  
(outpatient, NHS East of England, 2013)

### *Involving families*

Another area commented on was the extent to which nurses supported family and friends. Both patients and family members commented on this topic, though more comments about this were received from family members. Around equal numbers of stories included positive or negative comments about whether nurses had appropriately involved family and friends (1% each).

Whilst some family members said they appreciated being kept informed about care or involved in decisions, others felt that family members were dismissed or 'kept in the dark' about care, especially regarding end of life care.

Some family members felt strongly that it should be part of nurses' role to support families as well as patients.

*"The staff nurses seem busy and less able to provide what I should call family centred care for a, I shall admit, large family. I appreciate it is difficult to support relatives and family members but my mother is very poorly and the feeling that we are 'being looked after' as well, to even a small extent would go a very long way... Things that would be helpful: a response by management if a ward is short of staff and ensuring there are adequate staff to allow full and complete nursing care; volunteers or others who can give time for relatives and friends to talk, and direct them to the canteen, chapel etc; an area other than the canteen or ward where families can sit quietly or be spoken to by the nursing and medical staff in confidence; training for ward staff in dealing with grieving families and their reactions, so that if relatives appear angry, questioning, defensive, they are cared for and approached appropriately; that nurses and nursing staff listen to family members when they say that the patient is not 'right' and do not seem to dismiss the concern even if they do not ultimately act on it."* (family member of hospital inpatient, NHS South East Coast, 2012)



## Organisation of care

More than one quarter of comments about nurse behaviours focused on issues involving the organisation of nursing care (28%). Patients often referred to this as ‘continuity of care’ or linked organisations issues with continuity. Whereas the majority of comments about communication and, to a lesser extent, person-centred care were positive, **comments about the organisation of care were a little more likely to be negative.**

### *Not made to feel rushed*

On a positive note, some people appreciated that nurses did not make patients feel rushed. This was particularly true for district nursing.

*“I have now been having the district nurses ... visit me at home for eight weeks almost every day. They are such a fantastic team of community nurses, all so friendly, patient, empathetic, sensitive and so many more things... They really do see the person and not just the condition / illness / disability which makes such a difference. They are so incredibly busy and have so much pressure with so many patients to see but I can honestly say that they never let that affect the care. They will give that time to just sit and listen when you just need that little bit more... [When talking to one of the nurses] I said ‘you need to go. I am sorry I am keeping you as I know you're so busy.’ She said ‘you are just as important as the next person or the person before and when I am here it is you that matters.’ She may not have thought much about what she said but it really did make me feel like what I was feeling was important to them and it wasn't just about having the treatment I needed, it was about me as a person.” (person using district nursing services, West Yorkshire area, 2012)*

### *Neglecting patients*

However, on the more negative side, around 4% of comments about nurse behaviours related to a lack of co-ordination and 3% suggested that nurses may have neglected patient care in favour of other things. Family members were most likely to have made observations about nurses ignoring or neglecting patients.

*“[When] I arrived to visit my grandfather on the ward I was ignored / left standing for ten minutes before a cleaner asked if they could help. Now when you can find a nurse and you ask how he is doing, they do not know or contradict each other, eg ‘he's coming home/no having a scan/he is sick/he is good and coming home.’ Yesterday he pushed his buzzer as he needed assistance that I couldn't do and the thing went off for 23 minutes making one very loud noise in the corridor. I walked to see who was about. At least 5/6 people sitting behind the desk ignoring the noise completely, at the same time a patient further down the corridor was calling loudly nurse, which was also being ignored. As far as I am concerned this is not good. Either of them could have been dead by the time anyone goes to find out the problem... I feel the lack of care for the elderly is appalling. I hope I don't make it to 80/90 as I don't want that kind of care.” (family member of hospital inpatient, NHS East of England, 2012)*

Other stories reported on how nurses were perceived to place **paperwork and computers** ahead of patient care, and suggested that this was a barrier to providing high quality continuity of care.

*“Nurses’ manual handling, empathy and attitude [could all be improved]... Nurses did not log-roll a patient suspected of spinal injury. They asked me to slowly move myself to the other trolley. As I was fighting for my rights with a doctor and a nurse, the nurse walked away, asking the doctor to sort it out himself. (I thought nurses’ were patient’s advocate)... Also, all the nurses were busy resuscitating computers, not patients.” (A&E patient, NHS East of England, 2012)*

There were particular concerns over how people nearing the **end of life** were treated.

*“Later I had to go again and find a nurse. I said ‘I know my husband is dying, but he does need changing from all this sick!’ Two nurses came. They never spoke, never sponged him down. They just put a gown over the top of him instead of his pyjamas. Maybe this was easier for them! The next day my husband died under your care. Did I just say care? There must be another word for it. I know exactly what it is. It’s neglect. It would have taken so little for someone just to sit in a moment with the dying, just to say a few words, just to touch their hand, and give them a little reassurance that you care. You talk about ‘end of life care’. In my eyes, a dying person should always look neat, clean and comfortable, which then in turn will give comfort and acceptance to family and relatives in their final moments. I didn’t get that, maybe this is why I cannot get this matter out of my head.”(family member of hospital inpatient, NHS North West, 2012)*

The feedback shows that the things that nurses do – or fail to do – can have a lasting impact on how patients and families feel about the care they have received, and these impacts can last for a significant period.

As always, it is important to emphasise that these comments reflect one person’s view about a particular incident, often at times of heightened sensitivity.



## Clinical skills

### Good clinical skills

**One quarter of all stories containing comments about nurse behaviours described clinical or technical issues (24%).**

The majority of comments about nurses' clinical behaviours tended to be negative, but there were some exceptions.

Around 4% of comments about nurse behaviours focused on positive aspects of clinical care. This included feeling confident in the skills of the nurse providing care and believing the nurse was taking all necessary clinical steps.

*"I was treated in the A&E department by a nurse practitioner who did a thorough examination and requested X-rays of my painful knee... When the X-rays returned the nurse practitioner provided a clear explanation of the damage and advice for self-management. He bandaged the knee, demonstrated the use of the crutches and I felt fully confident going home."* (A&E patient, NHS North West, 2013)

*"[The nurse] provided an exceptional level of care. She demonstrated flexibility by fitting me into an appointment slot to meet my work schedule (this was outside the normal clinic schedule). She demonstrated clinical competence by being informed of my history, taking the time to read my self-assessment questionnaire, providing evidence and best practice information and doing so with care and respect. She has good listening skills and responded with appropriate reassurance."* (outpatient, NHS West Midlands, 2013)

### Problems with basic care and hygiene

Stories about negative technical behaviours were more common, with one in five comments made about nursing behaviours falling into this category (20%).

These stories tended to describe how nurses had overlooked basic care and hygiene and were often reported by family members.

*"[My husband] suffers with Alzheimer's. A urinary tract infection has left him completely helpless - he cannot speak well enough to make himself understood; cannot walk; cannot sit himself up; is doubly incontinent. The latest visit I made to him, I was disgusted to find him lying diagonally across the bed, the bedclothes were twisted across his middle, he had no pyjama trousers on, the curtains were open, and he was exposed to visitors passing by. He was naked from the waist down with his private parts on show to all. His head was wedged against the bars at the side of the bed - he had slipped off his pillows, and was unable to move himself, just trying desperately struggling to move. His bed table was pushed up against the wall, not that he could pour himself a drink even within reach. His lips were very dry, and when I offered a drink, he drank two cups of water straight down... This situation should not have been allowed to arise. Nurses are passing beds on a regular basis, surely it only takes a minute to observe whether or not a patient is uncomfortable or needs covering over."* (family member of hospital inpatient, NHS East Midlands, 2012)

People said that gaining **refreshments** or help to eat and drink was a great concern.

*“My mother is currently a patient ... The level of care she has received is unacceptably poor... She is finding it difficult to eat and drink but is receiving no assistance from nursing staff, who frequently leave drinks where she cannot reach them. Not surprisingly she is now dehydrated. In the last two days staff have neglected to make her comfortable in bed and have left her for some considerable time in uncomfortable positions. It seems that nursing staff give a higher priority to chatting at the desk than to patient care. This situation is wholly unacceptable, unprofessional on the part of the hospital staff and distressing to both patient and family members.”* (family member of hospital inpatient, NHS East Midlands, 2012)

Patients sometimes reported that they had not been helped to wash, and said that supporting **basic hygiene** should be a fundamental component of nursing care.

*“I am a fit and able person but due to my operation could not move at all the night before nor the day after. I was not offered assistance with a wash, not even a bowl of water. I had to ask for both. Just pulling the table to me was difficult and again there was no offer to ensure I had everything I needed. I was fine as I could ask and had plenty of visitors but there were those in the ward who could not. Nurses, please understand that looking after the basic personal needs of a patient is your first priority. If these are not taken care of all the other wonders that are performed could well be useless if someone becomes dehydrated or develops pressure sores!!!”* (hospital inpatient, NHS East Midlands, 2013)

There were a number of comments about nurses not helping people with their **toileting needs**.

*“That day [my grandmother] had undergone an operation and had to use the bed pan - she was left 45 minutes lying on top of the bed pan calling for the nurse to help remove the pan. Another incident occurred last night when she had difficulties breathing and she had been calling the nurse from 12am till 3am for assistance. She was not provided with a buzzer either - eventually after three hours the nurse came to her where the doctor was called and an x-ray showed she had fluid on the lungs. I believe the lack of care is due to the ward being understaffed with at times two nurses looking after 18 patients.”* (family member of hospital inpatient, NHS East of England, 2012)

*“I have visited daily and what I see with a number of the nurses is lack of basic personal care and attitude of staff too busy laughing and joking at the nurses’ station rather than looking after patients. One gentleman opposite my father had wet himself. He was left there while the nurses were laughing and joking. One eventually came over and mopped up with some old towel but no antibacterial spray was used or anything. I could understand if the nurses were busy, but they were just laughing and joking. Another lady was calling out and she was totally ignored. My father’s antibiotic drip just left when empty - he had to ask three times for it to be removed so he could go the toilet. He asked for a sleeping tablet but yet again but was ignored.”* (family member of hospital inpatient, NHS London, 2012)

Some stories suggested that a lack of clinical care had longer-term consequences, such as potential complications.

*“Following a fall my mother was admitted ... and received an emergency hip replacement. Medically she recovered well from this and was given compression socks to wear following the surgery. She [transferred between three wards]. At no time during her stay in any of these wards were her compression socks removed, even though she asked various nurses to take them off and wash her legs and feet. Eventually ... at her strong insistence, they were finally removed (after nearly three weeks). She now has an ulcer on her leg caused by the continuous wear of the socks. I have been given to understand that compression socks should be changed daily and not worn at night. Why is this basic procedure not being followed? (family member of inpatient, NHS London, 2013)*

Family members sometimes expressed anger at the perceived consequences of lapses in the continuity and quality of clinical care.

*“Mum went into [hospital] ... Initially, directly after the operation she was able to use her hands to full effect and all the signs were that she would make a good recovery. However, when my father and I went to visit the following day we found her slumped in a chair, leant forward with her eyes bulging, red in the face, struggling to breathe. We asked the nurse to get her back in bed and she made a remark about how busy she was. When they eventually came mum could not get out of the chair and told them several times that she could not feel her arms and legs. They had to eventually hoist her back in bed. After this, mum was admitted to critical care and has now been left totally paralysed and doubly incontinent. We have since complained but we feel we have encountered nothing but a smokescreen ... Mum went in for a relatively routine operation because she was losing feeling in her hands and now needs 24 hour care and can only move her head. We just feel this is disgraceful aftercare from nurses that we feel neglected their duties.” (family member of inpatient, NHS North West, 2013)*

As always, these stories should be interpreted with caution. They are reproduced to illustrate the scope of material included on the *Patient Opinion* website, rather than as accurate reflections of the care provided.

## *Differences between groups*

This section briefly highlights some differences between groups in stories about nurse behaviours but should be treated with caution due to the difficulties in ascertaining demographic features previously noted. The purpose of this section is to illustrate that there are **some trends which may bear further investigation**, rather than to detail every potential difference between groups in depth.

With regards to the **country of origin**, of the 703 stories about nurse behaviours, 661 came from England, 34 were about services in Scotland, seven were about services in Wales and one was about services in Northern Ireland. The number of stories about services outside England is too small to make comparisons. Taking only the two largest sets of country responses, stories about services in Scotland were less likely than those from England to be negative about organisation of care and more likely to be positive about person-centred care ( $p < 0.05$ ).

Where it was possible to discern whether the services being commented upon were in **rural or urban areas**, people describing services in large urban areas were more likely to be negative about nurse communication and those commenting about rural services were more likely to report positive nurse communication behaviours ( $p < 0.05$ ). There were no other major differences in the comments made by those focused on urban or rural services.

In terms of various **types of nursing services**, people commenting about inpatient hospital care were more likely to report negative behaviours than those whose stories were about primary or community care or mental health services. In particular, there were more reports of nurses working in hospitals demonstrating less person-centred care than those in the community ( $p < 0.05$ ).

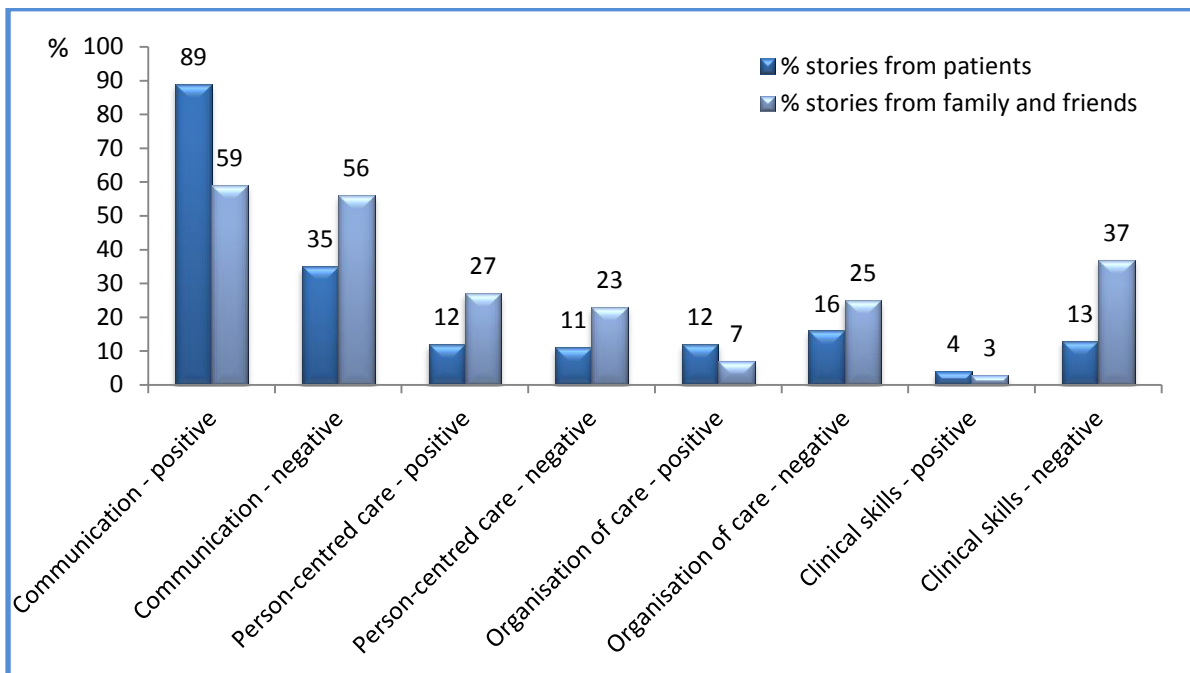
There were differences in the focus of stories from **patients versus family members**. For example, family members were proportionately more likely to comment on person-centred care and clinical skills than patients. There was also a difference in the extent to which patients and family members reported positive versus negative behaviours. For instance, family members were less likely to report positive nurse communication and more likely to report negative clinical behaviours ( $p < 0.05$ , see Figure 4).

There were also some trends regarding **gender**. It was possible to discern whether stories were from men or women in 278 cases. In these stories, women were more likely to comment positively about nurse communication and men were more likely to comment negatively about nurse behaviours related to the continuity and organisation of care ( $p < 0.05$ , see Figure 5).

There was a trend towards people who were under 30 providing more negative stories about nurse clinical skills compared to older people, but the number of stories from which age could be determined was miniscule (35 stories).

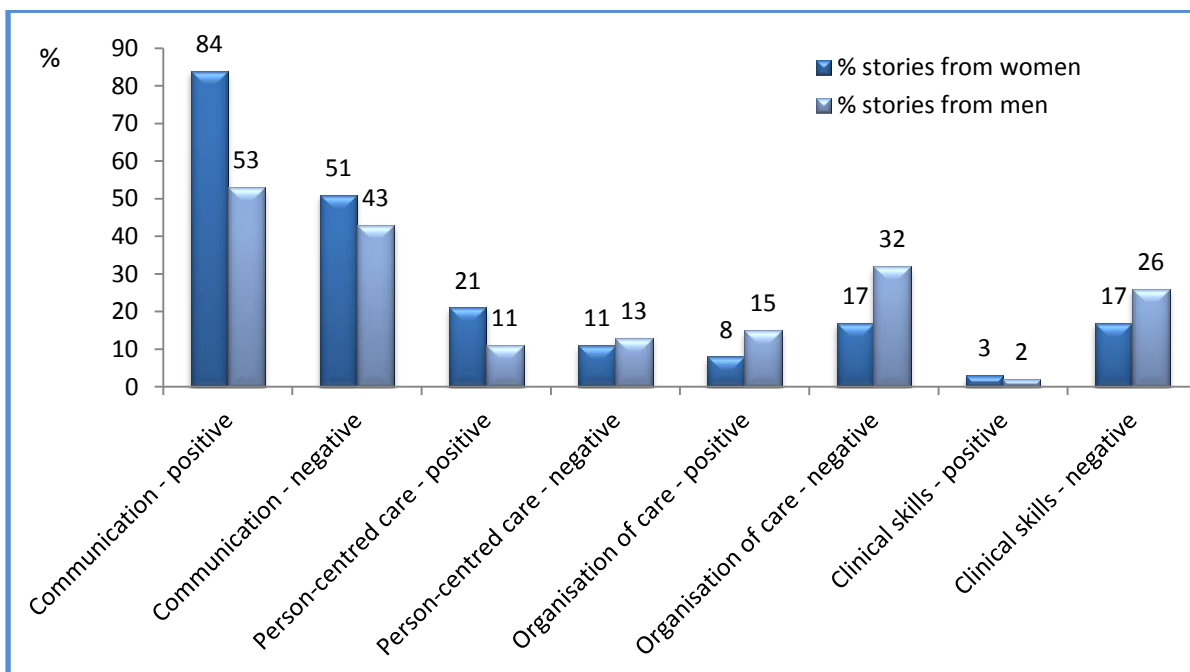
These brief snippets illustrate that there may be some interesting differences in the stories of patients and family members, men versus women, those from different countries and those commenting on hospitals versus community care. The content analysis was not designed to explore these differences in any depth, so merely signals their potential existence.

Figure 4: Comparing positive and negative stories reported by patients and family members



Note: The percentages are calculated based on the number of patients (503) or family members (200) who reported positive or negative components of nurse behaviours. Percentages add to more than 100% because patients and family members could comment about more than one type of nurse behaviour.

Figure 5: Comparing positive and negative stories about nurse behaviour from women and men



Note: The percentages are calculated based on the number of women (225) and men (53) who reported positive or negative components of nurse behaviours. Percentages add to more than 100% because people could comment about more than one type of nurse behaviour.

# Non-technical skills

The RCN was interested in the extent to which patients are concerned about technical versus non-technical skills in nursing. The *Patient Opinion* dataset is limited to specific individuals who feel motivated and competent enough to share their stories online. This does not necessarily represent the views of all or even most patients, so it is not possible to draw conclusions about the impact of behavioural and non-technical nursing skills on how patients and carers view nursing practice. However, what can be ascertained from this dataset is that those who submit stories online are commenting more about non-technical skills than the clinical tasks that nurses are undertaking.

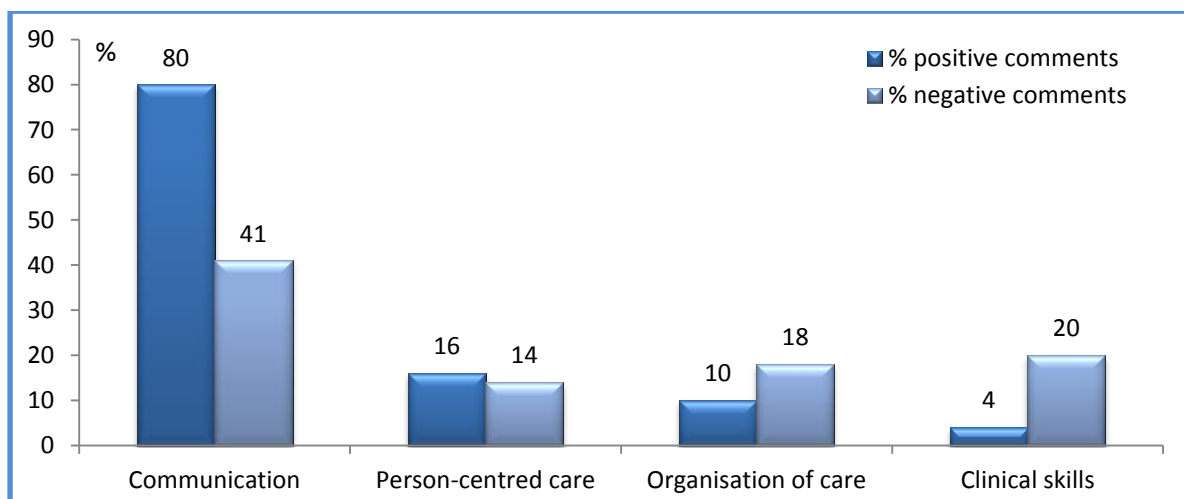
Of all the stories that commented about nurse behaviours, one quarter (24%) commented either positively (4%) or negatively (20%) about clinical skills / behaviours.

In comparison, for non-technical behaviours, all stories providing a specific comment about nurse behaviours (100%) said something positive (80%) or negative (41%) about communication; one third (30%) commented about positive (16%) or negative (14%) components of person-centred care and one quarter (28%) commented about positive (10%) or negative (18%) aspects of continuity of care. Percentages add to more than 100% because people could describe more than one behaviour.

Interestingly, **comments about non-technical skills such as communication were more likely to be positive** than those about clinical skills and organisation of care (see Figure 6).

There were no major differences between groups in the likelihood of making comments about technical versus non-technical skills. Family members and men were somewhat more likely to comment about clinical skills ( $p < 0.05$ ), but there were no differences between countries or those using different types of services.

Figure 6: Proportion of 703 stories about specific behaviours that focused on clinical or other issues



# Fit with other frameworks

## *Behavioural influences*

People provided feedback about things they were happy with or concerned about, but did not tend to go into detail about what they thought caused the issues. This means that the *Patient Opinion* dataset provides information about perceptions of helpful or hindering nurse behaviours, but few thoughts about what influences those behaviours.

However, 12% of stories did provide feedback about what they thought influenced negative nurse attitudes and behaviours (138 stories). This section describes factors that patients and family members thought may influence nurse attitudes and behaviours and explores the extent to which people's views mirrored frameworks such as the RCN's *Influence Map* and the *Principles of Nursing Practice*.

Here, themes fell into four key categories:

- **Staffing levels** and types of staff / skill mix (79 stories);
- **Skills** and training (60 stories);
- **Culture** and communication (54 stories);
- Facilities / physical **environment** (13 stories).

Of the 138 stories that mentioned potential influences on nurse attitudes or behaviours, six out of ten described issues with staffing numbers and types (57%); four out of ten mentioned something about organisational culture (39%); four out of ten commented on skills, training and supervision (44%); and about one in ten mentioned the physical environment (9%). These percentages add to more than 100% because stories could describe more than one potential influence.

All stories about potential influences focused on the possible causes of negative behaviours, rather than positive behaviours or attitudes.

The subcategories within these themes are illustrated in Figure 7 and included:

### *Staffing levels and skill mix*

- **Not enough staff** (49% of comments about influences);
- Too many **temporary staff** / students (4% of comments about influences);
- Not enough **time** for staff to devote to patient care (2% of comments about influences);
- Too many **managers** (1% of comments about influences).

### *Skills and training*

- Poor **personal qualities** eg rude / not focused on patients (17% of comments about influences);
- Not competent / **insufficient skills** / knowledge (10% of comments about influences);
- Not well trained in **communication skills** / customer service (9% of comments about influences);
- Not well trained in **clinical skills** (4% of comments about influences);
- Not good **supervision** / management (3% of comments about influences).



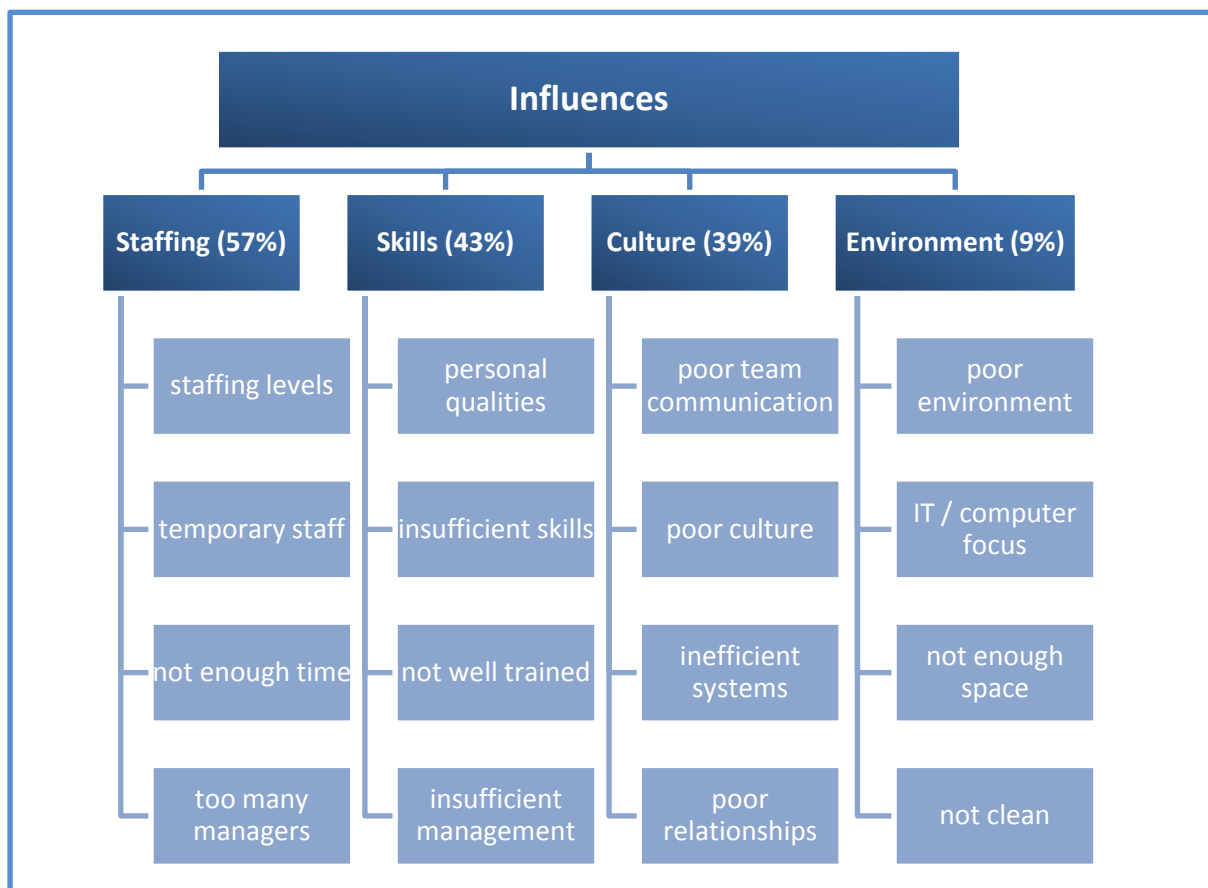
### Culture and communication

- Poor communication between **teams / staff** (16% of comments about influences);
- Environment with unrealistic or negative **expectations** eg focused on paperwork / getting people discharged quickly (9% of comments about influences);
- Inefficient **systems** (9% of comments about influences);
- Poor **relationships** within teams eg with head nurse or doctors (4% of comments about influences).

### Physical environment / facilities

- Poor working **environment** (5% of comments about influences);
- IT / focused on **computers** (2% of comments about influences);
- Not enough **space** (1% of comments about influences);
- Not **clean** (1% of comments about influences).

Figure 7: Key themes in comments about potential reasons for nurse attitudes and behaviours



Note: Percentages refer to the proportion of all 138 stories about potential influences that focused on a certain issue. Percentages add to more than 100% because each story could contain more than one comment about what may influence nurse attitudes and behaviours. Proportions are not based on the total number of stories because most stories did not comment about potential influences and one-fifth mentioned nothing about nurse attitudes and behaviours so this would not give a clear idea of the key issues amongst those who did comment.



## Staffing levels and skill mix

**Inadequate staffing** was the most commonly mentioned perceived cause of poor nursing behaviour, with half of all comments about potential influences mentioning this (49%). Almost all of these comments were from people commenting about inpatient hospital services.

*“I was very impressed with the care provided, however I did feel that there was just not enough nursing staff on the wards to allow them to do their jobs properly. They never stopped, absolutely flat out all the time, but I was still left on occasion wanting assistance (not urgent, admittedly) they were not able to provide. As an example the bed I was in when I was taken back to the ward ... appeared to have no control for me to adjust - staff having to do it from the bed end control. The NEXT DAY a nursing assistant pointed out the control was there, but had not been hooked to the bedside. No-one’s fault really they just don’t have time to look for things.”*  
(hospital inpatient, NHS North West, 2013)

Many couched their comments in positive terms, saying that they felt that nurses were very dedicated and had positive attitudes towards their roles, but may engage in negative behaviour due to insufficient staff capacity and other demands such as paperwork.

*“The hard working nurses were excellent! Even when they were being yelled at, spat at, and generally abused they never let their spirits drop... Even though they were never fully or safely staffed, they always worked as a team and were excellent advocates for their patients. They stayed way past their shift for time that they weren’t being paid for... The lack of staff that are available is diabolical. At night it was 1 trained staff to 15 patients...fifteen! And there were 30 patients on ward resulting in 2 trained staff at night... Not to mention the amount of paperwork these poor nurses have to go through! The lack of staff ruined my experience ... What this establishment needs is less paper-pushing managers and more hands-on nurses.”* (hospital inpatient, NHS West Midlands, 2012)

Whilst **most people did not differentiate between types of nurses, such as registered and unregistered staff**, some did make comments about the varying grades of nurses or different members of the wider nursing family available to provide care.

*“The commitment shown by 'the nurses', (healthcare assistants and nurses), can be exceptional, given that they are so short of staff, equipment, beds, etc. Having observed the various duties that the different grades of 'nurses' have to undertake, and some of the tasks that they are not, it should be seen a miraculous that things are kept 'on track' at all. I experienced evening 'shift change', when there was only one 'proper nurse' in charge of just over 26 patients! This meant that overnight, she had to review / handout the meds, complete the obs, coordinate any bed moves, etc. These nurses are being put under unbelievable pressure, whilst trying to do the job / vocation that they love, however, due to cost cutting / priority changes, they are now finding this almost impossible. A few observations: whilst the nurses are trying to deal with their regular shift duties, they get involved in conversations about broken equipment, catering, moving patients, etc. Yes, these tasks need to be dealt with, but why use the teams with the lowest number of resource?? We've also heard about cases when patients can't reach their water / emergency button, etc - I experienced this also. The catering team deliver their meal / drink whatever it is, then leave. If you don't realise immediately, you have to call the nurse to sort it out!!” (hospital inpatient, NHS South Central, 2013)*

Another component of this was the extent to which staff were adequately **supervised**.

*“[The hospital] has a lot of dedicated, competent and hardworking staff and management should be supporting them. However, I get the feeling that staff are not being supported and that morale is probably quite low. This is a great shame. Staffing levels were at times dangerously low. There were occasions when I had to wait a substantial time for pain relieving medication. These times usually involved very junior nurses who had only been in post for a matter of weeks... I believe these situations arose because the junior staff did not have ample supervision, due to the chronic shortage of more experienced nurses. The staff on the ward all came across as dedicated and caring. I'm sure they must feel like they spend their working life wading through treacle. They are putting in a superhuman effort and are seriously underfunded and understaffed.” (hospital inpatient, NHS East Midlands, 2012)*

## Skills and training

Whilst two-fifths of the stories that mentioned potential influences spoke about deficiencies in nurse skills or training (43%), these comments tended to be brief, throwaway remarks, rather than more detailed overviews of people's reasons for suggesting this.

*"My husband feels that some nurses just do not try hard enough and should step up their game or go for more training until they can get it right more often and I tend to agree . I do not think it is good enough to just turn up and do a lack lustre job. I feel the staff here should always look for excellence in their performance."* (person using outpatient services, NHS North East, 2012)

### **Stories reported that nurses may need more training in communication skills, person-centred care and clinical skills.**

*"The staff need more training on how to speak to their patients. Most of them are extremely rude and seem as though they don't even want to be there."* (hospital inpatient, NHS East of England, 2012)

## Culture and communication

Two-fifths of stories that mentioned potential influences on negative nurse behaviours described aspects of **organisational culture** and team communication (39%).

Whilst most comments about potential influences were related to what nurses were or were not doing, some comments took a broader view, emphasising organisational working practices and culture. Others highlighted the essential role of **leadership**.

*"Within any organisation, the senior leadership team has a key role in setting the tone, behaviours and standards that are to be followed throughout it. It is vital that these are communicated, clearly understood and replicated throughout the organisation."* (day surgery patient, NHS South West, 2012)

Other stories described poor communication between team members (16%) or problematic relationships between team members or between different types of teams.

*"I have found it necessary to remind nurses and junior doctors of the basics of hygiene and treatments. My elderly mother has been in and out of hospital [for the past year]... Attitude of staff was totally bad. Cleanliness throughout stay was terrible and had to be reported on more than one occasion. This was not due to staff shortages. Information on patients was definitely not passed from one team to another on changeover. Replacement nurses were very much in the dark and resented by other nurses."* (family member of hospital inpatient, NHS East Midlands, 2012)

Others felt there was an over-reliance on some members of staff, which led to communication problems.

*“My elderly relative was brought into a surgical ward. While individual members of staff showed warmth and concern, the structure was chaotic. Often other patients had more information than staff. Surgical wards do deal with everything, however even so, simply explaining procedures of care to patients seemed non-existent. A large amount of information was fed centrally to a hub-computer, which no one seemed to read. Instead one member of staff had to find the 'dedicated nurse', who was on the other ward, working at some task. Dedication and warm hearts were evident, as was the chaotic mess when understaffing exists under poor structure.”* (family member of inpatient, NHS South East Coast, 2013)

### *Poor structure and environment*

Around one in ten stories about influences mentioned issues related to the physical environment (9%).

Some of the comments made a link between environment and perceived attitudes and behaviour, leading to an overall impression of an ‘uncaring atmosphere.’

*“My father has bone cancer and had to be admitted to a general ward for a procedure. His usual pain relief is codeine, paracetamol and oramorph. Except for at night, all they gave him was paracetamol because 'the others are kept in the controlled drugs cabinet so we'd have to get them separately'. For the first four days, no one helped him wash or dress, he was in the same pyjamas as he was admitted in despite the stock of clean clothes brought in by us every day. It took my mother being found in tears by a doctor for someone to act. When admitted he had a small pressure ulcer which the district nurse had been successfully treating and it was well on the way to being cured. The nurses refused to continue her treatment regime and changed the type of cream being used. It is now twice the size it was, has gone from grade 1 to grade 3 and he has a rash from the dressing. The promised pressure mattress never materialised. The general atmosphere on the ward was totally inconsiderate. Sleep was difficult enough with dementia patients calling out and wandering around. It was made worse by the lack of attempts by staff to keep noise down - for example the water jugs were changed at around 5:45 each morning... The staff I met seemed uncaring and thoughtless.”* (family member of hospital inpatient, NHS North West, 2012)

### Differences between groups

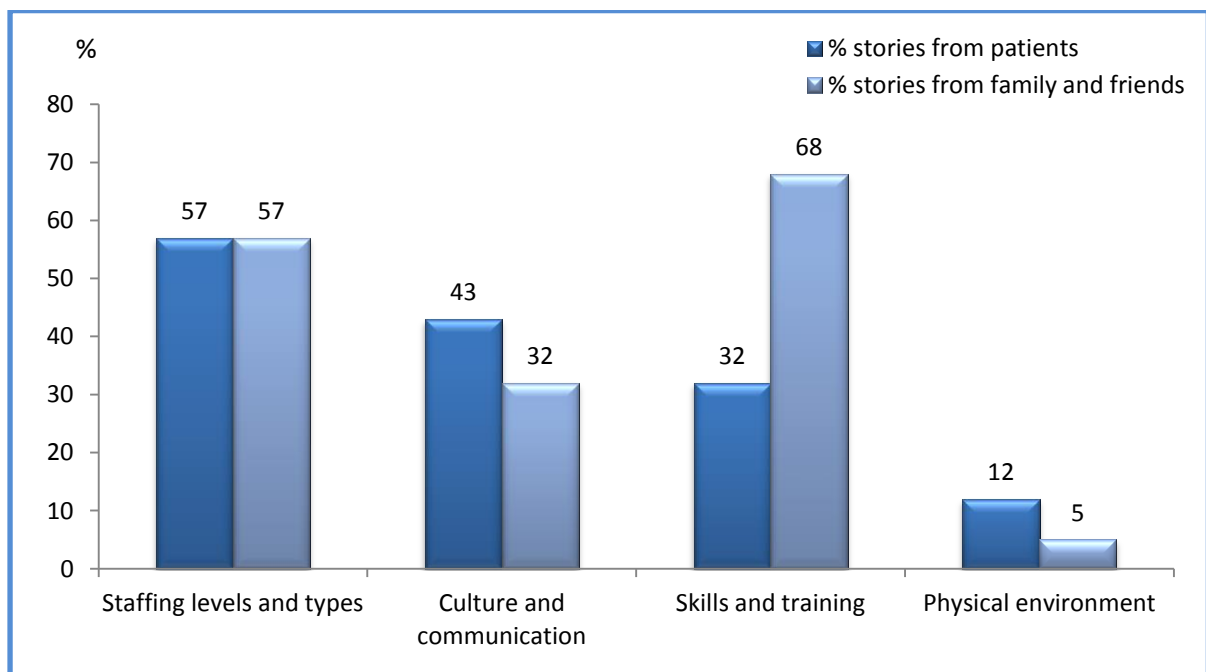
Bearing in mind the issues with identifying the demographics of those submitting stories, some trends were evident.

For example, people **aged under 30** were proportionately more likely to suggest that insufficient skills and training were a reason for poor nursing behaviour than other age groups ( $p < 0.05$ ). Family members were also more likely than patients to mention skills and training as influences on nurse behaviour (see Figure 8).

Those from **Wales and Scotland** were proportionately more likely than people commenting on services in England to suggest that staffing numbers and types were a core influence, though the numbers were too small to allow proper comparisons. Men were also more likely than women to suggest that insufficient nurse staffing led to negative nurse behaviours ( $p < 0.05$ ).

Issues relating to staff numbers were often focused on **hospital wards**. Apart from this there were few differences in the influences mentioned by those submitting stories about varying types of services. However, this is likely due to the small numbers involved in some categories rather than necessarily a lack of differences between groups.

Figure 8: Comparing suggested influences on behaviours reported by patients and family members



Note: The percentages are calculated based on the number of patients (94) or family members (44) who mentioned one or more potential influences on nurse behaviours. Percentages add to more than 100% because patients and family members could comment about more than one influence on behaviour.

## Links between influences and behaviours

It was possible to analyse the types of influences most likely to be associated with different negative behaviours (see Figures 9 and 10). The analysis illustrates some general trends, rather than distinctive patterns of perceived causation because not every comment about influences was directly linked to a negative behaviour.

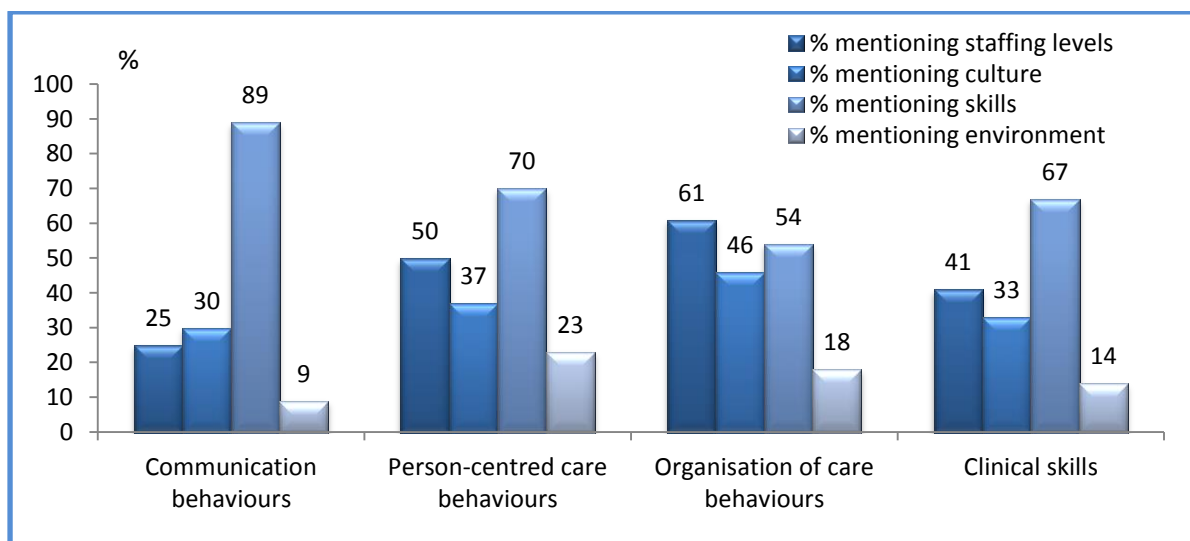
For example, a **lack of skills and training** was thought to influence most of the negative behaviours reported, including nurse communication, person-centred care, continuity and clinical skills.

**Organisational culture** was most commonly thought to influence person-centred care and organisation of care.

Although physical environment was no more likely to be linked to some types of behaviours rather than others, stories often reported that **inadequate staffing levels** caused a lack of continuity and patient-centred care.

*“The staffing levels in some wards are woefully inadequate for their responsibility and effectiveness to care for a lot of patients... The fact that nurses have not the time to spend with patients will create a rapid deterioration in the normally good standards... If we want to add personal care to patients we must surely provide enough staff to cater for that need even in the most human respectability level. The staff cannot maintain high standards of care at sixty miles an hour with no meal breaks as some try to do, and things will be missed and hurt caused. In my opinion, ultimately it is not the staff who are to blame but the decision makers who for financial reasons do not allow the correct number of staff on all levels to fulfil their true caring for patients... These people are the roots of the trees but cut the roots away and the whole tree dies.”*  
(hospital inpatient, NHS North West 2012)

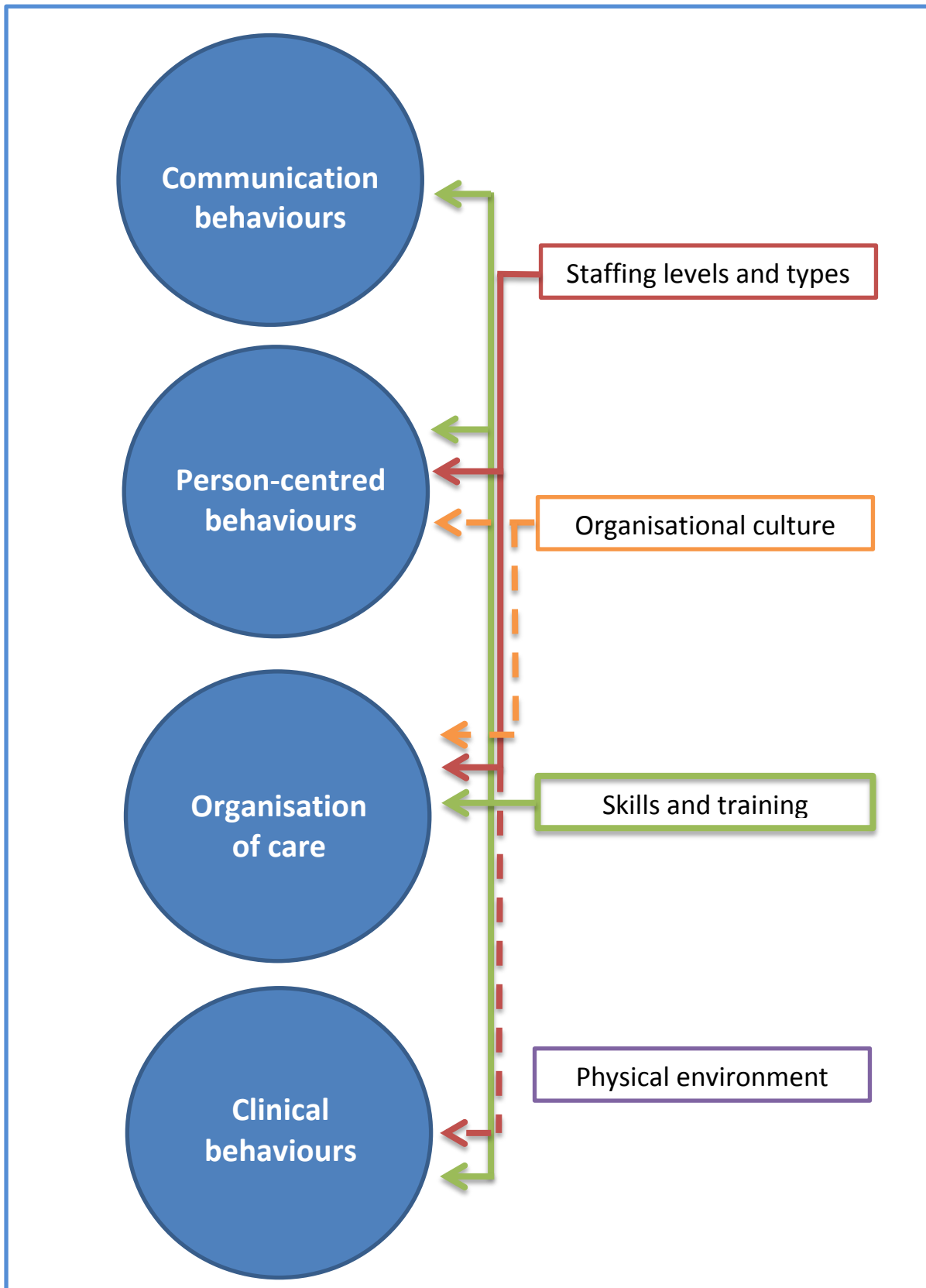
Figure 9: Comparing suggested influences on behaviours in Patient Opinion stories



Note: The percentages are calculated based on 207 comments about negative nurse behaviours that also reported a potential influence in the same story. Thus for example, the figure shows that two thirds of negative comments about clinical skills suggested insufficient skills and training as an influence. Percentages add to more than 100% because stories could describe more than one behaviour and influence.



Figure 10: Perceived influences on negative nurse behaviours



Note: Arrows with unbroken lines illustrate where many comments postulated a link between certain influences and behaviours. Broken lines illustrate a smaller number of stories suggesting a link.

## Principles of Nursing Practice

The content analysis constructed themes directly from the stories submitted to *Patient Opinion*, rather than starting from a theoretical framework and then comparing stories with this. However, it is also interesting to examine the extent to which material submitted to *Patient Opinion* reflects existing frameworks used by the RCN, such as the 'Principles of Nursing Practice' and the 'Influence Map.' This section provides a cursory overview of similarities and differences between *Patient Opinion* feedback and these two frameworks as a starting point to help the RCN undertake more detailed and robust comparisons internally.

The RCN developed the *Principles of Nursing Practice* to outline the key things that patients and staff can expect from good quality nursing.<sup>33</sup> The *Principles* were developed in partnership with nurses, patients and carers, service user organisations, the Department of Health and the Nursing and Midwifery Council.

Box 1 summarises the *Principles*.

### Box 1: Summary of the Principles of Nursing Practice

#### Principle A

Nurses and nursing staff treat everyone in their care with dignity and humanity – they understand their individual needs, show compassion and sensitivity, and provide care in a way that respects all people equally.

#### Principle B

Nurses and nursing staff take responsibility for the care they provide and answer for their own judgments and actions – they carry out these actions in a way that is agreed with their patients, and the families and carers of their patients, and in a way that meets the requirements of their professional bodies and the law.

#### Principle C

Nurses and nursing staff manage risk, are vigilant about risk, and help to keep everyone safe in the places they receive health care.

#### Principle D

Nurses and nursing staff provide and promote care that puts people at the centre, involves patients, service users, their families and their carers in decisions and helps them make informed choices about their treatment and care.

#### Principle E

Nurses and nursing staff are at the heart of the communication process: they assess, record and report on treatment and care, handle information sensitively and confidentially, deal with complaints effectively, and are conscientious in reporting the things they are concerned about.

#### Principle F

Nurses and nursing staff have up-to-date knowledge and skills, and use these with intelligence, insight and understanding in line with the needs of each individual in their care.

#### Principle G

Nurses and nursing staff work closely with their own team and with other professionals, making sure patients' care and treatment is co-ordinated, is of a high standard and has the best possible outcome.

#### Principle H

Nurses and nursing staff lead by example, develop themselves and other staff, and influence the way care is given in a manner that is open and responds to individual needs.

Note: The text above is drawn verbatim from the RCN website.<sup>34</sup>

Stories submitted to *Patient Opinion* reflect almost all of these principles, either in a positive or a negative light. Principles A, D, E, F, G and H were covered in comments about nurse behaviours and Principles F, G and H were mentioned in terms of potential influences on nurse behaviour.

For example, **Principle A** (regarding compassion, dignity and respect), was one of the core categories of nursing behaviour commented upon. Of the 703 stories that described nursing behaviours, 16% were positive about nurse kindness and respect, 11% mentioned that nurses provided reassurance and 6% were positive about nurse compassion and empathy. On the other hand, 7% of stories about behaviours thought that nurses had lacked respect or treated patients with a lack of dignity and 6% mentioned a lack of compassion or empathy.

**Principle D**, about patient-centred care, was also a key theme in *Patient Opinion* stories. Of the 703 stories about nurse behaviours, one third (30%) commented about positive (16%) or negative (14%) components of person-centred care. The extent to which nurses treated people as individuals and involved friends and family were key issues in this regard.

**Principle E**, about communication, was also central to stories about nurse behaviour submitted to *Patient Opinion*. Every story that mentioned something specific about nurse behaviours made a comment about communication (100%). Here nurses' manner when communicating and the clarity and frequency of communication were deemed to be important.

**Principle F** focuses on the skills and knowledge of nurses. This was covered in *Patient Opinion* stories too. One in ten stories about nurse behaviours commented positively about nurses being knowledgeable and able to provide useful information (10%). One quarter of stories about behaviour were focused on clinical / technical skills (24%) and two-fifths of the 138 stories that mentioned potential influences on nurse attitudes and behaviours singled out skills and training as a factor (43%).

**Principle G** relates to co-ordination and team-working. This was another key issue highlighted in *Patient Opinion* stories. More than one quarter of all 703 stories about nurse behaviours mentioned something about co-ordination or organisation of care (28%). Furthermore, a lack of communication and teamwork was mentioned as a potential cause of negative nurse behaviours. In total, 16% of the 138 stories about potential influences mentioned poor communication between teams or staff members and 4% spoke about poor relationships within teams.

**Principle H** is about nursing leadership. This was covered to a limited extent in *Patient Opinion* stories. Around 1% of the 703 stories about behaviours commented about the extent nurses showed authority and leadership. Furthermore, 3% of the 138 stories about potential influences commented on inadequate supervision or nursing leadership and 1% suggested that there were too many managers involved in healthcare.

Whilst most of the *Principles* were mentioned in *Patient Opinion* stories, there were also some gaps. For example, **Principle B**, about nurses taking responsibility for their actions, was not written about frequently in *Patient Opinion* stories. Whilst around 1% of stories about behaviour talked about whether nurses apologised appropriately when needed and around 1% wrote about the level of leadership and authority taken by nurses, whether nurses answered for their own judgements and actions and whether they made appropriate links with other organisations were not dwelled upon.

**Principle C**, about patient safety, was not well covered either. This is perhaps surprising given the focus on safety issues in healthcare, both in healthcare policy and in the media. *Patient Opinion* stories did mention safety in the context of poor clinical skills (8% of stories about behaviours), but most stories about nurse attitudes and behaviours did not concentrate on safety issues, except as an aside or as part of the quality of care more broadly. There are many potential reasons for this. For instance, hypothetically safety issues may be being well dealt with by organisations and thus be of less concern to patients. Alternatively, communication and non-technical issues may be much 'worse' than safety behaviours and thus more likely to capture people's attention. There are many other alternatives too. Content analysis of the *Patient Opinion* stories cannot provide reasons for divergences between what people are motivated to write about versus the *Principles of Nursing Practice*, only that such divergences exist.

**Overall though, this material suggests that the *Principles of Nursing Practice* largely capture the things that are important to the patients and carers submitting stories to *Patient Opinion*. In a way this helps to further validate the content of the *Principles of Nursing Practice*.**

## RCN 'Influence Map'

The RCN developed an 'Influence Map' as a way of diagrammatically representing potential impacts on nurse attitudes and behaviours (see Figure 11). The content was based on a review of relevant literature and expert opinion.

The influence map is broken down into four 'bands':<sup>35</sup>

- *Inputs* are elements that may influence nurse attitudes and behaviours, including the education and socialisation of nurses and nursing graduates, socio-economic conditions and patients' views;<sup>36</sup>
- *Processes* focus on routines and tensions that may influence attitudes and behaviours, including potential conflicts between nurses' need to be quick and efficient versus the desire to do a thorough job;<sup>37,38</sup>
- *Outcomes* describe the effects of potentially competing demands on nurses, such as the potential for prioritising speed over safety or implementing top-down policies rather than adapting for local circumstances and patient-centred needs;<sup>39,40</sup>
- *Mitigation* refers to approaches to changing or challenging the factors that influence poor attitudes and behaviours. This may include socialising nurses via mentoring or upskilling in non-technical aspects such as communication, customer services and teamwork.<sup>41,42,43</sup>

The feedback people provided on *Patient Opinion* about potential factors influencing nurse attitudes and behaviours concurs with some of the categories on the RCN's *Influence Map*, though the terminology used differs. For instance, in terms of the 'inputs' listed in the *Influence Map*, patients and carers mentioned **education and health service culture** / values and priorities. There was little focus on how personal or public values may have an impact on nurse behaviour, but some stories did acknowledge the roles of organisational culture and values.

*"The nursing staff I experienced ... were outstanding, given the additional tasks that they had to carry out, so support the rest of the hospitals processes and ways of working. One of the patients in my ward 'passed away' whilst I was there, and the nurses worked tirelessly with the gentleman to do all they could for him. It was a fantastic example of what motivated / driven nurses will do to ease the lives of their patients, it's just a pity that the rest of the organisation didn't show the same drive in improving general working practices!!"* (hospital inpatient, NHS South Central, 2013)

In terms of processes and outcomes, patients and carers mentioned the **drive for efficiency** and process-led systems as potential reasons why nurses behaved poorly.

*"Another patient who was unable to walk unaided or to shout for help had been put to bed, but his call button had been placed out of reach. I saw him struggling to get out of bed. I went over to him, and he managed to communicate that he needed the toilet. I went to find some help, only to find seven staff at the nurses' station: it wasn't a shift changeover, they weren't being briefed, each was occupied separately on computers or writing notes, reflecting the priorities in their work. I was very glad to be discharged the following day, even though it was sudden and without warning - I didn't feel safe."* (hospital inpatient, NHS West Midlands, 2013)

With regards to the factors mentioned in the 'mitigation' section of the *Influence Map*, the patients and family members providing stories appeared to place emphasis on **non-technical skills** such as communication and person-centred care.

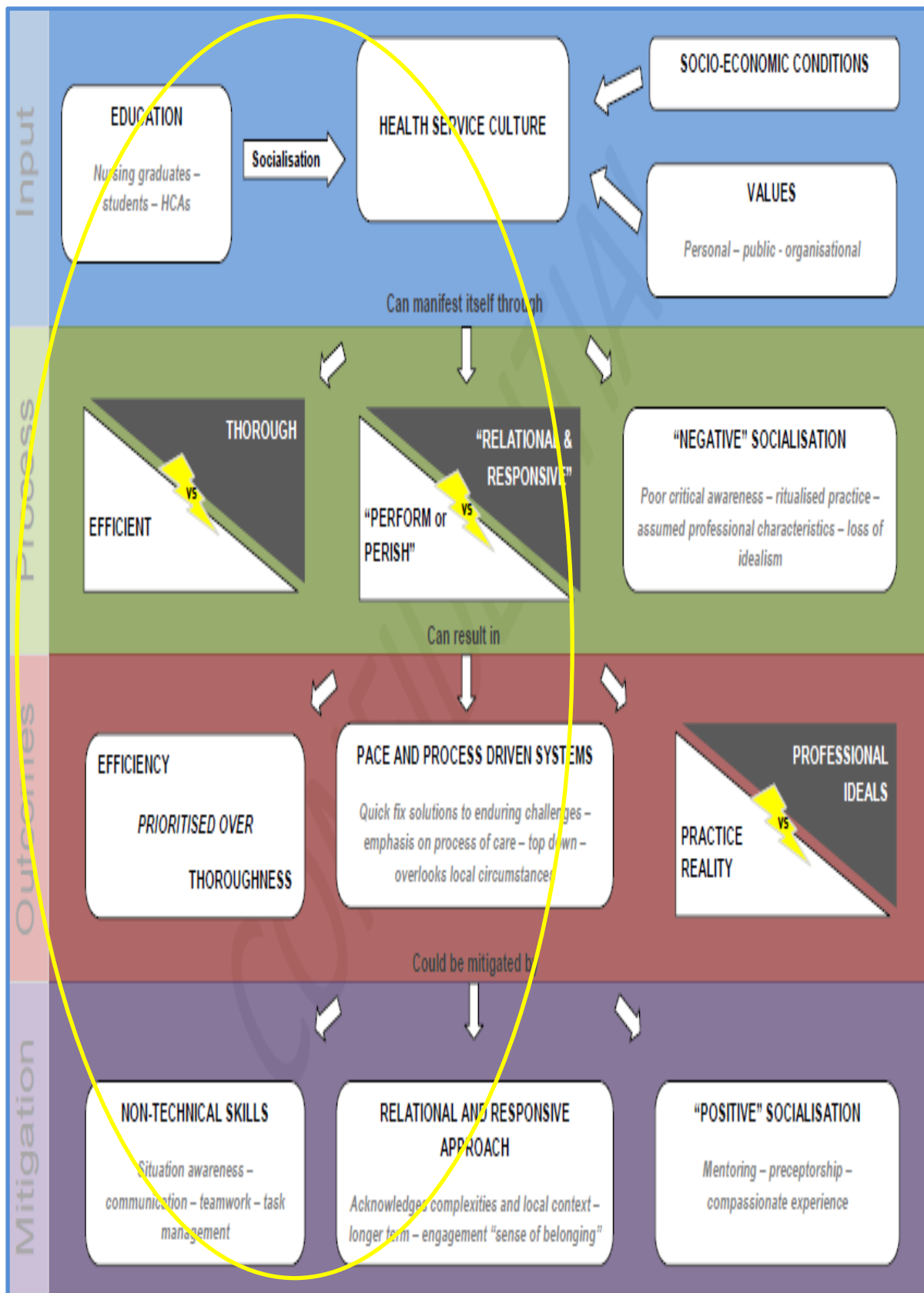
Some patients and family members wrote in detail about what they perceived to be a lack of dignity and compassion and how some basic non-technical skills could have alleviated this.

*“The staff ... are extremely over worked and communication seemed non-existent... When she arrived she was dumped on an all - bar 1 - male bay and was surrounded by male patients as the only other female was on the other side of the bay at the other end. My mum was understandably upset by this and said she would rather go home than stay... I cannot believe that no one took my mother’s concerns seriously over this! It’s a cardiac ward and my mum was there after suffering a heart attack, they must have realised how much stress this was causing her!... When my mum arrived back from having her angioplasty she was dumped back on her bed with all the covers scrunched up underneath her she had to ask one of the nurses to help move them, the nurse seemed incredibly annoyed by this and was very rough as she started tugging at the covers causing the wound from the angioplasty to bleed also the curtains were partially open and parts of my mum were exposed for all to see! The nurses only response to this was “I didn't realise” no apology again. Later my mum was experiencing some chest pain so the day sister came into do an ECG but rather than asking or even just being gentle she started roughly tugging at my mother’s hospital gown just pulling it up my mum had to tell her to hang on a minute, she was extremely upset and distressed at the total lack of dignity... That night not long after my mum had laid down, the night sister came up behind her and without asking pulled down the back of my mother’s bottoms again. Understandably my mum was quite upset by this invasion of privacy and total lack of dignity, apparently this is now hospital procedure to check for worms but no one has the right to do this without asking.” (family member of inpatient, NHS East of England, 2013)*

Interestingly, the aspects of the *Influence Map* highlighted by patients and carers are all on the left hand side of the diagram (see Figure 11). Areas such as socialisation, nursing values and professional ideals do not appear to be a part of the public consciousness, as evidenced by *Patient Opinion*.

On the other hand, structural issues such as **staffing levels** and types are much more explicit in comments from patients and carers than in the *Influence Map*.

Figure 11: RCN's Influence Map<sup>44</sup>



Note: The circled sections are mentioned to some extent in *Patient Opinion* stories.



# Value of the dataset

## *Positive aspects*

The RCN wanted to consider the potential pros and cons of the *Patient Opinion* dataset from the point of view of ease of analysis and the potential for further usage.

There are many positive aspects of the *Patient Opinion* dataset. For example:

- The database contains material that is constantly being **updated**.
- The dataset is part of a **trend** towards increased use of the internet to share information.
- Some information is available about the **geographic region** and organisation to which comments relate, so it would be possible to examine trends for particular areas or trusts. This may also have benefits for campaigning work.
- The dataset spans eight years so it would be possible to examine changes in the types of feedback provided **over time** as well as whether feedback alters in line with media stories or other happenings.
- Stories are available in **electronic form** so quotes do not need to be retyped for analysis.
- It would be possible to analyse the **responses** that NHS Trusts provide to the stories submitted and whether the information is being passed on to nursing managers to facilitate change.

In short, there is much potential with the dataset, and this content analysis has merely scratched the surface.

## *Negative aspects*

However, there are also some issues that make analysis more time-consuming or difficult:

- There are considerable limitations with the **scope and generalisability** of the stories submitted to *Patient Opinion*. These are outlined in the Approach and Caveats sections so are not repeated in detail here, but it worth emphasising once again that the stories submitted cannot be taken to represent the views of patients and carers more generally. People from England are more likely than those from Scotland, Wales and Northern Ireland to provide feedback. There is some evidence that women may be more likely to submit stories about nursing than men, and those who undergo surgery, attend for unplanned care and use maternity and gynaecology services may submit more stories.
- People who feel motivated to submit their stories online may well have different **demographic characteristics** to others. The dataset does not allow for easy identification of patient demographics so it is not possible to say whether some age, gender and ethnic groups are more likely to contribute or whether feedback is different in rural versus urban areas because the hospital trusts cover broad areas.
- The stories are likely to be things that people felt strongly about expressing because they took the time to find the website and submit material. **Much good quality care may go unreported.**

- More positive stories were submitted than negative ones but the **negative stories tended to be more detailed**. It may be easy for negative stories to overshadow the positive ones. This is more an issue with the interpretation process than with the dataset itself, but the varying levels of detail in positive versus negative stories is worth noting.
- The dataset is very **focused on hospital nursing care**, rather than practice nurses, district nurses or mental health nurses for example. There is not enough information to be able to compare different types of services.
- Furthermore, it is not **usually possible to differentiate nurses at different levels** such as the behaviours of staff nurses versus student nurses. Stories tend to describe ‘nurses’ without being specific about the type of nurse or whether registered or unregistered staff were involved. Some people may inaccurately describe a member of staff as a nurse when in fact they were another profession, such as a healthcare assistant or a doctor.
- People provide feedback about things they are happy with or concerned about, but do not tend to go into detail about what they think **causes** the issues. This means that information is available about nurse behaviours, but not much is available about the ‘influences’ of those behaviours.
- Most information focuses on **behaviours** rather than attitudes. Although some comments are made about ‘poor attitude’ this tends to manifest in behaviours such as rudeness and lack of compassion so the division between attitudes and behaviours may be slightly spurious from the point of view of patient feedback.
- The data is available in Word, Excel or pdf format, but is not presented in a manner that makes it easy to analyse quantitatively. The data needs to be **retabulated** to support robust coding and analysis. Even in the Excel format in which *Patient Opinion* data can be downloaded, the geographic area, trust name and story are not displayed in separate columns side by side, so it takes a great deal of time to cut and paste the basic details into a spreadsheet for analysis. In future, it may be feasible to work with the *Patient Opinion* team to gain access to the data in a more appropriately tabulated manner for ease of analysis.
- There is a **lack of consistency** in the format of stories because some material was submitted via the *Patient Opinion* website whereas other stories came from the *NHS Choices* website or a link through individual hospital websites. This meant the stories took different forms: some had broad questions prompting people about what they liked and didn’t like; others were open ended comments. The stories that were answering questions were sometimes cut off or had to go into new question sections to complete their answers, as not enough space was allowed on the form. These issues did not impact greatly on the analysis process, but are raised in terms of the scope and quality of data available.
- After the first few hundred stories, **saturation** was reached in terms of coding. In other words, no new codes were being generated. This means that a sample of 200-300 stories may be useful to draw out themes about a particular topic. In this instance a much larger sample was analysed because there was a desire to quantify the themes (ie state how common they were), but future analyses that are interested in generating themes may work equally well with a smaller sample.

- There are a significant number of **repeated stories**. Sometimes these are direct repeats in different categories (so stories contain the same id number) and sometimes these are where people have added their story more than once (so stories carry a different id number). At least 10% of the stories submitted between October 2012 and January 2013 were duplicated.
- Repeated stories may recur quite far apart from each other in the dataset, so unless **one analyst** is looking at all of the material (and has a good memory), repeats may not be captured and deleted.

These issues do not negate the value of the dataset, but are important caveats to be aware of both for the present analysis and if considering further use of this data source.

# Summary

The RCN has done a great deal of work to understand nurse attitudes and behaviours and the things that may impact upon them. Much of this work has been undertaken from a professional perspective rather than incorporating the views of patients and family members. The RCN wanted to understand the views of patients and the public about nurse attitudes and behaviours, both positive and negative. The RCN Research Institute has a number of projects about patient experience underway. In addition to this, the RCN sought to ascertain the extent to which *Patient Opinion* could add to the current knowledge base.

This content analysis has examined what 1,182 stories submitted to *Patient Opinion* over a four month period had to say about nurse attitudes and behaviours and the things that may influence these attitudes and behaviours. It also provides feedback about the extent to which this website can be seen as providing an independent and useful perspective on what patients are saying.

The analysis needed to trade off depth versus breadth. The focus has been on analysing a large quantity of stories at a high level (breadth), rather than delving into every detail about what the stories said. As such, the content analysis provides a surface picture with a selection of examples to illustrate key themes.

The analysis is useful because it helps to give a picture of what one group of patients felt most strongly about. This adds to knowledge from other parts of the RCN's professional attitudes and behaviours workstream. **The information cannot be used alone, but can provide added value for contextualising and supporting other information.**

Some of the key points of note include:

- **Feasibility of analysis process**

It is feasible to analyse stories submitted to *Patient Opinion* using a mix of qualitative and quantitative techniques. Simple searches can be used to identify all stories that mention nurses and nursing within a given time period. In this analysis, four out of every five stories selected in this way contained a comment about nurse attitudes and behaviours and three out of every five stories contained some specific details about attitudes and behaviours. Given the size of the dataset, the regularity of updates and the potential to examine stories by region and over time, there is much potential for further analysis of the dataset.

- **Learning about attitudes**

Most stories submitted to *Patient Opinion* do not contain information about nurse attitudes. This may be because attitudes refer to internal values, feelings and thoughts and are less directly observable than behaviours. Of all 1,182 stories about nursing analysed, 5% contained a comment about nurse attitudes and almost all of these comments were negative.

Stories about nurse attitudes tended to focus on perceived negative attitudes towards patients and family members, such as seeing people as an inconvenience. A smaller proportion mentioned negative nurse attitudes towards their roles or the environment in which nurses were working.

- **Learning about behaviours**

Six out of ten stories about nursing submitted to *Patient Opinion* between October 2012 and January 2013 contained specific feedback about nurse behaviours (60%). The four key issues that people commented either positively or negatively about were communication and information provision, person-centred care, continuity and organisation of care and clinical skills. The friendliness and manner of nurses was the thing most commonly commented upon. Whilst 100% of stories about behaviour mentioned non-technical skills such as communication, only one quarter mentioned technical clinical skills.

- **Behavioural influences**

Most stories did not consider what may influence nurse attitudes or behaviours, but 12% did. Within these stories the four key categories of perceived influences were the number of nurses available, organisational culture and communication, skills and training and the physical environment.

- **Fit with existing frameworks**

The themes in the analysis were drawn from the wording of stories themselves, rather than being based on a theoretical framework or existing model. This ensures that the findings were fully grounded in the things that were most important to people submitting stories. However, it is also possible to make comparisons with key themes in the RCN's *Principles of Nursing Practice* and *Influence Map*. The stories submitted to *Patient Opinion* had many overlaps with these frameworks, particularly in terms of the prioritisation of communication, training and person-centred care. There were some divergences however, with *Patient Opinion* stories being less likely to focus on nurse socialisation, leadership and patient safety.

Thus, **the content analysis serves to raise many questions**. It does not provide answers; but rather aims to stimulate debate about some of the experiences that patients are having and what can be done to help individual nurses and organisations to continue to support nurses to provide high quality care.

It is clear that *Patient Opinion* stories are not representative of patients and the wider public, either in terms of demographics or the quality of care received. The stories may overemphasise negatives and may not go into adequate depth.

The analysis does not suggest that these stories should be used as indicators of the quality of care, but rather that they are one amongst many channels for learning what some patients think. *Patient Opinion* gives insight into what drives patients' experience because the stories illustrate what some people feel most passionate about writing in this forum. This is particularly important in the context of an increasing availability of accounts of people's care on social networks, Twitter, blogs and hospital review sites.

*Patient Opinion* provides a **novel opportunity** to understand the experience of nurse attitudes and behaviours from a different perspective. As long as the caveats are acknowledged and the material is interpreted in conjunction with the wide range of other evidence available, the analysis has the potential to raise many new questions in the quest for continuously improving nursing care.

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