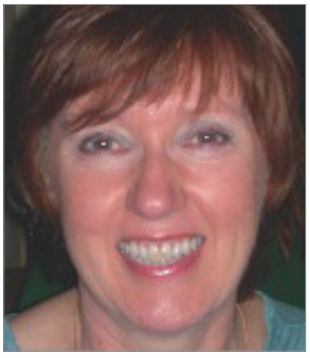
The Francis Report: Hear the warning bell



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When seen in retrospect, the warning signs detailed in the Francis Report (http://www.midstaffsinquiry.com) were obvious, it is clear that external agencies who should have acted in a regulatory fashion; the Strategic Health Authority and Monitor failed to acted in a robust fashion when the Commission for Healthcare Improvement (CHI) re-rated the Mid Staffordshire NHS Foundation Trust from 3 stars to zero. This re-rating occurred in 2004 and perhaps an enquiry at that time may have saved countless patients from unnecessary suffering. In addition, several peer reviews that took place at the Trust all identified serious concerns regarding the ability of the Trust to provide a safe service.

These signs, taken together with the auditors reports, which called into question the ability of the Trust to comply with standards of care, would surely have caused a healthy Trust Executive Board to react and re-examine the Trust's position. However, among Robert Francis' QC summary of the events at the Trust was his statement that the Trust board was weak and focussed on reaching targets, achieving financial balance and sought Foundation status at the cost of delivering acceptable standards of care. Poor leadership led to multiple failings, one of which was inadequate ward staffing that led to unacceptably low standards of care. This was detailed in the national press by relatives and patients who experienced it and I am sure it made for very uncomfortable reading by all nurses in the UK.

I wonder how many of us have examined this far-reaching report and felt uncomfortable, perhaps drawing some comparisons with our own organisation?

One has to question the ability of the senior nurses within the Trust to examine practice and act in a professional capacity to defend both patients and their nursing colleagues. There is evidence that nursing staff at ground level did attempt to draw the Trust's attention to the effects of poor staffing on the wards, however clinical governance appeared to be paid lip service only. Furthermore, nursing staff appear to have been discouraged from reporting failings and accusations of bullying were not investigated. To work under such conditions must have been extremely stressful and the resulting low morale was obvious in staff questionnaires – but ignored. It would appear the priority of the Trust board was to run a business on a shoestring, rather than making the necessary investment into appropriate staffing levels, training, and ensuring all clinical and managerial staff performed to the standards set by national guidelines.

KEY RECOMMENDATIONS

In the report, Fracis make 290 recommendations. The first and foremost among these is that patients must be the priority of any NHS organisation; it must ensure that patients receive care from compassionate and committed staff and are protected from avoidable harm and any deprivation of their human rights. Compliance with specified standards of care should be monitored by the Care Quality Commission and that metrics/procedures/guidance should be provided by NICE and should include evidence-based tools for establishing the staffing needs of a service.

Of great interest to all nurses should be the recommendation that noncompliance with a fundamental standard that leads to the death or serious harm of a patient should be prosecuted as a criminal offence, unless the provider or individual can demonstrate this was unavoidable. For those tissue viability nurses struggling with recalcitrant staff who fail to provide a basic pressure ulcer risk assessment and necessary care, this is an important statement.

Pressure ulceration causes serious harm to patients, who may lose their independence, mobility, or in extreme instances, their life as a result. This statement should be included

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in teaching to raise awareness among staff of their basic responsibility of care; the possible consequences of noncompliance being loss of registration, livelihood, and criminal charges being all too real.

CONCLUSIONS

In short, the message to all nurses from the Francis Report is simple: do not tolerate poor standards of care or noncompliance with Trust policies and procedures, to do so risks being tainted by the actions of those colleagues who are not interested in providing good care. It is time for the nursing profession to undertake some drastic housekeeping and sweep away any nurses, no matter how senior, who cannot fulfil their role and maintain a safe area of clinical practice for patients.

We need to learn from the experience of our colleagues at the Mid Staffordshire NHS Foundation Trust and ensure that all concerns are heard in an appropriate environment and taken seriously, acted on where appropriate, and staff are supported. The only way forward is to maintain a robust, open, and transparent means of auditing practice against stringent guidelines and to admit any failings. Undertaking these actions will foster a culture of improvement and engender good-will in regulating authorities.

To ask for assistance is a sign of strength, not failure, while to ignore failings and the cry for help from nurses at ward level is to risk a repeat of the Mid Staffordshire situation. Let us look to ourselves first and ask: "Are we robust? Transparent? Working in a culture of improvement? Providing stringent standards of care with audit – internal and external – to evidence that care?" Or not... WUK