EDITORIAL

A healthcare crisis, a nursing crisis, a time to breathe!

He take manaakitanga hauora nui, he take tapuhi nui, he wā mō te whakatā!

Over the past few months I have spent time talking with clinical nurses, both in New Zealand and overseas. These conversations always lead to the same place; nurses feel they are being asked to do more with less, to tick boxes, they feel tired of delivering care that is rushed and below the standards that the profession and public expect. This perspective is supported by the national and international literature that documents the worldwide shortage of nurses, along with a rise of bureaucratic and managerial environments. These kinds of environments can foster constrained nursing practice, missed care and lead to climates of distrust that erode therapeutic relationships that are essential for professional and compassionate nursing care.

There is not a day that goes by without some New Zealand media focus on the failings in healthcare, from cancelled surgery, long wait times, budget overruns, or inadequate resources. New Zealand is not the only country grappling with these issues. We are not the only country to have patients lying in corridors waiting for beds, we are not alone in having full hospitals or budget constraints. Both the United Kingdom and Ireland are facing similar challenges. The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013), commonly known as the 'Francis Report', outlined a litany of poor standards of care, lack of professionalism, and complacency from healthcare providers. There have been other reports that have cast doubt on standards of care and nursing's ethical and moral footings (Abraham, 2011; Harding Clark, 2006; Williams, 2011). In the Irish Lourdes hospital inquiry (Harding Clark, 2006, p. 316), which investigated the high rates of postpartum hysterectomies, the authors found it difficult to understand; "why so few had the courage, insight, curiosity or integrity to say, 'this is not right'". In an integrative literature review of 14 studies from seven countries, Jackson et al. (2014) proposed that for many nurses the repercussions of speaking out stops many from doing so. Despite nurses being best placed to raise concerns, speaking out or whistleblowing is viewed as having negative consequences, both mentally and physically, for the individual nurse (Jackson et al., 2014).

Consider this, there are 53,922 (inclusive of registered nurses, enrolled nurses and nurse practitioners) nurses practicing in New Zealand (Nursing Council of New Zealand, 2016), yet the voice of the profession about this crisis in healthcare is often mute or muffled. The reason for this may indeed be the fact that not only is there a healthcare crisis there is also a nursing crisis. The nursing crisis is reflected in a profession that is burntout, morally distressed, emotionally exhausted, cynical, sad, and silent. Nurses are so busy endeavouring to meet patient needs that there is no energy to verbalise their concerns. It may be even more sinister than that,

Rook, H. (2017). Editorial: A healthcare crisis, a nursing crisis, a time to breathe! *Nursing Praxis in New Zealand, 33*(3), 4-6.

nurses may feel that their voice is never listened to or there are personal or professional consequences if they do speak, so there may be a feeling of disillusionment, ultimately *what is the point*.

With this is mind I would like to reflect on the Praxis editorial where Dr Kathy Nelson argued for nurses to embrace diversity. Nelson urges nurses; "to use their voice to challenge the existing service arrangements and policy, make changes to how we deliver services including how we communicate with people, and create and enable innovation" (Nelson, 2017,p 5). In reading the editorial I was struck with how much nurses are expected to do and how nurses are urged to use their voice. The Office of The Chief Nurse makes a similar call to nurses, in a nursing leadership narrative the argument is presented that; "there are opportunities for nurses working in all settings to influence the development of services, demonstrate clinical leadership, drive innovation and collaborate with sector partners and users" (The Office of The Chief Nurse, 2017).

How will nurses, in the current context of healthcare, innovatively influence service delivery, reduce inequality or use their voice? Firstly, we, the profession, the community of nursing, need to be recognised within the context in which nursing practice happens and we need to articulate this context clearly; healthcare is challenging, healthcare is financially constrained. The way we practiced in the past may not be the best way to practice in the future. Once the context, including organisational culture, is articulated openly and candidly then we can move toward understanding the impact this has on an organisation and on individual nurses who are immersed in a clinical context that is profoundly busy and under resourced. The impact on nurses in these environments, as described earlier, is burnout, moral distress, exhaustion, cynicism, sadness and silence. No one has time to breathe!

It has been argued that having professional optimism is a way that the profession could build resilience in the face of healthcare challenges (Rook & Coombs, 2016). Others suggest the need for development of moral courage in nurses and nursing leadership (Gallagher, 2011). For now, in this period of profound distress, I suggest that we, the profession, take time to breathe, to think; do it now, as you read these words, breathe! We know that breathing reduces cortisol levels and compassion fatigue, so not such a far-fetched request. Before the profession can move forward with optimism, moral courage and resilience, nurses need to care for themselves, then we can care for others, our colleagues included. When we care for ourselves and embrace the values of the profession (respect, trust, partnership and integrity) we develop professional self-confidence and through this confidence a voice.

Helen Rook, RN, MN, PhD, Programme Director, Lecturer, Graduate School of Nursing Midwifery & Health, Faculty of Health, Victoria University of Wellington, NZ

References:

Abraham, A. (2011). *Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people*. (Fourth report of the Health Service Commissioner for England). London, England: Parliamentary and Health Service Ombudsman.

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* London, England: The Stationery Office.

Gallagher, A. (2011). Moral distress and moral courage in everyday nursing practice. *Online Journal of Issues in Nursing, 16*(2), 8. doi:10.3912/OJIN.Vol16No02PPT03

Harding Clark, M. (2006). *The Lourdes hospital inquiry: An inquiry into postpartum hysterectomy at Our Lady of Lourdes Hospital, Drogheda*. Dublin, Ireland: The Stationary Office.

Jackson, D, Hickman, L, Hutchinson, M, Andrew, S, Smith, J, Potgieter, I, . . . Peters, K. (2014). Whistleblowing: An integrative literature review of data-based studies involving nurses. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 48*(2), 240-252. doi: 10.5172/conu.2014.48.2.240

Nursing Council of New Zealand. (2016). *Annual report 2016*. Wellington: Author.

Nelson, K. (2017). Addressing diversity in everyday nursing. *Nursing Praxis in New Zealand*, *33*(1), 5-6.

Rook, H., & Coombs, M. A. (2016). Giving voice to optimism and hope for the future of nursing. *Collegian, 23*(4), 397-398. doi:10.1016/j.colegn.2016.11.002

The Office of The Chief Nurse (2017, June*) Nursing leadership narrative for change*. Retrieved from http://www.health.govt.nz/our-work/nursing/nursing-leadership/nursing-leadership-narrative-change

Williams, J. (2011). *Dignity and nutrition inspection programme: National overview.* Newcastle upon Tyne, England: Care Quality Commission.