



How does the length of day shift affect patient care on older people's wards? A mixed method study



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ARTICLE INFO

Keywords:

Care continuity
Communication
Eight hour shift
Hospital
Interaction
Patient care
Mixed method
Older people
Relationship
Twelve hour shift

ABSTRACT

Background: Internationally, studies have focused on whether shift length impacts on patient care. There are also ongoing concerns about patient care for older people in hospital. The study aim was to investigate how length of day shift affects patient care in older people's hospital wards.

Objectives: 1) To explore how length of day shift affects patient care in older people's wards; 2) To explore how length of day shift affects the quality of communication between nursing staff and patients/families on older people's wards

Design: A mixed method case study.

Settings: The study was based on two older people's wards in an acute hospital in England. One ward was piloting two, overlapping 8 h day shifts for 6 months while the other ward continued with 12 h day shifts.

Participants and methods: Qualitative interviews were conducted with 22 purposively recruited nursing staff (17 registered nurses; 5 nursing assistants). An analysis of patient discharge survey data was conducted (n = 279). Twenty hours of observation of nursing staff's interactions with patients and families was conducted, using an adapted version of the Quality of Interaction Schedule (301 interactions observed), with open fieldnotes recorded, to contextualise the observations.

Results: There were no statistically significant differences in patient survey results, or quality of interactions, between the two wards. There were three overall themes: Effects of day shift length on patient care; Effects of day shift length on continuity of care and relationships; Effects of day shift length on communication with patients and families. Nursing staff believed that tiredness could affect care and communication but had varied views about which shift pattern was most tiring. They considered continuity of care was important, especially for older people, but had mixed views about which shift pattern best promoted care continuity. The difficulties in staffing a ward with an 8 h day shift pattern, in a hospital that had a 12 h day shift pattern were highlighted. Other factors that could affect patient care were noted including: ward leadership, ward acuity, use of temporary staff and their characteristics, number of consecutive shifts, skillmix and staff experience.

Conclusions: There was no conclusive evidence that length of day shift affected patient care or nursing staff communication with patients and families. Nursing staff held varied views about the effects of day shift length on patient care. There were many other factors identified that could affect patient care in older people's wards.

What is already known about the topic?

- Length of shifts affects quality and safety of care in general hospital wards.
- Care for older people in hospital should be person-centred and promote staff-patient relationships but is often task-focused.
- Shift patterns may affect person-centred care and care continuity.

What this paper adds

- Nursing staff have varied views about how length of day shift affects patient care in older people's hospital wards
- It is difficult to implement 8 h day shifts in a hospital where 12 h shifts are the norm, especially when there are staff shortages and a reliance on temporary staff
- There are multiple factors other than day shift length that could affect patient care and interactions on older people's hospital wards.

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1. Introduction

In United Kingdom (UK) health services, older people, defined as 65 years and over (World Health Organisation, 2002), are core service users, comprising 43 per cent of people admitted to UK hospitals non-electively (Oliver et al., 2014). There have been ongoing concerns about the standards of hospital care for older people in the UK and shift patterns are one possible influencing factor. The aim of this study was to explore how day shift length affects patient care in older people's hospital wards. Whilst the study was small scale, the mixed methods design revealed insights about the complexity of changing shift patterns and the multiple influencing factors.

2. Background

Historically nurses have worked varied shifts, but recently long (usually 12 h) day shifts have been adopted, driven partly by perceived cost-effectiveness (Griffiths et al., 2014; Harris et al., 2015). Internationally, the prevalence of long day shifts varies. A survey of medical and surgical staff nurses in the United States of America (US) identified the most common shift length as 12–13 h, worked by 60% of nurses in non-intensive care wards and 80% in intensive care units (Stimpfel and Aiken, 2013). In Europe, 12 h shifts are generally less widespread than in the US. In a survey in 12 European countries (RN4CAST study), 50% of registered nurses (RNs) on medical and surgical wards worked 8 h or less on their last shift, 32% worked 8.1–10 h, and only 14% worked 12–13 h (Griffiths et al., 2014). However, 12 h shifts were the norm in Ireland and Poland, while in England, 32% of nurses worked day shifts of 12 h or more (Griffiths et al., 2014). UK employment surveys reveal increasing numbers of nurses working 12 h shifts (Ball et al., 2015).

Hospital nurses working shifts over 12 h has been associated with increased errors and near errors (Rogers et al., 2004) and there are growing concerns about how long day shifts affect care quality and safety (Ball et al., 2015). In the US, nurses working shifts of 10 h or more were significantly more likely to report poor safety and care quality than nurses working 8–9 h shifts (Stimpfel and Aiken, 2013). As the proportion of US hospital nurses working shifts of more than 13 h increased, patients' dissatisfaction with care increased too (Stimpfel et al., 2012). In Europe, nurses who worked shifts of 12 h or more reported lower care quality and safety than RNs who worked shorter shifts, and they reported more planned care left undone too (Griffiths et al., 2014). Thus there may be unintended consequences of 12 h shifts due to reductions in workforce efficiency and effectiveness (Griffiths et al., 2014). However, the UK's Royal College of Nursing's (RCN) (2012a) surveys revealed that most nursing staff preferred 12 h shifts, as they need to work fewer shifts.

Ball et al. (2015) identified some evidence that 12 h shifts may have negative effects on nurses and patients, which was mainly related to associated fatigue, but the evidence was weak to moderate quality. In a scoping review of the impact and effectiveness of 12 h shifts, Harris et al. (2015) proposed five themes: risks to patients, patient experience, risks to staff, staff experience, and impact on the organisation of work. They found inconclusive evidence of the effects of 12 h shift patterns in all five areas but stronger evidence of a negative effect on care quality and safety. A recent review of shift work identified insufficient evidence that 12hr shifts are safe (Dall'Ora et al., 2016). However, studies often did not consider the complexity of shift work characteristics: shift length; weekly work hours; the compressed working week; overtime; night work/rotating or fixed shifts; and rest opportunities (Dall'Ora et al., 2016).

In older people's hospital wards in the UK, 12 h shift working increased from 18 to 33% between 2005 and 2009 (Ball et al., 2015). In England, there have been ongoing concerns about standards of care for older people in hospital (Health Service Ombudsman, 2011; Commission on Dignity in older people, 2012; Francis, 2013). In addition, increasing numbers of older people in hospital have dementia

(Royal College of Physicians, 2012) and there are particular concerns about the quality of their care (Sampson et al., 2009; Cowdell, 2010; Jurgens et al., 2012; Clissett et al., 2013; Timmons et al., 2016). Person-centred care (McCormack et al., 2008) and relational care (Bridges et al., 2010) are advocated for older people's care and principles include a focus on the individual and developing relationships. For older people with dementia, person-centred care is considered synonymous with best practice (Edvardsson et al., 2010; Clissett et al., 2013) but is not widespread in hospitals (Dewing and Dijk, 2016). Barriers include: short lengths of stay, a task orientated approach and a lack of focus on individuals (Clissett et al., 2013), with other factors identified as being the shift patterns, high staff turnover and weak clinical leadership (Webster, 2011). The ratios of RNs to patients are a further factor affecting patient care and there are lower ratios of RNs to patients on older people's wards in England (Ball et al., 2012). The RCN (2012b) recommended a ratio of 1.5:1.7 RNs per patient in older people's wards but they did not comment on shift patterns.

In summary, the literature indicates that nursing staff shift patterns can affect relational care for older people in hospital (Bridges et al., 2010), and person-centred care for older people with dementia (Webster, 2011). Length of shift is integral to shift patterns but studies have not specifically focused on how day shift length affects hospital care of older people. International studies on shift length and the relationship with patient care have mainly been conducted on general medical and surgical wards and critical care, where many patients are likely to be older, but studies set in hospital wards exclusively for older people appear absent.

The study aim was to investigate how length of day shift affects patient care in older people's hospital wards. The specific objectives were:

- 1) To explore how length of day shift affects patient care in older people's wards;
- 2) To explore how length of day shift affects the quality of communication between nursing staff and patients/families on older people's wards.

3. Method

3.1. Setting

The study took place at an acute hospital in south east England, where full-time registered nurses (RNs) and nursing assistants (NAs), referred to collectively as 'nursing staff', worked 12 h shifts, on three days or nights per week. From July–December 2013, one older people's 28-bed medical ward piloted two overlapping 8 h day shifts (07.00–15.00 and 12.00 to 20.00) to replace the 12 h day shift; the night shift remained the same. The pilot was conducted because the hospital's management team were questioning whether shift length affected patient care, a question reflecting national discourses (Calkin, 2013). Only day shift length was changed as shortening night shifts would have increased the complexity of changing shift patterns. The pilot required additional staff, who were funded by the hospital. Staff who were unwilling to work 8 h shifts were redeployed in other wards or on the hospital 'bank', which employs staff to fill gaps on shifts across the hospital. The hospital also regularly used external agencies to supply temporary staff. The research team, from a partner university, were invited to conduct the study after the shift pattern had started, thus limiting availability of pre-pilot data.

3.2. Study design

The methodology was a case study, which is appropriate for investigating a contemporary phenomenon in depth, within a real world context, and addressing 'how' research questions (Yin, 2014). In line with a case study design, propositions were developed from the

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