Professional nursing culture on a trauma unit: experiences of patients and staff

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Abstract
Title. Professional nursing culture on a trauma unit: experiences of patients and staff
Aim. This paper is a report of a study to explore the day-to-day experiences of patients and staff on a unit dedicated to the care of adult patients who have sustained an injury.
Background. With the numbers of people suffering traumatic injury increasing, provision of their acute care and rehabilitation is also of increasing concern. Staff have the potential to optimize recovery but the factors that facilitate or inhibit this in practice are unclear.
Method. This ethnographic study took place on a trauma unit in the United Kingdom between November 2004 and January 2006. Sixteen periods of observation, qualitative interviews with 40 patients and 19 staff, and four focus groups with staff were undertaken. Thematic analysis was conducted and data were analysed by sentence.
Findings. The dynamic process of patient-centred care was expressed through the themes of closeness, therapeutic care and working as a team. Closeness conveyed the sudden and devastating nature of injury, and the necessity for staff to let go of feelings to maintain a positive momentum. Therapeutic care highlighted the social connection between the staff and the patients, combined with a proactive dynamic approach to care. Working as a team identified the importance of maintaining expertise and making the system work for patients to ensure the best possible care.
Conclusion. By identifying the context and processes that facilitate recovery, it becomes possible to provide a framework for individuals and units to develop and improve practice that enhances recovery. These findings may be useful for other similar areas of care.

Keywords: culture, empirical research report, ethnography, experiences, nursing, patient-centred care, patients, trauma

Introduction
Global numbers of trauma patients are predicted to rise, leading to major challenges for healthcare professionals (Roberts et al. 2005). This adds to existing international concerns about access to service provision and the quality of care provided for this group (World Health Organisation 2004). The conditions involved range from isolated minor
injuries to multiple life-threatening injuries with the potential for significant social and physiological consequences. Trauma care can be delivered in a range of adult and paediatric settings, including emergency departments, intensive care and acute wards. Hospital care of patients who have suffered trauma is a skilled activity that draws on a range of knowledge and skills such as those used in orthopaedics, plastic surgery, intensive care, gerontology, palliative care and mental health care that are combined within the art of caring (Langstaff & Christie 2000). For many patients, a traumatic event that leads to hospitalization has a major effect on their lives (Cox et al. 2002). Hospitalization, although only a small part of recovery, has the potential to lay the foundations for future health and well-being. Therefore, it is important to understand the processes that facilitate or hamper patients’ progress towards recovery.

Background

In nursing, a general trend towards focusing on the patient has taken place over time. This has occurred through the medium of the nursing process (Kratz 1979), individualized patient care (Redfern 1996), nursing models (Aggleton & Chalmers 1986), primary nursing and nursing development units (Pearson 1985, Salvage & Wright 1995). The underlying intention has been to structure and develop the process of nursing so that patients can get the best possible care. Binnie and Titchen’s (1998) study of a medical ward identified the changes in organization, culture, leadership, doctor nurse relationships and the ward sister’s role that were required to facilitate a patient centred approach to care.

A crucial aspect of patient-centred care is understanding patients’ experiences of their care (Staniszewska & West 2004). Through gaining an insight into the impact of illness and the consequences of treatments from a patient perspective, it becomes possible to tailor interventions/interactions around patients’ needs. Edwards (2003) found that patients undergoing elective orthopaedic surgery needed to make sense of their experiences to create a coherent story about their care. This was important for their recovery and future healthcare behaviours. Cox et al. (2002) suggested that when patients have serious orthopaedic injuries the story of recovery fits into a wider story of the person’s life. In rehabilitation, the nurses became actors within the patients’ stories and had the potential to create new plots that had a therapeutic outcome for patients.

The context of care can also have a strong impact on practice (McCormack et al. 2002). Studies exploring patients’ views of hospital care identify the imbalance of power between staff and patients (Edwards 2002). Staff identify the tension between their ideals, what can realistically be achieved in practice (Tutton & Seers 2004) and the emotional cost of caring work (Allan 2001).

The study

Aim

The aim of the study was to explore patient and staff experiences of being on a trauma unit.

Design

An ethnographic approach was chosen because experiences within the ward culture were key to understanding what it is like to be on a trauma unit. Ethnography is often described as a description of culture (Hammersley & Atkinson 1995). Whilst culture itself is difficult to describe and has many meanings (Savage 2000), for the purposes of this study culture was seen as the shared meanings within a group (Chambers 2000). The approach taken for this study involved the researcher (ET) being involved in the construction of the data. The study was informed by subtle realism (Hammersley 1992) and therefore we assumed that patient and staff experiences can be known but that an understanding of these will be influenced by cultural assumptions. The researcher’s aim is to obtain a view of the culture from the participants’ perspectives whilst also using the experience of being on the unit to gain deeper insight into what this was like for participants. The researcher was therefore immersed in the experience but was also able to step back from it (Schwandt 1998), which is important for data reduction and synthesis (Richards 1998). This process was facilitated through the use of reflection on the researcher’s positionality, described as personal experiences, beliefs and values Plowman (1995), which were identified in the field notes and supported through supervision.

Participants

The sample was purposive and included patients and staff who had experience of the trauma unit and who were able to talk about this. Forty patients and 19 staff took part in the interviews. When identifying the sample, population characteristics were considered to ensure a range of experience was gained. For patients, this included a range of injuries such as distal radius fracture, tibial plateau fracture, fractured neck of femur, spinal injury, head injury and polytrauma. Nineteen men and 21 women patients participated, with an age range from 23 to
Patients were given an information sheet and letter inviting interviews, observation and focus groups, all staff and Hospital Research and Development Committee. For the Research Ethics Committee and supported by the Local Approval for the study was obtained through the Local Ethical considerations.

Each lasting for the duration of a shift (7-9 hours) patients. Sixteen periods of observation were undertaken, degree of social acceptance amongst the staff and the foot stools and getting drinks. This approach maintained a when invited and undertaking minor tasks such as moving corner of the room, but participating in conversations observer as participant. This involved sitting quietly in one occupancy rooms and the researcher took the role of help/hindered you?’ Observation took place in the multi-trauma unit’. Prompts were used to gain further insights, For staff this question was ‘What is it like working on a trauma unit’? Many patients were interviewed in the ward area, as they chose not to take part because they felt too tired or unwell to talk.

Data collection

Data collection took place between November 2004 and January 2006. Patients and staff were interviewed in a quiet room on the ward at a time convenient to themselves. Many patients were interviewed in the ward area, as they were unable to leave their beds. Patient interviews focused on one question: ‘What is it like being on a trauma unit’? For staff this question was ‘What is it like working on a trauma unit’? Prompts were used to gain further insights, such as ‘Tell me more about that’; ‘How did you feel about that?’; ‘How was that different from your last experience?’ and ‘What was it about that interaction that helped/hindered you?’ Observation took place in the multi-occupancy rooms and the researcher took the role of observer as participant. This involved sitting quietly in one corner of the room, but participating in conversations when invited and undertaking minor tasks such as moving foot stools and getting drinks. This approach maintained a degree of social acceptance amongst the staff and the patients. Sixteen periods of observation were undertaken, each lasting for the duration of a shift (7-9 hours), and covering a variety of shifts over 24 hours, and the researcher activities, interactions and conversations were recorded in field notes written at the time. These were typed up the following day and further reflections undertaken. After initial analysis of the data, focus groups with staff took place on key themes. Each group was given written and oral information about the theme and asked for their views about the data.

Ethical considerations

Approval for the study was obtained through the Local Research Ethics Committee and supported by the Local Hospital Research and Development Committee. For the interviews, observation and focus groups, all staff and patients were given an information sheet and letter inviting them to take part in the study. For the interviews and focus groups, potential participants had at least 24 hours to decide if they wished to take part. All participants signed consent forms. For the observation, patients and staff often had <24 hours to consider their involvement, because of the transient nature of ward life. Patients who transferred into the observation area while the observation was in progress were asked for their consent for it to continue. One person preferred not to be involved and interactions/activities that took place around them were not included in the field notes. Other transient visitors were informed of the study, and if they formed part of a significant interaction were asked for written consent after the period of observation. Relatives’ assent, initially oral followed up by written consent, was obtained for patients who were unable to provide their own consent because of illness or mental incapacity.

Data analysis

Both interviews and focus groups were transcribed verbatim and the transcripts were returned to staff and patients (who chose to have a copy) for clarification and change as appropriate. Handwritten field notes of the observation were typed up and reflected on immediately after the observation period. The approach to analysis drew on the work of Fetterman (1998) and Miles and Huberman (1994). Data were analysed by sentence using QSR NUD*IST N6 (2002) (QSR International Pty Ltd, Victoria, Australia), a qualitative software package. Field notes were analysed by hand using Microsoft Office 2003 (2005) (Microsoft Ireland Operations Ltd, Dublin, Ireland). Each sentence or unit of meaning was given a label, usually using the participant’s own words, and these units were built up into subcategories, categories and themes. An example is the unit around emotionless: the staff member’s words ‘I’ve become emotionless’ were used as a label to express a lack of energy to engage in ‘feeling’ work. This was collected together with other data with similar meanings to create a sub-category of ‘attachment/detachment’. Other sub-categories were brought together under the category ‘emotional labour’, a term created through drawing on the literature on emotions in organizations. Two categories, ‘emotional labour’ and ‘emotional work’ were drawn together to create a theme of ‘closeness’ drawn from the literature on intimacy in nursing. The field notes provided the framework for developing the data analysis and added further insights. For example, observation highlighted the problem focused two-way dialogue that occurred between Registered Nurses and patients during assisted washing; this was then explored further in interviews with patients and staff.
Trustworthiness

Trustworthiness (Lincoln & Guba 1985) was ensured by spending an extended period of time in the field, gathering observation, and interview data. Although time for observation was limited, the researcher was undertaking other projects on the same unit and hence had further opportunities for developing trust and rapport with the participants. Credibility was also explored through sharing the preliminary findings in focus groups with staff towards the end of the study. The findings were agreed as generally reflecting the overall culture of the unit, although there was disagreement with some perspectives within the data, an issue identified by Mays and Pope (2000). For example, emotionlessness was not something all staff had considered and some thought it conveyed hardness and lack of caring. Others felt that it was a useful term to convey how they felt when they were worn out after emotionally and physically demanding shifts. A thorough description of the context of care was developed, based on a purposive sample of participants covering a range of characteristics such as age, gender and role. However, transferability or the usefulness of the findings to another setting will depend on its similarity to the area of comparison. The trauma unit was purpose-built and the majority of staff were White people, with largely female nursing staff and largely male surgical staff. The patients were drawn from a wide geographical area including rural and city areas, but were mainly White people and encompassed a range of socio-economic groups. A clear audit trail was identified and researcher reflection on the research process was undertaken through field notes and computer-based memos during analysis which helped to identify dependability and confirmability. An example of the audit trail is the process of analysis described in the section on data analysis above.

Findings

The study setting was a modern purpose-built unit comprised of two identical 26-bedded wards. Patients were admitted to the unit via a number of routes, predominantly the emergency and outpatients departments. However, as the unit was a tertiary referral centre, patients with polytrauma, spinal and head injuries were accepted from other United Kingdom and overseas hospitals.

The unit’s system of care delivery was based on dedicated specialist trauma surgeons, resident in the hospital, who provided 24-hour assessment for all patients; they also provided clinical supervision for junior medical staff. The success of this patient-oriented model within the discipline of medicine was dependent on the contribution of nursing. Nurses were the custodians of continuity in patient care and had authority to coordinate decision-making between disciplines. The head nurse in charge of the unit, practice development nurse and other senior nurses with specialist roles supported the practice of primary nursing within the nursing teams. All senior nursing staff undertook clinical work and carried a patient caseload. Three themes were developed from the data: closeness, therapeutic care, and working as a team.

Closeness

The theme of closeness was derived from patients and staff undertaking emotional work/labour as a result of the experience of being close to injury, death and suffering. Hochschild (1983) identified how feelings were used within the work environment as a form of labour, and used the term ‘emotional labour’ to differentiate ‘feelings work’ undertaken as part of a paid role compared with that undertaken in daily life.

Emotional work

Patients undertook a range of emotional work in relation to their experiences of the injury event, getting into hospital, struggling to recover and through their interactions with others. The event itself was devastating and often involved a near-death experience, or in some cases patients required cardio-pulmonary resuscitation. In the telling of these events, patients often portrayed themselves as lucky to be alive, and said that their injuries were not as bad as they could have been:

...I’m going to hit that roundabout and God I’ve crashed and I’m going to die....

I got off pretty lightly because, you know, more or less without a scratch apart from my broken back. (Patient 15)

Patients struggled to make their bodies work and were shocked at how little they could do, how long normal daily activities took, and how little energy they had to undertake activities:

The only thing I had done was just sat up in bed, with my legs hanging over the edge. They virtually spun me round, and I felt like I was an 80-year-old chap, just slumped there. Yeah, I felt like a proper little old man. (Patient 13)

Patients also worked hard to cope with the emotional rollercoaster of waiting for surgery, as regular rescheduling occurred because of new emergencies, and the uncertain process of recovery.
Their connection with others in shared rooms brought many benefits but also added to their emotional work, as they became part of the group dynamics and experienced fear and anxiety on behalf of others:

You just start to panic about it and think ‘Oh, what if she’s not all right, what if, you know and why hasn’t somebody come’. (Patient 6)

**Emotional labour**

Staff expressed real joy and love for their work. They liked the mix of older and younger patients and the variety of injuries that ranged from a quick ‘fix it and go’ to helping people with long-term disabilities and those who were dying:

I got a good feel for a lot of what was out there and this was the only place that I really felt challenged in the way that I am here, because you don’t know what’s going to happen next, you don’t know what’s coming through the door next, you’ve got to cope with whatever goes on and I really like that. I actually like working in a fairly stressful environment and I like being pushed most of the time. (Staff 3)

Emotional labour covered the sub-categories of holding on/letting go, attachment/detachment.

**Holding on/letting go**

Staff were confronted with a high degree of suffering on a daily basis and there was awareness that this was stressful in the long term. Staff often expressed their feelings as if they were tangible and said that they could choose to hold on to them or let them go. The process of letting go was considered essential to maintain momentum and they felt that if they held on to their feelings they would be overwhelmed:

I mean if you kept hold of everybody’s grief, you’d just go down. I couldn’t live with that, constantly mourning. (Staff 8)

**Attachment/detachment**

There was also a degree of attachment and detachment in relation to feelings. Staff identified that a degree of self-protection was necessary to function effectively. However, they also identified times when they felt emotionless – a form of enduring, identified by Morse and Penrod (1999):

I feel as though I’ve become so detached, I have detached myself from it I think, so detached that I feel like I’ve become emotionless with some of the patients…… it’s too hard for me, it’s too tiring and I don’t have the energy for it. (Staff 10)

This was a short- or long-term coping strategy that staff used when they did not have the emotional capacity to engage with ‘feelings’ work. They were concerned that emotionlessness was not portrayed as ‘hardness’ which was linked to not caring, but was more about a state of not having the energy to feel or engage with feeling work.

**Therapeutic care**

The therapeutic care theme was derived from an understanding of care as beneficial for patients. Two important processes were identified as underpinning therapeutic care: the social environment and the proactive dynamic approach to care.

**The social environment**

The social environment provided a crucial backdrop or basis for interaction through the social function and supportive actions through the support function.

**The social function**

The field notes, staff and patient data identified the vast amount of daily social interactions between staff and patients that provided a sense of openness, light heartedness, tolerance and sharing:

What is notable here is the intense amount of social interaction between the patients, patients and staff, which seems very important in relation to how patients pass the time ‘waiting’. (Field notes 3)

**The support function**

This constant friendly atmosphere gave patients a sense of normality and a basis for integrating with others within the rooms. Social interaction also provided a basis for therapeutic care by creating an emotionally stable environment. Patients identified staff who picked up on their emotional needs, listened to them, made them feel secure and helped them process their emotions:

They’ve kept me well-informed, kept me comfortable, kept me happy, kept me – well – kept me everything, that I haven’t needed to cry. (Patient 7)

Shared social interaction was the basis through which patients also supported each other:

I think relationships within rooms in wards are quite important. And there’s, you know, the feeling that you want to support one another, and if somebody’s suffering and you know you want to find out a reason why and sort of stick up for them. (Patient 9)

Relatives were identified as the ‘unsung heroes’ within the group support system:

The relatives who come in regularly, you know they already do the chocolate run and the sandwich run and all the rest of it. (Patient 31)
The proactive dynamic approach
The proactive dynamic approach to care encompassed the sub-categories of moving forward, making it easier and knowing. Underlying these sub-categories was a belief by staff that most problems could be solved. If staff and patients actively sought solutions then a rehabilitative momentum would be sustained, facilitating timely discharge.

Moving forward
Patients identified staff who showed concern for them, completed planned actions and made sure decisions were made:
I must say the nurses have come in on a regular basis and I’ve built up a rapport with quite a few of them, quite a few of them have taken an interest in me and care about what’s happened and just try to move things forward a bit. (Patient 3)

Making it easier
This approach to care was reflected throughout the different roles on the unit, with housekeepers and ward clerks performing a key facilitative role between patients, their families and the wider organization. An immense amount of work was undertaken to pre-empt problems occurring or escalating. This helped to smooth patients’ paths through the system and made life easier for them:
For me it’s easier to do it that way, now they automatically come in and they just automatically do it that way and it makes the process a lot easier. (Patient 13)

Knowing
Knowing the patients was crucial to both these processes, and staff felt that the continuity of care facilitated their understanding of patients and their ability to meet their needs:
And then at the end of 8 days you feel like you’ve known them all your life (laughs). Because you’ve just been with them all day, every day. (Staff 4)

Patients felt they were more relaxed when the staff knew them and knew how to manage their bodies. This mitigated against the natural fears and anxieties of the uncertain process of recovery and reduced the amount of work patients undertook.

Working as a team
The theme of working as a team was largely supported by data from staff and encompassed two categories: knowing through doing and making things work.

Knowing through doing
Knowing through doing identified the egalitarian basis for teamwork in which everyone was valued for their important contribution to patient care. This belief was situated within an understanding of the unit as nurse-led. A professional ethos based on the structure of primary nursing in which continuity of care combined with knowing the patient, being active in decision-making and discharge planning were the core components:
With the patients I look after here, not only do I wash them, wipe their bottom, check their pressure areas, but I also go and deal with all the occupational therapists, the physio, you know, the dietician, the consultants because I know that patient so well that they can ask me a question about them and I’ll be able to tell them. (Staff 6)

Active decision-making was facilitated through nursing staff co-ordinating daily doctors’ rounds for the patients they were allocated that day. The field notes identified that patients often contributed to discussion on these rounds and asked questions of the team. Working together to share the burden of care and having a good team atmosphere across the ward were important and knowledge of the work was gained through actively helping others. Making the system work highlighted the continual effort expended by experienced staff to develop the expertise of all staff and support standards of care across the unit. However, this process was difficult for staff and created some degree of role strain:
And then yesterday with being on with three junior members of staff, I found myself at one point in our drugs room and I had them queued up waiting to ask me questions… you’re trying to do your own work, you’re trying to make sure their work is going OK and you’re trying to keep abreast of what’s going on, on the whole ward and what the bed situation is like and what people you’ve got coming and what people you’ve got going, so in terms like yesterday I felt that I didn’t give adequate care to at least two of my patients because my time was just spent elsewhere, so... (Staff 5)

Making things work
Staff worked hard to make the system work despite poor skill mix because of a high proportion of agency (temporary casual) staff compounded by resource restrictions. To survive, staff had to learn to compromise and develop a certain degree of hardiness in relation to working within these limitations:
Short-staffed, under-resourced, but still having the desire to provide the level of care that you feel you should and can’t a good portion of the time. And it’s constantly having to compromise and I think that’s one of the hardest things. (Staff 3)
However, unit staff were not only articulate but were also prepared to argue in support of care standards despite the ongoing problem of resourcing.

Discussion

Study limitations

The study was undertaken on a limited basis and a traditional ethnography would have involved more observation over a longer period of time, although saturation of the categories and themes was achieved. A larger study could have incorporated a wider understanding of multidisciplinary team working and situated the study within the wider workings of the hospital.

Our findings confirm the importance of creating professional cultures within hospital areas where staff can develop their expertise as clinicians and maximize opportunities for patient-centred practice. In the study, staff were striving to do their professional best through a friendly approach, closeness, proactive problem-solving and acknowledgeable team. Patients were active partners in their care whilst suffering, enduring, and actively managing their recovery process.

The sociable, open and friendly atmosphere gave patients and staff opportunities to connect with each other and conveyed a sense of availability and accessibility to which patients could relate. Other studies have identified the importance of friendliness (Errser 1997, Cox et al. 2002). Healthcare assistants in our study provided a rich source of social interaction. Friendliness was a way of being that all staff used in a genuine way. There was no sense of the ‘smiley face’ identified by Bolton (2001), where staff felt they had to make an effort to smile to provide consumer satisfaction.

Closeness in our study was different from that in Savage’s (1995) work, in which she found that staff used close relaxed physical stances and strong family type relationships as in a home environment. The physical environment on the study unit was light and airy but clinical in nature and the staff had a relaxed but purposeful stance when approaching patients. Savage (1995) and Binnie and Titchen (1998) identified closeness in relation to undertaking intimate physical care as a means of developing meaningful relationships with patients. Intimate physical care, for the professional staff in our study, was a way of using closeness as a vehicle for understanding individuals’ experiences of the recovery process, being able to sort out problems and move the rehabilitative process forward. The observation showed that physical care provided by healthcare assistants was a social event that did not have the same complexity.

Staff expressed their feelings of grief, sorrow or horror as something they had to leave behind or let go to maintain their emotional capacity and keep working. This was similar to the metaphors used by hospice nurses in a study by Froggatt (1998), who felt they were containers that required emptying before they could experience any more emotion. Feeling emotionlessness was a point staff reached when their emotional capacity was used up and they were unable to feel as a result of their connections with others. This could be seen as enduring, a state that prevents an individual being overwhelmed by their feelings (Morse & Penrod 1999), or as emotional dissonance, where caring continues but feelings are suspended (Hochschild 1983). The use of the term ‘detachment’ in our data referred to the need to maintain a certain emotional distance to gain a better understanding of the current situation. Bolton (2001) identified this in the professional face of nurses, and Blomberg and Sahlberg-Blom (2007) described balancing closeness and distance as a way of managing difficult situations. From a psychoanalytic perspective, keeping an emotional distance can be seen as a way of protecting against anxiety and maintaining the smooth functioning of the clinic (Allan 2001).

In our study, staff members’ confidence was conveyed through the proactive dynamic attitude to care, underpinned by a problem-solving approach. This implied that staff felt empowered to use their knowledge and skills to benefit patients, and reflects the importance of maintaining expertise in practice (McMahon 1998, Rundqvist & Lindstorm 2005). Our study highlighted the amount of work required to maintain this approach, in which keeping a strong professional nursing voice and a critical mass of knowledgeable experienced team leaders was crucial. A constant cycle of new staff, students, changing multidisciplinary staff and temporary/casual staff generated an enormous amount of work and some degree of role strain for experienced staff.

The level of patient participation in active decision-making varied across the unit. Key events provided greater opportunities for patient participation in decisions about their care, such as nursing shift handovers at the bedside, morning doctors’ rounds with the nurses allocated to the patients, and nurses undertaking physical tasks such as morning washes. Nurses’ skills (Sahlsten et al. 2005), patients’ abilities or wishes to take part in the process, and the ward culture (Tutton 2005) all influence the process of participation. Thompson (2007) suggested that maintaining trust is crucial for involvement, and in our study continuity of care and knowing the patients was also a basis for developing trust. Patients preferred care when a member of staff knew them as they could relax the amount of work they performed in relation to monitoring their body and directing their care.
What is already known about this topic

- Trauma care is a composite speciality that covers areas such as orthopaedics, plastic surgery, gerontology, palliative care and mental health.
- Recovery from traumatic injury can be an arduous journey requiring intense facilitation from healthcare staff.
- The context of care – the environment, how care is structured and interactions with staff – influence how patients perceive their care.

What this paper adds

- Both patients and staff undertake emotional work and this is identified in staff through the process of ‘holding on’ and ‘letting go’ of feelings.
- A proactive dynamic approach to care where staff and patients constantly work together to move forward the process of recovery is crucial if care is to be therapeutic.
- A critical mass of experienced staff is required to support patient recovery from traumatic injury if patient-centred practices are to be part of the culture of care.

Conclusion

Our findings highlight the importance of developing cultures that value the importance of front-line staff and their impact on patients’ experiences of care. Maintaining an experienced team with professional and organizational knowledge was crucial to the maintenance of patient-centred activities. This affirms the importance of stable but dynamic teamwork if patient-centred care is to become a reality rather than an ideal. Further research is required to establish the impact of healthcare modernization agendas on the teamwork of frontline staff and its consequences for patient-centred care. Key opportunities for participation were identified in this study but further research is required to examine patient agendas throughout periods of acute care. The daily emotional life of the ward also requires examination in relation to how patients and staff process their emotions over time within acute care environments and, for patients, in the immediate recovery period once they have left the trauma unit.

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Author contributions

ET, KS and DL were responsible for the study conception and design and the drafting of the manuscript. ET performed the data collection and data analysis. ET, KS and DL made critical revisions to the paper. KS supervised the study.

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