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Managing Poor Performance in Nursing and Midwifery: does the evidence make the grade?

The way in which poor performance in nursing and midwifery is managed is of concern to individual practitioners, managers, employing organizations and to patients. The National Clinical Assessment Service (NCAS) which helps healthcare managers and practitioners understand, manage and prevent performance concerns, commissioned a review to identify which groups of nurses and midwives might benefit from the service[1]. The scoping study, undertaken in collaboration with the NNRU, included a review of evidence on the definition and management of poor performance in nursing and midwifery and here we present its findings and considers its implications of policy and practice.

Context

Nurses and midwives represent the largest clinical group in the NHS and often care for the most vulnerable in society. However health policy on suspension and management of poor performance has largely focused on doctors. [2] Nurses and midwives are subject to local procedures by their employing trusts and no longer have an appeal route in cases of suspension to the NHS regions. Some argue that changes in the NHS over the past two decades including the rise of managerial power have left some nurses and midwives vulnerable to individual suspension rather than organizational scrutiny. [3, 4]

The review

The review indentified 68 studies from 1981 relating to poor performance. Evidence was sparse, qualitative in nature and focussed on systemic and individual contributions to the poor performance of trained nurses. Hence issues relating to the increasingly important health care assistant work force are unknown as are factors contributing to one nurse performing poorly over another. Further evidence was collected through analysis of recorded NMC hearings (Oct 2009-March 2010) and observation of one day of NMC fitness to practice cases.

Is there a problem?

At present ascertaining an accurate picture of how many nurses are "poorly performing" is impossible as there is no effective requirement on the NHS or other organizations to report cases of suspension to the DH. There is little collation of evidence relating to performance concerns regarding nurses and midwives. Many such incidents are dealt with by the individual's employer, yet despite a voluntary reporting system, there is little available evidence which documents the scale of the problem. A National Audit Office report [5] is the only major national study on this topic. The study found that between April 2001 and July 2002, 562 nurses and midwives were suspended for at least one month; amounting to 53% of all NHS staff suspensions. Nurses were more likely to be formally suspended than doctors; their average length of suspension was nineteen weeks with only a small proportion then referred to the NMC.

A 2002 RCN survey noted that 207 trained nurses were suspended, 1 for every 1,500 members. Of these, the majority returned to work after a disciplinary hearing, 18% were dismissed. Our review of NMC cases, over a 9 month period (n=185), revealed nurses working in mental health and care home settings represented the biggest group of nurses referred to the NMC. (NMC 2008-2009). This may suggest a link with care setting rather than individual nurse competency. Organizational issues e.g. staff shortage; bullying and discordant relationships with other staff and managers increased the likelihood of complaints ([2]). Notable in the NMC data is the low number of hearings associated with clinically autonomous practitioners.

What is the definition of poor performance?

Several recent high profile cases of poor practice in the NHS, individual and institutional have highlighted the importance of managing and learning from poor performance. NCAS have recently

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defined poor performance as: "any aspects of a practitioner's performance or conduct which: pose a threat or potential threat to patient safety; expose services to financial or other substantial risk; undermine the reputation or efficiency of services in some significant way; are outside acceptable practice guidelines and standards"[6]. However this definition has yet to be evaluated against practice and the extent to which it proves to be a robust and shared definition of poor performance, necessary to assess, best manage and improve practice is unknown. Whilst current NCAS guidelines define poor performance primarily in relation to patient safety and risk, in practice fewer than 20% of nurses were suspended for professional competency reasons. Professional and personal conduct comprised the majority of cases (65%). Exclusions where patient safety is an issue was uncommon and complaints from colleagues (rather than patients) was the highest reason for referral for performance management.

Is there consistency in managing poor performance?

There is considerable variation in procedures and in quality management of performance between trusts. Eighty six per cent of trusts carried out initial investigations on clinicians, but the quality and rigour of investigations was variable. Two thirds who used DH guidance felt it was of little use and resulting local procedures were open to interpretation and widespread inconsistency (NAO 2003/DOH 2006). Inconsistent use of suspensions for nurses was noted and immediate exclusion, for reasons other than patient safety, was common. Managers often used suspension and exclusion as a tool of first choice [7] and approaches to poor performance were often punitive despite the lack of efficacy of this approach improving performance [8]. Furthermore nurses are not always aware of reasons behind the decision and documentation is poor. The evidence also suggests that clinicians who report poor performance are not clear what action is taken as a result [9].

What is the cost of nurse/midwife suspensions financially, professionally and personally?

The financial cost of managing poor performance is hard to determine because of lack of accurate evidence. Data from the National Audit Office estimates that £40 million was spent to cover staff exclusion, of which £10 million were nurse and midwife costs. The average gross cost to the NHS of the suspension of a midwife or nurse is £17,600 (at 2001-2 prices). Murray estimates the cost to her sample of suspended RCN members would be in the region of £4,429,800 [2]. There are ongoing effects on productivity and quality of care due to the remaining workforce knowing a colleague had been suspended [10] and some work has highlighted the trauma of suspension for individual clinicians - the grief response and threat to identity [7].

Conclusions and Implications

In conclusion, the management of poor performance in nursing and midwifery is variable and there is existing evidence of unsatisfactory practice. Overall, lack of policy guidance in relation to performance management and inconsistency in practice has led to a piecemeal, individualistic and often reactionary response to alleged poor practice.

1. There is little evidence in relation to the recorded number and management of poor performance. What evidence there is points to inconsistent management which is costly to the organisation, the provision of high quality care and individual nurses.
2. There is little evidence that autonomous workers or advanced clinical roles are a higher risk of poor practice and some suggestion that organisational rather than individual or role factors may be a better predicator of poor performance.
3. The evidence suggests that most nurses are not aware of the full reasons for suspension.
4. The evidence is sparse and there is a need for greater development and evaluation of policy guidelines already in place.

Key issues for policy

There is a need for:

- better data reporting requirements such as reason, length and outcome and national data on suspensions and exclusions for nurses and midwives
- better communication with staff who are performance managed and suspended so they understand the reasons and can learn from the process
- Better support systems for the reintegration of suspended / performance managed staff into the workforce.
- specialist provision to support staff whose suspension causes specific problems e.g. addiction
- Greater understanding of the perspective and support needs of managers who are responsible for the management of poorly performing staff.

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