

## Chapter 1

# Introduction

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*To be a nurse, midwife or care giver is an amazing role. There is hardly any intervention, treatment or care programme in which we do not play a significant part. ...We support the people in our care and their families when they are at their most vulnerable and when clinical expertise, care and compassion matter most.*

(DoH 2012a: 4)

Vulnerability is a key quality that all of us as health carers will encounter in the people we work with. To be a nurse, midwife, or carer working with such individuals is to have a privileged role within society, a role which demands that we exercise that privilege with responsibility, care, and compassion. We are aware that there are numerous examples of excellent care that people experience everyday within the National Health Service (NHS). It is our experience of working with colleagues and students that most people enter the profession with a desire to enhance the lives of individuals with whom they are working, to reduce their level of vulnerability, as well as an on-going commitment to enhancing the nursing profession and the NHS.

However, we are also aware that there are examples of poor quality care experienced. The recent Winterbourne View review (Flynn 2012) and Mid Staffordshire NHS Trust enquiry (Healthcare Commission 2009 and Francis 2010) have identified that some individuals who find themselves receiving care, can and have, received degrading, inhumane treatment by those paid to care for them. The highly publicised Winterbourne View review identified clear examples of horrific, abusive practices that appeared to be woven into the culture of the home. Whilst this case is a relatively rare occurrence in healthcare, there have been a number of recent examples highlighting the provision of poor quality care in health and social care settings (DoH 2008, Parliamentary and Health Service Ombudsman 2011, Commission on Dignity in Care for Older People 2012). In addition, the Mid staff NHS Trust review by Francis (2010) presented detailed accounts of poor quality care which were often linked to fundamental aspects of care such as nutrition and hydration, continence, privacy and dignity, personal care, and pressure area care. The findings are of great concern to anyone in a caring role and reflect a misuse and abuse of the privileged position we are given. As with the Winterbourne View review, it also transpired that the personal actions of practitioners were compounded by the culture of the organisation.

## 2 Understanding vulnerability

Therefore, when examining quality of care and the vulnerability of patients, clients, service users, or families, it is evident that we need to consider both the personal interactions between those individuals and healthcare practitioners as well as exploring the cultural aspects of the care environment. This book offers that breadth of examination of the topic, and also goes further by exploring some of the structural issues which affect vulnerability.

Nationally there are also structural factors that impact upon quality of care. There has been a drive within the NHS to provide evidence-based standardised care, and this has largely been achieved through the development of care pathways such as Liverpool Care Pathway (NICE 2004) and #Neck of Femur Care Pathway (National Clinical Guidelines Centre 2011). However, there is the possibility that by focusing upon ‘standardised’ approaches to care, it could be at the expense of personalised care – responding to the condition rather than the individual. In addition, there is also a focus nationally on meeting targets within the NHS (DoH 2011); this can result in people being thought of as a number within a service rather than as an individual who is unwell. This demonstrates how structural factors can also contribute to the care experienced by individuals within a service; indeed, this is one of the main criticisms of the Francis Review (2010), which highlighted that people must always come first:

... if there is one lesson to be learnt, I suggest it is that people must always come before numbers. It is the individual experience ... that really matters. (Francis 2010: 4)

Because of such high-profile cases identifying poor quality care in the NHS and private care organisations, there has been an increased focus nationally on identifying and promoting the core values of the NHS which were published as a part of the NHS Constitution (DoH 2012b). These core values include:

- *Respect and dignity* – Here a link between the constitution and human rights is established, clearly denoting a commitment to ensuring that people accessing services in the NHS are treated with dignity and respect as enshrined in the Human Rights Act. Specifically identified within this is the right not to be subjected to inhumane or degrading treatment as well as a right to respect for family life. This is central to providing high-quality care by ensuring that individuals are treated respectfully.
- *Commitment to quality of care* – The NHS is committed to providing high quality of care by suitably qualified and experienced staff. In addition to this, there is a clear commitment to monitor patients’ experience of care and, where necessary, make changes.
- *Compassion* – Compassion is at the heart of the NHS. When people are unwell, they feel exposed and vulnerable, and the NHS has a responsibility to ensure that people receive compassionate care.
- *Improving lives* – The constitution highlights the responsibilities of the NHS as well as the wider public in working together to improve people’s health by preventative measures, such as screening programmes, whilst also identifying that the public have a responsibility to proactively access health services.
- *Working together for patients* – This core value reflects how the NHS will work in partnership with individuals, highlighting that they are a central team member working

together with NHS staff. It also recognises people's autonomy acknowledging their right to refuse treatment and the importance of communication by individuals, having the right to have access to their own medical records as well as having sufficient information regarding any proposed treatment.

- *Everyone counts* – This last core value recognises that the NHS is a resource for all people within society. It reinforces that people have the right not to be discriminated against in the provision of NHS services on the grounds of gender, race, religion or belief, sexual orientation, disability (including mental illness and learning disability), or age.

We believe that this book has something to offer the reader in relation to each of these core values and can enhance the readers' depth of understanding of each value. A focus upon providing individualised, person-centred care is central to ensuring that the core values of the NHS are met within healthcare; this book will enable you to understand some of the factors that occur at the personal, cultural, and structural level which can inhibit the delivery of person-centred care. The last value 'everybody counts' reflects the fact that we live in a diverse society and healthcare practitioners must be equipped for this; yet numerous reports (Mencap 2007, DoH 2008, Michael 2008, Healthcare Commission 2009, Equalities and Human Rights Commission 2010) have highlighted that individuals from diverse backgrounds do not always experience high-quality care. However, professional codes of conduct assert that healthcare practitioners should provide anti-discriminatory practice (HCPC 2008, NMC 2008). Whilst educational preparation for the professional role will address such issues, there is also a potentially flawed assumption that individuals enter their preparation as 'an empty book, waiting to be written'. However, individuals enter their professional programme of training and practice having already been exposed to a wide variety of perceptions and having experienced a diversity of life experiences that may affect their ability to provide anti-discriminatory care without further time and attention to those perceptions. This book provides readers with the opportunity to critically question their individual and collective practices and beliefs and to do so at a time and place of their choosing. A key message of the book is that there should be no fear attached to such critical reflection; there are no recriminations. Indeed, it is the hallmark of a professional to be able to reflect and learn, rather than turning away from such opportunities.

Government strategy has traditionally considered vulnerability from the perspective that particular 'groups' of people who by reason of age, ethnicity, disability, and health status are deemed to be more vulnerable to harm than the rest of society. This book takes the view that such a perspective not only imposes vulnerability on members of these groups regardless of their individual situation and thus may deny their individual difference and experience, but it also obscures the potential vulnerability of other individuals who do not fit within these traditional categories but may still be feeling vulnerable. It is our contention that vulnerability is a 'condition humana' (Kottow 2003: 461), which is a potential experience for *all* people. In this way, the book encourages its readers to see vulnerability in its widest sense, and thus enhances their ability to address and reduce vulnerability for *all* their clients, not just particular groups of clients. Equally it encourages readers not to assume that an individual is vulnerable just because they can be categorised

#### 4 Understanding vulnerability

in a ‘vulnerable group’. This book aims to open the readers’ eyes to the individuality of each client, seeing the person for who they are, rather than making false assumptions based on a tick box mentality. Thus, readers may expand their understanding of the concept of ‘individualised, person-centred care’.

Another key difference in the book’s underpinning philosophy comes from our belief that vulnerability is a socially constructed phenomenon, and that vulnerability is created not by the individual’s personal qualities but by the world they inhabit. This follows the social model of disability (Oliver 1983), in seeing vulnerability as being the result of the environment the person lives in, consisting of attitudes, cultural beliefs, media images, power, strategy and policy, dominant discourses, and other factors. It is our contention that these factors create and construct the experience of vulnerability to an equal or greater extent than any condition or life experience. Through this text, these factors are explored in some depth, and their particular impact upon vulnerability is explored throughout the book.

This book is useful for all healthcare practitioners (students, qualified practitioners, and unqualified practitioners) that are committed to providing person-centred care from a variety of different professional specialties (nursing, physiotherapy, occupational therapy, paramedic science, operating department practitioners, and community workers). In addition, this book can also be used within the undergraduate nursing curriculum to support the essential care clusters identified in the Standards for Re-registration Nursing Education (NMC 2010). We believe that this book can assist practitioners in understanding the wider, human experience of vulnerability. A key strength of the book is its inclusion of people’s voices, thus offering the lived experience of vulnerability which we feel is central to understanding how care is experienced by others. These lived experience accounts are from our personal and professional practice, together with experiences that have been shared by other colleagues. In order to protect the confidentiality and anonymity of the individuals, names and circumstances have been changed, and some accounts have even been constructed from collations of several stories. This provides both the foundation for a critical examination of the social construction of vulnerability as well as a constant sense of the ‘real world’ to illustrate and bring to life the theoretical issues under discussion.

This book, we hope, will assist you in developing your thinking and enhancing your practice. As such the book challenges you to reflect throughout on your own contribution to vulnerability and the impact of the healthcare environment in which you work. Just a note regarding terminology: within the book a variety of terms have been used to denote people who experience care (patient, service user, client, people, individual), likewise a variety of terms have been used to denote people who provide care (carer, practitioner, nurse, care giver, health carer), and this has occurred in order to reflect the widest diversity of care and care settings.

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