Nursing Standard

Evidence & practice / quality assurance

CARE EROSION

Recognising and responding to care erosion: part 2

de Vries JMA, Timmins F (2017) Recognising and responding to care erosion: part 2. Nursing Standard.

Date of submission: 26 January 2017; date of acceptance: 28 March 2017. doi: 10.7748/ns.2017.e10821

Jan Martinus Anne de Vries

Assistant professor, School of Nursing and Midwifery, Trinity College, Dublin, Ireland

Fiona Timmins

Associate professor, School of Nursing and Midwifery, Trinity College, Dublin, Ireland

Correspondence

devriej@tcd.ie

Conflict of interest

None declared

Peer review

Online

Abstract

The term 'care erosion' refers to a gradual decline in care standards, which is a significant concern in many hospitals and other healthcare settings. While much has been written about this issue, the psychosocial mechanisms whereby individual nurses become implicated in care erosion are not well understood. This article is the second of a two-part series on care erosion, which explores core aspects of this issue using cognitive dissonance theory. Part 1 focused on how nurses can recognise care erosion and understand how it develops. Part 2 explores how care erosion can be prevented through nurse education and promotion of reflection, mastery of nursing skills and care, supporting strong nursing values, and addressing denial, trivialisation, and justifications for substandard care. It aims to improve nurses' understanding of these issues and to provide practical ways of preventing care erosion.

Keywords: care erosion, care quality, cognitive dissonance, psychology, quality assurance

Introduction

The term 'care erosion' refers to a gradual decline in care standards in healthcare settings, which is a significant cause for concern for healthcare organisations worldwide. This article is the second in a two-part series exploring how nurses can recognise and prevent care erosion. The first part of this series (de Vries and Timmins 2017) focused on recognising and understanding how care erosion develops, with an emphasis on psychosocial mechanisms, particularly cognitive dissonance. It also considered how care erosion may occur as a result of a lack of critical reflection on practise by nurses and other healthcare professionals. This second article further explores how care erosion can be addressed by individual nurses, nurse educators, and healthcare organisations.

The literature on substandard care highlights its relationship with social and economic factors, policies, organisational culture and safety culture (Hutchison 2016). Education, experience and quality of management and staff have also been considered. Furthermore, social factors such as peer pressure, ineffective staff relationships, and low motivation have been invoked to explain why substandard care occurs.

The underlying mechanism involved in a decline in care standards can also been seen as the effects of prolonged stress on healthcare staff and organisations. Whenever the balance between resources and demands in organisations is affected by reductions in resources and/or increase of demands, this generates pressure and stress (Cannon 1935, Dror 2014). Healthcare

organisations are often affected in this way (Hobfoll and Freedy 1993, Ganster and Rosen 2013). In recent years, there has been an increase in demands on healthcare services, including a rise in the number of patients, an increase in the number of procedures **that are being undertaken,** higher cost of treatments, and higher **patient** expectations of what medical science can do **in terms of quality of surgery and other interventions as well as health outcomes.** At the same time, healthcare resources are under pressure, as a result of a lack of funding, and subsequent cost-cutting measures and staffing reductions. This has put significant pressure on healthcare services to operate effectively and safely. This pressure means that staff have to undertake additional work, often with fewer resources.

The stress generated by this leads to a process whereby staff coping abilities decrease gradually, followed by mental and physical exhaustion and increased health risks associated with stress (Selye 1956). In this situation, further staff shortages typically occur, as a result of chronic fatigue (Smith-Miller et al 2014), as well as increases in sick leave (Bakker et al 2000, Adriaenssens et al 2015), burnout (Maslach et al 2001, Maslach 2003, Leiter and Maslach 2009, Schaufeli et al 2009), and high turnover of nursing staff (Leiter and Maslach 2009, Jameson 2015). This leads to a 'domino effect' in which even the most resilient staff, who have to compensate for the absence of those who have left and have not been replaced, may become affected by chronic fatigue (Smith-Miller et al 2014) and loss of morale and motivation. It has been demonstrated that in the end patient care levels deteriorate (Hall et al 2016).

Since the effects of stress on staff are gradual, it follows that its impact on care standards is also gradual. Slight declines in care standards typically remain unnoticed; individuals often become used to such declines, and, crucially, they may cease to feel distressed by them. This essential aspect of care erosion has not been well understood, since it takes place within individual staff. The first article in this series outlined how cognitive dissonance theory helps to explain this process within individual nurses (de Vries and Timmins 2017). We'll now take the next step and after a brief reminder of the theory and its relevance, we will outline what can be done about care erosion using the dissonance perspective.

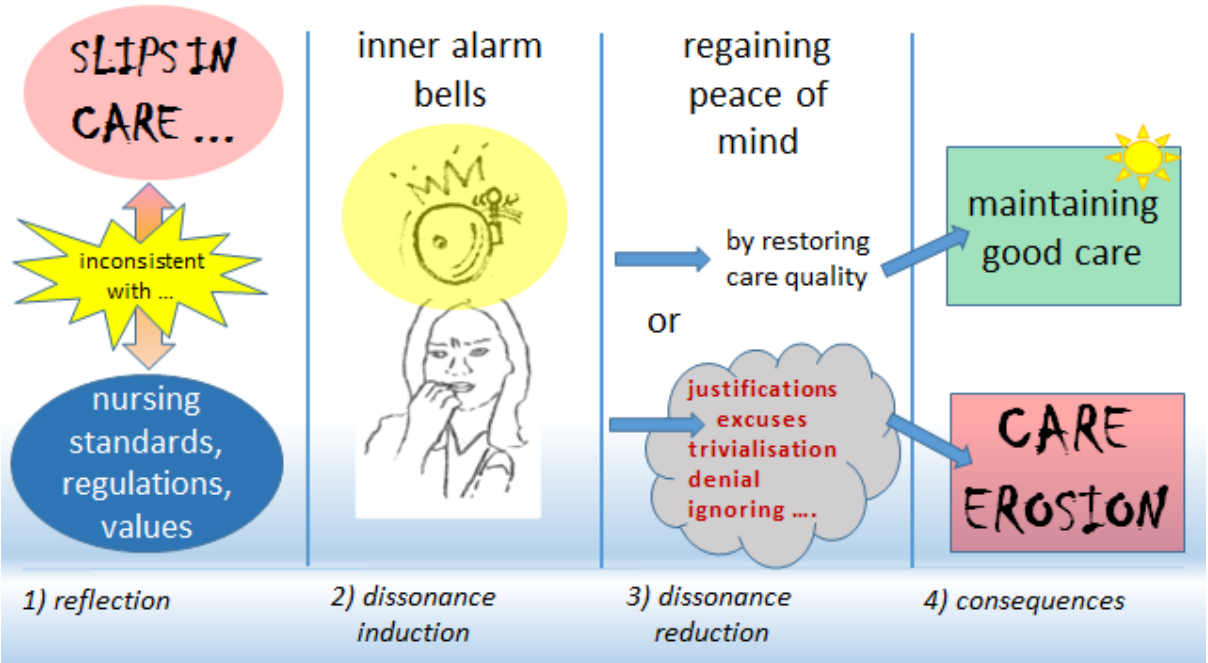
Role of reflection and cognitive dissonance in care erosion

If a nurse encounters or engages in substandard care, they may feel distressed, which motivates them to improve the care they provide, thus reducing their negative feelings. Being troubled or alarmed by substandard care is part of an internal regulatory process that can maintain high care standards. The psychosocial process behind this can be explained using cognitive dissonance theory (Festinger 1957, Cooper 2007). An individual experiences cognitive dissonance when there is incompatibility within and between their behaviours, thoughts and beliefs. This inner conflict, or 'dissonance discomfort', feels unpleasant and motivates the

individual to seek ways of reducing it, by changing their behaviours and/or thoughts, so that they become compatible again. Behaviours that are inconsistent with an individual's strongly held values, standards, or their perceptions of themselves as 'good' or intelligent are most likely to generate high levels of dissonance discomfort (Aronson 1969).

Figure 1 shows the process of how individual nurses might respond to errors, omissions, or substandard care, demonstrating how dissonance discomfort is induced and responded to, and its potential outcomes. Nurses' reflection on their practise should raise their awareness of errors or substandard care, for example forgetting to wash their hands, medication errors, unfinished tasks, failing to support a patient who is distressed, or other aspects of care that are inconsistent with nursing standards, regulations or values. This should usually result in dissonance discomfort being induced in the nurse and is expected to prompt them to correct errors or restore care standards. Thus, they attempt to reduce this dissonance discomfort and feel better. Simply making an effort to restore care standards will usually lead to effective care being maintained. However, if an error cannot be rectified or if it is too challenging to restore care standards, the nurse may seek alternative ways to reduce their dissonance discomfort, for example using denial, excuses, justifications, trivialisation or ignoring the issue.

Figure 1. Process of reflection and dissonance discomfort in response to errors or substandard care



Nurses might justify or find excuses for substandard care, deny that anything is wrong, deem it to be **low in priority or trivial** or ignore it. These ways of reducing dissonance **are often as**

effective as restoring care quality (Aronson 2004). The issue is that nurses may lose perspective on the quality of their care and they may no longer be aware when care standards are compromised or feel distressed by this. Consequently, care erosion will occur. Once care erosion has become widespread, it often becomes increasingly uncomfortable for nurses to reflect on the care they provide, because they may frequently observe errors and substandard care. At this point they might attempt to avoid reflection, which means it becomes increasingly challenging to reverse the occurrence of care erosion.

Prevention of care erosion

Once the process of care erosion is in motion, it is challenging to reverse; therefore, it is essential that nurses attempt to prevent it from occurring in the first place. As discussed in the first article of this series, nurses' awareness of the early signs of care erosion is important. However, its prevention in healthcare settings must involve maintained and systematic vigilance by all healthcare professionals and management staff.

Management and governance in healthcare settings often operate according to the belief that staff's behaviour can be managed and influenced by surveillance, auditing and detailed reporting on care activities (Busch 2012). Advances in technology can potentially generate transparency through CCTV (closed-circuit television) cameras, chip cards that document the whereabouts and activities of staff, equipment that self-monitors its use, and intelligent computerised reporting of care activities to create a hitherto impossible level of accountability. The idea that all intentional violations and acts of negligence could be eradicated through total transparency is not new, but technological advances are increasingly making it possible (Armellino et al 2011).

There are advantages and disadvantages of using increased surveillance to address the issue of care erosion. Research indicates that an individual's dissonance discomfort is increased if they know they will be publicly exposed for any negligence or errors in care (Gawronski and Strack 2012); thus, the fear of such public exposure and feelings of shame may be strong deterrents for providing substandard care. Crucially, it is not possible for a nurse to reduce their dissonance discomfort through denial when it has been objectively established through surveillance that substandard care has occurred. However, while the objective observation of clinical procedures and measurable tasks and activities is feasible, thus could benefit from enhanced surveillance and auditing, it is unlikely that hard-to-measure aspects of care such as kindness, patience, compassion, attentive listening, promoting dignity, and stress reduction activities can be improved through surveillance.

Besides, the more nurses learn to provide care in a particular way because of external pressures, the less they develop the motivation to perform optimal care for its own sake; their

intrinsic motivation (Benabou and Tirole 2003). Care activities that are difficult to measure may be devalued and are more often omitted as a result of this (Aiken et al 2012, Ball et al 2013). Therefore, it may be necessary for the prevention of care erosion to focus on the internal regulatory process of reflection, aiming to strengthen the awareness of this process, improve critical reflection on practise, and the increase of nurses' ability to prioritise maintaining optimal care, rather than using justifications, excuses, trivialisation, denial, and ignoring substandard care. The following four sections detail this approach.

Promoting reflection on practice

Reflecting on errors or substandard care is often unpleasant, and can result in the nurse feeling guilt, shame or discomfort. However, experiencing such negative feelings feeling in relation to substandard care ought to be seen as beneficial, because it will in most cases motivate efforts to address these issues and work towards providing optimal care. This message should be an essential part of nursing education, and in particular in teaching nurses about reflection on practise. If the process makes the nurse feel uncomfortable, it probably means they are reflecting critically and correctly, and instead of ceasing the process because of their negative feelings, the nurse should continue to analyse and understand what they can do to address the issue. Reflection has been advocated widely in the literature (Rolfe 2014) but exactly how to do it is a matter of debate (Jasper 2013).

When reflecting on the care provided, it is often advocated to compare one's performance with 6Cs of nursing (care, commitment, communication, compassion, competence, and courage) which each represent important values and standards for nurses (Cummings and Bennett 2012). However, to do this on a busy ward with a busy schedule is not easy. Without clear guidelines, reflection may be a confusing process for individual nurses, and as a result they may be overly focussed on the negative and positive feelings generated by the process and emphasise 'self-related' aspects, such as 'does this make me look good, intelligent, compassionate, or efficient.' And because we tend to favour positive over negative feelings, nurses may emphasise one over the other in their reflections. For instance, a nurse may experience dissonance discomfort about the lack of compassionate care they are providing but silence this discomfort by emphasising the competence that they feel because they completed their nursing tasks on time. As a result, they may not do anything about the lack of compassionate care they demonstrated.

This tendency is problematic and can only be overcome through methodical education on reflection. The method has to be simple and achievable not only in training, but also in routine nursing practise. Barriers to reflection include lack of times and individuals' limited attention span, meaning conscious focus on too many aspects at any one time is challenging. Simple aids,

such as laminated cards, could be used to improve focus. Technological approaches, such as the use of apps, could also be considered. Nonetheless, reflection will only be effective if it is part of nurses' daily routine and promoted by the healthcare organisation. It should be included in team meetings in which discussion is encouraged of aspects of daily practice nurses feel unhappy about. These are usually elements that have generated dissonance discomfort. The onus is on nurse educators and healthcare organisations to develop practical reflection tools that have a wide support base, promote optimal care, and avoid the pitfall of 'navel gazing' (Table 1).

Table 1. Interventions to address care erosion

	Individual nurses	Healthcare organisation	Nurse education
Reflection	• Daily • Maintain critical faculties during routine activities and when under pressure	• Support and promote reflection as a valuable activity • Engage with the process of reflection and its outcomes	• Methodical teaching of reflection • Secure active practice of skill • Address dissonance mechanism
Mastery of nursing care and skills	• Work towards excellence; Ensure recovery after errors Report near misses and substandard care	• Promote and reward excellence • Develop reporting Address issues related to routine and pressure	• Teach mastery of nursing care and skills • Sufficient practice of skills to achieve mastery
Strong nursing values and standards	• Regular reminders Resolve conflict between seemingly incompatible values and standards	• Communicate nursing values succinctly and regularly Prioritise standards clearly	• Teach values and their application Improve interface between education and clinical practice
Address justification, excuses, denial, trivialisation, ignoring	• Become aware of these mechanisms and how they lead to care erosion	• Remove all structural obstacles to optimal care • Provide training	• Generate awareness of mechanisms, justifications commonly used, and prevention

Achieving mastery of nursing skills and care

Nursing is a profession that requires learning in practice; often what is learned in practice is considered the most important aspect of nurse education. As a result, nursing values and standards of practice in hospitals and other healthcare settings remain the benchmark for nursing students in demonstrating their fitness to practise. Nurse education in the classroom may prepare students to have high expectations of themselves and ambition to excel as nurses, but their initiation and socialisation in practice placements is essential to develop the skills for safe and effective practice. If this initiation is inconsistent with the skills and values they have been taught in the classroom, this will be problematic for nursing students.

This can be a surprising and unpleasant experience for nursing students. Nursing students are rapidly socialised to adopt the practices undertaken in their placement settings, and will often internalise these practices. A common response by experienced nurses to nursing students' efforts to perform tasks in the way advocated during their education is 'this is not how we do things here' (Carroll and Quijada 2004). Since the nursing student or newly qualified nurse is inexperienced, practice standards will usually prevail over the values they have been taught during their nurse education in the classroom. And instead of feeling welcome for offering a fresh perspective (Francis 2015) they feel disappointed and conflicted. This may lead to a form of dissonance described as 'professional dissonance' (Crigger and Meek 2007). Critics have explained this issue as a clash between evidence-based practice and organisational cultures in which holding on to traditions prevails (Brown et al 2009). This is particularly problematic if care erosion is occurring in the practice setting. In such cases it is likely that newly qualified nurses or nursing students entering this environment will feel under pressure to accept substandard practice as the norm. It is crucial for nurse educators and healthcare organisations to work together to address this challenge; if they do not, care erosion will become embedded in many nursing students before they become registered nurses.

To strengthen nursing students' motivation to maintain high standards of practice, even in care environments in which this is under pressure, it is important that where possible mastery of nursing skills and care is achieved during nurse education. In particular, person-centred care and compassion can be developed to a high level through simulations and scenario-based learning. Of course, mastery during education needs to be matched by an organisational culture of excellence, which emphasises, draws attention to, and rewards all indications of excellence in practice. In environments where excellence and mastery of nursing skills and care are experienced, errors and decline in care standards will, by contrast, become more notable and shocking, thus leading to higher levels of dissonance discomfort if they occur. These higher levels of dissonance

discomfort are more likely to motivate behavioural correction rather than undesirable responses such as using justifications, excuses, denial, trivialisation and ignoring issues (Aronson 1969).

Establishing and supporting strong nursing values

Similar to the argument for excellence and mastery, cognitive dissonance theory also suggests that the stronger and more important a belief or value is to an individual, the stronger their dissonance discomfort will be if they undertake actions or behave in ways that violates this belief or value. Essentially, individuals will feel more shame, embarrassment, guilt, regret, remorse or other dissonance emotions if they violate strongly held beliefs and values. Furthermore, individuals will be more likely to avoid behaving in ways that are inconsistent with these values or beliefs. It follows, that it is important to ensure that nursing values are strongly internalised by nurses, rather than taught as abstract concepts. There is considerable concern that nurse educators may need to do more to ensure that nursing students adopt robust nursing values (Fisher 2014).

Strong values also determine how nurses prioritise practice. For instance, person-centred care and undertaking tasks efficiently are often incompatible. Without a strong person-centred value system, nurses would choose task completion over spending time with a patient to listen, relieve stress, or answer questions. It is necessary for nurses to receive signs that compassion is as important as efficiency and receive training in how to balance these seemingly irreconcilable principles; if they do not, compassionate care will erode.

For nursing values to be maintained, they should be part of daily conversations in hospitals and other healthcare settings. Unfortunately, values are often left implicit in team meetings, while task-oriented and clinical decision making are prioritised. Changing the discourse during these meetings is essential to emphasise the importance and relevance of nursing values. Nursing values can also be communicated using leaflets and posters on noticeboards. For instance, well-designed and frequently adapted poster displays can prompt values, standards and desired practice (Stewardson et al 2013). These type of reminders encourage nurses to become aware of occasions when they violate important regulations, values or standards (Aronson 2004) and be clear about how to improve their behaviour. Official documents on values, standards and regulations are rarely effective, because they are too extensive and often not written in the kind of language that individuals use when reflecting critically on their practise. In particular jargon and formal terminology do not help. Nurses, educators, and health care management should collaborate in the development of short and practical communications of important values and standards.

The big question is of course whether value based and person-centred care is possible in autocratic and hierarchical organizations which are in their core at odds with this ethos. If the

organisation can't resolve this issue, it is unavoidable that the obstacles to embrace principles of person-centred care will leave nurses feeling dissonant, frustrated and ultimately disillusioned. Unless educators and health care providers work in unison on this, the current drain from the profession of what may well be the most caring nurses will continue. A study by Aiken et al (2012) reported that 39% of nurses in England were dissatisfied with their jobs and 44% expressed a wish to leave the profession. Many of these nurses are young and conceivably looking for work in which they do not have to compromise their values, in which they are being listened to, and have more opportunities for advancement (Aiken et al 2012). If healthcare organisations operated in accordance with the values they purport to have adopted, this might improve nurse retention, and consequently achieve or maintain high care standards.

Addressing justifications, excuses, denial, trivialisation, and ignoring substandard care

As shown in Figure 1, the psychological precursors to care erosion are cognitive instead of behavioural ways of reducing dissonance when faced with sub-standard care. These can be sinister mechanisms, especially when nurses are only half aware of when they are using them. Blatant trivialisation, excuses, denial or looking the other way may not be so difficult to become aware of, but in reality this often manifests itself in subtle and deceptive format. Hence, detailed analysis of the arguments nurses tend to use to justify errors or substandard care is essential. This may protect them from using these justifications while being unaware of their effects. Nurses should critically examine common justifications, such as:

- There is not enough time.
- There are not enough members of staff.
- I can only focus on really important tasks.
- Others are doing this too.
- Most people do worse than I do.
- I cannot do any more than I do.
- If the organisation does not care, why should I?

There may be some truth to these arguments, since they might reflect the reality of what is occurring in the healthcare setting; this is often why such arguments are commonly used. For instance, a nurse might hear a colleague defend substandard care by saying 'there is just not enough time' and think 'this is so true', and when they provide substandard care themselves, they do the same, often without thinking about it. The authors fear that the process whereby nurses use these justifications may become automated and subsequently they cease to question their veracity (de Vries and Timmins 2016).

Nurse educators are well placed to address this issue. As part of nurse education on reflective practise, these justifications can be analysed and their merit can be debated using realistic examples and scenarios. Role play can be used to ensure that learning moves beyond theory. The teaching and learning sessions should include:

- Analysing situations in which justifications are valid or invalid
- Documenting inappropriate use of justifications.
- Exploring ways to report substandard care and other issues.
- Considering how to foresee time pressure and other structural limitations to optimal care.
- Taking steps to pre-empt issues relating to prioritising tasks and care and discuss solutions.
- Reporting recurring problems, infrastructural obstacles and 'accidents waiting to happen'.

Such preparation should enable nurses to be better equipped to address issues in which pressure leads to substandard care. It is essential to realise that nurses become part of the problem once they cease to report their concerns about time pressures, or cover up errors or substandard care, since they then lose their moral authority to protest against any work circumstances that make it challenging for them to provide optimal care. At this point, nurses become complicit in the occurrence of care erosion. In contrast, if nurses become fully aware of how to avoid the pathway to excuses, justifications, denial, trivialisation, and ignoring substandard care, and act accordingly, they become part of the solution.

In essence, healthcare organisations need to keep channels of communication open with their staff and respond to reported concerns to avoid the 'us and them' division that can result in diversion of blame away from themselves when things go wrong. Moreover, if healthcare organisations remove significant infrastructural and staffing barriers to the provision of optimal care, they will thereby ensure that these barriers are no longer an issue and therefore will cease to be used as justification for substandard care by health care staff. There is scope for discussions, perhaps in focus groups, to determine which common justifications are in use and establish whether (a) the organisation should take responsibility for addressing the causes of their use, and/or (b) individual staff should find ways of invalidating these justifications and stop using them. Such discussion should involve staff at every level in the organisation, from cleaning personnel to management.

Conclusion

Care erosion is a significant issue in healthcare, and once this process begins to occur, it is challenging to reverse. However, there are many steps that nurses can take to prevent care erosion and to respond effectively to the early signs of its development. Cognitive dissonance theory (Festinger 1957) can be used to understand the reasons why care erosion develops, and how it can be prevented or reduced. In our view, care erosion can be prevented by ensuring that

nurses (a) experience maximal dissonance in response to deficient care or slips in care; (b) optimise the likelihood that dissonance is reduced behaviourally by restoring care levels, and; (c) minimise the chance that cognitive mechanisms such as justifications, excuses, denial, trivialisation, and ignoring the problem become the response of choice to substandard care.

Individual nurses and other healthcare staff, healthcare organisations, and nurse educators have a shared responsibility in the occurrence of care erosion, and each should be aware of the ways it can be prevented. This paper has outlined four important ways of preventing care erosion in which each of the three parties have a role to play. *Critical reflection* is essential to ensure that inconsistencies between care levels and standards, regulations, and values are registered. Educators must ensure it is taught in a methodical way. Nurses and other staff need to practice it and organisations need to facilitate it. *Mastery of care activities*, particularly those prone to substandard execution greatly reduces the risk of slips, mistakes or care being missed. Educators need to teach to mastery, individual staff need to practice to mastery and organisations need to reward and promote excellence. Achieving commonly high levels of care will ensure that exceptions will be felt with high dissonance discomfort, which is the best guarantee that substandard care is avoided and if it happens will be responded to effectively. The same principles are at the basis of the need to develop *strong values* in health care setting. The stronger the values the stronger the dissonance a violation would generate and the higher the motivation to restore care. Finally, to *address justifications, excuses, denial, trivialisation, and ignoring substandard care is essential* because this is the main pitfall to be avoided in preventing care erosion. Health care organisations need to be aware of these dissonance reduction methods and take responsibility for addressing infrastructural and other causes that substantiate their use. Individual staff need to take responsibility for those justifications for deficient care that are most likely to advance the slippery slope to care erosion. Educators have an important role to play in introducing and discussing the mechanisms involved, as a way of 'inoculating' student nurses against unwittingly falling victim to their impact.

References

Adriaenssens J, De Gucht V, Maes S (2015) Determinants and prevalence of burnout in emergency nurses: a systematic review of 25 years of research. International Journal of Nursing Studies. 52, 2, 649-661.

Aiken LH, Sermeus W, Van den Heede K et al (2012) Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. BMJ. 344, e1717.

Armellino D, Hussain E, Schilling ME, Senicola W, Eichorn A, Dlugacz Y, Farber BF (2011) Using high-technology to enforce low-technology safety measures: the use of third-

party remote video auditing and real-time feedback in healthcare. Clinical Infectious Diseases. 21,54(1),1-7.

Aronson E (1969) The theory of cognitive dissonance: a current perspective. Advances in Experimental Social Psychology. 4, 1-34.

Aronson E (2004) The Social Animal. Ninth edition. Worth Publishers, New York NY.

Bakker AB, Killmer CH, Siegrist J et al (2000) Effort-reward imbalance and burnout among nurses. Journal of Advanced Nursing. 31, 4, 884-891.

Ball JE, Murrells T, Rafferty AM et al (2013) 'Care left undone' during nursing shifts: associations with workload and perceived quality of care. BMJ Quality and Safety. 23, 116-125.

Bénabou R, Tirole J (2003) Intrinsic and extrinsic motivation. The Review of Economic Studies. 70, 3, 489-520.

Brown CE, Wickline MA, Ecoff L, Glaser D (2009) Nursing practice, knowledge, attitudes and perceived barriers to evidence-based practice at an academic medical center. Journal of advanced nursing. 1, 65(2), 371-81.

Busch RS (2012) Healthcare fraud: auditing and detection guide. Second Edition. John Wiley & Sons, Hoboken NJ.

Cannon WB (1935) Stresses and strains of homeostasis. The American Journal of the Medical Sciences. 189, 1, 13-14.

Carroll JS, Quijada MA (2004) Redirecting traditional professional values to support safety: changing organisational culture in health care. Quality and Safety in Health Care.1,13 (suppl 2), ii16-21.

Cooper J (2007) Cognitive Dissonance: Fifty Years of a Classic Theory. SAGE Publications, London.

Crigger NJ, Meek VL (2007) Toward a theory of self-reconciliation following mistakes in nursing practice. Journal of Nursing Scholarship. 39, 2, 177-183.

Cummings J, Bennett V (2012) Compassion in Practice. Nursing, Midwifery and Care staff: Our Vision and Strategy. www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf (Last accessed: 14 July 2017.)

de Vries J, Timmins F (2016) Care erosion in hospitals: problems in reflective nursing practice and the role of cognitive dissonance. Nurse Education Today. 38, 5-8.

de Vries JMA, Timmins F (2017) Recognising and responding to care erosion: part 1. Nursing Standard. doi: 10.7748/ns.2017.e10785.

Dror OE (2014) The Cannon–Bard thalamic theory of emotions: a brief genealogy and reappraisal. Emotion Review. 6, 1, 13-20.

Festinger L (1957) A Theory of Cognitive Dissonance. Stanford University Press, Stanford CA.

Fisher M (2014) A comparison of professional value development among pre-licensure nursing students in associate degree, diploma, and bachelor of science in nursing programs. Nursing Education Perspectives. 35, 1, 37-42.

Francis R (2015) Freedom to Speak Up. An Independent Review into Creating an Open and Honest Reporting Culture in the NHS. (https://www.gov.uk/government/publications/sirrobert-francis-freedom-to-speak-up-review). Accessed on 7th October 2016.

Ganster DC, Rosen CC (2013) Work stress and employee health: a multidisciplinary review. Journal of Management. 39, 5, 1085-1122.

Gawronski B, Strack F (Eds) (2012) Cognitive Consistency: A Fundamental Principle in Social Cognition. The Guilford Press, New York NY.

Hall LH, Johnson J, Watt I et al (2016) Healthcare staff wellbeing, burnout, and patient safety: a systematic review. PLoS One. 11, 7, e0159015.

Hobfoll SE, Freedy J (1993) Conservation of resources: a general stress theory applied to burnout. In Schaufeli WB, Maslach C, Marek T (Eds) Series in Applied Psychology: Social Issues and Questions. Professional Burnout: Recent Developments in Theory and Research. Taylor & Francis, Philadelphia PA, 115-133.

Hutchison JS (2016) Scandals in health-care: their impact on health policy and nursing. Nursing Inquiry. 23, 1, 32-41.

Jameson D (2015) Persistent Burnout Theory of Chronic Fatigue Syndrome. peerj.com/preprints/860.pdf (Last accessed: 14 July 2017.)

Jasper M (2013) Beginning Reflective Practice. Second edition. Cengage Learning, Hampshire.

Leiter MP, Maslach C (2009) Nurse turnover: the mediating role of burnout. Journal of Nursing Management. 17, 3, 331-339.

Maslach C (2003) Burnout: The Cost of Caring. ISHK, Los Altos CA.

Maslach C, Schaufeli WB, Leiter MP (2001) Job burnout. Annual Review of Psychology. 52, 1, 397-422.

Rolfe G (2014) Rethinking reflective education: what would Dewey have done? Nurse Education Today. 34, 8, 1179-1183.

Schaufeli WB, Leiter MP, Maslach C (2009) Burnout: 35 years of research and practice. Career Development International. 14, 2, 204-220.

Selye H (1956) The Stress of Life. McGraw-Hill, New York NY.

Smith-Miller CA, Shaw-Kokot J, Curro B et al (2014) An integrative review: fatigue among nurses in acute care settings. The Journal of Nursing Administration. 44, 9, 487-494.

Stewardson AJ, Allegranzi B, Perneger TV et al (2013) Testing the WHO hand hygiene self-assessment framework for usability and reliability. The Journal of Hospital Infection. 83, 1, 30-35.

Timmins F, De Vries JM (2014) Nurses are not bystanders: a response to Paley. Nurse Education Today. 34, 10, 1269-1271.