KF

PROJECT PAPER

Number 52

Joint clinical-teaching appointments in nursing

A report of peer group meetings 1982-84

nd for London is an independent charity founded in 1897 and incorporated by Act of Parliament. It seeks to encourage good practice and innovation in health care through research, experiment, education and direct grants.

The King's Fund Centre was established in 1963 to provide an information service and a forum for discussion of hospital problems and for the advancement of inquiry, experiment and the formation of new ideas. The Centre now has a broader interest in problems of health and related social care and its permanent accommodation in Camden Town has excellent facilities for conferences and meetings.

JOINT CLINICAL-TEACHING APPOINTMENTS IN NURSING

A report of peer group meetings

1982—84

King's Fund Centre

Typeset by Prototype, Kenton, Harrow
Printed by G S Litho, London

King's Fund Publishing Office
126 Albert Street
London NW1 7NF

Foreword

A number of joint nurse clinical-teaching appointments have been created over the years and a number of different types of approach have been pursued. Diverse views exist about the value, feasibility and acceptability of these posts but little or no evaluation has been carried out in a formal sense. With this in mind a peer group met at the King's Fund Centre with the idea of getting a general picture of the situation and to try to find out how this particular way of working can help in the improvement of nurse education.

The group process was enormously valuable in helping individuals to see aspects of their jobs in a new light and as a supportive mechanism when considering the very real difficulties involved in their roles. This project paper highlights the results of this voyage of discovery. It is hoped that it will prove a worthwhile basis for those considering setting up similar appointments.

Hazel O Allen
Associate Director
King's Fund Centre

Contents

1

Introduction

This publication has evolved from a peer group of nurses who have worked in the role of nurse teacher while combining it with clinical responsibilities, and researchers interested in observing such roles.

Despite widespread interest, joint clinical-teaching appointments are relatively few in number and geographically dispersed. The peer group was established in 1982, and has met periodically at the King's Fund Centre in order that participants could learn from each other how they managed their complex jobs, and benefit from each others' experiences. In so doing, it was recognised that others might also gain something from reading about these collective experiences, since the literature to date has tended to focus on individual attempts to create and sustain new appointments. The process may have yielded something both richer yet tempered by multiple perspectives.

Membership of the peer group was *ad hoc*. Some invited joint appointees preferred not to become involved and so we cannot vouch for the representativeness of the group. Nevertheless we discovered, even within our small group, an enormous diversity of settings and administrative arrangements, united by a similarity of purpose in the education of nurses.

We would like to express our warm appreciation to King Edward's Hospital Fund for London, and particularly to Miss Hazel Allen, Assistant Director at King's Fund Centre, who provided the facilities and resources for us to meet, sometimes acted as our mentor, and encouraged us to produce this paper. At some of our meetings we also benefited from the advice of Dr James Kilty, Department of Health Education, University of Surrey.

For all of us these meetings were stimulating and sustaining. The group process itself was of enormous value in sharing, analysing and understanding each others' experiences, and coming to terms with what might be possible.

2

Joint clinical-teaching appointments: a current appraisal

'Tutors need clinical involvement if their teaching is to be relevant – joint appointments between the school and the service authority would be a means of achieving this; such appointments should also contribute to high standards of clinical practice.'
(Dame Catherine Hall, First Kathleen A Raven Lecture, 1983)

'In my view, it is impossible to be a teacher of *nursing* unless one is also a practitioner in nursing. . . It is not possible to be an expert nurse across a range of specialities.'
(Billie Thomson, RCN Association of Nursing Education Conference, 1982)

'we suggest that joint appointments between the schools of nursing and the nursing service could be developed with benefit to both nursing education and patient care'
(Royal Commission on the NHS, 1979, para 13.43)

'It seems to us that joint appointments between service and education have several advantages: they enable the teacher to keep in touch with clinical work and to avoid a too theoretical "classroom" approach to teaching; the nurse who is interested in teaching but does not want to give up her clinical work need not do so; and the more attractive salary scales at present available to the tutorial grades might be open to the nurse interested in clinical work who wished to improve her career prospects. . . we recommend that developments in joint appointments between schools of nursing and the service should be vigorously pursued. We envisage that this role could combine clinical research and teaching, and it could be seen as an expansion of the clinical teacher's role or as specialisation within the nursing officer role. In addition we consider it important that full-time clinical nurses should receive adequate training for their teaching role, and should be encouraged, say by honorary appointments or attachments to nursing schools, to pursue it.'
(Royal Commission on the NHS, 1979, para 13.55)

These recommendations indicate that joint appointments may take a number of forms, may contain different emphases, and might be expected to produce a range of effects.

Strangely, while making such a firm recommendation, little evidence apart from that of joint appointees themselves has appeared, and their development has been slow and uneven. It is unlikely that even one per cent of nurses engaged as teachers have clinical responsibilities.

Those advocating joint appointments are concerned with the quality of nurse education and,

in particular, the problem of how theory and practice in nursing can be integrated. This is an important and vexing question for nursing today. It is also a complex one containing a number of interpretations of what is meant by 'theory' and by 'practice'.

Theory in nursing may be identified as the school or college where nurses receive part of their education, the subject matter which students are taught in these educational establishments, and the best form of patient care indicated by research and other kinds of literature. Practice, in turn, means the clinical areas where nursing is done, the nursing that students experience in these clinical areas, and the care actually provided to patients. These meanings shade imperceptibly one into the other. They are used here to indicate that while theory and practice are most often used in the sense of pointing up a separation between what nursing students are formally taught in the classroom and what they observe, experience and are taught as nursing in their clinical placements, such tensions between theory and practice also exist in other closely related features of nursing.

University-NHS appointments

The impetus to introduce joint clinical-teaching appointments in the United Kingdom began in university nursing departments. This was a result of the marked physical and social separation of formal education from the clinical areas where students learned nursing. It was also in the belief that nurse lecturers should also be expert and knowledgeable nurses in order to teach students. The University of Edinburgh scheme began in 1969 with two nursing lecturers also holding appointments as nursing officers, one in a medical unit and the other in a surgical unit in two hospitals in Lothian Region. While the job descriptions were the same as those of other nursing officers, the number of wards for which they were managerially responsible was reduced, and they had, in addition, clinical teaching commitments with university students in whichever units in the hospital the students were allocated. The job expectations for the university lecturer were the same as for all university lecturers, that is, to participate in the teaching of graduate and undergraduate nurses, undertake research and publication, and participate in the usual course development monitoring and examination work of the university. Billie Thomson, one of these early joint appointees, lists as the main components of the job, or indeed the seven jobs, as:

1 undergraduate and postgraduate teacher;

2 unit manager;

3 staff developer;

4 clinical teacher;

5 nurse researcher;

6 standard setter;

7 liaison officer between the university and the NHS.

The two joint appointment posts were each filled in succession by two appointees before they were abandoned in 1975 because the workload was impossible to manage. However, as Billie Thomson notes, when her job was redefined to remove administrative responsibility for the wards, she no longer had the same right to work within the hospital system, and subsequent access depended on the good relationships with hospital colleagues developed when she had her administrative role. She advocated a continued move towards joint appointments as long as the job elements were circumscribed and there were adequate support staff and services. Interest in and commitment to the idea of joint appointments continued in

Edinburgh. The lessons learned from these initial appointments were used constructively by the University and the Health Board in setting up the current health visitor joint appointment there. No hospital joint appointments currently exist however, although some lecturers have honorary contracts with health authorities and are involved in clinical roles.

The second university appointments followed a different model entirely. These were established between the Nursing Department at the University of Manchester and Manchester Royal Infirmary in 1976. The objectives originally stated for the establishment of a professorial nursing unit (ward) under the immediate charge of two nurses holding joint university/service appointments were as follows:

1 The establishment of a base for clinical practice for the Department of Nursing, giving it credibility in the eyes of students, medical and nursing staff and the public.

2 The establishment and evaluation of joint appointments between the National Health Service and the University Department, so that the teaching of the Department is based on realistic practice.

3 The testing of approaches to the management of nursing care taught in the Department through, for example, the use of the nursing process.

4 Testing the 'interface' between medical and nursing practice in decision making about care.

5 Providing a setting in which clinical nursing methods can be tested.

As part of the nursing service in the Manchester Royal Infirmary the unit was later required to state its objectives, as were other clinical areas. To the above objectives were added the two general aims of:

1 Providing the patients the highest quality of nursing care which is possible within available resources.

2 Promoting the professional development of nurses working in the unit.

(Ashworth and Castledine 1980)

Two nursing lecturers, Pat Ashworth and George Castledine, assumed the joint roles of sister/charge nurse in one orthopaedic/trauma ward and clinical lecturer. As part of their responsibilities they introduced new ways of organising ward work and patient care, including methods of documentation and care planning. Their personal experiences were published in 1980 and this joint appointment terminated after 2½ years. However, the idea of the sister/clinical lecturer was retained and Castledine moved with a new partner to a different kind of ward to continue the scheme which is again under review.

There is a second continuing single person joint appointment at Manchester in midwifery. As at Edinburgh, and other university and polytechnic nursing departments, resources are insufficient to enable all nursing lecturers to have clinical responsibilities and, of course, some do not wish to have them.

The university-NHS schemes in the United Kingdom have incorporated ideas from similar types of appointment in the United States where university nursing courses were established long before their British counterparts. Some of these joint appointments occur at senior hospital administrative levels (Pierick 1973) as well as at clinical levels. However Powers (1976) noted some reluctance among nurses educated to doctoral level to assume roles in

clinical practice and, because the roles demand both experience in teaching and experience in practice, 'incumbents, at least for the present, will constitute a very select group'. Of course those willing to experiment in any new role are likely to be atypical of the rank and file and it is important to bear this in mind when reading of the achievements and problems of the joint appointees who formed the peer group discussed in this project paper.

NHS nursing school-hospital appointments

Joint appointments were subsequently created between NHS schools of nursing and particular hospital wards. Some of the reasons for advocating such appointments are similar to those for the universities. The background to these appointments is best appreciated by considering the problems created for learners and teachers by the theory/practice gap. Ideally what students are formally taught about nursing should correspond to the nursing they observe, and there should be a close time sequence between nursing as formally taught in school and nursing as observed in the clinical setting. Research evidence indicates that even at this level of theory/practice integration, all is not well. The literature is replete with examples of students commenting on the differences between classroom and ward practices (for example, Gott 1984, Birch 1972), and Abdel-Al (1975) found 'theory and practice unrelated in terms of administration, time sequence, distribution of content and sometimes of principles'. Bendall (1975) noted that a discrepancy existed between what students wrote in response to questions about practice and what they actually did in the wards.

While modular systems of organising training schemes have improved the time sequence and relationship between what nurses learn in class and their clinical placements, the experience available to students may bear little relationship to the titular speciality of the ward (Roper 1976). Students also require opportunities to learn from their experiences, and Alexander (1983) noted that they were often unable to recognise learning opportunities or benefit from them. Of course, while students are in clinical placements they are also an important part of the workforce providing a service. Young (1983) found a worryingly high percentage of learners felt that they had just been a 'pair of hands'. Since at least 80 per cent of a training course is spent in this way, the importance of students' clinical experience, if time is a criterion, is enormous. In this sense, nursing students are similar to apprentices, but as Melia (1983) noted, apprentices spend the majority of their training with an experienced tradesman and for lengthy periods. Student nurses work mostly with nursing auxiliaries and other students (that is, unqualified members of staff), or with staff nurses who may themselves only recently have qualified, and they change locations regularly. Lewin and Leach (1983) found student nurses reported that less than 10 per cent of their work was supervised by qualified nurses, and Alexander (1983) and Young (1983) noted that opportunities to pair students with qualified staff were not used. Yet as both Martin (1973) and Melia (1983) have noted, it is hospital work which dominates the student nurses' experience.

Of course this position places emphasis on the regular clinical staff to act as teachers of nursing, a role they may never have been prepared for, for which they may find little time or aptitude, and for which they are not remunerated. The role of the ward sister is complex (Pembrey 1980, Lewin and Leach 1983, Young 1983, Runciman 1983) and, after all, others are employed specifically to educate student nurses. Nevertheless, the Report of the Committee on Nursing (1972) advocated that ward sisters ought to teach relevant nursing subjects in schools of nursing.

Nursing officers, a grade advocated by the Royal Commission on the NHS for joint appointments, while suggesting clinical teaching and supervision to be appropriate activities, themselves undertake few of these activities (Lewin and Leach 1983, Jones et al 1981).

Just as sisters and nursing officers rarely teach in schools, so nurse tutors are rarely seen or teach in clinical areas. Young (1983) recently reported that the majority of staff in some group schools felt liaison between school and service to be unsatisfactory, with the virtual seclusion of nurse tutors in schools of nursing and ward sisters in their hospital settings. Only 13 per cent of students questioned by Lewin and Leach (1983) had been visited by a tutor on their last clinical placement, let alone worked with one. Ninety-one per cent of students in Alexander's (1983) study had never received ward tutorials, yet the large majority of tutors regarded teaching in the ward as a legitimate part of their role (Alexander 1983, Lewin and Leach 1983). Abdel-Al (1975) and Gott (1984) found tutors did not have time to teach in the ward because of their own commitments, including the organisation of work in school. Of course, many teachers of nursing are generic, in the sense that they teach nursing across a wide subject range, allowing no clinical specialisation and encouraging a dwindling of clinical competence.

The grade of clinical nurse teacher was created to compensate for the shortage of nurse tutors *and* to provide a teaching input in clinical placements. However when empirical data are examined, students report low levels of working with clinical teachers on the wards (Young 1983, Lewin and Leach 1983). Indeed, both these studies found that clinical teachers spent less than half their time on the wards. Some were asked to do classroom teaching, and Lewin and Leach (1983) comment that one factor hindering ward teaching was poor relationships between clinical teachers and ward staff. Some recent attempts to improve the quality of nurse education by integrating theory and practice have created identical roles for nurse tutors and clinical teachers (Taylor 1979, Alexander 1983) when substantial amounts of teaching during school-allocated times has taken place on the wards. In many instances the role of clinical teacher is but a stepping stone towards becoming a nurse tutor, and Kirkwood (1979) questioned the distinctiveness of a clinical teacher role. The continued usefulness of two nurse teacher roles is clearly questionable.

The creation of joint clinical-teaching appointments can be regarded as one potential answer to bridging the theory/practice gap. Other attempts have placed greater emphasis on the role of the permanent ward staff to create better learning environments (Fretwell 1983) and by temporarily releasing staff nurses from clinical responsibilities to assume a full-time clinical teaching role in their own units (Neimz and Bond 1984). Alexander (1983) and Kelly (1980) have shown the advantages to be gained by teaching nursing during periods allocated to 'blocks' in clinical settings rather than in the classroom. This ward-based teaching is patient centred, and designed specifically to facilitate the integration of theory and practice by using note taking in a 'nursing care plan' format, by individualising patient care and using patient-oriented rather than task-oriented assignments (Alexander 1983). These attempts, while involving major changes of attitude and behaviour, are less drastic than the creation of a new style of appointment, which, by its nature, bridges school and ward, involves educational and service management and demands flexibility of time and presence to fulfill both clinical responsibilities and formal teaching responsibilities. Indeed the major innovation in joint clinical-teaching appointments is that their is a continued clinical responsibility and not merely a clinical presence for educational purposes.

In this sense, joint clinical-teaching appointments already exist in the practical work teacher and fieldwork teacher roles in district nursing and health visiting respectively. As far as can be ascertained, these practising teachers have minor responsibility for the theoretical teaching of the practice of district nursing or health visiting in colleges and universities where the courses are held. Far less attention has been devoted to the relationship of theory to practice in continuing nurse education.

3

Variations on a theme

The term joint appointment encompasses a number of variants which have two things in common. First, the appointee has responsibility for the care of patients or clients with its attendant authority and accountability, and second, the appointee has formal teaching responsibilities. Beyond this, and in terms of how these responsibilities are met, variations occur depending on the role assumed by the appointee and the setting in which the appointee works.

Differences occur depending on whether the clinical element of the role is invested in ward sister/charge nurse responsibilities (hereafter referred to as sister irrespective of gender), or, in the case of community placement, that of fieldwork level health visitor; or whether the role is that of nursing officer or clinical specialist or primary nurse. Ward sisters' clinical responsibility is confined to patients allocated to a particular ward and health visitors' responsibility to a caseload determined by general practitioner attachment or geography; nursing officers have a responsibility over patients in a number of wards *and* work *through* ward sisters to influence patient care. Similarly, a joint appointee in a clinical specialist role has responsibility not only for some aspects of the care of a defined patient group but also works with and through ward sisters as well as other staff, and may do so in a variety of settings, such as outpatient departments and community locations as well as hospital wards. The clinical responsibilities of all hospital appointees are confined to single specialties (for example, orthopaedic surgery) or sub-specialties (for example, paediatric oncology).

All the joint appointees have clinical teaching responsibilities, in some cases confined to the ward or clients to which they are appointed, in others spread across a number of wards, but always limited to the specialty in which they have their clinical role. This means that whilst all appointees teach learners in the setting where they have clinical responsibilities, it may also happen – as in the case of usual 'visiting' clinical teacher – that they teach learners in areas where they have no clinical responsibilities.

A major variation is the number of persons involved. Joint appointments may consist of two people both occupying clinical and teaching roles in a defined clinical area, or one person with a split role. The ward sister type roles in our group are of the two person variety, and although one member of this duo always possesses a teaching qualification – whether as registered nurse tutor or registered clinical nurse teacher – the second member is not always qualified for teaching beyond City and Guilds course 730 preparation. In some cases this influences whether this person is also involved in teaching in the school of nursing. The single person roles apply to the health visitor, nursing officer and clinical nurse specialist roles, and in each case this person has a teaching qualification or, in the case of the health visitor, is an appointed university lecturer.

The financing of appointments varies. Examples are shown in the table in Appendix A. In some instances costs are fully shared between the service and education budgets. In other cases, especially when the appointments have been established as short term 'experimental' schemes, the education budget has met the costs. As far as our group was concerned, the financial aspects of the appointment have featured little, but it is conceivable that salary differences between sisters, clinical teachers and tutors, allocated to individuals occupying very similar roles, could create friction, as could service paid staff able to claim weekend and special duty payments.

While salary differences were said to be of little importance, status differences between the partners in a joint appointment were important and were cited as a potential source of friction. These differences may be attributable to differences in experience, in perceived seniority of one partner over another, or the unequal distribution of valued work. In part, status inequalities which are unacceptable to appointees stem from a failure to mutually agree role definition, either according to institutional requirements or on the basis of maximising available skills. Where status differences are not accepted, they can create tension which, if not resolved, can lead to conflict and the eventual breakdown of working relationships.

Other differences are not so much matters of administrative or social structure, but derive from the reasons the appointments were established, the interests of the appointees themselves and the circumstances in which the appointees work. Any description of joint appointments must take into account their dynamic nature. The appointees in our group did not step into an already established role or one they had attempted in another setting; they were in the process of role making, and were therefore obliged to adjust to existing circumstances as well as to circumstances they themselves created.

Differences in the aims and responsibilities of joint appointments tended to be in terms of relative emphasis rather than absolutes, although some elements are particular to some appointments. Appendix A shows the range of clinical and education responsibilities. For all group members a major responsibility was teaching students. In some instances a second main emphasis was on clinical innovations, so that time had to be created to facilitate this. Sometimes the improvement of the quality of care lay behind the creation of the joint appointment, so that inservice 'remedial' education of existing staff was a major work component. Some joint appointees saw the generalised continuing education of qualified staff as their responsibility, while others confined their interests to emphasising the teaching role of permanent staff with learners.

While none of the joint appointments was established for more than two years, their dynamic nature was evident from the way that priorities had to be established and constantly reviewed as some tasks were completed and new ones emerged. This was particularly the case when there were target innovations – nursing care plans, information booklets, patient allocation systems, pairing learners with trained staff – which, once established, left time and energy for another step forward. This kind of dynamism characterised all of the joint appointments but may be more a feature of the kind of nurses who will step into an experimental role than of the basic requirements of the job. Nevertheless the different emphases created endless variation.

4

What do joint appointees do?

A listing of components gleaned from formal job descriptions is given in Appendix A. Some of these are discussed here in relation to how the appointees did their work and what was expected of them.

Teaching and learning

The major thrust of joint appointments is towards improving nurse education. This is being attempted in a number of different but complementary ways. The first is the idea that students learn nursing by observing and modelling their behaviour on others. The joint appointee with an emphasis on teaching as well as clinical work is well placed as a role model. This necessitates increasing the time joint appointees spend with students – more so than average sisters – both in clinical demonstration and other methods of ward teaching. It also means increasing the amount of time learners spend working with other qualified members of staff, rather than with other students or with nursing auxiliaries. In some cases this has been achieved by introducing a pairing system, attaching each learner to a qualified member of staff – student allocation mirroring patient allocation.

For the joint appointees to make time to work with students, as well as for other members of staff to take on educational functions, it is necessary to exercise the managerial role of the ward sister. When the joint appointee is engaged in educational work, this creates opportunities for staff nurses to carry out some of the functions of the ward sister, thus extending and enhancing the staff nurse role. These achievements involve staff development work with other qualified staff.

Other ways of maximising the time joint appointees spend with learners include allocating all students during their training to the ward with two joint appointees; joint appointees conducting clinical teaching sessions as part of formal block educational time; and clinical teacher joint appointees reducing the hours spent teaching in school – sometimes drastically – to work more hours on the ward combining their clinical and teaching roles.

On the whole, this means improving the learning environment of the clinical setting, not only by making learning opportunities explicit and involving all qualified staff in teaching roles, but also by paying attention to the quality of relationships between all kinds of staff. In some cases this has resulted in developing weekly case conferences, combining their advantages for patient welfare with an educational opportunity for learners and other staff. By becoming a member of the ward team the teacher, while remaining in a senior role as the ward sister, removes the threat to learners of being 'examined' as compared with being 'taught', as well as providing them with feedback about how well they are learning.

The inclusion into the ward team is, of course, a major asset of the joint appointments. The sister appointee is no longer a 'guest' teacher in a clinical area where clinical authority is invested in others, but has the rights and obligations afforded to other sisters. The peer group felt that this had implications for students who were also there in more of a joint-role themselves – as important and integrated members of the work force but also as learners they were involved in sharing patient care and in so doing were learning about that care.

Joint appointees also extended the range of situations in which learners learn, for example, by including attendance at the outpatient clinics associated with the ward to which the student is attached. The university nursing students have begun a programme of visits to the elderly in their own homes, to day centres and local authority accommodation, as well as to other organisations with a special interest in the elderly. Extending the range of learning situations is intended to broaden learners' perspective on health care as well as to challenge their views of the elderly and the contribution of nursing and other organisations to their care.

While such extensions could occur, and probably do, without joint appointments, the range of innovations and the linking of theory and practice appears more encompassing when a clinical perspective is prominent in an education programme. This is most obvious when the joint appointees have taken sole or major responsisility for developing and teaching the module associated with the specialty in which they work. This necessitates greatly reducing their input to other educational modules. They are reducing inputs into other blocks where they would have to teach subjects other than clinical nursing (which can be done by people other than nurses) or to teach nursing with an abstract rather than a directly applied emphasis. When joint appointees teach in the classroom they are able to do so from their current clinical experience, relating the content of their teaching to current patient care. In this way they are specialising by optimising teaching from their current clinical knowledge. This not only brings a vividness to teaching, but renders the clinical setting and patient care as the reality from which teaching statements are made. This is important when the joint appointment ward functions under the same physical and staffing constraints as other wards.

For joint appointees to have responsibility for the relevant modules depends on the size of the school. In very large schools there will be a number of specialist teachers; in small schools teachers are more likely to be asked to teach a range of subjects. The appointees here found that it made sense to concentrate on teaching the clinical subjects with which they were familiar. They could therefore do much of their teaching in their own clinical areas using patient-centred methods, and this was welcomed by the students.

Broader educational functions are also part of the joint appointees' role. Curriculum development is perenially taking place in schools, and some joint appointees contribute substantially to this, bringing their own perspective, broadening the emphasis and devising feasible learning objectives based on clinical experience as well as educational theory. It is not only in development work that joint appointees spend time in the school. Like their other teacher colleagues they carry the same responsibilities for setting and marking tests and projects, as personal tutor to a number of students, and in carrying out the administrative functions of their educational role.

Standards of patient care

In some instances the appointment(s) were created in specific units or wards because the standard of care was recognised as inadequate and it was believed that, by changing the

leadership roles, the quality of care could be improved. While the major emphasis in setting up joint appointments has been in improving student and pupil nurse education, the issue of improving patient care has meant that the education of qualified staff and nursing anxiliaries has emerged as an associated concern. Therefore, for some appointments, improving the quality of care has been a critical reason behind their staff development roles in addition to their learner-centred work. When attention is given to the education of permanent staff, they, in turn, adopt a more obvious educational role with learners.

Becoming a troubleshooter and being deliberately placed in a setting to improve standards does, of course, create additional work in order to provide a safe patient environment and also a valuable learning environment.

Introducing new approaches

'Change is not the monopoly of joint-appointees' said one of our members. Yet there were expectations that the *status quo* would be changed and new methods of working introduced. This has happened in some instances when joint appointees have pioneered patient allocation, primary nursing, and elements of the nursing process, by introducing new forms of care planning. In this they have served as leaders in their hospitals and have been used as a resource for other members of staff in other wards. While in some cases this was expected by managers as a consequence of the joint appointments, in others it was due to the appointees themselves. As teachers they deliberately chose this role and promoted joint appointments in order to make the changes in clinical practice they regarded as a necessary prerequisite for effective nurse education. In this respect joint appointees are change agents in clinical practice.

The amount of clinical innovation possible depends in part on the role adopted by the joint appointee. Those who had sister type appointments, spending up to half their time in this capacity with another joint-appointee of similar outlook, found they were able to achieve a great deal in a relatively short period. The more the role moved away from the direct and shared responsibilities of the ward sister, the less the appointee was able to innovate in the same time period. This was because ward policies and practices remained the responsibility of the existing ward sister(s). In this way the jointness of joint appointments applies not only to dual clinical and teaching roles, but to the sharing of ideas and methods with those in a position to enact them. When joint appointees of the two person variety shared ideas and could reach agreement on ways of achieving them, then clinical innovation was successful. When this was not the case, or when the joint appointee was not in a position with overall or equally shared clinical authority, then their powers to innovate were accordingly fewer.

Some other functions

As suggested earlier, those embarking on new roles are atypical – they take risks, they demonstrate missionary zeal. They, as individuals, stand up to be counted, and not only as they portray the new role into which they have chosen to pour their very considerable energies. Because they are innovators they are often called upon, by their employing authorities and beyond, in excess of the narrower and necessary requirements of the job. Thus some become involved in advising on policy developments in their specialty, not only locally but at national level. Some take on remedial work with permanent staff who are operating in ways prejudicial to patient safety and staff welfare. Some become resources to be drawn on to assist in introducing other innovations in their hospitals.

Creating and broadening links between their ward and the community resources, professional

and lay, which support their patients and their families has been important. Indeed, forging community links and crossing professional/self-help boundaries has been a major thrust of some achievements while the joint appointment has been developing – again demonstrating a breadth of approach which demolishes not only the boundaries between education and service but the boundaries between the professional and the layman.

5

Joint appointments from the perspective of the learners

Throughout the duration of the joint appointments described in this project paper, attempts were made in different ways to assess the reactions of learners to this type of supervision. Some of these attempts were purely informal, consisting of discussions amongst teaching staff and between staff and learners about the benefits and disadvantages of a joint appointment. Other appointees undertook more systematic methods of evaluation, particularly in cases where the job description contained a research brief, and devised short questionnaires for learners to complete. In one case a controlled study was mounted to measure learners' opinions. This chapter is based on this widely differing material from different sources, and will focus on the common themes that emerge from an incomplete, but wide-ranging, picture.

Very little, in fact, has previously been documented about the philosophy and practice of joint appointments, and nurse learners have mixed expectations when embarking on a period of experience supervised by such appointments. Preparation from the joint appointees may simply be verbal, or it may be backed up with information given to each learner in booklet form. And, of course, the contact with peers who have experienced supervision by joint appointees at first hand must be an important factor in influencing the learners' expectations.

Some expectations are not confirmed by learners' actual experience, and two notable misconceptions commonly appear in reports of learners' comments. The first is, no doubt because of the additional educational input, that learners tend to expect an increase in theoretical work and tutorial teaching. It appears that they characterise education as a formal process, and are surprised to find very little increase in formal tuition in a joint appointment area. In fact, appointees up and down the country are agreed that what they are trying to achieve is, rather, an 'enriched learning environment' where learning takes place side by side with work, and occurs at every possible level. The evidence indicates that although learners may feel they have achieved much in terms of their training as a nurse, they are less likely to realise that they have encountered much additional 'teaching' on a joint appointment ward.

A second misconception which often accompanies the arrival of a new learner to a joint appointment area is that the presence of a teacher will mean additional and unwelcome supervision, and that 'someone will be watching every move'. In practice, most have found that they have been allowed to develop at their own pace, but have appreciated someone to answer questions and give guidance. The kind of supervision which is commonly received is well expressed in the following comment: 'X ward stands out. I've been encouraged to ask questions and at the same time to realise that staff can't look after you all the time.' These

two common misconceptions, then, seem to indicate that the context of opinion in which joint appointees arrive is one in which teaching is regarded as a formal process, and supervision is regarded as having a largely evaluative function.

The material contained in this chapter is gathered almost entirely from learners working on hospital wards, and the concept of the 'enriched ward learning environment' is a key feature of the learning experience gained on these wards. Although the wards referred to are many hundreds of miles apart, the learner voices from very different hospitals are strikingly similar. The most frequently uttered comment of appreciation concerns the working environment of the ward, which is usually described as 'a relaxed and friendly atmosphere where staff treat you as an equal'. This highly valued phenomenon, an egalitarian working atmosphere, is exemplified by many different ways in which the learner feels her status to be enhanced in a joint appointment area. Again, these different ways are echoed in similar comments from one end of the country to the other.

The following three quotes illustrate particular practices which are characteristic:

> 'it seems that all ward staff have more opportunity to suggest changes in patient care and ward planning';
>
> 'you are encouraged to ask questions and not made to look a fool when you don't know the answers';
>
> 'you are encouraged to talk with patients and with relatives, and don't have to give the appearance of keeping busy'.

There also seems to be a common tendency to adopt a constructively critical approach to the learner, with the emphasis on praise where it is merited, and this is reflected in the increased confidence the learners show. 'I matured on X ward' is a comment frequently heard, although learners may be at any stage of training when they pass through one of the joint appointment wards in our sample.

All joint appointees, too, are united in their commitment to the use of the nursing process, with its emphasis on individualised patient care, and, by implication, the encouragement of individual initiative on the part of the nurse, and this is clearly a further factor in contributing to an egalitarian, patient-oriented atmosphere. These elements of the learning environment can, however, create problems for learners and, indeed, staff, who are more accustomed to a task-oriented hospital routine with a greater emphasis on carrying out the orders of superiors. Some learners have found the process of adaptation to be difficult and fraught with anxiety as they find themselves in a situation where perhaps their duties are not quite so clearly defined as they would like them to be. And whilst the majority of learners consider the nursing care they have learned in a joint appointment area to be of a higher quality than elsewhere, there are those who feel that it is no better. Interestingly, the problems associated with working for 'two bosses' feature less strongly in the comments of learners than in the comments of trained staff and nurse managers. Divided loyalties seem more to be a matter of anxiety to learners which is usually, although not always, dispelled by experience.

The comparison with other areas, in fact, presents a problem in itself. Learners often express feelings of ambivalence because the singling out of one ward for educational innovation implies a criticism of other wards. The joint appointment ward is felt to be receiving 'special treatment', and is therefore privileged. This attitude prevails most noticeably when learner groups are split between the joint appointment ward and some other equivalent ward in the

same unit. In practice, one of the joint appointees will usually have clinical teaching responsibilities which would take in this other ward, and so learners are exposed to the same philosophies and concepts of patient care. However, they still seem to feel that their learning experience has not been as privileged as that of learners working in the joint appointment ward, which perhaps reveals a greater understanding of the concept of the 'enriched ward learning environment' than is immediately apparent among learners.

Because a ward-based joint appointment usually includes some formal teaching responsibilities, it happens that perhaps one of the appointees will encounter learners not only on the ward, but also at subsequent stages in training. It has therefore been possible for appointees to listen to the conclusions which learners have drawn about the value of their experience on a joint appointment ward. It appears that there are probably long-term benefits to learners in terms of their depth of understanding of patients' illnesses and concepts of care, and that these manifest not only in the practice of nursing care, but also through classroom discussion and in written papers. The aspect of experience on a joint appointment placement most commonly mentioned after one or two years have elapsed is the extent to which it was helpful in the process of personal development as a nurse. This seems to indicate that joint appointees function effectively as role models, and this is borne out by the number of nurse learners who state that they would like experience as a trained nurse in a similar environment.

Some of the wards in our sample have become more than just differently managed wards which learners happen to pass through. One in particular is set up specifically as a training ward, and the appointees – who call themselves in this case 'dual role appointees' – put in hours which almost approximate to two whole-time equivalents. The concept of individualised patient care and an egalitarian approach to ward management are imparted to some learners at an early stage in training. Comments from these learners when they return to the nurse training school at a later stage reveal that this can sometimes cause frustration on subsequent wards where seniority plays an important part in the allocation of responsibility. Thus, a very junior nurse may gain a confidence which fails to consolidate itself in later training. Conversely, a ward sister on another ward may find herself pleasantly surprised that learners who have passed through a joint appointment ward feel that more is expected of them, and that the team of colleagues benefits from an exchange of information. Another joint appointment ward has taken on an important inservice training role with special regard to the nursing process, and so learners on this ward expect to experience a thorough grounding in its principles and application.

Whilst most of the comments from learners have been concerned with the effects of working on a hospital ward alongside a teacher, the joint appointees usually have some teaching commitment in the classroom, and find they are able to inform their teaching by reference to patients they have themselves encountered. They feel that this increases their credibility as teachers, and this is echoed in the experience of singleton appointees who may teach and supervise learners in a variety of situations in the classroom, on the ward, or in the community. One student said of her health visitor/lecturer: 'I think it is more valuable having an instructor who is actually practising in a course. . . I learned more from going out and observing how an assessment of a child was done than I would have if I was just told and not shown'. Another appointee engaged in developing community liaison on a paediatric oncology unit noted that students 'seemed to value me more when they realised that the families saw me as a credible member of the team'. It seems, then, that the respect accorded to the joint appointee by patients and clients may be an important factor in enhancing his or her status in the eyes of the learner.

In sum, the opinions of learners, whether gathered anecdotally or by more systematic means, seem to reflect a positive experience whilst under the supervision of joint appointees. Although the areas vary considerably from each other according to patient turnover, staffing levels, specialty and location, there appears to be a markedly common theme to the learners' conclusions. The integration of theory with practice and the presence of a role model with both teaching and clinical responsibility seems to result in an appreciation of the joint appointment not just for its educational value, but also for the positive working atmosphere it promotes, and the recognition of the learner, along with the appointees, as no longer a guest in the clinical situation, but as an equal member of the caring team.

6

The effects of joint appointments on colleagues

The opinions of colleagues about the joint appointment were sought through one method or another in most of our cases, especially where the appointment involved the management of a hospital ward. As with the learners, the variation of material on which this chapter is based ranges from the detailed questionnaire responses of trained staff in a school and a hospital unit to informal discussions among groups of staff on the particular ward concerned.

The joint appointments involving two half-time teacher/sisters on hospital wards all found that the initial effects on the trained staff were unsettling. To begin with, staff had been very uncertain about what to expect, and in what ways their roles might change. As the appointments have progressed and settled into a pattern, however, these anxieties have generally subsided as a more stable situation developed and staff have clarified their roles in the new situation. On the ward where the two appointees work something more approximating to two whole-time equivalents, the staff do not appear to have experienced the same levels of initial anxiety.

Problem areas

There are three focal problem areas which emerge from the evidence, and they are: first, problems associated with continuity of care; second, the effects of working for two part-time managers; and third, the problems which have resulted from innovations initiated by the joint appointees.

To consider the first problem it seems that there is a real perceived risk among trained staff on a joint appointment ward of lapses in the continuity of care. Often where senior staff nurses have been happy to take over this function, the problem has been quickly resolved. Sometimes it happens that there is some resistance among senior trained staff to the assumption of greater responsibility, and joint appointees have devised various methods of gently and gradually assisting them in their new roles. Similar continuity problems have arisen for singleton joint appointees, and the most common manifestation has been that, as people, they are difficult to locate. The health visitor/lecturer, for instance, found that she had to make major effects to pass on information to colleagues 'because we don't run into each other in the normal course of a day'. Solutions to the continuity problems have varied according to the institutional setting, but in general, the identification of a problem in these terms has usually led to its resolution because it has normally been possible to devise a method of restoring the continuity.

A second major problem area has been in the potential conflict between two part-time sister/

charge nurses managing a ward. The evidence we have been able to gather from trained staff on joint appointment wards and in other areas suggests that this possible conflict is what worries them most about joint appointments, and our evidence from nurse managers and educators outlined in chapter 7 confirms this. However, it is difficult to establish to what extent these anxieties were actually encountered in the joint appointment situations, because many people who identified this potential conflict were not themselves working on joint appointment wards. It would appear that where there is a high degree of consensus between appointees, and especially where they work more than one whole-time equivalent on the ward between them, these problems are unlikely to arise in any significant way. However, should there be any fundamental mismatching of appointees, or disagreements on how the ward should be run, then the trained staff are likely to find the situation stressful and their loyalties divided.

Thus, the consensus between appointees must be regarded as paramount in deriving the full potential from a ward-based joint appointment. Interestingly, this does not necessarily mean that appointees should be equal in status – rather that they should agree on mutual role definitions and thus any differences in status. Whilst some of our joint appointments were interchangeable and completely egalitarian, others embodied a degree of seniority in one partner, most often the one with a tutor's qualification. The most important factor seems to have been a strong mutual agreement as to the definition of the respective roles.

The third problem which has arisen in some cases was not strictly attendant on the joint appointment so much as the changes which appointees were attempting to bring about. On some wards, the appointees specifically had the brief of introducing the nursing process, and the response to this has been varied. It cannot be denied that in some cases where the trained staff felt happier under a traditional task-oriented regime, some felt unable to cope with the redefinition of their responsibilities and resigned. In others, however, staff felt encouraged that their suggestions for change on the ward were listened to, and managed to adapt to the new situation. It seems probable that problems of this type would have arisen whether or not a joint appointment was involved.

Areas of benefit

On the positive side, the most outstanding feature of joint appointment wards was that they were felt to be friendly and egalitarian places in which to work. The importance of the 'friendly working atmosphere' to the nursing team is noted in the discussion of the reactions of learners to joint appointments. The value of discussion and communication has also been emphasised in joint appointment areas, and this emphasis has often spread to include an increase in communication at all levels, from patients to medical and paramedical staff, and to domestic staff too. Thus the nursing staff on a joint appointment ward frequently found that their membership of an interdisciplinary team had assumed a wider context and meaning.

It appeared to many of the joint appointees that trained staff on their wards were more satisfied with their work, and were often finding considerable stimulation in their teaching roles. One State Enrolled nurse commented that 'in helping them it also helped to increase my knowledge with all the up-to-date procedures and treatments'. On another ward, two staff nurses newly qualified and newly in post found that their educational roles as paired supervisors with learners, far from hindering their adaptation to a new situation, helped them to gradually widen their knowledge of a new specialty and to settle into the ward. On yet another ward, trained staff who had been working there for some years began to request 'reading time' in order to keep up-to-date with developments – a necessity they had previously not perceived.

In one hospital the opinions of both nursing and teaching colleagues were surveyed. There seemed to be little doubt in the minds of the respondents as to the benefit gained by learners from the joint appointment, and that there would be an attendant improvement in patient care. Again, the increase in job satisfaction at all levels for those working on a joint appointment ward was noted, and it was also observed that such staff were usually given more responsibility. Interestingly, there was some division as to whether this added responsibility was an advantage or a disadvantage.

In the sphere of teaching away from the clinical area, the benefits of joint appointments are perhaps less obvious. One joint appointee who lectured in the nurse training school for half of his appointment commented that his teaching was considerably enlivened by his ability to refer to cases he had encountered on the ward, and this comment was echoed by other appointees who had formal teaching responsibilities. The health visitor/lecturer appointee also reported that her joint appointment had stimulated interest elsewhere in the Department of Nursing Studies and that proposals to set up similar projects were under consideration in other areas of nursing. The cooperation of education colleagues has, in fact, been an important feature of the administration of joint appointments, and most have contributed valuable support.

Amongst other colleagues in the service area outside joint appointment wards, there seems to have been a critical interest in these new projects, mixed with uncertainties about the possibility that unfair advantage might accrue either to learners or to staff on the ward. There appear to have been varying amounts of support from medical colleagues; in some cases a high level of support for joint appointments from this quarter has been reported, and has contributed greatly to the development of an enriched ward learning environment. The health visitor/lecturer appointee noted that because her general practitioner colleagues also had teaching, research and clinical commitments, they were 'tuned in and supportive'; however she did add that it took much longer than usual to develop her relationships with colleagues as a joint appointee.

In sum, the reactions of colleagues, particularly those working alongside joint appointees, has varied widely, from undoubtedly high levels of anxiety, especially to start with, to an enthusiastic response to a new challenge. Some nursing staff have expressed the desire to gain promotion into joint appointment areas, and one staff nurse at least claimed to have changed her ambition from 'becoming a ward sister to becoming a joint appointee'.

7

Joint appointments from the perspective of service managers and educational managers

On 18 October 1983 a questionnaire was sent to nurse managers and educators and, in the case of the Edinburgh appointment, to the professor of general practice who had the job of overseeing the joint appointments. It was designed to obtain from each of them their perspective on the joint appointment with which they were involved. If a similar questionnaire were to be sent today, it is likely that the information elicited would be quite different. The very nature of a joint appointment is that of a process rather than a product, involving dynamic interaction between the appointee and others, and leading to continuous shifts in perception. The data are thus historical, as though a still frame had been extracted from a moving picture. It is therefore likely that in the intervening period, additional gains have been identified, new problems solved, and fresh areas of concern highlighted. What follows is a review of the observations of nurse managers and educators at a particular point in time.

Overall, the comments from managers and educators reflect a heightened awareness of the theory/practice gap and the education/service gap, a determination to find ways of bridging these gaps, and a continuing commitment to the concept of the joint appointment as a valid means of doing so. The variety of roles – dual and single roles, hospital or community based, involving a college of nursing or a university department – and the differing time scales involved, are reflected here as they are elsewhere in the report.

The observations of managers and educators suggest that the underlying aim of the joint appointment, that of bridging these gaps, has been achieved, at least to some extent, through closer links and better relations between education and service, the school and the ward, and the university and the community.

The perspective of nurse managers

With varying degrees of conviction, nurse managers identified a number of educational gains which they felt had resulted from their joint appointments. An important feature of these gains was the emergence of the clinical area as a valid teaching and learning environment where nurse teachers were able to identify and utilise the 'small learning situation'. The joint appointees appeared to have shared their expertise so that, in some areas, other trained staff – including some who had been in post for years – became aware of their own inservice training needs.

Patient care appeared to have improved, with an emphasis on implementation of the nursing

process and individualised care programmes for each patient. The joint appointments seem generally to be associated with a questioning of existing institutionalised behaviour, and this has perhaps manifested most strongly where care of the elderly has been involved. Indeed, it was suggested that the interest shown by learners in hitherto 'unglamorous' areas of nursing, such as geriatric care, had increased due to the joint appointment.

In some cases, a fruitful dialogue had been opened up between the nursing and medical staff as a step towards a shared philosophy of care in a specialist area. Often, the joint appointments appear to have enhanced the status of the nurse as a core professional within a multidisciplinary team and the importance of her particular role has been more openly recognised by other members of the team.

The joint appointments were also felt to have improved the working environment for staff at all levels, and in particular to have stimulated greater discussion amongst ward staff. In one case staff had set up groups to talk through problems. Interestingly, those nurses who managed joint appointments appeared to have found them to be valuable learning experiences, although exactly what they felt they had learned was not articulated.

The nurse managers also identified a number of problems they had encountered, and agreed that some of their expectations had not been fulfilled. The conflict of loyalties between education and service for the joint appointee was mentioned, and it was also noted that on occasion, relationships between the joint appointees and other members of staff had not been harmonious. As far as delivery of care was concerned, some nurse managers felt that a lack of continuity had presented problems, particularly for patients, nurses and medical staff, in identifying 'who's in charge' of the ward. This was especially the case where it was felt that the appointees were mismatched and that this had led to conflict and lack of consensus between them.

In order to avoid or solve these problems, nurse managers suggested a number of different approaches. In different circumstances, it was variously felt that there had been insufficient planning of the appointment, or that the job description had not been adequately set out, or that there had been insufficient preparation of colleagues at various levels. It was felt that time should be provided, and set aside, for joint appointees in dual roles to get together to discuss continuity and to express their differences and problems. Interestingly, finance did not appear to have caused any major difficulties. In one case, the joint appointment had led to a request for increased staffing levels, and in another, had stimulated an increase in spending on inservice training.

Evaluation of the joint appointments seemed to be problematic, and much confusion and uncertainty was expressed about this, chiefly because the nurse managers were agreed on the need for evaluation, but were unclear about how it could or should be done. The very nature of these appointments is such that change and flexibility are central to their underlying philosophy, and, of course, they operate in the real world of staff changes, staff sickness, and changes in patterns of care. There was a sense that evaluation in terms of how far the original aims had been achieved did not do the appointments, nor the appointees, sufficient justice. It seems very difficult to reach a 'conclusion' about a joint appointment, and a need to improve and devise methods of evaluating its progress was expressed. The question also arose as to how far the success of the scheme lay in the character of the appointees rather than in the appointment itself. There was an impression, too, that a great deal had been learned, that education and care had both improved, but that it was difficult to process these lessons into a form that could be utilised elsewhere.

Some nurse managers felt that their original timescales had been unrealistic, and that with hindsight they might have allowed more time for the planning stages of the project. It was acknowledged that problems are not solved overnight, and that original expectations may have been too high.

On the whole, nurse managers appeared to be keen to continue joint appointments, to replace current appointees if they should leave, and to create new ones where feasible. The appointments seem to have stimulated a desire to build up trusting relationships between education and service so that problems could be acknowledged and dealt with openly and honestly. There was some caution, however, in the light of experience, and it was acknowledged by some that better preparation and more careful selection of appointees would be advantageous.

The perspective of nurse educators

The nurse educators all identified educational gains which they felt had been made by the joint appointments, although respondents were generally cautious about drawing substantive conclusions from their subjective impressions. These benefits were attributed to the provision of a good role model for both students and teaching staff, the experience of reality-based teaching, and a high quality of supervision for learners. The nurse educators felt that the joint appointments were successfully providing a base for teaching in the clinical area, with the result that the teacher could maintain her competence and confidence in her specialty. The increased credibility of the teacher as a clinical expert was acknowledged, with a greater acceptance of the clinical teacher as part of the ward team.

Like nurse managers, the educators perceived that joint appointments had stimulated a greater awareness amongst trained staff of their inservice training needs, and encouraged trained staff to become more involved and confident in the teaching of learners.

A number of measurable indices were noted by the nurse educators, which might be incorporated into an evaluation of a joint appointment from the educational viewpoint. These included an observed reduction in complaints from learners and an increase in newly qualified staff wishing to return to the joint appointment unit as their first choice.

The delivery of patient care, it was felt, had undoubtedly been enhanced. This was thought to be due to the better supervision of the nurse learners on the wards, improvement in the coordination of services, and the identification of areas in need of attention. Like the managers, the nurse educators commented on how the nurse's contribution to care had been acknowledged by other professionals, enabling her to participate more fully in the inter-disciplinary development of her specialty. Improved staff morale was again identified as an important feature of a joint appointment situation.

Educators again suggested a number of possible indices which could be measured. These included an observed reduction in the number of complaints from patients, a higher bed occupancy rate, the reduction of iatrogenic disorders, an increase in voluntary input into the clinical area, and a reduction in custodial practice.

The very survival of the joint appointees in these intensely demanding posts appeared to have validated the concept as something that can work (although not all the joint appointees have in fact continued). This seems to be confirmed, too, by the reduction of the initial anxiety felt by service managers about the possible consequences of teachers working full-time in the clinical area.

A number of problem areas were identified by the nurse educators, and the division of loyalties, conflicting demands, and uncertain lines of communication were a common theme in their observations. In one case it was felt that the desired integration between education and service had not been achieved as fully as had been hoped. Where the joint appointments had a research component, this had not been developed to any major extent, and there seemed to be a potential conflict between the nursing/social science model of care and the medical model of illness.

From the educational standpoint, there seem to have been some losses of theoretical teaching input due to the removal of joint appointees from classroom work, and in one case it was felt that a joint appointment ward had become 'overloaded' with learners. In another case, the lack of a formal teaching qualification in one of the appointees was thought to have reduced her potential effectiveness. Thus, the balancing of clinical and educational demands was evidently a problem which was by no means solved by the introduction of a joint appointment.

Like the nurse managers, the educators also identified the relationships between the appointees as a possible problem area. Sometimes the appointees appeared to be seen as a threat by the more traditional teachers, and by some management and service colleagues. In addition, there was the implication that the joint appointment ward was in some way privileged in comparison with others.

In offering solutions to the problems they had identified, the comments of the educators very much echoed those of the managers. The need for adequate preparation was stressed, as was the importance of consultation between education and service in advance of the appointment, and continuing into a dialogue as it progressed. The need to clarify the term 'joint appointment' was mentioned. It was also acknowledged that liaison between the two appointees was all-important, and that sometimes a safe and supportive environment was needed to allow them to 'let off steam' and talk through problems. From the point of view of supervising joint appointments, it was generally felt that a non-directive style of supervision worked best, giving the appointee a good measure of autonomy, along with the authority to assess their own priorities and to develop their posts accordingly.

Like managers, educators seemed keen to continue their joint appointments and to create new ones where appropriate. The problem of financial constraints on expansion was noted, and one respondent seemed worried about there being a danger of 'everyone jumping on the bandwagon', and pointed out that joint appointments were not necessarily appropriate in every area.

New developments

Beyond the education/service gap, there exists a gap, highlighted by the observations of managers and educators, between service and research. It was suggested that joint appointments may be one way, although by no means the only way, of trying to bridge this gap.

Some of the joint appointments have been discontinued in their original form, or had been limited to an experimental timescale, and the experience used to create new management and clinical posts. The joint appointments, generally, appear to have stimulated new ideas for the improvement of nurse education in particular, and these ideas have spawned other professional developments in nursing practice. Some of these developments, both planned and already under way, include the appointment of a specialist health visitor in the care of the elderly, a research nurse at staff nurse level, a tutor/clinical teacher with direct

responsibility for patient care and education, and the introduction of normal ward shift-work for clinical teachers. It was suggested by the majority of respondents that there should be more ward-based teaching and that better preparation was required for the teaching role of the ward sister.

In sum, the overall impression was one of enthusiasm on the part of both managers and educators; of a general consciousness raising and of new energy and ideas bubbling through, sometimes meeting resistance, but also leading to change in a positive and healthy direction.

8

The effects of joint appointments on patients, clients and relatives

Although the ultimate aim of all joint appointments is to improve patient care, there was a general apprehension among joint appointees that initial problems could arise in the delivery of care. The main problem envisaged – and this has also been a focus of concern amongst colleagues, managers and educators (see chapters 6 and 7) – was that continuity of care might be at risk. In two of the hospital wards, a small number of patients (and relatives, where patients were unable to respond) was asked about their stay on a joint appointment ward. Results indicated that patients were, in the main, aware that two people were 'in charge' of the ward, and did not feel that continuity had been adversely affected. A couple of patients felt that the joint appointment was 'not necessary', one with the illuminating comment that 'two very experienced nurses aren't needed on an old people's ward'. On the more positive side, one patient on the same ward observed that 'both appointees bring something extra to their work'.

The fact that patients were generally able to identify both the appointees, and knew their position, and that they reported no problems in their own experience of care, seems to indicate that from the patients' perspective, continuity of care did not arise as a problem. One area in which lapses of continuity were sometimes felt by some of the appointees, however, was in dealing with relatives, particularly over the telephone, and most appointees have specifically devised solutions to this problem. The health visitor/lecturer appointee added that a difficulty arises over her accessibility to her clients because she is based in more than one place, and many of her clients neither have their own telephones nor are 'geared to leaving messages'. Thus there is clearly a need for appointees to identify and resolve any ambiguities that might arise over their accessibility to relatives and clients.

All the wards and areas in which joint appointments took place were committed to implementing and improving upon patient allocation through the nursing process. It was observed by appointees that the individualised care received seemed to help the patients to feel more comfortable. A further common feature of the joint appointment wards was the introduction of minimal constraints upon visiting times, and one appointee noted the educational value of this for learners who were able to spend more time with relatives, and often in so doing, to elicit valuable information from them. One of the joint appointment pairs has found the need for mutual agreement on policy to be an important factor in 'guarding against the possibility that relatives might manipulate one of us against the other', and they have noted that the need to check on agreement sometimes leads to a delay in giving a satisfactory response to a questioning relative.

Most of the wards made some attempt to evaluate changes in the quality of patient care delivered to their patients whilst in the charge of joint appointees, but quickly found that it was impossible to ascribe unambiguous meaning to their measures. An example here will clarify. One improvement to patient care in a geriatric ward concerned the removal of cotsides to increase the possibility of mobilisation. An immediate consequence of this could be an increase in the number of accidents to patients who had formerly been cared for in such a way that the likelihood of accident was eliminated. Thus, any interpretation of accident rates would have to be made within the context of mobilisation figures. The subjective comments of appointees are therefore the only source of information on changes in patient care. All the appointees for whom pressure sores presented an area of clinical difficulty felt that they had successfully decreased the rates in pressure sores on their wards; most appointees felt that death rates had decreased, and that there had been a reduction in substantive complaints. All noted an increase in the number of complimentary letters they had received, and often found that these unsolicited testimonials confirmed that they were achieving their aims of individualising patient care and promoting an educative environment. One of the joint appointees in the geriatric area was able to collect some 90 different items on a list of changes and innovations on the ward. These covered improvements to the physical environment, additions to clinical equipment, utensils, clothing, recreational facilities and individualised supplies, and the removal of outmoded equipment. The general increase in communication among staff on the ward also included improvements in communication with patients. Several information booklets are available for patients; one on the ward in general (including a brief description of the joint appointment) and others on the more common conditions which are treated on the ward.

Patient education seems to emerge on joint appointment wards as a special feature. In addition to the tangible elements, such as information booklets, patients have reported that they learn as a result of bedside teaching. 'I've learned quite a lot', said one patient. 'They show them [the learners] the dressings and traction, and they explain it to them.' Clients seen by the health visitor/lecturer are reported to be 'interested and gratified' that the appointee teaches students and that the teaching is based on the real life experience of working with them.

Over all, the patients and relatives seem not to perceive any discontinuity of care, and the general impression is one of benefit from the patient allocation system, and from being part of an enhanced ward learning environment.

9

What do joint appointees gain in return?

Without exception, joint appointees in the peer group agree that as a result of working in these roles they obtained an enormous measure of satisfaction and gratification. This is partly due to their trail blazing activities, to actually making a success of a job which is often regarded as too complex and difficult to be feasible, and to seeing that it is possible to have more than just a foot in both nursing education and practice.

The sources of this high level of satisfaction are many: from monitoring changes in care and identifying improvements to the reduction of absenteeism as a consequence of improved staff morale; from students who approve this linking of theory and practice to staff nurses who begin to expand their own teaching commitments; from seeing positive links established between education and service to innovations in new types of service; from newly qualified nurses asking to work in previously unpopular units to the actual use of current clinical experience as a basis for teaching.

Without exception, joint appointees felt that they were making progress on a number of fronts simultaneously and that this was achieved because they had both clinical and educational responsibilities. This is not to say that they could not have introduced some of the innovations as clinicians or as teachers. Indeed, having read through the previous chapters, many readers will have identified clinical and educational practices which have arrived by means other than the creation of a new type of role. What is important about the joint appointees' sense of achievement is that developments can occur simultaneously in both patient/client welfare *and* the education of nurses – one informing the other, in a way that was not considered or experienced as possible while being a full-time teacher or clinician.

It was during the course of discussion within the peer group, as well as in joint appointees' reviews of their work at base, that joint appointees recognised what they felt they were achieving. This is not to say that at times there were not disappointments about the pace at which progress was made or the seeming insurmountability of the obstacles to be overcome. For some there was a tendency to feel an absence of support from higher levels of nurse management, along with a recognition that nurse managers were in a position to introduce changes which sisters could not. As a consequence, a number of joint appointees have opted to move into management roles, temporarily relinquishing their formal educational status and 'hands on' clinical roles. Others have also moved on to interesting new appointments, and it is questionable for how long individuals can sustain a joint appointment without suffering physical and psychological exhaustion or, to use the current term, 'burn out'.

What is evident is that to carry out the complex role, all of the joint appointees work hours far in excess of those they are employed for, or are paid for. In some cases this is due to the carrying of a workload in excess of the portion allocated for either educational or clinical work, exacerbated by the extra organisation involved in managing a clinical case load as well as formal educational inputs, and the necessity to find time to devote to both. When having to introduce clinical changes and to promote a high level of staff development, this produces a grinding workload. While the job is in a development stage our group of joint appointees tolerated the workload – indeed they may be the kind of people who always work to excess. Yet one is left to wonder for how long this workload can be maintained, and whether the limited financial reward for it, and satisfaction gained, compensates sufficiently for the added pressures in carrying out the dual roles.

These pressures were not only of the kind mentioned above. They were also related to interpersonal and relationship issues, particularly in working with the right partner, so that dual does not become duel! The sharing – of ideas, ideals, methods and, to some extent, lifestyle – was regarded as both enriching, yet fraught with difficulties if the 'other half' was wrong. When off-duty patterns were structured so that little time was allocated to be together, then there were insufficient contact hours to find out how each other thought, to establish what were top priorities, or to review developments. When two partners shared a clinical appointment, then honesty and trust were vital to its success. Of course the singleton joint appointees, while lacking a shoulder to cry on, or another person by which to be stimulated and sustained, also lacked the additional task of working out a shared role.

Some points to consider

So what would appear to be the major issues from the perspective of joint appointees themselves, when considering establishing such posts?

As with any new development, there are good and less good ways of introducing them. For some joint appointments they were introduced in a hurry to meet some expediency, and allowing little opportunity for those who might be significantly affected by the joint appointment, especially permanent members of the ward team, to be made conversant with its aims, how it might function and how it would affect them. This allowed misunderstandings to arise, misapprehensions to swell resistance, jeopardised the early days, and prejudiced the development of the new roles.

In all cases it was not only new roles which were being introduced, but also new ways of delivering patient care which involved other members of staff in significant changes over which they felt little control and which created tensions between the joint appointees and those with whom they had to work. Some resistance is inevitable, but in some cases the absence of a sufficiently well planned intervention created more hostility and stress than need have been the case. Careful planning is therefore necessary to minimise identifiable problems.

The resistant behaviour of colleagues was exacerbated in some cases by an absence of support and guidance from educational and service managers. It was as if, once the jobs had been created, it was entirely up to the incumbents to make them work. In a complex organisation where there is a lack of obvious and tangible support from managers, this further reduces the likelihood of success of any new venture, and leaves the joint appointee to his or her own resources. When the roles involve two people, they have each other for sharing and mutual re-inspiration. When the role is split for a single person there is no other person near at hand

who is experiencing similar difficulties, no one to share with and no one with whom to try to recreate positive sentiment or identify positive gains. Indeed, without a peer, the sense of frustration and failure can be intolerable, even when to the outsider some significant achievements have been made. Someone has to fulfill the 'supportive-other' function as well as managerially create conditions which are receptive to a new role.

Peers also permit a reassessment of the time scale of innovations, an appraisal of achievements and successes as well as a re-ordering of priorities and expectations. For this, and other reasons, it is important that additional problems are not created by appointing mismatched joint appointees, since it is inevitable that they must work closely together and fairly quickly establish workable relationships. Otherwise the whole enterprise is jeopardised, and there is danger of not only splitting the cohesiveness of the roles but also the expressed aim of bringing 'school' and 'service' closer together.

While joint appointees have their own expectations of what the job entails and the direction in which it should develop, these are not necessarily shared by other educational or service managers. This can lead to disputes over whether each side is getting its fair share, whether one is making a greater contribution than the other, and whether this is the kind of role which should be allowed to continue. Without clear objectives and workable school-service agreements continuity, beyond the initial teething troubles, is at risk. The absence of agreed educational and service objectives, leaving it to the joint appointees to devise their own programme and make all the running themselves – not really knowing whether they are running in the right direction or at an acceptable rate – adds tension. This may be more likely to happen when a joint appointment is set up for expediency or accepted because the appointees themselves have pushed for it, rather than being carefully and mutually planned by educational and service managers.

Some difficulties are inherent in the role itself. This can be especially the case where two half-time sisters replace one full-time. Who is sister? This is unlikely to be a great deal different to having a senior and junior sister as is the case in many wards, but there needs to be agreement about the specific functions for which each is responsible. It may be necessary, however, to teach others to live with the 'split role'. But again this is little different to establishing team nursing and revising the sisters' role. However, it is easy to attribute *any* difficulty to a joint service-educational role rather than to regard such problems as inevitable with any significant role change. Consideration should be given to the advisability of introducing too many new ideas and changes simultaneously.

One feature the peer group were unanimous about was that their jobs were 'over-peopled'. Not only had appointees to deal with the wide range of people normally met in clinical settings, they also had their educational colleagues and learners to deal with and, because in some cases extensions of teaching settings and community links were being created, this added significantly to the size of role sets. We did not arrive at any solution but regarded it as an occupational hazard which had to be endured.

10

Conclusions

1 Joint appointments were established in most instances with the major aim of improving nurse education through the closer integration of nursing theory and practice. Without exception, members of the peer group agree that the clinical environment can be made into much more of an arena for learning when those with major clinical authority also have the education of nurse learners as a primary concern. Given that nurse learners undergoing the basic statutory training spend 80 per cent of their time in clinical placements, then it is vital that they are provided with circumstances and opportunities to learn nursing during that time. When those with clinical responsibilities are also qualified nurse teachers with a remit to teach, then there is an increased opportunity to make learning nursing an explicit feature of clinical experience.

2 When those with clinical responsibilities also have significant employment as nurse teachers, then there are opportunities to enhance the reality base of their teaching. They are no longer in a position of teaching from previous and increasingly dated experience or of having to negotiate and construct teaching experience using patients under someone else's care. There is a direct right of entry for educational purposes into clinical areas for which they have responsibility and, with it, an increased opportunity for patient-centred methods of learning.

3 Joint appointees, as far as they are able, want to be able to teach about the nursing they practise and to practise the kind of nursing they teach. They are in the position of not wishing to relinquish either their clinical skills, which they would have to do if they adopted a traditional nurse teacher role, or to relinquish their contribution to the formal education of nurses embodied in the school, college or university department. The development of joint clinical and teaching appointments permit the continuation of these two intertwined strands of professional practice in a manner not otherwise possible, because such appointments provide status as both teacher and clinician.

4 What can be achieved depends in part upon the nature of the role created within the broader remit of having both clinical and teaching responsibilities. When two joint appointees share the position of ward sister, then more can be achieved in the way nursing work is organised and managed than when a single joint appointee has a half-time clinical role. When an appointee has a role more in the clinical specialist mould, their talents are likely to be used in specific and narrower aspects of patient care rather than in the day-to-day running of a ward. The kind of roles created require to be set in the context of identified objectives.

5 When clinical developments are a major element, then the continuing education of permanent ward staff is an important feature of the joint appointees' work. This broader educational function is sometimes not recognised or used as a resource but is a vital component in making significant progress.

6 There have been no attempts to identify what are the specific skills and knowledge required by joint appointees and whether specific educational preparation is warranted. The peer group identified the personal qualities needed, such as creativity, tolerance of uncertainty, being constructively critical, and being physically and mentally resilient, but managing a complex role requires other forms of knowledge and skill. In particular, it requires interpersonal skills, communication and group dynamics skills, together with political skills to identify the strategies and tactics which are necessary to forge the developments sought. In such a full-time schedule, planning and organisational skills and the ability to identify and set priorities are vital. Analytical skills are warranted to collect and review information which can be used to assess achievements, or their absence, and to present a case for resources when this is necessary.

7 The above suggests that those wishing to make joint appointments have to consider whether they can attract people of appropriate calibre and possessing the range of educational and experiential preparation, or whether they have the resources to assist appointees to develop those skills. What is evident is that much can be provided by good education and service managers who themselves have the knowledge and skills to assist joint appointees, if time can be found to talk through issues and plan together.

8 Perhaps it is because joint appointments are so complex and demanding that there are so few of them and, to date, are held for no longer than three years in any one setting. Current evidence suggests they are an important but intermediary step in the career development of a small number of nurses. When the nurse in question moves on, the post is likely to terminate. If this is the case, it opens an interesting debate about the future of joint appointments on a wider basis than has existed until now, and it implies a need to test in a limited way the recommendation of the Royal Commission on the NHS that 'development in joint appointments between schools of nursing and the service should be vigorously pursued'. If nurse teachers are to spend half their time in clinical work, then twice as many nurse teachers will have to be provided, with the consequent training costs absorbed. Employment costs will be shared with service budgets.

9 Joint clinical teaching appointments are not ends in themselves. They were created with a specific educational purpose in mind. Those who have held such appointments feel, on the basis of their own experience, that they have achieved a considerable amount for the education of learner nurses. Some evidence from others presented here also indicates a generally favourable impression on their effectiveness. Joint clinical teaching roles are *one* means of enriching nurse education and, in so doing, creating interesting and worthwhile posts. It is time that this way of closing the theory/practice gap in nursing was reviewed, together with other methods of doing so, to provide a basis for the educational preparation that future generations of nurses deserve.

Appendix A Information abstracted from available job descriptions

Location	Title	Grade	Qualification	Accountable to	Report to	Finance	Clinical	Educational	Administration
West Cumbria Health Authority, West Cumberland District General Hospital Commenced: January 1981 Ended: September 1981	Nurse Teacher/ Ward Sister Ward based – 37½ hours pw Nurse Teacher/ Charge Nurse Ward – 18 hours pw School – 19½ hours pw	Clinical Teacher Clinical Teacher	SRN, teaching qualification, experience in orthopaedics SRN, graduate, clinical experience	Director of Nurse Education Senior Nursing Officer "	Nursing Officer Steering Group "	Joint Education Service "	Maintain high standard of nursing care. Liaising with medical staff re patient care. Clinical supervision of learners. Individual patient care.	Teaching – school – ward. Clinical teaching on one other ward. Clinical supervision. Assessing on 2 wards. Updating knowledge. Inservice training of staff. Research. Developing 'learning environment'.	Management of ward. Liaising with other departments. Reporting to Nursing Officer. Acting as Nursing Officer. Meetings – Education – Service. Records of students. Implementing District policy.
West Lambeth Health Authority, South Western Hospital, Nightingale School of Nursing Commenced: April 1981 Ended: December 1983	Ward Sister/ Charge Nurse Clinical Teacher Geriatric Area	Ward Sister Clinical Teacher	4 years post-registration, minimum 2 years as sister. Preferably Joint Board Course of Nursing Studies in Geriatric Nursing, teaching qualification, assessor English National Board.	Director of Nurse Education Director of Nursing Services	Nursing Officer – Geriatrics Senior Tutor assigned	Education, fewer weekends etc. Clinical teacher + special duty payments.	Maintain high standards of care. Liaising with medical staff re patient care. Individual patient care.	Providing learning environment. Teaching – school – ward. Coordinating ward teaching programme. Inservice training. Assessments research. Teaching on 2 other wards.	Management of ward. Acting up for Nursing Officer. Liaising with other departments. Meetings – Education Service. Reporting to Nursing Officer. Implementing District policy.
Tameside and Glossop Health Authority, Tameside District General Hospital Commenced: November 1981 Continuing	Nurse Tutor/ Charge Nurse Clinical Nurse Specialist Clinical Teacher Ward Sister	Tutor Clinical Teacher	RNT, SRN RCNT, SRN	Director of Nurse Education Director of Nursing Services	Divisional Nursing Officer Nursing Officer Senior Tutor	Joint Education Service	Standard of care. Staff relationships. Clinical nurse specialists. Common code for nursing practice within unit. Innovator.	Teaching – ward school. Clinical supervision. Inservice training Research the role/practice. Updating knowledge. Developing 'learning climate'. Role model. Resource person.	Ward management. Records. Reporting to Nursing Officer. Meetings – School/Unit/ Ward. Acting across – Nursing Officer. Acting Senior Tutor.
Newcastle Health Authority, Royal Victoria Infirmary Commenced: November 1981 Ended: November 1983	Nurse Tutor/ Clinical Nurse Specialist – paediatrics	Tutor	RSCN, RNT	Director of Nurse Education Divisional Nursing Officer	Senior Tutor Senior Nursing Officer	Regional Nurse Training Committee	Coordinate nursing care. Staff development. Draw up standard care plans. Clinical commitment. Introduce patient centred care.	Teaching – School Clinical teaching. Learning environment. Assessing. Inservice training. Update knowledge. Research.	Reports, meetings and committees.

Location	Title	Grade	Qualification	Accountable to	Report to	Finance	Clinical	Educational	Administration
Paddington and North Kensington Health Authority, St Charles' Hospital Commenced: Ended:	Clinical Nurse Specialist – care of elderly	Nursing Officer I		Director of Nurse Education Divisional Nursing Officer	Senior Nursing Officer Senior Tutor	Joint Education, clinical teachers salary + supplement to Nursing Officer I + geriatric lead.	Cooperate with Nursing Officers on patient care programmes. Liaise with medical staff. Responsibility for a caseload within a ward. Advisor for geriatric unit.	Reponsible for clinical teaching of learners. Facilitator in development of new concepts of care. Inservice training.	Shared supervision of ward. Liaise with Nursing Officer on policy.
Eastbourne Health Authority, Eastbourne District General Hospital Commenced: January 1982 Continuing	Nurse Tutor/ Clinical Teacher Ward Sister Surgical Ward Ward based – 20 hours pw School based – 17½ hours pw	Nurse Tutor	Minimum SRN, Nurse Tutor Diploma or Registered Clinical Nurse Teacher Desirable Diploma in Nursing or graduate	Director of Nurse Education Senior Tutor	Nursing Officer Steering Group	Education	High standard patient care. Individualised patient care. Liaise with medical staff on patient care. Clinical supervision of learners.	Teaching – school – ward. Assessing. Updating knowledge. Inservice training. Research. Learning environment. Research. Implement continuous assessment.	Implementing District policy. Management of ward. Maintaining teaching records.
	Ward Sister/ Charge Nurse Surgical Ward Ward based – 37½ hours pw	Grade II	Minimum 3 years post registration experience. Desirable 1 year ward sister qualification. English National Board Assessor. Attendance at 1st line management course.	Senior Nursing Officer Nursing Officer – Unit	Nursing Officer Steering Group	Service		Inservice training. Assessing. Teaching clinical skills. Attend study days, conferences. Research. Counselling.	Responsible for organisation of ward. Implementing District policy. Attendance at unit meetings Liaising with other departments. Acting Nursing Officer.
Lothian Health Board, University of Edinburgh Commenced: September 1982 Continuing	Health Visitor Part-time lecturer 50/50 case load Teaching	Nursing Officer Grade II	RCN/HV Graduate	Professor of Nursing Studies	Divisional Nursing Officer after April 1984 Advisory Group + Joint Appointee	Lothian Health Board	Health visiting. Establishing priorities. Promotion of health. Liaison with Health Care Team. Developing skills in research.	In relation to the primary care component of the course. (Teaching (Assist with assignments etc. (Organise attachments. (Development of curricula. Research. Clinical supervision. Inservice training.	Maintain records – staff. Supervise ancilliary staff. Reporting repairs. Prevention of accidents. Investigation of mishaps and complaints. Keeping Nursing Officer fully informed.

Appendix B

Common elements found in joint appointments

1 A joint venture between service/education.

2 The aim of improving liaison between service/education.

3 A joint teaching and clinical responsibility.

4 Updating and disseminating clinical knowledge.

5 Supervising learners in the clinical setting.

6 Assessing learners.

7 Acting as a resource for clinical development.

8 Developing research awareness.

9 Developing a learning environment.

10 Revising and updating clinical education.

11 Teaching in schools of nursing/departments of nursing.

12 Counselling staff and learners.

13 Inservice training/staff development.

14 Selecting and interviewing staff.

15 Implementing district/health board/hospital policy.

Appendix C

Joint appointment peer group members

Continuous membership

Ruth Balogh	nurse education researcher, West Cumberland Hospital
Senga Bond	nursing research liaison officer, Northern Regional Health Authority senior lecturer, School of Behavioural Science, Newcastle Polytechnic
Bridget Durham	ward sister, dual role appointment ward, surgical area, Eastbourne District General Hospital
Christine Howden	joint health visitor/lecturer, Lothian Health Board/Department of Nursing Studies, Edinburgh University
Sandra Mills	formerly joint clinical teacher/ward sister, care of the elderly, Tameside General Hospital presently professional officer, Royal College of Nursing Association of Nursing Students
Joan Pollitt	formerly joint clinical teacher/ward sister, orthopaedic area, West Cumberland Hospital presently clinical teacher, West Cumberland Hospital
Eileen Walden	formerly joint clinical teacher/ward sister, geriatric area, South Western Hospital, Lambeth presently clinical innovator, Purley Hospital, Surrey
Pauline Wenban	ward sister/clinical teacher, dual role appointment ward, surgical area, Eastbourne District General Hospital
Steve Wright	clinical nurse specialist, joint nurse tutor/charge nurse, care of the elderly, Tameside General Hospital

Other contributing members

Mary Earl	formerly clinical nurse specialist in care of the elderly, Paddington and North Kensington Health Authority
Melody MacFarlane	formerly joint clinical teacher/ward sister, geriatric area, South Western Hospital, Lambeth

Cyril Murray	clinical teacher/charge nurse, care of the elderly, Tameside General Hospital
Anne Nicholson	formerly tutor/clinical nurse specialist, paediatric oncology, Royal Victoria Infirmary, Newcastle presently senior nurse, paediatrics, Royal Victoria Infirmary, Newcastle
Ruth Sander	formerly joint clinical teacher/ward sister, geriatric area, South Western Hospital, Lambeth presently nurse specialist, Queen Alexandra Hospital, Portsmouth

Appendix D

Specimen job description devised for a joint appointment on a surgical ward

1	**Title**	Nurse educator, ward sister/charge nurse in a surgical ward
2	**Grade**	Nurse tutor or clinical teacher
3	**Qualification**	Registered on General part of Register Registered nurse tutor or clinical teacher 4 years post-registration with 2 years experience as surgical ward sister/charge nurse
4	**Responsible to**	Director of nurse education Director of nursing services
5	**Reports to**	Senior nurse manager – surgery Senior tutor
6	**Overall aim**	To integrate theory with practice through a joint education/service appointment
7	**Job summary**	
	7.1	To promote the concept of on-the-job teaching by being involved actively in clinical practice on a surgical ward.
	7.2	To promote the highest possible standard of nursing care by developing a model for nursing based on the practice of individualised patient-centred care.
	7.3	To promote the use of relevant nursing research findings in the planning of individualised nursing care.
	7.4	To participate in the education of student and pupil nurses in both classroom and clinical situations.
	7.5	To promote realistic inservice training for newly qualified and newly appointed nursing staff.
8	**Educational responsibilities**	
	8.1	Teaching of student and pupil nurses in the classroom and on the ward in accordance with the school curriculum.

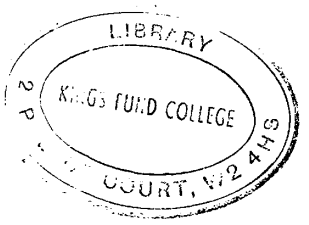
8.2	Providing clinical supervision of nurse learners on the surgical ward.
8.3	To foster a suitable learning climate on the surgical ward.
8.4	To take part in practical ward based assessments of nurse learners as specified by the English National Board.
8.5	To assess the practical competence of learners and trained staff and give advice and assistance where possible.
8.6	To further the concept of on-the-job teaching on the surgical ward by involving the trained nursing staff in the training of nurse learners.
8.7	To promote professional interest and development of the trained nursing staff through advice and counselling.
8.8	To keep relevant teaching records of all nurse learners.

9 Clinical responsibilities

9.1	Maintain a thorough knowledge of the patients and the ward organisation.
9.2	Ensure a high standard of nursing care by developing positive relationships between all groups involved in the welfare of the patient.
9.3	Ensure a high standard of nursing care by being involved personally in the nursing care of the patients implementing and evaluating on-going care plans.
9.4	Maintain continuity of nursing care by giving and receiving reports and evaluating care plans with the ward team.
9.5	Liaising with medical staff and other professional staff regarding the clinical care of the patient and advising on the integration of this care into the nursing care plans.

10 Management responsibilities

10.1	To work closely with the joint appointee in the routine management of the ward.
10.2	To keep up to date with, and maintain the implementation of, the district policies within the ward.
10.3	To maintain and control all drugs in accordance with the agreed procedures and policies.
10.4	To participate in director of nursing services/nurse manager meetings.
10.5	To participate in interviewing applicants for trained staff posts on the ward.
10.6	To act up for the nurse manager in the unit on a rotational basis.



References

Abdel-Al H (1975). Relating education to practice within a nursing context. Unpublished PhD thesis, University of Edinburgh.

Alexander M F (1983). Learning to nurse: integrating theory and practice. Edinburgh, Churchill Livingstone.

Ashworth P M and Castledine G (1980). Joint service/education appointments in nursing. Medical Teacher, 2, 295-299.

Balogh R and Bond S (1984). An analytical study of a joint clinical teaching/service appointment on a hospital ward. International Journal of Nursing Studies, 21, 2, 81-91.

Bendall E (1975). So you passed, nurse: an exploration of some of the assumptions on which written examinations are based. London, Royal College of Nursing.

Birch J (1972). To nurse or not to nurse. London, Royal College of Nursing.

Christy T E (1980). Clinical practice as a function of nursing education: an historical analysis. Nursing Outlook, 28, 493-497.

Dexter P A and Laidig J (1980). Breaking through the education/service barrier. Nursing Outlook, 28, 179-182.

Fretwell J E (1983). Creating a ward learning environment: the sister's role. Nursing Times Occasional Papers, 79, 17 August, 37-39 and 24 August, 42-44.

Gott M (1984). Learning nursing. London, Royal College of Nursing.

Jones D, Crossley-Holland C and Tadeusz M (1981). The role of the nursing officer. London, Department of Health and Social Security.

Kelly E M (1980). Bolton's introductory course. Nursing Times, 75, 213-214.

Kirkwood L (1979). The clinical teacher. Nursing Times Occasional Paper, 75, no 12, 49-51.

Lewin D and Leach J (1983). A clinical learning project. Nursing Times, 79, 23 November, 61-65.

Kuhn J E (1982). An experience with a joint appointment. American Journal of Nursing, 82, 1570-1571.

Martin J L (1973). The scope for learning. Nursing Times Occasional Paper, 69, no 29, 113-116.

Melia K (1983). Students views of nursing. 3. Nursing in the dark. Nursing Times, 79, 25-31 May, 62-63.

Neimz K and Bond S (1984). Evaluation of a learner support scheme provided by staff nurses. Unpublished report. Hartlepool Health District.

Oda D (1977). Specialized role development: A three phase process. Nursing Outlook, 25, 374-377.

Pembrey S (1980). Ward sister. Key to nursing. London, Royal College of Nursing.

Pierik M (1973). Joint appointments: collaboration for better patient care. Nursing Outlook, 21, 576-579.

Powers M J (1976). The unification model in nursing. Nursing Outlook, 24, 482-487.

Report of the Committee on Nursing (1972). (Chairman: Professor Asa Briggs.) London, HMSO. Cmnd 5115.

Roper N (1976). Clinical experience in nurse education. Edinburgh, Churchill Livingstone.

Runciman P J (1983). Ward sisters at work. Edinburgh, Churchill Livingstone.

Ryland R and Moysey J (1983). Joint appointments 2: collaboration for a more productive future. Nursing Times, 79, 12 October, 51-53.

Salvage J (1983). Joint appointments 1: building bridges. Nursing Times, 79, 12 October, 49-51.

Sherwen N and Salvio K (1983). The teacher/practitioner appointment. Nurse Educator·8, Summer, 30-33.

Taylor J (1979). The opinions and expectations of the staff and students involved in an experimental introductory course for student nurses. Unpublished dissertation, University of Manchester.

Walden E, Gallant K and Sander R (1982). Sharing the pleasure and the pain. Nursing Times, 78, 833-837.

Werner J (1980). Joint endeavours: the way to bring service and education together. Nursing Outlook, 28, 546-549.

Wilkinson K (1983). Joint appointments 4: a blue print for a joint appointment. Nursing Times, 79, 19 October, 29-30.

Wong J (1979). The inability to transfer classroom learning to clinical nursing practice: a learning problem and its remedial plan. Journal of Advanced Nursing, 4, 161-168.

Wright S (1983). Joint appointments 3: the best of both worlds. Nursing Times, 79, 19 October, 25-29.

Young A (1983). Aspects of nurse training in Northern Ireland. Centre for Applied Health Studies, The New University of Ulster.

£2.50