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THE NURSING PROCESS AND HANDICAPPED PEOPLE

Notes of a Workshop held at

King's Fund Centre

Monday, 20th October, 1986

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King's Fund Centre
126 Albert Street
London NW1 7NF

THE NURSING PROCESS AND HANDICAPPED PEOPLE

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Chaired by James P Smith, FRCN, Assistant Director, Long Term and Community Care Team, King's Fund Centre.

Introduction

This workshop was unique, said James Smith, in that student nurses rarely sat round a table with directors of nursing education (DNEs) to discuss nursing practice, and even more rarely included a group of people on the receiving end of that care. This initiative was one of several stemming from a meeting held at the Centre in February 1986, that had brought together representatives from various professional training boards and national disability organisations and which had identified the need for basic and post basic training to nurture a more positive and normal approach to people with physical handicap.

The purpose of today's discussion was to focus on the 'nursing process' model of nursing care and how it responds to the needs of disabled people in general hospitals. The chairman stressed that the discussion was to be limited to the care of the disabled person in the acute hospital setting.

He went on to say that other workshops had or were to be convened to look at other aspects of training, including the training needs of nurses working in long term care (workshop 1st September, 1986, report in preparation); and multi-disciplinary student training (10th December, 1986).

The Disabled Person's Perspective

Lin Berwick, Counsellor with Carematch, and herself multiply disabled, wanted to look at the difficulties of the disabled person with a multi-handicap including that of blindness. Such patients faced tremendous difficulties in getting from one hospital department to another because of lack of access and the fact that no help was available from staff such as porters.

Blindness brings specific problems, you do not know how many people in the queue before you; no doctor comes to get you; and then you will be called but cannot get there. You will not be aware of what is going on around you, and will have a sense of everything being vast and echoing. You will not be able to get up onto the couch, there will be no disabled loo, and you will not be able to have a bed pan in the out-patients department. No help will be offered to you and all things will make for anxiety. Voices will be strong, you will not know rank of staff and will have no physical contact with people around you. The staff will have no concept of what blindness means, and will make no effort to help you to orientate yourself on admission to a ward; nor will they introduce you to the other patients. You will find yourself in a lonely frightening situation, the more so as you will be unable to look around. You will put your things away in a locker in a structured position, a nurse may come and tidy up this locker not realising that you will be unable to find your things for yourself. You may not be shown where the bathroom is just told 'It is over there!' A nurse will come to your bed but will not announce herself, will not tell you what is going on, or what she will be going to do to you. Your food will be placed beside you, but no one will tell you exactly where the food is on the plate, what sort of choice there is, and will not ask if you need help cutting

your food up. Lin saw a need for nurses to be given general everyday hints about coping with blindness, she also felt that there was a need for a visible notice on the wall above the bed stating that a particular patient was blind.

Cathy Sells, a registered nurse tutor, who now lectures to a variety of students and professionals on disability awareness, asked participants to think about what was special about the nursing process and then what was special about the hospital patient. As an ex-nurse, Cathy felt that all patients required the same or similar care, extra care was needed because all patients were worried. Disabled people had a certain amount of independence and were worried whether this would be removed on entrance to hospital. They were right to worry as all their independence would be removed. Her experience was that a rapport developed between the nurse doing the written nursing process and herself, and so Cathy was lulled into a sense of security that the nurses were going to listen to her. She would heave a sigh of relief. Then her wheelchair would be removed, her catheter regime would be changed and the majority of the processes she had learned for coping would be taken away. She became dependent, and part of a process in an acute situation. She said she felt silly about asking again. It had nothing to do with resources, nursing created dependency. As a disabled person you needed to hang on to your independence amongst other able bodied people. Cathy was sure that the nurses inability to ask her came from their fear of her as a disabled person. The disability became a physical barrier, and nurses must get beyond the fear of disability and be aware of the circumstances of disabled people generally. Cathy felt rejected in hospital, having given so much personal information. This rejection actually stemmed from the nursing process which did not meet her needs.

Peter Swain, a member of the Spinal Injuries Association Management Committee, co-ordinator of Exeter Council for Independent Living and a member of Exeter Health Authority, said that in his capacity as a health authority member he had visited a great many hospitals but as a disabled person his direct experience of the health service was limited. However, during a short stay in the local DHA a few years ago it became apparent that if anything required doing the ward cleaner was the best person to ask.

He regarded the two single most serious problems with the NHS at the moment as being the fact that it is run by professionals and it has patients to deal with!

Admission to hospital could be a dehumanising experience. It is far too easy to be regarded more as a statistic, a bed occupant and a medical condition rather than a person. Disabled people are particularly vulnerable in that they are used to coping in familiar surroundings, possibly with the assistance of carers who fully appreciate the attendant problems.

Within hours of admission to a ward in the DGH he had acquired a bed sore, his first in more than twenty years as a disabled person. At no time during his stay was he asked about his particular requirements. Not only had trained staff failed to appreciate his needs, they were not prepared to ask. Far too much reliance was placed on information held on the ward computer.

This proved a stressful experience and did not help in improving the condition which necessitated admission in the first instance.

Disability awareness training should be built into nurse training programmes at the earliest possible stage. Such courses should be conducted by disabled people from lecturing through to examination stages. At present there is no requirement on the part of schools of nursing to incorporate this important subject in the curriculum.

There is currently an identity crisis in the nursing profession. Successive documents produced by the ENB and the UKCC in the last two years seem to be aiming towards producing a nurse so highly skilled in scientific skills that the old idea of the cool hand on the fevered brow is no longer part of the so called 'nursing process'. Interpersonal skill is the essence of good nursing practice, let it not be forgotten in an obsession with status.

The Students Perspective

Paul Mangham, chairman of the RCN's Association of Nursing Students, introduced himself and his two colleagues, who were training for the Registered General Nurse qualification, and were also members of the executive committee of the RCN Association of Nursing Students. That was where the similarities ended. Paul was a post-enrolled student, working in a district general hospital in Merseyside, Ann Mills was following the mainstream three year training at a prestigious Oxfordshire hospital, and Nick Williamson was taking the undergraduate course at the Southbank Polytechnic in London and gaining clinical experience in major teaching hospitals.

In their preparation for the workshop they had thought that their experience would all be very different, this had not proved to be the case, as their presentations would show. They had faced the depressing truth that the nursing process was being used to make patients out of people.

As a student Paul could use the word masturbation! The concept of patients being sexual beings seemed to be one largely confined to textbooks, and rarely filtered down to the hospital ward. The first time that the sexuality of a patient reared its head during his training had been during a ward handover from night staff. "That awful patient Mr J was.....with himself". There it was, Mr J was for the rest of the day condemned as a dirty degenerate and to some extent treated as such. His bedding was changed, in a manner which had not hidden the nurses' repugnance of his crime. Paul had mentioned this incident to the ward sister who said that it just went to prove that the nursing process could help, they had identified a problem - Mr J was a masturbator, now they could see what they could do to stop him. To Paul this had been wrong, masturbation was not the problem Mr J had, indeed he found little difficulty with it at all, it was a problem for the nurses.

He felt that nursing was processing patients rather like peas not seeing them as individuals, and allowing nurses, still paying lip service to individualised care, to reduce disabled people to problems of mobility, excretion, bedsores and bums, and mentally handicapped people to 'What can you expect, isn't it a shame'.

It seemed to Paul that what the abused and misunderstood nursing process did was to impose a poorly educated view of 'normality' on to those in its grasp.

He understood that one of the major reasons for hospital admission was urinary or faecal incontinence. Glibly the nurses' objective would be defined as wanting to preserve dignity. Paul was sure that as he was talking, a patient somewhere would be having their trousers pulled down in full view of complete strangers, and that their carers, unaware of any wrong doing, would be evaluating this with an uncomprehending 'care given as planned, continue as required'. If you had a lot of demanding work to do, it was much easier to reduce it down into tasks. 'Ah' says the nursing process 'you cannot do that, because I'm about individualised nursing'. The nursing process had been described as a prescription for nursing care and yet the care plans themselves were all too often written by very caring, deeply committed, unqualified nurses with very little supervision or support. Care plans in these circumstances might stop short of being what he had once heard described as 'don't care plans' but were most likely to be 'I don't know how to care properly' plans.

On behalf of nursing students he wanted to make a plea to those qualified staff present to show how best nurses could serve the interests of patients in their care. If students could see that the way patient care was currently being planned and implemented was wrong, could not they? If students could see the need for flexibility in care to preserve the best of what the person had had before admission, why was it that so many nurse managers seemed unable to. Were nurse managers frightened by the concept of the nursing process, or did they not really believe in it? Or was it that in order to allow a patient to be able to participate in their own care it took greater trained intervention than undoubtedly existed at the moment. If the nursing process was to be allowed to be a tool used by nurses with realistic aims agreed upon by nurses in conjunction with clients, then we should stop pretending that the way things were now was anything other than lip service. If nurses were slaving away to get plans and evaluations written up in time for handover, whilst those in their care sat alone wanting to talk or laugh or cry with another human being, but unable to, then this made a travesty of all the nursing process should stand for.

Ann Mills, outlined her personal experience of the nursing process. She had done a year as an SEN then changed to the RGN course. Whilst an SEN she had briefly been told about the nursing process, and the RGN training had also given her a brief introduction to it, in that she had been given a list of tasks. Once in the ward situation she had found most wards had had the nursing process. She felt that the nursing process did help you judge what was wanted for the patients, gave order for tasks to be done, and could tell why/what patient was having treatment. Sometimes the ward sister might show you how the nursing process should work. However she had observed the following situations: 12 patients coming to a ward for admission, all told to arrive at 9 a.m. then sitting in the ward corridor for several hours, until seen and shown where their beds were. This had made her feel inadequate, she had wanted to stop and talk and reassure them. On another occasion she had found a disabled woman weeping, and on asking what was wrong, had learnt that the patient had been moved into the corner of the ward without consultation, felt thoroughly rejected and that the staff did not like her.

As a student nurse what was she to do? She would like patients to be able to criticise the care they received by completing a survey form on discharge, which would give some idea of how they viewed the care they had had. But patients were not encouraged to criticise. It was her experience that where the nursing process had been properly implemented it worked well, but equally her experience encompassed situations, which she had queried, where the outcome had been most unsatisfactory.

Nick Williamson, wanted to focus on the implementation of the nursing process. Those nurses who had worked on wards where the nursing process had been used as an effective tool in delivering a high standard of care to patients, would have experienced, like him, the excitement and satisfaction that this could bring. However as his fellow students had already indicated this was not always the case, and even today some accounts of nursing practice had more in common with the writings of Charles Dickens that of good practice in a modern district general hospital.

He wanted to know why were we still hearing stories of bad practice? It was not an easy question to answer but he believed the answer lay in the comment made by Jane Salvage in her book The Politics of Nursing, where she said that the social, political and economic forces largely determined who nurses were, the work they did, the way they did or did not do that work. He felt that you had to look at nursing not as an isolated entity but within the broader context, and that was what he wanted to do.

Today we were discussing the needs of disabled people, and he thought he was right in saying that very few practising nurses had had direct experience of living with disability. This was therefore the first major problem in the relationship - how do you assess the needs of an individual, plan, give and evaluate care when you have had no direct understanding of that individuals problems. The answer lay in education.

Nurses generally were beginning to accept that the present apprenticeship system of training needed a major re-think. Interest in the RCN's Judge report and the UKCC's Project 2000 confirmed this. Students were an integral part of the work force, carrying responsibility for a major part of delivery of care, and particularly for the role of the nursing process in delivering that care.

It had been estimated that qualified staff gave only 25% of care, the remaining 75% was given by students, pupils and unqualified auxiliaries, often without direct supervision by qualified staff. This raised the question of manpower.

Nurses needed to acquire communication skills if they were to bridge the gap between nurse and patient and successfully use the nursing process. He felt there must be greater emphasis on communication skills in basic nurse education.

Being a nursing student was not just about acquiring the appropriate knowledge and skills to be a safe practitioner. It also served the vital function of socialisation into the nursing profession, a process that gave the patterns of behaviour, thoughts, feelings and beliefs appropriate for a nurse. He was reminded of the example of professional behaviour that had been presented to him. With a staff nurse he had gone to help to put back to bed an elderly, confused, partially paralysed man, who also had urinary problems. They had found the patient sitting beside his bed, with a pool of urine under the chair. Nick had said to the staff nurse that he would go and get the things to clean the patient and wash him. The staff nurse said they did not need to wash him, he would be wet again in an hour. What was it that happened to people during their training that made them care less, or made them think it was okay to put a patient to bed knowingly leaving that patient wet?

The Trainer's View

Charlotte Green, a Senior Clinical Psychologist involved in cooperative planning and implementation of a nursing process approach in practice, said that the model she had developed for mental handicap nursing in the UK could be applied, if the emphasis was adjusted, to all nursing specialties. Some of the difficulties discussed arose because the nursing process was new, and there was a need to use it correctly, particularly on night duty. She felt that it was very important to address the problems that had been raised today, because in the future, with the move to community, the general hospitals will have a greater need for all nurses to be able to cope with all client groups.

She did not see the nursing process as the problem, the problem was the attitude of nurses to using it as a problem solving approach to nursing care. Used properly the nursing process was not weak.

As a first step we needed to look at the content of nursing care whatever group was concerned. Charlotte admitted that the nursing process documents were closed ended in early stages, with individual nursing priorities limited to these restrictions. Thus in practice these documents were produced to meet the needs of the majority of patients, and were not so receptive to the needs of the minority patient groups, such as disabled people. Nurses also needed to be able to consider where the emphasis lay between long and short term care.

Charlotte then briefly outlined those modes of care which would assist the nurse in developing her care plans for disabled people when implementing the nursing process.

Physical Care - this will be concerned with the care of the disability itself, and for care related to the reason for admission.

Psycho-Social Care - this will be an important part of care for all patients, but particularly so for the long stay and rehabilitation patient.

Skills Development - this will be closely aligned to rehabilitation and part of the psycho-social care. The nurses will need to understand the permanent disability and how they could influence the patient, by encouraging the maintenance of existing skills, or encourage the development of new skills, thus leading to increasing confidence on the part of the patient.

Activities of Daily Living - a vital area of nursing, particularly where disabled people were concerned. In some circumstances this received little emphasis. Attention might be paid to ADL in specialised units, but there was little opportunity for students on general wards to implement this, which might be at the simple of level of adopting a mechanism by which the patient could attract the attention of the night nurse. This whole area had barely been looked at, and something needed to go into the curriculum.

Moderation of Undesirable Behaviour - there might be times in the field of nursing care where it is important to emphasise this mode of nursing influence, i.e. to discourage the patient to talk about pain resulting in lessening of pain and increased level of function; where the patient might have withdrawn as a method of coping, this could be seen as unacceptable and the nurse could formulate care plans using the nursing process to influence patient behaviour.

The delivery of nursing care may draw on one or more of the above modes, but it must be remembered that no one patient is the same, thus care plans must be flexible and nurses must have the ability to exercise flexibility in carrying them out.

Jean Heath, Information and Projects Co-ordinator at the ENB Learning Resources Unit, had been greatly saddened by what she had learned during the day. So many problems had been raised, just where did one start to intervene? She had been able to identify some common threads - these were attitudes, perceptions and awareness.

There was pressure from the press and media for more awareness from health care professionals and this push for change meant that nurses must use an individualised approach to care. She did not accept that the tool was weak, it was a problem of implementation. There was a gap between theory and practice, and in this the disabled person was the same as everyone else. It was a problem of awareness and perception in the delivery of care.

It was important, she felt, to be concerned that the professions were actually questionning how to deal with the options and choices facing staff, the more so as students were expected to make informed choices for their patients. We must continue to help the nursing process development through staff support, so that nurses understood what it was about. It was encouraging that educational organisations were now supporting more flexible ways of learning which did enable some disabled people to be involved in care plans. However we needed to stop talking about implementing collaboration and do it.

Jean did not accept that it was impossible to get staff to change their attitudes. Management did encourage team work, and was now more client centred, taking teaching into the clinical areas. Perhaps potential clients could have specific disability tapes to lend to ward sisters, so that no disabled patient coming into hospital would be stripped of their role, but would maintain some control over their own care. She pointed out that evaluation of care was very weak, if this was going to be done properly then the disabled person has to be involved. Goal setting must be realistic, but it would not be if there was still a gap between the nurse's ability to assess and her ability to determine the realistic goals.

What was the English National Board's Learning Resources Unit doing about improving implementation of the nursing process? They print and distribute the Nursing Process Link newsletter which looks at education, goal setting, evaluation, media teaching materials, as well as other issues around implementing the nursing process.

Jean said that the workshop had identified to her as a trainer the following needs:-

1. The need to address the continuing gap between theory and practice.

2. The need to shift caring for to caring with people.

3. The need to move in training to a multi-disciplinary approach.

4. The need for clients to be heard, so that they can be heeded.

Discussion

The final session was a frank and wide ranging one covering issues raised during the presentations. It has been found possible to present these under several topic headings.

Experiential Training

An enthusiastic request from one student for more experiential training sparked off a lively debate amongst disabled participants as to its real value in training.

Peter Swain felt that role play was not the whole story and should be avoided where possible. Sitting in a wheelchair or walking around blindfold for a few hours conveyed nothing of the real problems faced every day by thousands of disabled people. Much more could be learned by talking to disabled people and learning from them about what disability means and this can vary enormously amongst individuals.

Ann MacFarlane, a member of National Council of Arthritis Care and herself severely disabled, had recently attended a seminar on independent living where a consultant physician had spent the entire time sitting in a wheelchair and emerged saying that he had enjoyed his day. However Ann felt that this had been a dangerous practice as he might have learnt one or two things, but there would still be much that he was not aware of.

Cathy Sells agreed, it was not only dangerous but voyueristic. She emphasised that during the day the importance of involving and listening to disabled people had been raised time after time, we had to do this. To tell students to go and pretend to be disabled to learn what it was all about was not the way to do it. Students and disabled people have to learn to communicate with one another.

The students agreed, disabled people have problems to face every day, and they accepted that a student may only nurse a disabled person for a very short period of time, if there was effective communication they should help one another.

For Cathy the nursing process relationship was the tip of what students should be giving carewise, the student also had to share of themselves. Cathy did feel that there was an element of fear in dealing with disabled people, and experiential training often reinforced this barrier.

Lin Berwick however felt that there was nothing wrong with trying to experience disability.

The trainers present felt that there was a place for it as long as it was properly supervised.

Manpower

Manpower equals time, and a ward sister required time to spend with students. The ward sister was seen as the key contact point for the students, however the ward sister's workload was phenominal, and nurse education asked for a tremendous input from the ward sister. Concern was voiced at the high burn out rate amongst ward sisters.

One of the DNE's reported that two ward sisters had recently presented figures for admissions to their ward over a six day period - 65 admissions; 22 in one day, with 12 patients going down to theatre before noon on one day. These were taken from the records of an average acute ward. She accepted all that was being said, but wanted to know how you could help patients in a ward where change was total over a 24 hour period. To her this intimated that we were at the point of helping students just to survive in a ward situation. It was evident from the wastage rates that the profession was losing those who could not cope; but cared the most.

The student response was that there was a need to be honest about resources.

Nursing Process

It was pointed out that the nursing process was not accepted all the way up the nursing hierarchy. It was known to work well where senior staff understood it and taught students how to implement and use it properly. Those students present had demonstrated that they, as individuals, had thought about the ways in which they could implement things for themselves. The nursing process was about initiatives, criticism of ourselves and others. There was a need to understand that it was very difficult for a student to tell other staff that they were unapproachable. Members of ward teams must talk to one another.

Charlotte Green said that it was important that there should be more understanding of the independent contribution of a nurse when working. We should ensure that those senior nurses who did not feel part of the nursing process understood this, as they might then ensure that nurses in long stay situations particularly, were not moved around so much.

One DNE felt that patients and relatives should be more involved with the nursing process, for it was being used as a tool without principles. Where principles were being applied it worked properly. This provoked the comments that some of the disabled participants experience of being involved was that the nurse was concerned as to how she preserved her control. One message that needed to be got across was just who did nurses think they were?

The students wanted more honesty in admitting that there was a burden of care, and that 22 admissions in one day was not care, but a burden. If the nursing process does not work in such a situation then it should be thrown out.

Education

One director of nurse education felt that there was conflict in what was being said. There were limits, nurse education could not do everything. We had to teach students to say that they did not understand, and that would not be easy. What did we need to do to educate nurses so that they could cope with disabled patients; were we saying that we needed to re-think the entire education process for the student? We must remember that the nursing profession takes in students who one week into their training course begin to learn how to slot patients into the situation.

The students had said that they thought that nurse education should be moved into the higher education setting, the one nurse tutor present did not agree, nursing was practice based and should remain so both in the hospital and the community. Nurses come into the profession wanting to do practical work, however he said this should not stop the improvement of the academic preparation for the job. It was stated that the general public had an image of the role of the nurse, perhaps we needed to create a more realistic image of the work nurses did. The same applied for the student who arrived with certain expectations, perhaps these also needed to be broken down. Other participants felt that the need for nurse education to move away from a practical basis was so that we were able to evaluate what was being taught. At the moment most nurse learning is by example, seeing what actually happens on a ward. The example of the nurse not caring about the incontinent patient showed that things can go very wrong.

The student following the polytechnic course was not ward based, however when he was working on a ward he saw his tutor each week. The ward based students saw their clinical tutors perhaps twice during their entire training.

The chairman intervened to establish where the polytechnic based student got his support from at other times during his ward experience. The student confirmed that it came from the ward sister. There appeared to be very little difference between the different training methods, the chairman said, however there was the problem that ward sisters did not get much training to help them when teaching and supporting students.

The suggestion was made that there was a need for a clinical nurse specialist in disability rehabilitation. The students said that they wanted the ward sister to have more training, particularly on patient needs. It was admitted that there was wide concern within the profession about the standard of ward teaching. The ENB was already encouraging courses on ward sister training and eventually such training would be compulsory for ward sisters. It was reiterated that such training must have more awareness of the needs of patients and relatives.

Quo Vadis?

Miss Hazel Allen, Associate Director, Education and Training, King's Fund Centre, drew the session to its close briefly summarising the messages the day had had for her.

1. Each group had mirrored the other's anxiety. For example the nurses had shown a certain amount of grief and guilt at their inadequacies demonstrating defensive attitudes in the compartmentalization both of patients and in working with them. In turn patients had expressed piecemeal grief of loss in their views.

2. There are both disabled patients and disabled nurses - it is difficult to understand the lifestyles of other people, whoever they are. In the incident of the patient masturbating do we associate this with the individuality of the patient or put it down to undesirable behaviour.

   The semantic massage of the nursing process sometimes prevents clear appreciation of such issues.

3. The need to look at the issues of manpower, adequate educational facilities, pay, status of women etc. Everyone needed to be aware of and understand these.

4. The need to maximise the independence of patients, the student was an important vehicle for the patient. Knowing more about the patients' needs should ensure that the patient was not made more dependent by the nurse.

   However we need to appreciate that 'proximity does not collaboration make'. The day hinged around the question of combining proximity and collaboration.

So where did we go from here? Would participants be prepared to commit themselves to meeting in small groups of patients, students, tutors and ward sisters, to consider ways in which it might be possible to help the ENB facilitate some of the issues that had been identified during the day. There would need to be a commitment from each individual, for possibly up to two years.

Participants were asked to think about this and write to the chairman, once they had had a copy of the notes of the day.

The chairman expressed his thanks to everyone for what had been a very thought provoking and truthful day.

Diana Twitchin
November, 1986

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THE NURSING PROCESS AND HANDICAPPED PEOPLE

MONDAY 20th OCTOBER, 1986

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