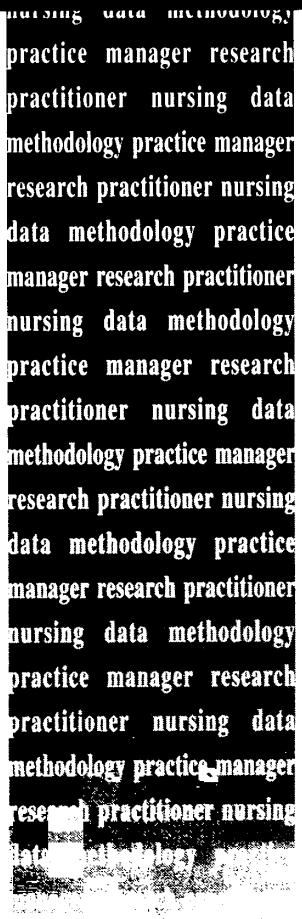

Nursing
Development
Units

THE GROWTH OF **TAMESIDE NURSING DEVELOPMENT UNIT**

An exploration of perceived changes in nursing practice over a ten-year period

Mary Black

KING's FUND CENTRE

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We are grateful to the Department of Health for funding this study

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The King's Fund Centre is a service development agency which promotes improvements in health and social care. We do this by working with people in health and social services, in voluntary agencies, and with the users of these services. We encourage people to try out new ideas, provide financial or practical support to new developments, and enable experiences to be shared through workshops, conferences, information services and publications. Our aim is to ensure that good developments in health and social care are widely taken up. The King's Fund Centre is part of the King's Fund.

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Foreword

Nursing has come a long way since the days of battling against communicable diseases, long stays in hospital after surgery and custodial care for the mentally ill. There has been a continuous strive for improving nursing care for patients, a continuous strive for pioneering of healthcare technology and a continuous pushing forward of the frontiers to improve our knowledge and give better insight into the complexity of maintaining and improving the health of the nation.

The pioneering of NDUs had its origin in the desire to systematically put in place all the essential elemenets to enable best nursing practice, based on patients' needs and perceptions and the knowledge gained by research. Above all it is motivated by the desire to improve the quality of care. Oxford's Burford Unit and the NDU at Tameside were early examples, followed by four pilot Nursing Development Units funded by the King's Fund Centre through the Sainsbury Family Trust. This led to the funding by the Department of Health of a further thirty demonstration sites.

To find out the benefits as well as the pitfalls of establishing NDUs the Department of Health funded a descriptive study of the four pilot sites and the Care of the Elderly Nursing Development Unit at Tameside.

This book is one of the two evaluative studies describing developments in the four pilot sites and in the Care of the Elderly Unit at Tameside. It provides valuable insight into the important issues which contribute to the success of NDUs or indeed inhibit their development.

The experience of these early units provides many useful lessons for those who wish to work as NDUs in the future and will act as a guide for both managers and practitioners.

I would recommend this text and the complementary study, *A Way to Develop Nurses and Nursing,* as background to your own development work, and am confident that you will find the material useful.

YVONNE MOORES
Chief Nursing Officer/Director of Nursing
Department of Health
August 1993

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Managers, educationalists and clinical leaders, who gave up their time to tell me about their contribution towards developing the Unit.

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Between autumn 1990 and autumn 1992 Mary Black was a researcher at Tameside General Hospital based in the STAG College of Nursing. She is now a research associate at the Centre for Primary Care Research at the University of Manchester.

Introduction

This study examines the changes in the nursing care of elderly patients that have taken place since the early 1980s in the former 'Geriatric' Unit which is now the Tameside Nursing Development Unit. This Nursing Development Unit (NDU), formally established in 1987, was one of the first in Britain and its work became well known through publicity in the nursing press and the publications of Steve Wright, who was consultant nurse until the end of 1991.

In 1990, the Department of Health and King's Fund Centre facilitated the establishment of a two-year research project to examine systematically the achievements of the Tameside NDU and to draw implications from its experience which could be applied in other nursing environments. With an increasing demand for objective evidence about both the quality and the cost effectiveness of nursing, studies such as this are of critical importance as they provide valuable information on which developments in policy and nursing practice can be based. The publication of this report is therefore seen as very timely.

Since this study began, the concept of Nursing Development Units has gained momentum and there has been a steady increase in the number of units that have been established in a wide variety of nursing settings. In 1991 the Department of Health made available funding for a further 30 units and early findings from this report, coupled with Turner Shaw's (1993) study of the four units funded by the Sainsbury Family Trust in 1989, have been informative in providing guidance for these new NDUs.

Many of the initiatives which have taken place in Tameside over the past 10 years are already reflected in the newly funded units, demonstrating a critical feature of NDUs, namely that of sharing their ideas and spreading the outcomes of their work to other areas. This places the currently funded units in a strong position to move forwards in other areas of nursing development work, with particular reference to government initiatives such as the *Patients' Charter* (1991), *Health of the Nation* (1992) and A *Vision for the Future* (1993), taking into account an emphasis on patient/user involvement, the rights of individuals and, of course, value for money.

Purpose of the study

The lack of accessible baseline data on the standard of nursing care in the early 1980s meant that part of this study was retrospective and drew on the collective knowledge of the key actors who began and sustained the process of change in the 'Geriatric' Unit at that time. The establishment of the NDU in 1987 followed a five-year period during which joint appointees, who had responsibility for both education and service, and were based on wards, began to implement changes in nursing practice.

It was within this context that the following aims and objectives were formulated:

Aims of the study

1. To describe the ways in which nurses perceive that patient care has changed in a Care of the Elderly Unit, over a ten-year period.
2. To examine the impact of these changes on the nursing staff who are now working in the NDU and the students allocated to the unit.

Specific objectives

1. To explore the background factors which have contributed to initiating organisational changes in the Care of the Elderly Unit at Tameside General Hospital since 1981.
2. To examine the ways in which these changes have affected nurses' perceptions of patient care.
3. To investigate the attitudes to staff development and job satisfaction held by nurses working in the NDU.
4. To evaluate student nurses' views of their experiences in the Care of the Elderly Unit (NDU).

The structure of the report

The structure of this report is outlined below to enable readers to identify specific chapters which may be of particular interest to them.

Chapter 1

Data were collected by a variety of qualitative and quantitative research methods which are described in Chapter 1. A reader who wishes to proceed straight to the presentation of the data can omit this chapter or refer back to it where necessary for clarification.

Chapter 2

This chapter sets the context for the changes in nursing practice that are described later in the report. It is based on interviews conducted with managers, educationalists and clinical leaders who had been instrumental in introducing and implementing changes in nursing practice in the Unit in the early 1980s.

Chapter 3

Nurses who have worked in the NDU for a number of years describe the ways in which attitudes, the ward environment, their approach to patient care and professional issues relating to their work have changed over the years.

Chapter 4

This chapter is based on a survey of NDU staff conducted in 1992 and provides a more representative picture of nurses' views on issues relating to staff development and job satisfaction.

Chapter 5

The perspective of student nurses is included in this chapter of the report. Their comments on the experience of working in the Care of the Elderly Unit were collected by means of short questionnaires.

Chapter 6

The report concludes by drawing together themes identified in the key summary points at the end of previous chapters. Qualitative and quantitative research methods were used, and the perspectives of different groups of nurses presented. In bringing the themes together, this chapter assesses the extent to which issues were identified as important by more than one group of informants.

Implications of the study

Because the research project on which this report is based is a case study of one particular Nursing Development Unit (Tameside NDU Care of the Elderly), it is not appropriate to make definitive recommendations based on the findings. However, a number of themes have emerged which have implications for policy making and the development of nursing practice. These themes are outlined below and described in more detail in Chapter 6.

1 The process of change

- The need to improve standards of nursing care in the 'Geriatric' Unit at Tameside General Hospital in the early 1980s was perceived by nurses working on the wards, managers and educationalists. The ward nursing staff, especially trained nurses, were few in number and although individuals began to change traditional ways of working, it was the shared commitment of managers and educationalists – who instigated senior joint appointments with responsibility for both education and service, based on wards – which initiated and sustained the process of change throughout the Unit.

- It took five years of commitment to change through the system of joint appointments before the Tameside Nursing Development Unit was established. Although the development of the Unit started from a very low base in terms of standards of nursing care, it is important not to underestimate the length of time it can take to implement significant changes in nursing practice. The continuity of personnel in key managerial and clinical positions was an important factor in developing a different vision of such practice.

- The support that student nurses received from joint appointees encouraged them to apply for jobs in the Unit by the mid-1980s. The presence of newly qualified nurses who chose to work there contributed to the change process and helped to alter the view, commonly held at the time, that 'Geriatrics' was where nurses worked if they were not 'good enough' for other clinical areas.

- The Tameside Nursing Development Unit, through its outreach activities, raised the profile of the nursing of elderly patients. The NDU label and the publicity that

innovations received challenged the stereotype of elderly care as just being 'basic nursing'.

2 Patient care

- The data presented in this study emphasise the importance that nurses give to their relationships with patients. These relationships have developed as the nurses' professional autonomy has increased, so that they are no longer mediated through routine or hierarchy. In the survey of NDU staff conducted for the study, nursing staff showed high levels of satisfaction with the standard of care that they had provided during the previous week. This finding is particularly important as Carr-Hill *et al* (1992) found that staff satisfaction correlated positively with both the quality and outcome of nursing care.

3 Staff development

- Professional development opportunities for all nursing staff were seen by Steve Wright as a key feature of the Nursing Development Unit when it was established. Nurses who were interviewed for the study commented that staff development had brought about changes in attitudes so that existing nursing practice was questioned more. Student nurses appreciated the reflective approach to nursing that they encountered during their allocation to the NDU.

4 Retention of nursing staff

- An analysis of information that was available concerning the number of nurses who had left the NDU between 1989 and 1992 showed a lower turnover than that reported for nurses caring for elderly people in a national survey of Royal College of Nursing (RCN) members conducted by Seccombe and Ball (1992). The continuity of care provided as a result of the low turnover of nursing staff enabled local expertise to develop further.

5 Comparisons of the opinions of NDU nurses with the findings of other surveys

- The morale of NDU nurses was found to be higher than that found by Seccombe and Ball (1992) and Waite and Hutt (1987) in their surveys of RCN members. The nurses were questioned about the importance of features of working life related to patient care, professional autonomy and working conditions, and the extent to which these features had been present in their own experience. The discrepancy between individuals' own values and their nursing experience was found to be much smaller for the trained nurses in the NDU than it was for the sample of RCN members.

6 Use of research data

- The data collected for the study were used by managers to inform policy decisions during the course of the project. An example of this was the introduction of an orientation day for student nurses after their responses to questions about the features of Nursing Development Units and primary nursing in questionnaires administered for the study. These showed low levels of awareness of these aspects of nursing.

Conclusion

This study aimed to provide as robust a retrospective picture as possible of the changes in nursing practice which have taken place in the former 'Geriatric' Unit which is now the Tameside Nursing Development Unit. It is evident that transformation into an NDU, a high profile, and dynamic leadership all contributed to high morale and continuing commitment to change among the staff, which have been sustained over a long period of time.

The findings of this study and those by Pearson (1992) and Turner Shaw (1993) have contributed to the debate about the ways in which newly established NDUs can develop nursing effectively. In particular, the growing body of knowledge on Nursing Development Units demonstrates that investment in the development of staff has, in turn, an impact not only on the morale and turnover of nursing staff but also benefits patients by improving the quality of the care that they receive.

1
Research methods

Introduction to the structure of the report

The aims and objectives of this study necessitated the use of a range of research methods, in order to answer different types of research questions. There are two arguments for combining qualitative and quantitative methods. The first is triangulation, which Hammersley and Atkinson (1983:199) describe as:

> an attempt to relate different sorts of data in such a way as to counteract various possible threats to the validity of our analysis.

The second argument is more pragmatic and sees combined methods as contributing towards the completeness of a research study. As different research methods each have different strengths and weaknesses, Finch (1986:183) suggests that:

> their combination provides the opportunity for research outcomes which are more authoritative and convincing.

If this study is seen in terms of a jigsaw puzzle, then a combination of qualitative and quantitative research methods can make more of the pieces accessible (Knafl and Breitmayer 1991). It also contributes towards providing a more complete picture of the events that have taken place in the Care of the Elderly Unit at Tameside Hospital since 1981.

The lack of written documentation, in a form that could easily be accessed, concerning nursing at the ' Geriatric' Unit at Tameside General Hospital in the early 1980s limited the scope of this study. Without baseline information, it was not possible to evaluate the extent of the changes that have taken place in the Unit since that time. Part of the project therefore was retrospective in nature, charting the changes from the perspective of two groups of informants who had observed and participated in them. Unstructured interviews were conducted with clinical leaders, managers and educationalists who were able to provide a strategic overview of the process of change (see Chapter 2). These data provide a context for the description of the changes that have taken place, which were obtained in unstructured interviews with those ward nurses who had worked in the Unit since 1985 or earlier (see Chapter 3). The historical data therefore were collected by qualitative research methods.

It was important to assess the extent to which the changes in nursing practice that had been initiated in the 1980s were perceived as important by the nursing staff currently working in the Unit. A survey of ward staff, which included nursing auxiliaries as well as first- and second-level nurses was conducted in order to obtain a representative picture of nurses' attitudes towards staff development and job satisfaction. The findings of this survey, which used a self-completion questionnaire, are reported in Chapter 4. In addition, data relating to the turnover of nursing staff during the years 1989–92 were collated.

Short questionnaires were also administered to student nurses, who were in the second year of their training for Part 1 of the Register, before and after their allocation to the Care of the Elderly Unit. This enabled the perspective of an additional group of informants to be included in the study. These data are presented in Chapter 5, together with information collated from questionnaires administered by a clinical nurse specialist to the first three groups of Project 2000 students that were allocated to the Unit during the Common Foundation Programme.

Throughout the project, I have sought to make use of data that already exist in some form within the Unit or the Health Authority, which relate to the movement of patients through the Unit, for example, data on deaths and discharges and the average length of patient stay.

Although the order in which these research methods are described relates to that of the objectives of the project, it does not reflect the chronological order in which the different strands of the research were carried out. The interviews with ward nurses took place between May 1991 and January 1992, and the survey of NDU staff between January and March 1992. Data from student nurses were collected from the summer of 1991 to the autumn of 1992, while the interviews with clinical leaders, managers and teachers were conducted between December 1991 and July 1992.

This outline description of the research methods used in this study provides a framework which enables the reader to understand how the research project evolved. As the research site was chosen because of its importance with respect to nursing developments, not because it was an ideal setting for a well-designed research project, the methodological approach taken to the study has been pragmatic. The research methods adopted for each strand of the research are described in detail below.

Methods used to collect data on organisational changes in the Care of the Elderly Unit at Tameside General Hospital

As indicated above, the absence of baseline information regarding staffing levels, the ward environment and the approach to patient care meant that these data were collected using unstructured interviews from the people who were involved in those changes: clinical leaders, managers, and educationalists. People who were in a position to have observed the changes were also interviewed: a physiotherapist and an occupational therapist.

Method

The research method adopted was inductive, because I was not in a position to know 'the salient parameters of the topic under study' (May 1991:191). Unstructured interviews were conducted, drawing on the ethnographic approach described by Hammersley and Atkinson (1983) and Burgess (1984). This interviewing technique requires that interviews should be tape-recorded, so that the interviewer's attention can be focused on careful listening and the direction of the interview, rather than on writing down what has been said. The informants talked in their own terms about their experiences of implementing and observing changes in nursing care.

This account of the research methods used has been written using the first person

singular active voice rather than the third person singular passive voice, as is customary in the methodological sections of quantitative research reports. Webb (1992:750) argues that not to use the first person is:

> inconsistent with the epistemology of the approach ... preventing readers from evaluating the adequacy of the research.

A structured format was not imposed on the interviews, so that the informants were able to introduce new issues of which I had not been aware. As these interviews took place in the second year of the project, and after all but one of the interviews with the ward nurses, I was able to test out some of the impressions I had gained about the history of the Unit, to see if they were widely shared. The tapes of the interviews were transcribed by the part-time project assistant after I had listened to them. I then checked the accuracy of the transcripts by listening to each tape as I read the transcript.

Sampling

The population of potential informants for this strand of the research was limited and the approach taken to identify them was a combination of opportunistic and nominated sampling (Morse 1991). Nominations of potential informants were made, not just by people who were themselves interviewed, but also by members of the Liaison Group for the project that had been set up at Tameside, which included managers from the Care of the Elderly Unit.

Access to informants did not present a problem, in that no attempt was made by the gatekeepers of the project to control who was interviewed. Individual informants decided whether or not to take part in an interview. However, even if I had the name of a potential informant, it was not always easy to contact people who were no longer employed by the Health Authority. I relied on informal contacts who had kept in touch with the person concerned, or knew someone else who was likely to have his or her address. Although it felt as if my letters were going out into a void, all five people contacted in this way did eventually agree to be interviewed. This group of informants comprised: Kate Wilkinson and Sylvia Ashton, former director of nurse education and senior tutor respectively; and two former joint appointees, Sandra Mills and Cyril Murray. A former sister, Ann Shaw, was still based at Tameside General Hospital, but was away on a course.

Within Tameside Hospital the key actors whose views it was essential to obtain were Stephen Wright, whom I interviewed before he left the post of consultant nurse, and Michael Johnson, deputy unit general manager. In addition, I interviewed Shirley Brierley, the most senior physiotherapist, and Marion Kay, the most senior occupational therapist responsible for elderly services at Tameside. Both have worked in the hospital for a number of years. Finally, I interviewed Jim Marr, the consultant nurse, who came into post in April 1992. His appointment provided the opportunity to seek the views of a relative newcomer on nursing practice within the Unit.

Data analysis

The data are presented so that the 'voices' of the informants can be heard, an approach that Denzin (1989:136) terms descriptive realism:

> It tells the native's stories in his or her own words. It allows interpretation to emerge from the stories that are told.

The analysis of the data was conducted by selecting those extracts from each transcript that were particularly illuminating and provided a vivid picture of a particular aspect of an individual's experience, in terms of what they observed, how they had reacted to particular situations and how they had felt. Webb (1992:749) describes the researcher's role in the selection of data:

> The word 'findings', implying that it is almost due to chance that certain information has come to light, misrepresents a deliberate search for some data as against others. New knowledge is constructed rather than found.

The extracts from the transcripts were photocopied and stuck on to five by eight inch index cards. The marked up transcripts were retained so that I could refer back easily to the context in which the extracted comments had been made. The index cards were then sorted and placed in a box under headings according to the subject matter of the quotation. This system was very flexible and made it possible to rearrange cards under different headings, if they covered more than one issue, or to put them into an order that I could use when writing the account.

In Chapter 2, the data are presented in a descriptive narrative account which follows the course of the development of the Care of the Elderly Unit since the early 1980s, and comprises quotations with a linking narrative.

Validity and reliability

The concepts of reliability and validity are used to assess the adequacy of scientific research, and imply standardised rules and procedures for collecting and analysing data. Qualitative research methods do not meet these criteria. An alternative approach to reliability that can be applied to qualitative research is that of auditability, which, according to Guba and Lincoln (1981) and Sandelowski (1986), means that the researcher should make explicit the 'decision trail' that he or she has used so that it could be followed by another researcher.

The concept of validity is more important than reliability, because qualitative research claims to present data of a different order to those of fiction or journalism. Qualitative research lacks those qualities that are valued in scientific research such as detachment, objectivity and impartiality. Some researchers claim that those prerequisites ignore the social elements of the research process (Webb 1992). The strengths of qualitative research lie in areas which fall outside the domain of scientific research, such as reflexivity, which, Hammersley and Atkinson (1983:234) state, require:

> explicit recognition of the fact that the social researcher, and the research act itself, are part and parcel of the social world under investigation.

A particular threat to validity with respect to these interviews was that they relied on the memory of the informants, who were asked to recall events that had taken place, in some cases, more than 10 years previously. Subsequent events also gave informants the benefit of hindsight. However the informants seemed to have little difficulty in recalling past events. After I had written up the first draft of the account based on these interviews, I sent it to informants requesting their comments. The feedback I received suggested that the draft chapter had accurately captured the situation in the Care of the Elderly Unit. The purpose of qualitative research, according to Field and Morse (1985:116), is:

> not to determine objectively what happened ... but rather to objectively report the perceptions of each of the actors in the setting.

The verification of the accuracy of the account by the informants affirms its validity.

Ethics

The ethical issue arising from this phase of the research related to protecting the interests of the informants. As the informants took part in the interviews on the understanding that they would be named, the completed transcripts, highlighting the passages that I wished to include in the data analysis, or extracts from the transcripts, were sent to them for comment. Some informants requested the opportunity to make minor editorial changes, to improve the flow of the quotation or to make it more succinct. I agreed to this. After the narrative account was written up, the first draft was sent to all the informants. This was so that they were able to see the context in which their quotations had been used, and also to see references that had been made to them and their work by other informants. Minor changes were made to the document as a result of the comments received.

Data collection from ward nurses by interviews

Method

These interviews followed the same ethnographic, inductive approach as the interviews with nurse leaders, managers and educationalists. All but one of the interviews with ward nurses were conducted before that set of interviews, as I did not want to approach ward nurses with preconceptions associated with a strategic overview from a management perspective. As I am not a nurse, I entered into these interviews in the role of a stranger (Merton 1972, Simmel 1950), whose knowledge of nursing apart from some of the nursing literature was extremely limited. This had the advantage of reassuring nurses that I did not want to interview them to test their nursing knowledge, but to learn about nursing from them. Acker, Barry and Esseveld (1983:427) describe the process in this type of qualitative research as:

> a dialogue between the researcher and researched, an effort to explore and clarify the topic under discussion to clarify and expand understandings; both are assumed to be individuals who reflect upon their experience and who can communicate those reflections.

The sampling procedure for the interviews is outlined below, but it is appropriate at this point to describe the way in which nurses were contacted. A letter was sent to each potential informant that:

- described the project
- requested agreement to take part in an interview
- outlined the unstructured nature of the interviews and stated that they would be tape-recorded
- gave assurances about confidentiality
- indicated that unless the refusal slip was returned, I would contact the nurse on the ward to arrange a time and a place for an interview that was convenient for them.

The interviews took place either in my office in the College of Nursing or, if the nurse mentioned that there was a room available, in the clinical area where they worked. The nurses themselves decided whether to arrange an interview for a time when they were on or off duty, an agreement having been reached with the senior nurse manager that nurses would be paid for their time if they took part in interviews when they were off duty. If

day staff were interviewed when on duty, they chose a time when there were least pressures on staffing levels. When night staff were interviewed, I would go to the ward at 11.30 pm, a time recommended by the clinical nurse manager for night duty.

Most of the interviews were between an hour and an hour and a half in length. I began each interview by asking the nurse about how she came into nursing. After that question, however, the structure of each interview differed, because, although I had expected the interviews to describe the development of each nurse's career, I found that they did not follow a linear path. As the interviews progressed, some issues emerged that I tested out in other interviews, by saying 'Other people have told me that... What do you think?' This approach is described by May (1991:192):

> As a study proceeds interviews often become more focused as the investigator ... begins to look for areas of commonality and difference in respondents' stories.

The tape-recordings were transcribed by the project assistant.

Sampling

The purpose of the interviews with ward nurses was to explore their views about their working lives in the Care of the Elderly Unit. About 150 nurses worked in the Unit and, during the time I spent on the wards in the early stages of the project, I had not met them all, let alone found out how long they had worked there. I wanted to contact nurses directly, rather than have the requests for interviews mediated through managers, to ensure that consent to participation in the research was 'informed and freely given' (Royal College of Nursing 1977). The secretary to Mr Johnson, the deputy unit general manager, provided a list of nurses working in the Unit, with their grade and date of starting there, rather than the date when they began working in their current post. This list enabled me to find out which nurses met the criterion of long service, and would therefore be in a position to comment on the ways in which nursing in the Unit had changed.

I was able to identify a group of 24 nursing staff who had started work on the Unit before 1980, which included 9 day staff and 15 night staff, of whom a total of 15 were nursing auxiliaries. As this group of staff did not provide the wide range of nursing experience that I wished to explore, I compiled a list of nursing staff, 20 in all, who had started working on the 'Geriatric' Unit between 1981 and 1984. Initially, I had intended to use quota sampling to select nursing staff for interview. The argument of Morse (1991), however, persuaded me that this would be inappropriate, because to ensure adequacy, the emphasis should be on the quality, completeness and amount of information contributed by informants, rather than on the number of cases.

The option that I chose was nominated, or 'snowball', sampling. This meant that informants were asked to make recommendations as to whom I should contact requesting an interview, and the first two nurses that I contacted were recommended to me by managers. I was concerned that I might have been directed to uncritical informants, but this did not seem to be the case. However, although nurses were willing to make nominations, this did not lead to a steady flow of potential informants. There were three main reasons for this:

- there was considerable duplication of names and, although a list of six names might include only one new name, it was not appropriate for me to reveal that I had contacted the other nurses already
- there was no internal rotation of nursing staff between day duty and night duty, so that day staff tended to nominate other day staff
- some nurses who were nominated did not meet the criterion of having worked in the Unit in the early 1980s.

It was necessary, therefore, to start a second 'snowball' for day staff and a 'snowball' for night staff. In addition, the criterion of long service was relaxed for two nurses, nominated by their colleagues, who started working in the Unit after 1984 but before the establishment of the Nursing Development Unit. Two nurses returned the slip attached to the letter indicating that they did not wish to take part in an interview.

As two members of staff were interviewed together on two separate occasions, 18 interviews were conducted with 20 nursing staff, 19 of whom were women, between May 1991 and January 1992. Of the staff interviewed, 9 were Registered General Nurses, 7 of whom were sisters; 5 enrolled nurses also took part, together with 6 nursing auxiliaries. Of the total number interviewed, 8 worked nights and 12 worked days.

Data analysis

Wolcott (1990:18) describes one of the difficulties of writing up qualitative research as 'winnowing material to a manageable length'. I marked up extracts from the transcripts that seemed to encapsulate particular aspects of the informants' experience, perhaps a decision that was a turning point in a nurse's working life, a description of an event that was deeply ingrained in a nurse's memory or an account of how they had dealt with a difficult situation. Morse (1991:139) states:

> Theoretical richness has nothing to do with 'how much or how many', has nothing to do with the most common or least common experience, has nothing to do with likelihood; rather, the researcher seeks to describe the experiences as richly and accurately as possible.

These interviews included a much wider range of data than the interviews exploring the history of the Unit. The procedure, however, was similar: sticking extracts of the transcript on to five by eight inch index cards, marked with the number of the interview and the page of the transcript. I did not concern myself at that stage with the category into which each extract would fall, nor did I select extracts on the basis of how many nurses had made similar comments.

Conceptual categories were not imposed on the data before the process of analysis began. When I read through the extracts, of which there was a total of 290, I decided on the issue each related to, wrote a heading on a piece of paper and started a pile of cards. By far the largest pile of cards at the end of this sorting process was 'patient care'. This category was then subdivided. The outcome was 32 headings, with the number of cards under each varying between 4 and 25. The cards were arranged under these headings in a box, so that relevant material could be retrieved easily. I did not expect to use all these headings, as further selection of the material was necessary to narrow the focus of the study. Some of the themes emerging from these data were presented in the thesis for an MSc that I was undertaking in the Department of Nursing at the University of Manchester (Black 1993), but for this report a narrower selection of data was made, using 121 cards. Residual categories, which did not group together or relate to the main themes, were excluded from the analysis.

The conventions used in the presentation of data are as follows: a dash (–) indicates a pause in speech; three dots (...) show that intervening words between the portions of speech before and after the dots have not been included; square brackets ([]) show where I have added a word that was missing or contextual information to make it easier for the reader to follow. Punctuation has been difficult to introduce without the risk of changing the sense of what nurses said and so there is less punctuation than is customary with written accounts. Grammatical errors have not been corrected.

Validity and reliability

The general concerns about reliability and validity that this type of qualitative research raises are discussed on page 9 in relation to the research methods used for the interviews with nurse leaders, managers and educationalists. The groups of informants did, however, differ. The first group agreed to take part in the interviews on the understanding that they would be named, because the positions that they had held within the Unit could be identified. The ward nurses had a lower public profile and were not so easily identifiable. They also provided more varied and personal perspectives on their working lives. I felt that it would be a daunting task for these nurses to look through the transcripts of their interviews and that this checking process was unnecessary, as the ward nurses were protected by assurances of confidentiality. However, when the first draft of the chapter was completed, I wrote to all the nurses who had taken part in interviews for the study and offered them the opportunity to see the chapter and comment on it before it was circulated more widely. The majority of informants requested a copy of the draft chapter.

These interviews could not be replicated. They represented a selection of incidents recalled by each nurse from her or his working life, which might have been presented differently if the interviews had taken place at a different time, in a different order or with a different interviewer. However, May (1991:193) argues for a specific definition of consistency. This, for researchers in qualitative studies, is one of the factors contributing to reliability which:

> does not require that every informant be asked all the same questions; rather, the goal is to assure that questions, which appear to be important at a given point in the data collection phase, are asked of as many informants as possible, so that subsequent interviews can be informed by them.

Ethics

The main ethical concern in this strand of the research was protecting the interests of the informants. First, I did not want nurses to feel obliged to take part in an interview, as this would have contravened ethical guidelines requiring 'freely given and informed consent' (Royal College of Nursing 1977). Access to the nurses was direct, by a letter that I sent to them, rather than through managerial channels of communication. Nurses who did not want to take part in interviews were given the opportunity to return a refusal slip to me, so that they did not have to refuse my request face to face; McRobbie (1982:56) suggests that female informants are so used to servicing people that they are 'bad at rejecting requests to give of themselves'.

The second issue relating to informants was confidentiality. The letter contacting nurses stated:

> The interviews will be tape-recorded, but will remain confidential, as no-one will listen to the tapes or see the transcripts, except my secretary and myself, and quotations from interviews will be used in ways that protect anonymity.

It was not possible for the fact that a nurse had participated in an interview to remain known only to the researcher and the informant. Nurses taking part in interviews when they were on duty checked with the nurse in charge of the ward that this would be convenient. Nurses taking part in interviews when they were off duty received payment for their time if I informed the appropriate manager. Despite this, I did not unnecessarily volunteer information about which nurses I had interviewed, taking the view that nurses were entitled to discuss the interviews with colleagues if they wished, but that as far as

possible they should control how far that information spread.

In presenting the data from the interviews with ward nurses two approaches were taken to maintain confidentiality. The first was to exclude some of the data (for example, about conflicts at work or personal difficulties, such as a marriage ending) from the analysis. As these nurses have worked together for a number of years, some aspects of their personal lives will be known to other nurses. As an outsider, I needed to be cautious about disclosing information that could be attributed to particular individuals. Stacey (1988:23) states that:

> Fieldwork represents an intrusion and intervention into a system of relationships, a system of relationships that the researcher is far freer than the researched to leave.

A second way of protecting anonymity was by not providing, in the presentation of the data, details about an individual nurse's age, grade, the type of ward worked on, or whether she or he worked days or nights. Field and Morse (1985) refer to these types of data as 'demographic identifiers'. If several of these details had been combined, nurses and managers might have found it easy to identify an individual nurse.

Obtaining the views of nursing staff on staff development and job satisfaction

Method

The purpose of the survey was to examine the attitudes of nursing staff in the Nursing Development Unit to staff development and job satisfaction. As staff development has been a major focus of the NDU's work, it was important to find out whether the availability of opportunities for study and self-development was valued by the nursing staff. Job satisfaction is associated with recruitment and retention issues in nursing, and is particularly relevant in a unit for the care of elderly people for two reasons. The first is the legacy of underfunding and low status originating from the historical development of hospital care for elderly people in poor-law institutions in the 19th century (Abel-Smith 1960, White 1978). The second is because studies of student nurses by Melia (1987) and Smith (1992) indicate that caring for elderly patients is perceived by students as less valuable than other types of nursing, especially those associated with high technology.

The purpose of carrying out a survey for this research project was to investigate whether the staff development provided by the Nursing Development Unit was likely to lead to increased job satisfaction. This would mean that the NDU was less likely to face problems associated with the recruitment of nurses and a high turnover of staff. A questionnaire was devised by the researcher to investigate these issues. Questions from two other surveys of nurses were included to facilitate comparisons. One was a national survey of members of the Royal College of Nursing reported by Waite and Hutt (1987) and Waite, Buchan and Thomas (1989), and the other a survey of nurses employed by a health authority in the north-west of England (Williams, Soothill and Barry 1991).

Pilot study

A pilot study of nurses working in the Psychiatric Unit at Tameside General Hospital was undertaken in the autumn of 1991. This could not be conducted in the Nursing Development Unit itself, because the survey was designed to sample the whole population of nursing staff working there. Minor modifications were made to the questionnaire for the pilot study to take into account the different qualifications likely to be held by nurses working there. A question was also included to find out how long it took respondents to complete the questionnaire.

A satisfactory response rate of 65 per cent was achieved in the pilot study, as 22 of the 34 questionnaires were returned. Amendments were made to the questionnaire, such as the inclusion of additional pre-coded responses, the amendment of some of the open-ended questions so that they became closed questions, and an alteration of the order of some of the sections. As the majority of respondents to the pilot study stated that it took between 16 and 25 minutes to complete the questionnaire, it was decided that it was not necessary to reduce its length. The data from the pilot survey were analysed, using SPSS/PC+, and copies of a brief summary of findings were distributed to respondents who had completed a separate tear-off slip.

Sampling

The survey was carried out from January to March 1992. A list of staff working on each of the wards was provided by the secretary to the senior nurse manager. The questionnaires were distributed to all nursing staff graded A–G in the Unit, except for nurses who were on long term sick leave or maternity leave. Nine nurses, who were on annual leave or on courses during the time the survey was in the field, were sent a letter inviting them to opt into the survey if they wished. Six of these nurses subsequently requested questionnaires. The final sample size was 149.

I visited the wards to distribute questionnaires, together with a personalised covering letter, to the individual nurses. In order to cover all the shifts, I visited each ward three times on two consecutive days at the end of January, and then on an additional day the following week. After this, I found out when individual nurses were on duty and visited the wards at those times. The rationale behind the personal contact with nurses was the expectation that the response rate would be higher. My repeated visits to the wards also served as a reminder to nurses who intended to complete the questionnaire and may have increased the response rate.

Data analysis

I entered the data from the questionnaires on to SPSS/PC+, using the Data Entry module. The data were analysed, and tables showing frequencies and cross-tabulations were produced. As most of the closed questions had pre-coded responses, the data were not normally distributed and so were unsuitable for the use of parametric tests. Chi-square, a test of proportion, was used to compare the responses of the two samples to the sets of questions from the survey of RCN members (Waite and Hutt 1987). The responses to the open-ended questions were typed by the project assistant, and I then coded them. New variables were created on SPSS/PC+ and frequencies produced. A brief summary of the findings of the survey was distributed to all nursing staff on the NDU in May 1992, after the management team had been given the opportunity to read the summary report.

Validity and reliability

There are well established procedures for carrying out social surveys, which have been followed in this study. Marsh (1982:6) defines the first component of a survey as:

> an investigation where ... systematic measurements are made over a series of cases yielding a rectangle of data.

It is important, therefore, that the cases in the study provided a cross-section of the population being investigated. In this strand of the research, this was achieved by sampling the whole population of ward nurses and obtaining a good response rate. When survey data are analysed to see if they show patterns, it is too late to change questions or redefine variables. This process should, therefore, take place during the piloting phase of the investigation, and in this case, a pilot study was duly conducted.

This survey provided an objective, representative picture of the views held by the majority of nurses in a workplace setting. This allowed variation across cases to be considered in a systematic fashion (Marsh 1982). The survey therefore met the criteria for validity and reliability for this type of investigation.

Ethics

The question of confidentiality in survey research is slightly different from that in unstructured interviews. First, rather than talking in their own terms, the respondents are answering questions devised by researchers, which are defined as important by researchers. Second, the survey questions will be known to all participants, and in this study the draft questionnaire was shown to managers before and after the pilot study.

After taking advice from a quality assurance specialist who had previously conducted a survey of NDU staff, I decided not to include any form of identification on the questionnaire, such as a reference number, or to ask the respondents on which wards they worked. It was assumed that, if nurses could be confident that their anonymity would be protected, they would be more likely to respond and to express their views openly. This had the disadvantage that personal reminders could not be sent to non-respondents, because they could not be identified. Assurances were also given in the covering letter to the questionnaire that no one would see the questionnaires except the project assistant and myself. I entered the data on to SPSS/PC+, and the project assistant word processed the answers to open-ended questions. Open-ended questions were included in the survey, not only because of the different type of data that they provided, but also because they provided opportunities for respondents to include information that they perceived as important.

A brief report summarising the findings of the survey was distributed to all the nursing staff. This enabled them to see how their perspectives and those of their colleagues, had been presented and showed that their contributions had been valued.

Student nurses' evaluations of their experience of working in the Nursing Development Unit

Method

The views of student nurses were included in the study, to explore whether they perceived their experience of working in a Nursing Development Unit as different from allocations to other clinical areas. During the time span of this study, the last two groups of students in the Stockport Tameside and Glossop College of Nursing training for Part 1 of the Professional Register were allocated to the Care of the Elderly Unit during their second year of training. After a preparation week in the college, they were divided into two groups, one of which was allocated to Psychiatry and the other to the Care of the Elderly Unit, each for eight weeks. The groups then changed round and after a further eight weeks they returned to the college for a consolidation week.

Short questionnaires which included both closed and open-ended questions, were administered to the students, in both the preparation and consolidation weeks, by the nurse teacher responsible for the Care of the Elderly module. This made it possible to investigate changes in attitudes to and knowledge of Nursing Development Units. The preparation weeks were in July and November 1991 and the consolidation weeks in November 1991 and March 1992. I did not meet the students because, had I explained the purpose of the study in detail, the responses of the students might have been influenced, reducing the value of the data. The questionnaires were returned to me by the nurse teacher. Data collected by a clinical nurse specialist, through questionnaires administered to the first three groups of Project 2000 students during 1992, were also included in the study.

Sampling

The questionnaires for the 'traditional' students were distributed and collected while the students were in class. In the preparation weeks, 13 student nurses in the first group and 14 in the second group completed questionnaires. In the consolidation weeks, 14 students from the first group and 16 from the second group completed questionnaires. As these did not have reference numbers and the number of students who filled them in varied slightly between the preparation and consolidation weeks, the impact of the students' experience could only be assessed at a group, rather than at an individual, level.

The questionnaires for the Project 2000 students were administered by Nasrin Khadim, clinical nurse specialist. They were sent to each student with an accompanying letter requesting that the questionnaire be returned to her by the sixth week of the placement. Three students from the first Project 2000 group, whose first placement began in May 1992, completed questionnaires as did five students from each of the two following groups, whose placements began in July and September 1992.

Data analysis

When the completed questionnaires were received from the 'traditional' students, I entered the responses to the closed questions on to SPSS/PC+, and the project assistant word processed the responses to the open-ended questions. The responses to the open-ended questions in the Project 2000 questionnaires were also input by the project assistant.

Ethics

Student nurses were not identifiable from their questionnaires, so they were able to comment frankly on their expectations and experience of the Nursing Development Unit, without fear of being called to account. Some of the comments made by the first group of 'traditional' students about stress and understaffing on the Care of the Elderly wards caused considerable concern to the managers to whom these data were reported through the Liaison Group. It is possible that, if the students had not received assurances of confidentiality, they would have been less open about commenting on the negative aspects of their experience in the NDU.

The questionnaires devised for the Project 2000 students were designed to help improve the quality of the clinical experience of students. It was necessary to request the number of the ward to which a student had been allocated to allow any problems that arose to be followed up through discussion between the clinical nurse specialist and the ward staff.

Summary

In this chapter the methodological approaches taken to the study have been described, and the reasons for selecting qualitative or quantitative research methods for different strands of the research project outlined. The characteristics of the groups of informants and respondents have been set out, together with the techniques employed for: sampling; data analysis; determining the reliability and validity of the research; and ethical issues. This study examines changes in nursing practice in the Tameside Nursing Development Unit from the perspective of different groups of informants and the data will be presented and discussed in Chapters 2–5.

2

The historical background to the Tameside Nursing Development Unit

Introduction

This chapter provides a retrospective picture of the 'Geriatric' Unit at Tameside General Hospital in the 1980s from the perspective of nurse managers and educationalists, and clinical leaders who have been influential in initiating and sustaining the process of change within the Care of the Elderly Unit. Wilson (1990:83) states that:

> The process of change is not just a sequence. It is a process fuelled by a variety of interpretations, each of which provides the spur to action, creates the vision and sustains the energies of those participants caught up in the process of change.

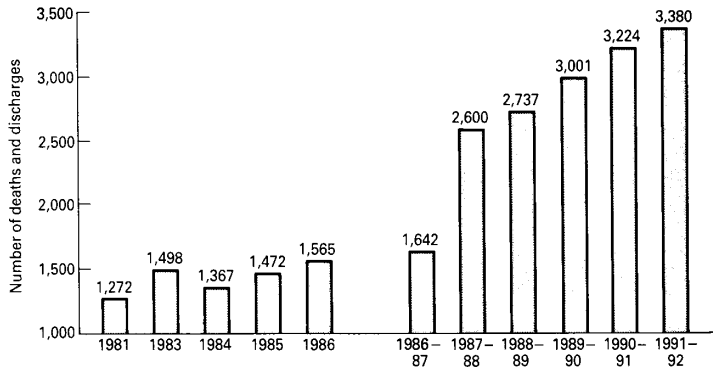
The organisational context in which changes in nursing were taking place was one of a steadily increasing number of patients being admitted to and discharged from the wards since the early 1980s and a declining length of stay (see figures 2.1 and 2.2 and Table 2.1).

The need for change

All the informants expressed their concern about the standards of patient care that were prevalent in the 'Geriatric' Unit in the early 1980s. Part of the reason for this was historical, as elderly patients were nursed in wards that had formerly been part of the workhouse. Two of the wards were L-shaped and had more than thirty beds. Ann Shaw, a former sister, recalls her experience as a student:

'Right, what used to happen was because of the sheer numbers of clients in relation to the staffing levels. From my perspective as a student, the majority of trained staff would be working within the large ward area, where you would have the majority of dependent clients, people who required the maximum amount of nursing care. Invariably one nursing auxiliary would monitor and supervise the clients within the small ward. These clients would be ready for discharge or have semi-independent skills, for example needing assistance to the toilet. The NA would seek help when needed, so apart from medications, administering dressings, etc. the bulk of trained members of staff would concentrate their skills within the large ward area.'

Figure 2.1
Hospital stays finished at the Care of the Elderly Unit

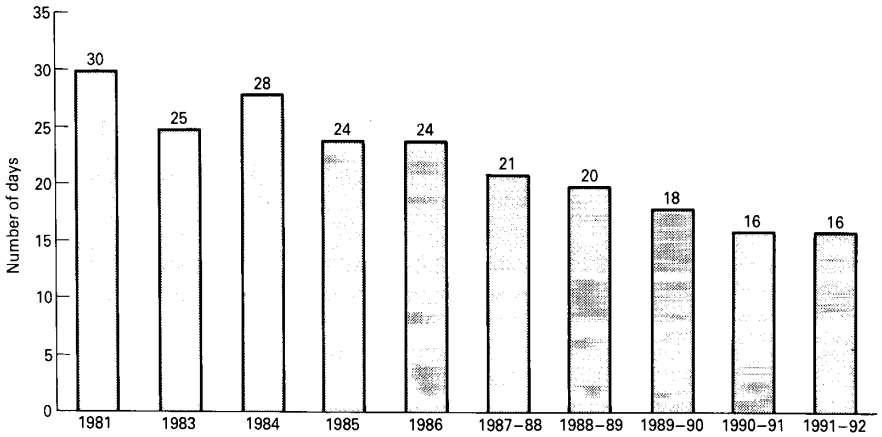


The data for 1982 were presented in a different format under different headings and have been excluded from the analysis.

The average number of beds available increased from 109 in 1986 to 174 in 1987–88 when three new acute wards opened.

Source: North Western RHA, Statistical Analysis Section in Hospital Activity in the North West Region, annual publication

Figure 2.2
Average length of patient stay at the Care of the Elderly Unit



The data for 1982 were presented in a different format under different headings and have been excluded from the analysis.

Source: North Western RHA, Statistical Analysis Section in Hospital Activity in the North West Region, annual publication

Table 2.1
Deaths and discharges 1987–91 at the Care of the Elderly Unit

	1987–8	1988–9	1989–90	1990–1	1991–2
Normal discharge	2050	2180	2325	2513	2770
Discharged by self/relative	12	8	9	7	7
Deaths	634	619	622	597	600
Total	2696	2807	2956	3117	3377

PERCENTAGES

	1987–8	1988–9	1989–90	1990–1	1991–2
Normal discharge	76.04	77.66	78.65	80.62	82.02
Discharged by self/relative	0.45	0.29	0.30	0.22	0.20
Deaths	23.51	22.05	21.04	19.15	17.76
Total	100.00	100.00	99.99	99.99	99.98

Source: Korner Episode Systems, supplied by the Information Unit, Tameside General Hospital

It was difficult to recruit trained nurses to work in the Unit. Mike Johnson, who was appointed divisional nursing officer in 1979 commented:

'You name it, the Unit was deficient in every area, there was no area where I could honestly say, "We've got it right".'

Kate Wilkinson, the former director of nurse education, commented on the provision of patient care by nursing auxiliaries:

'They were institutionalised and they ran the wards because actually there was nobody else to do it, so you had the level of nursing care determined by the auxiliaries. Very little therapeutic activity went on, they were all called "geris", you worked on the "geris" with "geris" and, by implication, if you worked there you couldn't get a job anywhere else, I mean that's how it was.'

Mike Johnson made observations on the quality of trained nurses who worked in the Unit when he came to Tameside:

'Several of them had qualified at the third attempt, so they'd had, you know, difficulty academically in getting through and two or three, I remember, had written on their files and their references "Suitable only for geriatrics". And one or two had also been moved from the acute side, the acute general wards to geriatrics because ... the people that weren't very good and weren't seen as being able to cope were moved to geriatrics, because of course 'anybody' could work in geriatrics.'

Of the four wards in the 'Geriatric Unit', one was a male acute ward to which patients were admitted. Most female patients were transferred from medical wards in the acute part of the hospital, except for a few female patients who were admitted as a result of domiciliary visits. Mike Johnson stated that the lack of designation of the non-acute wards meant that there were considerable variations between the types of patient cared for on the wards:

'In any one ward you would find a percentage of the patients who'd been there for perhaps more than five years, a percentage that were in for a short period of time and then went home again, and a percentage of quite old people, who really probably should have gone through a designated acute admission ward who would either get better or not get better and go home. So there was no system, there was no structure.'

The ward environment was not conducive to good patient care. Sandra Mills, who had been a sister in the acute part of the hospital, commented:

'The surroundings were awful – and you wouldn't nurse anybody else there. You wouldn't nurse coronary patients there, or you wouldn't deliver babies there, but it was okay for old folk, because people would say, "What do they matter?", you know.'

The lack of facilities which meant that the dignity and privacy of patients was not preserved, were described by Mike Johnson:

'On almost every ward the toilet doors had been removed because staff had difficulty in getting wheelchairs in. Some attempt on some wards had [been] made to preserve some dignity and privacy by getting curtains, which were all sort of shrunken so you could see under them and see the patients anyway; half of them were torn and tattered, and some of them had been removed altogether.'

The introduction of joint appointments

The descriptions above illustrate the difficulties that the 'Geriatric' Unit presented to service managers and educationalists. They saw joint appointments – individual senior nurses based on wards with responsibilities for both education and service – as a way of resolving the problems.

In the early 1980s, the Unit was unsuitable as a learning environment for students. Steve Wright recalled that, in the School of Nursing, as it was then:

'Geriatrics was seen as a "bad" area, it was getting notorious bad reviews from students, there was some indication that the ENB were dissatisfied with it.'

Cyril Murray, a clinical teacher who later became a joint appointee, commented:

'The number of days off sick of students who were going through the elderly module was higher than with any other module within the three-year training programme.'

Kate Wilkinson and Mike Johnson decided to create two joint appointments on the Geriatric Unit, which would combine education and service responsibilities. They were aware that there were risks involved, but as Kate Wilkinson said:

'I'll tell you why we chose the Care of the Elderly, it was so bad you couldn't get any lower. So if it didn't work, there was nothing lost.'

The selection process for joint appointments was crucial. Steve Wright, who had been a clinical teacher before going to Manchester University to do a Masters degree, spoke about his perception that:

'I don't see how you can teach nursing unless you actually do it.'

Kate Wilkinson recalled:

'So I said to Steve ... before he came back from his course, "Okay Steve, you're not coming back into the School. What I want you to do is to go out there and sort that Unit, that area out for me. We've got to help the nurses understand there is a different way of doing this, right, to show them a different vision".'

Sandra Mills, who had qualified as a clinical teacher while working as a sister in the Acute Unit, was approached to work with Steve Wright. She said:

'So in lots of ways the idea of the joint appointment – was a miracle really, because it suited everything that I wanted to do. It was in elderly care but – I thought, well it's an opportunity for me to, to try out new skills. Of course the people on the acute side said, "Don't do it. This is going to be death to your career" and "Nobody makes it in geriatrics".'

Cyril Murray described his reactions to becoming a joint appointee about two years later:

'It was something that I wanted to do. At that time I saw it as an honour really to be asked and it was an opportunity that I'm glad I took. I learnt a lot from it, both positively and negatively.'

Initially, towards the end of 1981, Steve Wright and Sandra Mills went to work on the male acute ward in the 'Geriatric' Unit. Steve Wright commented on what he found:

'Ward 22 was a dreadful ward you know ... it was kind of universal bad practice with one or two people striving against immense odds to treat patients as human beings .... You had to look at the situation and say, what has gone so terribly wrong ... what part have we played as an organisation, and as managers and others, in reinforcing the fact that it's actually more rewarding to sit in the bathroom and have a fag in the morning – instead of going out there and caring for people who were in wet beds and uncomfortable and need you?'

Sandra Mills outlined her reactions:

'People had been very comfortable doing their own thing for a long time and nobody wanted criticism ... They weren't really willing to see or to acknowledge ... what was there or what was wrong you know, whereas, you go in with new eyes and you're horrified. But they'd become used to it, they'd become used to the smell and you know the noise and that had become the norm. That had become acceptable.'

Ann Shaw, a former sister, described how the work was organised in a task-based way, so that the valued skills of nursing staff were related to getting the work done:

'You didn't particularly have to be credible within that system. I think people could hide behind tasks and speed, speed was, I think, something that was seen as being very useful, and sadly very skilful, irrespective of the task being performed for that person.'

The difficulties that the joint appointments faced initially were detailed by Kate Wilkinson:

'That first year ... I don't know how Steve and Sandra kept their sanity ... because almost everything they touched, there was a major, major problem, you know, like nothing was easy ... When you suggested that perhaps it would be a good idea for patients to get up, well naturally accidents go up, especially if nurses aren't skilled at making sure they're as risk-free as possible ... There were huge arguments about why patients couldn't have a bed pan when they wanted one.'

Sandra Mills described the way that her management style differed from Steve Wright's:

'He believed you could love people into doing what you wanted and I believed that you told them and if they didn't do it you hit them with a brick, so we were at opposite ends of this spectrum .... But he found, you know, these people were playing games you know, when he was away ... so we came to this middle line together.'

She also found that she learned a lot about nursing from working with Steve Wright:

'Steve was great, I have to say for the time that I worked with him, I would never criticise him, he was an inspiration. I'd never worked with anyone like him before. He'd come in with all these pieces of paper ... and everybody would, you know, go into the office and he'd spread all his plans and things round and I mean this was wonderful. I'd never seen anyone manipulate people if you like, in a nice way, he made nursing fun and he made it human. He made jokes, it was all right to laugh you know.'

Kate Wilkinson said that an important factor in making the joint appointments effective was the support they received from the education and service managers:

'You see the other thing about the joint appointments that you have to remember in those early days, they had weight behind them ... Those auxiliaries ... on that Unit, knew that Mike Johnson and I were committed to try to make it work, therefore there was a tremendous amount of weight because, you know whether it's fear or whatever it is, they knew hell would reign on them if they did something.'

In Ann Shaw's view the joint appointments had greater authority because of their links with the School of Nursing, which most nurses saw as a powerful place:

'Steve and Sandra were an unknown entity, purveyors of good practice. I feel this made people take stock of their own standards and nursing practice generally.'

Implementing change through joint appointments

The aims of the joint appointments were set out in a table in a journal article by Salvage (1983:51):

1. To show that the joint appointment is a workable concept in the ordinary NHS hospital.
2. To return a teacher to the clinical setting as a role model for trained and untrained staff, aiming for excellence in nursing care.
3. To introduce and develop individualised care for the elderly using the nursing process.
4. To retain a nurse specialist in the clinical setting as a resource person.
5. To develop a learning climate on the ward.

Staff development, in the broadest terms, was seen as a priority and as the vehicle for improving patient care. Kate Wilkinson said that, before the joint appointments were introduced, no staff development opportunities were available:

'Nobody in the Elderly Unit went on a course, you know, even if she paid for it herself.'

Steve Wright described the approach that he took:

'You cannot develop nursing unless you develop nurses. A lot of the work we did was actually not just, well let's try and do the back rounds differently, it was actually saying, how can I do some work with these people, so that we can get them to think critically and maybe see differently and feel stronger about themselves?'

Ann Shaw described her experience of working as a sister on Ward 22 with another sister, Steve Wright and Sandra Mills:

'People seemed to have a sense of what their team was then going to do. There was a lot more supervision, discussions, it seemed to come together. I think people's spirits were raised basically.'

Mike Johnson explained how one aspect of the approach to patient care changed:

'Staff really were not encouraged to actually give patients relative freedom, they felt that they'd got to protect them at all costs ... You weren't here to rehabilitate, you were here to prevent old people injuring themselves. And it took me about three years to actually, and I wrote the policy personally, to get everybody to see that that was not the best thing to do.'

Ann Shaw maintained that the changes which were introduced led to conflicting loyalties for some of the long-serving members of the nursing staff:

'There were a few people who'd obviously been there since the year dot, who had allegiances and loyalties to people who'd worked there for a long time .... They were teetering on this better practice but perhaps part of them said, "Well, you know Sister Bloggs did this and that worked very well for twenty odd years", you know what I mean?'

Steve Wright described how that he persuaded nursing staff to see the benefits of change:

'Part of the argument for changing some things was saying, it's actually to our advantage to do it, because if we can get our act together right in the first place we will save ourselves problems. That was an argument I used with some nurses. "Well, why should we do all these funny things, Mr Wright?" "Well, don't you understand you might actually make life easier for yourself? ... By doing some of the things you do while you are getting through the work, what kind of work have you got? ... You don't actually like what you're doing, it's dull and it's boring".'

There was a rapid turnover of nursing staff in the early 1980s. Mike Johnson stated:

'We chased staff really, by heavy counselling if you like, staff were encouraged to move on ... Some people had formal warnings because either their attendance was dreadful or their attitude was poor or incidents occurred, and it seemed to me that prior to my coming these things were glossed over. Like somebody spoke sharply to a patient or shouted at them, so what? Perhaps some patients deserve shouting at, that was the attitude, and of course I made it clear that that would not be tolerated and ... would result, at the very least, in a verbal warning. And I think that, when people got the message, that did in fact encourage certain people to review their attitude and encouraged others to decide to move on.'

Convincing some of the nursing staff of the need to change their attitudes towards patients was difficult. Sandra Mills recalled the staff on a ward she moved to after having been on Ward 22:

'I mean, people knew where they stood, so they behaved, sort of, when I was there, but when I wasn't they didn't. So what do you do? You start working double shifts, you start going in at the weekends, you start popping in, you know. All things that people do when they are burning out.'

Ann Shaw described how the role of the sister changed so that she spent more time out on the ward rather than in the office:

'Prior to that, I personally feel, sisters to some degree were seen as an entity that stayed in the office, manned the ship basically, surveyed the ward periodically. They seemed to know what was going on instinctively, but appeared detached from "hands-on" nursing practice. Occasionally they would show somebody how to perform a nursing task, but they were quite a detached figure. Credibility began to develop when sisters began to demonstrate their nursing skills and work alongside team members on a diversity of tasks within the ward area. For some of the old timers, I feel this initially created problems in accepting such a "hands-on", active role from the team leader.'

The educational impact of the joint appointments

I asked Sylvia Ashton, a former senior tutor in the School of Nursing, how long it took for the student nurses' perceptions of the Unit to change after the introduction of joint appointments. She responded:

'Almost immediately, because from my viewpoint the interest that was shown in the student as opposed to being a pair of hands, somebody who went...into this turmoil, this conveyor belt system, the fact that interest was shown in them as learners, there was an almost immediate improvement which eventually, I couldn't tell you the length of time, was matched by the interest of newly registered nurses wanting to go and work in the area.'

Students' interest in working on the Unit during 1984–5 was recalled by Mike Johnson:

'In-house trainees started then to apply regularly for jobs in that Unit. I think that's because they'd come into contact with the joint appointees and seen the changed attitudes, although we'd only marginally improved staffing and we'd only marginally improved the environment .... But they knew that the will was there and the commitment, and I think they were convinced that there was a future.'

Publicity for the joint appointments

In 1983, the 21 October issue of the *Nursing Times* featured Steve Wright and Sandra Mills on the cover and articles by Steve Wright and Kate Wilkinson. Articles about joint appointments at Tameside General Hospital appeared regularly in the nursing press in the years that followed. Steve Wright told me that he saw publicity for the Unit as a way of safeguarding the achievements:

'I was always thinking whatever we do is it worthwhile writing about it, can we get it published? In the knowledge that there is survival in this, the more people who know about it, the more difficult it is to get rid of it.'

Kate Wilkinson commented on the reaction to the publicity about joint appointments:

'I think one of the sad things that I found was that when it ... started being in the press, people would come and see us and they would ... say, "Oh yes, marvellous", so they'd see Mike there and me there ... and we'd say, "Oh, but there are difficulties you know, I mean it is not quite as easy as that". Now, what they would do is take it, put it into wherever and it didn't work, or it went horrendously wrong, but that was because they didn't actually think, wait a minute, there is a certain combination of people in there who, all for their own motives, continued to work together .... Well, if you haven't got that relationship, then it doesn't work or it's very difficult.'

Sandra Mills, however, did not share Steve Wright's enthusiasm for publicising the changes in patient care that had taken place:

'Steve and I had conflict about that because I'd say, "Steve, you can't say that it's good because it's not it's still the pits. It's still awful". And he'd say "But it's not half as awful as it was when we came". [Laughter] And I'd say, "But it's still not acceptable. It's not barely acceptable". And he'd say, "Well, it's a hundred per cent better". And I still had difficulty with that. I'd say, "You can't invite people in because it's embarrassing".'

The balance between educational and service responsibilities

According to Ann Shaw, having two joint appointees on one ward may have demoralised staff on other wards:

'What it must have seemed like, I think, to a lot of people on other wards was "Oh my God, we're getting all this hype, there's all these dynamic people arriving, 22 seems to be the hub of what's going on". I think perhaps some people might have felt very left out, not quite in receipt of some of the information about what was going on up there. It sometimes seemed, well, 22 must have the staffing levels but other wards perhaps sometimes didn't. I mean, I was basking in the glory, I enjoyed every minute up there, but I can understand why some of the people on other wards might have been a little bit bitter or, you know, "Why isn't it happening down here?".'

The system of joint appointments was extended: a joint appointee was recruited to work in the Psychiatric Unit and there were usually three joint appointees working on the 'Geriatric' Unit. Kate Wilkinson and Sylvia Ashton found that it was difficult to attract suitable candidates. Kate Wilkinson commented:

'I think what a lot of them didn't understand is how difficult [it is] in the real world to balance education and ward management .... Most people are either educationalists or they're service managers, and the value systems are different and the sort of nature of the way in which the decisions are made are different, the nature of the decisions is different.'

Cyril Murray, who was appointed as a joint appointee in 1984, described how he balanced his responsibilities to education and service:

'The changes that you bring about from an educational perspective can largely be achieved through your service role and that's what tended to happen. I mean it wasn't a straight off "I work 50 per cent for you, and I work 50 per cent for you". It was probably, if anything, I would have thought 80/20, but of that 80 per cent to the service sector, quite a large part of it would increase the 20 per cent input that you'd be giving from an educational perspective.'

He also commented on his role as a joint appointee on the ward:

'I was only one part of the ward, it was a team effort. I just happened to be the person in charge of it. At the end of the day, it wasn't me who actually brought about the changes, it was the team itself and obviously you have to create an environment that brings about that change.'

The winding up of the system of joint appointments

In retrospect, joint appointments are seen as having fulfilled their purpose after a period of about five years. Steve Wright said:

'They ran their course, they were a thing at the time that was right for the purposes of the Unit in terms of what we were trying to develop ... I don't think it would have done it otherwise.'

A similar comment came from Kate Wilkinson:

'I think joint appointments were a means to an end, they weren't an end in themselves ... they had a limited life, and they should have a limited life, because, when that person has done what it is that you intend them to do, there isn't anything left for them to do, because all the staff related to them will, hopefully, be at that level, so they should work themselves out of a job, right?'

Steve Wright was the only joint appointee who performed that role for the duration of the joint appointments project. Most, but not all of the people who had been joint appointees opted for educational rather than service roles. Mike Johnson maintained that the main problem they faced was the lack of resources:

'The real reason that they all found difficulty with it was because, although they got I think very good support from both Kate and hopefully from me, there were tremendous frustrations because there wasn't enough money to upgrade the wards to the standards that clearly were needed, and, though the glaring things like putting toilet doors on were by and large attended to, there still wasn't enough space. The beds were outdated, each ward probably needed fifty or sixty thousand spent just on furnishings. We just hadn't got that kind of money and we were nibbling away at it rather than, you know, whole-heartedly making changes. And also the biggest difficulty for them was we were still very poorly staffed and, though we were making progress, it was tedious, it was slow.'

The establishment of a Nursing Development Unit

The joint appointments ended in 1986. Steve Wright considered leaving Tameside, but Mike Johnson suggested to him that he should continue to work within the Care of the Elderly Unit in a new role:

'The advantage of having Steve is not only was he well-educated because he'd got his Masters degree, he was a trained tutor as well ... he had the credibility and care of the elderly was his area of expertise, so Steve had got boundless enthusiasm and a tremendous number of ideas, some of which I personally thought would be difficult to achieve, although I thought there were other elements that were clearly achievable. He drafted out a job description and I was rather concerned to note the suggested title, consultant nurse, because I realised that the consultants might not be happy about this.'

The opportunity for developing the Unit further came about when three new acute wards were opened in 1987. This made it possible to improve staffing levels. Mike Johnson commented that until 1987:

'We bid for a few more staff each year and we did get a trickle and all the staff we appointed were trained. We couldn't afford to change the "skill mix" because there just weren't enough pairs of hands anyway.'

When the new wards opened, he rebalanced the staffing across the Unit:

'Clearly it would have been unfair to have put all the money for the new Unit into the new wards otherwise ... the contrast between the old and the new would have been much more marked ... We did mix the money up into one pot and try to balance it fairly across all the patient care areas.'

The increase in the number of beds brought about by the opening of the new 24-bedded acute wards also made it possible to improve the ward environment in the existing wards. Mike Johnson stated:

'For example Ward 25 had 17 beds and we reduced that to 15 beds, Ward 22 had 25 beds and we reduced that to 18 beds, and round the Unit we knocked two or three beds out of most areas too, and all that a) unblocked fire exits, some of which were partially blocked, which should never have been of course, and b) it allowed nurses to get in between beds without having to move beds, for the first time. So it took me all that time to get to that point ... even to get to that stage.'

The Care of the Elderly Unit became a Nursing Development Unit, Steve Wright said:

'In my head was this idea of the NDU, for example as saying, "You know we've done it now, we've cracked it, these four or five wards are on their way, there's a new Unit opening, here's a great opportunity, now let's give it a formal name, let's tell everybody in the Health Authority".'

Just as earlier, with the joint appointments Steve Wright had seen publicity as a way of safeguarding achievements, in 1987 he saw official support for the Nursing Development Unit as a way of ensuring its survival:

'It is important for nurses if they're out on the boundaries of doing things which, in retrospect don't seem terribly important things, but at the time had elements of risk to them ... that the organisation couldn't say, "Let's sack the bad nurse", because the organisation has said, "We actually encourage you to do it".'

Although the Tameside Nursing Development Unit, Care of the Elderly, was created after the process of change was initiated by joint appointments, the transition from one to the other was not perceived by all those involved in the joint appointments as an inevitable step. Cyril Murray said that he saw them 'as two quite separate things' and Kate Wilkinson took the view that:

'the interests of patient care nationally are not served by the creation of Nursing Development Units.'

Mike Johnson stated that a strategy and objectives were written for the Nursing Development Unit. He recalled:

'We talked about which posts we felt were important to support that role [consultant nurse] and we clearly felt there should be at least one clinical specialist, perhaps, staff education and development, and we also felt at an early stage there needed to be somebody involved in quality assurance and an incontinence clinical nurse specialist, or continence adviser. I think those were the ... first three posts that we identified and within, I think, a year we found money for those three posts.'

Talking about the process of change within a Nursing Development Unit, Steve Wright said:

'In a sense what you're doing, you're constantly pushing back the barriers, expectations of what might be. And my feeling is that when you do that you create a dynamic that enables change to carry on, because people will constantly question and nag and gnaw away at things and demand things. And eventually you do get them, by which time the goalposts have moved on yet again, because ultimately we've got that now. We've sorted that out, now we need more because there's something else we want to do.'

Jim Marr, who was appointed consultant nurse in April 1992, found:

'An expectation of change among the staff, and I really like that. I've had experiences as a manager and in various other roles, where to try and implement change the reaction was, "Oh we don't want to, we've always done that". Whereas here there is an expectation that change is about to happen and we're going to change.'

Staff development in the NDU

The Tameside Nursing Development Unit has placed great emphasis on staff development. Income generation from activities such as study days, workshops, visitors' day and the sale of books and packs, for example on primary nursing, enabled the NDU to set up a bursary which provided funding for development opportunities for nursing staff. These included: opportunities for academic study, from 'O' levels and GCSEs for nursing auxiliaries, who needed qualifications to enter nurse training, to degree level; complementary therapies, such as aromatherapy and therapeutic massage; personal development, such as assertiveness, and leadership and management skills. An international exchange scheme was established with hospitals caring for elderly people in Atlanta in the United States which enabled nurses from Tameside to go to that city for two weeks to study nursing practice there. A 16-week course was devised for care assistants.

The importance of offering development opportunities to all nursing staff was emphasised by Steve Wright:

'One thing I've always questioned when planning the programmes ... when it's typed up I'll say, "Now am I happy that there's something in here for everybody?" Can I actually reassure myself that no one can turn round and say, "There's nothing for me". People can turn round and say, "don't want it".... But that's their choice.'

The NDU has also encouraged enrolled nurses to convert to registered general nurse. A characteristic of the long-serving nursing staff in the Unit is that few of them entered nurse training at the age of 18. Some nurses, who are now RGNs, came into nursing as nursing auxiliaries or as enrolled nurses after having children. Mike Johnson said:

'We've given, as you probably know, a lot of support for staff to convert, either by the direct course or the open course, and I constantly remind enrolled nurses, I go round, "Are you going to convert? We will support you and we will have you back". Quite a few of them have.'

Patient care in the Care of the Elderly Unit from the perspective of a physiotherapist and an occupational therapist

I interviewed Shirley Brierley, the superintendent physiotherapist (elderly) and Marion Kay, the head of occupational therapy, elderly services. They have both worked in the Care of the Elderly wards for a number of years. Their perceptions of the extent to which there had been changes in nursing practice that affected their work provided a way of examining whether the aims and objectives of the Nursing Development Unit were translated into changes in practice that were evident to other professional people working with nurses.

Shirley Brierley recalled that in the mid-1970s there were three or four physiotherapists and eleven helpers working in the entire hospital, whereas by 1992 there were six physiotherapists and five helpers in the Care of the Elderly Unit. She commented on the change in nursing practice towards mobilising patients:

'I mean things obviously have improved, because going back quite a few years now, I can't say how many, maybe a decade, walking was the physio's job you see. I mean the nurses were up to their eyes and short staffed and – pushing the patients to the toilet. Well, I mean if you've got ten patients to take to the loo and they take five, ten minutes to walk there, you cannot do that.'

She also spoke about the 'real multi-disciplinary approach' that had developed through physiotherapists, nurses and occupational therapists working together in the Day Hospital for the Elderly:

'We're just one large body of people without enough time, so I wouldn't criticise the nurses for not doing something, because I know we suffer the same problem, if things aren't done it's because of time. But I ... really do feel this Unit is pretty good.'

The heavy workload associated with the high turnover of patients in the acute Care of the Elderly wards was also mentioned by Shirley Brierley:

'You can get as many as, I suppose, eight or more in a day, admissions and often they're people with chronic chest problems and they need seeing to right away. Stroke patients sometimes need seeing to right away for chest, they need seeing within a day if possible, to really set out the plan for positioning and the way they should be progressing right from the start, preventing contractures and pressure sores. Obviously the nurses are on to it, but there's our side of it too.'

This situation contrasts starkly with that found by Marion Kay when she first came to work at Tameside General Hospital in 1986:

'One of the very noticeable things for me, because of the nature of my job, was going on a ward round ... week in, week out, with what appeared to be the same patients on the ward, and you'd say, "But why are these people here? Why aren't they home?" Because I was used to the pressure that we have here now, discharge, discharge, releasing beds, that was just a way of life for me. So to be in this quagmire of no structures for discharge was an incredible shock.'

The lack of discharge planning was associated with the lack of designation of wards mentioned by Mike Johnson (see p.22), and with what Ann Shaw called 'misdirected kindliness':

'I think sometimes that block was because the choice of community facilities wasn't that varied. And I think people wanting to be caring would hang on to Mrs Bloggs rather than send her home to a cold house.'

Marion Kay dealt with the situation in the following way:

'So the first thing I did was sort of implement structures, and the first one was this pre-discharge home assessment, which immediately speeded up the discharges, because you could assess what was required and then plan a discharge.'

I asked Marion Kay whether she felt that nurses in the NDU had an adequate knowledge of patients' domestic circumstances:

'I would say their knowledge of the patient ... the social side and the relatives ... which is very important to me, and very vital, is fine. So that you know if I say "Oh, so the daughter comes every week and provides a meal?", they might not be able to provide that answer, but they're tuned in enough to say, "Oh well, I don't know, but I'll find out".'

In addition, Marion Kay commented on the calibre of the nursing staff now working in the Unit:

'I enjoy working with the nurses on the ward. That hasn't always been the case, and I would say on the whole, but then that's fair enough isn't it? Nobody's perfect .... There are times in the past where – some people's approach to patients I felt was very contra-indicated, and there's no point in providing treatment if basic stuff isn't being met. Whereas now I think there are some good key workers there.'

As a consequence of the pressure on beds in the Unit now, Marion Kay has found that there is not always time for some patients to regain their independence sufficiently for them to be able to go home:

'I mean I can remember and I'm sure Shirley can remember, patients that we had for up to 12 months and discharged them home, we could get them home. We don't enjoy that [opportunity] now .... As soon as they're admitted, we're talking about discharge and certainly after a period of three months people are getting very impatient then.'

Nursing practice in the NDU

Primary nursing, by which individual nurses are responsible for co-ordinating the care of specific patients throughout their hospital stay, has been introduced gradually into all the wards in the NDU. However, as Mike Johnson said:

'We're espoused to practice primary nursing. Now I'm not sure whether we do and I'd perhaps better qualify that. I think that we attempt to practice the principles of primary nursing, but if we look at the pure logistics of the number of primary nurses we are able to afford to employ, and the number of associate nurses ... probably we achieve it, I would guess 60 per cent of the time.'

The pressure that staff felt when they tried to maintain primary nursing was described by Steve Wright, who has been told:

'"We're not keeping primary nursing going tonight because we just haven't got the staff and somebody's had to move". And I've said, "Well, let's think about it carefully. What is primary nursing? It's not just the organisation. Are you suddenly stopping patients having access to their notes? Are you going to close down the visitors' time again? Are you going to stop being nice to them? Are you stopping giving them information? How are you dealing with it?" "Well, I just simply told the patient she's not here tonight, but she'll be back tomorrow". I said, "Well, you've done it, you've communicated, the 'my nurse' theme is running through".'

Mike Johnson talked about the changes in patient care in the NDU as extending beyond primary nursing:

'I think it's all the other things we've done like letting patients see their care plans, talking to relatives, involving relatives in their care, the whole ethos of involving whoever, Community Health Council, Age Concern. We're critically looking at what we do, and saying, "Well, if we've got it wrong, or you think we've got it wrong, tell us". [At] the very least, I think that the average patient feels that people care about him or her and take a personal interest. Now if primary nursing and all the other things that go with it achieve just that, that's marvellous to me.'

The shift in perspective that these changes demanded from nurses was mentioned by Ann Shaw:

'A lot of the people who worked on the Unit prior to 1980 had a very different form of training. I would suggest it was more like on military lines really ... The family was somehow detached, it was viewed as ... a bit of a nuisance really, they were getting in the way of caring for your patients. So I think people grew up with that and then it was quite difficult ... to say, "Right, if Mrs Smith wants to come in this afternoon that's fine, she doesn't have to come in between six and seven or whatever". And I think people felt initially conscious of working and having relatives around. It was a bit like, "Well, this is an inner sanctum and really should these people be sat there being able to view nursing in progress?".'

Steve Wright left the NDU at the end of 1991, after working in the Unit for ten years. After Jim Marr was appointed to the post of consultant nurse, Mike Johnson said:

'I've suggested to him [that] he needs to have a completely fresh look with a blank sheet of paper at what we've got here and I think a new and fresh perspective. There may be all sorts of issues that we've overlooked or have got lost in the mists of time. I think that supporting nurses and helping them to feel valued is still as important, but I think renewal of input into ... nursing practice here is as important.'

Jim Marr talked about the way in which he planned to change the focus of the NDU's development:

'I think that there's a need for us to focus more on clinical skills to help nurses to care better for elderly people. I think a lot of the development that has gone on in the past has been around things like primary nursing, self-administration of drugs, other practice issues that weren't specifically related to elderly care. I really feel I would like us to be seen to be developing the skills and speciality of nursing elderly people.'

He also commented favourably on the way that nursing staff in the NDU relate to patients:

'They go the extra step with elderly people and with their care. Like, for example, an incident on a ward one day, when behind the screens a nurse was obviously caring for an old lady who was going to the day room. I heard her saying to the patient, "What about us getting you some jewellery to put on?" There seemed to be one or two necklaces and the old woman chose a necklace and then the nurse said to her, "Here's a nice brooch. What about the brooch?", and that was nice because that to me was complete care. She wasn't just content with the old woman being clean and having her hair brushed, but she wanted her to look her best. That's the kind of thing that I think often nurses caring for elderly people don't do.'

Key summary points

Shared commitment to change

This account shows how the shared commitment of a group of nurse managers and educationalists to improve the quality of care for elderly patients changed the Unit from a clinical area, where the legacy of the workhouse was still evident in the poor facilities, and where students and nurses were reluctant to work, into a Nursing Development Unit with a different approach to nurses and nursing. Managerial support for those nurses based on wards who were involved in improving nursing practice was essential for sustaining the process of change.

The timescale of implementing changes in nursing practice

It took five years of commitment to change before the Tameside Nursing Development Unit was established. Although it is hoped that few nursing settings now have the characteristics of the 'Geriatric' Unit at Tameside General Hospital in the early 1980s, and thus that nursing in other units will be developing from a higher base, it is important not to underestimate the length of time it can take to implement significant changes in nursing practice, especially if resources are limited. Continuity of key personnel played a significant part in ensuring sustained work over a number of years to secure 'a different vision'.

Staff development opportunities

These data emphasise the importance, when creating a climate of organisational change in nursing, of providing a broad range of staff development opportunities, which are accessible to untrained as well as trained nursing staff.

Recruitment of trained nursing staff

The role of joint appointees in the early 1980s in providing support and encouragement to student nurses on the wards helped to end the difficulties faced by managers in recruiting trained nurses to work in the Unit. Staff development opportunities have enabled nursing auxiliaries to obtain educational qualifications so that they can enter nurse training, and support has been provided for enrolled nurses to convert to RGN.

3

Changes in nursing practice described by ward nurses

Introduction

In Chapter 2, data were presented that described the managerial and educational initiatives and innovations which were implemented in the 'Geriatric' Unit that later became the Nursing Development Unit. In this chapter data from interviews with ward nurses who have worked in the Unit for a number of years will describe nurses' perceptions of their experience of nursing and, in particular, the ways in which nursing practice has changed. The data have been organised under three main headings:

- changes in attitudes and the ward environment
- patient care
- professional nursing issues.

Changes in attitudes and the ward environment

These data provide a framework for examining the changes that have taken place in the approach to patient care, and explore the attitudes of nursing staff, their perceptions of patients and the ward environment in which patients were cared for.

Attitudes of patients

Until 1987, when three new acute wards opened, all the 'geriatric' patients were cared for in wards that had once been part of the workhouse. The transition from the modern acute wards to the old Nightingale Wards for rehabilitation causes patients considerable concern, as the stigma of the workhouse still lingers. One nurse observed:

'A lot of them [patients] think they are not going to come out of hospital if they go over there [to the rehabilitation wards]. You have to try and explain to them, "It's only while you're having a home assessment, or you're having your services sorted out and then you can go home".'

A nursing auxiliary took the view that patients' expectations of the care they would receive in hospital used to be low:

'They never asked very many questions because, I don't know, they just didn't expect anything.'

However, she thought that the situation has now changed:

'The elderly people of today know their rights now. In times gone by they didn't know their rights, they didn't know how to complain, there wasn't a system for them.'

Another nursing auxiliary said that, at one time, patients:

'used to be frightened to say anything to you. They would be frightened of asking for anything.'

One nurse commented that patients' concerns and anxieties can be allayed by what they can observe on the ward:

'I think they expect it to be very grim ... a lot of them haven't been in hospital before ... so I think it's quite nice when they see people walking about, and dressed because we encourage people to get dressed in their own clothes.'

Summary

The descriptions by nurses in this study of patients' attitudes reflect the historical legacy of institutional care for elderly people being provided in the workhouse, in conditions that were designed to be worse than those for working class people living in the area (White 1978). Even in the 1980s Harrison (1984) describes the social realities of the National Health Service inheritance as:

> Nineteenth century workhouse turned into 'chronic sick' wards of municipal hospitals, turned yet again into NHS geriatric departments.

The low expectations, referred to by nurses, of elderly patients entering hospital were at one time realistic. Baker (1983:103) studied the ways in which nurses cared for elderly people in the 1970s and refers to a:

> usual view that the geriatric patient should be grateful for any service received and that the mode in which such service is given is entirely at the discretion of the provider.

The changes in patients' perceptions of nursing reported by nurses are linked to the move away from task oriented care towards a more individualised approach and will be described in more detail in the data on patient care.

It was not possible to seek the views of patients on their nursing care within the timescale of this study. However, in the late 1980s a small-scale research project, involving 20 patients, examined their opinions of the care that they received in the acute wards of the Unit (Arnold 1989). Karen Arnold, who was at that time a quality assurance specialist within the Unit, found that, while most patients were satisfied with their care, there were a few areas of dissatisfaction. These included the lack of communication concerning medication and the results of tests, and in addition some patients thought they needed more information about their condition before they were discharged from hospital.

Attitudes of sisters

Both RGNs and nursing auxiliaries talked about their experiences with authoritarian sisters. An RGN commented:

'When I was training, a large majority of the sisters – were role models of how we would never, ever be if we ever got to be a sister. We had sisters reducing us to tears in the sluice, they tore strips off you in front of patients and you would think, "Oh God, what have I done to deserve this?".'

Two nursing auxiliaries also spoke about their experiences with sisters:

'What she said was law ... she owned you in a way, you weren't a person ... whatever you felt, you couldn't express ... you wouldn't dream of saying it to her, oh no!'

'A lot of the sisters were very, very, very strict. You know you couldn't speak or do anything at one time.'

The way in which sisters work in the Unit now was perceived as being very different. One nursing auxiliary said:

'They don't only sit in the office all day, they muck in on the wards so they see what's going on, you know, that's changed a lot.'

Primary nursing has had a considerable impact on the role of sisters and charge nurses, one of whom commented:

'Your primary nurses are the ones that make the decisions for those groups of patients and ... if you're going to be practising primary nursing you've got to allow them the autonomy ... You have to sort of hold yourself back, but let them know that you are there if they need you.'

Summary

The way that nurses describe sisters is associated with the traditions of nursing. Fretwell (1985:128) states that:

> In the past nurses have been socialised to an authoritarian way of life and a desire for order, with every minute detail determined without question.

The characteristics of some of the sisters in Revans' (1964:52) study relate very closely to the comments of the RGN quoted:

> One or two sisters seemed to have developed an austere outlook on life in general and unfriendly attitudes towards young people in particular; they were seen as the authors, in that hospital of many of the student nurses' problems ... several potentially suitable girls were seen as having 'been driven out of the profession' by sisters who had subjected them to petty persecutions, who had reprimanded them in the presence of the patients and who had denied them privileges which had been granted to others.

The information gathered from the nurses through interviews suggests that this style of working has altered as changes in patient care have taken place.

Attitudes of nursing auxiliaries

Nursing auxiliaries used to be perceived as very powerful by staff nurses and enrolled nurses because many of them had worked on wards for a number of years and they comprised the majority of nursing staff. One RGN described how she came to insist that care was carried out in the way she felt was appropriate:

'I actually put on a mask as I came in ... because that was the only way I felt I could survive at the time .... I remember one auxiliary in the middle of the night, as I dragged the trolley out, asking me "What ... did I think I was doing?" I said, "I'm going to do the turns". She said, "We don't do them". I said, "From now on, we do".'

This type of reaction changed over time. This nurse continued:

'Gradually they all came round. You find that if you can get someone else, just one more person, on your side, who can carry on where you left off, it comes slowly but surely.'

Another RGN talked about the changes she had observed in nursing auxiliaries whom she had first encountered as a student nurse:

'They tried to dictate to you what to do .... They just liked to do what they'd been doing for years and they didn't like change and they didn't like other people's ideas. But they're like different people now ... It's amazing really. Most of them have left, but the few that have stayed they're really good.'

A sister spoke about how she communicates with nursing auxiliaries:

'I think you've got to get them on your side ... you've got to involve auxiliaries in your planning and give them a reason for doing this ... Like [with] primary nursing, the care assistant ... gives ideas, just because she's not a qualified person, doesn't mean to say she hasn't got good ideas.'

Summary

In terms of status, nursing auxiliaries are the least important members of the nursing staff, but it is apparent that trained nurses in this study had perceived them as powerful. Melia (1987:63) addresses this issue:

> The auxiliary is in a potentially powerful position, even though she is at the bottom of the hierarchy; the students rely upon her for guidance in their early days on a ward and the ward sisters make extensive use of them.

Some of the processes that can be seen here have been reported by Mechanic (1962). He presents several hypotheses concerning the sources of power of those he terms 'lower participants' in organisations. The power of these lower status employees lies, not with authority, which they lack, but in factors such as: length of time in an organisation, delegated responsibilities from higher ranking participants, and coalitions and informal contacts. One of the examples Mechanic (1962:363) gives is from a study of Scheff, where attendants in mental hospitals took on responsibilities legally assigned to the ward physician. When change was opposed by the attendants, they refused to continue carrying out this work. Mechanic (1962:360) comments:

> When an organisation gives discretion to lower participants, it is usually trading the power of discretion for needed flexibility. The cost of constant surveillance is too high and the effort required too great.

Mechanic's hypotheses could also be applied to nursing auxiliaries, and might explain the sense of helplessness that trained nurses recalled from working with auxiliaries some years ago.

The other difficulty that nurses in this study described was the resistance to change displayed by nursing auxiliaries. Fretwell (1985:23) identified reasons for this:

> There is evidence from a variety of sources to show that innovations are often met with resistance, either because they are seen as a threat, or criticisms of past practices, or because people feel that their needs are already being met and do not see that a problem exists.

A comment in Chapter 2, by Kate Wilkinson the former director of nurse education, indicated that in the past nursing auxiliaries had determined the level of patient care. In view of the discussion above, it is scarcely surprising that nursing auxiliaries were seen as powerful and resistant to change.

Changes in the ward environment

Two nurses who were interviewed together, described the ward environment as it had been until the new acute wards opened in 1987:

Nurse 1 *'The day rooms have nice curtains and things, it wasn't like that before ...'*
Nurse 2 *'In fact there'd be no screens at the beds at one time, there were no bed curtains.'*
MB *'So how did you go on?'*
Nurse 1 *'We used to have a screen, you know, a folding screen ...'*
MB *'Oh, on wheels?'*
Nurse 1 *'Yeah, we used to wheel those around.'*
Nurse 2 *'There was not much privacy with them ... they didn't cover the bed the same, did they?'*

Another nurse commented on the lack of space:

'There was just enough room between the beds to get a locker and a nurse. Basically, it was very cramped ... and when the new wards opened every ward lost a number of beds, so it ... made your working environment that little bit more spacious.'

A nursing auxiliary commented on patients' reactions to being transferred to a rehabilitation ward:

'They look round and you can see them so afraid ... strange though after a few weeks on my ward they don't want to go home some of them ... Many of them have said to me, "It's not the carpets and fixtures, it is the nurses that make the place", and that's nice I suppose.'

The environment of the new acute wards has advantages for both the patients and nurses in terms of patients' expectations:

'They said they didn't want to come into hospital in the first place, but they said, "It's like being in an hotel and they bring our food and they ask us what we want to have ... They've got a lovely day room". ... It's their entitlement isn't it? It's how everyone should be cared for.'

Another nurse commented on the advantages of small bays:

'If you're just getting somebody mobile, if you point the toilets out, 10–15 steps away, they are more happy to do that than if you're pointing to the distance and ... you tend to find, that they're quicker to go themselves, it's a lot easier for them.'

The bays also facilitate socialising between the patients:

'People get quite friendly with each other and it's nice because they keep in touch when they go home so they've made a new friend while they've been in.'

The contrast between the environment of the acute wards and rehabilitation wards does cause anxiety among patients. One nurse commented:

'They still think they're not getting as good treatment because it's not new. A lot of them still remember it as the workhouse you see.'

Summary

The ward environment in the Care of the Elderly Unit at Tameside General Hospital has improved during the last ten years for all patients. However, nurses are aware of the ways in which patients' perceptions are affected by the stark contrast between the new environment of the acute wards and the lingering associations of the rehabilitation wards with the workhouse.

Patient care

The changes in the attitudes of nursing staff previously described are closely linked to changes in patient care. Data concerning the several aspects will be presented under the following headings:

- talking with patients
- patients' choice/rights
- meeting patients' needs
- patients' relatives
- organisational issues relating to patient care.

One of the features of these interviews with nurses was the extent to which their descriptions of their working lives focused on their relationships with patients.

Talking with patients

One nursing auxiliary described how her job has changed:

'I feel that I'm a carer now, where before I weren't nursing, it were just a routine, like a machine really. You didn't have time to talk to patients, you just went to them, washed them, fed them and that was it. But now you can sit and talk.'

Another nursing auxiliary commented:

'You were wasting time if you spoke to them. I mean, now you can, that's part of the treatment to draw them out, and you talk about your family, talk about theirs, you have a laugh, but then it wasn't encouraged.'

Nurses spoke about how they now need to identify the patients who hesitate to talk to them. One RGN said that:

'If you sense that there's something troubling your patient, you know that you can sit there and listen until they feel ready to tell you.'

A nursing auxiliary observed that:

'Being a care assistant is a very important job really, because you can spend a lot of time with the patients ... and have little talks with them and find out a lot about them.'

However, two nurses talked about the pressures of work that prevented them from having time to talk to their patients:

'To me that's more important talking to them than anything else, but ... sometimes all I've said is "Hiya" to one person and I've thought that's really bad ... they're just looking at everyone running round and nobody speaks to them. It really does wind me up sometimes.'

'Some days are busier than others. Some days you've had a sit down and a talk to somebody and then other days it's, "Right, I've done your blood pressure, that's fine and there's your tablets and I'll see you tomorrow". But, I mean some of them don't want to talk anyway, you just have to judge it.'

Summary

Talking with patients is an indicator of patient care that is not task oriented. As Fretwell (1980:628) states:

> Because the routine itself is a form of communication it inhibits overt communication between the nurse and the patient.

The assumption, mentioned by a nursing auxiliary above, that talking to patients was a waste of time was echoed in Melia's (1987:27) study of student nurses:

> The students who are talking with patients are demonstrating by the very act of talking, that they are not working. Not only are they not working, but they are not prepared to adopt the 'look busy' tactics which support the efficient nurse front dictated by the 'unwritten rules' of the wards.

The Audit Commission handbook for ward sisters, *Making Time for Patients* (Audit Commission 1992:17), emphasises the importance of nurses:

> getting to know their patients well enough to understand and empathise with their problems. And without that level of understanding, they will continue to see not 'patients with problems' (that are potentially amenable to solutions), but 'problem patients'.

The nurses in this study have showed awareness of the importance of talking with patients in order to provide good care for them.

Patients' choice/rights

The following two accounts by nurses working night duty show the contrast between past and current nursing practice on wards in the early morning:

Nurse 1 *'You weren't supposed to do anything 'til six, and the lights, it were like Blackpool illuminations ... a big surge of electricity come on in the morning ...'*

Nurse 2 *'Then it were one mad rush to the beds, weren't it?'*

'The patients that receive two-hourly care are the ones attended to in the morning as usual, then as the other patients wake up, they're asked "Would they like a drink? Would they like a wash?" And if they say yes or no, then that's up to them. We don't turn the lights on – it's their choice really.'

Information is now made available to patients so that they can make a choice. Two nurses commented on how patients are no longer 'kept in the dark' about their treatment, and they now have access to their nursing notes. One of them said:

'At one time you'd give somebody a tablet [and] they'd say "What's this?". And it were a case of "Doesn't matter, you take it". Well, it's not like that now ... you might say "Do you want any painkillers?" Whereas you just used to give them, didn't you?'

Another situation in which nurses have relinquished their control over patients is in mobilising them. An RGN described the change of approach:

'One of the factors that held them [nurses] back was the risk element. They weren't prepared to acknowledge that the patients had the right to take that risk, to get up and walk, you know. Whereas now we would say, "Well, okay, if you want to walk I'll walk with you", then they would say "No, you can't walk because you'll fall". ... I think in nursing the elderly there is always going to be an element of risk, but you can't take away their independence, simply because you are a nurse.'

However, not all nurses appeared to subscribe to choice. One nurse took the view that sometimes patients were allowed too much choice. The example she gave was of patients who did not want to have a bath:

'It was automatic, you're in hospital ... because you need some help and some treatment, it was part of your treatment to have a bath ... and you did it. Now if they don't want it, they stay dirty and everyone has to put up with it.'

On the whole, nurses talked favourably about enabling patients to make decisions for themselves:

'All the regimentation has gone through the window, which is good really. I wouldn't mind being a patient sometimes.'

'You do what they want. Try and make them feel as if they are at home amongst friends.'

'The wards nowadays, they're so much better, patients have got so much choice, relatives are so involved. Things are so much more relaxed without losing sight of the fact that you're there for a reason and those ladies [the patients] are there for a reason.'

Awareness of death

The following quotations from nurses concern changes in nursing practice in relation to dealing with death and how the traditional policy of concealment restricted patients' rights.

A nursing auxiliary recalled a patient many years before, who was dying of cancer:

'She wouldn't have known and it's very sad when you look back, because I'm sure a lot of them would have wanted to say things to their own family, if they'd been aware of how ill they were .... When somebody dies at home they have the family around them and that's the way it should be when somebody dies in hospital.'

Another nurse talked about the atmosphere on the ward when somebody died:

'Death was something that you actually shut out ... it was all hush hush, you'd keep the curtains closed and you'd go sneaking in and out of the curtains, when in actual fact 90 per cent of the other patients on the ward knew perfectly well what was happening .... It could well be that they've become quite close friends with patients from the ward and you found that the other patients were denied the chance of saying their farewells.'

Two nurses spoke about how they no longer conceal death from patients:

Nurse 1 *'If they ask outright we'll tell them, if they ask a direct question we'll answer them truthfully.'*
Nurse 2 *'I think at one time if ...'*
Nurse 1 *'At one time you just said they've transferred.'*
Nurse 2 *'You did, if somebody said "Has 'suchabody' died?" you'd say "Oh no, she's gone to another ward". Didn't you? Which is a bit silly really isn't it?'*

Summary

Wells (1980:127) describes how routine was paramount in the geriatric wards she studied in the 1970s:

> Individual patient preference or even necessary variation in care appeared obstructive to the work goal, which was completion of the routine.

Baker (1983) referred to a 'routine geriatric' style of nursing, which placed 'orderliness' before the meeting of patients' individual needs. Menzies (1960:101) suggests that task oriented care prevented nurses:

> from coming effectively into contact with the totality of any one patient and his illness and offers some protection from the anxiety that this arouses.

Chapman (1983:16) discusses ritual and rational actions in hospitals:

> Some rituals appear designed to assuage the terrors of death and chaos. It might be useful to call them concealment and avoidance rituals

and (1983:20) concludes that:

> Strategies for development and progress in the nursing profession require a full understanding of the level of human experience (psychological or sociological) to which any given nursing action is addressed.

Nurses interviewed for this study have moved away from task-oriented care and they indicated, by the way in which they talked about patients, that they valued them as individuals to whom choices should be made available.

Meeting patients' needs

One RGN summarised her approach to meeting patients' needs as follows:

'Ultimately, no matter what, their needs are their needs and they're very important to them when they're poorly. No matter how trivial they may seem to us.'

Another RGN observed how the approach to a particular nursing activity, feeding patients, had changed:

'It's obvious when you think about it. People would stand up at the side of them and shovel this food in as quick as they can, instead of sitting down with them – or even assisting them, thinking about the aids that you can actually get so easily to assist them with their feeding and to encourage family to help as well.'

One nurse described how she assessed patients, while she was in a bay carrying out small tasks for patients such as shaking their pillows:

'You'll say, "Are you walking to the toilet all night or do you want a bottle?" You're not interested whether he walks or not, it's just a point of conversation. If he turns round and answers you briskly, you know he's okay; if he turns round slowly you can tell by this.... You don't call it routine, but then you go to the next bay and you do the same thing there.'

Another aspect of meeting patients' needs is the recognition by nurses of the life style of their patients outside hospital. This issue arose in an interview with a RGN working nights:

MB *'When I was in on Saturday night and there was somebody up watching the snooker, I thought it's nice that they can do that.'*

Nurse *'It's good for the elderly because as I said before a lot of them probably at home don't go do bed 'til late.'*

One nurse spoke about giving information to patients in ways that made it easier for them to absorb:

'You'll tell them one little bit one day, then you'll tell them a bit more the next day. Some patients you can [tell] they don't want to know, so obviously we just discuss it with the relatives or we try to tell them the basics before they go home so they know what's happened to them. But they use simple language, if you said to somebody they'd had a CVA, everybody round here calls it a stroke, so there's no use calling it something different.'

One nursing auxiliary commented on how relationships with patients have changed generally:

'You can enjoy it now, you can be a human being with them, you can; if they're feeling sad you can be sad with them. You don't have to have this big front up like you used to ... if somebody'd died, get them [the relatives] out of the way quick. You don't have to do that any more, you can stay with them and you can put your arm around them, you know, you can be with them.'

A specific problem that nurses raised in interviews was that of ways of dealing with competing demands from patients. When I asked one nurse how she coped, she responded as follows:

'Oh, I just try to share myself out between everybody, give myself, give them all the same... If I know someone is quiet, I won't just not bother with them. I always go and say something to them, because otherwise the only time they get to speak to people is if you're giving them medicines or giving them some breakfast or dinner.'

Summary

Wells (1980:131) concluded her study of nursing care on 'geriatric' wards in the 1970s by suggesting an alternative to the routine task-based care that she had described:

> The nursing model most likely to be helpful is one focused on the elderly person who is experiencing illness instead of one focused on either his physical problems or the tasks associated with his care. This person-oriented approach will help the nurse select priorities and effectively utilise her energy and concern in meaningful patient care.

The Audit Commission (1992) found, in a survey of patients carried out by the Health Policy Advisory Unit, that 27 per cent of patients felt they lacked 'individual care and attention' and 19 per cent felt that nurses could try harder to make sure that patients 'understand the information they are given'. Approaches such as those described by nurses above are likely to reduce patient dissatisfaction in those areas.

The data presented above illustrate aspects of individualised nursing care that are responsive to patients needs. The nursing auxiliary who talked about 'being with' patients showed the skill that Benner (1984) describes as 'presencing'. The exemplars presented by Benner (1984:57–58):

> point to the importance of touch and person-to-person contact between patient and nurse. They also speak to nurses' need to allow patients to ventilate their feelings, often, without speaking at all themselves.

Patients' relatives

An RGN described the attitudes about nursing care that used to be held by patients' relatives:

'They wanted their parents... kept safe and warm and cosseted and nice and cosy in bed and having cream slapped on their bum every two hours and that sort of thing was seen as being a good nurse.... You weren't actually promoting any independence, you were just sort of there to make sure nothing untoward happened to them.'

Another RGN talked about discussing patients' safety with their relatives:

'They will ask for cot sides but then – you can involve the families [as] to why they want cot sides up. Explain about cot sides – do they need these cot sides? ... I don't mean in a condescending manner.'

Nurses spoke of the advantages of open visiting, such as elderly people preferring to go out in the day rather than at night, especially if they use public transport. One nursing auxiliary commented on the reassurance that relatives can provide for each other if they visit at different times:

'You get a lot who finish work and they might not get home 'til seven; they'll come at nine and visit for an hour and then they're quite happy ... They can go home, ring their relatives and tell them, "He were comfortable when I left him".'

One RGN who works night duty mentioned requests from relatives to visit during the early hours of the morning:

'I've had people phone up at four o'clock in the morning saying, "I've just woken up and I was thinking about my dad and I'll not get back to sleep. Do you mind if I come, I'll be very quiet and I'll just sit?" And I'll say, "Come on, it's all right", because I know in the end I'd feel the same if it was my mum.'

Nurses provide information for relatives in much the same way as they do for patients. One commented:

'You get a lot of relatives who go in and dish out the tablets and they want to know what they're for, because obviously they'll feel responsible, you know, going giving their mum the tablets.'

However, patients may not wish their relatives to have access to information about their medical condition. One nurse said:

'Relatives haven't got the right to pick up your folder [for nursing notes] from the bottom of your bed and read it .... It is the patient's folder ... they have the right to allow their relatives or their friends to look at it, but they've also the right to say, "No, that's mine and I don't want you looking".'

She recalled a patient who had decided that she did not want her family knowing her business and requested that her nursing notes should be kept at the nurses' station.

Nurses also talked about assessing whether relatives and friends wished to be involved in the physical care of a patient. When I asked one nurse about this, she responded:

'Sometimes they think that we're skiving out of a job, asking them to do it, so I kind of suss out what they're like first. [Laughter] I mean if they're quite keen to help I'll ask them, but if I think they're going to think, oh they're not doing their job, they're getting us to do it, I won't ask them.'

Dealing with relatives is not always straightforward. They may make inappropriate requests because of their inadequate knowledge base and they make complaints to nurses. An RGN described both the difficulty of accepting relatives' complaints and her understanding of why they are made:

'Sometimes, you know, you get patients' relatives and they'll come in and complain ... You feel, "Oh God, what do you want from us?", you know, and you just have to pin a smile on your face and take it, whatever they want to dish out. But you've also got to understand that no matter what ... they're dishing out to us they're grieving and they're upset and they're worried.'

Summary

The presence of visitors on a ward throughout the day means that nurses' work is more open to scrutiny. Nurses' commitment to individualised care and involvement with the patient's family is more likely to result in criticism if expectations are not met.

Closer involvement with relatives can be stressful for nurses. In her study of five general wards, Fretwell (1985) found that nurses ranked 'dealing with bereaved relatives' as the second main stated cause of stress after understaffing. Benner (1984:63) cites providing emotional and informational support to patients' families as one aspect of the helping role:

> The nurses provided many examples of considering the patient's family as their clients and as important resources for the patients' recovery. They often provided emotional support to the families or gave them the opportunity and the information necessary for them to provide physical care for the patient.

The involvement of the nurses in this study with patients' relatives is not only associated with individualised patient care, but also demonstrates a recognition that patients have lives and relationships that extend beyond the hospital ward.

Organisational issues relating to patient care

The main issue that arose in interviews with nurses about the organisation of patient care concerned the provision of a 24-hour nursing service. One nursing auxiliary described the pressure she used to be under to get through the work:

'I was on days or evening shift and everything was one mad rush you know. At the time I felt everything had to be done at a certain time, well it had in them days.'

One RGN talked about the difficulties of changing that approach:

'It were hard work changing people's attitudes, like late shift auxiliaries would come and say, "Lockers haven't been done and laundry hasn't been done, I've got all that to do now". I'd say, "Well, you're here for eight hours", and they couldn't see that .... Night staff used to say, "You haven't done this and you haven't done that", and I said, "We're here for 24 hours". ... We're blended a lot better now, which is great because days and nights were horrific rivalry.'

Other nurses took the view that it was not fair to the next shift coming on duty to leave them to collect cups or to tidy the kitchen. Consequently this is an area of tension and disagreement between some nurses.

Two nurses working nights said that there is now a greater understanding between day and night staff:

Nurse 1 *'We're giving a 24-hour service and we work until we're ready to go off and then they take over.'*

Nurse 2 *'At one time, of a morning, say there was somebody wanted a commode or something and we were nearly ready for going off, you either sort of said, "They'll be coming in a minute, the day staff" or you'd give it them and then you'd be hovering and have to move it, which is ridiculous isn't it? But that's how it was.'*

Nurses working night duty commented on how their views about patient care are now taken into account:

Nurse 1 *'You can even make a suggestion, "Well, why don't you try doing such a thing"... And, they'll say, "Well yeah we'll give it a try" ... And if it works they'll say "You know it works smashing that"... And they actually ask you things as well, don't they?'*

Nurse 2 *'They do. They involve you all the time which is how it should be .... At night we're doing for patients just as much as sister, staff nurse, whoever's on during the day.'*

Summary

Wells (1980:129) writes about her study in the 1970s:

> Training has encouraged nurses to perform ritualistic routines without thinking of the effect of such routines on patient care.

The data presented above illustrate a move away from the view that performance of particular tasks at certain times is an indicator of effective nursing care. The nurses have described how they work more effectively as a team and how their communication has become more focused on the patients, rather than on tasks which may or may not have been completed.

One RGN summarised this approach:

'The bottom line is the patient isn't it? That's what it all comes down to, the kind of care, the standards of care they get and that's what it's all about... that's what things should be judged of.'

Professional issues

The data on patient care provided many examples of how nursing practice has changed in the Nursing Development Unit. In this section data will be presented on professional issues affecting nurses, including:

- staff development
- dealing with doctors
- job satisfaction.

A common theme which brings these issues together is that of nurses having the self-esteem and self-confidence to value their role of caring for patients.

Staff development

One of the main features of the Tameside Nursing Development Unit has been its emphasis on staff development, following on from Steve Wright's belief, outlined on p. 24, that nursing cannot be developed unless nurses are given the opportunity to develop. One enrolled nurse commented:

'The opportunities are unbelievable, whether you're interested in going on to the next grade and going up the ladder or whether you're interested in keeping up to date at your level and still making the best of yourself and still getting the knowledge that you need.'

One sister mentioned how important the workshop that was introduced for G grade staff had been for improving communication and co-operation:

'The G grade workshop started and that's when we started to trust each other, and we talked about the problems that we had within the rehab and the new unit and we could see each other's point of view.'

The staff development programme has not been restricted to trained nursing staff. Steve Wright took the view that nursing auxiliaries:

'were often an invisible part of the team who donkeyed along and did the work, but were not seen as trained nurses and didn't necessarily need anything further .... They're all part of the team, everybody's got something to offer and you've got to give everybody something.'

The reaction to the course for nursing auxiliaries that was set up in the NDU was mentioned by an RGN:

'The ladies on the ward I work, they've all thought, "I don't want to go on this", and every single one of them, when they've come back, they've enjoyed it, they've loved it and they've all done an assignment ... and it's nice to see that they're actually given something.'

Nurses also talked about the impact of staff development opportunities in terms of changing attitudes towards nursing practice:

'We're being taught now to question whatever we do, why are we doing it? That's only been brought about by workshops, through courses to make you more aware of what you are doing.'

'So you do get blinkered into some things you do even now, because we've always done it, until you sit back and question it or perhaps somebody new comes along and questions it. I think now our RGNs and ENs are willing to accept criticism, whereas you know ten years ago they weren't.'

One RGN commented that, in retrospect, the need for change seems clearer than it was at the time:

'I've been thinking about the changes that I've seen and ... wonder why other people didn't implement changes when they were so obvious ... I mean everybody had nightdresses on at three o'clock in the afternoon ... I was just thinking about what it was like when everybody had these flaming split-back nightdresses on.'

Summary

Staff development provided nurses with the opportunity to increase their self-esteem, improve their skills in communication and facilitate using their judgement, as well as gain more technical knowledge relating to nursing practice. Fretwell (1980:626) comments:

> Nurse education and patient care are inextricably linked, for the quality of education received by one generation of nurses influences the quality of care and education for succeeding generations of patients and learners.

In the Tameside Nursing Development Unit, the emphasis placed on development for all nursing staff helped to bring about a different approach to patient care.

Dealing with doctors

The confidence that nurses in this study show, when they describe the ways in which they relate to doctors, derives both from their knowledge of individual patients, which enables them to act as the patient's advocate, and from the professional development associated with working in a nursing development unit.

Regarding the way in which nurses used to relate to doctors, one nurse said, 'Sister was the only one who spoke to the consultant' and another observed:

'I think the changes on our unit have filtered through to the consultants because ... you used to do the ward round and everybody used to be by the bed and that .... The registrars are good, they don't expect you to be at their beck and call, and the housemen that come along ... you do get one or two people say, "Get me a syringe" and we'll say, "Well, they're in that room round there". ... It's only once in a while now.'

The difficulties that nurses face when dealing with doctors often relate to the shortage of beds. An RGN commented:

'We've actually said, "This lady is not ready for rehab, you've got to think again, it's not a conveyor belt". But, you see, the staff on there [the acute wards] are getting pressure from the doctors, the doctors are getting pressure obviously if they've no beds – it's a catch 22 situation.'

The pressure on beds can also lead to disagreement between doctors and nurses when a patient's discharge is planned. One RGN recalled her concern that a particular patient would not be able to manage at home, together with the conversation that she had had with a junior doctor, who had said:

'"They've managed before" I said, "Yeah, but there's a difference between managing and being safe, and he's not safe".... That's all they see: get the bed empty, get the bed empty .... But luckily we're standing up to doctors now, aren't we?'

Another nurse talked about greater co-operation between nurses and doctors:

'They're quite open to suggestions on this unit, even the consultant. I can say to the consultant, "Well, I don't think this lady's going to manage at home," and he'll listen to our opinion .... He's quite happy to say, "Right, well, let's get social services in". And that might delay the lady going home ... but you'll probably find that she won't be re-admitted as quick ... I don't know about all consultants, but he is quite good at listening to the staff's opinion.'

Summary

Gamarnikow (1978:105) claims that in the nineteenth century nurses:

> were taught a form of nursing care which established and maintained the hierarchical divisions between nursing and medicine ... which subordinated nursing to medicine in all matters defined as 'medical' by medicine itself.

These status divisions have until recently been reinforced by gender divisions, with a predominantly male medical profession and a predominantly female nursing profession. Women are frequently associated with a caring role in the home and the workplace, which is often taken for granted and undervalued (Graham 1983). Salvage (1990:85) suggests that:

> The development of nurses as autonomous professionals had also been hindered by the need to manage a very large work force. Nurses, as the worker bees of the health care system, have been organised on bureaucratic rather than professional lines.

Despite the historical legacy that allots different degrees of status and control to doctors and nurses, Porter (1992:524), in a study of the influence of gender on nurses' working lives, refers to:

> the refusal of many nurses to acquiesce without objection to the subordinate position that some doctors expected them to take. These actions were predicated upon an increasingly positive self-evaluation of nurses about their role as female workers.

Nurses in this study have shown a high level of professional autonomy in their interactions with doctors.

Job satisfaction

Individual nurses in this study express satisfaction and dissatisfaction with their jobs in different ways. Some of the different strands of job satisfaction will be explored below and this issue will feature prominently in Chapter 4 which reports the findings of a survey of NDU staff.

Two comments by nurses reflect a change in nurses' perceptions of their colleagues:

'I never realised, until I went into training, you only went into geriatrics if you couldn't get a job anywhere else and it was as simple as that.'

'I think the people who work on the unit now, work on the unit because they want to ... and not because they were sent there, which is what happened in the past.'

Nurses also spoke about how they valued working with elderly people, one commenting on negative attitudes that some people have:

'They must think if they see a little lady with grey hair sat there, very quiet, that she's gone, her mind's gone and they've got a lot to learn, I'll tell you. If they took the time and the effort to involve the patient in their care, and find out what they want and what they are capable of doing, you see some smashing results, you know.'

The dangers of stereotyping elderly people were discussed by another nurse:

'This lady of a hundred, she said to me, "I know it sounds silly ... but in here [the nurse pointed at her head] I only feel 50, but I can't do the same as I did at 50, I don't feel any different." So it's a state of mind, isn't it, really, age?'

A nursing auxiliary described why her work was rewarding:

'It's strange ... with the elderly, there's something that draws you all the time. I'm happy when I'm at work and I feel I've done something good when I get home. Better than working in a factory, it's just the routine in there, but this is something different every day. I mean, you see a lot of sadness of course, but you get a lot of pleasure.'

Two nurses described their preference for nursing particular types of patient:

'It's very rewarding to see somebody that's had a stroke and you've rehabilitated them to the point where they are able to go home ... that really is the reward, that maybe they was incontinent and you've been able to help them ... you're giving them some sort of dignity.'

'I prefer acute nursing ... I suppose it's excitement and the adrenalin that pumps in me, the busier I am, the better I feel ... I'd rather have the pace over here.'

Others derived self-esteem from their achievements at work:

'I can go home and go to bed and I've done a good night's work ... I said the day I go home and I know I haven't, that's the day to chuck it in and call it a day. I just like nursing, that's all.'

'You might be on seven days before your days off ... but it flies by and it's always a bit of variety every day, different patients you've got, or what's happening on the ward and the unexpected always happens you know – so it keeps you going.'

The team spirit among the night staff was mentioned by one nurse:

'I think there's a better relationship at night ... probably because there's not very many of us and you are more dependent on each other. I think perhaps we work better as a team than day time and mostly people on nights are not ladder-climbers either.'

However, nurses also talked about difficulties associated with their work, particularly about coping with the pressures of change:

'There's too much going on to try and do it properly ... I will try things and ... then I will see it out to the end and do it properly, I won't half-heartedly do it. But I can't do with all these things ... coming through the post that you've got to be there at and they expect you to be dead knowledgeable about. I think they do expect too much of us.'

'We're having to do all these new things with the same amount of staff as we had when we weren't doing them, and it's just like a constant pressure to have to do all these things, and we never get any time to learn how to do them ... Sometimes when you're at home and you've been dead busy, you don't feel like doing it.'

Two nurses felt that nurses do not always value the place where they work:

'When I get fed up and I want to leave, I think about all these other people in other hospitals and that's why I stay put.'

'When you go to other hospitals you appreciate how different your hospital is, which you tend to take for granted. I do appreciate how lucky we've been and it's like a lot of girls have said, you don't appreciate it until you lose it, or you think that you're going to lose it, and all of a sudden you realise how far we have gone and have been taken.'

Summary

Job satisfaction reflects the interaction of an individual with his or her working environment. It is, therefore, to be expected that different individuals will describe job satisfaction in different ways, and that they will also mention aspects of their work that cause them problems.

Fretwell (1985:26) comments:

> Reports of a number of projects in which nurses abandoned a system of task allocation in favour of some form of individualised patient care suggest that nurses find increased satisfaction in their work because of their deeper knowledge of, and involvement with, individual patients.

This statement relates to the experiences of nurses in this study, especially in the ways that the data presented comment on nurses' attitudes towards elderly people and how they should be cared for.

Nurses in this study raised many issues relating to job satisfaction. Other ways in which nurses expressed satisfaction with their work varied in their emphasis, ranging from preferences for nursing particular types of patients, to more personal and interpersonal aspects of the work, such as self-esteem and working as part of a team.

Key summary points

Relationships between nurses

In the past, relationships between nurses in the Unit had been determined by the hierarchy and tradition. Changes in patient care initiated by trained nurses with management support enabled all staff to work in different ways, and to value both their own contribution and that of other ward staff towards improving patient care. The reduced tension between different grades of nursing staff made it possible for nurses to redirect their attention so that patient care became the central focus of their work.

Nurses' relationships with patients

The nurses in this study had learned that communicating more with their patients enabled them to get to know them better, so that nurses could respect their choices and rights, meet their needs more fully, and involve patients' relatives in their care. These changes increased nurses' job satisfaction, as well as improving the quality of care provided.

Staff development

Staff development opportunities have increased the self-esteem of the nursing staff, which has enabled them to value themselves and the work that they do more highly. Opportunities for professional development have also enabled nurses to question accepted nursing practice and to accept the questioning of other nursing staff, so that further changes and improvements can be made.

Nursing elderly patients

The Nursing Development Unit has raised the profile of the nursing of elderly people, which was traditionally seen as the last resort for nurses unable to obtain jobs elsewhere. Now that the negative stereotypes of elderly people have been discarded, nurses in the Unit derive job satisfaction from the provision of good care for elderly patients.

4

Findings of a survey of NDU staff

Introduction

The rationale for conducting a survey of nurses' attitudes towards staff development and job satisfaction in the Nursing Development Unit is outlined in Chapter 1, p. 14. The survey was designed to investigate whether staff development opportunities in the NDU were linked to job satisfaction, which in turn would reduce problems associated with recruitment and retention of staff.

Response to the survey

Information about the pilot study and sampling is included in Chapter 1. Data concerning the response rate to the survey are presented here to indicate its representative nature. By the closing date for the return of questionnaires in mid-February 1992, 88 responses had been received, a response rate of 62 per cent. As the questionnaires did not identify the respondents through the use of reference numbers, a memo was sent to all nurses which served as both a thank you and a reminder.

The survey was closed in mid-March, by which time 109 questionnaires had been returned, a response rate of 74 per cent. Of the day staff, 71 per cent completed questionnaires (64 out of 90), together with 78 per cent of the night staff (45 out of 58). There was a variation among grades of nursing staff, with a response rate of over 80 per cent from sisters and charge nurses (18 out of 21), staff nurses (31 out of 38) and enrolled nurses (25 out of 30), but a lower response rate of 60 per cent (35 out of 58) from nursing auxiliaries. This may have been a consequence of the questions being seen as inappropriate by some of the untrained staff, or because some auxiliaries found a questionnaire of 15 pages too long.

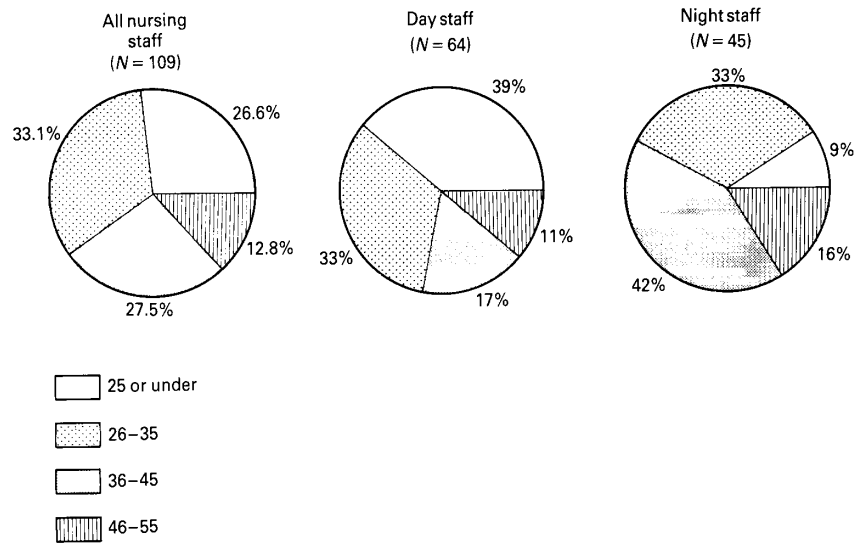
Profile of the nursing staff

Age

Of the nursing staff who completed questionnaires, 89 per cent were female (97 out of 109) and 11 per cent were male. Men were found to be working at all grades.

The age distribution of nursing staff shows that the proportion of nursing staff in the

Figure 4.1
Age distribution of NDU staff



Source: Survey of NDU staff 1992

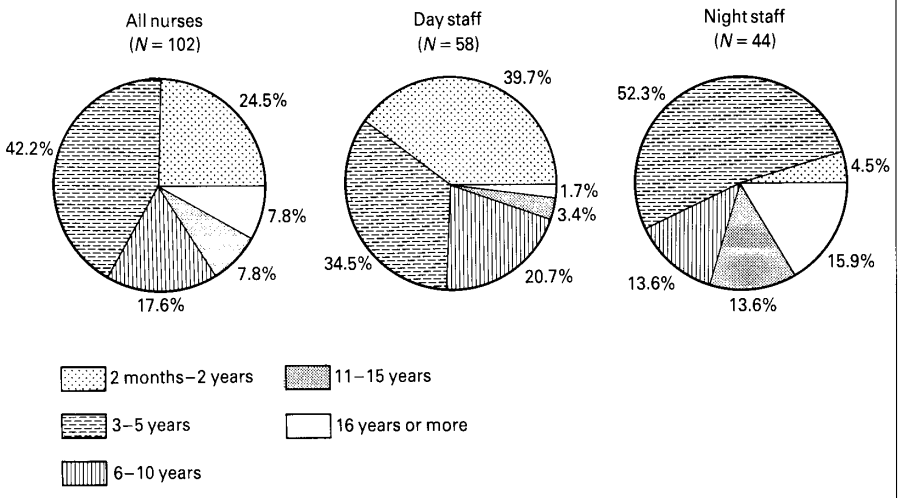
older age groups is greater for the night staff than for the day staff (Figure 4.1). The age distribution of nursing staff also differed by grade, as 89 per cent of sisters and charge nurses and over 70 per cent of enrolled nurses were clustered in the 26–35 and 36–45 age groups, over 85 per cent of staff nurses in the under 25 and 26–35 age groups, and 60 per cent of nursing auxiliaries in the 36–45 and 46–55 age groups. Overall, 69 per cent of qualified nurses were aged under 35, compared with 51 per cent of the sample of RCN members in the survey carried out by Seccombe and Ball (1992). The younger age profile is probably due to the emphasis in the Unit since the mid-1980s on recruiting trained nursing staff.

Nursing qualifications

Among the nursing staff who took part in the survey, 45 per cent (49) were RGNs and 23 per cent (25) were enrolled nurses. As the response rate for trained nurses (over 80 per cent) was higher than for nursing auxiliaries (60 per cent), this sample over-represents trained nurses, who comprise 60 per cent of the population of nursing staff in the NDU. Nurses in the Unit have had opportunities to upgrade their nursing qualifications; 5 RGNs had initially trained as enrolled nurses and subsequently converted to RGN; 2 enrolled nurses were undertaking a conversion course at the time the survey was in the field. In addition, 2 nursing auxiliaries were waiting to start RGN training. Two nurses in the Unit stated that they were graduates and 3 others were studying for degrees in nursing. Nearly 60 per cent of nursing auxiliaries had attended the 'Helping with Care' course.

Of the RGNs and ENs working in the NDU, 78 per cent (58 out of 74) had trained at Tameside General Hospital.

Figure 4.2
Length of time nurses have worked in the Care of the Elderly Unit



Source: Survey of NDU staff 1992

Working hours

Full-time working was undertaken by 47 per cent of nursing staff (51), while 53 per cent worked part-time (58). Day staff were more likely to work full-time (69 per cent or 44 out of 64) than night staff, of whom 84 per cent worked part-time (38 out of 45). Part-time nursing staff were clustered in the lower grades: 31 of the 35 staff graded A/B worked part-time and 15 of the 25 enrolled nurses worked part-time. However, the majority of RGNs worked full-time: 22 out of 31 staff nurses and 15 out of 18 sisters and charge nurses. Overall, 36 per cent of trained nurses worked part-time (27 out of 74), slightly less than the 42 per cent working part-time recorded in the most recent survey of RCN members (Seccombe and Ball 1992).

The working hours of part-time staff were clustered at 20 hours per week for 20 members of staff and 30 hours per week for 35 members of staff. There were 3 part-time members of staff who stated that their working hours differed from those of the other part-time staff. Part-time staff were predominantly female, with only 3 out of 58 being male. Similar numbers of part-time day and night staff worked 30 hours, but the 21 part-time staff who worked around 20 hours per week all worked nights. Part-time staff were represented in all age groups.

Nursing elderly people

Figure 4.2 shows that there is great variety in the lengths of time that nurses have worked in the Unit, but that a higher proportion of night staff, nearly a third, compared with 5 per cent of day staff, had worked in the Unit for more than 11 years. There are also grade differences relating to the length of time nursing staff have worked in the Unit, as nearly 30 per cent of nursing auxiliaries have worked there for 11 years or more, but less than 15

per cent of enrolled nurses and 11 per cent of sisters and charge nurses.

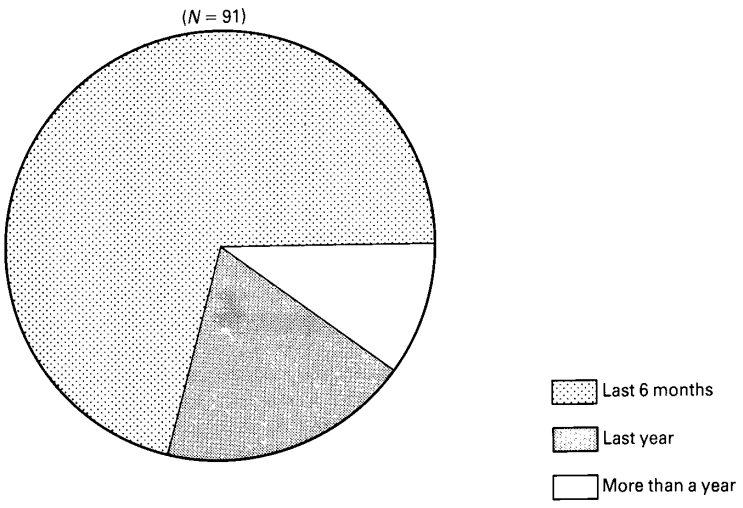
This grade distribution shows how nursing care used to be provided by predominantly untrained staff. Of RGNs on the Unit who trained at Tameside, 20 per cent (7 out of 35) started working there between 1983 and 1986, which is when student nurses began to apply for those jobs (see Chapter 2). Recruitment of student nurses who trained at Tameside has continued, as 40 per cent of these RGNs (14 out of 35) have worked on the Unit for between three and five years, and 37 per cent (13 out of 35) for between two months and two years. This question was not answered by 4 RGNs.

Just under 30 per cent of nursing staff (32) had worked in the care of elderly people before coming to Tameside General Hospital. Of these, 11 nurses thought that patient care was better when they came to Tameside compared with their previous workplace, 13 thought it was about the same and 7 believed it was worse. Of the 20 nurses who described differences in patient care between Tameside and where they had worked before: 8 nurses mentioned that, in the elderly units where they had worked before nursing was task oriented; 3 commented that care in their previous workplace had not been individualised because primary nursing had not been introduced; and 2 stated that staff development opportunities had been lacking in their previous posts. However, 2 nurses said that staffing levels had been higher at their previous workplaces.

Staff development

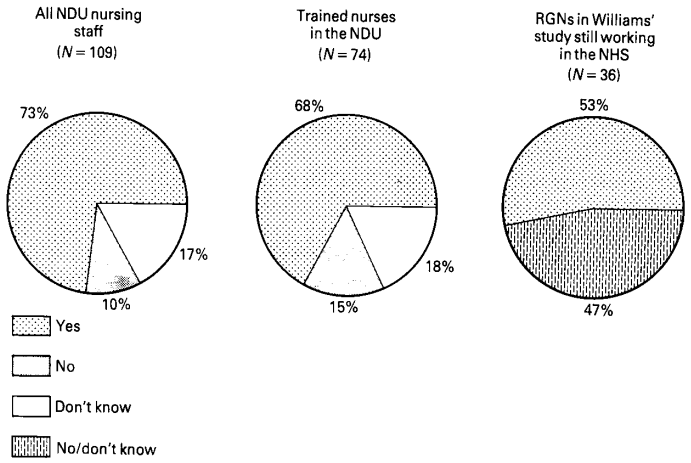
Among the staff who took part in the survey, 79 per cent (86 out of 109) had attended further training, further or higher education, or any study days or workshops since working in the Nursing Development Unit. Day staff had received more training; 54 nursing staff who worked days (84 per cent) attended events compared with 32 nurses working nights (71 per cent). Figure 4.3 shows the time span in which staff had taken up

Figure 4.3
Attendance on a course or study day



Source: Survey of NDU staff 1992

Figure 4.6
Responses to the question 'If you could start again, would you still choose nursing as a career?'



Source: Survey of NDU staff 1992 and Williams, C, Soothill, K and Barry, J, (1991)

(1991:18). The nurses in the study by Williams et al. had left one health authority in the north west of England for 'a wide variety of reasons ranging from promotion to discontent', but were still working for the National Health Service. A comparison of the nurses in the study by Williams et al. with those working in the Tameside NDU shows a higher level of job satisfaction among the nurses at Tameside, 61 per cent of trained nursing staff in the NDU stating that they would still choose nursing as a career, compared with 53 per cent of the nurses in the Williams et al. study.

Importance of aspects of working life

Questions concerning nurses' perceptions of the importance of certain aspects of nursing work, and the extent to which these had been present in their own experience of nursing, were selected from the questionnaire developed for a survey of members of the Royal College of Nursing carried out by Waite and Hutt (1987).

Comparison of qualified nurses in the NDU with the total NDU sample

Before focusing upon the trained staff from the two samples, it is appropriate to investigate the differences between the trained nurses in the NDU and the total sample of NDU nursing staff. A higher percentage of trained nurses regarded certain aspects of working life as more important than the group as a whole :

- 66 per cent of trained nurses (49 out of 74), compared with 56 per cent of the total number of respondents (56 out of 100), saw 'using your leadership/management abilities' as very important.
- 78 per cent of trained nurses (57 out of 73), compared with 71 per cent of the total (72 out of 102), rated 'using your intellectual/academic skills' as very important.
- 83 per cent of trained nurses (60 out of 72), compared with 80 per cent of the total (83 out of 104), stated that 'using your initiative' was very important.
- 69 per cent of trained nurses (51 out of 74), compared with 63 per cent of the total (65 out of 104), took the view that a 'high standard of supervision/management abilities' was very important.

The first three of the items above are concerned with professional autonomy, which trained nurses would be expected to view as more important than would a group that also contained untrained nursing staff. The higher level of concern expressed by trained nurses about management and supervision may have indicated a greater concern about a framework of authority in which they could work with a degree of professional autonomy.

There were also differences between trained nurses and the total sample regarding the importance placed on two aspects of nursing practice :

- 73 per cent of trained nurses (54 out of 74) stated that 'helping patients' families' was very important to them, compared with 64 per cent of the total (67 out of 104).
- 76 per cent of trained nurses (56 out of 74), compared with 69 per cent of the total group (72 out of 104) saw 'dealing with patients' psychological problems' as very important.

These differences are not unexpected and reflect the concern expressed by nurses in the interviews reported in Chapter 3, about meeting the needs of their patients and involving patients' relatives in their care. For the other items, the views of trained nurses are very similar to those of the total group, with a difference of not more than 3 per cent between the two groups regarding these items as very important.

Further variations occurred showing differences between the experience of qualified staff in the NDU and the total NDU sample:

- more trained nurses stated that 'using your leadership/management abilities' and 'using your intellectual/academic skills' were mostly present in their experience, a difference of 11 per cent between qualified nurses and the total NDU sample for both these items.
- 76 per cent of trained nurses (56 out of 74) stated that 'using your initiative' had been mostly present in their own experience, compared with 69 per cent of the total sample (74 out of 107).
- the variations between the two groups relating to the importance of 'helping patients' families' and 'dealing with patients' psychological problems' also applied to their experience. Among trained nurses, 60 per cent (44 out of 74), compared with 51 per cent of the total sample (54 out of 106), and 36 per cent (26 out of 73), compared with 28 per cent (29 out of 104), stated that these items were 'mostly' present in their experience.

These differences between trained nurses and the total sample of NDU staff indicate consistency between the importance attached to various aspects of working life and the extent to which they have been present in nurses' experience.

Comparison of responses of qualified nurses in the NDU with the RCN sample

In order to make the two groups comparable, it was necessary to select the trained nurses from the NDU sample and restrict the range of grades represented in the survey of RCN members, so that both samples include only enrolled nurses, staff nurses and sisters/charge nurses. The numbers for these three groups in the RCN survey were recalculated from the percentages and bases in Waite and Hutt's (1987) report.

Table 4.1 compares the trained staff from the NDU with those from the RCN sample. The numbers of respondents can be found in Appendix B. The most marked difference between the samples is for the item 'fair level of basic pay' as 77 per cent of the RCN sample compared with 57 per cent of the NDU sample rated this as very important. The other main differences in the percentage of each group regarding an item as 'very important' are: 'dealing with patients' psychological problems' (76 per cent of NDU staff and 63 per cent of RCN members); and 'using your intellectual/academic skills' (78 per cent of NDU staff and 61 per cent of the RCN sample). These differences relate to one aspect of nursing practice and one aspect of professional autonomy.

When the differences between the NDU and RCN samples are examined in Table 4.2, it is clear that for every item the NDU staff were more likely to have stated that it was 'mostly' present in their own experience. The differences between the samples ranged from 6 per cent for 'doing a "worthwhile job"' to 62 per cent for 'fair level of basic pay'. The average percentage difference across all the items was 26.3 per cent, which demonstrates a much more positive picture of nursing experience shown by the NDU nurses than the RCN sample.

These variations were investigated further by using a test of proportion, chi-square, to see whether they were statistically significant and the results of this are shown in Table 4.3. The number of nurses from both samples on which the analyses are based are included at Appendix B. In the first column of Table 4.3, there is only one item for which the high percentage of NDU staff shows a statistically significant difference, 'a fair level of basic pay'. Apart from this one item, there is an overall lack of difference in the views of the two samples about the importance of these items, which shows that both groups value similar features of their working lives. This contrasts with nurses' experience set out in the second column, which shows that all but two of the items have statistically significant scores. This means that the NDU sample rated these aspects of working life as being 'mostly' present in their own experience much more frequently.

One explanation for this discrepancy between the experience of the NDU and RCN samples could be that the time difference had affected the results. However, this does not seem to be supported since few nurses seem to take the view that their job has become easier since the mid-1980s when the survey of RCN members by Waite and Hutt (1987) was carried out. Furthermore, the 1992 RCN survey found that 23 per cent of RCN members working in the National Health Service indicated positive satisfaction with pay and current employment, 23 per cent were neither positive nor negative, and 54 per cent expressed negative views (Seccombe and Ball 1992:103).

Another possible criticism of the validity of these results is that nurses might have completed these questionnaires while considering different issues. For example, since the RCN is a professional association, its members might be more likely to express their discontent than nurses from the NDU, who might not wish their workplace to be shown in a bad light. However, both samples gave a similar rating to the importance of the items, and the differences emerged in the responses to questions about nurses' experience. These findings indicate that the nurses working in the Tameside Nursing Development Unit have similar expectations to the RCN sample, but higher levels of job satisfaction. This may be related to the way in which patient care is organised and delivered in the NDU.

Table 4.1
The importance of aspects of working life: a comparison of the findings of the IMS survey of RCN members and trained nurses from the survey of Tameside NDU

	How important is this to you?					
	Very		Quite		Not at all	
	NDU %	RCN %	NDU %	RCN %	NDU %	RCN %
Able to control your own workload	55	59	41	35	4	5
Dealing with patients' psychological problems	76	63	22	35	3	2
Doing a 'worthwhile job'	82	84	18	14	0	2
Fair level of basic pay	57	77	42	22	1	1
Good atmosphere at work	88	91	13	9	0	0
Good job security	81	79	19	19	0	1
Good support/counselling for nurses	74	67	24	30	1	3
Helping patients' families	73	69	27	30	0	1
High standard of supervision/ management abilities	69	70	30	28	1	2
Preventing ill health	80	78	19	21	1	1
Using your initiative	83	87	15	13	1	0
Using your intellectual/ academic skills	78	61	21	36	1	2
Using your leadership/ management abilities	66	61	31	36	3	3
Using your personal abilities to the full	75	83	23	17	1	0

Notes:
There were 74 qualified nurses in the NDU sample (25 enrolled nurses, 31 staff nurses and 18 sisters/charge nurses) and 1981 in the RCN sample (458 enrolled nurses, 1003 staff nurses and 520 sisters/charge nurses). The number of respondents in each category is set out in Appendix B.

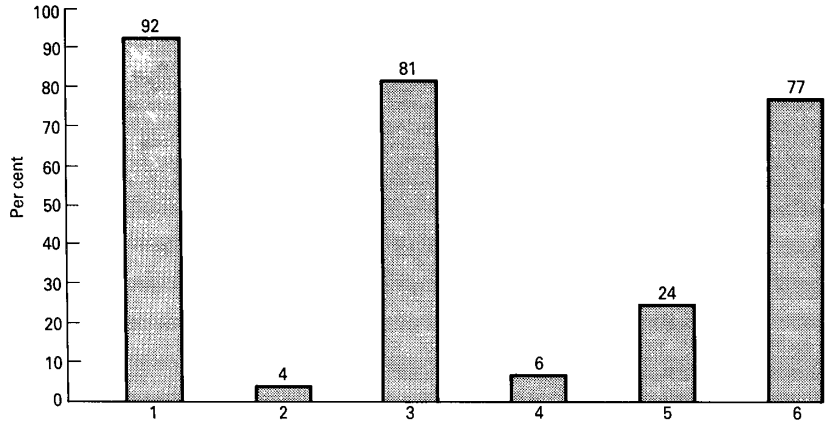
The RCN category 'staff nurse' also included midwives, health visitors and district nurses. These groups comprised 8 per cent of the RCN sample.

Of the RCN sample 12 per cent specialised in the care of elderly people and long-term care. All the NDU sample specialised in the care of elderly people, but not long-term care.

Numbers after the decimal points have been rounded up or down to create whole numbers.

Source of data on RCN survey: Waite and Hutt (1987).

Figure 4.4
Nurses' views on the most important reasons for attending courses

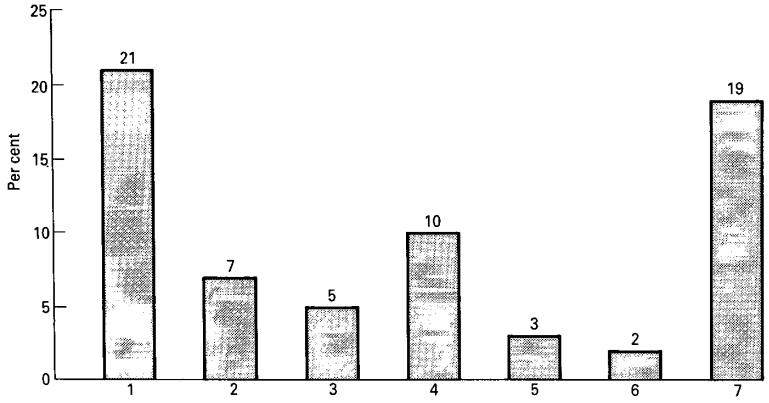


1. To help provide better patient care
2. For a change
3. To develop nursing knowledge
4. To help get a better paid job
5. To talk to other nurses
6. To aid personal development

Nurses responded to each question separately

Source: Survey of NDU staff 1992

Figure 4.5
Problems associated with attendance on courses



1. Arranging child care
2. Time away from home
3. Away from ward
4. Travel to courses
5. Content of courses too difficult
6. Courses not relevant to work
7. Leaving ward when there are staffing difficulties

Nurses responded to each question separately

Source: Survey of NDU staff 1992

staff development opportunities. Although 70 per cent of these respondents had attended courses in their own time at least some of the time, only 9 per cent had paid fees themselves to do so, showing the level of financial support provided for professional development through the NDU bursary.

The overall level of satisfaction with study leave arrangements was high: 42 nursing staff out of 99 were very satisfied; 35 were fairly satisfied; 17 were undecided; 4 were fairly dissatisfied; and 1 was very dissatisfied. Of those staff who had not taken part in courses or study days, only 2 were dissatisfied with the study leave arrangements, while 7 were undecided and 8 were satisfied. Among people who had been on a course within the last six months, 4 were fairly dissatisfied.

Nursing staff saw patient care as the most important reason for attending courses (see Figure 4.4). This emphasis mirrors the importance attached to patient care in the interviews with ward nurses discussed in Chapter 3. Indeed, more than 90 per cent of nurses (100 out of 109) ticked the box 'to help provide better patient care'. More than three-quarters of respondents also ticked the boxes 'to develop your nursing knowledge' (88 out of 109) and 'to aid your personal development' (84 out of 109). The option 'to help you get a better paid job' was ticked by 7 nurses and 4 nurses attended 'for a change'; these answers suggest that nurses were not simply giving the 'right' answers that they thought would be expected.

The value placed on training contrasts with the logistics of attending courses, because 40 per cent of nursing staff (44 out of 104) stated that going on courses had caused problems for them. Figure 4.5 shows the extent of these problems, with the percentages relating to the whole sample rather than just those nurses who had encountered problems. Nurses were requested to respond to each item separately. All but 1 of 23 nursing staff who ticked the box for 'arranging child care' were women, and all but 5 worked nights. This problem is not unexpected and is one of the reasons why a smaller percentage of night staff attended courses or study days, given that the child care arrangements enabling women to work nights are unlikely to have been appropriate to enable them to attend courses during the day. In contrast, the other problem that attracted a relatively high response, 'being unable to leave the ward when there are staffing difficulties', which was related to the workplace rather than nurses' domestic lives, applied to 19 of the day staff, but only 2 of the night staff. One-third of the respondents who identified this problem were men and respondents to this question were distributed across all grades.

Choice of nursing as a career

The responses to the question 'If you could start again, would you still choose nursing as a career?' are shown in Figure 4.6. The likelihood of a positive response increases with the age group of the respondents: 62 per cent of nursing staff aged 25 or under (18 out of 29); 72 per cent of those aged 26–35 (26 out of 36); 83 per cent aged 36–45 (25 out of 30); and 79 per cent aged 46–55 (11 out of 14). It is scarcely surprising that people who have invested much of their working lives in nursing feel a stronger sense of commitment to the career than more recent entrants, especially as nurses without this sense of commitment were more likely to have left nursing.

There were grade differences in the responses, as 86 per cent of nursing auxiliaries (30 out of 35), 80 per cent of enrolled nurses (20 out of 25), and 68 per cent of RGNs (30 out of 49) ticked 'yes'. This may reflect different perceptions of the alternative avenues of employment that would have been open to these groups; for example, a nursing auxiliary might compare nursing work with factory work, whereas an RGN with educational qualifications might compare nursing with another professional career.

This question was included in the survey so that the responses of NDU staff could be compared with a group of first-level nurses in a study by Williams, Soothill and Barry

Table 4.2
The extent to which aspects of working life had been present in nurses' personal experience: a comparison of the findings of the IMS survey of RCN members and trained nurses from the survey of Tameside NDU

Has this been present in your own personal experience of nursing?	Mostly		Sometimes		Not at all	
	NDU %	RCN %	NDU %	RCN %	NDU %	RCN %
Able to control your own workload	45	21	43	46	12	33
Dealing with patients' psychological problems	36	23	64	66	0	11
Doing a 'worthwhile job'	64	58	36	39	0	3
Fair level of basic pay	71	9	26	48	3	43
Good atmosphere at work	60	35	39	61	1	4
Good job security	88	56	11	40	1	4
Good support/counselling for nurses	32	9	50	51	18	40
Helping patients' families	60	30	39	62	1	8
High standard of supervision/ management abilities	50	18	49	67	1	15
Preventing ill health	37	27	59	60	4	13
Using your initiative	76	48	22	48	3	4
Using your intellectual/ academic skills	66	27	34	65	0	8
Using your leadership/ management abilities	55	29	43	62	1	9
Using your personal abilities to the full	51	33	47	61	1	6

Notes

There were 74 qualified nurses in the NDU sample and 1981 in the RCN sample. The number of nurses in each category is set out in Appendix B.

Numbers after the decimal point have been rounded up or down to create whole numbers.

The headings for the first two columns are those used in the Tameside NDU survey. In the IMS survey for the RCN, the headings were, 'To considerable extent' and 'To some extent'. The column headings were shortened to facilitate the layout of the page in the questionnaire.

The grades included in the Tameside sample were enrolled nurse, staff nurse and sister/charge nurse. These grades were selected from the RCN sample, but the RCN category 'staff nurse' also included midwives, health visitors and district nurses. These groups comprised 8 per cent of the RCN sample.

Of the RCN sample, 12 per cent specialised in the care of elderly people and long-term care. All the NDU sample specialised in the care of elderly people, but not long-term care.

Source of data on RCN survey: Waite and Hutt (1987)

Table 4.3
Comparison of responses of Tameside NDU trained nurses with RCN survey

Features of working life	Importance to nurses (Chi-square)	Presence in nurses' experience (Chi-square)
Able to control your own workload	0.591	0.000
Dealing with patients' psychological problems	0.060	0.002
Doing a 'worthwhile job'	0.335	0.264
Fair level of basic pay	0.001	0.000
Good atmosphere at work	0.606	0.000
Good job security	0.616	0.000
Good support/counselling for nurses	0.380	0.000
Helping patients' families	0.503	0.000
High standard of supervision/management abilities	0.837	0.000
Preventing ill health	0.877	0.035
Using your initiative	0.112	0.000
Using your intellectual/academic skills	0.016	0.000
Using your leadership/management abilities	0.705	0.000
Using your personal abilities to the full	0.164	0.002

Source of data on RCN survey: Waite and Hutt (1987)

Enjoyment of work

High levels of job satisfaction were reflected in nurses' responses to the question about whether they enjoyed their work: 55 per cent (60) stated that they enjoyed their job very much, and 43 per cent (47) responded that they quite enjoyed it. No respondents stated that they did not enjoy their job, but 2 people did not answer this question. Among the nursing auxiliaries, 71 per cent (24 out of 34) enjoyed their work very much, the highest percentage for any grade. Seccombe and Ball (1992:112) distinguished between motivation and morale in the responses to the survey of RCN members and commented :

> Nurses were well motivated in terms of the jobs they were doing, but were less positive about statements concerning their level of morale with regard to nursing generally.

If their finding also applied to the survey of NDU staff, satisfaction would be expressed in terms of commitment to patient care and dissatisfaction in terms of conditions of employment and pay.

What nurses liked least about their job

Nurses were asked to write down in their own words what they enjoyed least about their work. Almost 50 aspects of nursing work were mentioned by the 96 nurses (88 per cent) who made at least one comment. A shortage of nursing staff was the issue mentioned most frequently, with 55 nurses commenting on it, and more than 20 nurses (17 per cent of the total sample) referred to having insufficient time to meet patients' needs. The following response from a staff nurse was fairly typical of those regarding this issue:

'The frustration of patients not receiving 100 per cent of the care they should have due to shortage of staff.'

Of the total sample of nurses, 16 (15 per cent) stated that staff shortages hampered their enjoyment of their job, and 6 referred to stress caused by short staffing. One nurse commented:

'Sometimes the work can be stressful, especially when we are short staffed and have acutely ill patients requiring one-to-one care and you can't always give it.'

Seccombe and Ball (1992:96,97) also found that concern about staffing levels was expressed in the responses of RCN members to their survey:

> In the main, nurses were dissatisfied with the workloads they were confronted with, and they felt the staffing levels were inadequate .... Nurses who felt dissatisfied with resourcing were more likely to feel that they were under too much pressure and to feel dissatisfied with the level of [care] they could provide to patients.

Shift work was mentioned by 15 nurses as an aspect of their work that they liked least, with references to the length of the night shift and the shift patterns. However, as the shift pattern in the Nursing Development Unit was modified shortly after this survey was carried out, with the night shift becoming marginally shorter and the early shift considerably shorter, the extent of this discontent may have lessened.

There were many other issues that a few nurses stated they did not like. However, 3 nurses found that there was no aspect of their work that they disliked. One nursing auxiliary stated:

'I am fairly happy in my job and quite honestly I can't name anything specific in answer to this question.'

What nurses liked most about their job

Among the nurses who responded, 93 per cent (101) wrote at least one comment about what they liked most about their job; 25 referred to assisting patients to recover and 10 to seeing patients who were able to return home. One nursing auxiliary wrote:

'Being able to care for people who need help, thinking that it could be my mother or even myself one day, and hoping someone will care for me in the same way I try to care for our patients.'

Another nursing auxiliary stated that she liked:

'The caring and nursing aspect, helping the aged through illness with good nursing and kind words, and being able to talk and enjoy their life with them. Mostly seeing them regain good health again.'

A staff nurse stated:

'Direct patient care, especially if I have time to get to know them and their families and feel I have made a positive contribution to their rehabilitation, prevention of further illness, coping with disability or helped them to achieve a dignified and pain-free death.'

A sister/charge nurse commented:

'Obtaining job satisfaction at the end of the working day, that you've ... managed to successfully discharge "social problems" to their home by contacting anyone possible who can help, when the doctor has "demanded" nursing home and the patient desperately wanted to go home.'

Contact with patients and meeting their needs was an aspect of patient care mentioned by 20 nurses, one of whom, a staff nurse, wrote:

'The chance to meet different people and feel you are doing a worthwhile job. The ability ... to make a difference in the care of the elderly people of Tameside, by being able to use my own initiative, knowing that my opinion is heard.'

A nursing auxiliary wrote:

'Being able to help patients to do things (dressing, walking, etc.) and talking to them.'

An enrolled nurse stated:

'Being in contact with people, patients and staff and relatives. Feeling good when you've achieved high standards.'

Another staff nurse commented:

'When I develop a good relationship with my patient, because this leads to better communication ... and you get satisfaction when the patient confides in you and they end up getting the care they need.'

A sister/charge nurse responded:

'Contact with the general public ... ability and encouragement to help physically, psychologically and socially, a very vulnerable section of the community.'

Some nurses specifically mentioned primary nursing as contributing to their enjoyment of their work. A staff nurse referred to:

'Knowing that my opinions and ideas will be heard and critically assessed, probably due to primary nursing.'

Another observed:

'I most enjoy giving full care to patients, as you can do with primary nursing.'

Just less than 20 nurses referred to being part of a team. A nursing auxiliary wrote about working with a caring team for the good of the patient, and an enrolled nurse stated:

'Being able to use my initiative and personal skills and being recognised as a useful member of the team. Seeing patients get better and go home. Just doing my best.'

Another enrolled nurse wrote about:

'Comradeship between colleagues on nights.'

A staff nurse commented on:

'The satisfaction of knowing that I am a valued team member.'

Staff development opportunities were viewed by 14 nurses as contributing to their enjoyment of their job, and 2 sisters/charge nurses made the following comments:

'I enjoy the fact that we have good management support and are allowed to develop our skills and feel that these are appreciated by patients, relatives and management. All round, the NDU is a satisfying place to work.'

'The ability to manage a ward and use my personal skills to help teach/develop others and to provide excellent patient care.'

Two staff nurses also mentioned that there are lots of opportunities for staff development and an enrolled nurse referred to opportunities to develop a career. A nursing auxiliary stated:

'Not being qualified, I have learned a lot about nursing.'

What aspect of their job would nurses like to change?

After nurses were asked about what they liked least and what they liked most about their job, the next question was: 'If you were able to change one thing about your job, what would that be?' Many of the issues raised in the responses to the question about what nurses liked least re-emerged, for example, staff shortages, which were mentioned by more than 20 nurses, and shift patterns, to which 18 nurses referred. In order to avoid repetition, the quotations from nurses set out below mostly refer to other issues that nurses would like to change:

'To be a trained nurse, because sometimes I get frustrated at not being able to do more.' (Nursing auxiliary)

'Nurses to have a bigger say in the care and discharge of patients.' (Enrolled nurse)

'The apparent scramble for bed space makes, at times, for rather undignified and rushed transfers or discharges of patients.' (Enrolled nurse)

'More staff so primary nursing could be carried out properly at all times and patient care could be excellent at all times.' (Staff nurse)

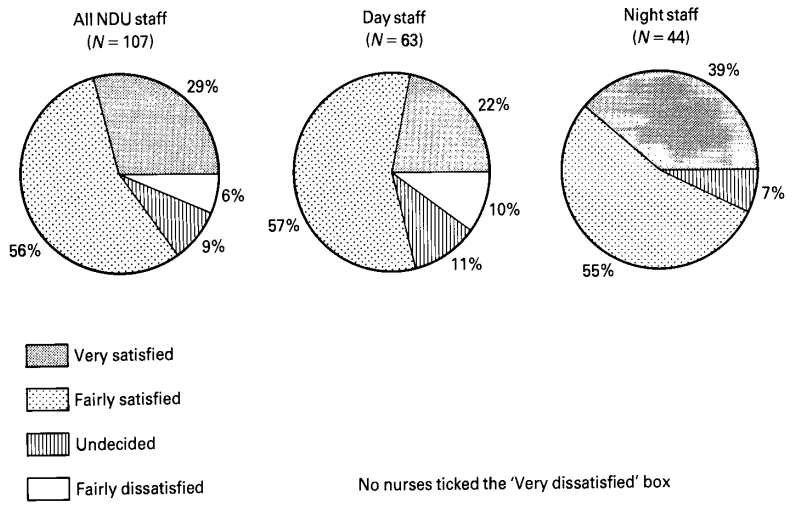
'Nurses need a counselling service.' (Enrolled nurse)

'Staffing numbers and support for first-level nurses. Although this is a nationwide problem, the frustration and disillusionment of not being able to do what you should be able to do for your patients is unbelievable, especially with the advent of the White Paper and the Patients' Charter.' (Staff nurse)

Satisfaction with management support

Figure 4.7 shows that 28 per cent of respondents (31 out of 107) stated that they were 'very satisfied' with the management support that they received, 55 per cent (60) were 'fairly satisfied', 9 per cent (10) were 'undecided' and 6 per cent (6) were 'fairly dissatisfied'. This question was not answered by 2 people. There were grade differences relating to the level of satisfaction, with sisters and charge nurses most likely to be very satisfied. Figure 4.7 shows that if the day and night staff are compared, 39 per cent of the night staff (17 out of 44) and 22 per cent of the day staff (14 out of 63) were 'very satisfied' and no members of the night staff expressed dissatisfaction with the level of management support they received. The high level of satisfaction of the night staff shows

Figure 4.7
Nurses' satisfaction with the management support received



Source: Survey of NDU staff 1992

that they do not feel marginalised or excluded from the benefits of working in a Nursing Development Unit that has made a sustained effort to provide managerial support for nursing staff.

Nurses were asked to add explanatory comments if they wished and 32 per cent (35 nurses) did so. Changes in the management structure of the Unit were being implemented when the survey was in the field and there have been further changes since then. More of these comments were favourable than unfavourable and sometimes different opinions were held about the same issues. A selection of comments representing different views is presented below:

'Management on nights are very supportive and very approachable, always there when needed.' (Enrolled nurse)

'I have always had good support from management, as a staff nurse and as a sister. There is always someone willing to help with any problems within this Unit.' (Sister)

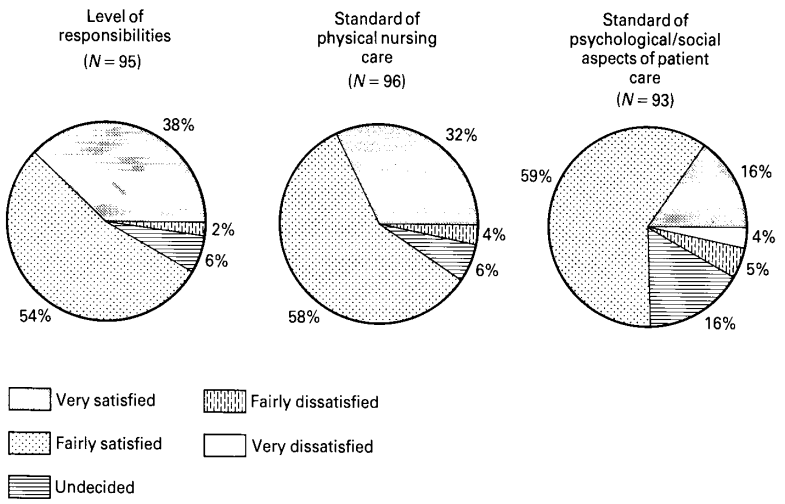
'Tend to get more criticism than praise (generally). Sometimes feel your hard work is not appreciated.' (Staff nurse)

'When, unfortunately, complaints occur why are nurses always wrong? Working with the public on such a large scale will obviously make complaints sometimes become apparent. Unfortunately, nurses are not supportive within their network towards each other.' (Sister/charge nurse)

'On the wards stronger management is needed. Staff don't know what is expected of them. They work one way with one person in charge and another way with a different person in charge.' (Staff nurse)

'Recruitment and retention of staff speak for themselves.' (Enrolled nurse)

Figure 4.8
Nurses' satisfaction with aspects of their work in the previous week



Source: Survey of NDU staff 1992

Nurses' levels of satisfaction with the content of their work in the previous week

First nurses were asked if they had been at work in the previous week. If they answered that they had not been at work, as 12 per cent did, they were asked to go directly to the next set of questions. This request was made so that nurses could focus on a specific time span which they were likely to be able to recall accurately. A total of 17 nurses wrote in responses to the question, 'If you have answered yes and last week was not a typical week, please describe briefly why it was unusual.' All but 2 of these comments indicated that the workload had been heavier than usual.

Figure 4.8 shows nurses' levels of satisfaction with respect to three aspects of their work in the previous week: level of responsibilities; standard of physical nursing care; and standard of psychological/social aspects of patient care. For the first two items, at least 90 per cent of nursing staff (87 out of 95) were either 'very satisfied' or 'fairly satisfied', and no nurses were 'very dissatisfied'. There were some variations between grades of nursing staff: sisters and charge nurses were most likely to be 'very satisfied' with the level of responsibilities they had dealt with, with just over half (9 out of 17) indicating this compared with 43 per cent of nursing auxiliaries (13 out of 30) and 29 per cent of enrolled nurses and staff nurses (14 out of 48). Night staff were more likely to be 'very satisfied' (45 per cent or 18 out of 40) than day staff (one-third or 18 out of 55).

Conversely, satisfaction with the standard of physical care was highest lower down the hierarchy: 39 per cent of nursing auxiliaries (12 out of 31) were 'very satisfied'; 31 per cent of enrolled nurses and staff nurses (15 out of 48); and a quarter of sisters/charge

nurses (4 out of 17). Again, night staff were more satisfied: 48 per cent of night staff (19 out of 40) were 'very satisfied' compared with 21 per cent of day staff (19 out of 65 respondents). If trained nurses are examined as one group, 29 per cent (19 out of 65) were 'very satisfied', 63 per cent (41) were 'fairly satisfied', 3 per cent (2) were 'undecided' and 4 per cent (3) were 'fairly dissatisfied' with the standard of physical care in their work area.

The responses to the question concerning the standard of psychological/social aspects of patient care revealed lower levels of satisfaction: 75 per cent of nursing staff (70 out of 93) were either 'very satisfied' or 'fairly satisfied'. More nurses were 'fairly dissatisfied' and 3 per cent of nurses were 'very dissatisfied'. Trained nurses were less likely to be 'very satisfied' than nursing auxiliaries, 12 per cent (8 out of 65) compared with 25 per cent (7 out of 28). Compared with 13 per cent of day staff (7 out of 55), 21 per cent of night staff (8 out of 38) were 'very satisfied' with these aspects of patient care. When qualified nurses were selected from the sample, their levels of satisfaction with the 'standard of the more psychological/social aspects of patient care' were as follows: 'very satisfied', 12 per cent (8 out of 65); 'fairly satisfied', 63 per cent (41); 'undecided', 15 per cent (10); 'fairly dissatisfied', 6 per cent (4); 'very dissatisfied', 3 per cent (2).

Some of the reasons for lower levels of satisfaction with psychological/social aspects of patient care may have been associated with the difficulties in quantifying it: nurses never know whether these needs have been fully met, whereas when a patient requires physical care, a nurse knows when the task has been finished. The psychological and social needs of patients may not be met if nurses feel that other more pressing demands are made on their time, especially when there are staff shortages. James (1992:498) states:

> From a nursing perspective one of the effects of embracing an ideology of 'total care' is that, as in domestic care, your job is never complete.

Overall the levels of satisfaction with patient care expressed by NDU staff are high, especially if they are compared with the findings of Seccombe and Ball (1992). In their study, 49 per cent of RCN members working in the National Health Service responded positively to the statement 'I am satisfied with the level of care I provide to patients' 32 per cent responded negatively and the remaining 19 per cent were neither positive nor negative. This suggests that NDU staff are highly motivated to provide good patient care, a theme that also emerged in the interviews with ward nurses (see Chapter 3.) However the importance of nurses' satisfaction with their jobs extends further. Carr-Hill et al. (1992:103) in their study, *Skill Mix and the Effectiveness of Nursing Care* found that the use of Qualpacs on 20 medical and surgical wards showed:

> Positive correlations of 0.47 (p=0.038) and 0.56 (p=0.015) between staff satisfaction and the quality and outcome of care delivered on the ward.

Caring responsibilities and time spent away from nursing

Caring responsibilities

As nurses are predominantly female the balance of commitments at home and work affects staff recruitment and retention (Seccombe and Ball 1992). Among the nursing staff in the Tameside NDU survey, 57 per cent (62 out of 108) stated that outside their work they looked after 'dependants such as children, elderly, disabled or ill relatives'.

Compared with 37 per cent of day staff (23 out of 63), 87 per cent of night staff (39 out of 45) had dependants, as did nearly two-thirds of D and E graded staff (36 out of 56), compared with half of A/B graded staff (17) and F/G grades (9). The two age groups of nurses who were most likely to have these responsibilities were 26–35, 71 per cent (25 out of 35) and 36–45, 77 per cent (23 out of 30); two-thirds of the 46–55 age group (8 out of 14) had dependants compared with 21 per cent of those aged 25 or under (6 out of 29). A survey of RCN members (Seccombe and Ball 1992) found that 52 per cent of respondents had caring responsibilities for children and dependant adults. Nurses taking part in the RCN survey aged 26–35 were most likely to be looking after children aged under 5 (33 per cent) and those aged 46–55 most likely to be looking after dependant adults (24 per cent).

Nursing staff in the Tameside NDU were asked whether they were 'the only carer or do you share responsibility for example with a partner or relative?' Of nursing staff who had dependants, 82 per cent shared the responsibility (51 out of 62) and 18 per cent were sole carers (11).

Other non-nursing jobs

Nursing staff were asked, 'Have you done other jobs besides nursing?' Three-quarters of respondents had done other jobs (81 out of 107), with a slightly higher percentage of male nursing staff, 83 per cent (10 out of 12), than female staff, 75 per cent (71 out of 95), responding positively to this question. The grades of nursing staff who were most likely to have had other occupations were A/B, 85 per cent (29 out of 34), compared with 74 per cent of E graded staff (17 out of 23), 72 per cent of D graded staff (23 out of 32) and 67 per cent of F/G grades (12 out of 18). Night staff were more likely to have done other jobs, 82 per cent (36 out of 44), compared with 71 per cent of day staff (45 out of 63). The likelihood of nursing staff having had non-nursing jobs increased with age, as all those aged 46–55 had done other jobs (13), compared with 83 per cent of 36–45 year olds (25 out of 30), 71 per cent of 26–35 year olds (25 out of 35) and 62 per cent of those aged 25 or under (18 out of 29). Grade and age group were linked as the profile of nursing staff above (p. 53–54) indicates.

Nurses were then asked to state whether the work in their other job(s) was more rewarding, as rewarding or less rewarding than nursing. Of the nursing staff responding to this question, 86 per cent (70 out 81) stated that it was less rewarding. Full-time nursing staff were more likely to have found other jobs less rewarding (92 per cent or 34 out of 37) than part-time staff, (82 per cent or 36 out of 44), which may reflect the more routine nature of part-time jobs in the labour market. The responses of day and night staff to this question were similar. All 18 nursing staff aged 25 or under had found their other jobs less rewarding then nursing, which shows that nursing had been an appropriate career choice for them.

When nurses were asked how the pay in their other jobs compared with nursing, one-third said that it had been better (27 out of 81), 24 per cent that it had been 'about the same' (19) and 43 per cent that it had been worse (35). Half of the male nursing staff (5 out of 10) had found the pay in their other jobs better against just under one-third of females (22 out of 71), which is not unexpected given the earnings differential between men and women (Equal Opportunities Commission 1991). Just over half of A/B graded staff (15 out of 29) stated that the pay in their other jobs had been better, compared with less than a quarter of trained nurses (12 out of 52). This suggests that nursing auxiliaries had traded a higher level of pay for a more interesting job, as over three-quarters of A/B graded staff (23 out of 29) had stated that their other jobs were less rewarding. Younger members of nursing staff were more likely to have stated that the pay in their other jobs had been worse, two-thirds of those aged 25 or under (12 out of 18) compared with half the 26–35 year olds (13 out of 25) and 2 of the 13 nursing staff aged 46–55.

Time spent away from nursing

Since entering the occupation, 36 nursing staff, 34 of whom were women, had taken a break of more than three months from nursing. Over half of staff graded D (18), one-third of staff graded E or F/G (13) and 15 per cent of staff graded A/B (5) had taken a break from nursing. Part-time staff were more likely to have spent time away, 46 per cent (26) compared with 20 per cent for full-time staff (10). Night staff were also more likely to have taken a break from nursing than day staff, just over half (23) compared with one-fifth (13). Part-time work is linked to working nights, as two-thirds of the night staff work part-time compared with just under one-third of the day staff. The two age groups of nurses who were most likely to have taken a break from nursing were 26–35 year olds, 54 per cent (19), and 36–45 year olds, 41 per cent (12). This compared with 4 nursing staff aged 25 or under, and one aged 46–55.

More than half (21) of the 37 nursing staff who had taken a break from nursing were away for less than a year, one-third were away for between one and five years (13) and 3 nurses took more than six years away from nursing. All but 2 of the nurses who took a break from nursing were female and more than half of the nurses who had spent time away from nursing were graded D. Among the nurses aged 26–35, 20 had taken a break from nursing, two-thirds of them for less than a year, while half of the nurses aged 36–45 (6) who had spent time away from nursing had been away for between one and five years. Of the nurses who had taken a break from nursing, 60 per cent (23) worked nights, and 70 per cent of those who had spent time away from nursing (26) worked part-time.

The reason most frequently given for spending time away from nursing was pregnancy, mentioned by 23 nurses, 24 per cent of all female nursing staff. The other reasons given by nurses were (in descending order of importance):

- child-care responsibilities, referred to by 9 nurses
- ill-health, 5 nurses
- a move to a different area, 3 nurses
- the hours did not suit home life, 2 nurses
- other caring responsibilities, 1 nurse
- to widen the individual's experience, 1 nurse.

As nurses had been requested to tick any answers that applied to them, individual nurses may have ticked both pregnancy and child-care responsibilities, or other combinations of reasons for leaving nursing. Of the 9 nurses who had taken a break from nursing because of child-care responsibilities, 8 worked nights and all were female. Nurses who had left because they were pregnant were more likely to be graded D, to be in the 26–35 age group, to work nights and to work part-time. Other reasons for having taken a break from nursing were mentioned by 5 people, among them: going to university; being disheartened by their grading; needing a complete break because of stress; and two comments relating to reasons for sick leave.

Nurses were asked why they had decided to come back into nursing after a break and of the 37 who had spent time away from nursing, 32 wrote down their reasons for returning. Several nurses referred to their maternity leave ending or needing to work for financial reasons, but other nurses wrote about their feelings about nursing as an occupation:

'Mainly because I missed the work and caring for ill people, especially the elderly.' (Enrolled nurse)

'Seemed to me (after investigating other careers) as the best job for me!' (Sister/charge nurse)

'Because it is a job I love and because it allows me to work hours that are suitable for looking after my children as well.' (Enrolled nurse)

'I wanted to do something else besides being "just a housewife".' (Sister)

'I have always felt quite committed to nursing in a sense. It is certainly the least boring of professions. I also wanted to prove to myself that I could come back after the long break I had.' (Enrolled nurse)

'Because I missed a lot of things and didn't feel that what I was doing was worthwhile.' (Staff nurse)

Compared with 26 nurses who did not encounter any problems, 9 nurses found it difficult to return to nursing.

Final comments by nurses

The last question nurses were asked was, 'Finally, do you wish to make any comments about the questions you have been asked or to describe your personal experience of working in the NDU?' and 38 nursing staff took the trouble to respond to this open-ended question, even though it appeared at the end of a long (15 page) questionnaire. Their comments addressed many issues, some of which had been covered earlier in the questionnaire. Nurses used this opportunity to write about both the positive and the negative aspects of their work, as they perceived them. The quotations below reflect that divergence.

'It makes a nice change to see that we can as a society care for the elderly in the way they deserve. And with hard work and dedication it can really work.' (Enrolled nurse)

'On the whole I think that working in the NDU is a fairly pleasant experience. One of the best things about it is the opportunities offered to further one's skills and knowledge, which are available through the many courses and workshops offered.' (Enrolled nurse)

'It's interesting and educational working in the NDU. It is sometimes very hard work and heavy work but satisfying.' (Enrolled nurse)

'Slightly disillusioned – I love primary nursing but it can only work effectively if staffing numbers and skill mix are good.' (Staff nurse)

'I find most people to be happy and highly motivated. Having had other jobs, I am now settled and would be surprised if I took employment other than nursing in the future. I have a feeling of coming home to where I belong. Patients are treated as people these days.' (Enrolled nurse)

'I feel that there should be more facilities for counselling for nurses.' (Sister/charge nurse)

'It is very rewarding to see the patients go home feeling that they were looked after very well. I think this Unit is excellent compared to units for the elderly in other authorities.' (Nursing auxiliary)

'Working on the NDU has been excellent, although recently we have had our difficulties, but in comparison to other areas [I] feel we provide an outstanding service to the elderly. I think it's not until one speaks to nurses from other authorities that you realise the benefits/advantages of working in this environment, where nurses are not seen as doctors' handmaidens but valuable members of a multi-disciplinary team'. (Sister/charge nurse)

'The NDU is much better than more units in support, development and change. However, a brighter picture is often painted in the press and publications than is actually the case.' (Staff nurse)

'I have seen big changes in nursing. I am pleased that nursing standards and education are to a high standard and we are seeing changes for the better all the time. I would like to see more courses for care assistants who play a large part in caring for patients.' (Nursing auxiliary)

'I have found it extremely enjoyable and [the NDU] allows nurses to develop although I think we still have a long way to go before we are able to provide the best care for everyone at all times.' (Staff nurse)

Nursing staff who have left the NDU

Although the data concerning nursing staff who had left the NDU derive from information collected for management purposes, it is appropriate to include them at this stage in the report, because they relate to issues covered in the survey.

Information about the number of nursing staff of each grade who had left the Care of the Elderly Unit during the financial years 1989–90, 1990–1 and 1991–2, had been collated by the deputy unit general manager's secretary. These data have been condensed into Table 4.4, which shows the percentage of nursing staff (in whole time equivalents) who left each year. Overall, the percentage of trained nurses, grades C–G, who left shows a decrease over the three years, while the percentage of nursing auxiliaries, grades A–B, showed a marked increase in 1991–2. Seccombe and Ball (1992:65) found that 25 per cent of qualified nurses responding to the RCN survey had changed their employment status during the previous six months, and state:

> This level of job change fits into a pattern of gradual reduction in turnover through the late 1980s and early 1990s which is consistent with the impact of both economic recession and organisational change within the NHS.

When Seccombe and Ball (1992) examined the sub-sample of nurses who were in the NHS in 1992, they found that 19.6 per cent had changed jobs in the preceding twelve months, with 62 per cent of the turnover resulting from nurses moving from one NHS

Table 4.4
Percentage of nursing staff graded A–G who left Tameside NDU Care of the Elderly Unit, 1989–92 (Whole time equivalents)

	1989–90	1990–91	1991–92
Day staff A–B	6.2	8.3	28.3
Grades C–G	16.4	20.7	13.6
Total	12.2	15.7	19.3
Night staff			
Grades A–B	8.8	5.9	7.4
Grades D–G*	22.2	12.0	5.2
Total	16.0	9.7	6.2
Day and night staff			
Grades A–B	7.1	7.5	21.4
Grades C–G	18.2	17.7	10.7
Total	13.4	13.7	9.3

***There were no nurses graded C on the night staff**

Table 4.5
Tameside NDU nursing staff, grades A–G, main reason for leaving, 1989–92

Main reason for leaving	Nursing auxiliaries	Qualified nurses				Total
Grade	A	D	E	F	G	
Job opportunities						
New career	0	0	1	0	0	1
New post	4	3	6	2	1	16
Transfer	2	0	1	0	0	3
Work abroad	0	0	1	0	0	1
Further training						
RGN	4	4	0	0	0	8
Health visitor	0	0	0	1	0	1
Not specified	1	0	3	0	0	4
Personal/family responsibilities						
Ill health	6	0	1	0	1	8
Moved away	1	1	0	3	0	5
Personal/domestic	3	5	1	0	0	9
Pregnancy	1	1	1	1	1	5
Retired	0	0	1	0	0	1
Other reasons						
Died	1	0	0	0	0	1
Dismissed	1	0	0	0	0	1
No reason given	2	2	1	1	0	6
Total	26	16	17	8	3	70

Note
No nursing staff graded B or C left the Care of the Elderly Unit between 1989 and 1992.

post to another. The turnover of nurses working in the care of elderly people, at 23.1 per cent, was higher than average. From a unit level perspective, Seccombe and Ball (1992) found that wastage, which they defined as all those who left, was 11 per cent.

Table 4.5. shows the main reasons why nursing staff left the Tameside NDU between 1989 and 1992. Some categories may overlap, because in some cases managers recorded the main reason nurses gave for leaving, or recorded the reason themselves on a termination form. During the time period within which the data were collected, coded choices were introduced on the termination form. Table 4.5 distinguishes between turnover within nursing, for example, departure to other nursing jobs or further training, and 'wastage', whereby staff left nursing because of personal or family responsibilities, or for other reasons. In the Tameside study, as in the survey of RCN members by Seccombe and Ball (1992), the highest rate of change in employment was among staff nurses. The NDU's encouragement of staff development is shown by the fact that four nursing auxiliaries entered RGN training and four enrolled nurses undertook conversion courses to become first-level nurses. This can be seen as a 'positive' turnover of staff.

Nursing auxiliaries were more likely than qualified staff to leave nursing because of ill health, shown by the departure of six staff graded A, compared with two nurses from the other grades. Three F graded sisters/change nurses moved away, although whether they moved to obtain a promotion elsewhere is not known. More nursing auxiliaries and D graded nurses left nursing for personal/domestic reasons, though it is possible that they gave these reasons to mask other reasons for leaving. Five nursing staff from a range of grades left nursing because of pregnancy. The small proportion of G graded staff who left the NDU during the years 1989–92 is an indicator of stability, which was especially important as there were a series of management changes during this period, particularly in 1991–2.

Key summary points

Motivation and morale

Herzberg et al. (1959:114) suggest that:

> The wants of employees divide into two groups. One group revolves around the need to develop in one's occupation as a source of personal growth. The second group operates as an essential base to the first and is associated with fair treatment in compensation, supervision, working conditions and administrative practices.

The survey of NDU staff conducted for this study examined both the motivation and morale aspects of job satisfaction. The motivation of the nursing staff in the Tameside NDU to develop their nursing skills, in order to provide high quality patient care, was found to be very high. This shows that the emphasis placed on patient care by the ward nurses in the interviews reported in Chapter 3 is representative of the majority of nurses in the Unit. Although there are aspects of their working conditions that cause nurses dissatisfaction, particularly the shortage of nursing staff, the morale of the nurses in the Tameside Nursing Development Unit was found to be higher when it was compared with the surveys of RCN members conducted by Waite and Hutt (1987) and Seccombe and Ball (1992).

Staff development

Just under 80 per cent of nursing staff in the Nursing Development Unit, including nursing auxiliaries as well as trained nurses, had attended some form of training since working in the Unit. They perceived improving patient care as the most important reason for attending courses or study days, with 100 out of 109 nurses (92 per cent) ticking the box 'to help provide better patient care', compared with 84 nurses (77 per cent) who gave 'to aid your personal development' as a reason. This finding from the survey, to which 74 per cent of nursing staff in the NDU responded, again demonstrates that the commitment to patient care shown by the nurses in the interviews reported in Chapter 3 is representative of the nursing staff in the Unit as a whole.

Comparisons between nurses' views of their experience

As this study was conducted in one NDU, it was necessary to look for other sources of data in order to make comparisons between the views of nurses working in the Tameside NDU and other groups of nurses. The present survey included questions which had formed part of a survey of RCN members by conducted by Waite and Hutt (1987). These questions encompassed 14 features of working life concerned with patient care, working conditions and professional autonomy together with the extent to which nurses saw these three factors as important and how far such positive outcomes had been present in nurses' experience.

The findings were striking. The two samples had similar opinions concerning the importance of the features of working life, except for one item, a 'fair level of basic pay', for which the difference was statistically significant ($p=0.001$). However, the variations between the two samples regarding the extent to which these aspects of working life had been present in nurses' experience were statistically significant for 12 of the 14 items (see Figure 4.3). The reason for this marked difference was that the trained nurses in the NDU sample had rated these items as being 'mostly' present in their own experience more frequently, which shows that there was a greater degree of consistency between the NDU nurses' values and their nursing experience than existed for the sample of RCN members.

Staff satisfaction with managerial support

The NDU nurses showed a high degree of satisfaction with the management support that they received: 28 per cent (31 out of 107) were 'very satisfied' and 55 per cent (60) 'fairly satisfied'. This shows that the managerial input into the Unit described in Chapter 1 has had lasting effects.

Staff satisfaction with the nursing care they provide

Over 90 per cent of nursing staff (87 out of 95) were either 'very satisfied' or 'fairly satisfied' with both with the level of responsibilities they had held and the standard of physical nursing care they had provided in the previous week. Satisfaction with the level of psychological/social aspects of patient care was lower, 75 per cent (70 out of 93) were 'very satisfied' or 'fairly satisfied'. This may have been because these aspects of care cannot be quantified; nurses can never be sure that these needs have been fully met. These needs are also less likely to be met if nurses lack time just to 'be with' with patients because of staff shortages. Staff satisfaction has wider implications for nursing: Carr-Hill et al. (1992) found, in their study of nursing care on 20 medical and surgical wards, that staff satisfaction correlated positively with both the quality and outcome of care delivered.

Retention of nursing staff

An examination of the numbers of nursing staff leaving the Care of the Elderly Unit between 1989 and 1992 showed a turnover of trained nurses of 18 per cent a year in 1989–90 and 1990–91, and 11 per cent in 1991–2. This is substantially below the level, 23 per cent, reported by Seccombe and Ball (1992) for nurses caring for elderly patients. Of the nurses who left the Unit during the three-year period, 13 did so to undertake further training; these included 4 nursing auxiliaries and 4 enrolled nurses who left to train as RGNs. The staff retention rates reflect the high levels of satisfaction shown by NDU staff with their work.

5

Student nurses' views of their experience in the NDU

Introduction

There have been a number of studies concerned with the ways in which the ward learning environment affects student nurses. Reid (1986:97) found that the activity analyses of the wards in her study revealed that student nurses were working alone and unsupervised for 80 per cent of the time. Reid (1985:145) was able to divide the wards studied into two categories through statistical analysis, which related to their suitability as clinical training areas. She concluded:

> The percentage of students' time that they were in contact with trained nursing staff was significantly higher in the 'better' wards than in the 'worse' wards ... The percentage of patient centred learning appeared to be higher on the 'better' wards.

Fretwell's (1985:68) findings from an action research project were similar. She states:

> The conclusion was reached – that in order to create a 'good' learning environment a sister needed first to provide an atmosphere which was conducive to learning and second to include teaching and learning in the routine.

Student nurses' evaluations were included in this study to investigate whether the Tameside Nursing Development Unit provided a good learning environment and influenced student nurses' perceptions of nursing practice. The additional perspective from another group of informants also provided the opportunity to examine whether the attitudes and approaches to patient care that emerged from the interviews with ward nurses were carried through to their nursing work and were observed by student nurses.

Student nurses' views in the preparation weeks

Questionnaires, administered by the nurse teacher responsible for the Care of the Elderly module, were completed by 13 student nurses in July 1991 and 14 in November of that year. All the students were undertaking the preparation week for their eight-week allocation to the Care of the Elderly Unit in the second year of their training.

The level of awareness about nursing development units among student nurses was fairly low prior to their allocation to the Tameside NDU. Only 3 students from each group claimed to know anything about NDUs, compared with the 10 students in the first group and 11 students in the second group who stated that they did not. However, the majority of students stated that they were looking forward to finding out more about NDUs. Student nurses were more knowledgeable about primary nursing, as 5 from the first group and 9 from the second group stated that they knew something about it. More than three-quarters of students stated that they liked caring for elderly patients.

Student nurses' views in the consolidation weeks

Questionnaires were completed by 14 student nurses during the consolidation week in November 1991 and by 16 students in March 1992, after their allocation to the Care of the Elderly Unit.

Responses to closed questions

The responses of the two groups showed a far greater divergence in the consolidation weeks than in the preparation weeks. More students in the first group (8) answered 'No' to the question 'Do you know more about what nursing development units are?' than answered 'Yes'(5). In the second group, 11 students answered positively and 3 negatively. All but 2 students in the second group, 13 out of 15, stated that they liked nursing elderly patients more after working in the Care of the Elderly Unit. In the first group, 3 students stated that they liked nursing elderly patients more, 3 stated that they liked it less and 8 students reported no change in their attitudes.

Table 5.1 shows the changes in student nurses' views regarding the clinical areas in which they would prefer to work when they qualify. Although these students were in their second year of training at the time when these questionnaires were completed, and their final choices might be very different, the answers to this question do show whether student nurses' preferences changed as a result of their experience of working on the NDU.

The differences between the two groups show very clearly in these responses. Two students in the first group stated, in the consolidation week, that they would choose to work in the Care of the Elderly Unit, compared with none in the preparation week. However, stated preferences for working in other clinical areas increased to a greater extent, especially for Psychiatry, to which students had also been allocated between the preparation and consolidation weeks, and Accident and Emergency. In the second group, preferences for working in certain clinical areas remained fairly stable between the preparation and consolidation weeks, except for Care of the Elderly, where the number of students stating a preference for working in this area increased from 1 to 6.

Student nurses were also asked 'If you could choose where to do your management elective next year, where would that be?' The most popular preference stated by the first group was surgery, selected by 5 students, but in the second group Care of the Elderly was mentioned by 9 students (Table 5.2).

Table 5.1

Student nurses' responses to the question: 'Have you any preferences as to which clinical areas you would like to work in when you qualify?'

	Group 1		Group 2	
	Preparatory Week	Consolidation Week	Preparatory Week	Consolidation Week
Accident and Emergency	5	9	4	3
Care of the Elderly	0	2	1	6
Medicine	1	2	2	0
Mental Handicap	0	1	0	0
Orthopaedics	0	0	3	3
Paediatrics	0	1	0	1
Psychiatry	0	4	0	0
Surgery	1	1	0	0
Theatre	3	4	4	3
Number of students stating one or more choices	7	13	9	11

Table 5.2

Students nurses' responses during the consolidation week to the question: 'If you could choose where to do your management elective next year, where would that be?'

	Group 1	Group 2
Accident and Emergency	1	2
Care of the Elderly – any ward	1	6
Care of the Elderly – acute ward	1	1
Care of the Elderly – rehabilitation ward	0	2
Medicine	3	0
Orthopaedics	2	4
Paediatrics	1	0
Psychiatry	1	0
Surgery	5	2
Theatre	1	1
Number of students stating one or more choices	11	12

Student nurses' responses to open-ended questions

The variation in the responses of the two groups of student nurses to the closed questions showed differences which can be explored further by examining the responses to the open-ended questions.

Table 5.3 summarises the responses during the consolidation week, to the question 'What would you say a nursing development unit is?' Three students in the first group stated that their experience of working on the Care of the Elderly Unit had not increased their insight into NDUs. One student nurse stated:

'I personally have found no difference in working in the "Nursing Development Unit" from my other clinical experience and therefore cannot comment from experience.'

The second group of student nurses mentioned a proportionately greater number of features of nursing development units, especially in relation to primary nursing and nursing research.

When student nurses were asked to list any advantages or disadvantages of primary nursing, the second group placed greater emphasis on building relationships with patients, this being mentioned by 10 students compared with 3 in the first group, and communication with relatives, 4 students compared with none in the first group. Students in the first group referred to more disadvantages of primary nursing (18) than advantages (12). This contrasts with the comment of the students in the second group who mentioned 30 advantages and only seven disadvantages. The major disadvantage of primary nursing referred to by 11 students in the first group and 5 in the second group was that it requires adequate staffing levels. One student in the first group wrote:

'I can list advantages of primary nursing but believe it is not being initiated at present because of low staffing levels. We have patient allocation/team nursing and prioritised care.'

Table 5.3

Student nurses' responses during the consolidation week to the question: 'What would you say a nursing development unit is?'

The features of nursing development units described by students are listed below, with the number of students in each group commenting on particular issues.

	Group 1	Group 2
Development of nurses through education and training	4	5
Development of nursing skills	3	4
Improvement in standards of nursing care	2	5
Individualised care	1	4
Primary nursing	1	6
Use of nursing research	1	7
Developing new ideas	0	1
Experience had not increased insight into NDUs	2	0
Total number of students answering this question	12	16

Student nurses were asked if their attitudes towards elderly patients had altered, and if so, what influenced the change in their views. One student nurse in the first group wrote:

'While working on other wards elderly patients were "labelled" "bed blockers". Working in COTE [Care of the Elderly Unit] made me realise that the elderly have problems which may need more time to rectify. Also the "positive" attitude towards elderly patients had influenced me tremendously.'

Another student stated:

'I have always enjoyed working with the elderly but felt on occasion I was unable to spend the time with each individual that I would have liked.'

The comments of the second group of student nurses about caring for elderly patients did not mention the lack of time available for contact with them. One student nurse's comment shows a change away from very negative stereotyped views of elderly people:

'Contact with patients has shown me that they are not all dirty, stubborn, ungrateful, incontinent and demented.'

Another student nurse commented on the care provided for elderly patients:

'Having experience before of working with elderly patients in a different setting it was excellent to see what can be done with a little commitment.'

Finally student nurses were asked if they would like to comment on their experience as a student on the Nursing Development Unit. There were positive and negative comments from both groups of student nurses. The following comments are from the first group of students:

'I found the COTE unit experience very rewarding. I feel that I have finally realised my full potential as a nurse. I also feel for the first time I was treated as an individual and my opinions were valued.'

'The past nine weeks have been exhausting. I hope the experience has improved my skill/knowledge and in that respect my opinion is positive. However, I am very disillusioned about the nursing care in the Unit. I feel there had been a great deal of hype/publicity about primary nursing and believe the reality of the situation is somewhat different.'

'I have more insight into the needs of the elderly. An introduction to primary nursing which I feel worked successfully during my time on the Unit. An extremely beneficial and enjoyable experience.'

'I have enjoyed working with the staff (very supportive, helpful and knowledgeable), and I love nursing the elderly. However, the workload, due to low staffing levels and very long days, has been almost unbearable and I just could not wait for this allocation to end.'

The following quotations are selected from the responses of the second group of students:

'Very rewarding. I have been shown what nursing CAN be and can achieve.'

'In theory it was ideal. However in practice there was little time/opportunity for personal teaching. I felt mainly like a pair of hands.'

'Good learning environment for students. However, ward too busy to set aside time for teaching sessions.'

'I thought that the nursing care given was of a high standard, and I would be quite happy to have my grandparents nursed on these wards.'

'On the NDU I felt more a member of the team. The nursing care was better and more consistent than any other ward I had worked on. The patients related to the nursing staff in a more positive way.'

Although some of the comments from the second group of students suggest that there was not enough time on the wards for teaching, the high stress levels referred to by some of the first group of students were not apparent. The contrast between some of the comments of the student nurses indicate, not only differences between students but also between the wards to which they were allocated. The variations between students' experiences on different wards cannot be investigated because student nurses were not asked for this information as it could have compromised the confidentiality of their responses. However, one of the acute wards was singled out for praise by 2 students from the second group:

'Ward 33 was exceptionally good for my learning needs.'

'As the nursing care was so consistent and good on Ward 33 it gave me more encouragement to do the same.'

These 2 students were the only ones to refer directly to an individual ward.

Outcomes of the student nurses' evaluations

Response of managers

The first group of students completed questionnaires in their consolidation week in November 1991. An interim paper, setting out their views and including all the comments made about student nurses' experience of working on the NDU, was presented to managers of the Care of the Elderly Unit in January 1992, at one of the Liaison Group meetings held every three months to keep them informed of progress on the research. Considerable concern was expressed about the nature and extent of the comments about stress levels and staff shortages. These data were used constructively by managers and played a part in persuading the purchasers, at the beginning of February 1992, that it would be appropriate to reorganise beds on the rehabilitation wards by closing one ward in order to improve staffing levels.

The second group of students returned to the College of Nursing for their consolidation week in March 1992. When a paper comparing the responses of the two groups of student nurses was presented to managers, it was apparent that the stresses experienced by the first group of students had not been as great for the second group.

Further evaluations of student nurses' experience

The evaluations of student nurses for this study were carried out with the last two groups of students in training for Part 1 of the Register before the introduction of Project 2000 in the Stockport Tameside and Glossop College of Nursing. As the data collected for this study had proved to be a useful source of management information, one of the clinical nurse specialists in the NDU devised a questionnaire to evaluate student nurses' experiences when Project 2000 students were allocated to the Care of the Elderly wards, in terms 3 and 4 of the Common Foundation Programme. Students were allocated to a ward for two days per week for a period of seven weeks.

As the questionnaires administered for this study had shown a lack of awareness among student nurses concerning nursing development units and primary nursing, an

orientation day for Project 2000 students was introduced. The orientation day included presentations about the Unit's philosophy and approach to care, and the role of the support team and the link teacher. It also provided the opportunity for students to talk about their expectations and anxieties, to walk round the whole Unit and to meet the nursing staff on the ward to which they were allocated.

Evaluation of Project 2000 students' experience in the Nursing Development Unit Care of the Elderly

Student nurses' comments on their enjoyment of their placement

Thirteen student nurses, whose placements in the Care of the Elderly Unit began in May, July and September 1992, completed questionnaires administered by a clinical nurse specialist. The responses to the question 'What did you enjoy most from your experience in the COTE Unit?' were all positive and the comments below are representative of the issues raised:

'The help from the staff, always willing to explain and show me procedures and being made to feel part of the team.'

'I managed to see and get involved in quite a varied amount of practical experiences and became much more aware of how to meet patients' needs.'

'I have enjoyed all aspects of my experience, particularly seeing the way that elderly patients are actively rehabilitated and encouraged to live as full a life as possible. I felt I was able to openly question staff and always received in-depth answers.'

When students were asked what they had enjoyed least during their experience on the Unit, 5 referred to spending only two days a week on the ward, which inhibited the development of their relationships with patients. Three students stated that this question was not applicable as there was nothing they did not enjoy. One student referred to:

'Getting to know patients who then died.'

Another student mentioned :

'Occasionally the lack of qualified staff on the ward.'

Comments on the role of the clinical facilitator

All 13 students stated that they had received support from a clinical facilitator throughout their placement; 9 stated that the support they had received was more than adequate and 4 had found the support adequate. No students reported that the support which they received had been inadequate.

Many students referred to the advantages of working the same shifts as their facilitator. The following comment is the only one that contained an element of criticism:

'The guidance received was good. Philosophy of the ward was well explained, including the putting of it into practice. Would have welcomed more practice in the clinical area, i.e. care of wounds, administering injections, etc.'

The following comment is more representative and refers, as many did, to the balance between the students' need for support and allowing their self-confidence to develop:

'I felt that I was constantly supervised, often from a distance so that I was allowed to develop my skills without feeling pressured, but I always had back-up if I needed it. I felt very secure and safe working this way.'

General comments

Seven student nurses took the opportunity to make further comments about their experience. Students expressed appreciation of the nursing staff, as the following comments show:

'I feel that the learning atmosphere which was produced was good. The attitude of COTE staff to Project 2000 also assisted to promote a pleasant, enjoyable placement.'

'The staff ... encouraged questions. They also answered them at a level I could understand.'

One student, however, complained of low standards of hygiene on one ward, and this claim was followed up by the clinical nurse specialist.

Key summary points

Ward learning environment

Student nurses referred to changes in their attitudes towards elderly patients and how they had found that individualised nursing care can meet patients' needs more fully. The students' statements demonstrate that the way in which nurses talked about their work in Chapter 3 is followed through in their nursing practice and that their approach to patient care can be communicated to student nurses. Appreciation of the role of nursing staff in providing guidance and support, answering questions and accepting students into the nursing team was also shown by students. This relates back to nurses' comments on p. 48 about how staff development had enabled nursing staff to question nursing practice. As nursing staff are now more reflective about their own experience, they are better equipped to assist students in developing nursing skills.

Use of research data

The high level of stress experienced by the first group of student nurses, which was associated with low levels of staffing on the wards, was a factor in the decision to redistribute nursing staff by closing one of the rehabilitation wards.

In addition, the lack of knowledge shown by student nurses in the first two groups concerning nursing development units and primary nursing led to the introduction of orientation days for Project 2000 students, to provide information about NDUs, primary nursing, the support team and the role of the link teacher.

6
Conclusions and policy implications

Introduction

Historical data

This study has examined the perceptions of nurse managers and educationalists and a group of 20 ward nurses about their working lives in the Care of the Elderly Unit at Tameside General Hospital, which is now a Nursing Development Unit. Since 1981, the environment in which they have been nursing has changed in terms of: staffing levels; the grade mix; ward environment; and the way in which nursing care is organised.

Wilson (1992:53) suggests that models of organisations are useful since:

> They remind us that the outcomes of change cannot be considered independently of the processes by which they were achieved.

This study examined those processes retrospectively because base-line data about standards of care in the early 1980s in the then 'Geriatric' Unit were not readily available. At that time, the care that patients received was task-oriented and based on routine practices that were taken for granted; this was perceived as the only way of getting the work done. In addition, the lack of trained nurses working in the Unit meant that nursing auxiliaries determined the level of patient care provided.

Data concerning nursing practice in the early 1990s

The multiple research methods used in this study have produced rich qualitative and quantitative data from different perspectives, which contribute towards providing a broad picture of the ways in which nursing in the Unit has changed since 1981.

A survey of all nursing staff in the NDU, grades A–G, was conducted early in 1992 and achieved a 74 per cent response rate. The findings provide a representative picture of the views of nursing staff in the Unit which complements the data from the in-depth interviews with ward nurses referred to in Chapter 3. The issues explored in the survey related to job satisfaction and staff development, and some of the findings were compared with those of national surveys of Royal College of Nursing (RCN) members by Waite and Hutt (1987) and Seccombe and Ball (1992). The comparisons with the findings of other surveys provided a wider context and made it possible to investigate the ways in which nurses' experience of working in an NDU differed from that of other nurses. The

relationship between job satisfaction and the retention of nursing staff was explored by analysing the percentage of nursing staff who left the NDU between 1989 and 1992, and the main reason given for leaving.

A further dimension to the study was provided by questionnaires administered to student nurses before and after their allocation to the Unit during the second year of their training. Additional data concerning the experience of Project 2000 students was collected by a clinical nurse specialist and included in this study.

Implications of the sources of data

The combination of research methods in the study means that representative data from the survey of NDU staff have been included, as well as the insight of smaller groups of informants who described their own experiences in in-depth interviews. The study also includes a wide range of informants who have each contributed a different perspective to the study. Differences in viewpoint would be expected, both within groups of informants and, more importantly, between them, because each group has only a partial perspective. For example, a manager's views would not necessarily be echoed by a ward nurse who had worked in the Unit for many years; his or her opinions of the Unit might contrast with those of a nurse who had recently come to work on the Unit; and all these views could be very different from those of student nurses. Drawing together these perspectives in one study means that, if an issue that was seen as central to the development of the Unit by one group of informants was also regarded as such by other informants, the validity of considering that issue a key finding of the research could be confirmed. This chapter will draw together the key summary points identified at the end of Chapters 2–5 into themes, in order to examine the extent to which the contributions of different groups of informants provide a complete and consistent picture of nursing within the Unit.

Themes from the research findings

The need for change

The interviews with nurses reported in Chapter 3 provide examples of poor nursing practice in the early 1980s and show how the process of change affected the ways in which they cared for patients. Within the hierarchy of relationships that was prevalent at that time (see pp. 37–39), nurses felt that the authority of sisters could not be questioned, whereas the nursing practices of nursing auxiliaries could be challenged by qualified nurses only at the cost of constant supervision to ensure that their instructions were being carried out. The framework of relationships between nurses and routine work with low staffing levels meant that there was very little likelihood of an impetus for change emerging at ward level.

Mike Johnson and Kate Wilkinson were in positions of authority, and thus in a position to assess the need to improve standards of nursing care in a strategic way. The system of joint appointments brought educationalists on to the wards in senior positions, with formal backing, so that it became clear to nurses that patient care would be carried out in a different way from that which they had previously known. Kate Wilkinson described this as 'a different vision'. The shared commitment of managers and educationalists, and the support that they provided to nursing staff on the wards through the joint appointees, was very important in sustaining the process of change.

The timescale of change

It took five years of commitment to change through the introduction of joint appointments before the Tameside Nursing Development Unit was established. Although the starting point for change was a very poor clinical area, it is essential not to underestimate the length of time it can take to implement significant changes in nursing practice, if they are to be made with the support and co-operation of nursing staff.

As the process of changing elderly care was long and drawn out, the continuity of key personnel was very important. Mike Johnson was responsible for managing the Unit from 1979–1993 and Steve Wright worked there for ten years. Without the foundation of the joint appointments, it is unlikely that a Nursing Development Unit could have become established. A Nursing Development Unit was not the inevitable outcome of the joint appointments, but it was an idea that Steve Wright wanted to carry forward which seems to have fitted in with the needs of the organisation. Without taking a position that Wilson (1992:122) refers to as 'reliance on analysing change as primarily the outcome oriented pursuit of great and charismatic individuals', it is essential to acknowledge the importance of Steve Wright's persuasive powers and talent for publicity in the establishment of the Tameside Nursing Development Unit, as well as his personal vision of how nursing care should be provided for patients.

The impact of the joint appointments on the recruitment of trained nursing staff

As a result of the introduction of the joint appointments, the Unit received greater input in terms of education and also of resources, to enable the process of improving patient care on the wards to begin. In addition, the support that student nurses received from joint appointees encouraged them to apply for jobs in the Unit by the mid-1980s (see p. 26). Many of the current G grade staff in the Care of the Elderly Unit were student nurses there in the 1980s. The presence of newly qualified nurses who chose to work there contributed to the change process and also helped to alter the commonly held view at that time, that 'Geriatrics' was the place where nurses worked who were not 'good enough' for any other clinical settings.

Revans (1964:86–87) suggests that :

> Where the staff of a hospital know what they are supposed to do or are able to find out what to do: or in the absence of exact information, can with confidence assess the risks that they are obliged to take, this hospital will tend to display two favourable responses. First the staff will wish to stay there, secondly the patients will recover more quickly.

The development of clinical leadership through the introduction of joint appointments led to the fulfilment of these criteria in the Care of the Elderly Unit over a period of years.

The role of the NDU in raising the profile of nursing elderly patients

Extensive publicity in the nursing press concerning the Tameside Nursing Development Unit was perceived by Steve Wright as a way of safeguarding the achievements of the NDU (see p. 29). Some nurses expressed concern that there was a certain amount of 'hype' about the claims that were being made about nursing practice in the NDU.

However, the Tameside Nursing Development Unit did raise the profile of nursing elderly patients which, because of the historical legacy of institutional care for elderly people being provided in the workhouse, had traditionally been seen as low status nursing work (see p. 36). Two of the four Nursing Development Units, which received funding for three years from the Sainsbury Family Trust via the King's Fund Centre in 1990, were in elderly care settings, namely Southport and Brighton. The Nursing Development Unit label and the publicity about the innovations challenged the stereotype of elderly care as just 'basic nursing'.

Staff development

Professional development opportunities for all nursing staff were seen at the outset by Steve Wright as a key feature of the Tameside Nursing Development Unit (see p. 30). Workshops and study days were also organised at Tameside and were attended by NDU staff and nurses from other hospitals. This 'outreach' work generated income for a bursary, which then funded courses for nurses.

Staff development was also perceived as important by the nurses who were interviewed for the study. One RGN saw the course for care assistants as very important because it showed that the contribution which they made to patient care was valued, and a sister referred to the importance of the G grade workshop (see p. 48). However, staff development was also seen as having played an important part in bringing about changes in attitudes, allowing accepted nursing practice to be questioned and trained nurses to accept more willingly comments and suggestions from other members of the ward team. This reflective approach was identified by student nurses as a positive factor in their experience on the NDU (see p. 85).

In the findings of the survey of NDU staff, the response to questions concerning staff development was positive. Nearly 80 per cent of staff had attended some form of training while they had been working in the Unit. More importantly, 92 per cent of nurses gave 'to help improve patient care' as an important reason for going on courses (see p. 58). Responding to an open-ended question, 'What do you like most about your job?', 14 nurses mentioned issues relating to professional development (see p. 68).

Patient care

The most fundamental change that took place within the Unit during the 1980s relates to patient care. The data presented in this study emphasise the importance placed by nurses on their relationships with patients, which are no longer mediated through the routine (Fretwell 1980) or hierarchy. The nurses in this study talk in a thoughtful, reflective way about how they care for their patients, which suggests that they have moved beyond what (Fretwell 1985:125) describes as a:

> 'veneer of change' through documentation, whilst leaving underlying practices untouched.

It was not until I had finished presenting the data and was looking for nursing literature which related to the findings of this study, that I realised that the emphasis which nurses placed on communication with patients and on the involvement of relatives in patients' care seemed to be unusual. One nursing auxiliary talked about how she is now able to 'be a human being' with patients and their relatives (see p. 44).

The increased emphasis on relationships with patients appears to have been paralleled by the diminishing importance of the nursing hierarchy. A certain degree of professional autonomy is a prerequisite of providing individualised care for patients. The transition to

primary nursing alters the relationships between ward nursing staff and diminishes the central role of the sister in relating to patients, their relatives and doctors.

In the survey of NDU staff, nurses showed very high levels of satisfaction (over 90 per cent) with the level of responsibilities they had dealt with and the standard of physical care that they had provided in the previous week (see p. 70-71). Three-quarters of nursing staff (70 out of 93) were satisfied with the level of psychological/social aspects of care that they had provided. These needs are harder to quantify and James (1992) suggests that commitment to total care by nurses means that the care can never be complete, which may explain the lower satisfaction with the more social and psychological aspects of patient care.

Although staff satisfaction is important because of the way in which it relates to motivation and morale, it also has wider implications. Carr-Hill et al. (1992) found that staff satisfaction correlated positively with both the quality and the outcome of nursing care in the 20 medical and surgical wards that they studied. These findings seem to be reflected in the Tameside Nursing Development Unit.

Some student nurses commented on the positive relationships between patients and nurses on the Unit, and the impact of individualised care on elderly patients (see pp. 83 and 85).

Comparisons between the satisfaction of nurses working in the Tameside NDU and the findings of other surveys

The survey of NDU staff showed that the motivation to provide good quality patient care which had emerged in the interviews with ward nurses (see Chapter 3) was representative of the majority of the nurses in the Unit. The morale of NDU nurses, though they expressed dissatisfaction with some aspects of their working conditions, particularly staff shortages, was higher than that found by Waite and Hutt (1987) and Seccombe and Ball (1992) in their surveys of RCN members (see pp. 62-65).

Although trained nurses in the NDU and RCN members in Waite and Hutt's survey shared similar views about the importance of certain features of working life relating to patient care, professional autonomy and working conditions, the NDU nurses rated these items as being 'mostly' present in their experience much more frequently. The variations between the two samples relating to their nursing experience were statistically significant for 12 out of 14 items (see Table 4.3). This showed that the discrepancy between their own values and their nursing experience was much smaller for the nurses working in the Tameside NDU than it was for the sample of RCN members. This finding suggests that Tameside NDU nurses are more likely than nurses in the RCN sample to perceive that they can offer high quality nursing care to their patients.

Retention of nursing staff

Various aspects of nurses' satisfaction with their jobs were described above, which indicated that the Tameside Nursing Development Unit was unlikely to be affected by a high turnover of trained nursing staff. An additional factor was that the survey of NDU staff found high levels of satisfaction with the management support received by nurses (see pp. 68-69). An analysis of information that was available concerning the number of nurses who left the Unit between 1989 and 1992 showed a lower turnover than that reported by Seccombe and Ball (1992) for nurses caring for elderly people.

Thirteen nursing staff left the Unit during the three-year period to undertake further training, including 4 nursing auxiliaries and 4 enrolled nurses who left to train as RGNs. This suggests that staff development can contribute to the turnover of nursing staff, but in

a positive way (see p. 76), which leads to greater continuity and provides the necessary time span to develop local expertise (Benner 1984).

Use of research data

Managers in the Nursing Development Unit used the data concerning student nurses collected for this study to inform policy decisions. An example of this was that an orientation day was introduced for Project 2000 students allocated to the Unit, because the 'traditional' students had shown low levels of awareness of the features of Nursing Development Units and primary nursing. The questionnaires which were administered to Project 2000 students showed higher levels of satisfaction with their experience on the Unit than the 'traditional' students. This was likely to have been related to the Project 2000 students having more information about the NDU and possibly more realistic expectations.

The wider context

The need for trained nurses

During the past ten years, managers of the Care of the Elderly Unit have been concerned to increase the proportion of trained nurses working there. They are therefore now in a majority, compared with the early 1980s, when most of the patient care was provided by nursing auxiliaries. Recent changes in nurse education through Project 2000 have made student nurses supernumerary and health care assistants have been introduced to replace them as pairs of hands on the wards. With National Vocational Qualifications, which at level three will encroach on work previously carried out by trained nurses, health care assistants are likely to become increasingly important in providing patient care resulting in fewer trained nurses being seen as necessary.

Concern about the lack of national recognition for the contribution made to patient care by a skilled nurse was expressed by Mike Johnson, the deputy Unit general manager, and Kate Wilkinson, the former director of nurse education. They both told me about the difficulty of defining good nursing and defending the need for qualified nursing staff. Mike Johnson commented:

'You see there's a lack of understanding of what a trained nurse is about ... and we're not very good at explaining to lay people why we need trained people. I know why, a lot of it sounds emotive and subjective, and perhaps it is, but what I always say to people is, "Look, someone with that level of training can observe significant changes in patients' conditions".'

Kate Wilkinson stated the problem in the following way:

'Some of the activities that nurses undertake are skills that can be learned by anybody. There's a failure to understand there's a whole body of knowledge beyond that.'

The development of an internal market within the National Health Service and the trend towards Trust status for hospitals, with an emphasis on financial viability, may make Nursing Development Units such as Tameside appear to be an expensive way of delivering care. Seccombe and Ball (1992:99) state:

> With the nursing paybill accounting for roughly a third of the running costs of units, it is inevitable that tighter control of the wage bill – directly through pay levels or through increased productivity of qualified nurses or indirectly through re-profiling – will be seen as ways of gaining competitive advantage.

The assumption that adequate patient care can be maintained through a reduction in the proportion of trained nurses has however, been challenged by Bagust (1992:23), who claims that:

> There is strong evidence that both the number of nurses present and the proportion of them who are fully trained have an influence on the quality of care which can be delivered to patients.

Bagust (1992:24) bases this argument on the flexibility of trained nurses, who are able to respond to any demand for nursing care, whereas:

> An excess of untrained nurses may mean that they stand idle for significant periods while patients must wait for attention from hard-pressed trained staff.

These findings suggest that the emphasis since the 1980s on recruiting trained nurses to work in the unit for the care of elderly people at Tameside General Hospital has been an effective strategy for providing good quality patient care.

A publication by the Audit Commission (1992), entitled *Making Time for Patients*, stresses the importance of continuity of care and suggests that primary nursing is the most appropriate way to provide this. It is, however, not a model of care that can be implemented with limited numbers of trained nurses supervising the work of health care assistants.

The long term implications of wider political developments for the future of the Tameside Nursing Development Unit are impossible to predict, but Mike Johnson described the difficulties that the Care of the Elderly Unit might face:

'What concerns me is I can see this Unit going back to the situation it was in when I came. I'm not saying that the attitudes will go back to those attitudes, I'm not saying the environment will, but in terms of staffing, yes. And yet the expectations are a hundred times greater than they were back in late 1979 and what will happen in effect is we'll make lots of banal statements about quality standards which won't exist. And the danger is then that staff will get criticised for something which is way beyond their control.'

The findings of this study indicate that changes involving a reduction in nursing staff, particularly of trained nurses, would have a detrimental effect on the quality of patient care, both directly and indirectly through the impact on nurses' morale.

The political implications of Nursing Development Units

The provision of government funding to encourage the development of nursing practice through Nursing Development Units is to be welcomed. However, as contracts for delivering patient care are left to market forces, the costs of those services will be a major criterion in determining where contracts are awarded. Robinson (1992:7–8) maintains that nursing issues, such as the maintenance of adequate staffing levels, are often:

> disguised as nurses' inability to manage scarce resources adequately.

The emphasis on cost containment in the current environment does not appear to facilitate the promotion of nursing practice through Nursing Development Units. Although the King's Fund Centre provides funding to NDUs for research, development and evaluation rather than additional nursing staff, the perception of NDUs as elitist and better

resourced than other units may lead to resentment of nurses within them from other nurses who see them as privileged. The morale and self-esteem of those nurses who are not working in such units may be adversely affected by the lack of recognition of their achievements which the NDU label offers to nurses working in those settings. Strategies are needed to ensure that NDUs are seen as benefiting nursing as a whole, rather than as creating divisions between nurses.

However, NDUs can contribute towards the development of nursing practice in the current political climate. The purchaser/provider division in health care has now been established, with all its market forces implications. As nursing values do not easily fit in with policy decisions based on cost considerations, Nursing Development Units are likely to become increasingly important as clinical areas concerned with promoting high quality nursing practice. Nursing should take up all the opportunities available to continue to examine ideas about what constitutes good patient care and to safeguard high standards of nursing practice.

Implications of the study for further research

Nursing Development Units

As research and dissemination of research findings are regarded as key features of Nursing Development Units, substantive studies of NDUs are likely to be published during the next few years. The King's Fund Centre encourages NDUs which receive external funding to collect base-line data, so that it should be possible for those units to publish studies about innovations in nursing practice using data collected for evaluation purposes. This will avoid the need to collect data retrospectively, which proved necessary for this study.

One of the main features of NDUs is the importance attached to disseminating research findings and there is a need for more research data on the impact of work organisation, i.e. primary nursing, on the quality of care. The costing implications of primary nursing also need to be investigated further.

Skill mix

The debate about the effectiveness of qualified nurses providing high quality patient care is likely to continue against a backdrop of political pressure for cost containment. If these pressures are to be resisted, nursing research needs to be able to explain more effectively to a wider, lay audience the particular nature of the care that only qualified nurses can provide.

Conclusions of the study

The themes that have emerged from this study demonstrate how improvements in nursing care have been achieved in the Care of the Elderly Unit at Tameside General Hospital since the early 1980s. The emphasis on the recruitment and retention of qualified nursing

staff, and the provision of staff development opportunities, have led to the nursing staff being strongly motivated to provide good quality nursing care to meet the needs of the elderly population of Tameside.

These changes have been brought about by the long-term commitment of managers and clinical leaders who were able to create an organisational climate in which individualised nursing care could develop and flourish. It is to be hoped that units for the care of elderly people or other clinical settings beginning to develop nursing practice in the 1990s will not face many of the hurdles and difficulties which had to be overcome in the Tameside Unit in the early 1980s.

A recently published study (Carr-Hill et al. 1992) focused on the relationship between skill mix and the effectiveness of nursing care, and was based on a professional assessment of those aspects of care which were within the control of nurses. Carr-Hill et al (1992:144) state that:

> The overall conclusions therefore of this study are simple: investment in employing qualified staff, providing post qualification training and developing effective methods of organising nursing care appeared to pay dividends in the delivery of good quality patient care.

Although the research methods used in the Carr-Hill et al. study were different from those adopted for this study, and the wards in their study were acute medical and surgical rather than wards for the care of elderly people, the findings of the two studies are remarkably similar.

Appendix A

NDU staff questionnaire

Note: The coding column included in the original questionnaire has not been reproduced.

Where there is a choice please tick the answer that applies to you. If there are lines please write in your answer. Please complete all sections of the questionnaire.

Background information

1. Are you

   a) FEMALE ☐ b) MALE? ☐

2. Which age group are you in?

   a) 25 or under ☐
   b) 26–35 ☐
   c) 36–45 ☐
   d) 46–55 ☐
   e) 56 or over ☐

3. Outside your work, do you look after any dependants, e.g. children, elderly, disabled or ill relatives?

   a) YES ☐ b) NO ☐

   If you have answered NO, please go on to question 5.

4. Are you the only carer or do you share responsibility, e.g. with a partner or relative?

   a) Only carer ☐
   b) Shared responsibility ☐

Nursing experience

5. Do you have any nursing qualifications, or have you been on a course to learn about your job?

   Please tick as many answers as necessary

   a) Helping with Care Course ☐
   b) EN ☐
   c) RGN/SRN ☐
   d) Diploma in Nursing ☐
   e) Degree ☐
   f) Other, please write in ☐

   _____

   _____

6. Are you studying for any qualifications at the moment?

   a) YES ☐ b) NO ☐

   If you have answered YES, please write in the qualification that you will obtain at the end of the course.

   _____

   _____

7. If you are a trained nurse, what year did you qualify?

   19 _____

8. If you are an RGN or EN, did you do your training at this hospital?

   a) YES ☐ b) NO ☐

   If you have answered NO, where did you train?

   _____

   _____

9. Please could you tell me the grade of your present job?

a) A/B ☐ b) D ☐
c) E ☐ d) F/G ☐

10. Do you work

a) DAYS ☐ b) NIGHTS? ☐

11. Is your job

a) FULL-TIME ☐ b) PART-TIME? ☐

12. If you work part-time, how many hours a week do you usually work?

_____ hours

13. If you are a qualified nurse, how many years have you been nursing, including time as a student or pupil?

_____ years

If you are an NA, how many years have you worked in a caring role?

_____ years

if you have been an NA less than a year, please write in the number of months you have been doing this work.

_____ months

14. How many years have you worked in the Care of the Elderly Unit in this hospital?

_____ years

If you have worked in the Unit for less than a year, please write in the number of months you have worked here.

_____ months

15. Since coming to work in this Unit which wards have you worked on?

a) All or nearly all ☐
b) Acute wards only ☐
c) Mainly acute wards ☐
d) Mainly rehab or rotation/respite wards or Day Hospital ☐
e) Rehab and rotation/respite wards or Day Hospital only ☐

16. Had you ever worked in the Care of the Elderly before you came to this hospital?

a) YES ☐ b) NO ☐

if you have answered NO, please go on to question 19.

17. If you answered YES to question 16, when you came here was the patient care

a) Better ☐
b) About the same ☐
c) Worse? ☐

18. If patient care was different in the other place(s) you worked, can you describe briefly those differences?

_____

_____

_____

_____

_____

_____

_____

_____

Further Training

19. Have you done any further training, further or higher education, or attended any study days, or workshops, since you have worked on the NDU?

a) YES ☐
b) NO ☐
c) CAN'T REMEMBER ☐

If you have answered NO or CAN'T REMEMBER, please go on to question 23.

20. Have you been on a course or study day within the:

a) Last six months ☐
b) Last year ☐
c) More than a year ☐
d) Can't remember? ☐

21. Do you usually attend courses in your own time?

a) YES ☐
b) NO ☐
c) SOMETIMES ☐

22. Do you usually have to pay any fees?

a) YES ☐
b) NO ☐
c) SOMETIMES ☐

23. Are you satisfied with the study leave arrangements in the NDU?

a) Very satisfied ☐
b) Fairly satisfied ☐
c) Undecided ☐
d) Fairly dissatisfied ☐
e) Very dissatisfied ☐

24. In your view, what are the most important reasons for going on courses?

Please tick any answers that apply to you.

a) To help provide better patient care ☐
b) For a change ☐
c) To develop your nursing knowledge ☐
d) To help you get a better paid job ☐
e) To talk to other nurses ☐
f) To aid your personal development ☐
g) Other, please write in

_____

25. Does going on courses ever cause you any problems?

a) YES ☐ b) NO ☐

If you have answered NO, please go on to question 27.

26. If you have answered YES to question 25, are these problems to do with:

Please tick any answers that apply to you.

a) Arranging child care ☐
b) Spending time away from home ☐
c) Worries about being away from the ward ☐
d) Travel to courses ☐
e) Content of courses too difficult ☐
f) Courses not relevant to your work ☐
g) Being able to leave the ward when there are staffing difficulties ☐
h) Other, please write in

_____

Satisfaction with Your Job

27. In general, would you advise a friend or relative to take up nursing?

a) YES ☐
b) NO ☐
c) DON'T KNOW ☐

28. If you could start again, would you still choose nursing as a career?

a) YES ☐
b) NO ☐
c) DON'T KNOW ☐

29. Nurses in a national survey have described the features of working life listed below as being important to them. **How important is each of them to you personally?**

	How important is this to you		
	Very	**Quite**	**Not**
1. Able to control your own workload	☐	☐	☐
2. Dealing with patients' psychological problems	☐	☐	☐
3. Doing a 'worthwhile job'	☐	☐	☐
4. Fair level of basic pay	☐	☐	☐
5. Good atmosphere at work	☐	☐	☐
6. Good job security	☐	☐	☐
7. Good support/counselling for nurses	☐	☐	☐
8. Helping patients' families	☐	☐	☐
9. High standard of supervision/management abilities	☐	☐	☐
10. Preventing ill health	☐	☐	☐
11. Using your initiative	☐	☐	☐
12. Using your intellectual/academic skills	☐	☐	☐
13. Using your leadership/management abilities	☐	☐	☐
14. Using your personal abilities to the full	☐	☐	☐
15. Other, please write in	☐	☐	☐

_____

30. To what extent have you found the items listed below **to be present in your personal experience** of working in the NDU?

	Has this been present in your own experience of nursing in the NDU?		
	Mostly	**Sometimes**	**Not at all**
1. Able to control your own workload	☐	☐	☐
2. Dealing with patients' psychological problems	☐	☐	☐
3. Doing a 'worthwhile job'	☐	☐	☐
4. Fair level of basic pay	☐	☐	☐
5. Good atmosphere at work	☐	☐	☐
6. Good job security	☐	☐	☐
7. Good support/counselling for nurses	☐	☐	☐
8. Helping patients' families	☐	☐	☐
9. High standard of supervision/ management abilities	☐	☐	☐
10. Preventing ill health	☐	☐	☐
11. Using your initiative	☐	☐	☐
12. Using your intellectual/academic skills	☐	☐	☐
13. Using your leadership/management abilities	☐	☐	☐
14. Using your personal abilities to the full	☐	☐	☐
15. Other, please write in	☐	☐	☐

31. Please write in the number of three items from the lists above that are most important to you personally.

First choice ☐
Second choice ☐
Third choice ☐

32. Taking your job as a whole, how much would you say that you enjoy your work?

a) Enjoy it very much ☐
b) Quite enjoy it ☐
c) Do not enjoy it much ☐
d) Do not enjoy it at all ☐

33. What do you LEAST enjoy about your work?

_____

_____

_____

_____

_____

_____

_____

34. What do you like MOST about your job?

_____

_____

_____

_____

_____

_____

_____

35. If you were able to CHANGE one thing about your job what would that be?

_____

_____

_____

_____

_____

_____

_____

36. How satisfied are you with the management support that you receive?

a) Very satisfied ☐
b) Fairly satisfied ☐
c) Undecided ☐
d) Fairly dissatisfied ☐
e) Very dissatisfied ☐

If you wish to make any comments that explain your response, please write them in

_____

_____

_____

_____

_____

_____

_____

The Content of Your Job

37. Were you at work last week?

a) YES ☐ b) NO ☐

If you have answered NO, please go on to question 41.

If you have answered YES and last week was not a typical week, please describe briefly why it was unusual.

_____

_____

_____

_____

_____

38. How satisfied were you with the level of RESPONSIBILITIES you had to deal with last week?

a) Very satisfied ☐
b) Fairly satisfied ☐
c) Undecided ☐
d) Fairly dissatisfied ☐
e) Very dissatisfied ☐

39. How satisfied were you with the standard of PHYSICAL nursing care in your work area?

a) Very satisfied ☐
b) Fairly satisfied ☐
c) Undecided ☐
d) Fairly dissatisfied ☐
e) Very dissatisfied ☐

40. How satisfied were you with the standard of the more PSYCHOLOGICAL/SOCIAL ASPECTS of patients' care in your work area?

a) Very satisfied ☐
b) Fairly satisfied ☐
c) Undecided ☐
d) Fairly dissatisfied ☐
e) Very dissatisfied ☐

Time Spent Away from Nursing

41. Have you done other jobs besides nursing?

a) YES ☐ b) NO ☐

If you have answered NO, please go on to question 44.

42. How did the WORK in your other job(s) compare with nursing? Was it

a) More rewarding ☐
b) As rewarding ☐
c) Less rewarding? ☐

43. How did the PAY in your other job(s) compare with nursing? Was it

a) Better ☐
b) About the same ☐
c) Worse? ☐

44. Since you came into nursing have you ever had a break of more than three months from nursing?

a) YES ☐ b) NO ☐

If you have answered NO, please go on to question 49.

45. How long was your break from nursing?

a) Less than a year ☐
b) 1–5 years ☐
c) 6–10 years ☐
d) More than 10 years ☐

46. Did you leave nursing because of

Please tick any answers that apply to you.

a) Ill health ☐
b) Pregnancy ☐
c) Child care responsibilities ☐
d) Moved to a different area ☐
e) Hours didn't suit home life ☐
f) Wanted to widen experience ☐
g) Other caring responsibilities, e.g. sick relative ☐
h) Other, please write in

_____

47. Why did you decide to come back to nursing?

_____

_____

_____

_____

_____

_____

_____

48. Did you have any difficulty in returning to nursing after a break?

a) YES ☐ b) NO ☐

49. Finally, do you wish to make any comments about the questions you have been asked or to describe your personal experience of working in the NDU?

Please continue on a separate page if necessary.

Thank you for completing this questionnaire.

Please return it to me in the envelope provided. Your reply will be treated in the strictest confidence.

Mary Black

Department of Health/King's Fund Centre Researcher

College of Nursing

Section 1

Tameside General Hospital

Appendix B.1

Comparison of the findings of the IMS survey of RCN members and trained nurses from the survey of Tameside NDU

	How important is this to you?					
	Very		Quite		Not at all	
	NDU	RCN	NDU	RCN	NDU	RCN
Able to control your own workload	40	1175	30	702	3	104
Dealing with patients' psychological problems	56	1244	16	693	2	43
Doing a 'worthwhile job'	58	1656	13	285	0	40
Fair level of basic pay	42	1529	31	441	1	12
Good atmosphere at work	63	1798	9	181	0	2
Good job security	60	1571	14	384	0	25
Good support/counselling for nurses	55	1330	18	592	1	59
Helping patients' families	54	1360	20	594	0	26
High standard of supervision/ management abilities	51	1386	22	550	1	44
Preventing ill health	59	1549	14	413	1	19
Using your initiative	60	1719	11	258	1	4
Using your intellectual/academic skills	57	1217	15	717	1	48
Using your leadership/ management abilities	49	1217	23	703	2	62
Using your personal abilities to the full	55	1645	17	328	1	9

Notes:
There were 74 qualified nurses in the NDU sample (25 enrolled nurses, 31 staff nurses and 18 sisters/charge nurses) and 1981 in the RCN sample (458 enrolled nurses, 1003 staff nurses and 520 sisters/charge nurses).

The RCN category 'staff nurse' also included midwives, health visitors and district nurses. These groups comprised 8 per cent of the RCN sample.

Of the RCN sample 12 per cent specialised in the care of elderly people and long-term care. All the NDU sample specialised in the care of elderly people, but not long-term care.

Numbers after the decimal points have been rounded up or down to create whole numbers.

Source of data on RCN survey: Waite and Hutt (1987).

Appendix B.2

Comparison of the findings of the IMS survey of RCN members and trained nurses from the survey of Tameside NDU

	Has this been present in your own personal experience of nursing?					
	Mostly		Sometimes		Not at all	
	NDU	RCN	NDU	RCN	NDU	RCN
Able to control your own workload	33	417	31	918	9	648
Dealing with patients' psychological problems	26	460	47	1302	0	219
Doing a 'worthwhile job'	46	1148	26	777	0	57
Fair level of basic pay	52	175	19	956	2	851
Good atmosphere at work	44	691	29	1210	1	82
Good job security	65	1107	8	799	1	75
Good support/counselling for nurses	24	177	37	1009	13	797
Helping patients' families	44	595	29	1224	1	163
High standard of supervision/ management abilities	37	350	36	1323	1	308
Preventing ill health	27	538	43	1192	3	252
Using your initiative	56	942	16	959	2	81
Using your intellectual/academic skills	49	525	25	1299	0	157
Using your leadership/ management abilities	41	572	32	1233	1	178
Using your personal abilities to the full	38	651	35	1202	1	129

Notes

There were 74 qualified nurses in the NDU sample and 1981 in the RCN sample.

Numbers after the decimal point have been rounded up or down to create whole numbers.

The headings for the first two columns are those used in the Tameside NDU survey. In the IMS survey for the RCN, the headings were, 'To considerable extent' and 'To some extent'. The column headings were shortened to facilitate the layout of the page in the questionnaire.

The grades included in the Tameside sample were enrolled nurse, staff nurse and sister/charge nurse. These grades were selected from the RCN sample, but the RCN category 'staff nurse' also included midwives, health visitors and district nurses. These groups comprised 8 per cent of the RCN sample.

Of the RCN sample, 12 per cent specialised in the care of elderly people and long-term care. All the NDU sample specialised in the care of elderly people, but not long-term care.

Source of data on RCN survey: Waite and Hutt (1987)

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Nursing Development Units

THE GROWTH OF **TAMESIDE NURSING DEVELOPMENT UNIT**

An exploration of perceived changes in nursing practice over a ten-year period

This report examines the changes that took place over a ten-year period to transform the 'Geriatric' wards at Tameside General Hospital into one of the first Nursing Development Units providing nursing services for Care of the Elderly. The growth of the Tameside NDU is presented from the perspective of nurses working on the ward who were involved in implementing changes in nursing practice; nurse managers and educationalists who initiated change in a strategic way; and student nurses whose programme included allocation to the Care of the Elderly wards.

A particular strength of this study is that it draws on both qualitative and quantitative data. Information has been presented in an easily accessible form and in such a way that the voices of the nurses can be heard.

The report shows what can be achieved in terms of improving standards of nursing care for elderly patients through shared commitment and vision. It demonstrates how the joint efforts of all concerned could provide a framework of support and staff development opportunities which have improved nurses' self-esteem and motivation to provide high quality patient care for their patients.

The study will be of value to:

- managers requiring greater insight into the processes which are required to develop the nursing service
- nurses at all levels who are caught up in the process of change brought about by the health service reforms
- educationalists who have a responsibility to ensure students gain a true understanding of the value of caring for elderly patients.

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