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Essays on Nursing

Jean McFarlane

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by Jean McFarlane

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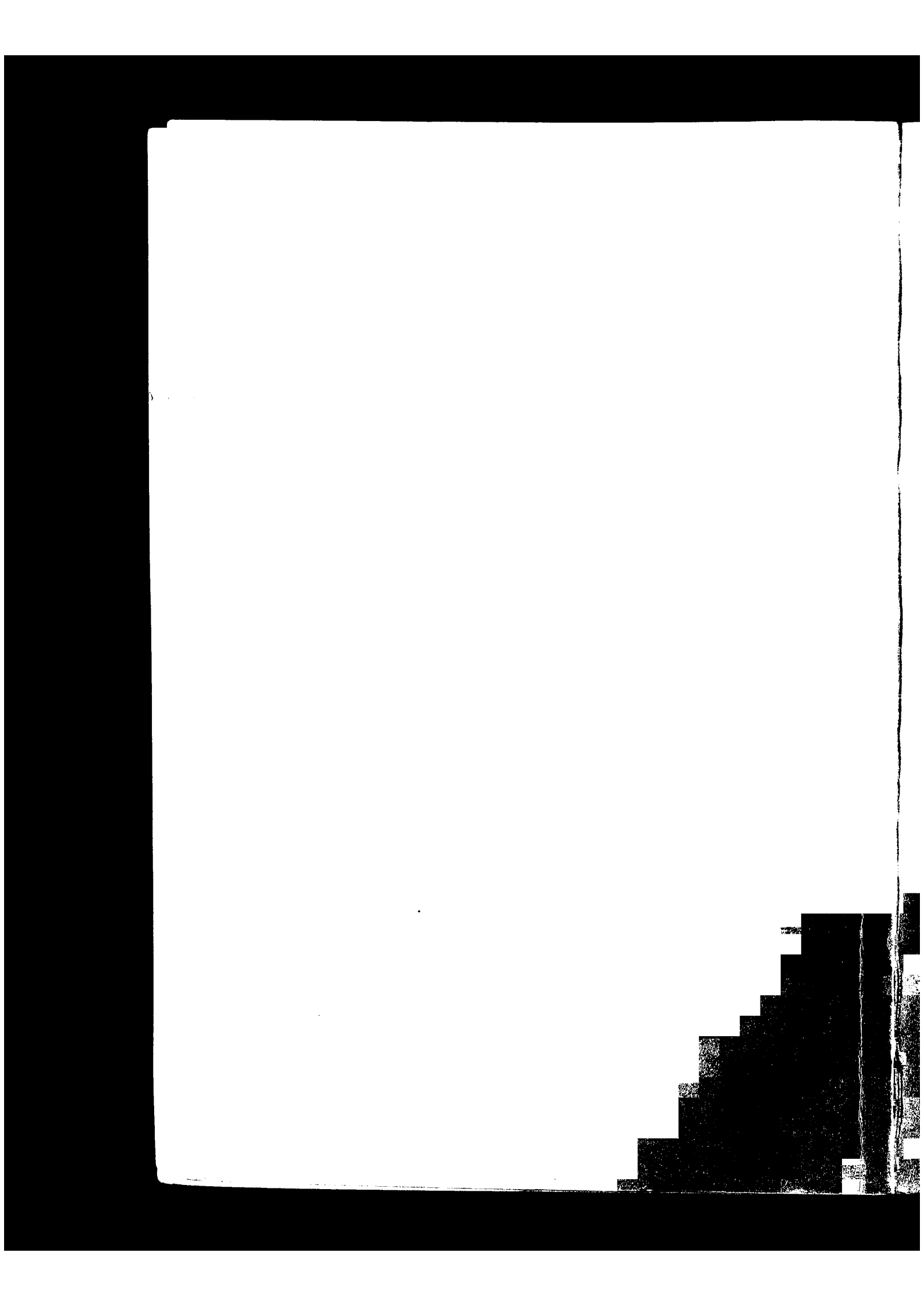

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EDITORS' INTRODUCTION

As the report of the Royal Commission on the National Health Service points out, nurses are the largest staff group in the NHS and account for over one quarter of the total current expenditure in the NHS. Compared to doctors, their manpower and training needs have received relatively little attention until the recent past.

In this series of essays, Baroness McFarlane considers four vital areas of concern to the nursing profession: the role of the nurse; career structures; nurse education and research; and the quality of nursing care. The papers were written for the Royal Commission in 1977/8 and much of the thinking in them was incorporated into the two chapters of the final report which deals specifically with nurses; chapters 7 and 13. We are presenting them in this series in their original form, because they represent an important contribution to the continuing debate on nurse manpower and nursing care. Baroness McFarlane has been an active and influential figure in the nursing field for many years and her essays offer, to those who are concerned with the future of nursing in this country, a knowledgeable and carefully considered review of the current literature and developments in each of the four areas discussed. The views expressed in the essays are her own and do not necessarily reflect those of the Royal Commission or the King's Fund.

This is the second in a series of project papers based on the working papers of the Royal Commission on the NHS. We are grateful to King Edward's Hospital Fund for London for giving us a grant to enable this series to be produced, and to the Polytechnic of North London where this project has been based.

Christine Farrell
Rosemary Davies

THE ROLE OF THE NURSE

Nursing Manpower

Within the terms of reference of the Royal Commission on the National Health Service, the Nursing Service is the largest manpower group and commands the largest salary bill in a labour intensive industry. The deployment of nurse manpower is therefore likely to have profound economic consequences for the NHS.

In the attempts to make some progress towards legislation to achieve the educational recommendations of the Report of the Committee on Nursing (Briggs 1972)[1], the equally important section of that report on manpower has been comparatively neglected and very little progress has been made beyond the statements in the report. For a fuller statement of the position readers are referred to Chapters V and VI of the report, 'Nursing and Midwifery Resources and their Utilisation', and 'Opportunities, career structures and conditions of work'.

Those problems in respect of nurse manpower which were met by the Briggs Committee and summarised in paragraph 406 still remain:

(a) There are no adequate data relating to the overall balance between nursing and midwifery supply and demand at national level;

(b) No satisfactory measure of general staffing needs has yet been devised;

(c) What attempts have been made to measure the need for nursing staff have concentrated on acute hospitals. Little effort has been made to extend the study of staffing difficulties into community nursing or those areas and sectors in hospital where there seem to be the worst problems, particularly psychiatric, geriatric and long stay hospitals;

(d) Since the very serious difficulties in nursing staffing relate largely to local pockets within the NHS . . . national statistics dealing in aggregates cannot reveal the full severity of local problems;

(e) The variations, some of them sizeable, in local staffing patterns which can be traced from any breakdown of national figures are not easy to understand. They suggest to us that inadequate attention is paid locally to determining criteria for staffing needs and to pursuing effective personnel policies. Moreover the figures are not normally subject to regular review;

(f) Attempts to apply formulae . . . are recognised as having weaknesses;

(g) There are not only regional variations; there are variations in the same kind of hospital within the same Region which cannot be attributed to the layout of wards, the presence of day patients or the presence or absence of centralised services. Moreover, the amount of non-nursing support is variable and is not related to the amount of nursing time. The highest staffed hospitals in most Regions have about one-third more staff than the least well staffed hospitals;

(h) Chief nursing officers tend to think in terms of budgetary rather than manpower ceilings and naturally, if they can, spend up to the budgetary ceiling, recruiting whatever balance of staff can be obtained;

(i) National machinery necessary for the planning of the whole system is inadequate, although the need to plan is being increasingly recognised.

The situation has altered little since 1972. There are arguments in favour of the establishment of national machinery for dealing with health manpower as a whole. It would seem ineffective to concentrate only on medical manpower since the manpower needs of other health professions interact dynamically with medical manpower. This is particularly so of nursing.

One of the basic considerations in determining nurse manpower requirements is an understanding of the role and function of the nurse as a basis of determining how much nursing work requires to be done and at what level of skill (i.e. what level of training). It is necessary, therefore, to look at the Role of the Nurse and its interaction with the Role of the Doctor.

The Nurse's Place in the Health-Care Team

Whilst traditionally health care delivery has been preceived as medical care carried out with the assistance of other professions, there is now a wider recognition and acceptance of the fact that health care is given by an extremely complex interaction of a team of professionals with the patient, his family and the community. In that interaction the medical role may be extremely important and dominate all other contributions, but equally the nursing role or the role of the family in caring may predominate. It is likely that in a team function there will be overlap in the roles but it is also important to distinguish the unique input of each member of the team. With undue emphasis on one aspect of care, other aspects may be impoverished and the total care of the individual suffer. This kind of interaction and overlap has been represented diagrammatically by Dorothy Hall (WHO, Copenhagen) in an unpublished paper in which she shows the interaction of three health professions.

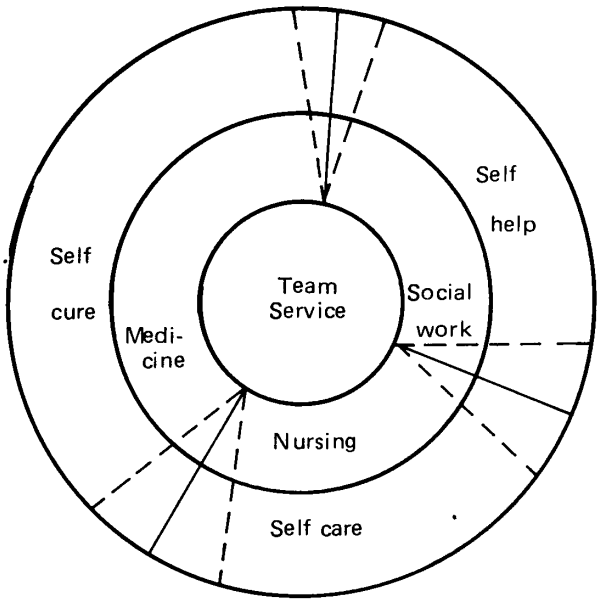


FIGURE 1 Roles and relationships in the health care team
(after Hall, D., World Health Organisation, Copenhagen)

The report of the Committee on Nursing[1] recognised the considerable overlap between medicine and nursing. In particular they say, '. . .all medical activities and developments affect nursing and midwifery directly or indirectly' [para 146], and 'We believe that while doctors, nurses and midwives are permanent partners in care, it is possible to distinguish in the first instance between the caring role of nurses and midwives (which involves coordination and continuity) and the diagnostic and curative function of doctors [para 140]. We believe in this context it is essential to dispel the notion. . .that nursing and midwifery constitute a substitute profession for medicine. . . [para 141]. We believe that nursing and midwifery will remain distinct but related professions in the future. Examining their future relationship, we note that:

(a) the roles of doctors and nurse or midwife are complementary. . .

(b) on particular occasions their roles may be interchangeable. . .

(c) in situations where the 'curing' function (as distinct from the caring function) is subordinate or non-existent. . .the role of the nurse is central.

(d) in situations where there is a high degree of risk. . .the intensity and complexity or treatment being provided. . .may make it difficult to define specific nursing functions. . .

(e) where treatment cannot be adequately maintained by other professional members of the health team because of insufficient staff or workload inadequate to justify the employment of specialist staff. . .nurses on account of their availability and continuity of service service are usually the staff expected to attempt to take over the function of other specialists. Conversely, sometimes the doctor will have to attempt to carry out certain nursing or midwifery duties [para 142].'

The Role of the Nurse

Whilst recognising the inter-relationship of nursing and medical roles it is

important to identify the particular contribution of nursing to health care delivery. There have been many attempts at defining the role of the nurse and none is universally acceptable. It is probably simplistic to think that there is such a thing as a unitary definition of the medical role. Each has a very wide range of function. Henderson's (1966)[2] statement of the unique function of the nurse is probably that which has been most widely accepted as a basis for discussion. Most nurses are taught it in their introductory course, so that it becomes part of their own self perception. 'The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible.'

From this statement some important facts about the nursing role can be abstracted:

(a) Nursing consists essentially of acts of helping or assistance;

(b) There is a nursing role in respect of well people (preventive) as well as sick people;

(c) The major focus of nursing is on activities which people normally do for themselves. Other authors call these 'self care activities' or 'daily living activities' Henderson (1966)[2] lists fourteen such activities including breathing, eating, drinking, eliminating, sleeping, dressing, etc.

(d) The conditions which validate nursing action are lack of strength, or will, or knowledge. The nursing role therefore takes in physical and psychological assistance and it has a teaching function.

Henderson continues this statement by saying 'that aspect of her work, this part of her function, she initiates and controls; of this she is master. In addition, she helps the patient to carry out the therapeutic plan as initiated by the physician. She also, as a member of. . .a team, helps other members as they in turn help her, to plan and carry out the total pro-

gramme whether it be for the improvement of health, or the recovery from illness, or support in death.'

Following this analysis, the nurse has a role in the sphere of self care activities where she has total professional responsibility. She assesses the need for care, initiates it and controls it. Besides her unique role she also has a collaborative role with doctors and other health professionals.

It is often difficult to define the collaborative role with any precision, and it varies from ward to ward, hospital to hospital, and in the community setting. In her collaborative role the nurse takes over 'medical' tasks very often on the basis of expediency. In an institutional setting the nurse's constant presence makes her the convenient person to make frequent observations or to carry out diagnostic and therapeutic procedures where the element of risk is not great. In this role she becomes a very convenient doctor's assistant. Because of her continuous contact with the patient, the nurse, and particularly the ward sister, becomes a coordinator of the care given by other professionals, i.e. she coordinates the patient's day.

Whilst this collaborative role may seem to be in the best interests of patient care there is probably need for more conscious decision making about the amount of medically derived work undertaken by the nurse, its repercussions on her own unique role and her level of competence in undertaking new tasks.

(a) Tasks allocated by the doctor may appear to be more urgent or more prestigious than 'mere nursing'. They are in fact very often repetitive tasks requiring relatively little skill.

(b) If too great a value is placed on the technical tasks delegated by doctors the unique caring role of the nurse may be crowded out.

(c) The caring role is then delegated to the less skilled and there is a great deal of evidence that standards of care are deteriorating.

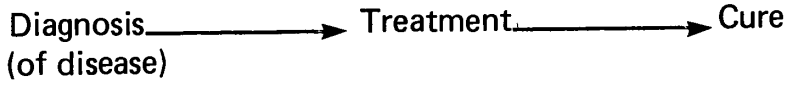
(d) If the medically derived tasks demand special skill or knowledge, then the nurse must be adequately trained for their performance.

(e) Some would argue that there is a need for a grade of medical auxiliary or assistant to take over less skilled medical tasks. Others argue that this would lead to a fragmentation of care and an estrangement between medicine and nursing.

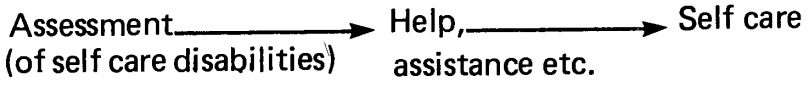
(f) Should more medical tasks be accepted into the nursing role then the implications for nursing establishments need to be calculated. There is a tendence to attempt to solve medical manpower problems by precipitating nursing manpower problems. The argument is often put that nurses are 'cheaper' than doctors to employ. This may be so, but the cost of 'extra' nurses is not very often included in these calculations. The tasks are very often extra tasks for existing nurses with an erosion of their caring function.

Extended and Expanded Roles of the Nurse

A great deal of discussion has taken place on both sides of the Atlantic about the possibility of extending the role of the nurse. This usually is taken to mean an extension in breadth, i.e. taking on more of the collaborative role outlined above. Studies have been made of the work of the nurse in the primary care team and her position as a worker of first contact for the patient. Such a role requires certain basic diagnostic skills for which the nurse is not at present trained (but for which she could be trained). The Americans recognise a 'nurse-clinician' who diagnoses and prescribes therapy. It is my view that she operates mainly to a medical model of care, i.e.:



It is possible also to argue that the caring role of the nurse has been so neglected that this needs expansion (in depth) and that the nursing model of care needs to be more adequately developed, i.e.:



Techniques of assessment and methods of helping need to be placed on a more scientific basis.

The Clinical Nurse Specialist/Consultant

Discussion has also taken place about the development of specialised and consultant roles in nursing. The Royal College of Nursing (RCN) document 'New Horizons in Clinical Nursing'[3] shows that these discussions are still in their early stages. A number of nurses however are occupying specialised roles within nursing, but an analysis of the job content of these posts show that they are widely different (evidence to the Royal Commission compiled by G. Castledine).

There is agreement that the clinical role of the nurse needs to be developed and that there should be career opportunities in clinical nursing comparable to those in nurse teaching and management. There is as yet no agreement as to the form the career structure should take and whether there is any clinical role possible beyond that of ward sister level. The original concept of the nursing officer in the Salmon Committee Report[4] was that there should be considerable clinical involvement and specialisation. This role concept has not been realised in very many places. There could be at least two reasons for this:

a) nursing officers were originally recruited from the existing assistant matron grade who had not had clinical involvement over a number of years;

b) it has been difficult for nursing officers to come between the relationship of medical consultant and ward sister in the clinical care of the patient.

Nevertheless, there seems to be a need to develop the clinical role of the nurse as being the central nursing role. In this respect it would seem timely to review the role of the staff nurse and ward sister in the light of developments since their inception. Demographic trends are such that the average 'life' of a ward sister is now about three years and there would seem to be a case for a nurse who specialises and acts as consultant to

other nurses and other health professionals in her field.

The clinical role of the nurse is not a unitary one. It varies very much in job content and skills between for instance, geriatric nursing and intensive care nursing, between general and psychiatric fields and particularly in the community in health visiting and district nursing.

Summary

Nurses and midwives form the most numerous and most costly group of manpower in the NHS. Their role is exercised as members of a team of professionals working together with the patient and the community in achieving health care. In this enterprise nurses exercise a unique, caring role and a collaborative role with others particularly doctors.

The collaborative role with doctors shifts dynamically so that the relationship of the professions needs to take its cue from the interests of patient care rather than from professional boundaries. In such a relationship there is room for extended and expanded roles for the nurse. This needs to be undertaken as a conscious decision rather than a drift, or at the dictates of the needs of one manpower group, or economy. Undertaking an extended role in breadth may hinder the expansion of the caring role of the nurse in depth.

The unique role of the nurse is one for which she is professionally responsible, i.e. she initiates and controls it. She is legally responsible for it.

Some specialised roles and consultant roles have been identified in nursing but there is as yet no unanimity in the profession about the nature of specialisation in nursing and their relationship to established roles such as staff nurse and ward sister. Health visiting and midwifery preeminently exhibit specialised roles to the full, in which an independent professional function has been most fully developed.

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3 ROYAL COLLEGE OF NURSING. *New horizons in clinical nursing.* London, RCN 1976.

4 GREAT BRITAIN, MINISTRY OF HEALTH. *Report of the committee on senior nursing staff structure* (Chairman, Sir Brian Salmon) London, HM Stationery Office 1966.

CLINICAL CAREER STRUCTURE FOR NURSES

Extracts from the evidence to the Royal Commission on the NHS frequently refer to the adverse effect which the Salmon[1] and Mayston[2] structures have had on clinical nursing and the common perception that Salmon has:

1 withdrawn able, clinical nurses from the practice of clinical nursing into management, often against their will;

2 that this has led to a comparatively young and inexperienced nursing force being left in the clinical situation;

3 that standards of patient care have consequently declined.

Despite the weight of so called evidence, we have seen that the proportion of administrative grades as a percentage of all nursing staff declined between 1966 and 1975[3] and factors other than Salmon could have contributed to a perceived deterioration in standards of care. These include:

1 the trend to earlier marriage in society

2 the unsocial hours in nursing in reference to a married woman's needs in employment.

3 whereas there has been an increase in whole-time equivalent (WTE) staff of 17.4 per cent between 1971 and 1975 other factors have affected this:

   (a) the number of hours per WTE decreased from 42 to 40 in 1972

   (b) changes in annual leave took place in 1974

   (c) (a) and (b) together account for an estimated nine per cent reduction in available hours

(d) the number of hospital medical staff rose by 17.1 per cent WTE creating an extra nursing workload.

(e) the percentage of qualified nursing staff remained less than fifty per cent of the total. The imbalance of trained to untrained staff is exacerbated by the growth of specialised units in which a greater proportion of qualified staff are deployed and leaving other units where auxiliaries are carrying responsibilities beyond their capabilities and with inadequate supervision.

(f) a greater proportion of patients in acute wards is of persons over 65 years (fourteen per cent of the total population). These are patients with a higher dependency on nursing staff.

(g) the early discharge of patients has lead to a higher dependency level for the in-patient with more diagnostic procedures being carried out and an additional workload associated with adequate discharge procedures. There is also an increased workload for community nurses.

(h) there is an increased technical and scientific element in medical care which makes greater demands on nursing care.

Quite apart therefore from the management structure designed by the Salmon Committee factors have been at work which have altered the content of clinical nursing. Salmon assumed that the functions of ward sisters and charge nurses 'were well understood' and in a sense the implementation of the report diverted attention and resources from the primary clinical role of the nurse. Salmon stated with good intention 'The starting point is the patient, whose cure or care is the object of the enterprise and to this end many functions are discharged by many people working together.[para 3.26]' They then described a system of management antithetical to the development of the professional role of the nurse practitioner. 'There should be managers. . .and their duty is to control their subordinates, that is to give them orders and to coordinate their jobs. . . [para 3.26).'

Woodward (1965)[4] in analysing management structures in industry demonstrated that different kinds of product demand a different style of management. Mass production demands a different style of management from small scale production or a one-off job. If nursing care is to be individualised to the needs of one patient, it is my view that the management structure required is that for a one-off industry, i.e. a shallow management structure with room for individual initiative and responsibility rather than a hierarchy.

Having said that, the nursing service is the largest manpower group in the Health Service. Employment, deployment and personnel policies need to be managed on a wide scale for the best use of resources. There is also benefit in the discussion of nursing policies on a unit or district basis. But the clinical function of the nurse takes place at the level of the patient in consultation with other professionals. Only the individual nurse can prescribe the nursing care for an individual patient and the major responsibility for clinical practice lies therefore with the individual nurse practitioner

Whereas Salmon may not have diverted more nurses than before from clinical responsibility, it has diverted serious consideration of the profession from the development of the clinical role of the nurse and the rewards given by Whitley Council have been on the basis of management criteria (span of control etc.) rather than the quality of clinical decision making. There are signs that the profession is re-assessing the value system which it has adopted and there is a growing interest in the clinical role of the nurse and a demand for a career structure and consequent rewards in clinical nursing. It is possible that in its wish to enhance the clinical role the considerable gains made in nurse management may be undervalued and the educational role be the Cinerella of all.

The Practitioner of Nursing and Midwifery

In talking about the clinical role of the nurse and career opportunities one is immediately involved in semantic difficulties because some practitioners of nursing, for example health visitors, do not see themselves as having a clinical, literally bedside, role. Others, for example midwives, see themselves as a distinct profession. To cover all these eventualities I have

alluded to, the practitioner of nursing and midwifery and health visiting i.e. those who practice the art and science of the profession as distinct from those who manage it or teach it or research it.

The structure of the practitioner grades has altered little since Miss Nightingale's day with probationers (students), staff nurses and ward sisters. It is remarkable that the structure should have survived when the job content has altered so considerably. It is remarkable too that the structure is matched, not so much to meeting patient needs as to an architectural anachronism – the ward. The precursors of wards can be seen in the infirmaries of monastic buildings, in the poor law institutions with their punitive regimes denying the sick any individuality and in the military hospitals designed for the large scale reception of casualties. I would suggest that the ward is no longer a viable unit of clinical nursing care and that a **patient group** manageable by one practitioner as leader of a team of nurses and related to the patients of one physician would be more rational. For many years the delivery of supplies and hotel services may be related to a physical 'ward' entity but this is now too large and complex a unit for the management of individualised clinical nursing care.

A great many studies have analysed the content of the clinical role of the nurse in different settings: acute, general, psychiatric, and district nursing. Most of these studies have used work study methods based on observation. Their bias is therefore that they have recorded physical tasks or procedures carried out by nurses and the decision making element and judgements based on scientific premises have been unrecorded. Work measurement methods have also been used to establish the time taken to care for patients of different dependency levels as a step in determining the number of nursing staff required. This has not as yet been complemented by an analysis of the level of skills required to carry out the given quantity of care.

These studies have however produced useful indicators of the quantity of clinical care being carried out by different grades of nurse practitioners. The first studies carried out by Goddard[5] (1953) using work study and work measurement indicated that seventy-five per cent of all direct care in acute wards is carried out by student nurses, i.e. untrained staff. Goddard

classified the tasks nurses perform into basic (emanating from daily living activities like sleeping, eating, eliminating) and technical (emanating from the patients disease and medical treatment). Most subsequent analyses have made use of these categories. The most recent study to which I have access is an MSc thesis supervised at UMIST by Dr Brian Moores. For all clinical nursing staff the following proportions of categorising of work were found:

44% Basic	15% Technical	29% Administrative
For students:		
50% Basic	17% Technical	16% Administrative
For ward sisters:		
15% Basic	8% Technical	72% Administrative

One can say therefore that there is a considerable fall off of the clinical content of work as soon as the nurse becomes registered. There is no indication as to whether the ward sister selects her contribution to basic and technical care on the basis of 'critical' aspects of care or supplementing staff shortage. Nor is there a satisfactory analysis of the content of the seventy-two per cent administrative work. It is likely to contain jobs seen as work allocation which require an assessment of nursing needs and the prescription of nursing care to be carried out by others, i.e. the most important decision making aspects of clinical nursing.

The UMIST study also shows that of 142 nursing tasks which were observed and classified, eleven occurred far more frequently than others and were nearly all related to basic nursing care. They involved tasks in the sluice, the bathroom, the kitchen, with food and drink etc., i.e. work with the basic daily living activities occurred more frequently and took up more of the clinical nurses' time than technical tasks.

It would appear then that the ward sister is less involved in clinical nursing than the nurse in training. She pays considerably less contribution to the technical care of the patient and devotes a great deal of her time to administration at ward level. It is possible that the ward sister sees herself more as a manager of clinical care than an executive.

She retains the decision making element of prescribing nursing care and thus fragments the nursing care by splintering off the assessment of needs and prescriptive element from the nurse who carries out care.

This division of labour in clinical nursing into a 'planning' level and an 'action' level has at least two negative consequences:

1 Neither the student nor the ward sister sees the whole consequence of care through

Assessment ⟶ Planning ⟶ Action ⟶ Evaluation

Studies by Hawthorne (1974)[6] and Lelean (1973)[7] show the gap in the ward sister's perception of what is happening and what actually is happening. The ward sister may make her plans and evaluate on inadequate feedback of clinical facts from the student. Gray (1977)[8], in a study of the assessment of patient needs in terminal care, shows that the ward sister rarely hears more than what is given verbally at a daily report session and nurses only elect to tell what they perceive as important. There is a loss of reality in the ward sister's data base for clinical decisions.

2 The student who is delegated nursing actions from the ward sister on the basis of job assignment never has practice in assessing patients' needs or prescribing a plan of care until she becomes a ward sister.

The organisation of clinical nursing care needs to be reformed on the basis of a patient or client group for whom the qualified nurse practitioner is responsible. The qualified nurse would work with a team of assistants to whom she might well delegate aspects of care, but the nurse who is responsible for assessment and the prescription of a plan of care must be far more intimately concerned with the delivery of care than at present so that she can evaluate the care given and revise the plan, i.e. the nurse carrying primary responsibility for the care of a patient needs to be identified and other nurses work to her prescription. The assessment and prescription of nursing care not only take in the daily living activity needs of the patient but treatment and modifications in care which the disease of the patient and his treatment may indicate. The nurse carrying the

prime responsibility for a patient therefore should be identified as the nurse who works with the physician as part of the multi-disciplinary team.

Systems of 'patient assessment' or 'team nursing' incorporate these principles. In many places it is claimed to be impossible with present levels of staffing, but there is no work on the staffing levels required by different methods of clinical management. One could hypothesise that the same amount of work is required and that a more rational team structure for different fields of nursing (e.g. acute and geriatric) might be evolved.

The Americans have called the system of identifying one nurse being primarily responsible for one patient, 'primary nursing'. In this system there is no hierarchy of clinical tasks into 'basic' and 'technical' with one being identified as more difficult and therefore senior to the other. The primary nurse is responsible for assessing and planning and evaluating nursing care for the patient in totality, though she may share the execution of nursing care with a team.

The time is overdue for a re-assessment of the nursing function in this way, so that nurses responsible for clinical care would be intimately involved in all aspects of care – not just assessment and planning – but also in giving both basic and technical care.

There has been a false dichotomy in between basic and technical care. As stated by the Briggs Committee[9] '. . .their [nurses] central role is to ensure the care and comfort of the person being nursed, to maintain oversight and coordination of that care and to integrate the whole – both preventive and curative – into an appropriate social context.'

In this respect it is difficult to support the expressed view that the current emphasis upon nursing 'care' is likely to impede the development of an extended role for the clinical nurse. The present emphasis on 'care' in nursing is a more precise identification of the focus of nursing activity in daily living activities such as elimination, eating etc. The nature of the nursing act of care is in helping or assisting an individual in these activities. Whilst helping and assisting requires art, the assessment of the individual's problem in elimination for example requires a knowledge of anatomy and

physiology, enough psychological insight to assess how to sustain the patient's dignity and the threat to independence. In prescribing action appropriate to the problem, it may be necessary to have a knowledge of techniques and, for example bacteriological principles, the physiological outcomes of different approaches to care etc. In this respect nursing, by its neglect of the clinical role, has not kept pace with medicine in applying relevant scientific principles and technology. It is at the beginning of this however, and much of the recent nursing research has contributed to a more scientific approach to nursing care. It is because of the recognition of the need for the development of clinical nursing in its own right that some nurses are apprehensive of any development which diverts nurses from their unique role to that of a doctor's assistant. At the same time, these developments in nursing are complementary to those in medicine. For example, the development of perenteral feeding as an adjunct to medical treatment has highlighted nursing problems associated with it and this is currently being worked upon (Neilson 1978)[10]. Developments in nursing in its own right will take place alongside those linked to medical developments.

Specialisation in Nursing

The previous paper attempted to show that specialisation in nursing and extension of the nursing role could take place both in the assisting of patients in daily living activities and in collaboration with medical advances.

Just as in medical specialisation, specialisation in nursing has taken place in a number of different directions – by client age group (child health and geriatric nursing) by the location of nursing care (acute general, psychiatric, district nursing, or occupational health nursing) by particular skill and knowledge (stoma therapy, infection control etc.). The number of syllabuses approved by the Joint Board of Clinical Nursing Studies (JBCNS) illustrates the proliferation of so called 'specialties' in clinical nursing. Most of these however are post basic courses which it would be wise for a nurse to take before practicing in that area of nursing. If they are analysed however, there is a core of knowledge and skills common to most specialties in nursing on which is built the special knowledge and

skills relevant to practice in that specialty.

There is however a debate, as in medicine, about the generalist and specialist roles in nursing. Nursing education aims to produce a generalist on registration, but does the ward sister of a medical ward remain a generalist or does she become a specialist in the nursing care of patients with problems associated with medical diseases and treatment? Some nurses see very little difference in the nursing care of patients in medical and surgical wards and identify 'medical surgical nursing' as a specialty. There are particular problems in the nursing care of elderly patients not specifically receiving medical treatment in the promotion of continence, and in the occupational health nurse's approach to the control of an industrial environment. It is probably best that nursing specialties should evolve at the instance of the need of the patient and the extent to which nursing can be developed to meet those needs.

Institutional and Community Nursing

Nursing has traditionally specialised into hospital and community services. The integration envisaged in 1974 has not brought about the amount of integration which might have been envisaged. In a service such as the midwifery service where there can be fairly well formulated admission and discharge plans, integration has been attempted and is seen by some as successful. It breaks down however where special medical procedures such as induction are used and the mother is transferred from the care of one midwife to another.

Integration of care has been growing in the field of psychiatric nursing where the follow up of the patients into the community is planned and continuity is desirable. It has been recognised however that the psychiatric nurse who has worked in hospital needs special training for work in the community and courses have been instituted.

Similarly the role of the district nurse is not exchangeable with that of the hospital sister. The district nurse is more of a generalist, i.e. she deals with a wide variety of cases on discharge. But she too has special skills and is concerned far more in the education of the patient and the family in

giving care when she is absent. She needs a far more intimate knowledge of social services and the network of contacts with other health workers.

Given such a specialised role in the interests of the patient there needs to be an integration over admission and discharge to provide continuity of care. All liaison schemes have not been a resounding success and contact between nurses at field worker level needs to be developed with more precise objectives.

Structure and Incentives

A greater involvement of the nurse practitioner in giving integrated nursing care to patients who are identified as their responsibility needs to be developed. No doubt the delivery of care to a smaller group of patients than the conventional ward size will demand that a co-ordinating role should be developed. This is how the nursing officer role was originally conceived – co-ordinating the nursing work of a unit. Discussion has taken place with a view to developing the clinical content of the role of the nursing officer. The role has a large management content at present and it is difficult to act as advisor to ward sisters unless clinical expertise is maintained by retaining responsibility for the clinical care of a small group of patients.

The working life of a ward sister is now about three years. The working life of a nursing officer tends to be slightly longer but she quickly loses her clinical expertise.

With the developments in nursing the division of patients into smaller groups with 'primary nurses' co-ordinated by a nursing officer retaining a clinical involvement could be envisaged.

The teaching of nursing has suffered by being divorced from clinical nursing. There would be educational and service dividends by the appointment of 'clinical tutors', i.e. tutors who would retain the care of a small group of patients.

It is essential that rewards should be made available to the nurse staying in

clinical nursing. These should be commensurate with those for managing the nursing service for a few nurses demonstrating outstanding expertise. Besides extending the range of the ward sister's salary it could be possible to look at distinction awards. But criteria for clinical expertise would need to be established.

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ALTERNATIVE CAREER STRUCTURES IN CLINICAL NURSING

Definitions

The clinical role of the nurse has traditionally been regarded as that aspect of her function which involves direct patient care. It is contrasted with the administrative role of the nurse (which has to do with the management of the nursing service and the multi-disciplinary management of the Health Service as a whole) and the educational role of the nurse (which has to do with basic and post basic nursing education).

Role Content

Most of the analyses of the content of clinical nursing roles have followed the categories of function outlined by Goddard in 1953:

1 Basic nursing care (to do with daily living activities).

2 Technical nursing care (to do with the patient's disease).

3 Administrative.

4 Domestic.

5 'Self' time.

I have indicated elsewhere that I believe these are unsatisfactory divisions (basic and technical are so inter-related) and the method of job analysis by the observation of tasks performed give no indication of the cognitive element of the clinical nursing function. (This criticism of method and criteria is at the basis of the rejection of the latest job evaluation work by many in the nursing profession.)

It is necessary to spell out the content of the clinical role in order to identify a basis for a career structure.

In any clinical nursing role (including health visiting and midwifery) one can identify **five** major phases of activity and associate skills:

1 Data collection about the patient so that the nurse has sufficient basis of fact on which to plan nursing care. The skills employed in this phase are observation, interviewing and communicating with patients, relatives and other professionals.

2 Assessment of patient problems. By sorting the data the nurse identifies those problems either in daily living activities or in the effects of disease or therapy which are amenable to nursing treatment. The skills required are largely cognitive – a knowledge base of normal and disordered physical and psychological function and an ability to apply this knowledge in determining a patient's objective and subjective abilities, so that problems are identified.

3 Developing a plan of care. Based on the identification of problems the nurse must select from alternatives the nursing action which might answer the problems and make a prescription of nursing care. This includes a statement of the content of care, the methods and apparatus to be used, the identification of who in the nursing team is qualified to carry out the care, how frequently it should be given, where it should be given, an order of priorities between patients and a long term plan for rehabilitation and discharge. This stage calls for experience and knowledge of the expected outcomes of nursing action and their rationale. It has a large 'management' component in organising a team of nurses with different levels of skill, knowledge and ability. It calls for co-ordinating skills in planning for discharge into the community and the input of other health professionals into the day to day programme of care.

4 Implementation of the Plan of Care. This calls for executive ability in carrying out nursing care, i.e. an intricate combination of manual, cognitive interpersonal skills and the ability to adapt the skills to individual patient's needs, e.g. the surgical dressing is never the same twice – the stitchline may be in a different site, the condition of the stitchline varies, the patients' reaction to the procedure varies. The

skills of teaching and counselling are also important in this phase.

5 Evaluation of the care given. In this stage the nurse needs to measure the actual outcomes against the expected outcomes of care (the objectives). She must be able to re-assess and modify the plan of care. The skills used are largely cognitive.

Given these five phases of clinical nursing activity, it is possible to identify skills that are perceptually, cognitively, or manually more stringent than others and where an increased clinical expertise is called for. Alongside this analysis one can identify clinical skills which are used relatively rarely and which are consequently rare. Some examples are given:

1 skills in data collection with some categories of psychiatric and geriatric patients may be more difficult than with other categories of patient. Special techniques such as the analysis of 'process recordings' are being evolved. Similarly work done on communicating with the aphasic patient in intensive care units has indicated special methods may have to be developed;

2 the assessment of nursing needs of chronic and long term sick is in some ways more difficult than the assessment of needs in routine admissions for cold surgery. The assessment of psychological and spiritual needs of the terminally ill setting appropriate objectives for care is exceedingly difficult. The ability of the district nurse to assess the family's ability to contribute to care either physically or psychologically is more difficult than giving routine care. The ability to assess in intensive care nursing may only become expert after considerable experience;

3 the planning phase is a particularly complex one and has traditionally been undertaken by the most experienced clinical nurse. The prescription of nursing care can be routinised in some cases but a greater depth of knowledge and experience is required to make an adequate prescription, for example in geriatric and intensive care nursing. The aspects of clinical management which involve the management of the nursing team are complex because of the

mobility of the team. The co-ordinating role has increased in importance because of increased patient turnover, admission and discharge procedures and therapy from many professions needing to be integrated. Although in this aspect the work volume has increased, some of it is not difficult and is increasingly delegated to clerical staff;

4 nursing actions have shown a shift in their complexity. A great many 'routine' tasks remain to be done (and are often neglected!) but with the increasing emphasis on self care the routine skills in maintaining hygiene are not so frequently performed. The nurse is sometimes inadequately prepared to care for the 'ambulant' patient. Scottish Home and Health Department work has shown that more chairfast than bedfast patients get bedsores. It may be more difficult to assess the disabilities of an ambulant patient than one who is wholly dependent. There is no doubt too that nurses have an 'extended' range of skills in the technical and scientific sense in intensive care units. Alongside this her skills are expanding in psychological support of patients and teaching them to live with disabilities. Extended and expanded roles in nursing have developed with greater expertise in both these aspects;

5 evaluation techniques have been poorly developed in nursing and a great deal of care takes place with no foundation in 'proven value' or scientific rationale.

Present Developments in Clinical Nursing Roles

The traditional roles in clinical nursing are that of staff nurse and ward sister with assistance from nurses in training (who carry out most of the nursing action) and untrained auxiliaries.

In the previous paper an attempt was made to show that these roles have not been adequately developed to meet present demands on the nursing service. Reports from the Lancet Commission (1932)[1] onwards have demonstrated the unsatisfactory nature of clinical nursing. More recently reports such as those from the Platt Committee (1964)[2], Briggs (1972)[3], Prices and Incomes Board (1968)[4], Nurses in an Integrated Health Service

SHHD (1972)[5] have all emphasised the changing nature of clinical nursing which has been unmatched by proper clinical career development of the nurse.

Certain developments have however taken place in posts which indicate a demonstrated need.

Some have segregated part of the traditional work of the ward sister. Beside the clinical role (the content of which is analysed above) the ward sister has a responsibility for administration and the clinical teaching of students and pupils. In the early 1960s the King's Fund conducted an experiment in the use of 'housekeeping ward sisters' who carried the major administrative load of the ward and liberated the ward sister for clinical work. They were superseded when much of the 'hotel management' aspects of nursing were given to domestic supervisors. In the early 1960s the role of clinical teacher was developed to supplement the ward sister's role in clinical teaching. This was an expediency because of the lack of time to teach experienced by most ward sisters. The delegation of clinical teaching to as few as two people in a hospital can be questioned for its educational value. The clinical teacher is however on a higher salary grade than the ward sister and this could be seen as a career advancement in clinical nursing even though it is often removed from the full range of responsibility for patient care (assessment, planning and evaluation).

In district nursing and health visiting specialised roles have developed by concentration on one aspect of the generalist role. For example, in Birmingham a specialist district nurse followed up paediatric patients. In Cardiff there were specialist health visitors for the care and after care of groups of patients such as cardiac, asthma, paediatric, tuberculous, psychiatric, mentally handicapped, diabetic, etc. Specialities developed where there was a special need for more intensive work with special knowledge and expertise. These staff were used as consultants by the generalists.

Some ward sisters have developed special knowledge and expertise in certain fields of nursing. Their specialist function is recognised by other nurses and they are used on a consultancy basis within the hospital group

or even more widely in an area. Three examples were studied in the Manchester AHA Central District in the early 1970s:

1 a ward sister with special expertise in nursing of head injuries was widely consulted. Her expertise lay in her ability to assess and prescribe more adequate nursing care than the generalist nurse could do;

2 a second example was in the casualty/orthopaedic department who had developed special expertise in the nursing of orthopaedic patients, the application and care of plasters and who was consulted by other sisters;

3 a third example was in a small psychiatric unit in the group where an experienced psychiatric ward wister was freely consulted by sisters of acute general wards in respect of patients with behaviour problems.

An attempt was made to develop a consultancy role beyond that of ward sister. The first ward sister was relieved of ward administration and advised throughout the hospital on nursing problems of neurosurgical and head injuries patients. The source of her work was analysed. Some came from referrals from other ward sisters, some from her independent assessment of the care being received by such patients. Her clinical expertise was such that advice was accepted. The second and third examples were promoted to nursing officer level but maintained a large clinical content in their role.

Certain specialised clinical roles have developed which transcend the ward boundaries and are used on a hospital or area basis. For example, many hospitals now have an infection control sister who advises the other sisters and conducts surveys and trials. Nurses who specialise in stoma therapy are now employed on an area basis. They have a more specialised knowledge of available equipment and expertise in its application and skill in meeting the psychological needs of patients with stoma.

Many districts and areas are now recognising the need for a career in clinical nursing and attempts are being made to develop the clinical role of the nursing officer. This has been resisted in other places.

Some districts and areas have recognised the need for research in nursing practice and have established a nursing research post.

Alternative Clinical Career Structures

Given the fact that it is possible to identify aspects of the nursing role where greater knowledge and expertise are required and/or where the knowledge and expertise are of a specialised or rare nature it should be possible to evolve a career structure in clinical nursing. Certain roles have already developed which have received no adequate reward in status or remuneration. The whole position is bedevilled by factors such as the pay policy, sectional interests in the profession, relativities in the pay structure etc. Certain suggestions have however been put forward.

1 **Maintaining the status quo**, i.e. that the two existing roles in clinical nursing, staff nurse and ward sister, should be maintained. This was covertly recommended in much of the medical evidence to the Royal Commission on the NHS. A corollary is usually added that there should be financial inducements to stay in the ward sister grade, i.e. there should be an elongation of the salary scale for ward sisters.

Advantages: these grades are known and sanctified by age. The doctor in particular understands this role and the benefits of a ward sister who relates to him and understands his therapeutic regimes. He resents any interference with this valuable relationship either for promotion or marriage of 'his' ward sister or by a more senior nurse attempting to have any part in the clinical management of 'his' patients.

Disadvantages: the staff nurse role is now a 'non role'. The ward sister's role is confused. She is overloaded with administrative functions and her job satisfaction from clinical involvement is reduced. She is incapable of making adequate assessments and plans of care for the number of patients under her control. Evaluation of care and clinical research is virtually impossible.

2 **The report of the committee on nursing** (Briggs 1972) suggested the following structure for the ward team (para 683):

Nursing aide
Trainee
Staff nurse (registered or certified)
Senior staff nurse
Ward sister

They also suggested (para 684):

> 'We consider. . .that clinical skills above the existing ward sister level should be recognised by enhanced status and reward within the grade or by promotion to nursing officer within the same job as appropriate, by the creation of joint teaching, research and clinical posts and by the creation of special staff posts at various levels in, for instance, clinical research.'

These recommendations were made after a two year study of the nursing profession in depth which was supported by research. The career structure suggested is a logical development of the suggestions for 'nursing and midwifery teams' made in the Briggs Report (C2 paras 122–137). It is a matter of great concern that after accepting the report, the proposed legislation deals only with a structure for nursing education. The more vital aspects of the report on manpower and the clinical role and function of the nurse, have received relatively little attention even though they were presented as an integrated set of recommendations.

Disadvantages: the suggestions in respect of nursing and midwifery teams and patient centred rather than task centred approaches has not been costed. In particular the manpower implications are unknown.

The unrealistic span of control of ward sisters for clinical care was not recognised. No precise job specification for posts beyond ward

sister level were developed.

3 **Proposals from the profession:** in its evidence to the Briggs Committee on Nursing the RCN[6] recommended a career progression in clinical nursing. At a seminar in Leeds Castle a small group of nurses who had occupied consultancy and specialist roles augmented with Canadian and American nurses examined further the concept of the specialist/consultant in clinical nursing. The RCN report New Horizons in Clinical Nursing[7] attempts to outline the need for advanced clinical roles and to define some aspects of such roles and their relationships with others. They outline qualifications for the post of clinical nurse consultant before appointment – experience, proven expertise, and relevant post registration education such as Joint Board of Clinical Nursing Studies courses.

In respect of relationships with the existing nursing officer they say '. . .the job description would differ greatly. . .' However, it would seem possible that a role of clinical nurse specialist might be identified as an intermediate step between that of nursing sister grade 2 and clinical nurse consultant, this role might not differ greatly from that of the established nursing officer except that the greater part of the managerial aspects of the present role would need to be removed and the job description amended accordingly. The nursing sister grade 1 might emerge as the intermediate grade.

In respect of accountability the group found that consultants might operate at Divisional, District or Area level according to the need for the expertise and that accountability would be determined accordingly.

In respect of role relationships they found that the clinical nurse consultant would relate to the nurse managers as outlined above and would act as advisor, consultant etc. to nurse managers at a lower level. She would teach in agreement with the nurse educationalists.

In respect of pay, the group were not prepared to make suggestions in advance of research. The RCN are anxious to mount a research

project to test their suggestions. Their proposed career structure from ward sister upwards includes:

Ward sister grade 2
Ward sister grade 1 } specialists
Clinical nursing officer }
Clinical nurse consultants — Divisional } as required
District }
Area }

4 **Developments in the nursing officer role:** The nursing officer role as envisaged by the Salmon Committee had a large clinical content. This became obliterated by the large management content of the role and the fact that many ex-assistant matrons were absorbed into the grade who had little clinical expertise. Some had difficulty in making any access into the clinical decision making carried out by ward sister and doctor. More recently emphasis has been placed on developing the clinical aspect of the role. In some places clinical nursing officers have been appointed who hold no management responsibilities. The Department of Health have encouraged these developments and are funding a piece of research on the clinical aspects of the nursing officer role.

Advantages: developing a role in the existing structure where the relationships are defined and known would be an advantage. It would not be so great a threat to established management grades!

Disadvantages: the 'Salmon' structure was designed as a management structure for the nursing service rather than a structure suitable for the professional function of clinical nursing. The profession would identify the nursing officer role with the first step in the management structure with little status in its own right other than an intermediate step on the ladder to higher things. It does not identify a distinctive career structure in clinical nursing parallel with those in management and education.

5 **Other suggestions:** clinical nursing structures need a more

fundamental review with a synthesis of the suggestions of the Committee on Nursing and the RCN. It would be arrogant to make suggestions without first stating the need for research (vide the error in the implementation of Salmon recommendations without research).

It is possible to hypothesise the following structure:

Nursing aide
Trainees
Nurse practitioner (a) Generalists — equivalent to present S/N and ward sister 2
Nurse practitioner (b)

These grades would form the basis of ward clinical nursing teams as outlined by Briggs.

Clinical nurse specialist: a specialist equivalent in grading to ward sister 1 or nursing officer. Functions:— clinical expertise in a special area of nursing (medicine, surgery, geriatric nursing, etc.). Expert in special aspects of assessment, planning, care and evaluation, expert in technological aspects. Carries out small-scale research. Teaches in specialty.

Clinical nurse consultant : a specialist whose expertise and knowledge qualifies her to be consulted by other nurses and who gives advice on standards of care. The knowledge base, research and teaching functions are more highly developed. The level of appointment could be at Divisional, District or Area level depending on content and span of consultancy work. The salary would be negotiable on the basis of job content and evaluation up to area level and the lines of responsibility would be dictated by the level of appointment. For example, the role of the Area Nurse (Child Health) would readily be developed into a consultancy role over the whole field of child health in hospital and community.

Advantages: such a scheme needs researching to explore possible job content in greater detail than has been possible with posts which

have grown on the basis of local demand. It would offer a satisfying career structure in clinical nursing to area level. It would enable the present inadequacies of the ward sister/staff nurse roles to be overcome. It would provide a basis for better patient care at ward level and by clinical research; for better teaching of students by expert practitioners; and for the development of nursing as a practice profession.

Disadvantages:

(a) Time and resources for research into roles;
(b) Anxiety at further changes for the profession;
(c) Possible costs to be researched under (a).

However, it need not be assumed that the scheme would cost more. A rationalisation of nursing work at ward level would achieve some savings. Ideally some specialist and consultancy posts would be occupied by nurse educationists (as in medicine) so that the total number of those in post from Grade 6 and over would not necessarily be increased.

Preparation for Roles

It is a basic requirement of such a scheme that education to the level demanded by the post should be required before appointment. It would be virtually impossible for a nurse with the present basic training to develop the clinical expertise required of a clinical nurse specialist or consultant. Appointment without further preparation would bring the scheme into disrepute.

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NURSING EDUCATION AND RESEARCH

Nursing Education

Background

The unsatisfactory state of nursing education has been outlined by successive reports, for example The Lancet Commission (1932)[1], the Nursing Reconstruction Committee (Horder 1943)[2], The Nuffield Work of Nurses in Hospital Wards (1953)[3], The Platt Report (1964)[4], and more recently The Briggs Report (1972)[5]. It is evident that the state of nursing has been so unsatisfactory over a number of years that at roughly ten year intervals a major piece of work is undertaken by a committee which is then debated and abandoned in most cases for financial reasons. It is small wonder that members of the profession have been angry and frustrated at their inability to achieve any major reforms in a matter which so intimately affects patient care. In particular the student members of the profession are most intimately affected by the inadequacies of the present system.

The case for reform has been reiterated in many of the reports mentioned above, but some of the major problems can be summarised as:

1 the ambivalent position of the nurse in training both as learner and worker. The clamant demands of service to patients must always take primacy over the educational needs of the student and moral pressures are brought to bear on students and educationists to sacrifice adequate professional preparation for the future to present crises. Because the hospital service tends to be organised on a perpetual crisis basis few students experience a planned and integrated learning experience. The result is that patients receive inadequate and even dangerous standards of care from both inexperienced students and inadequately trained staff.

2 inadequate supervision. Because there has been an increasing dilution of the proportion of trained to untrained staff there is inadequate

supervision. Hunt (1974)[6] showed that after being supervised only once or twice in the school the student may be supervised once in the ward in the performance of critical procedures. Errors rather than good practice are re-inforced. A study of industrial schemes of apprenticeship show that where accuracy (printing) or safety (gas industry) are concerned, strict ratios of apprentice to journey man are laid down often on a one-to-one basis. In nursing where there are many critical aspects to the work, one trained nurse may be leading a team of seven or more 'apprentices'.

3 the present system of training is an inadequate preparation for work in an integrated health service.

4 those areas of health care which have been identified as priority areas receive less than adequate attention in the training programme. There is emphasis on training for acute specialties whereas the main volume of work is in chronic and long term disease, geriatric and psychiatric nursing. Little work has been done to change the training programme in these areas from a custodial to a therapeutic approach.

5 an undue emphasis is still given to education for physical care rather than total patient care including training in communication skills and the psychosocial aspects of caring.

6 education is often inadequate for the role of the nurse in more highly specialised work in high technology areas of medical care and advances in medical practice are inadequately supported by advances in nursing practice.

7 because of the complex nature of nursing skills calling for an integration of cognitive, affective and psychomotor aspects in a single nursing function, the correlation of theory and practice in training is essential. Research (Bendall 1975)[7] has shown how inadequately this is accomplished. Her work indicates the need for an entirely different approach to the teaching of nursing.

8 in previous papers the growth of specialist and consultant roles in

nursing which demand a system of continuing education has been indicated. This is inadequately recognised and developed. The work of the Joint Board of Clinical Nursing Studies has been limited by lack of available finance for secondment from area health authorities.

9 the six fundamental problems outlined in paragraph 212 of the Report of the Committee on Nursing (Briggs 1972) still remain.

The Report of the Committee on Nursing made fundamental proposals for a reform of nursing education. Paragraph 253 summarises in broad terms some of the considerations at the back of their proposals. In brief they state the need for:

(a) a broad basic preparation suitable for work in an integrated service with emphasis throughout on community nursing;

(b) careful integration of theory and practice;

(c) a continuing process of professional education through Certificate to Registration to Higher Certificate stages;

(d) that each step in the career should be dependent on attaining the education and experience necessary for the level of responsibility;

(e) that the emphasis throughout should be on comprehensive patient care.

The report dealt in detail with proposals for changing the learning environment and the status of the learner. Perhaps the most fundamental proposals were in respect of the teachers of nursing since without adequate preparation and sufficient numbers of enlightened teachers the whole scheme is incapable of implementation and the resultant continuance of a poor quality of patient care inescapable.

For professional, political and economic reasons there have been long delays, in gaining acceptance of the Briggs proposals; in costing; in framing legislation; and in gaining time in the legislative timetable. Only that part

of the report concerning the structure for nursing education has been taken on and little progress has been made on the manpower aspects. Given legislation implementation cannot be earlier than 1980 by which time much of the thinking may be outdated and will certainly need review.

Some of the most urgent needs are:

(a) a review of the status of the learner (undertaken by a sub-committee preceding legislation).

(b) more adequate supervision by trained staff including tutors in clinical practice.

(c) research into methods of education aiding the integration of theory and practice.

(d) more adequate financial provision for continuing education for JBCNS and other courses in specialist nursing, health visiting and midwifery roles.

Nurse Teachers

As has been stated, the training and recruitment of an adequate number of enlightened teachers is pivotal to the future of nursing education and the picture is not encouraging. Two articles from the General Nursing Council research unit Sims (1976)[8] and House & Sims (1976)[9], indicate that recruitment has not been successful in building up numbers to anything like those needed for the implementation of the Briggs proposals, coupled with a vast undermanning in the grade of tutor and a general dissatisfaction amongst nurse tutors. Subjectively, there seems to have been a movement of some of the most able and committed nurse educationists into management. (The career structure in nursing education is not as rewarding as that in management). The most urgent needs are:

(a) for recruitment to the grade of tutor.

(b) a more adequate career structure for nurse teachers.

(c) a revision of the method of preparation of nurse tutors so that they can teach more adequately in a clinical setting.

(d) a healing of the breach between service and education to which joint appointments might make a contribution.

Nursing Research

The Briggs Committee drew attention to the need for research in nursing and an appreciation of research by the practitioner of nursing, in fact that nursing should be a 'research based profession' (para 370).

Whilst there has been a healthy growth in the number of research appreciation courses and the research content of JBCNS courses is giving the profession an awareness of research, a great deal of fundamental work on methods, equipment and the management of patient care remains to be done.

Simpson (1971)[10] indicated that nursing in the UK had been starved of research for 100 years since the days of Miss Nightingale. We are now making up lost time, but the studies in clinical nursing which have so far been undertaken are of necessity descriptive studies and nursing as a practice discipline is in need of studies which will provide prescriptive data.

A few nurses have been prepared as researchers but the growth of ability is necessarily slow. If nursing is to enter the 20th century in the methods it employs then this is an essential growth area to which resources must be given. Research and Development should receive high priority in the allocation of resources.

Whilst the growth of departments of nursing in universities and polytechnics are a natural focus for research developments these need to have real base in clinical nursing. The greatest problem is perhaps the gap between researchers and practitioners and the need to develop strategies

of implementation of findings.

One of the ways of encouraging a growth of knowledge is by the nurse practitioner herself researching in her own specialty. This demands awareness, adequate preparation and supervision. The number of nurses qualified to supervise research undertaken by others is at the moment small and joint supervision by nurses and other disciplines is sometimes of value.

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QUALITY OF NURSING CARE

Introduction

The principles of quality assessment and control are relevant to all health care professions. Quality studies carried out by the Nursing Profession have followed similar typologies of evaluation and met similar difficulties to those experienced by the Medical Profession.

Review of Work to 1967

A critical review of the literature associated with the quality of nursing care was made in 1967 (McFarlane 1970)[1]. From over 200 references, 54 studies were isolated in which attempts had been made to develop criteria of quality for nursing care. These fell into two main groups:

(a) Criteria of nurse performance

(b) Criteria of patient welfare

The nurse performance criteria were developed by a variety of methods. In the majority, experienced nurses drew up descriptions of nurse behaviour at different levels of quality. The descriptions were validated by a jury of experts. Nine studies used Flanagan's critical incident technique in which descriptions of 'most effective' and 'least effective' nurse behaviours were collected from patients, nurses and other personnel. Two studies collected incidents of omission of care and others studied nurse-patient interaction and equated quantity of interaction with quality of care.

Criteria based on patient welfare (outcome measures) were developed in only 17 studies. Aydelotte (1962) for example used 15 patient welfare measures in three categories:

1 Clinical Measures
   (a) Days in hospital

(b) Days of fever
(c) Days post-operative
(d) Narcotics and drugs used

2 Scaled Measures
(a) Mental attitude
(b) Physical dependence
(c) Special aspects of independence
(d) Mobility
(e) Skin condition
(f) Opinion of care
(g) Physician's evaluation of condition and progress

3 Sampling Measures
(a) % time in bed
(b) % time in chair
(c) % time up
(d) % time in communication and occupied leisure

Quality of Nursing Care: English Project

This review of the literature was carried out as a preliminary to a research project 'The Study of Nursing Care' which was sponsored by the DHSS with the objective of developing criteria of nursing care. The cost of the project was well over £100,000. The interest of the Department of Health grew out of studies of the deployment of nurses which had revealed that in certain similar nursing situations in which many of the variables were constant, there were as many as three times the number of nurses employed. But any effective staffing methodology needed not only a measure of the quantity of nursing care to be performed (available through dependency studies) but criteria of quality which were non-existent. The development of criteria of quality was therefore seen as an essential management tool in the effective deployment of nursing staff. Such criteria were also needed if any evaluation of new methods in clinical nursing care, management or educational systems was to be possible.

Significantly all the studies which were reviewed were carried out in either

the USA or Canada, with the exception of one in New Zealand. The only English study which contributed in any way to the problem was that by Revans (1964)[2].

The Study of Nursing Care Project was thus the first English attempt at developing measures of the quality of nursing care. The Steering Committee was at first of the view that one of the major American studies by Reiter and Kakosh (1963)[3] should be replicated and tested in English nursing. More intimate acquaintance with the conceptual difficulties associated with quality measures diverted us from this intention. The study by Reiter and Kakosh was a monumental work which took six years and from which a very cumbersome tool describing nursing performance at three different levels of care was developed and validated. We might have spent six years on a similar English study and achieved little more. Additionally, the usefulness of nurse performance (process) measures was questioned, as against patient welfare (outcome) measures. It was therefore decided to use an approach which would identify those factors which contribute to the quality of nursing care.

The project was conducted so that three groups of six research assistants were appointed for two years each over a period of six years. Since the quality of professional practice was being assessed, nurses were appointed. At that time (1967) few nurses had had any experience in research, so the first three months of their programme were spent in an intensive course in research methods. Thereafter they selected a topic of study which in their professional experience they had found held factors critical to the quality of nursing care. Inman (1975)[4], in summarising the six years of the project, says that a total of 46 instruments involving 35 criterion measures were developed in the 18 studies. These were in widely disparate aspects of nursing care such as pre-operative fasting, pain control, nasogastric feeding, emotional support of children in hospital, admission procedures, dressing techniques, etc. Because the studies were so widely dispersed it was not possible to build the criterion measures into a scale, but the publication of the reports has made a major contribution to the quality of nursing care, in that nurses have been alerted to practices which result in poor quality nursing care and some potential criteria of quality are now available.

Developments Since 1970

Because of the conceptual difficulties involved in developing any scale of quality of nursing care, the number of studies emanating from North America has decreased perceptibly since 1970. Instead there has been a greater emphasis on audits of nursing care and quality assurance programmes in nursing. These often form a sub-system in the Professional Standards Review Organisation (PSRO) which is mandatory under Section 249F of US Public Law 92-603. The legislation requires ongoing quality assurance programmes laying stress on health service processes and outcomes.

The current literature such as Lang (1976)[5], Froebe and Bain (1976)[6], Aydelotte (1973)[7], Wandelt and Ager (1974)[8] describe quality assurance programmes (QAP), namely programmes 'designed to determine the extent to which a practice achieves selected objectives based on specified values. . .explicitly stated in terms of standards and criteria'. A quality assurance programme includes establishing standards, assessing practice in the light of standards and subsequent change in the behaviour of the organisation and professions where indicated. Standards have to be established in the structure, process and outcome aspects of the care provided as suggested by Danabedran[9].

The question of outcome measures is extremely complex and Hagen[10] cautions that evaluations should be explicit about the frame of reference they are using before drawing inferences. A decision has to be made as to whether the frame of reference is the individual patient, the family, the caseload of a single professional, or professionals in various relationships to each other, or an institution.

Quality Controls at Present

Finally it may be profitable to review some of the approaches to quality control used at present which in the language of the Americans form part of a Quality Control Package (QCP) which needs to be further developed.

Structural Evaluation: just as the medical profession has certain structural

controls, so these are mirrored in nursing. They include the policies of a ward, department, or Area, the Registering body (GNC) with its educational and disciplinary functions, the bodies responsible for post-basic nursing education, legislation and legal sanctions. Professionals would stress the importance of education at basic and post-basic levels, as a major contributant to the quality of care. Whilst a system of post-basic nursing education is developed in the UK it is still not mandatory before practice.

Process Evaluation: perhaps the greatest advances have been made in this aspect of quality assurance. North American nurses, and increasingly, English nurses, are evaluating the adequacy of nursing care in terms of the use of the stages of the nursing process (Assessment, Planning, Implementation, Evaluation). Standards have been developed which delineate adequacy of performance in each of these stages. In the use of this decision making process the plan of nursing care is based on an assessment of the patient problems. Objectives (expected outcomes) for care can then be set to meet these problems. If these are stated explicitly in behavioural terms, they form the basis of subsequent evaluation of nursing action in terms of whether the expected outcomes have been achieved. Hence a precise objective for fluid intake or mobility can be evaluated over a relatively short period. In this respect the evaluation of nursing care may be more immediate and ongoing than is possible in the evaluation of medical care, although there will be long term goals in addition to those evaluated over a shorter term.

The Problem Oriented Record is a tool of this approach to planning and evaluating nursing care. In the Department of Nursing, University of Manchester, problem oriented nursing records have been developed and these have become a tool of ongoing evaluation of the quality of care measured in terms of patient outcomes. Ideally, an integrated Problem Oriented Record for use by all health professionals could be developed but the content of design of the nursing contribution needs testing.

Other approaches which concentrate on process include:

(a) The Slater Nursing Competencies Rating Scale [11] and the Qualpac

scale based on it. The latter lists 68 items delineating actions by nurses arranged according to the primary scientific basis for nursing care.

(b) Audit of the ongoing care received by a patient.

(c) Audit of the nursing records after discharge.

Some very tentative developments in nursing audits have been made in the UK.

Such tools can be used for self-evaluation or subordinate evaluation, individual or unit evaluation and have many management uses.

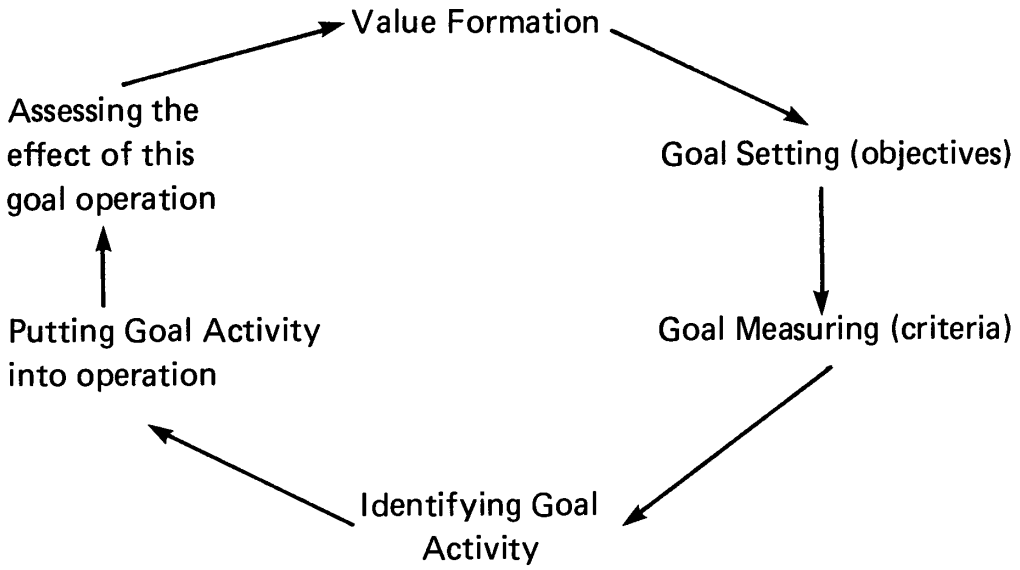
Outcome Evaluation: attention is drawn to the importance of outcome measures in evaluating health care. But there are difficulties attached to their development. Most evaluate the function of the team rather than individual professionals, but as stated above the problem oriented approach with stated objectives provides a link between professional action and patient outcomes which it is important to establish.

It enables a more realistic evaluation of nursing care in, for instance, terminal care, when many of the scaled measures of patient outcome may indicate a deterioration of care whereas a stated objective 'to achieve a peaceful death' may well be accomplished at a high level of quality. Undoubtedly, part of the quality assurance package should include measures of patient satisfaction with care.

Evaluation by Whom for Whom?

This returns us to the statement by Suchman (1967)[12] that 'Evaluation is basically a judgement of worth – an appraisal of value' and 'The process of evaluating is highly complex and subjective. Inherently it involves a combination of basic assumptions underlying the activity being evaluated and of personal values on the part of both those whose activity is being evaluated and of those who are doing the evaluation'. He outlines the evaluation process as starting explicitly or implicitly with value formation

which precedes the setting of goals.



There is a dilemma in health care delivery as to whose values should form the basis of objectives, those of society, the patient, the professional, the team, the institution. In the evaluation of management training, Hessling (1966)[13] suggests a typology of evaluation based on the questions 'by whom and for whom?'.

Conclusion

Measuring the quality of nursing care is as complex as measuring the quality of professional practice in any field but it is an essential tool of accountability and control. Nursing would benefit from a far more precise statement of standards in the structural category, for instance in continuing education and minimum staffing levels for safety. Greater mileage may be achieved by the ongoing evaluation of care by use of the problem oriented record with a clear statement of objectives. Some nurses are apprehensive about the time that such an approach demands in making an assessment and writing objectives. In the ward unit run by the Department of Nursing, University of Manchester, it has been found that with no extra staff it is possible to use this method, writing down the plan of care achieves better communication with the ward team. Such records form a more adequate basis for the retrospective audit of care after discharge.

This can be a useful management tool in checking fluctuations in quality of care in a ward over time. The concurrent audit of care is another useful method but it has to be conducted separately from the delivery of care and may not be related to outcome measures.

Whilst it is a proper function of a professional person to evaluate their own performance, it is probably more meaningful to evaluate the work of the team since the work of professionals is in such close interaction.

By some means evaluation by patients should form part of the quality package which I suggest should have some of the following elements:

(a) An adequate assessment system (nursing history)

(b) Problem oriented records

(c) Written care plans

(d) Clinical nursing 'rounds' and care conferences for review of outcomes of care

(e) Audit of nursing performance and patient outcomes

(f) Patient satisfaction studies

The implementation of a quality assurance programme cannot be achieved without intensive education of all involved.

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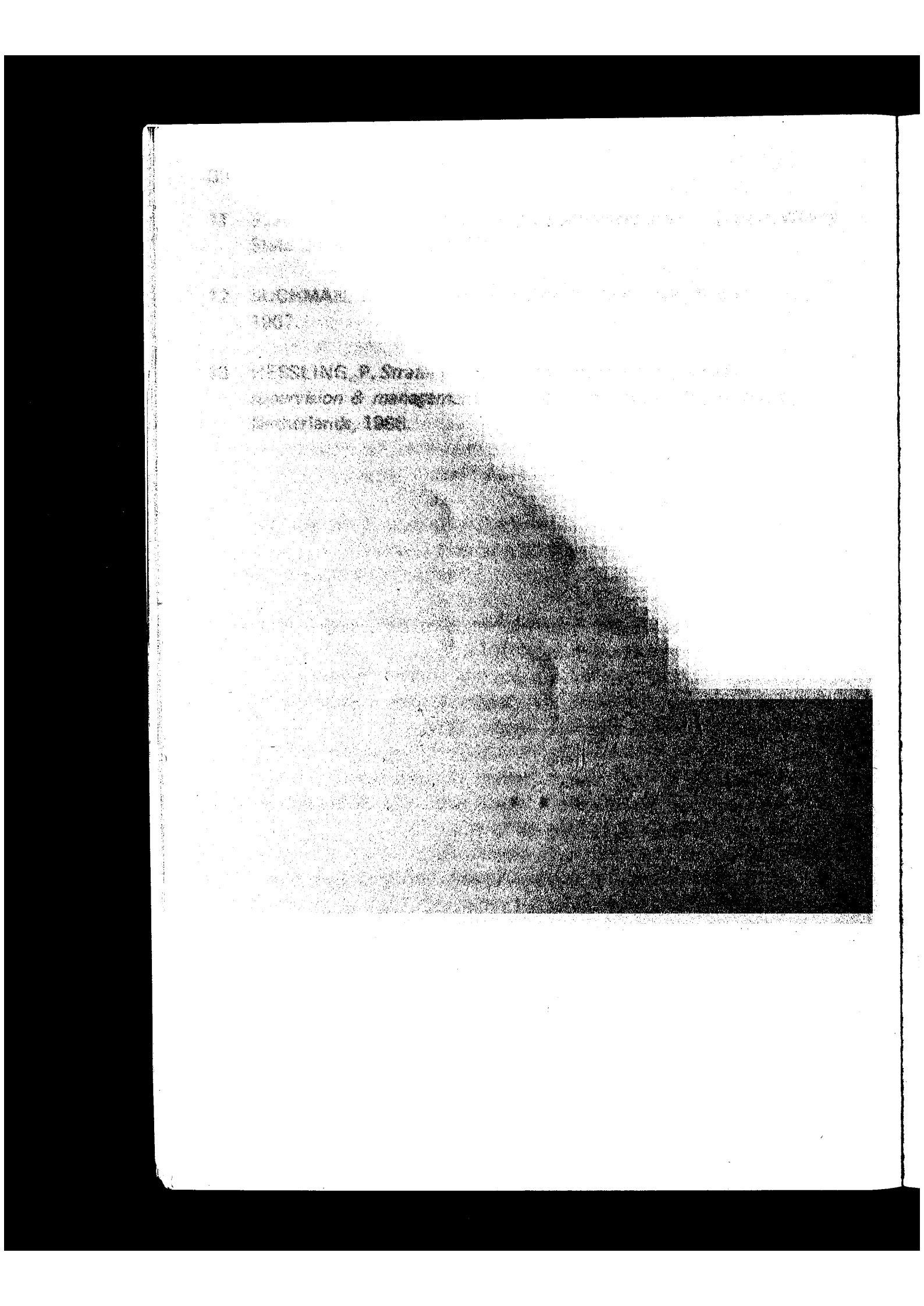

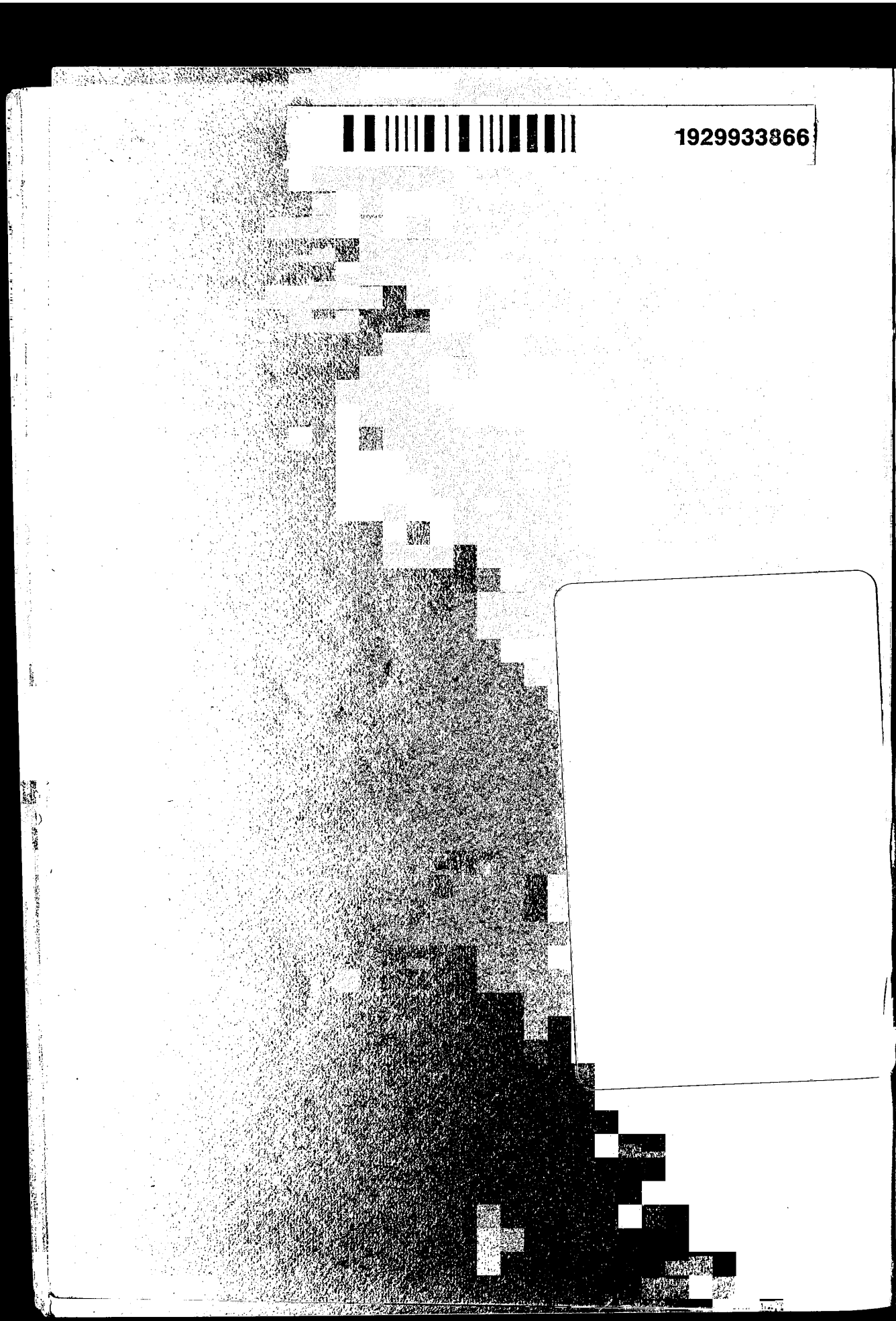
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