in progress ... work in progress ... work

NURSE EMPOWERMENT; PATIENT EMPOWERMENT

Brighton ● Camberwell ● Southport ● West Dorset

Nursing Development Units

NURSE EMPOWERMENT; PATIENT EMPOWERMENT

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KING's FUND CENTRE

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The cornerstone of our work

A retrospective examination of the work of the Camberwell NDU since its conception in 1988 would demonstrate that central to all our work has been the theme of role development. We have defined, refined and re-defined our roles within a chosen philosophy, that of promoting partnership, and within a chosen form of nursing organisation, primary nursing. What has underpinned this development has been the concept of empowerment. A very personal paper by Dalton[1] describes just how fundamental this concept is:

> *The bottom line is empowerment. For staff nurses, empowerment grows out of being valued as professionals in the health care system. In practice empowerment grows out of the confidence we have in our own competence. As we grow in our social and political awareness, as we attain a level of participation in decision making, we will be able to use our individual and collective resources to create an environment for valuing health.*

This paper sets out to examine this concept, to look at how it is demonstrated through the changing roles within the unit and to think about the effect it has on patient care.

An analysis of the concept of empowerment by Hokanson Hawks[2] defines empowerment as 'the interpersonal process of providing the resources, tools and environment to develop, build and increase the ability and effectiveness of others to set and reach goals for individual and social ends.[1] Thus, the concept is about enabling, making possible. She views it as occurring between two or more people, the person who empowers and the person who is empowered, rather than being entirely self-driven. Hawks goes on to describe core ideas underlying this concept which must exist for empowerment to occur. These include: a nurturing, caring

environment with open communication and mutual respect, a shared vision and commitment. When examining the concept within the setting of the NDU, our initial thoughts lay with the nursing roles, but our belief is that in empowering nurses one creates the opportunities to empower patients.

In our situation, it could be argued that on a macro-level the NDU was first empowered by the wider organisation who gave it the freedom to explore and develop in a way that was appropriate for its clients, rather than always being bound by policy and procedure (although, in fact, our development has frequently mirrored the political and professional agenda the organisation has to meet). On a micro-level, all members of the NDU team have been involved as 'empowered' and 'empowerer' as we have sought to redefine our roles and shift responsibilities from one to another in order to provide the optimum service for our clients. The underlying principles of all the role changes have been:

- to increase the amount of registered nurse/patient contact
- to enhance the role of the staff nurse as the primary care deliverer
- to create a structure congruent with the devolution of management to ward level
- to develop new support roles for unqualified staff.

The ultimate aim is to develop a better quality service for patients.

An empowered nursing team

The change in practice on the ward from an ill-defined form of patient allocation — as was the situation in 1988 — to the present

structure, is largely the result of the developing role of the staff nurse. As has already been mentioned, the framework within which these changes have taken place is primary nursing, chosen because of its principles of continuity and accountability. We saw these as important and fundamental to our practice as well as congruent with the nursing team's values.

At the present time, there are no commonly agreed definitions of roles within primary nursing; although based on a similar philosophy and much the same values, the roles of primary and associate nurse are interpreted in very different ways depending on the setting. It is therefore necessary at this point to discuss the way these roles have developed within our unit in order to explore the way in which nurses have further been empowered.

The key care provider to the patient is the *primary nurse*. The primary nurse has two roles: that of clinical manager and manager of staff. The primary nurse manages a caseload of patients but also a team of staff and has clearly-defined responsibilities within each area. As clinical manager, the primary nurse is accountable for the nursing care provided for patients in his or her care. Being accountable for their caseload, primary nurses use their ability and authority to plan the direction of their patients' care. They are also the named nurse manager for the team of nurses working with them to provide that care. As such they get involved in recruitment, orientation, appraisal and development of this group.

The *associate nurse* role has developed alongside this. The associate nurses work for one primary nurse and the opportunity is thus created for learning and development through role modelling. It also enables the primary nurses to ensure that the care they prescribe is understood and carried out, as well as enabling the group of nurses to develop an understanding of each other's strengths in a much closer way than in a large ward team. Looking into the future, this kind of structure would seem to be ideal for

the soon-to-be-qualified Project 2000 nurses, enabling them to consolidate their clinical skills.

The other role which has changed dramatically is that of the *ward sister*. It has become a multi-faceted role devoted to strategic planning, day-to-day management of personnel, resources and teaching, as well as clinical practice, with time allocated to each. Thus I work clinically on only two of my duty spans per week when I then take a case-load as an associate nurse. This, together with methods such as case supervision, enables me to assess performance and standards and also stay in touch with the reality of what the rest of the ward team are facing.

Finally a description of roles on the NDU would not be complete without mentioning the role of *ward co-ordinator*, a new role developed with one of the unqualified staff members, a former nursing auxiliary. We developed this role expressly to begin to address some of the issues thrown up by an analysis of nursing activity on the ward which, in common with numerous other similar studies, demonstrated that a significant proportion of nursing time was taken up with clerical or reception type work. This role combines functions of receptionist and hostess for the ward and has liberated registered nurses from much of the telephone work, ordering and searching for information which formerly made up a great part of their day.

From this, I hope, emerges a picture of primary nurse teams who have been given both the responsibility and the authority to make decisions about a patient's nursing care, as well as a flattened hierarchy resulting in decisions resting with those who actually deliver the care rather than with someone removed from the situation. The empowered nursing team is then in a position to set about practising in line with the ward philosophy which talks about patient partnership.

As the practitioners themselves have grown more confident in their roles, they have become better at marketing themselves and their responsibilities so that now the expectation from the multi-disciplinary team is that this is the norm on the ward. I have been committed to discouraging behaviour perpetuating the model of 'the all-knowing sister'. It has taken a long time to get to this point and to break the cycle of responding to other people's expectations of nursing roles. I believe that anyone else attempting the same change should not underestimate the size of the necessary attitudinal change.

Confidence in our competence ...

The key to this achievement has been the development of our Individual Performance Review process. This process clearly demonstrates the flattened hierarchy within the ward. With the primary nurses appraising their own staff, they are in a real position to influence outcomes for their client group. The IPR process focuses very clearly on skills, enables individuals to identify their strengths and deficits and matches skills to the role. An associate nurse promoted to the post of primary nurse, for example, was given opportunities to further her skills in counselling and assertiveness in the transition phase. She had identified a different level of skill as essential to her new role.

In order to develop new roles and skills, nurses need time. In a climate of financial restraint, time is a very valuable commodity. We have achieved this by using monies given to the NDU project by the Department of Health to undertake internal evaluation. This has enabled us to employ Doreen Brown, a D grade staff nurse, for two half-shifts per week. This means that for every shift Doreen is on duty, one of the rostered staff is free for the whole shift for development work. The concept of 'Doreen time' is now

firmly enshrined in our working and highly valued by all the staff. Funds have been found within the nursing budget to enable 'Doreen time' to continue beyond the Department of Health support, so important is this seen to be. It makes good management sense; a small-scale financial investment (less than £5000 a year) for potentially a large return.

The other factor which has been important has been the legitimising of the authority of the primary nurses within the organisation. Now, in the situation where the 'named nurse' concept is on everyone's agenda, this presents few problems but initially it was difficult. In other areas, for example, nurses on a similar grade were acting as deputy sisters and the expectations by the organisation for people holding this title were fairly clear. The title 'primary nurse' was foreign to the organisation four years ago and a great deal of explanation was necessary before it was understood. Credibility for these practitioners in the eyes of the organisation was won by demonstrating their expertise in various practice forums. For example, one of the primary nurses has made a significant contribution to the wound management policy team. Job descriptions were designed and re-designed in conjunction with the nurses so that the specifics of the roles were clearly stated and there could be no confusion about them in the eyes of the organisation.

Thus we have employed a variety of means to promote the empowerment of nurses within the team. The next thing to consider is the effect that this empowerment has had on the patient.

...to provide an optimum service

The tension between caring and empowerment is considered at length by Malin and Teasdale[3]. Such tension should be familiar to

all nurses as the perception among the public of nurses as 'doers' rather than 'enablers' still holds strong. Empowerment, as Malin and Teasdale point out, 'implies that the nurse must maximise patients' independence and minimise their dependence'. However, blanket enforced participation is as reprehensible as enforced doing. The skill, of course, is the creation of relationships between nurse and patient which are based on mutual trust and respect. In such circumstances real empowerment can emerge and difficult situations can be confronted and decisions reached.

An example of this from our own practice is when one of the primary nurses reached a decision with a patient and her family for the patient not to be turned regularly to remove the pressure in the last days of her life, but to let her remain on her back where she was most comfortable, in spite of the very real likelihood of skin breakdown. In this situation both the nurse and the patient were sufficiently empowered to reach a decision and carry through practice contravening the norm. The nurse had established real partnership with her patient and had the authority and the organisational support to carry through such a decision. This aspect of partnership with patients has enabled nurses to act as patient advocates beyond the limiting definition of the advocate as spokesperson to embracing some of the more philosophical aspects of the role. Gadow[4] calls this 'existential advocacy':

> *Advocacy is ... the effort to help persons become clear about what they want to do, by helping them discern and clarify their values in the situation and on the basis of that self-examination to reach decisions which express their reaffirmed, perhaps recreated, complex of values.*

The way the ward is organised facilitates this partnership as does the underlying philosophy. A great importance is placed on the interpersonal skills of nurses and on their spending a great deal of time talking with and listening to their patients. We would define

'being busy' very differently, I suspect, from many comparable practice settings. Certainly the reaction of many of those practitioners, who come to work alongside us to find out more about our work, would tend to support this.

A springboard for development work

The rate of role change is now slowing down, but the new roles have themselves become a springboard for other development work within the unit. On a macro level, the consultancy work the unit is doing for the rest of the organisation in respect of the 'named nurse initiative' has come directly from this work. Time is spent discussing the concepts of responsibility and continuity (rather than preaching about wholescale conversion to primary nursing). Similarly, the work we have been involved in in planning staffing for new initiatives has its roots in our own work on roles. Work we have done on discharge planning is also clearly tied up with roles and relationships.

And so to the future: the continued devolution of responsibilities to ward level, the accompanying alteration in the sister's role, and the debate about how health care in London should be delivered in the future will all have an impact on how roles will develop in the NDU. We need to continue to examine our practice, further refine our roles, and explore the NDU's role as a provider of health care and be responsive to changes in demand.

We make no claims that the work we have outlined in this paper is unique to our setting. We know of many other practice settings which are treading the same path and which share our philosophy. Some are behind us and some of them are ahead. However, the purpose of this paper has been to demonstrate the importance of the development of our work as an NDU. The empowerment of nurses and partnership with patients really has been the

cornerstone of our work, both as an end in itself but also as a means of generating new ideas, and it is in this light that we have wanted to share the work.

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This series looks at some of the ways nurses in Nursing Development Units (NDUs) have tried to make their nursing more beneficial for patients. The nurses assess to what extent their initiatives really do contribute to patient well-being and what has helped them bring about the changes. Each book will help nurses to introduce new ideas to their work and will suggest ways to evaluate changing practices.

The four NDUs which have contributed to this series have been supported by the King's Fund Centre and the Sainsbury Family Charitable Trusts since 1989 as part of a three-year project. A further 30 new projects have just received funding from the Department of Health and join the growing network of Nursing Development Units.

In this booklet, Amanda Evans, a ward sister, examines the new roles that nurses are taking and their impact on the nurse and patient.

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