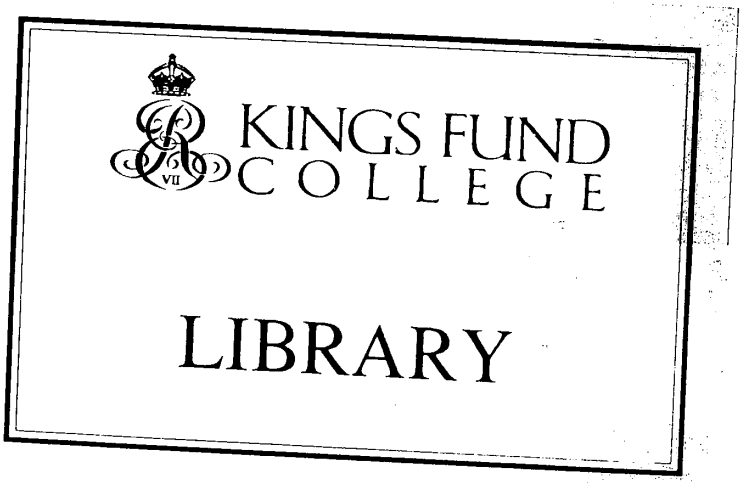
THE DEVELOPMENT OF A NURSING-LED IN-PATIENT SERVICE

AMANDA EVANS • PETER GRIFFITHS

KING's FUND

Nursing Development Units



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

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Foreword

The establishment of a service which provides in-patient beds for people who primarily need nursing and which are managed by nurses has been piloted in a number of settings over the last thirty years. The Loeb Center for Nursing at the Montefiore Hospital in The Bronx; the Burford Nursing Development Unit; and the Oxford Nursing Development Unit have all pioneered nursing beds and subjected them to rigorous evaluation. In all three units, there were significant benefits for staff, patients and health services. However, in spite of these positive results, the introduction of nursing beds on a larger scale has never occurred and why this is so is both intriguing and disappointing.

I am particularly pleased to see that previous work on nursing beds is now in progress at King's. As well as replicating this previous work, this publication demonstrates an expansion of the work which takes it further. The need to replicate and test innovation in nursing is critical if we are to make nursing's contribution to health and healing more explicit. More importantly, the provision of innovative services and the development of new practices for the seekers of health care in times of economic rationalism and crisis in health care is both timely and essential.

This initiative represents another example of nursing's capacity to respond to the needs of people and of the ability of nurses to pioneer new ideas in a climate which often restricts innovation.

I congratulate the authors of this monograph, Amanda Evans and Peter Griffiths, on the vision and effort expended on the real work of introducing such a radical approach to care provision and on the clarity with which this project is described. The need for nursing to demonstrate its effectiveness has never been greater, and this work serves as an excellent example of how this can be done.

Alan Pearson,
University of New England, Australia

1 Background

The development of the nursing-led service on Byron Ward, Nursing Development Unit (NDU) King's Healthcare came about as a creative response to internal reorganisation which was threatening the continued viability of the NDU: an alternative service had to be developed if the unit was to survive. The NDU's response to this challenge was a proposal to develop a nursing-led service to meet the needs of clients within the medical directorate to whom the beds 'belonged'. This service would consist of a nurse-managed in-patient service on Byron Ward, and would be aimed at reaping benefits for patients on one side, and for the organisation and nursing on the other. The *raison d'être* of an NDU must be to develop and promote practice, to test out new approaches and to apply them in ways congruent with local need. This project would seem to be entirely consistent with such aims.

As an established development unit (supported as one of the 'first-wave' NDUs by the King's Fund), Byron Ward was ideally positioned to respond to the challenge of developing an autonomous nursing service. The unit had a proven track record with considerable managerial and clinical expertise, and the well-established system of primary nursing had already enabled nurses to make considerable strides in developing their roles as autonomous accountable practitioners. Research expertise and funding (from the King's Fund, King's Healthcare and South-East Thames Region) also placed the unit in a unique position to fully evaluate the outcomes of the service for its patients.

On 1 February 1993, following much negotiation and planning, the NDU began to accept patients to the ward under the care of nurses.

THE CASE FOR A NURSING-LED SERVICE

For many patients, there is a change in need as their hospital stay progresses. In the acute phase, their primary need is for technical intervention, medical diagnosis and treatment. However, as the hospital stay goes on, the patient's needs frequently shift towards education, rehabilitation and nurturing. For these patients, the role of nursing also alters through the stay to reflect their changing need.

The Audit Commission's 1992 report[1] on the use of medical beds recommended structural innovations in bed use to maximise the efficiency and quality of care given to patients. The establishment of an in-patient nursing-led service is a creative and constructive response to many of the problems highlighted in that report. The report noted that 48 per cent of patients occupying acute medical beds did not need acute medical services. Of these, the majority did, however, remain in need of in-patient care, but their requirements shifted away from medicine. For many of these patients the need for in-patient therapy, as opposed to out-patient therapy, is based on the need for significant nursing care which cannot be or is not provided in the community (see Fig. 1). Preliminary surveys conducted by the NDU showed that within King's Healthcare 30–40 per cent of medical patients fell into this group.

In acute wards, it is inevitable that potentially life-saving medical and supportive intervention (from nursing and other therapists) will take priority over non-acute, educative, rehabilitative and other needs. However, not only will these interventions take priority, but they are also potentially completed to the exclusion of the needs of non-acute patients. For example, a patient with acute chest pain will inevitably take priority over a patient

FIG. 1

TYPE OF PATIENT BENEFITING FROM A NURSING-LED IN-PATIENT SERVICE

❒ **Patients needing education**	For example, those requiring significant input for them to manage complex drug regimes necessary for the management of chronic disease.
❒ **Patients needing rehabilitation**	For example, patients needing to regain their confidence in mobility and self-care following falls.
❒ **Patients admitted for nursing, but who are currently placed in an acute bed**	For example patients with significant wound-management problems.

needing to learn to draw up insulin before his or her supper; in this circumstance, the nurse can step in and give the insulin without the educational input to the patient, in order to create time to deal with the patient with chest pain. While this situation can be criticised and defined as inadequate, the reverse situation (non-acute care to the exclusion of acute) is clearly totally unsustainable on an acute ward. The consequences of this relative neglect are seen in inadequate patient education, poor discharge planning, delayed discharge, failure to comply with medication regimes and consequent readmissions.

Changing the focus of care

Nursing and medical literature suggests that changing the focus of care to concentrate on the patient's altered needs will be of great benefit. Transfer of responsibility for decisions regarding discharge to ward-based staff will reduce length of stay by avoiding administrative delays.[2,3] Early discharge planning can reduce length of stay by 11 per cent.[4]

Nursing-based services have reduced mean length of stay by as much as 50 per cent for a variety of patient groups.[5,6,7,8] This is largely through the mechanism of decreased patient dependency and patient-centred care.

Work by Graham and Lively[9] and Weinberger and Oddone[10] suggests that up to 24.8 per cent of admissions are readmissions, of which nearly half are preventable. Nursing-led programmes of emotional support,[11] education,[12] discharge planning,[13] and rehabilitation[14] can improve long-term outcomes as measured by readmission, relapse, complications and drug regime compliance.

The most similar ideas to those which we were proposing were those tested in Oxfordshire in the mid-1980s as reported by Pearson *et al.*[15] In this unit, a nursing-led service was offered to clients with one of three medical diagnoses:

- CVA,
- fractured neck of femur,
- lower limb amputation.

They were cared for in a unit funded by the Monument Trust and independent from the core hospital services, which appears to have been the root of many of the unit's difficulties.[16] In spite of encouraging findings from the evaluation, the unit was closed in 1989.

The NDU's proposal to establish the nursing-led service within the medical care group was based on the view that patient outcomes for a designated group would improve if for that part of their stay when the primary need is nursing, patients were transferred to a unit led by nurses.

THE CONTEXT OF THE CHANGE

The evolution from an NDU on an acute medical ward to a unit offering non-acute patients a nursing-led service was not an entirely smooth one. The transition occurred at a time of considerable upheaval for all of King's Healthcare.

At the time, acute medical services were divided over two sites – Dulwich and Denmark Hill, South-West London – Byron being a 17-bedded unit on the 'satellite' Dulwich site. A crisis in the ability to provide junior medical cover for both sites led to a proposal to centralise all acute services on to one site, Denmark Hill.

The Byron team felt that a move to Denmark Hill, thus becoming part of a much larger ward, risked diluting many of the strides that had been made on the NDU in the past few years. The unit was given the opportunity by the medical care group managers to contribute a proposal to solve the problems raised by the reduction in medical cover at Dulwich. Among the many proposals and plans being discussed and circulated was one from the Department of Health Care for the Elderly, which envisaged a small 'nursing home' being created on the Dulwich site. Consultation with staff on the unit pointed to a general feeling that they wished to maintain the integrity of the team, which would be threatened by any move to a larger ward on the Denmark Hill site. The idea that the NDU might develop a nursing-led service, something which had been considered previously but abandoned as unfeasible, now seemed more viable. More detailed discussion between the three primary nurses, the NDU leader (then Ward Sister) and the unit's researcher showed an enthusiasm for developing the idea of the 'Nursing Unit'.

The challenge now became one of developing the idea of a nursing-led service into a credible plan for a unit offering positive therapeutic care to patients in need of active nursing.

2 Operation of the nursing-led service

In planning any radical innovation in the provision of hospital services, there is a clear need to develop guidelines for the unit's day-to-day functioning, responsibilities, delivery of patient care and relationships with other hospital disciplines. Many of the issues which can normally be taken for granted, or many of the responsibilities which can simply be handed to another colleague, must be examined and clarified. This is particularly the case when *the innovation involves a shift in the normal power base of provision of all clinical services* – that is, from medicine to nursing.

This chapter outlines the guidelines and operational methods which were developed in the planning stage of the nursing-led service and were subsequently refined during the first few months of the unit's operation. Our system and procedures are still subject to constant review; this is fuelled by the unit's self-evaluation and learning in response to problems which have been identified both internally and externally. Any detail given here should not therefore be seen as a definitive position, but should give a flavour of the central issues and the operational solutions developed by the unit to date.

REFERRAL TO THE UNIT

Medical services at King's Healthcare are provided by three teams of consultants (firms). The unit's key point of contact with the acute wards is through multi-disciplinary team (MDT) meetings held weekly by each of the three firms. A member of the unit team attends these meetings. Referrals are accepted either through these meetings or directly by contacting the unit. Referral forms have been made available on all medical wards in the hospital.

Having received a referral, a member of the screening team will assess the patient according to the unit's criteria. No action will be taken on a referral beyond initial assessment unless, the referral is documented in the medical notes. The criteria are deliberately broad (see Fig. 2). Essentially, at this point we do not know which patients will benefit from the therapy offered by the unit. The key is to identify nursing needs which *might* be alleviated through nursing intervention. A patient's static nursing needs (simply compensating for permanent disability) could and should be met in any ward of the hospital or indeed a nursing home.

Written consent from the patient is not required although all patients are given a full written and verbal explanation of the nature of the service and the assessing nurse is required to document the patient's assent on the screening form. The decision to admit to the unit rests with the nurse screening the patient. The decision is based on the fulfilment of the admission criteria, the availability of a bed and the overall dependency of patients currently on the unit.

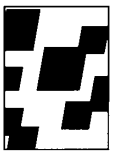

FIG. 2
ADMISSION CRITERIA

1. The patient has been assessed by us as potentially benefiting from continued active nursing interventions.
2. There must be an identified goal for patient care which can be achieved through nursing and other therapy available on the NDU.
3. There are no significant changes in medical management anticipated.
4. The patient has been assessed by medical staff as stable for at least 24 hours.
5. The referral is approved by a consultant physician or member of medical staff to whom responsibility for discharge has been explicitly granted.
6 A stay of more than four days is anticipated.
7 The patient or next of kin gives informed consent to transfer.
8. The patient is over 16.
9. There is an identified target place of discharge.

NURSING CARE

Two primary nursing teams operate on the ward. The primary nurse takes over responsibility for care of patients transferred to the unit. The primary nurse is responsible for assessing the patient, agreeing potential outcomes and planning the care necessary to achieve these. The primary nurse will be responsible for ensuring that the care plan is operationalised, for evaluating its effectiveness and for amending it as necessary in agreement with the patient. Specialists from other disciplines are consulted and involved in care as appropriate in order to meet the patient's needs.

The primary nurse is responsible for negotiating the time of discharge with the patient and the MDT, based on the agreed outcomes for the patient's stay. Patients are generally transferred with a guideline length of stay. Any significant deviation will normally be subject to peer review and, if necessary, review by the referring medical team. A discharge summary is sent to the patient's GP and the referring consultant.

Weekly multi-disciplinary team (MDT) meetings are held on the unit with participation from a variety of other disciplines. There is also a weekly nursing care review meeting with NDU leader to facilitate regular review of each primary nurse's caseload.

Early experiences have shown the need for risk analysis to be allocated a significant amount of this time, as the nurses adjust to taking the responsibility for the discharge decision. The additional responsibility is tangibly leading to increased communication with community staff, both in terms of gathering opinions and handing over information. Research should shed light on whether this transforms itself into improved outcomes.

Roles and responsibilities

Primary nursing was already well-established on the unit, as the method and philosophy of work organisation. The system as implemented here fulfils the organisational principles outlined by Manthey.[17] Responsibility for decision-making has been clearly given to a named individual who holds the operational responsibility for planning and managing the care given to patients 24 hours a day, seven days a week, and also for giving that care when on duty. Continuity of care and direct communication are operational principles underpinning the organisation of the ward. Philosophically, the unit would tend to support Manley's assertion that the relationships between nurse and patient are of value in their own right.[18] The ward philosophy talks about nursing very much in terms of partnership. In order to fully exercise accountability, the primary nurses have been invested with managerial authority for staff as well as for their caseload.[19]

Further extending the role to encompass new responsibilities of managing episodes of in-patient care might be seen as a natural progression. The 'doctor-nurse game' as described by Stein[20], and the subsequent debate demonstrate the extent to which nurses in many settings 'manage' patients albeit 'through' doctors. The experience of the practitioners here would indicate that taking on the responsibility for that management in an explicit and legitimate way does in fact feel very different since the safety net of blanket medical responsibility is removed. No matter how often nurses reiterate the fact that they are responsible for their own actions, the ability to refer decision-making on to others seems to enhance a feeling of security and collective responsibility in some settings. Putting primary nurses in the lead position, thus increasing their responsibilities and making additional demands on their skills, does inevitably increase the level of their stress. We decided to deal with this increased pressure by instituting weekly case reviews as a mechanism for reflection and supervision aiming to be both supportive and challenging.

MEDICAL CARE

The patient population admitted to the nursing unit will have been assessed as *medically stable* prior to transfer. However, 'stability' is a transient concept and it is recognised that it does not eliminate the need for medical intervention, albeit of a changed nature.

FIG. 3
CATEGORIES OF MEDICAL INTERVENTION

- ❒ Medical emergency
- ❒ Non-acute medical intervention
- ❒ Medical contribution to multi-disciplinary care
- ❒ Specialist consultation

The unit's need for regular medical input (i.e. non-acute medical intervention and medical contribution to multi-disciplinary care) can be met from a variety of sources. Various models for this provision have been explored and medical cover is currently provided by a locum GP employed on a sessional basis four days a week (see Fig. 4). As on a general medical ward, the doctor relies on the assessment skills of nursing staff to identify and report any changes in the patient's medical condition requiring action.

The medical needs of our patients are generally non-acute, and the need for emergency intervention is rare. When required, emergency cover is obtained from the normal provision made at the hospital. Should the patient require specialist medical review, urgent or non-urgent, appropriate referrals are to be made, either by the unit medical officer or the primary nurse. Should the patient become medically unstable, care is then transferred back to the consultant physician, or shared with the primary nurse depending on the severity of condition and the needs of the patient. Patient condition, preference, need for specialist facilities and availability of alternative beds all inform the decision as to the most appropriate unit on which to manage the patient's care. The decision ultimately rests with the consultant physician.

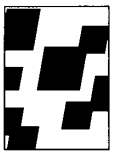

FIG.4
ROLE OF UNIT MEDICAL OFFICER

Medical care

To provide day-to-day medical care for in-patients of the NDU. This will include:

- ❒ Maintaining the patient's prescription sheet.
- ❒ Prescribing medical care for newly occurring minor medical conditions.
- ❒ Examining and advising on any patient at the request of the primary nurse or designated deputy.
- ❒ Facilitating referral to other specialists, medical and non-medical.
- ❒ Advising the primary nurse on the patient's medical care and day-to-day management of the patient's condition from a medical perspective.
- ❒ Advising the primary nurse or other member of the multi-disciplinary team regarding aspects of a patient's medical condition which impinge on nursing or other care.

Multi-disciplinary work

- ❒ To participate in multi-disciplinary case conferences at the request of the primary nurse.
- ❒ To contribute to any multi-disciplinary team meetings regarding those patients whose medical care is significant and any other patients as appropriate.
- ❒ To assist in the development of non-hierarchical relationships between all members of the multi-disciplinary team.

Research

- ❒ To contribute to the development of this model of care through research.

OTHER THERAPY SERVICES

Many of the patients identified as potentially suitable for nurse management will have significant needs for therapy provided by other professions. Referral to other therapists has generally been made by the time the patient arrives on the unit. Mechanisms have been negotiated with each profession individually in order to facilitate new referrals if necessary. The unit is also currently negotiating with pharmacy to develop protocols for the use of certain drugs (for example, wound-care products, over-the-counter medicines, emergency interventions such as IV glucose). All therapy services are invited to participate in the unit's weekly MDT meetings.

Work is progressing with pathology and haematology to develop protocols for the ordering of appropriate investigations by nursing staff, although at the moment requests must still be signed by a doctor.

DOCUMENTATION

Work already undertaken in the NDU has identified problems with the documentation of nursing actions.[21] In spite of the commitment of the nursing team to documentation, and a significant amount of energy and thought being invested in this process, our documentation was still considered to be lacking in several respects. A new approach was felt to be necessary which would more appropriately address the issues of recording nursing interventions and providing an on-going picture of a patient's status.

Further demands

The nursing-led service has made further demands on the documentation. The need for an on-going record of nursing's intervention in response to patient need remains constant, and the problems previously identified remain relevant. What is different and specific to the new responsibilities is the need for nursing staff to systematically review their patients in order to make best use of the medical service available, and to be able to make informed and coherent referrals.

As we saw earlier, patients are accepted as 'nursing patients' on the basis of several criteria, one of which is medical stability; this is identified by the referring medical team and is verified by the nursing team on their assessment of the patient. However, as noted previously, medical stability is often a transient phenomenon, especially for patients coming from acute medical wards. Anecdotally it would seem that the patients being cared for by nurses on Byron Ward are 'sicker' than those referred to the Oxford Unit. This may reflect alterations in the accepted lengths of stay between patients in the 1980s and those in the 1990s, so that patients are being referred to Byron earlier because their expected length of stay has decreased. Certainly, our clients suffer from a wide range of chronic medical conditions, far more varied than the limited groups catered for by the Oxford Unit.

In an acute ward, where medical staff are easily at hand, it may be enough for nurses to alert junior doctors to changes in condition in a non-specific way: 'Mr Smith looks unwell'. However, where medical input is formally dependent on nursing initiation, a far more structured approach is necessary so that nurses can be clear that they are ensuring the safety of their patients.

A systems approach

After much discussion, a systems approach to physical assessment and documentation was felt to be the best way to proceed with this issue. Nursing staff did not want to diagnose: this is beyond the scope of their role. However, there was a clear need for them to be able to identify and articulate deviations from a given patient's norm, and make appropriate referrals based on this information, including requesting medical review. To this end, a flow-chart has been developed which encompasses a systems approach to facilitate referral. Each day, the most senior registered nurse caring for a patient is required to systematically assess the patients and address their current respiratory, cardiovascular, neurological and elimination status. The nurse initials next to the outcome observed. Certain categories (marked in bold to facilitate ease of usage) require action. For example, a clear chest with unlaboured respiration demands no action (see Fig.5).

FIG. 5

TIME:		M	T	W	T	F	S	S
	unlaboured	AE	AE					
	laboured							
	other abnormality							
R	Rate: normal (12–18)	14	16					
E	rapid							
S	sounds: clear	AE	AE					
P	moist							
	cough							
	stridor							
	wheeze							

However, should respiration be deemed to be laboured and moist, then the nurse is expected to document her assessment further and record any action (see Fig. 6).

The intention is to use this framework to identify early signs of medical instability which can be dealt with by the unit doctor – for example, chest infection, or mild cardiac failure. It is also intended to guide nurses to be more specific in their requests for medical advice. Using such a structured form of charting is time-saving, enables trends to emerge and, most importantly, gives a picture of information pertaining to patients that does not necessarily constitute a 'problem'. As such it has begun to address one of the issues identified in our earlier work,[22] that nursing documentation as presently constituted makes no provision for documenting action that is not responding to an identified problem.

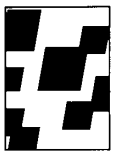

FIG. 6

TIME:		M	T	W	T	F	S	S
	unlaboured	AE	AE					
	laboured			AE				
	other abnormality							
R	Rate: normal (12–18)	14	16	18				
E	rapid							
S	sounds: clear	AE	AE					
P	moist			AE				
	cough							
	stridor							
	wheeze							

Medical notes entry Chest sounding moist, patient complains of productive cough – yellow sputum. Apyrexial. Sputum specimen obtained. Medical review requested.

3 Preparatory work

The preparatory work for the opening of the nursing-led service took place between July 1992, when the service reorganisation was first proposed, and January 1993. The work took three forms:

- negotiation with the organisation,
- publicising and informing,
- preparing the NDU team for their new roles and responsibilities.

We were keen to try to engender a spirit of ownership of the project beyond the NDU, to establish the project as part of mainstream service.

Negotiation with the organisation

Our strategy centred on marketing what we saw as the potential benefits of such a service not only for patients (see Fig. 7) but also for the directorate and the wider organisation (see Fig. 8). Our first 'target' was the care group to whom we 'belonged', the medical care group. We used the established network of meetings to put forward our case and try to stimulate debate as well as talking to the key personnel individually. Issues of beds and bed allocation are among the most sensitive in hospital life. This project did not involve the creation of new beds, but redesignating existing beds from acute medicine to nursing, albeit for some of the same client group. Without the support of the directorate management and their ability to see the possibilities of our vision it is unlikely that we would have succeeded. However, with a clear evaluation strategy built into the proposals, we were able to convince the directorate of the viability of the project.

FIG. 7
BENEFITS FOR PATIENTS

- ❒ Concentration on the patients' changing needs
- ❒ Increased patient satisfaction with the service
- ❒ Increased patient independence
- ❒ Decreased length of stay and readmission

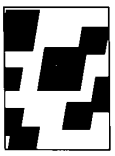

FIG. 8
BENEFITS FOR CARE GROUP

- ❒ Shorter lengths of stay in acute beds
- ❒ Shorter lengths of stay per patient episode
- ❒ Reduction of readmission rates
- ❒ Possibility to become income generating

However, merely establishing a right to use beds in a particular way does not ensure a service can run. Health care is an interdependent business. The numbers of those who had to be informed and consulted with is vast, and includes pathology, bed management, transport, administration as well as therapists, medical staff and other nurses.

With respect to other health care professionals, in the first instance our energies were concentrated on medical staff, as it was from them that we were taking on the beds and our patient population would emerge. We were

met with the whole range of possible reaction, from support and enthusiasm through incredulity and misunderstanding to a small pocket of actual hostility. Our presentations to care group, audit and executive meetings encountered a range of behaviours reflecting such attitudes. Adequate preparation was essential in order to be able to cope with these, and great efforts were made to respond promptly to suggestions and questions. Having subsequently had the experience of seeing a medical team put forward proposals, and witnessing the easy and unquestioning way in which these proposals were accepted, has made us realise how hard nursing still has to fight for the right to be a leading discipline.

As a result of the fact that all discussion and planning was completed in addition to our normal day-to-day workloads, the attention and time devoted to medical staff seemed to be to the detriment of our negotiations with therapists and their managers. Although meetings were held both to inform and to seek support, the first few weeks of the new service's operation demonstrated that we had not fully communicated our message.

It was clear that some therapists felt that they had not been informed of the unit's operation and were under the impression that the unit was crossing their professional boundaries by offering a 'rehabilitation service'. The perception that the unit was operating as a dedicated rehabilitation service raised significant issues for the delivery of therapy services which were not addressed until after the unit's opening. With hindsight many of these problems could have been avoided by more intensive and sensitive negotiation.

Although 'rehabilitation' formed just one potential client group, the potential sensitivity of this issue is illustrated by Gibbon's review of the nursing role in stroke management.[23] Nurses are seen as providers of maintenance care rather than having any therapeutic value in their own right. Articulating the potential role of nursing as something of value in its own right became the key here if nurses on the unit were to 'reclaim' some of the responsibilities the profession had abdicated to therapists.

PUBLICISING AND INFORMING

The decision was taken early in the planning for the project to concentrate on an internal strategy of publicity in the first instance. As an established NDU, the unit was aware of the pressure that external publicity can bring upon individual team members. We were anxious to offer some protection to them in the early stages. However, we were also determined to get the maximum internal exposure in order to generate a feeling of organisational ownership for the project. Thus we took all the opportunities which were available to publicise the project – speaking at meetings, writing for bulletins and holding seminars. The level of response to such attempts was disappointing, especially among our nursing colleagues; but we continued, also offering to speak to teams individually.

In reality, much of the most effective communication has been carried out by those involved in patient assessment on a one-to-one informal basis. However, we do continue to take advantage of the more formal opportunities given to us so as to keep all levels of the organisation informed.

PREPARING THE NDU TEAM

Although the idea for the project arose from discussion among the ward team, suddenly being asked to operationalise such a concept inevitably brought about heightened anxiety. We were keen to address the educational needs of the nurses embarking on this venture, and also to give them an opportunity to explore the underlying issues in a 'safe' environment.

An initial assessment of learning needs focused on increasing interpersonal skills and in making provision for teaching physical assessment skills. Strategies were devised to meet these needs:

- a member of the interpersonal skills team from the Normanby College, the local college of nursing, began work with nurses of all grades;
- the assistance of a supportive consultant physician was sought to begin to teach the techniques of physical assessment.

This latter area has led to some very rewarding collaborative work by the NDU, Normanby College (now part of The Nightingale Institute, King's College, London) and the Department of General Practice in developing a module on patient assessment which will be offered as part of The Nightingale Institute's Higher Award structure.

The team was also given the opportunity for two days 'out' before the start of the project. This provided us with a unique opportunity to be together and explore our concerns and fears. The issues which seemed to cause most anxiety were, as might have been predicted, *accountability* and *responsibility*. We used a re-examination of the team philosophy to begin this exploration, and then moved on to discuss issues pertaining to responsibility and the scope of professional practice. Using imaginary case studies, the team came to the realisation that although there was no established blueprint which could answer all their concerns, they already possessed a considerable body of knowledge and skills which they would be able to use in order to make appropriate and safe responses to these new challenges.

RESOURCES

The project has largely been supported from within existing resources as part of the medical care group. Much of the expertise which was needed to develop the service was already in place within the NDU. The experience acquired during the previous years as one of the first-wave King's Fund NDUs had given the unit considerable skills in managing change. The development of a well-established system of primary nursing ensured that clinical staff were best placed to respond to the additional responsibilities involved in full management of patient care. Some additional support for staff development and continuing education has been provided by The Nightingale Institute. The unit's expertise in quality assurance has enabled ready identification of the evaluation requirements for the project. The central thrust of this evaluation, the outcomes project, was developed from existing work conducted by the unit's clinical researcher, a post part-funded by the original King's Fund grant, and by the King's Healthcare Executive

Nursing/ Quality Assurance Team (ENQT). The research receives academic support and supervision from the Department of Nursing Studies, King's College, University of London.

The major outstanding need was for close liaison and support of medical, nursing and therapy staff on referring wards during the initial period. The innovatory nature of this project required additional input to develop referral mechanisms. Our discussions with those involved in the Nursing Unit at Oxford[24] suggested that screening and advising on referrals require a full-time post in the initial stages in order to ensure the success of the project. We met this need by reorganising the ward establishment so as to allow one primary nurse to participate in patient screening, and to part-fund a new post of project development nurse. The project development nurse's role is to participate in the outcomes research, screening and the development of the referral process. This post secured funding of £4,000 from the regional health authority practice development funds.

Problems in identifying a stable hospital resource for routine medical cover necessitated the employment of a locum GP on a sessional basis.

Nursing beds – a general management perspective

The merry-go-round of constant change continues at breakneck pace in London's health care provision. The challenges this presents are often met with dismay and discord. If a culture can be developed where each challenge is seen as a potential opportunity, then the stage is set for innovative responses and exciting new developments. A major element which must always be taken into consideration when adopting this type of approach is that there will inevitably be successes and failures; but – and it is a large 'but' – if the culture is kept bubbling, real failure can often be averted as the change process remains fluid enough to adapt.

The development of the nursing-beds initiative is an example of a positive response to the challenge of change.

My overriding concern as the general manager responsible was that the concepts and ideals so eloquently expressed could not only be converted into reality but, more importantly, be 'sold' to and accepted by all members of the care group. The care group is a large, diverse and complex entity, encompassing a whole host of parties with particular vested interest; it spans two sites, has over 400 staff, and ranges from providing general medical and health care to elderly people services, through diabetes, dermatology, rheumatology, endocrinology, haematology and haemato-oncology. Hence this indeed was a plan which had all the elements of potential explosive risk.

Other parties also needed to be taken on board, but my feelings were, and still are, that success 'at home' could easily be translated to encompass other concerns.

It may seem strange that I have not yet mentioned money. However, it seems facile to go into detail about a cost-effective service when obviously we would not have even considered supporting this idea had its main components not been designed to provide an improved use of resources and an increased throughput of patients.

While success can be measured on a variety of levels, at the most basic the pressure is on to quickly demonstrate efficacy on the terms set by peers in the care group, leaving the more esoteric measurements and applause for other forum.

Caroline Grey, Care Group Director, Medicine

4 Quality assurance and research

The establishment of the nursing-led service presented a number of challenges and opportunities for evaluation. The unit had already established itself as a resource to the hospital in quality assurance, particularly in the use of QUALPACS[25] and care-plan audit tools. A novel and significant development had been made with the use of the QUALPACS tool as a peer review instrument within the unit. It was clearly important that this work should continue and that the process of care be monitored and maintained at a high standard during such a dramatic and unstable time.

However, the radical nature of the unit demanded that evaluation should focus on the ultimate results of the service – both in terms of patient well-being and overall service provision. There are three main strands to this.

- First, we are conducting a significant outcomes-based research project aimed at evaluating the effectiveness of the service as to overall health status and efficiency of bed usage.
- Second, the project development nurse is responsible for a qualitative research project aimed at determining the perception of the service among other professional groups. The purpose is to use this information to refine the referral mechanisms.
- Third, the peer review process has been expanded to include weekly case reviews with the NDU leader in order to continuously monitor clinical performance and facilitate the functioning of primary nurses in their new roles.

Currently we are also exploring the possibility of performing detailed nursing care audits for problematic cases with groups of staff as support, peer review and development exercises.

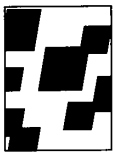

FIG. 9
KEY OBJECTIVES OF THE UNIT AND QUALITY ASSURANCE STRATEGIES

Objective	Strategy
❒ Care tailored to individual patient needs	QUALPACS, documentation audit, peer review
❒ Closer patient involvement in care	QUALPACS, documentation audit, peer review
❒ Increased patient satisfaction with the service	Outcomes project
❒ Improved health status for patients	Outcomes project
❒ Lower rates of nursing-related complications	Outcomes project
❒ Increased patient independence	Outcomes project
❒ Shorter length of stay in acute beds for our patient group	Outcomes project
❒ Shorter lengths of stay per patient episode	Outcomes project
❒ Reduced readmission rates	Outcomes project
❒ Greater independence in the community	Outcomes project
❒ Development of multi-disciplinary team work and co-operation in the unit and on referring wards	Perceptions study

OUTCOMES

The establishment of the nursing-led service will have considerable impact in many fields, and ideally any evaluation would address them all. However, the prime focus must be on patient outcomes. The minimum requirement for quality assurance is that the service provided by the unit results in no worse patient outcomes than a traditional (medically managed) model of care delivery. There is little evidence upon which to decide which, if any, outcome variables are key quality indicators for nursing,[26] and scant evidence linking variation in outcome with the other elements of Donabedian's[27,28] 'structure–process–outcome' framework (see Hegyvary and Haussman[29] and Haussman and Hegyvary[30] for empirical research in this area).

The need to measure outcomes is twofold. First, there is a need to assure quality outcomes from a broad perspective in order to evaluate the effect of the service on the patient's health as a whole. Second, there is a requirement to determine which, if any, aspects of health outcomes are sensitive to 'nursing'. The urgent imperative for this assessment within the unit is to determine whether links can be made between particular patient groups, nursing therapy and patient outcomes in order to refine the criteria for selection of patients to the unit.

Research

Outcomes will be evaluated by a research study conducted by the unit's researcher. The study is quasi-experimental in nature. Since preliminary work suggested that there would be a large excess of suitable patients in relation to beds available on Byron Ward, formation of a control group through randomisation is both feasible and desirable. Patients are randomised into control or treatment groups prior to screening them, and invited to participate in the project on the appropriate basis if assessed as being suitable patients. A traditional randomised controlled trial would demand that patients are asked to consent to both the research and transfer to the unit prior to randomisation. Cook and Campbell's discussion of research design[31] highlights a threat to the validity that one treatment condition is more attractive than another. Patients must be asked to consent

to transfer to a new service, out of the care of their doctors for further nursing care. Some will then be told that this new service is not available to them owing to their participation in the research project. The consequences are twofold. First, there may be selective attrition from the control group with patients more likely to withdraw from the research. Second, randomisation to the control group may lead to a 'resentment' effect if this condition is seen by patients as less satisfactory. In effect, the control group might be a 'negative placebo'. While neither of these conditions may actually apply, there are strong theoretical grounds for believing that the process of selection into experimental groups becomes a treatment in itself, which will affect the two groups differently (a treatment X selection interaction).

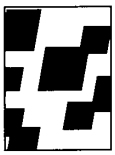

FIG. 10
REQUIREMENTS FOR STUDY DESIGN

- There must be no appreciable impact on bed usage and on the unit's ability to respond to operational requirements.
- Patients must not be put in the position of being offered a service which is subsequently withdrawn purely for research purposes.
- The selection process must be designed in such a way as to minimise the impact and theoretical importance of any possible selection X treatment interaction effects.
- The design must maintain the ability to make reasonable attribution of cause and estimate the impact of the unit on patient outcomes.

The study utilises a variety of outcome measures in order to give a broad picture of the implications of the service for the physical health and well-being of patients. Areas measured include psychological distress, distress caused by physical health, complications and physical dependence.

SERVICE PROVISION

The complementary aspect of 'patient' outcome is the 'outcome' for the organisation as a whole. This is multi-faceted but there are two key areas.

- First is an assessment of the unit's ability to meet its own objectives in terms of patient throughput and length of stay.
- Second is the extent to which the unit is able to meet the needs of other healthcare professionals and the provider organisation as a whole.

Data on patient activity and waiting times are provided by the outcomes research. However, whereas 'health outcomes' can be seen as an index of the unit's success in meeting individual patient needs (and indeed its own internal objectives), the needs of other professionals and the wider organisation beyond these positive outcomes are less clear. Reduced or equal cost or cost-effectiveness will be relevant to the organisation's requirements, but the needs in the broader context of health care delivery are in many ways undefined. For this reason there is a need for qualitative research in order to clarify perceptions and expectations among all those involved in the unit, patients and health care professionals.

PEER REVIEW

The weekly case conference with the NDU leader provides each primary nurse with the opportunity to evaluate her clinical caseload. This is a forum for a review of individual patient outcomes and the effectiveness of nursing care delivered. Problems, such as delayed discharge, can be rapidly identified allowing both individual practitioners and the unit as a whole to continuously respond to the areas highlighted.

Perhaps more importantly, this meeting is also a mechanism to assist primary nurses to reflect on their practice. They are encouraged to examine their response to patient problems from different perspectives in order to ensure that the chosen course of action is both appropriate and sensitive to patient need, current and anticipated. Where issues are particularly problematic, practitioners are encouraged to reciprocally utilise one

another's expertise, expanding the case review to involve their peers. This has led to imaginative and constructive debate analysis, and creative problem-solving.

The unit aims to extend this process to include all levels of staff by conducting case-history review meetings in order to reflect on all aspects of patient care as and when problems are encountered.

5 Staff reactions

It would be misleading to say that reactions to such a significant upheaval were unambiguously positive, or indeed that the proposed nursing-led service was accompanied by the clearest vision of the end point.

For many, the prime motivation and appeal of the change was the preservation of the current ward team and the ethos of the NDU.

> *'... how do I know whether I'm going to enjoy it or not until I've done it? Got to be positive!'*
> **(Associate Nurse, July 1992)**
>
> *'... to me we're lucky ... we've got a good team and I think if we go to King's it will break up.'*
> **(Health Care Assistant, July 1992)**
>
> *'What's important to me is that the ward stays together ... the people, the attitudes, those sorts of things.'*
> **(Primary Nurse, July 1992)**

The notion of change was in itself perceived as threatening, particularly in a climate where jobs might always potentially be under threat. However much information staff were given, the long period of uncertainty while plans emerged, and the wait for authority to proceed gave rise to a general perception that staff were not being kept fully informed of plans as they developed. This contributed considerably to stress and anxiety.

'...because of the uncertainty of jobs you're thinking what's happening to us. It's frightening, we don't know what's going on. When someone sits down and talks to us I feel more at ease but there's still all the uncertainty.'
(Health Care Assistant, August 1992)

For many junior qualified staff a particular concern was the loss of acute medical experience and skills. Many had chosen to work on Byron specifically in order to gain acute medical experience. Many were worried that this would restrict their future career choices.

'I can see that junior staff feel that they're going to lose a lot. The acute medical skills that you develop in your first year being qualified...'
(Primary Nurse, July 1992)

'... I feel that if I don't carry on in an acute medical ward now I'm going to lose it all...'
(Associate Nurse, July 1992)

In many ways this concern was reinforced by a difficulty in gaining a clear vision of just what the unit would entail. For many, the picture of what was being proposed did not become clear until near to the unit's opening after many months of discussion. For others, it was a matter of being unable to picture the vision in reality, being unable to imagine it actually happening. However, there was general agreement that whatever the idea was, it was a good idea.

' ... I just can't imagine there being nursing beds down there. I mean medicine is run by doctors. It sounds a good idea though.'
(Primary Nurse, July 1992)

'It sounds good but to be honest I don't really know very much about it. What I've heard about it is where we'll actually be nursing.'
(Health Care Assistant, August 1992)

Many found it difficult to articulate their own vision of the project. Some however, in particular the primary nurses, had a developing understanding which closely mirrored the emerging thesis of the project. The primary nurses were more able to recognise that the key aim of the project was to concentrate on nursing a group of patients whose needs could not be defined by their medical condition and were potentially neglected in the face of the needs of acutely ill patients.

'... I said "what on earth's a nursing therapy unit?" I didn't know, I hadn't a clue!'
(Associate Nurse, July 1992)

'The ward doesn't work at the moment. You've got these patients who are long term and the acute medical patient. When a patient comes in and wants two-hourly Pethidine – that's what they need and that's what they should have. You have this conflict between yourself, rather than yourself and the doctors.'
(Primary Nurse, July 1992)

'Doctors aren't interested in the long-term patients. They see them once a week and that's it. I see these nursing beds as being able to give the time you want to those patients.'
(Primary Nurse, July 1992)

Despite many reservations and worries, most staff felt that there was a challenge for them, either to make the best of a perplexing situation which had been imposed on the ward team by circumstance or a positive challenge to extend skills and responsibilities in order to maximise the potential of their own nursing care.

'I don't think the work would change very much but your responsibilities would be extended. I'm going to have to be a lot more resourceful. It's going to be nursing, nursing care.'
(Primary Nurse, August 1992)

'It's something I've never done before, something I will look forward to. I suppose a little bit scared. I can see the first few months of this work, touch and go, learning by mistakes.'
(Primary Nurse, August 1992)

'I think you've got to have it in your head and I haven't at the moment ... but I had this glimmer today that it might be all right.'
(Associate Nurse, July 1992)

'PUBLIC RELATIONS'

If there was one problem which could have been predicted for the early days of the unit, it was that the problems which we had predicted would pale into insignificance in comparison to those which we had not. This has largely been the case. For example, we had anticipated a considerable degree of hostility from our medical colleagues to the point of being actively disruptive. In consequence the majority of our 'public relations' effort was targeted at explaining our proposal and allaying the fears of the doctors. While there remains an undercurrent of hostility, little is overtly expressed.

We have, however, been surprised by many active votes of support, and in particular the attitude expressed by some senior consultants that *it is crucial that the unit sink or swim on its own merits, rather than fail because of lack of co-operation.*

Misunderstandings

From our discussions with managers of the therapy services we had not anticipated the degree of hostility from some therapists to what we were doing. While the managers seemed supportive and in general felt that the idea was a good one, it is perhaps unsurprising that our plans were not as crucial to them as they were to us. Thus it appeared that the first ward-based therapists heard of the unit was when one of their patients suddenly disappeared to Byron Ward. Members of the team screening patients had to spend a great deal of time and effort in allaying fears from therapists and attempting to limit damage caused by a series of misunderstandings. The problems seemed to stem in part from our concentration of energies on liaising with and securing the co-operation of medical staff.

This highlighted a general problem. It was all too easy for many of our colleagues to attribute blame for any management problems to the unit. For example, while the screening team took great care to ensure that all key therapists were informed of a referral and consulted before transfer, much of the information we received was inaccurate. Thus in one instance we were faced with a phone call from an understandably annoyed speech therapist who had not been consulted about the transfer of a patient when we had been assured that no speech therapist was involved in care.

The screening team acknowledged that since problems lay in the operation of the referral and transfer process as a whole, and that the process existed only because of the existence of the new service, it was ultimately their responsibility to remedy any problems rather than merely point the finger of blame elsewhere. Many of the early misunderstandings and problems were addressed at a meeting arranged between the unit and managers of the individual therapy services within the first few weeks of operation.

Enthusiasm

A more positive response came from many of the junior medical staff. While some clearly regarded the unit as merely a repository for difficult placement problems, equally common was an active enthusiasm for what the unit might be able to achieve for some of the patients for whom medicine was no longer the key determinant in their recovery.

Stress

Meanwhile staff on the ward were experiencing the stress of transition. The absence of the junior doctor to take responsibility for minor medical problems as soon as they arose seemed to cause particular concern. Although in the early days the system of medical cover was not radically different from the previous system, with a senior house officer attending the ward and dealing with problems which had been added to a list kept on the ward, staff appeared to feel considerably more stress. It was as if in the past the addition of a problem to this list succeeded in shifting ultimate responsibility to the doctors. Once on the list, the nurse's assessment of the problem – in need of non-urgent medical attention – could generally be reviewed if necessary, but caused little anxiety. Now the responsibility remained with the nurses, and delay in obtaining medical attention often caused extreme anxiety. Similarly, staff seemed to feel considerably more anxious about the possibility of essentially stable patients suddenly deteriorating.

In tandem with this stress was the difficulty in meeting the needs of a very physically dependent patient population while attempting to broaden their responsibilities and activity with those patients. The need to carefully manage the physical dependency level of the ward was emphasised very early on, as was the difficulty in actually succeeding in doing so. The imperative of maintaining the full number of 'nursing beds' on the ward conflicted with this need to a great extent, and solutions so far have only been partially successful. While ward staff felt nearly overwhelmed by the strain, both physical and psychological, the outside observer might have noticed some quite remarkable achievements with some of the first patients admitted to the ward.

CASE HISTORY – Elizabeth

In the first few weeks of the unit's operation we (myself and one of the primary nurses) spent most of our time trudging around wards, attending multi-disciplinary team meetings and apologising for things which were not our fault. This was the reality of life as a member of the 'screening team'. The only advantage of this utterly thankless task was, we agreed, that at least we could give each other support and moan about our lot there and then.

One of the first referrals I screened was a patient who I had met some weeks earlier (before the unit began admitting nursing patients) on a post-take ward round. This, we agreed, was a patient who, in a few weeks' time might become a suitable candidate for the unit. Elizabeth was a lady in her mid-seventies who had been admitted to hospital following a stroke. Although previously fit and well, her prognosis for a good functional recovery did not seem particularly good. However, there was clearly much scope for improvement if only to vastly increase the quality of life available to her in a nursing home. At the time of the ward round she would not have fitted our criteria in that she had a severe chest infection which was being treated with intravenous antibiotics.

We received a referral during the unit's second week of operation. When I went to visit Elizabeth, she had clearly deteriorated considerably. Her stroke had left her with a dense hemiplegia, dysphasia and dysphagia. She was sitting hunched in a chair with her neck flexed to her affected side, causing her great pain. She had been unable to tolerate naso-gastric feeding and appeared emaciated and dehydrated. Her mouth looked sore and coated. Her urine was dark, cloudy and foul smelling. She was catheterised due to incontinence. Her skin was hot and sweaty .

Elizabeth was virtually unable to speak during my assessment, making only whispered affirmations to direct questions. I was unable to assess her mental state fully owing to the dysphasia. I discussed the possibility of transfer to Byron with Elizabeth's sister. My initial feeling was that transfer would probably not be appropriate. Although Elizabeth clearly

had an active infection, a decision had been made not to treat her further with antibiotics. It was difficult to see that she could benefit from transfer in the sense we had envisaged.

I felt that if Elizabeth survived this infection, then the next step would be to secure placement in a nursing home where she would remain totally. She did not meet our criteria and therefore I informed her doctors that she was not suitable. I also told her sister that in my opinion Elizabeth would not benefit from moving.

At the same time I had a strong feeling that Elizabeth needed 'looking after', that she was suffering considerable distress which might be alleviated. If I am totally honest, the real reason I reconsidered is that I felt sorry for Elizabeth, she was suffering. I discussed the case with the other member of the screening team. On reflection we felt that Elizabeth's infection would not exclude her from the unit. Since she was not being actively treated this could hardly be considered as 'medical instability'. Strategies for dealing with this could be encompassed in a medical handover and should be amenable to review by the medical cover of the unit if that seemed appropriate. One of the key reasons for her referral was the problem of feeding.

Elizabeth's house officer felt that concentration on strategies for maintaining the placement of the naso-gastric tube might have more success. Since this feeding was obviously a key nursing activity for Elizabeth which, if successful, might have significantly impacted on her eventual outcome, we decided to change our decision and accept her to the unit, provided arrangements could be made for the siting of a percutaneous gastrostomy for long-term feeding. The house officer gladly agreed to arrange this. He was clearly feeling helpless in the face of Elizabeth's obvious suffering and was glad to have something to offer her. .

On arrival on the unit she had her naso-gastric tube resited but she pulled it out. Instead staff had asked the unit doctor to commence sub-cutaneous fluids. Elizabeth seemed to be more stimulated in the middle of the ward than she had been in the two-bedded bay she had come from. She often motioned to staff to give her something with which to

rinse her mouth. She was soon able to communicate much more successfully, albeit in a whisper and occasionally having trouble finding the correct word. With care Elizabeth could be sat out of bed in a comfortable position although this was only done infrequently and for short periods in the first week as she quickly found it tiring and the spasms in her neck tended to recur.

About two weeks later the registrar from Elizabeth's medical team expressed surprise that she had not died, and three weeks later while visiting the ward completely failed to recognise the woman sitting upright and chatting to her sister.

While the staff on the unit have often found it difficult to see their achievements and were very concerned that they were unable to do all that they wished with the patients, this surprise (if not amazement) expressed by 'an outsider' most eloquently expresses not only the potential of the nursing-led service but also the very real benefits some patients have already received.

Certainly it reminded those of us who had been conducting the 'thankless' task of assessing and screening patients for transfer that what we were offering could be far more than a 'nice idea' and meant far more than an advance in the status of nursing. The purpose of the exercise is to benefit patients. I believe that this case shows just how significant those benefits might be.

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As the interest in nurse-led initiatives increases, it is critical that those who are exploring ways forward share their experiences. This early account describes the rationale behind the move to introduce nurse-led beds in a busy acute general hospital, as well as outlining some of the practical steps taken during the initial stages of the work. The importance of evaluation of such initiatives is stressed and an outline is given of the approach which is being followed.

The work described in this text is still at an early stage but offers exciting prospects for the way in which nurses can creatively contribute to health services. Not only are patient needs met efficiently and effectively but nurses are expanding their clinical skills as they develop new roles. The experiences of those involved in the project are shared in an open and honest way, and offer valuable insights for others who are interested in exploring similar approaches within their own units. It will undoubtedly stimulate debate.

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