KING'S FUND CENTRE

CONTINUING EDUCATION IN NURSING ~LUXURY OR NECESSITY?

Report of a day conference at the King's Fund Centre
8th November 1984

1984

Chairman

Miss Hazel O Allen, Associate Director, King's Fund Centre

Contributors:

Dr J. Birch, Chief Nursing Officer, North Lincolnshire Area Health Authority.
Miss A. Emerton, Chairman, English National Board for Nursing, Midwifery & Health Visiting.
Mrs M. Lahiff, Principal Lecturer, North East Surrey, College of Technology/University of Surrey.
Mr A. Pearson, Senior Nurse, Burford Community Hospital & Nursing Development Unit.
Mrs M. Reed, Senior Tutor (Continuing Education), St. Bartholomew's Hospital.
Ms J. Rogers, Research Officer, University of London Institute of Education.
Miss W.W.Thomson, Nursing Officer, Scottish Home and Health Department.

King Edward's Hospital Fund for London

Patron: Her Majesty The Queen

Govenors: HRH Princess Alexandra, The Hon Mrs Angus Ogilvy GCVO
Lord Cottesloe GBE TD
Sir Andrew H Carnwath KCVO DL
Treasurer: R J Dent
Chairman of the Management Committee: The Hon Hugh Astor JP
Secretary: Robert J Maxwell JP PhD

King Edward's Hospital Fund for London is an independent Foundation, established in 1897 and incorporated by Act of Parliament 1907, and is a registered charity. It seeks to encourage good practice and innovation in the management of health care by research, experiment and education, and by direct grant.

Appeals for these purposes continue to increase.

The Treasurer would welcome any new sources of money, in the form of donations, deeds of covenant or legacies, which would enable the Fund to augment its activities.

Requests for the annual report, which includes a financial statement, lists of all grants and other information, should be addressed to the Secretary, King Edward's Hospital Fund for London, 14 Palace Court, London W2 4HT.

CONTINUING EDUCATION IN NURSING - LUXURY OR NECESSITY?

CHAIRMAN: MISS Hazel O Allen, Associate Director, King's Fund Centre

C O N T E N T S

CHAIRMAN'S OPENING REMARKS - Miss Hazel Allen, Associate Director, King's Fund Centre

I think it is very important to note that the word is **continuing** education in the title of today's Conference because 'continuing' denotes an imperfect tense and I think we would all agree that education is imperfect throughout life. It is an on-going thing; it is an action not completed and I think maybe that is something on which we need to concentrate today.

When we say "we are accountable for service to the patient", that demands responsibility for education. By responsibility I mean something which comes from inside the "internal sensor" who says 'it is my business to do this because I am accountable to the patient'.

It was one of the minor prophets who said "My people are destroyed for lack of knowledge" and I would suggest that is something we need to consider seriously.

We need to know what resources we have and how to use them. Part of the answer to our difficulties lies in the ignorance of what might be effective. There are also problems of resistance to change as a result of professional self interest; political dogma; and financial constraints. These are topics which require the extensive and untiring attention by all of us.

Today we shall attempt to paint some dazzle onto the dark canvas, so the shapes of the dilemmas may be clearly defined and we can go away and start grappling with them.

---oo0oo---

SCENE SETTING - Mrs Margaret Reed, Senior Tutor, Continuing Education, St Bartholomew's Hospital.

I should like to welcome you to the Conference on behalf of the group and to thank the King's Fund Centre, particularly Hazel Allen and Christine Davies, for their support which has enabled the group to invite you all here today. As the present Chairman/Co-ordinator of the Staff Development Interest Group I will provide some historical perspective concerning this group.

Miss Hazel Allen, the Chairman at the June 1980 Colloquium, 'Continuing Education - Development for Nurses', stated "Perhaps participants should organise peer groups locally, or knock on the door of the RCN to ask them to convene a group to examine continuing education. The King's Fund might help - it was always there with resources. But the ball is in your court, yours is the responsibility; it's going to be your service, your education, and not 'theirs' whoever 'they' happen to be".

Following the Colloquium a list of those participants who had contacted the King's Fund Centre expressing an interest was compiled and circulated in June 1981. We were asked if we were interested in an exploratory meeting later in the year. 'Exploratory' in the sense of facilitating a small group of those involved in staff development, to brainstorm, to discuss, to disagree, to consider the direction of this development for nurses in the 1980's.

The first meeting took place in November 1981, attended by 13 Post-Basic Teachers/In-service Training Officers from all areas of England, with two from Scotland. The aim of the meeting was to identify the responsibility of the Central Council for Nursing, Midwifery and Health Visiting for continuing further education. Many points were raised concerning continuing education/post-basic education/in-service training/staff development, and it was realised that the impetus to act as a Pressure Group to the Central Council would be lost if action did not take place early in 1982.

Whilst it was difficult to predict with accuracy the life span of the group, between 1-2 years was considered a probable guidance. The frequency of meetings would depend on the deliberations of the group. Commitment to the group was emphasised and the two Socttish representatives thought that distance would preclude their future attendance, but both of them would be pleased to comment on any written work produced by the group.

It was decided that the express purpose of the group was to promote the concept of continuing education which was defined as, 'planned, organised learning experiences designed to increase the knowledge, skills and attitudes of qualified nurses for the enhancement of nursing practice, education, administration and research, in order to improve the performance of the professional'.

The group recognised that the promotion of the concept of continuing education could be done in a variety of ways and suggested the following:

1. Stimulating national interest and awareness through the dissemination of information and ideas via Conferences, Publications and Workshops.

2. Examining the role of the teacher in continuing education with the intention of designing a course to prepare the person for the role.

3. Analysing relevant reports and forwarding comments to the appropriate bodies.

4. Sharing ideas with and supporting other members of the peer interest group.

5. Reviewing and evaluating the work of the group at regular intervals.

Since this first meeting the group has met quarterly at the King's Fund Centre. There has been some change in group membership and number. The present group size is ten, a group Chairman/Co-ordinator is elected on a yearly basis.

What **have** we achieved since that first meeting in November 1981? We have:

1. examined various aspects of continuing education in nursing, looking also at the medical and paramedical professions approach to continuing education

2. sent comments on documents produced by the UKCC

3. looked at the role of the continuing education tutor/in-service training officer, with particular reference to the preparation for the role.

4. invited guest speakers to our meetings to gather information about the present and possible future direction of continuing education/ staff development.

5. sent a document to the English National Board expressing our concern and making recommendations. The document is available for reading during the lunch break.

6. shared ideas and supported each other.

7. gathered service and education colleagues together here today to provide a forum for discussion.

We have only touched the surface of the problem and are aware that there is still much to be done.

The future of the group has been discussed at recent meetings, and at a Debriefing Conference Day later this month, we will continue with discussions and decide the next step.

---oo0oo---

CURRENT PROVISION FOR CONTINUING EDUCATION - Ms Jill Rogers, Research Officer, University of London Institute of Education

I am delighted to be here today and to have this opportunity to discuss with you the current provision for continuing professional education.

Continuing education is the key to professionalism in nursing, if we ignore continuing education we deny nursing the opportunity to establish its credibility as a profession. Education is the foundation of the maintenance of adequate professional standards, and consequently professional groups such as nurses must accept responsibility for the educational development of their members.

The UKCC has already decided that for the future all nurses and health visitors will be required to maintain their professional competence to enable them to practice. The second edition of The Code of Professional Conduct for Nurses, Midwives and Health Visitors states "that every nurse, midwife and health visitor is accountable for his or her practice, and in the exercise of professional accountability shall take every reasonable opportunity to maintain and improve professional knowledge and competence". Secondly, "shall acknowledge any limitations of competence and refuse in such cases to accept delegated functions without first having received instruction with regard to those functions and having been assessed as competent". There are tremendous implications in just these two of the 14 points of the Code of Professional Conduct for everyone involved in continuing education. It is vitally important to take stock of where we are now; of where we want to be; and to think carefully of how we plan to get there.

My own interest in continuing education extends over several years, working with different health professional groups and particularly with nurses. Some of you may be familiar with the study that I carried out for the Joint Board of Clinical Nursing Studies, which was designed to look at the career patterns and the use made by nurses of their Post Basic Clinical Courses. This study revealed that a great many nurses taking post basic courses were doing so in order to gain professional confidence. Respondants emphasised that the course gave them the opportunity to develop their professional skills; to be aware of their own internal resources, and in their own words "to become complete nurses". It is salutory to remember that between 1973 and 1983, 16,000 certificates and 8,000 statements of attendance were issued for people taking post basic clinical courses. When these figures are seen in the context of the total number of staff in the National Health Service,they show that large numbers of qualified nursing staff do not possess a post basic clinical qualification. Of the 250,000 qualified nurses employed by the NHS at the most 9.7% could possess a post basic qualification, and that assumes that all of those who have taken a post basic clinical course are still in nursing. We know from a survey of Joint Board certificate holders that they are not.

Why was it necessary for nurses to take a post basic clinical course in order to become professionally confident? What happens to all those nurses who do not take a post basic course of this particular kind? These questions coincided with the English National Board and UKCC's public commitment to continuing education and the DHSS agreed to proposals for a research study to examine the present provision for continuing education.

Today I want to share with you some of the findings of my current survey (CPE), about the overall provision and organisation of continuing eduction; to raise some of the issues that these findings generate and which must be considered in the move to develop continuing professional education (CPE).

What do we mean by continuing education? The American Nurses Association's definition is, "planned learning experiences beyond the basic nurse eduction programme designed to promote the development of knowledge, skills and attitudes for the enhancement of nursing practice thus improving health care to the public". If we adopt this overall definition we can divide continuing education in the United Kingdom into 2 main areas:

1. Post basic courses for which a nationally recognised certificate is awarded, for example courses in nursing, clinical teaching or management.

2. In-service education which has been defined by the National Staff Committee, as "an aspect of the career long development of nursing personnel provided and controlled by the employing authority, and for which no nationally recognised certificate is awarded".

Less than 10% of qualified nurses hold a post basic clinical course certificate, even fewer numbers of nurses have taken the Diploma in Nursing or a degree. Some Polytechnics and other Colleges of Higher Education put on courses for qualified nurses such as management courses, which are taken by a large number of nurses. Few other opportunities are readily available for nurses to continue their education. At present the responsibility for in-service education rests with District Health Authorities. One of my main concerns in the past six months has been to find out just how health authorities regard CPE, and to find out what is available.

In June 1984 questionnaires were sent to 201 District Health Authorities in England and Wales, 14 Regional and 7 Special Health Authorities, and to Universities, Polytechnics and Colleges of Higher Education. The overall response rate for the survey was 87% and may reach 90%. The high response rate is invaluable in establishing a picture of the current position of continuing education. It is very important because we can plan for future developments from an understanding of what exists at the moment. "Without a vigorous continuing education programme neither individual staff nor patient care will develop and improve", this quote from a CNO typifies many of the reactions to continuing professional education and brings together the varied elements that are important in planning the management and provision of education.

Organisational Structure for CPE

There are perhaps two schools of thought about whether continuing education departments or units are best sited within or under the aegis of the School of Nursing, and therefore answerable to the Director of Nurse Education or whether they are better situated within the service side of the hospital organisation. Despite the recommendation that continuing education tutors should be responsible to the DNE practice is varied.

The survey has revealed 18 broad different educational patterns. 80% of Health Districts had adopted a line relationship from CPE Tutor ------> DNE ------> CNO. In 16% of Health Districts the CPE Tutor was

responsible directly to the CNO. The remaining 4% had quite different organisational structures that did not fit into the preceding two categories, for example one tutor was responsible to the Senior Nurse Personnel.

Within each of these broad organisational structures are a multitude of different combinations. For instance within the most common structure CPE Tutor ------> DNE -----> CNO there are variations. 61% had a relatively straightforward relationship between CPE Tutor ------> DNE ------> CNO. In 6% of cases there were parallel organisations within the district for in-service education and post basic certificated education, and then linking via DNE to CNO. In 9% of cases an Assistant Director of Nurse Education was involved who was specifically responsible for continuing education.

Number of Staff Directly Involved in CPE

The DNE was excluded. Staff who were responsible for National Board Courses were included.

11% of districts had only one person responsible for CPE
47% of districts had 2 - 5 people responsible for CPE
24% of districts had 6 - 9 people responsible for CPE
13% of districts had 10 or more people responsible for CPE

Grade of the Person with Overall Responsibility for CPE

(Excluding DNE but including ADNE when they had specific responsibility for continuing education).

The situation has improved considerably during the past 3 years since previous surveys by Jean Heath and Bill Mitchell.

68% of districts have a Senior Tutor resposible for CPE
9% of districts have an Assistant Director of Nurse Education responsible for CPE
10% of districts have a Nursing Officer responsible for CPE
12% of districts have a Senior Nurse responsible for CPE
1% of districts have others responsible for CPE

An important indication of the Health District's commitment to continuing education is shown by whether there is any time specifically built into the staffing figures to allow for staff to take part in in-service education activities.

34% of all districts said that time was specifically allowed for staff to take part in in-service activities, but the amount of time varied considerably.

37% allowed less than 2% of time for in-service education
21% allowed between 2% - 5% of time for in-service education
12% allowed more than 5% of time for in-service education
19% allowed time for in appropriate activity.

One of the crucial aspects of continuing education is the way in which topics are chosen. Identifying need is complex, so often we are unable to identify what it is we most need ourselves because we do not necessarily recognise our own deficiencies.

Districts were asked how topics for in-service education were identified. Most districts mentioned several ways.

Requests from Senior Managers - 40% of districts

Requests from individuals - 34% of districts

"to meet demand" - 30% of districts

In line with planned professional development - 12% of districts

By a survey or forward look to identify areas of need - 6% of districts

The existance or otherwise of a regular performance review scheme is an important factor in identifying need. When asked if performance review was carried out in the district:

33% - "yes in all units"

35% - "in some units"

24% - "no"

6% - "planning to introduce it"

A frequent allegation about in-service education is that it is difficult to find out what is available.

For 47% of districts the main way of distributing information was through line management

38% provided a programme, or a timetable

34% had a bulletin, or newsletter

32% sent information direct to the wards

More than one method was used by some districts

The survey did not cover the way in which staff perceive and receive the information that is made available. Programmes can be produced but people have to be made aware of them.

The range and content of in-service courses and study days provided by District Health Authorities varies enormously. In numerical terms the greatest number of courses relate to management topics, and introduction to management being the most frequently mentioned. With some notable exceptions many districts do not have coherent planned programmes for different groups of staff, by specialty or by grade.

Many districts are attempting to evaluate in-service courses.

54% use a post course questionnaire

37% meetings held to discuss the courses or study days attended

31% report by managers

20% of districts claimed to observe practice in the wards after staff had taken part in in-service and continuing education events.

Many districts appreciate that their attempts to evaluate in-service education are limited.

A survey of this kind generates as many, if not more, questions than it answers. One of the fundamental issues must be the way in which we identify needs in continuing education and use them to plan a programme. Nursing staff have needs, the service has needs in terms of sufficient educated staff to care for groups of clients. Patients too have needs. Each of these has to be considered when designing continuing education programmes. Inevitably we have to respond to a particular training need, for example Insulin 100. We have responsibility to provide opportunities for all grades of nurses to develop their confidence as professionals with clinical, managerial, teaching, and research commitments and interests. Such opportunities should be a regular part of staff development programmes.

Laxtell has commented that needs assessment is one of the most difficult and least understood aspects of continuing education. While perceived needs represent the perspective of the learners, and are important because motivation is clearly a key factor in the success of any education programme; true needs should be more objectively determined by independent assessment using factually recorded data. The latter brings with it the issue of nursing audit and of the assessment of the quality of care provided by staff. Other health professional groups, notably doctors, have attempted to establish systems of audit of the care that is provided. In a recent review Richard Caplin argued that quality assurance was an aid to continuing education in identifying topics and assessing the impact of continuing education. He stressed that not all continuing education has to relate to quality assurance activities, and not all quality assurance activities are necessarily educational. He discussed some of the apparent reasons for the limited impact in medical education of the audit of care. He suggested that few people really understand the language and logic of audit so that interpretations can often be inadequate or inaccurate. There is also a danger with audit systems that we may audit the wrong things. It is relatively easy to record and study content, and far less easy to study interpersonal skills. The very word 'audit' is surrounded by negative connotations and arouses negative attitudes. The concept of assessing or analysing the quality of care provided, and relating this to a programme of continuing education is clearly at the heart of what continuing education is about.

The characteristics of the learners also need to be considered. It has been said by Premi that learners learn most effectively when learning is the discovery of the meaning and relevance of ideas to the learner, and when learning is able to simulate closely the conditions within which the learner works. Adult learners bring with them a wealth of their own experiences; a need to focus on realistic problems; and an ability to learn from each other.

Reasons for participating in continuing education are linked to patient care and personal goals. Research that has explored professionals motivation to take part in continuing education has shown that people participate not only to improve their clinical skills but also to understand themselves better as professionals; to interact with colleagues; and to improve their personal and professional position. Continuing education must serve all those needs as well as those specifically related to improving patient care.

Availability or lack of availability of resources are the subject of heated debate as much in continuing education as in any other area of nursing education. We could look more imaginatively and energetically at the prospect of sharing resources, both financial and human. Frequently two adjoining districts are providing the same course or study day for a relatively small number of staff. With planning and exchange of information it should be possible to combine groups of staff for particular activities. Individual staff members within the district have skills and experience that they can share with others.

There are challenges and opportunities in continuing education. We need to consider:

1. the balance of responsibility for continuing education between individual nurses, the health authorities, and the professional bodies.

2. the recognition for continuing education involvement for nurses

3. most importantly, that continuing education programmes are rooted in the multifaceted practice of nursing and interact with changes and developments in that practice.

---oo0oo---

A STEP FURTHER - Mrs Maureen Lahiff. Principal Lecturer North East Surrey College of Technology and University of Surrey.

A step further from what, you may ask. In the Spring of 1983 I presented a paper to the RCN Association of Nursing Education at their annual conference, entitled **'Attitudes to continuing nurse education'.**(1) In that paper I reached the conclusion that the British nursing profession held quite strong anti-education attitudes, on the basis that our actions were at variance with our policy statements. This paper is a step further, then, from the recognition that the profession has negative attitudes; an exploration of what we could do in spite of them!

Shortly after preparing the previous paper I spent several weeks as a Florence Memorial Committee Fellow on a study tour in North America. The subject of my studies was continuing nurse education. I found it a very positive experience. North American nurses demonstrate considerable commitment to a great variety of continuing education. While they do not have total agreement about where they are going the publications of their professional organisations indicate well thought out goals together with some strategies for their achievement. They also indicate a healthy awareness of the obstacles, not least those within the nursing profession itself.

A brief summary of the background to their changing scene is a useful preliminary to the proposals that I wish to make. Following the publication of the Surgeon General's Consultant Group on Nursing report on nursing in 1963 (the equivalent of our Brigg's Report) a national study of nursing was carried out. Initiated by professional nursing organisations and privately funded, the National Commission for the Study of Nursing and Nursing Education (NCSNNE) sought to **'determine how best to bring the profession's needs and resources into focus'.**(2) Several reports have followed. Their titles are worth quoting. They are **'An Abstract for Action' (1970), 'From Abstract into Action' (1973), 'Action in Nursing' (1974)** and most recently, **'Action in Affirmation: Toward an Unambiguous Profession of Nursing' (1981). (3,4,5,6).**

These reports represent the findings of an independent, objective inquiry into the state of the profession, the repatterning of nursing roles, education, and career perspectives which would make

> **'American nursing a full and unambiguous profession capable of serving as a principal partner in the enhanced delivery of health care to our people'.**(6)

An important point to note is that the National Commission resolved that a formal implementation effort would be mounted to ensure that the proposals were heard and debated, and that a beginning would be made on reorganising the largest of the health care professions.

Subsequently, the professional organisations continued a considerable information exercise directed at nurses, physicians, administrators, public agencies, private groups and the lay public about the strengths and flaws discovered in the nursing profession and the rationale behind the changes that were proposed. The most recent phase in this Herculean task has been the study of the successes and failures of some of the key recommendations of the earlier reports.

The overall impression gained from studying this literature is one of positive progression. It is a classic example of a profession setting

about changing itself. I believe that the nursing profession in the United Kingdom should be doing a similar exercise.

There are several steps we should be taking. Firstly, we need to consider the present and future health care needs of our society. Secondly, we need to take a long hard look at the strengths and weaknesses of the present position of nursing today. With this background we should consider what kind of profession would meet the needs of both its members and the society which it serves.

From such a perspective, it is likely that a different professional structure will be necessary. **Historically, entrants to nursing have been recruited to form the basis of the nursing service. This compromise was worked out to enable a form of education to be given at the lowest possible cost.** (7) It was possible within a social structure where educational and professional opportunities for women were limited; where marriage was the most likely prospect for adult women - a situation considered generally incompatable with a career.

Today, we must consider the educational needs of nurses not only on their entry to the profession but during the thirty to forty years of their career. In such a situation continuing education becomes a necessity. It will be the key to the maintenance of the motivation that steers people into the nursing profession; to ensuring a high standard of professional commitment where practitioners are able to deliver nursing care of the highest standards. It will also be the means by which individuals are enabled to cope with the drastic changes in nursing practice which will become essential and possible.

When nursing care is delivered by an untrained or half trained work force it is essential to have a task allocation as the basis of the service. By this method the simplest tasks are performed by the least qualified and the more complex by those further up the hierarchy, all with a reasonable degree of safety. The system is organised by the trained nurse whose educational needs are likely to be seen as managerial.

Attempts have already been made to change these aspects of nursing practice. The nursing process has been introduced to a greater or lesser extent. Gradually we are beginning to realise that this problem solving approach to care requires a different educational emphasis. When nurses become decision makers rather than procedure operators they need a more substantial knowledge base and some decision making skills. Important questions arise - Should the unqualified nurse be making the decisions? Should there be a different use of trained staff?

Rather than answer these questions just now I propose to consider a different basis for practice. Primary nursing has developed from the concept of team nursing which was found to have drawbacks. The major one was that the professional nurse in charge of the team delivered very little care. With primary nursing each patient is assigned a primary nurse who is responsible for the total nursing process throughout the course of treatment. The primary nurse is expected to carry out all the steps of the nursing process, using other, less qualified nurses to assist her. When off duty an associate oversees the management and performance of the care plan but does not modify it except to adapt it to changing circumstances. This concept of nursing increases the identification of the practitioner with the patient, the physician, the family, and other health care professionals. It enlarges the scope of nursing care and the accountability.

Such a concept requires an adjustment of institutional organisation for the full potential of the nursing profession to be used. **Nursing staff must be permitted:**

the expression of clinical self-direction;

the fulfilment of their responsibility to patients;

the acceptance of after-the-event sanctions rather than before-the-event controls over their practice.(6)

How do we get there from here? Firstly we accept that change will come about anyway. There are many social forces at work which are beyond the scope of professional control. **The important point for us to grasp is that change is our opportunities positively and surviving the stresses and strains that result.**(7) Where changes can be predicted then we should be ready with our strategies. We certainly must not be constrained by our ambivalance.

Having accepted that change is coming about anyway, we need to prepare our strategies - and it is necessary to empahsise here that we must not wait for others to tell us what to do, or what we can or cannot have. We must decide our priorities ourselves and then set about getting the best out of the future - the best for ourselves and for the society we serve.

Using the American experience already referred to there are several strategies we could usefully employ. They include raising the funding for an independent study of nursing; setting up a comparable public relations exercise with all the relevant groups; monitoring our progress, or lack of it; introducing mandatory continuing education; making promotion dependent on continuing education; creating an environment where autonomous nursing practice can take place. These are only examples - it is for the profession to identify its own strategies.

The contribution to be made by continuing education will be development of a confident, knowledgeable practitioner who is highly skilled as a primary nurse, but who is also politically aware. Because the task is so vast we will need many kinds of educational opportunities in various settings. They will range from short in-service courses through to higher degrees and will include traditional learning environments and innovative distance learning ones. Collaboration between nursing and general education will be essential if nurses are to have access to the range of essential disciplines and innovations in the development of skills.

Innovations in practice can be a direct result of continuing education. The Burford Experiment - of which you will shortly hear more - is not an accidental development in the Oxfordshire countryside. It is the outcome of deliberate policies - policies which have enabled individuals to step away from practice for a while, to learn, to question, to think creatively. On return, such individuals should not be expected to take up their original post without some rethinking of their job description. Judicious use of well educated staff can result in considerable diffusion of new knowledge, the creation of an environment where attitudes can be challenged and changed, where morale can be boosted.

With postive planning the British nursing profession can make its own way to becoming

'a full and unambiguous profession capable of serving as a principal partner in the enhanced delivery of health care.....'

We must not let our ambivalence discourage us from overcoming the many obstacles which will be in our path. When we experience set backs and disappointments we must recall our strengths, take another look at our goals and keep going.

---oo0oo---

REFERENCES

1. Lahiff M E, Attitudes to the need for continuing education, Nursing Times, Vol 80 No 2, Jan 11, 1984

2. "Toward Quality in Nursing," Report of the Surgeon General's Consultant Group on Nursing, U S Department of Health, Education, and Welfare, PHS Publication 992, Washington, DC, 1963.

3. Lysaught J P, An Abstract for Action, McGraw-Hill, New York, 1970.

4. Lysaught J P, From Abstract into Action, McGraw-Hill, New York, 1973

5. Lysaught J P (ed), Action in Nursing: Progress in Professional Purpose, McGraw-Hill, New York, 1974

6. Lysaught J P, Action in Affirmation: Toward an Unambiguous Profession of Nursing, McGraw-Hill, New York, 1981

7. Davies C, Nurse Education - A Constant Casualty, IN Davies C (ed), Rewriting Nursing History, Croom Helm, London, 1980

8. Owne G M, The stress of change, Nursing Times, Occasional Paper, Vol 79 , No 4, Feb 23, 1983.

-o0o-

CONTINUING EDUCATION IN PRACTICE - Mr Alan Pearson, Senior Nurse, Burford Community Hospital & Nursing Development Unit

Introduction

I have been looking forward to today since I first heard about it - not because I was to have an opportunity to spout forth but because my job hinges on introducing changes into nursing practice, and although I believe in the changes currently being promoted with almost religious fervour, I believe with as much passion that they can only come about if the vast army of clinical nurses who actually give care begin to value the ideas inherent in the new ideology of nursing. And this can only come about through continuing education. Nursing is controlled by qualified nurses, and students acquire many of their values from these nurses. So I have looked forward to today to hear about ideas for continuing education, and have not been disappointed by the preceding speakers, and suspect that the rest of the day will be equally as enlightening.

I am to address **continuing education in practice** and therefore intend to talk about my experiences at Burford, and the views I have developed from them. For me, this is a good time to do so, because the last three years at Burford have been the subject of a research project, and I am at the moment on sabbatical leave to write it up. Consequently, all of my waking hours at the moment concern analysing and reflecting on the Burford experience, and I can think of little else. Here I have a ready audience to give voice to, rather than a typewriter and reams of white paper.

The idea of change has received a lot of press lately, and the management of change is being taken seriously. I'd like to discuss some of the current arguments for change in nursing; to relate them to the targets for change identified at Burford; to talk a little about change itself; to very briefly outline how change came about at Burford, and the results and finally to throw in some of my own thoughts about the topic of today's conference - Continuing education in nursing - Luxury or necessity?

Changes needed in nursing

All of us here today are aware of the 'new' ideology being promoted in nursing, as a result of changes in the society we live in. Because nursing is a human service, and social change is an ever-present process, nurses have to change all the time. We have been exhorted to change at least since Florence Nightingale came on the scene, and no doubt it will always be so. There is enormous evidence that the direct care giving nurse needs to re-think things, and adopt a number of radical changes if the receiver of that care is to be given something which he or she really wants, needs and has a right to. The observations by sociologists such as Davies (1976, 1977) and Menzies (1960), Stein (1978), Stannard (1975), Miller and Gwynne (19) and many many more; the findings of studies on nursing such as Clarke (1974), Towell (1975), Stockwell (1972), Hawthorn (19), Faulkner (19); and the feedback from patient surveys such as those carried out by the Royal Commission (1978), Cartwright (1964), Raphael (1969) suggest that nursing needs to change for the sake of patients.

And all of us know the sort of changes which are currently being advocated:

The adoption of a holistic/care oriented model and less reliance on a medical/ cure oriented model, which will emphasise:

* the individual and his needs, rather than routinisation

* accountability of the nurse to the patient
* practice which is knowledge based
* the development of a close relationship centred on partnership between nurse and patient
* the use of a systematic, problem solving, or need-meeting process

We hear about them every day - nursing's leaders believe the issues to be of vital importance, and official bodies such as the ENB and WHO assert that nurses must try and adopt these new values and practice norms to reflect them. Seven years ago Duberly (1977) pointed out how difficult it was then to introduce practice change and suggested how resistance was likely to occur. Little has changed, in my opinion, since then. For years nurses were socialised to view the world of the patient and the nurse differently, and those nurses are the role models for the neophytes coming up. The suggested changes sound right, it would benefit patients in the long run if they were pursued, and as a side issue, would do much good for nursing as an occupation.

Burford three years ago

This sort of general view was held in my head three years ago when I began at Burford, and started collecting data about the place. It was, of course, very small, and had a core of staff who had been there some time. But a percentage were passers through and the general view of nursing did not really differ that much from the views of other nurses in the other wide variety of hospitals I became involved in. The description of nursing which arose out of the writings of the social commentators, the researchers and the patients polled really pretty well matched nursing at Burford. They were a pretty normal, pretty average group of nurses working in the way they knew, were taught and thought to be best. And thye saw no real reason to change in any fundamental way, although would have liked some people sacked, some new equipment and nicer patients. A list of edicts would probably have led to a cessation of the routine early morning waking with tea; crisp new assessment and care plan forms and perhaps the gradual introduction into everyday vocabulary of jargon words like 'nursing process', 'patient-centred care' and the like. But it would have done little else. The answer was to pursue a planned change strategy.

You are all probably quite familiar with the three basic change strategies (Chin and Benne 1976) but it is useful to mention them again:

> **The rational-empirical approach** assumes that people are likely to view change positively and work towards it if they are given the basic facts and empirical information and if this evidence "indicates that they will derive some benefit from the change". This strategy therefore requires a logical argument and its supporting evidence to those to be involved in the change.
>
> **The normative/re-educative approach** believed that "people have values, norms and attitudes that influence, if not direct, their behaviour (Archer et al 1984). Giving the arguments, facts to support them, is therefore seen to be not enough to persuade people to change and the normative/ re-educative line focuses on "helping people to re-examine their values in the hope that they will come to view situations differently".
>
> **The power coercive approach** is applying power invested on individuals who are superior within the institution.

The Burford staff had been subject to some attempt to change practice, both by a nurse manager, who had given them talks about the value of patient assignment and problem solving, and two of the nurses had attended courses. But this rational-empirical approach had had little effect. My intention was to utilise a strategy which was normative/re-educative. I wanted to both pass knowledge on and to spend time on handling the values which were argued for from this knowledge. I also wanted to base this on team centred teaching, on site. That is, teaching the team as a group, in their own environment, by someone who worked with them.

The staff development programme

It was agreed by the staff to run a weekly afternoon seminar for six months and a plan drawn up by me was accepted:

Staff Development Programme - Phase I

	SESSION	INDIVIDUAL PROJECTS
1	**Introduction** - fieldwork, feedback, discussion of programme planned	Guided reading
2	The patient - who is he or she?	Formulate own beliefs for presentation at next session
3	a) Discussion on 2 b) What is nursing?	Guided reading
4	Nursing as it is now - comparing 3b with nursing at Burford	Guided reading
5,6,7	Models for practice	Guided reading
8	A model for us? Discussion on the relevance of models etc.	Prepare discussion paer on own views
9	Presentation of individual discussion papers	
10,11	Organising care	Guided reading
12-18	The nursing process	Guided reading
19-22	Role play - patient simulation	
23,24	Identifying problems which need changes to overcome them	

(Session = 1 afternoon per week) (Individual projects = each nurse will be asked to do set work in own time and/or during quiet periods at work)

24 sessions, all on a Monday afternoon, were planned for.

All of the nurses were invited to attend, and it was explained individually to every nurse that the next six months was to be a time of thinking about the work in the hospital, learning about new ideas and deciding what needed changing.

Throughout the period, all of the day nurses attended each week, but the night nurses were unwilling to do so and requested a "special" session for themselves. It was agreed that a three day workshop would be organised near the end of the six month programme, for the night staff.

Content of the sessions

The first session was a free discussion centred on the results of the previous data collection and about the programme itself. It was a heated afternoon, with some of the staff feeling angry about inferences made by me about the work at Burford.

Session 2 - 18 consisted of the presentation of a seminar paper and then discussion of the paper by the group. Because the group members knew each other and I was a working member of the team, discussion was always easy and lively. The ideas discussed were related to Burford itself.

Session 2

This session asked the group to consider the nature of man, and argued the premise that before nurses could be clear about who they were, what they should do and what their contribution to care could be, it was necessary to agree on a basic philosophy of nursing which encompassed beliefs about Man (Mayers 1972). Brief accounts of the theories/philosophies of Plato, Marx, Freud, Sartre, Skinner, Christianity and Holism were given and the concept of holism was explored in greater depth.

Session 3

The first part of the session considered the individual beliefs written down by each nurse. All presented statements which reflected a belief in the worth of the individual and the notion of holism.

The seminar paper concentrated on attempts by nurses to define nursing.

Session 4

This was a development of the discussion in session 3 and led to the group suggesting that nursing should be an interactive process, aimed at meeting individual needs and therefore based on the patient's individuality. The complexity and impracticality of defining nursing was discussed at great length and the notion of constructing conceptual models, rather than stating definitions, was raised.

Sessions 5 - 7

These sessions proved to be very heavy and the group found much of the American literature confusing. The sessions considered nursing models and then pursued one model in depth at the request of the group, who decided that the model developed by British theorists (Roper et all 1980) was appropriate to their work, and asked that the British model be explored in depth.

The other systems models were dismissed as either meaningless, irrelevant or a lot hooey about nothing! Those models discounted were those of Bower (1977), Saxton and Hyland (1975), Neuman (1980) and Roy (1980).

Session 9

This was an open discussion based on individual papers presented by the group on nursing models. The overall feeling of the group was that using a model would clarify their thoughts, create a shared understanding of the nursing role in the study hospital, focus on patients rather than nurses and give nurses more strength to delineate their contribution to care,in the multi-disciplinary clinical team. They were extremely critical of all of the American models, largely because they had difficulty in understanding the language used.

Sessions 10 and 11

These began with a discussion of how care was organised in the hospital, and consideration of task assignment, delegation of nursing to unqualified nurses and continuity of care. The seminar paper presented considered alternative methods of organisation.

Sessions 12 - 18

Six sessions were devoted to exploring the nursing process - a concept being widely advocated at the time in the nursing press and the subject of much discussion throughout nursing. The group had little understanding about the nursing process and the sessions were very much didactic at first, until the group felt able to contribute. They included practice on the ward itself.

Sessions 19 - 22

These sessions were of a different format and were conducted by a team of professional actors who were experienced in conducting group work using role play. Because they were not health professionals and identified with patient and lay groups, they aimed at teaching professional practitioners to relate to their clients, from a lay perspective, through empathising with them.

The method was based on simulating patients by actors which is a form of role play, in which the role of the patient is taken by a trained simulator, and that of practitioner, by the participants of a training group. Simulators role play a patient, or relative or one, with specific problems; a participant from the group is asked to interact with the simulator in his/her 'professional' capacity; the interaction is observed via closed circuit TV by the group and the volunteer returns to the group and the interaction is discussed, using video feedback.

The theatre company involved in the sessions had previously developed an approach which utilised the simulators as lay teachers (Whitehouse et al 1984, Pearson et al 1984). The simulator returns to the group after the interaction, and becomes involved in the discussion, at first remaining in the simulated role and later, out of role. In addition, a member of the company co-leads the group with the professional teacher, to ensure that the lay perspective is emphasised, and the simulators are part of an independent company who develop roles from the basic medical/nursing/ biographical brief given by the professional teacher. Because of this, learning centres on attitudes between the professionals and patients, rather than on clinical 'scientific' aspects.

As the sessions progressed, trust developed and more difficult aspects of nurses relating to patients emerged, and were discussed sensitively,

in depth, and with increasing openness. By the end session, the group discussions had become long and wide ranging, and painful personal stories were being shared by the group.

Evaluation of the sessions in a later group meeting evoked entirely positive responses, although an acknowledgement that they were traumatic and exhausting at the time.

1. One of the more reticent nurses had, within a few days, found it possible to overule a doctor who had wanted a patient to be kept in the dark about her impending death. She said "It was cruel to let her die in the frame of mind she was in - but I couldn't, or at least wouldn't have pursued the topic with her before the session".

2. SN.1. said "I'm able to talk to relatives now - not happily, but without fear and trembling - having watched my colleagues sort it out in the sessions. And I'm conscious if a patient says he doesn't want something done, I think about why, instead of just persuading him otherwise".

3. "I've learned a lot about our own fears. It's something we've all talked about. There are no clear cut answers and I always thought there should be. But it's not like that. You can start with your relationship with that patient and work it from there. You're taught for years that there are nurse and patient roles to play, whatever your feelings may be. It's hard to cross that border".

4. "Oh, I've learnt so much. About me. About patients. About the others. We're much closer as a team of people, really. And I ache about the way I talk and behave with patients".

Sessions 23 and 24

These were scheduled to take place on the two weeks following the role playing sessions. However, the group opted to cancel these meetings because they felt a need to come to terms with the learning experienced in them. Four weeks after the role plays two further meetings were held. On the first, the educational programme itself was discussed and evaluated. All comments were positive; all participants expressed a desire to "change" the work of the hospital and all participants felt excited about the prospect of such changes. It was agreed that we would commit thoughts for change to writing and that a further session would be planned.

The experiential sessions more or less clinched the deal, by provoking group members to personally handle the values, and come to terms with them.

However, I do not want to particularly dwell on the teaching methods, or the content, except to say that the content was broad and the methods varied.

The points I want to draw out relate to the context, and the effects. First of all, withdrawing people to centres of learning would not have been appropriate at Burford because the problem of transfer of learning was apparent from past experience, and sending individuals or pairs is not the same as the whole group being involved.

had ever expected. Real attitudinal changes took place; the norms were changed and this became reflected in radical practice change. I believe that it had little to do with my expertise as a teacher - my past work in that role had not been memorable. It had more to do with my credibility because I did the same work as them, we all could contribute our ideas, and we were always relating it to Burford, and not to the various wards that participants come from in centralised workshops.

The unit's staff - nursing and the others - chose an alternative to the medical model for nursing practice. They joined in re-organising the structure to help in promoting individual accountability to patients; they began to believe in partnership, with shared records being made available to patients, and their choices supported, and they tried to be systematic in assessing, planning, implementing and evaluating individual patient needs.

The short, sharp six month job was not an end in itself. Since changes have been adopted, the need for more education has become more obvious, and absolutely essential. For example, the problems which primary nurses eventually recognised arising out of getting close to patients, and of the burden of coping with uncertainty arising out of that and explicit accountability to patients, demanded an ongoing input to increase communication and coping skills: conflict with other professionals demanded inter-disciplinary sessions; the need for up to date knowledge skills in such diverse areas as breaking bad news, to the physical management of incontinence began to be loudly expressed as the realisation of individual accountability sunk in.

Continuing education has in fact become an absolute necessity. And the way we practice has become useful to the post-basic/continuing education department in the School of Nursing, who use us by sending nurses to us for short 3 day periods where they work with primary nurses, and are taught in the adjacent seminar room.

Relating this to continuing eduction in general

What, though, can be generalised from the work of a small unit, in one area? I believe that the differences between specialties and units are less than we think; the experience at Burford suggests a number of things which I think are important:

1. Nurses are willing to change, but don't know enough to do so.

2. Team based teaching, on site, is important.

3. If the teacher is also clinically involved, and knows the unit, he/she is more credible.

4. Current changes require broad education on fundamental issues, rather than discrete skill teaching.

More importantly, change in practice is something that will always be needed, as knowledge develops and community needs change. It can only be achieved by qualified nurses who have access to continuing education. We at Burford have been fortunate in that it cost little to provide an educational input, and the little it did cost was forthcoming from understanding nurse managers.

But is that the case in most places? I leave you with some comments made by Pembrey (1984) made in the Kathleen Raven Lecture:

"...maintaining professional standards of competence requires frequent practice and continuing mastery of new knowledge and skills. Thus the standard of professional work depends on two things: qualified practitioners and the quality of the professional education in both the initial preparation and in the continuing mastery of the discipline throughout professional life".

---oo0oo---

A TEACHING QUALIFICATION AS A CONDITION OF SERVICE FOR NURSE MANAGERS AT WARD LEVEL - Dr John Birch, Chief Nursing Officer, North Lincolnshire Health Authority

The time that I am in relative to nursing and the district general management function is one of the most exciting that I have ever contemplated in my professional career.

Firstly, "our destiny is in our hands". We are not the puppets of a general management system, not puppets of political initiatives and incentives, we stand today as nurse professionals with the largest part of the budget. We need to look at that budget and ask some concrete questions about it because a lot of myth is talked about shortages and cut backs.

I think the definition of continuing education on the programme is grossly imperfect and falls far short of the ideal. When we talk about knowledge within a definition it really does form the tools of our trade in terms of real applicability. I reject the view that we are talking about the enhancement of nursing practice as a result of our continuing education. What we are really talking about is enhancement of the quality of care and that is very different.

If we believe that our own destiny is in our hands I think we have to be courageous enough to be politically sharp.

When we talk about the absence of places, for young people to read nursing, don't you think we are rather hypocritical when we continue to allow a situation where 38% of nursing is carried out by unqualified staff, and I am not referring to learners? Why don't we first of all say to ourselves that within a 5 year period we wish to phase out auxiliary nursing altogether? Is it an over ambitious objective? I believe that "man's reach must be beyond his grasp or what's a heaven for?" (Browning). There is a commitment in our own district to do that. Any auxiliaries appointed have a nine month contract which allows us to phase in more trained nurses. The differential in cost terms between the financing of nursing auxiliary posts and staff nurse posts is almost negligible in comparison with the gross local product.

I wonder how many of you in your respective districts enjoy relationship with the DMT, or with the executive team, where you rank as a unit in your own right along with all other units in your district and produce operational and strategic plans; and bid along with everyone else for the financial resources? If you haven't got such a structure then it is time you had.

In arguing that each ward sister or charge nurse in the North Lincolnshire Health Authority should possess a formal teaching qualification within 5 years, I am in no way emphasising the teaching qualification over and above that of sound clinical foundation. The clinical base must be the cardinal consideration in the ward managers armoury. Basic nurse training with a 'little topping up' at staff nurse level fails to begin to prepare the manager for the complex role that has been analysed so frequently.

The reasons for choosing the City and Guilds Further Education Teachers' Certificate are many and varied. It is an example of a course outside nursing at a very small cost, and addresses itself to the philosophy so crucial to the delivery of care. One cannot conclude such a course

without being forced to internalise the implications in Bloom's Taxonomy of Educational objectives. Bloom is to education what Freud is to psychology. Bloom aids in the understanding of the complexities of the nursing process. The course is an educational preparation, and an introduction to abstract thinking. It may be the first opportunity for a nurse practitioner to pass from the stage of precision to generalisation; and from antithesis to synthesis. For a day a week over one academic year, nurses are able to pursue concepts and philosophies with educationists, in an environment where "each student's conversation becomes a lecture to each" (Newman). Nurse managers at ward level are almost in a position of glorious isolation, the course brings them together regularly.

It is critical that in this Griffiths era we begin to address ourselves to the measurement of quality indices and performance indicators. Nursing has failed to describe a single output of care that effectively gives credibility to the art. We delude ourselves that we intuitively know that our work is of a high standard. For ward managers to understand the pressures of managing the components of activity, dependecy, and quality we must no longer live in Plato's cave where shadows are perceived as real, but emerge into the first blinding light of the real world to eventually become accustomed to a new way of living and a complete new way of thinking. We must try to ensure that those at the sharp end have the equipment to deal intellectually with the concepts required to carry out their tasks.

It is a Mode 3 course, which means that it encompasses a system of continuing assessment as the instrument of examination. My own experience indicates that selected candidates at ward sister and staff nurse level are quite capable of the academic demands made even though very few perceive beforehand the actual pressures of successful completion. The course is part time and I am almost persuaded that we should ban all full time courses. Ward sisters, charge nurses and staff nurses can meet on one day a week on the course and are able to generalise the knowledge which is built-in for the rest of their working week.

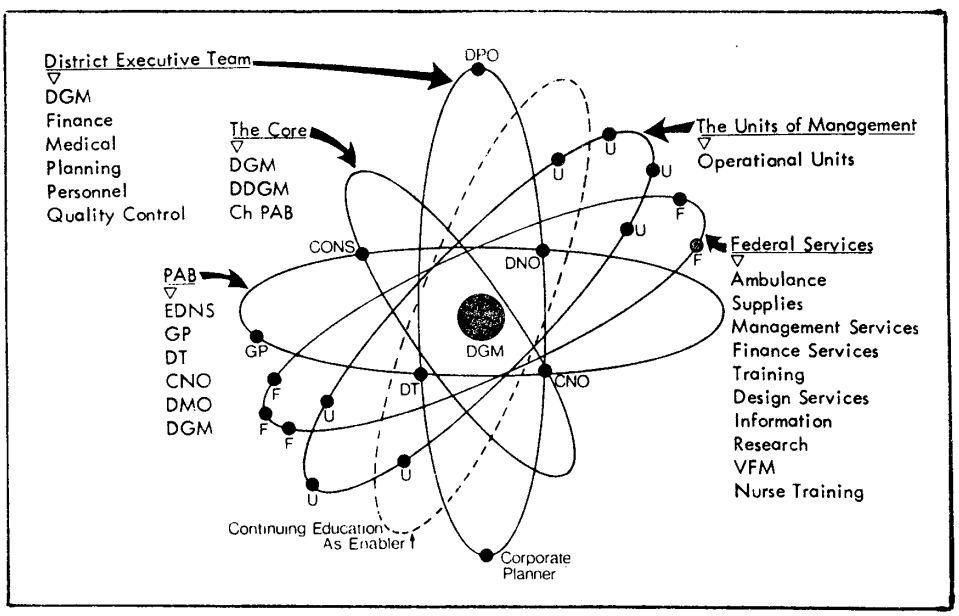
This course is in the nature of an intellectual pump primer pointing the way forward to other study courses at diploma and degree level. You cannot escape this course without being introduced to research elements of a real kind and that being so I believe that thinking mechanisms change almost at a stroke.

Lastly, it does introduce the professional to a formal consideration of education and teaching, and you will note the order of priority objectives today.

There is, I believe, a significant argument that one of the profound disadvantages that nursing personnel suffer is that their course of duty is such that few manage to cease becoming nurses. The thesis that I believe in more and more is that, only when nurses cease to think of themselves as nurses per se will we move forward in a number of dimensions. The recent abreaction caused by the Griffiths proposals is almost exclusively because of this factor in my opinion - both in my management and educational experience within the profession. I believe that our success at this particular time depends absolutely on the degree to which you and I are able to side step the nursing title. Education is not so much about imparting nursing techniques and skills per se but it is more about self awareness, listening, and the art of communication; and how to stand alone without the need to bounce ideas to the public we meet via consultant medical staff satellites.

Listening recently to a number of communications between ward sisters and their patients and relatives, it is incredibly fascinating to watch how everything that they communicate is via a second person. They may not be conscious of what they are doing, but listen and prove it for yourself. Some might concede that by redesignating the title of say Director of Nursing Services to that of Director of Patient Services, we may be taking the profession a light year leap ahead in our concepts. We have allowed empires to develop around us like flourishing mushrooms. We have ECG technicians and expose the patient to yet another face in the cold clinical analysis. Our domestic managers have emerged taking precious resources out of the system which could be spent on continuing education, you and I have allowed this to take place. Can we not rationalise the whole of the domestic worksforce so that it becomes accountable to the ward sister, as we have done within 2 units in our district? If the Assistant Director of Nursing Services gets into orbit there is no need for domestic services supervisor, and large sums of money could be reallocated.

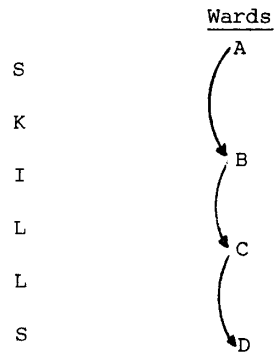
I would like to suggest an unusual configuration of management structures differing from the straight line organisation to a 'model relating to astronomy' or 'some nuclear physics model' and where continuing education may form a much more natural impetus within the framework. I warmly welcome the departure of the CNO title. I think I will be able to convince you that there are skills there residing in the CNO that have not been exploited, and if they were exploited then a redesignation of that particular name might make that person the most important person in the Griffiths organisation. We have got rid of straight lines and this configuration is how we are describing the district structure. The educational unit is there and always has been from the first day of this current reorganisation. The DNE along with his colleagues and a unit accountant meet regularly and present their operational and strategic plans in exactly the same way as all other units.



Around every orbit is continuing education, the guarantees for that to occur is due to the very strong multidisciplinary steering group that has been in existance for 2½ years.

If we can get away from persons and designations, because they are addressing themselves less and less to nursing and more and more to patient services, then we have made a step in the right direction.

We have decided to abandon the role of the Nursing Officer. We are moving to where the Assistant Director of Nursing Services is the clinical manager of a particular ward and is a ward sister or charge nurse in the truest sense of the word. The person is also the clinical co-ordinator of the 3 other wards of like specialty (B,C,D). She is the manager of corporate image. (And in 1985 we have declared publicly that we are having the corporate year of the nurse in North Lincolnshire). That person is also the director of quality control and will have direct access to CNO via DNS.



One of my prime functions in Griffiths is Director of Quality Control. I love the title, it is meaningful to nursing and I think it will become an extremely powerful influence when arguing for particular resources throughout the district. There is a tutor attachment to Ward A and we are making our first joint appointment this week. We are moving to a point where every teacher in the School of Nursing has a joint appointment with clinical accountability. Staff nurse training modules take place in Ward A, and it is the area in which ward sisters receive their primary preparation before going on a course.

Before we can argue for massive sums of money for continuing education we have to define very clearly the skills that are needed for all nurses in the organisation to become expert in. Cost of continuing education is uppermost in all our minds although I believe that as principle budget holders, nurses have failed to identify strategies of resource shift to free monies for development and redeployment. I believe that the average nurse budget is grossly over endowed both in staff terms and the supplies one consumes during delivery of care. If we asked management consultants to come in and rationalise our nurse staff budget they would say immediately that they would be looking for 10% to be quoted as a reasonable sum for redeployment and development. If you analyse the average shift overlap in any general or maternity division within a district of 250,000 population, the cost of that overlap is £1.413 million if North Lincolnshire is the average. Recent studies in our own district have shown that 7% of time spent during overlap periods is non-productive and inversely related to the quality of care provided. The cost of that is £98,951. Districts which switch from the use of flat

packed toilet tissues to conventional standard roll stand to save a minimum of £10,000 recurrently on an annual basis. Similarly if tin foil trays are replaced by papier mache trays in CSSD packs a single hospital of 500 beds can save in excess of £2,000 per annum. A Consultant and I spent 4 hours going round and identified £95,000 savings in medical and nursing sundries alone. We were able to go back to the DMT and say we have found this money, we want ⅔ of it for continuing education. We advertised for a Senior Nurse grade 2, who would have no management role except to look at efficiency and economy. The contract is defined in such a way that it is terminated if he fails to save £200,000 in any one year. He was appointed 1st April 1984 and has already identified £¾ million pounds and I believe he has enough work for 10 years.

The money is there - we have to become so politically motivated that we tell management what monies they are wasting and say to them beforehand "if we can save you £250,000 can we have a £100,000 of that for continuing educating?" It works and I commend the method to you.

---oo0oo---

THREE YEARS ON - FOCUS FROM SCOTLAND - Miss Billie Thomson, Nursing Officer, Scottish Home and Health Department

Since the publishing of the Report on Continuing Education for the nursing profession in Scotland 3 years ago it seems appropriate to take stock of where we are now. The happenings are not all a direct consequence of the reports' publication, many other influences have a direct and indirect bearing on the subject.

At the time of publication we ordered a print run of 500 copies. It was soon apparent that this was an underestimate of the demand and a further run was ordered almost immediately. We have had 4 reprints and orders still continue to come in at a steady rate from Scotland, England, Wales, Northern Ireland and colleagues overseas.

On the whole, Scotland and other parts of the United Kingdom, have been enthusiastic about the recommendations in the report. The profession generally, seems to have welcomed the existence of the report and supported the ideas for a framework for continuing education.

The former Scottish Training Bodies lent support to the proposals, and since then the National Board for Nursing, Midwifery and Health Visiting in Scotland has also accepted the major recommendations.

The report suggested that our current system of post-basic education is random, piecemeal, and not cost effective. It suggested that the same money could be better spent by a more systematic approach to nurse education; and that rationalisation could produce savings which could be spent on new courses. The claims of the Working Group could be demonstrated and illustrated, but could not be proved. Despite repeated attempts by the Working Party it was impossible to obtain any reliable information from the Health Boards in Scotland about the amounts of money that were currently being spent on post-basic and continuing education. This lack of hard financial data was, and is, a major weakness in that report. It is a deficiency which may continue to hamper our progress in the future unless we begin to be much more accurate in our estimates of costs of continuing education.

At the time of publication, the Scottish Home and Health Department circulated the report to the Health Boards in Scotland, and asked them for their reactions to the proposals. The 15 Health Boards agreed in principle to the main recommendations, and supported the notion that education for nurses is a life long process. On the question of implementation, their responses were more guarded.

The Report on Continuing Education does not exist in a vacuum. A major consideration affecting our provision in continuing education is the 1979 Act, which allows us the opportunity to regulate nurse education under a single unified structure.

There are very important assumptions underlying the report. Education is a life long process which involves learning to learn; the development of skills and habits of study required for self directed learning. The educational foundation must be built upon, and the profession must accept that retraining and updating will be required on a frequent basis. The development of the individuals' potential is important. We are mainly a female profession, and must expect breaks in service, part time work. The education and training proposals must take account of these needs. Education which is concurrent with work is essential. In continuing education, both the organisations' need for skilled personnel and the

individuals' desire for further education must be identified and matched so that we can make optimum use of resources. The report assumes that talent should be spotted and developed, both in the sense of potential to expand the scope and range of abilities in the present job, and to take on added spheres of responsibility in promoted posts. Another important assumption is that professional qualifications in nursing should be able to demonstrate their level of academic achievement so that they can be explicitly compared with awards made in the general education sector. Post-registration qualifications should be available in all fields of nursing, and individual nurses should progress to advanced qualifications in their chosen fields of specialisation rather than obtain further first level qualifications as some sort of quasi-validation for other registrations. We in Scotland may have to change our view about separate initial qualifications, and think about a foundation which is more generic than specialist.

The Report on Continuing Education is about a total education system which will lay down the foundations for a personal commitment to a lifetime of study and updating, and later allow individuals to build further clinical knowledge and skills upon these foundations. It will create a system where good management practice demands the development of each individual to full potential, and provides opportunities for the aquisition of additional skills in management, teaching and research as the professional career develops. The system must also recognise that the working week is short and may become shorter. The system must be sufficiently flexible to allow for the needs of part time staff having breaks in service. We cannot any longer afford to work on an outmoded model of a female spinster profession with a long linear career pattern.

These things take time, and it was emphasised in the report, that they must evolve within a sound system of staff appraisal and staff development. It is not just changes in courses and in structures that will be required, but changes in attitudes and emphasis; changes which each of us are involved in, or should be involved in right now. Staff appraisal and staff development is a means by which the appropriate learning experience for individuals can be identified. Continuing education is about the placement of individuals so that they are afforded opportunities to try out new types of work; and managers, teachers and clinicians working together, pooling resources so that the NHS can have the benefit of staff with the appropriate knowledge and skills for the job.

In Scotland the National Board has accepted the main recommendations but may wish to modify certain recommendations to take account of local circumstances. The Board, in its first three years lost no time in planning the way forward in continuing education. It set up a number of working groups to look at the various courses recommended within the report and invited the groups to submit proposals on the following:

1. Induction and orientation period for newly qualified staff nurses

2. Stage 1 and Stage 2 Clinical Diploma Courses. To make recommendations for the provision of such courses in General Nursing, Mental Nursing, Mental Handicap Nursing and Sick Childrens Nursing.

3. Types of course and study which might be appropriate for the preparation of the ward sister

4. Specific short modular courses for experienced ward sisters.

The four groups have produced advice and guidelines which have been considered by the Board. Priorities have had to be considered and plans made for bringing a system into action. The report talks about a system

of continuing education as if it already existed. The plans must make provision for the transition period when the majority of nurses who are already in the system have not had the opportunity for this type of study. The new system of training for General, Mental, Mental Handicap and Sick Childrens Nursing in Scotland started in 1982. The first pupil nurses have already qualified and the first student nurses will register in 1985. It therefore seemed appropriate for the Board to set a target date for Induction and Orientation programmes to be available for the first staff nurses who complete the 1982 syllabus. Guidelines for this induction programme, which recommends a minimum of 50 hours tuition, have been issued to the Health Boards in Scotland. The induction programme will not lead to a National Board Certificate or Statement. The National Board has indicated that comments and information will be welcomed from the 15 Health Boards, about how these programmes are being developed and the problems and strengths they are discovering within them. Already before the target date, more than 50% of the Health Boards are offering such programmes to newly qualified staff nurses. It is hoped that these guidelines for induction programmes may form the basis for induction programmes for other grades of staff as they move into new posts.

The next priority the Board identified was to enhance the knowledge and skills and to improve the confidence of experienced charge nurses who play a major part in the future development of the Clinical Diploma Courses. Many able charge nurses are anxious about their role as teachers and have expressed a desire for assistance with the development of this important aspect of their work. The Board has prepared an outline syllabus for a short modular course and has secured funds to pilot the courses in 3 centres in Scotland. These courses are already running and will be evaluated quite soon. They are an interim measure and not the type of courses for subsequent years when charge nurses will have had a good clinical foundation and specific preparation for ward teaching.

Midwives, Health Visitors and District Nurses have also featured in the Boards discussions about continuing education. The National Board has produced guidelines for a new advanced course in Midwifery. Work is continuing on a core curriculum for District Nurses and Health Visitors Courses and we may in time be able to include School Nurses and Community Psychiatric Nurses in the exploration of common core studies.

I have concentrated today on developments specifically related to the Report on Continuing Education for the nursing profession in Scotland, but we have a long history of provision of education for nurses within the University and Higher Education sector. In the University and Higher Education sector there have been developments which contribute to our continuing education; many of these started long before the writing of the Report on Continuing Education, and some may have been influenced by the recommendations within the report. In addition to research degrees, there are opportunities for nurses to study for Masters Degrees in Administration, Education and Clinical Studies, Diplomas in Management and professional studies plus part time first degrees for nurses who have already qualified are all a part of the totality of provisions for continuing education.

Progress sometimes seems slow, but the report was issued very late in 1981 and became generally available in the Spring of 1982. By early 1983 the National Board had endorsed its main recommendations and set up Working Parties to make proposals for continuing education. By July 1983, guidelines for induction and orientation courses had been issued, followed in August 1983 by the syllabus for the ward sisters

module. Plans and proposals for Clinical Studies 1 and 2 (the Diploma type courses referred to in the report) are currently at an advanced stage of development.

Personally, I feel a sense of excitement that continuing education is recognised by our profession to be not a luxury but an essential part of our professional life. In the case of Scotland, the Report on Continuing Education is not going to go away, and I believe that we can find the resources to make this essential provision a reality.

---oo0oo---

THE FUTURE OF CONTINUING EDUCATION - Audrey Emerton

Maureen Lahiff said "Do we seize the opportunity of change?" "Change is inevitable, in a progressive country change is constant" (Disraeli 1867). In considering the future of continuing education it is important that we keep in mind that change is constant.

There will always be people requiring care but the care will differ with the needs of the individual, rapidly changing concepts and new philosophies of care. It is necessary to be proactive, rather than reactive.

Alan Pearson remarked "even the Statutory Bodies are changing". The Nurses, Midwives and Health Visitors Act 1979 states that the National Boards under the United Kingdom Central Council have "to make new provision with respect to the education, training, regulation and discipline of nurses, midwives and health visitors". One of the functions of the National Boards is to provide courses of further training for those already registered. There are 400,000 qualified nurses, midwives and health visitors currently employed in England. The problems in identifying the needs of the individual staff, organising the means of meeting and financing the needs are enormous.

In order that the Statutory Bodies can be proactive, there is an urgent need to identify the knowledge and skills necessary to equip nurses, midwives and health visitors to meet the present and future requirements of health care. The shift towards community care for the elderly, mentally handicapped and mentally ill, and the technological advances reflect a rapidly changing era of health care provision.

Each one of us has a responsibility for our continuing education; a personal accountability for ourselves, our peers and subordinates. This is clearly set out in the UKCC Code of Practice (Points 3 and 12).

The English National Board has forty five members who have taken on the work of 150 members of the previous organisations. In addition to developing strategies the Board has continued with Approvals and Applications, and Investigations of Misconduct and had a 4.5% cut in finance.

Before the handover of functions in July 1983, the shadow English National Board had discussed the importance of continuing education and stipulated that it should be a priority for the attention of the elected Board. The shadow Board recommended that a rolling programme be developed. Existing continuing education opportunities would have to be identified, any possible deficiencies or overlap noted and suggestions made as to how all nurses, midwives and health visitors could benefit from the educational provision.

3 months after coming into being the English National Board Members attended a residential seminar to address themselves to the questions:

What is a nurse ?
What does a nurse do ?
What should be basic and what should be continuance ?

As a result of this seminar Working Groups were set up to put together a composite strategy for the short, medium and long term. The strategy must take into account inter relationships of basic and continuing studies, post-basic and in-service training programmes, the organisation of such

programmes and funding the means to achieve them. The strategy will be ready for presentation to the Minister in May 1985, and then put out for consultation with the profession. The Board recognises that it is important that future continuing education is both progressive, building upon the foundation of the first level course, and developmental, meeting the needs of the individual and service to adjust to changing systems of care.

1. Building on the foundation of the first level course - this cannot be restricted to the National Boards. The UKCC must determine the future, and has set in train Project 2000 which is looking at the future strategy in terms of the total role of the nurse. The National Boards are looking at the first level nurse syllabus and continuing education courses in clinical studies.

2. Meeting the needs of the individual - we have failed to develop fully the means of identifying the needs of the individual. Job Performance Review identifies key tasks and training needs. Jill Rogers' Survey illustrates the number of Health Districts who are not or only partially implementing this approach, some having laid it aside since the 1982 re-structuring. Job Performance Review is something which can be done now!

   The needs of individuals working in the private sector, agencies, occupational and other forms of non NHS employment need to be considered. The Statutory Body has a responsibility for ensuring that there are means of continuing education for all those employed in the professional whether working in the NHS or not.

3. Meeting the needs of the Service - the National Health Service is producing by May 1985 strategic plans for the next 10 years. The plans will indicate the service to be delivered by Health Districts, manpower implications and consequential education and training requirements.

   The English National Board has a mechanism for scrutinising strategic plans so that educational strategies take into account service requirements. When District and Regional Strategies are being considered there must be a positive input relating to the training and education of nurses, midwives and health visitors from educationalists.

4. Resources - we have already had an emphasis on effectiveness, efficiency and value for money in the present national economic climate. We have to take into account not only the costing of the recommendations which will form the strategy for continuing education, but also our credibility. Are we credible when we put forward a case for more resources? The former General Nursing Council and Shadow English National Board experienced Regions who were underspent on their education budgets. Whatever our cash limit is, let us make sure that we put the money to the best use in a cost effective way.

The prospects for the future are exciting in the rapidly developing range of methods for persuing continuing education e.g. distance learning. Having distance learning available so that clinical staff avoid the need to attend courses away from home must be the way forward. The means of financing this development is also exciting in that non NHS funds are being utilised i.e. the Manpower Services Commission are providing the finance.

We must put away our traditional approach and be leaders in the field of education and training methodology to benefit the profession and in turn, the population we serve.

The English National Boards' programme is as follows:

> In January, 1985 a Seminar is being held to formulate the proposals to be incorporated in the Boards strategy for the short, medium and long term.

Whatever the Board incorporates into the strategy to meet staff development, continuing education, post basic and in-service training, it will be to no avail unless there is a means of implementing the recommendations. There has to be co-operation, understanding and willingness on the part of health authorities, nurse managers, and educationalists. Commitment and provision of resources are required.

Education and training must be given clearly defined parameters of responsibility and accountability within the new organisational structures with the introduction of the general management concept. The Board will be sending out guidance to health authorities in relation to the position of nurse education under Griffiths.

"Change is inevitable in a progressive country change is constant". Nurses, midwives and health visitors are used to frequent organisational changes, not other discipline has survived so many organisational changes in the last 15 years. We need to stimulate a change of attitude of mind to continuing education in the future. Let us not be defensive but take up the challenge which is before us, ensuring that there are means to provide appropriately qualified nurses, midwives and health visitors to meet the needs of the population we serve.

The challenge rests not only with the Statutory Bodies but with nurse educationalists, nurse managers, and practitioners who need to influence health authority chairmen, members, general managers, Ministers, Secretary to State and the government. The challenge is ours to prove positively and cost effectively that continuing education is a necessity and not a luxury, in the interests of the profession and the public.

I would like to end with two quotations. "Where there is no vision, the people will perish" (Proverbs III). "United we stand, divided we fall". I hope that it will not be as "service" and "education" but as the nursing profession that we go forward together in the interests of those whom we serve.

--oo0oo--

CHAIRMAN'S CLOSING REMARKS - Hazel Allen

The time has come to thank the afternoon group of speakers for continuing the stimulation, if not the irritation, into the afternoon.

You have decided today that continuing education is a necessity if we are going to survive as a profession. We have had some exciting things presented to us which need careful thinking about. Thinking is a painful, difficult exercise and can only be done by individuals. We must think about what we want, how we are going to get it and how we are going to plan our strategies and tactics.

There has been talk of power and everybody here thinks that the power is elsewhere, for example, with the English National Board. The Latin derivative of power, 'potere' means 'to be able'. Everyone in this room is able to examine the issues we have explored and to produce some growth points, however small. I end as I did at the last conference on continuing education: **each one of us has the capacity to be able to do something, each one of us is responsible for the power we possess.**

---oo0oo---

CONTINUING EDUCATION: Planned, organised learning experiences designed to increase the knowledge skills and attitudes of qualified nurses for the enhancement of nursing practice, education, administration and research in order to improve the performance of the professional.

EDUCATION AND TRAINING: Education and training are regarded as functions of the school of nursing. It is important to distinquish between working towards the concept of the 'educated man' and having the more limited and specific goals implied by the term training. (Hirst and Peters, 1970)

Training ensures the individual's capacity to respond to a given situation in a given way, by a process of instruction followed by practice under supervision. Education is the means of giving opportunities to sharpen the mind, thus increasing the individual's capacity to think for him/herself, to reason and indeed to continue to learn. Education implies professional development which should be the concern of those providing learning experiences.

HIRST, P H and PETERS, R.S. The Logic of Education. London, Routledge & Keegan Paul, 1970.

APPENDIX B

* Miss Hilary Brown	Senior Tutor - PB Education, Salisbury School of Nursing
Miss E A Comely	Senior Tutor - PB Education, John Radcliffe Hospital
* Mrs Kathy Eeles	Senior Nurse Tutor, Thomas Guy School of Nursing
Mr John Horton	Senior Nursing Officer - CE and SD, Hastings Health Authority
Miss June Horton	Assistant Director, Continuing Education Royal United Hospital, Bath
Mrs Hilary Hyde White	Senior Tutor - PB and CE, School of Nursing Barking Hospital
Mrs Jackie M Oliver	Asst. Director of Nurse Education St Mary's Group School of Nursing
Mrs Margaret Reed	Senior Tutor - Continuing Education School of Nursing, St Bartholomew's Hospital
Mrs Sue Studdy	Asst. Director of Nurse Education St Bartholomew's Hospital

* Left the group since 8 November 1984