REPORT OF A STUDY VISIT TO THE BETH ISRAEL HOSPITAL, BOSTON, MASSACHUSETTS

MONDAY, 18TH MAY 1987 until FRIDAY 22ND MAY 1987

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King's Fund

Beth Israel Hospital, Boston

Mr. H.I. Day for School Library

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SUMMARY

This report outlines a visit to the Beth Israel Hospital, Boston, where I looked at the way nursing care was organised and delivered.

I am based in the Central Nottinghamshire district in the Mansfield and Worksop School of Nursing and, as a nurse teacher, I have an academic interest in the nursing process. I am also the link person for the U.K.C.C. Project 2000. This fuelled my interest in Primary nursing, which I see as the way forward for nursing.

Interest was expressed in Primary nursing from several areas in this district who believed that local application was a possibility.

Primary nursing is the delivery of care in a highly individualised manner. The primary nurse assesses the patient, plans the care, implements the care when on duty, evaluates the patient's progress and is responsible for the patient through to discharge, being accountable for the patient's recovery and discharge needs. It can be contrasted with patient allocation where a group of nurses have responsibility for a group of patients - but these are interchangeable. It can also be compared with task allocation where the ward team divide the work load into tasks which are carried out on a hierarchial basis.

The Beth Israel hospital has a philosophy and purpose that is patient centred and goal directed and, because the Royal College of Nursing had positive links with this hospital and they had a reputation for encouraging study visits by nurses from other countries, I decided to go to the Beth Israel with the intention of discussing with the staff my areas of interest and concern as outlined in my aims and objectives.

PRIMARY NURSING DEFINED

PRIMARY NURSING:

Primary nursing emphasises continuity of planning and patient care, accountability and responsibility of the professional nurse and the decentralised decision making.

Old organisational structures, in which decisions are made at the top and "trickled down" to staff, do not work in a decentralised, primary nursing model.

PRIMARY NURSING STRUCTURE:

1. Every patient has a primary nurse on admission.

2. Each Registered General Nurse should carry a minimum of one primary patient at any given time.

3. Assignment of primary nurses should be based on the nurses time schedule, current case load and ability to independently carry out the Nursing Process required by the patient.

4. The name of the primary nurse assigned to each patient will appear on the patient's notes, kardex and by the bedside. A complete posting of their assignments of primary nurses and their patients should be in a central location on the ward.

5. Daily patient assignments should be based upon each patient's individual requirements for varying levels of nursing care. The primary nurses should be responsible for the direct care of their patients where possible.

6. Primary nurses should communicate with associates and other professionals involved in the patient's care through shift reports, ward rounds and multidiscipline care conferences and documentation.

7. Primary nurses can also be night shift workers, in some areas, especially if they work fulltime. Part-time day staff can also participate.

8. Off duty involvement should be discouraged.

THE PURPOSE OF THE PRIMARY NURSING MODEL:

- promotes planned, consistent, appropriate patient care.
- promotes patient/family/staff education.
- promotes professional accountability and advocates the R.G.N. role.
- promotes more effective communication pathways.
- promotes an effective system for monitoring patient care quality.

THE PURPOSE OF THE PRIMARY NURSING MODEL (continued):

- promotes decision making at the patient care giver level.
- promotes the Head Nurse (Sister/Charge Nurse) as direct patient care giver.
- promotes R.G.N./physician collaborative practice.

PRIMARY NURSE AND PATIENT ALLOCATION BOARD:

BED NO.	PATIENT'S NAME	DOCTOR	PRIMARY NURSE	NURSE ON DUTY

This board should be placed on the wall in a central location.

Physicians and hospital personnel can readily look to see which nurse is caring for a patient.

The board becomes essential in planning shift assignments and in determining each primary nurse's patient load.

ACKNOWLEDGEMENTS

I would like to acknowledge the contributions made to this report by the following:-

Rosemary Causer, Sister, Curie Ward, King's Mill Hospital, Mansfield.

Pamela Gamble, Sister, Maltby Ward, Forest Hospital, Mansfield.

Beverley Stone, Staff Nurse, Ward 5, Harlow Wood Orthopaedic Hospital, Mansfield.

I would also like to thank Mr. H.I. Day, Director of Nurse Education, Mansfield & Worksop School of Nursing, for allowing me the time to make this visit.

AIMS AND OBJECTIVES

AIMS:

The aim of my visit to the Beth Israel Hospital in Boston was to look at the way nursing care is delivered and contrast this with the system that I know.

OBJECTIVES (1 - 4):

The objectives were:-

To gather data relevant to a structural set of questions about nursing practice. The questions related from 1 - 4.

1. To observe the way the ward is organised and how this affects the nursing care, including nursing assessments and documentation.

2. To contrast these findings with the way care is organised in my own hospital.

3. To use these findings to introduce new ideas into my own district.

4. To consider whether Project 2000 will move the British system in the direction of this method of organising care.

STUDY PROGRAMME AND COMMENTARY

STUDY PROGRAMME OF APPOINTMENTS:

The following is an outline of my programme:-

Monday, 18th May 1987

09:30 - 11:30 hours: Meet with Marjorie Bachmann RN, Assistant to the Vice President, Nursing.

Tuesday, 19th May 1987

10:30 - 12:00 hours: Meet with Heidi Picard RN, MS, Nurse Manager 6 Gryzmish.

12:00 - 13:00 hours: Meet with Jean Gilbert RN, MS, Faculty member, Northeastern University College of Nursing.

Wednesday, 20th May 1987

11:00 - 12:00 hours: Meet with Nancy Zarle RN, MS, Nurse Specialist, Continuing Care (published book).

12:00 - 13:00 hours: Lunch with Nancy Miller RN, MS, Nurse Specialist, Quality Assurance.

Thursday, 21st May 1987

07:30 hours: Consultation and observation on a patient unit, 6 Gryzmish, with a primary nurse.

Friday, 22nd May 1987

07:30 hours: Consultation and observation on a patient unit, 6 Gryzmish, with a primary nurse.

Meet with Marjorie Bachmann RN, Assistant to the Vice President, Nursing:

Meet with Heidi Picard RN, MS, Nurse Manager, 6 Gryzmish:

Discussed the role of nurse manager.

Shown around 6 Gryzmish.

Introduced to staff.

Exchanged ideas.

Meet with Jean Gilbert RN, MS, faculty member, Northeastern University College of Nursing:

Discussed role of teacher.

Exchanged ideas.

Discussed difference in American and British curriculum and resultant attitudes.

Meet with Nancy Zarle RN, MS, Nurse Specialist, Continuing Care:

Discussed role.

Looked at books Ms. Zarle had written.

Discussed the way the nursing process is used in the community.

Lunch with Nancy Miller RN, MS, Nurse Specialist, Quality Assurance:

Discussed role.

Exchanged ideas.

Talked of mutual interest in stress related disease and therapies.

FINDINGS 1 - 4

1. ORGANISATION OF A WARD IN THE BETH ISRAEL HOSPITAL THAT HAS IMPLEMENTED PRIMARY NURSING:

The motto of the Beth Israel Hospital in Boston is "from strength to strength" and the way that nursing has developed under the auspices of Joyce Clifford, the Director of Nursing at that hospital, is reflected in the response of patients and the rigorously positive approach of the nurses to their work.

The objective of primary nursing is the positive outcome it has on the patient and the improvement in the continuity of care delivered.

Introducing patients to the ward:

Patients receive a card on introduction:-

Ward .....

Hospital .....

Your Primary Nurse is responsible for planning and co-ordinating your care from admission to discharge

Primary Nurse .....

The patient is usually referred by a G.P. There is an admitting room where the patient is received and investigations take place and a history taken. Then the patient comes to the ward. If they are having surgery, they come in early morning - 06:00 hours - and have surgery the same day. Only open heart surgery and transplants come in beforehand. A Co-ordinator (who is equivalent to a Ward Receptionist) receives a call saying that the patient is coming to the ward and the Admissions Department is responsible for locating an empty bed for the patient. This could be on a number of wards because there is a mixture of medical and surgical patients. On the ward that I observed there was a patient who had had a kidney transplant and in the next room a patient who had suffered a myocardial infarction. The Co-ordinator has a microphone and announces that there is a patient to be "picked up". Decisions are made on the ward as to which nurse will become the primary nurse for that patient. She will usually have approximately four patients for whom she is caring, so it is negotiable. The old notes come up to the ward, the primary nurse receives her patient and makes her introductions. The primary nurse then welcomes his/her patient and makes the assessment using a model that includes physical, psychological and social guidelines (see Appendix 1). She uses the SOAP model as an overall guide.

S = subjective assessment;

O = objective - how the nurse herself percieves his/her difficulties;

A = assessment - going through the whole system in guideline;

P = problems - identifying specific nursing problems.

The nurse's data is then written on a history sheet and she will use SOAP to record her findings. She will then describe her patient's problems and write a care plan for these problems and set a goal and an evaluation date. He/she will record the problems on a card (see Appendix II). The document is filed within the medical notes.

Patients' response:

When I spent a few days on 6 Gryzmish ward, I was impressed to observe a gentleman patient's eyes light up when he saw his primary nurse approaching and a lady registered disappointment when her primary nurse didn't appear. "Where's Mary?" she said, referring to her primary nurse, "She knows me".

Under a team functional system of nursing, interaction between nurse and patient is sporadic and fragmented. Implementing care and evaluation is done by whoever is on the shift - there is depersonalisation and ritualisation of patient care.

"Primary nursing differs from the traditional approach in which several nurses are responsible for different aspects of a patient's care". In other words "team nursing is fragmented care; primary nursing is personalised care" as Marti Morrison RN stated.

2. TO CONTRAST THESE FINDINGS WITH THE WAY CARE IS ORGANISED IN MY OWN DISTRICT:

The system is not totally divorced from the one that we use in the Central Nottinghamshire Health Authority. At present we do not have a ward clerk. A nurse may admit a patient and carry out a nursing assessment, using a model of nursing that was devised by the Mansfield and Worksop School of Nursing. This is based on the work of Virginia Henderson and Nancy Roper and incorporates sixteen activities of daily living (see Appendix III).

The care plans may be written by a different nurse and the care carried out by different nurses, including students and auxiliaries.

The nursing notes are kept in a separate file to the medical notes.

We use a Kalamazoo system of documentation which has a separate sheet for taking the history of the patient, an assessment sheet which is blank apart from observations, and a problem sheet and progress sheet (see Appendix IV).

Patients' response:

This is in contrast with the situation in many United Kingdom settings where patients will say how kind the nurses were etc., but sometimes they never see the same nurse twice. Care is delivered by many nurses - there is no one person who sees them. From admission to discharge, the primary nurse is aware of the patients' psychological and social states and intervenes directly as advocate and carer. Patients appreciate and respond to personalised care. It actually happens that nurses become attached to patients in a task allocation ward but the routine of care for all the patients on the ward is uppermost in the ward objective.

Patients often reveal many problems of an intimate nature to a wide variety of people and this information is not always documented or acted upon because no one is sure whether or not this has already been done.

A nurse is currently doing a piece of research in this District asking nurses to give their opinions comparing the usual delivery of care to primary nursing. They like the idea of having a small number of people that they know really well. They like the fact that they can follow them through to discharge as opposed to fragmented delivery again. However, some nurses (both R.G.N. and S.E.N.) found many reasons to object to this method, preferring a nurse to be in charge of the nurse (see Appendix V).

3. USING THE FINDINGS TO INTRODUCE NEW IDEAS:

History:

Sister Rose Causer on Curie Ward believed that on her ward there had been little change in the approach to patient care since the 1960's. Nursing Process was non existent, although distribution of work was patient rather than task orientated, there was no continuity of care as one day you would probably be looking after the men and next day the women. The work was also unfairly distributed as those who worked harder ended up with the most to do. Nurses also felt "second class" in the profession when contrasted with their colleagues in the high powered acute nursing situations.

She believes the problem was two-fold:-

(a) No continuity for the patients (very institutionalised) no one with whom they could identify as a friend and mentor.

(b) To get the nurse to recognise herself as a professional worthy to stand beside the other professionals.

How to implement change:

None of the nurses knew anything about the Nursing Process so Sister decided that the whole ward staff, including auxiliary nurses, should complete the Open University Course on the Nursing Process so that all staff had a good grounding and could discuss and decide which concept of the Nursing Process would best fulfil the needs of the patients and the staff. On looking at the three methods of organisation - task allocation, patient allocation and primary nursing - the staff decided on primary nursing.

How to implement primary nursing:

At first nurses were allocated to patients. Once this started, and the nurses saw the benefits, it was decided to commence primary nursing and create proper teams with primary, associate and helper nurses (see Appendix VI). The ward was extremely short of staff and Sister was the only Registered General Nurse on the ward at the time so, in order to overcome the problem of accountability, it was decided that Sister would act as "resource" to all the primary nurses. Plans were made of all the staff and patients and, on average, it was found that a nurse would be Primary to one patient and associate to about three others, with auxiliaries fulfulling the role of helpers. Where auxiliary nurses had taken a real interest in a particular patient, Sister became Primary to that patient in order that they could carry on the work they had begun.

It was decided that day nurses would be the primary nurses for the permanent residents and the night nurses would be primary nurses for the patients in for respite care.

The logistics were worked out by noting the number of trained staff to the number of beds and dividing the patients equally among them. The auxiliaries were then divided into helpers for 'X' number of patients. This method has now been used when introducing primary nursing into other areas.

Change in ward routine:

In order to develop each trained nurse to her full potential, it was decided to give each one the chance to run the ward, regardless of seniority. Therefore, when the off-duty was made up, a ward co-ordinator for each shift would be appointed (throughout the week each trained nurse would be given the chance to be co-ordinator). This would be indicated by a small letter "c". The ward co-ordinator would be responsible for the smooth running of the ward in the old sense of the word.

Ward reports:

It was decided that the co-ordinator of each shift would take and give reports to all staff, rather than primary and associate nurses just reading the kardex on their patients, in order that everyone on the ward knew what everyone else was doing. (It was felt that the nurses were not yet ready to lose the security of having a structured report.)

Planning and delivering care:

These were planned on the new documentation by the primary nurses, in consultation with associates and helpers, and countersigned by the ward sister. Medical and paramedical members of health care teams are encouraged to consult the plans with primary nurses. Wherever possible, delivery of care should be by the primary nurse. If changes need to be made and the primary nurse is not on duty, these are made by the associate nurse and the primary nurse is consulted when she returns to duty.

Medicine rounds:

During the day this is the responsibility of the primary or associate nurse. If she is too busy to ensure that her patient gets the required medication she must appoint a colleague to give her medications for her. Unfortunately, in the evening and at night, staff shortages made this impossible and the old style medicine round is still performed.

Ward rounds and multidisciplinary meetings:

As these occur only once per week it was found to be impossible for each nurse to present her own patient. It was felt, therefore, that it would better if the nurse presented her patient if there was a problem that she wanted help with or if she could see the solution but needed some sort of authoritarian sanction.

If the Consultant decided upon any changes for a patient, and the primary nurse was not available, then the Co-ordinator reported to the primary nurse. If the primary nurse was not available to represent her patient then she would ask the Co-ordinator to do so on her behalf.

Medical and multidisciplinary staff are encouraged to consult the primary nurse at all times as she knows more about her patient than anyone else.

Accountability:

The shift co-ordinator is responsible for the smooth running of the ward.

If the Registered General Nurse is not a primary nurse then the resource nurse is ultimately accountable for the plan of delivery of care; but all care is planned and delivered by primary nurses. From a legal point of view, however, a Registered General Nurse is the only one who can be held accountable.

Dealing with relatives:

The primary nurse would be expected to introduce herself to relatives and involve herself in dealing with problems.

Introduction cards are being made in our Occupational Therapy Department and also a large wipe-over board is in a central position in the ward with the patient's name and his/her primary and associate nurse.

Review and workshops:

Nursing staff reviews of care plans, involving all available staff, are carried out by primary nurses when appropriate (depending on patient changes).

Advantages:

There is a better relationship between patients and carers. They now feel they have someone who cares and with whom they can identify. The nurses are accepting and coping with more responsibility. They are acting like professionals, making good, advantageous decisions and acting on them. The nurse is now being recognised as a professional among professionals.

Disadvantages:

Some nurses are not yet ready for all the encumbant responsibility. Some nurses may become too attached to their charges. More staff are needed on the afternoon and night shifts to facilitate continuity of care.

4. TO CONSIDER WHETHER PROJECT 2000 WILL MOVE THE BRITISH SYSTEM IN THE DIRECTION OF THIS METHOD OF ORGANISING CARE:

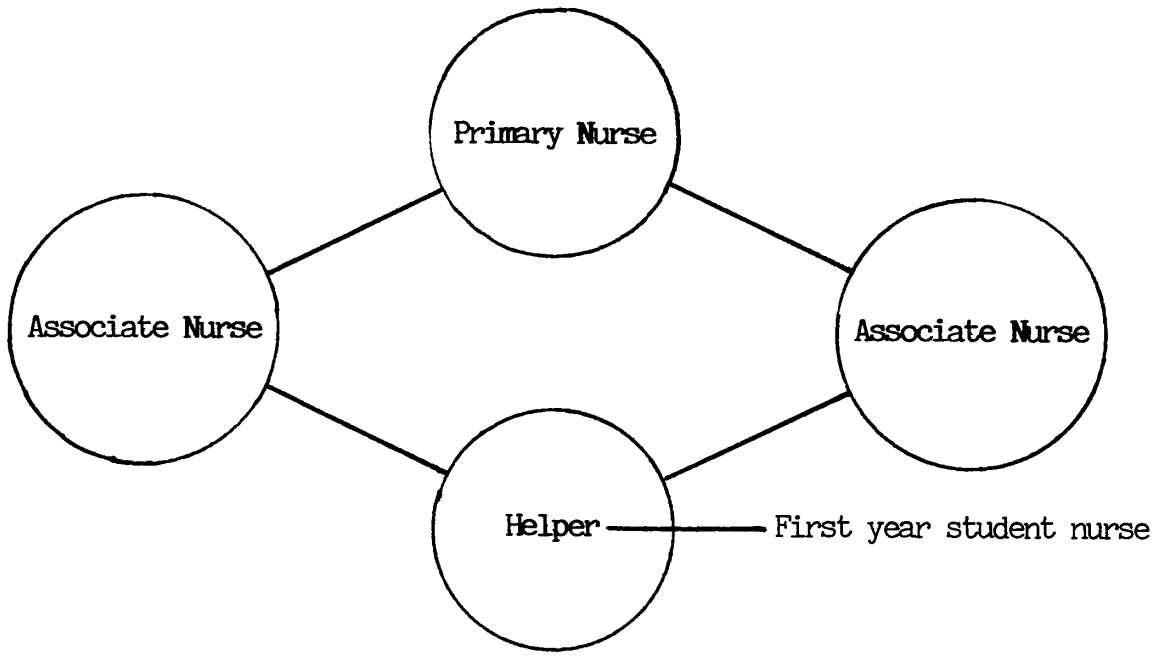
Appendix VII is an outline of Project 2000 and the critical responses in the form of a series of questions. I have selected some of the questions and have responded in the light of the positive value of Primary Nursing.

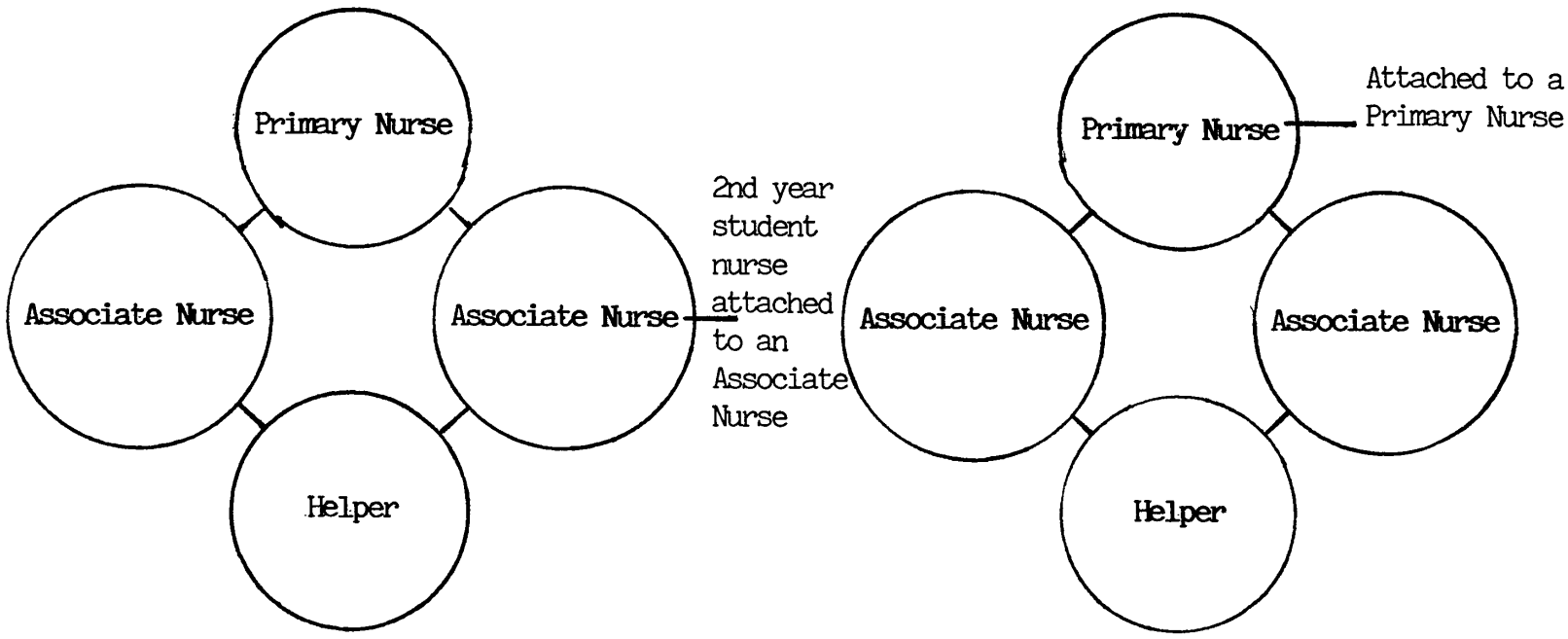
Question 4:

What are the main considerations you would have to take into account in establishing the proposed 20% service contribution?

Response:

The student service contribution may be utilised where Primary Nursing is implemented as follows:-





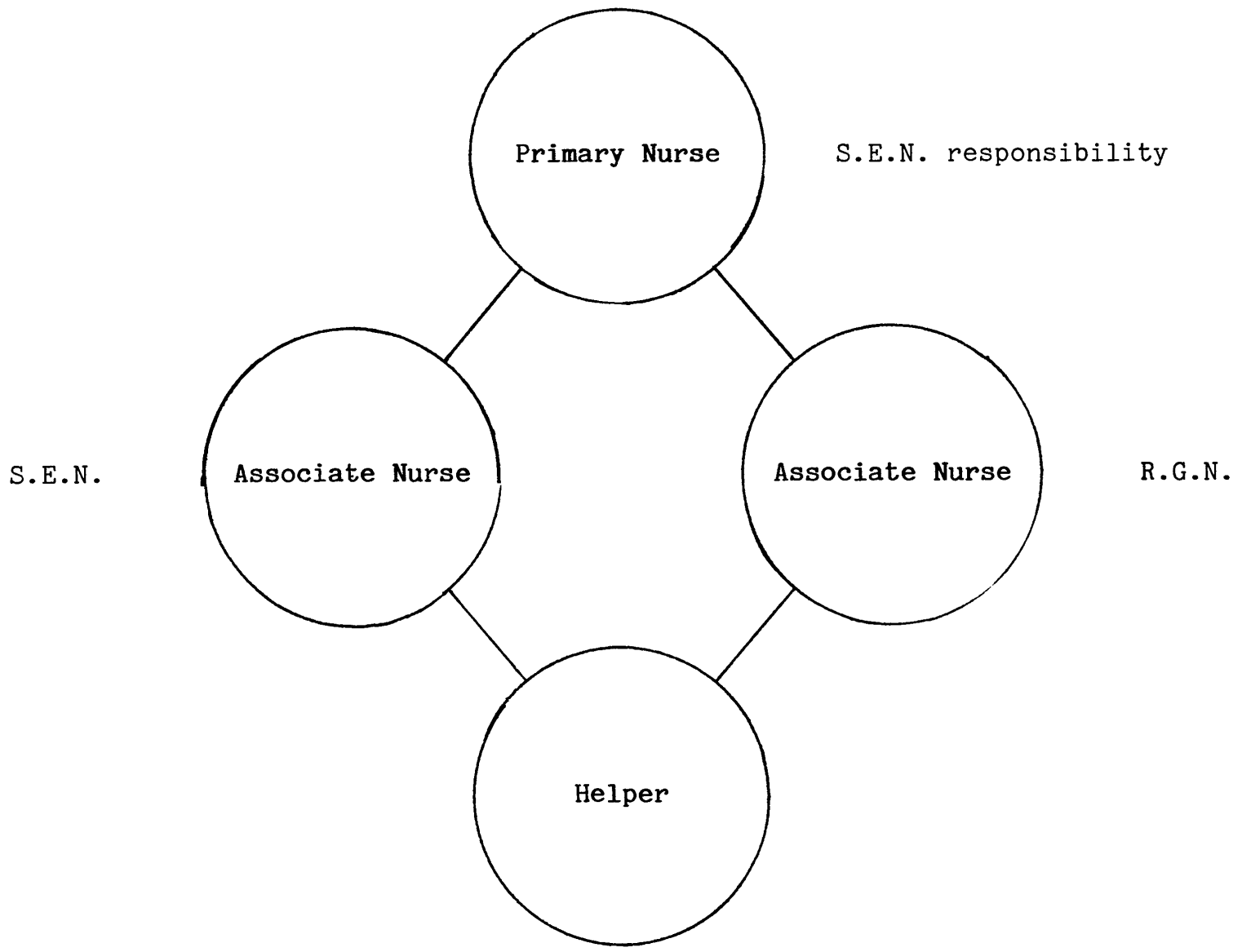
Question 7:

What would be the implication for your Authority of the proposed cessation of enrolled nurse training? In particular your views would be welcomed on timing, training existing enrolled nurses to first-level standard, the role and career structure of those unable or unwilling to convert and the desirability and feasibility of the proposals.

Response:

Where appropriate, the Enrolled Nurse who elects not to convert to a Registered General Nurse can be utilised as follows within primary nursing:-

Resource R.G.N. accountability



Question 8:

Based on local experience, what effect on recruitment and retention to nursing as a whole do you see stemming from the UKCC proposals?

Response:

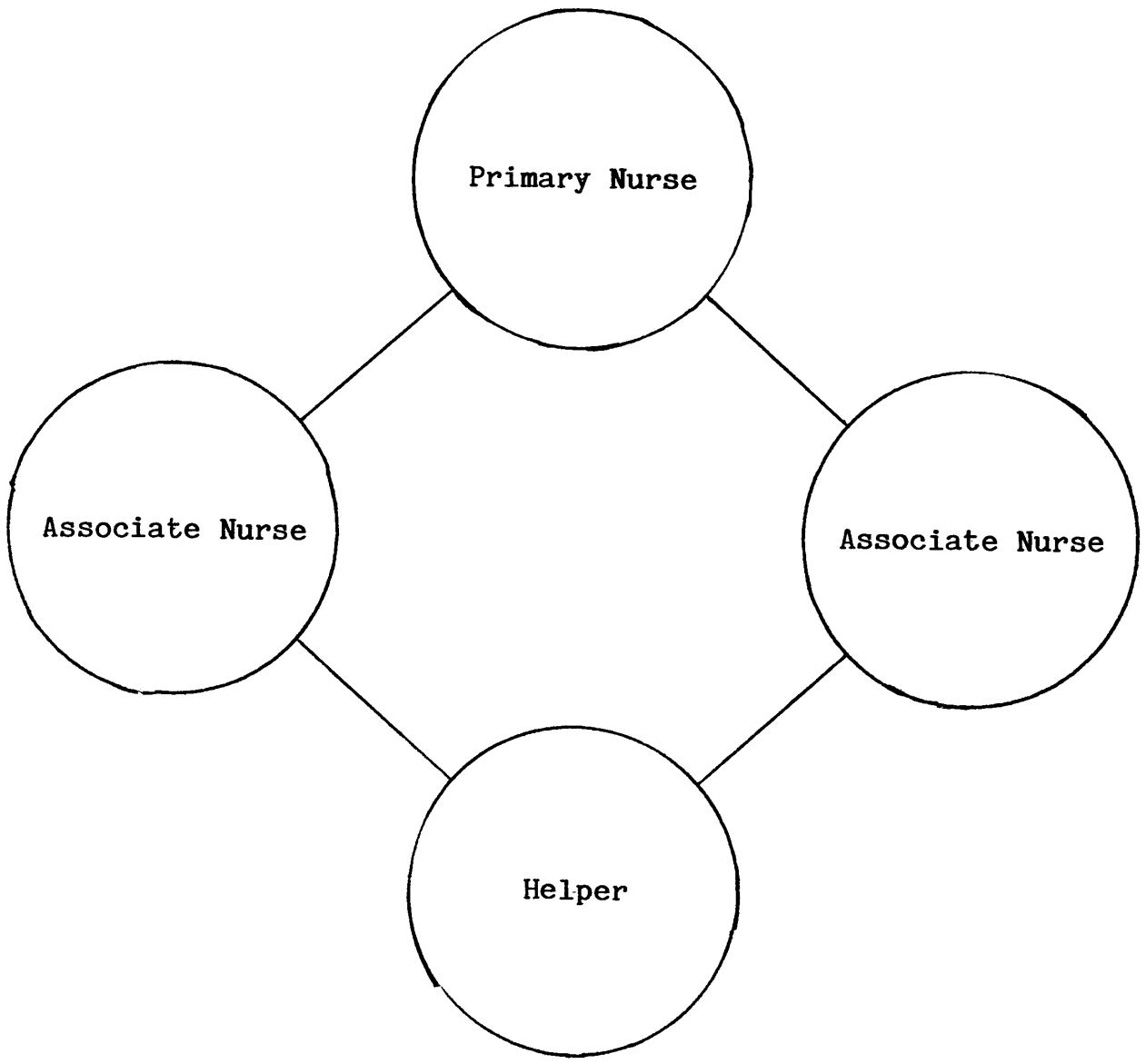
Primary nursing means accountability which moves nurses towards fuller professionalism. There is job satisfaction, motivation, a new sense of achievement and purpose and opportunities for professional updating in specialist areas.

Question 13:

What is the reaction of your Authority to the UKCC proposal fora new grade of helper to support professional practitioners in the light of the report on support workers from the group Chaired by the DHSS Chief Nursing Officer?

Response:

In Primary Nursing the nursing auxiliary becomes the helper. He/she works as part of a team delivering care for 'X' number of patients.



Question 15:

What are your views on the timescale for implementation of the proposals bearing in mind manpower and cost implications? Are there any aspects of the proposed timescale which could be modified to ease the transition process?

Response:

Workshops are necessary which will include all levels of staff.
The number of qualified staff is identified, e.g. there may be eight trained members of staff and four auxiliaries (helpers):-

Sister
Sister
Staff Nurse
Staff Nurse
Staff Nurse
Enrolled Nurse
Enrolled Nurse
Enrolled Nurse

The number of beds on the ward is then identified, e.g. twentyfour.

The number of primary nurses being eight between twentyfour patients means that each nurse will have three primary patients and will become an associate nurse for

The sisters may have less primary patients to enable them to act as resource specialist nurse (as in Project 2000).

APPENDIX I

6N NURSING ADMISSION WORKSHEET

NAME PN

S+O:

Health Perception/Management

Reason for Admission:
Status on Admission (LOC, Wt, VS):
Allergies
General Health
PMH
Meds
Alcohol/CIGS/Drugs

Other

Sexuality/Reproductive

Effect of Illness on Sexuality

Roles/Relationships

Home Environment
Significant Others
Occupation
Important Telephone Numbers

Other

Self Perception

Effect of Illness on:
Lifestyle
Body Image

Nutrition/Metabolic

Dentures
Diet
Skin Status

Cognitive/Perceptual

Pain Tolerance/Management
Sensory Deficits
Glasses/Hearing Aid
Safety-Risk Factors

Elimination

Last BM/Laxatives
Appliance/Self Care
GU

Discharge Planning

D/C to
Home
Other Facility
Home Care
Present Services
Telephone Numbers

Anticipated Needs/Services
Anticipated Teaching Needs
Expected Date of D/C
Method of Transportation
Home
Amount of Time to Arrange Transportation
Inform Patient of 11:00 A.M. Discharge Time

Activity/Exercise

Activity Level
Assistive Devices

Sleep

Sedatives

Coping/Stress

Usual Methods of coping
Coping with Present Illness

A: Nursing/Medical Diagnoses

P: Problem #
Goal
Plan of Care

Values/Beliefs

Religion

APPENDIX II

BETH ISRAEL HOSPITAL
Nursing Services

INPATIENT PROBLEM LIST

No.	Patient Health Problem	Date Identified	Date Resolved

Assessment Guide Sheet.

Using the Mansfield Curriculum Steering Group's activities of daily living model, the nurse consults the following list to carry out an assessment of her/his patient:

1. maintaining a safe environment, for example:
   -cross infection;
   -falling out of bed;
   -blind person coping with ward layout.
2. communicating, for example:
   -talkative/reserved;
   -non-verbal cues;
   -orientation in time, person, and place;
   -level of understanding.
3. breathing, for example:
   -breathing and posture;
   -smoking.
4. eating and drinking, for example:
   -appetite;
   -eating difficulties;
   -food likes;
   -special fluid requirements.
5. eliminating, for example:
   -control and regularity;
   -stomata;
   -menstruation.
6. personal hygiene and dressing, for example:
   -condition of skin;
   -mouth and teeth, hair, nails;
   -shaving;
   -bathing habits;
   -aids to dressing.
7. maintaining body temperature, for example:
   -feeling hot or cold;
   -preferred ventilation.
8. mobilising, for example:
   -aids to walking;
   -level of exercise.
9. working and playing, for example:
   -hobbies and interests.
10. expressing individuality, for example:
    -fears of disfigurement.
    -dignity and privacy.
11. sleeping and rest, for example:
    -sleeping pattern;
    -rest periods;
    -hypnotics.
12. maintaining beliefs, for example:
    -spiritual requirements in hospital.
13. physical and psychological comfort, for example:
    -preferred bed and chair position;
    -degree of pain;
    -mental state.
14. learning, for example:
    -deficiences in self care skills;
    -knowledge of preventative health.
15. fulfilling social needs, for example:
    -mother's concern for family's welfare;
    -preference for solitude/gregariousness.
16. dying, for example:
    -awareness;
    -acceptance/denial.

APPENDIX IV

IDENTIFICATION SHEET

Name: _____

Address: _____

_____

Telephone: _____

Date of birth: _____ Age: _____

Married / single / widowed / divorced _____

Occupation: _____

_____

Religion: _____

Ward: _____

Record Number: _____

Consultant: _____

General Practitioner: _____

Date of admission: _____

Time of admission: _____

Next of kin/relationship (1): _____

_____

Address: _____

_____

Telephone: _____

Next of kin/relationship (2):

_____

Address: _____

_____

_____

Telephone: _____

Discharge and follow-up arrangements:

_____

Diagnosis/reason for admission: _____

_____

_____

Medical history: _____

_____

_____

_____

_____

_____

Medication on admission: _____

_____

_____

_____

_____

Allergies: _____

_____

_____

Valuables: _____

_____

_____

_____

Community Resources:

	On admission.	On discharge
	Frequency:	Date ordered:
District nurse	_____	_____
Home help	_____	_____
Meals on wheels	_____	_____
Social worker	_____	_____
Health visitor	_____	_____

Discharge:

Date: _____

Transport arranged: _____

Medication arranged: _____

Out patient's appointment: _____

General practitioner letter: _____

District nurse letter: _____

CP28/33248

ASSESSMENT SHEET (Please refer to guide sheet).

Patient's name: ____________________

Date & Time:	Patient's assessments:	Signature:

Continued over page

Temperature: __________ Pulse: __________ Respirations: __________

Blood pressure: __________ Weight: __________

Urine: __________

Social assessment. Date: __________

Signature of nurse: __________

Referrals: __________

ASSESSMENT SHEET (Continued)

Patient's name: ______________________________

Date & Time:	Patient's assessments:	Signature:

NURSING PLAN

Patient's name: ______________________________

Start date & Signature:	Stop date & Signature:	Problem, goal and nursing plan:

CP28/33250

NURSING PLAN

Patient's name: ______________________________

Start date & Signature:	Stop date & Signature:	Problem, goal and nursing plan:

CP28/33250

PROGRESS SHEET

Patient's name:

Date:	Time:	Patient's progress:	Signature:

PROGRESS SHEET

Patient's name:

Date:	Time:	Patient's progress:	Signature:

A Comparative Study of Nursing Care in Two Long Stay Areas

Introduction

For the purpose of this research two areas were studied, both wards having long stay patients; one using the task centred approach and the other Primary Nursing.

Nurses from all grades were interviewed using the attached questionnaires. The total sample consisted of six nurses - three from the task centred area and three from the area employing Primary Nursing. The first to be interviewed were two R.G.N.'s and one S.E.N. from the task centred area and the same number and grades from the area employing Primary Nursing.

Task Centred Approach

Geriatric wards are busy places where nurses are continually trying to keep on top of the work load. Cormack(1) states: It is likely that the extent to which nurses encourage patients to be dependent on them increases as the quantity and quality of staff decreases. Wells(2) Why do nurses on most geriatric wards still rely on ward routines instead of giving individualised care; anything that puts patients' needs before ward routines must surely be preferable. Nursing is not focused on patients' needs but routines, meaning the needs of the patient are not met.

The Findings Task Centred Area

It has long been recognised that a move to patient centred care is desirable. Norton McClaren Exton Smith (3) and all informants interviewed agreed with this, stating the benefits of individualised care as an improvement in care for the patient and an increase in accountability and professionalism for the nurse.

Benefits to the Patient

One nurse stated that a more individualised approach would be very good for the patient as they would have their 'own nurse' and develop a relationship with her rather than a mass of blue and beige dresses passing by their beds. Wright(4) states that if task allocation is in use, the patient may find a bewildering array of nurses helping him; one to bath, one to toilet, one to check blood pressure, one to relieve pain and so on - which one of these, if any, does the patient relate to.

The need to develop a relationship with the nurse was recognised by all three informants. The patient would then be able to confide in the nurse and discuss any anxieties or problems he may have. A difficult patient would interact better with his own nurse, therefore the need for patient/nurse allocation was recognised as being of great importance. Jones(5) relates the change in one difficult patient. Demands softened into requests, the perpetual frown became a smile. Everyone remembers that the beginning of the change in the patient was when Primary Nursing came to long term care.

Benefits to the Nurse

All three nurses recognised a change in nursing care would increase job satisfaction. One nurse stated that she would know exactly what nursing care and treatment her patients were receiving. Instead of knowing a little about a lot of patients, Manthey(6) main aim was to develop a pattern of care that would permit nurses to take on more individual responsibility for fewer patients and provide them with comprehensive care.

Two nurses expressed doubts about staffing levels as the unit does not employ any full time nurses and doubted that care could not be improved without full time staff. Two of the nurses took great pains to defend the nursing care already given, one stating we give a good standard of nursing care already. Wright(4) Change in nursing needs a clearly planned and rational strategy, otherwise it is doomed to meet immense odds, and probably fail. Resistance will come not because people are delibarately malicious or ignorant, but because they do not see the need for change; it may be irrelavent or unrealistic, or the stress it brings overwhelms even the most willing to change. Although recognising the need for individualised care and the benefits to both patient and nurse, two of the nurses thought they were giving adequate care with the present patient/staff ratio, and observation shows obsession with ward routines. Wells(2) noted that focus on the nurse instead of the patient was an inevitable result of ward work organised by routine, e.g. what did the rapid undressing of patients and putting them to bed before 5.00 p.m. have to do with the patient. Might it be more sensible, and surely no greater effort, to base patients going to bed times on individual needs, performance and abilities - yet there was an unwritten ethic that 'daywork' had to be completed before the night staff came on duty. This could be applied to all routines of daily living. The goal of care should be continuation, as near as possible, of the normal life style Eliopoulos(11).

Planning Patient Care

All nurses felt they could plan and take charge of a patients' care from admission to discharge and two recognised the need for a proper use of the Nursing Process. Both McFarlane and Castledine(7) and Manthey(6) advocate this. Manthey(6) Staff Nurses have consistently and repeatedly requested in-service education on nursing care plans. In Primary nursing, care plans serve two purposes:

1) to communicate information about a patients problem and programme of care to others who need it,

2) to document the fact that the nursing process has been used as the basis of the patients care.

Unfortunately, before the advent of Primary Nursing, the first purpose was seldom realised in practice.

It is apparent that the 'school of nursing' must be involved if individualised care is to be implemented and staff participate in educational workshops if personalised care is to evolve in long term care.

One nurse recognised the need for the co-operation and support of the multi-disciplinary team, the need for education, visiting other hospitals where individualised care is adopted, involving the 'school of nursing' and participation in educational workshops, also the support of the hospital manager to facilitate staff training and allowing time off to attend relevant courses. Without this support, individualised care is only the dream of a few nurses.

The Sister's Role

Two nurses recognised the need for change in the sister's role, stating the sister would delegate patients on admission to suitable nurses, ensure the smooth running of the ward and act as resource person. Wright(8) It is also asserted that Primary Nursing allows a change in the ward sisters role. She is better able to act as resource person and is free to develop her clinical leadership skills and to develop her research and education input. McFarlane and Castledine(7) see a fundamental change; under this system she is now able to:

1) work on the ward more with patients

2) take on the duties of Primary Nurse where her expertise is especially required

3) assign nurses to patients according to the care needs of patients and the abilities and/or case load of the staff nurses.

4) continue to manage the ward, the patient environment, and facilitate the development of the holistic patient care approach and the development of the nursing staff.

It is obvious that before Primary Nursing can be undertaken, ward sisters have to be highly motivated Kratz(9).

Conclusion

Initial reaction was one of apprehension and defence of the quality of care being given. The nurses do appreciate the benefits of personalised care, but fail to see how it can be accomplished with present staffing levels. Manthey(6) It will not solve staffing problems caused by an inadequate budget, nor will it increase the workload, so budgets should not be expanded in the name of Primary Nursing. It will not solve personnel, management, or interpersonal relationship problems. It is a system originally designed for the delivery of nursing care to sick people, in a way which we would all like to be nursed, and must be an improvement on old methods.

Much is needed to be done, changes in nursing do not come easily. There is no simple solution to introducing personalised care into a hardened task centred area. It will probably take a long time to achieve and will not be easy, but with education, support motivated nurses could make the change to Primary Nursing.

Primary Nursing

Primary nursing is a relatively new concept in English hospitals, few practice this form of nursing. It was pioneered in America by Marie Manthey, whose inspiration and role model was a Nurse Florence Marie Fisher, who cared for her at the age of five when she was in hospital suffering from Scarlet Fever. Although she never saw her again her personalised and humane care inspired her to work on the implementation of Primary Nursing. She states ' Primary Nursing is a system for delivering nursing care in an in-patient facility, that is all it is. High quality nursing should be the goal of every nurse. High quality nursing means care that is individualised to a particular patient, administered humanely and competently, comprehensively and with continuity. Primary Nursing is one way of accomplishing that quality of care.'

The Findings in the Area Employing Primary Nursing

Benefits to the Patient

All three nurses agreed that the main advantages for the patient was having someone with whom they could identify with personally, one stating they have a personal friend in their nurse.

All nurses were aware of their patients as individuals, with their own specific needs and problems, and made great efforts to overcome them. Great care was taken with personal laundry, all the nurses took pride in their patient's appearance, making sure they always looked their best.

Patients were kept supplied with their favourite sweets and, if they smoked, cigarettes. Social outings were arranged, the nurse often taking their patient out in their off duty time. During my visit, great preparations were being made for the Christmas Party and patients were being taken shopping for new clothes. Opportunities were given for patients to pursue hobbies and were also helped to entertain their visitors with a meal. Nearly all activities of daily living were pursued according to the ability of the patient. It was obvious that a close relationship developed between patient and nurse, thus making the patient more relaxed and secure knowing 'his nurse' cared about him, his needs and fears. The patient has someone with whom he can identify.

Benefits to the Nurse

All three nurses described the benefits of Primary Nursing as becoming more responsible and aware of themselves as professionals. Stephen Wright(8) Primary nursing gives nurses a clearer definition of their role in the multidisciplinary team and involvement with the patient and his family gives a heightened sense of responsibility for care. Reducing patient contact to a smaller number of nurses assumes that nursing care will be more personal with better understanding of the patient and his needs and a better opportunity for the nurse to meet them. Hegyvary(15) Primary Nursing is not just a way of assigning nurses to patients but rather a view of nursing as a professional patient centred practice.

Advice on the Implementation of Primary Nursing

All three nurses agreed that a long period of planning is necessary to ease the transition to Primary Nursing. All nurses on the unit had done the Open University Course on the Nursing Process. Manthey and Jones(6)(5) recommend a Primary Nursing Facilitator be appointed to work with staff unit by unit. Hegyvary(15) states at least six months followed by a similar period of development before full Primary Nursing is achieved. Ashley(12) recommends teaching sessions at which the nursing process and the concept of activities of daily living are introduced, with the provision of further reading in the form of articles and reprints.

All nurses agreed the need for everyone in the multidisciplinary team to understand what they are trying to achieve. Jones(5) states that they are given copies of the Primary Nurse assignments, explaining that with the new system they would know with whom to talk when they had questions or communications about a patient. All agreed they had had problems in the past, with nurses saying: "sorry, I don't know, I have not taken care of him recently", or being unable to trace anyone who had taken care of him.

One nurse stated the need for everyone to know the name of the patient's Primary Nurse. Manthey(6) recommends that the nurse's name be made known to patients, relatives and doctors and be displayed on the patients bed. Jones(5) also advocates this method and also displays it on charts and patients' kardex. Thus, there can be no doubt who is responsible.

The staff also use a wipe off board outside the office indicating which Primary Nurses are on duty. Primary nursing results in two kinds of nurse - the Primary nurse and the associate nurse, who is someone who can be a learner or an auxiliary nurse. All the Primary nurses act as associate nurses to one another. Manthey(6) insists that the Primary Nurse is a registered nurse, but in this unit, enrolled nurses act as Primary Nurses but the Sister remains accountable.

Reaction of Relatives and the Multidisciplinary Team

Two nurses stated that the relatives were enthusiastic and they had had a good response from the multidisciplinary team, although junior doctors tended to ignore the system but one did state they had probably not explained well enough what they were trying to achieve. Jones(5) method of issuing Primary Nurse assignments may overcome this problem.

Main Problems Encountered on the Implementation of Primary Nursing

All nurses stated that nurses get tired of looking after the same patients day after day which results in minor irritations. One nurse stated that there had been instances of nurses getting too involved with their patients. Punter(12) states that the stress of Primary Nursing did not become obvious until after a year. It became evident when many small tensions came together and erupted, the eruption being repeated at three monthly intervals.

Over one week, three Primary nurses working independently of each other will have little contact. Nurses are trained to work as part of a team but Primary Nursing was isolating the nurse from her peers. The nurses recommend the formation of a staff support group who would successfully meet at monthly intervals, away from the hospital. Minor problems would be solved, suggestions discussed and hopefully tensions would not build up; prevention being better than cure.

The problem of looking after the same patient week after week and also of looking after the difficult patient, is recognised by most authors. Jones(5) states that after starting with six week cycles for patients in long term care, because changes come slowly the nurses found they were just beginning to see change at six weeks. Nurses wanted the opportunity to see the achievement of their goals. Three months does not seem long enough to some and there is talk of extending the assignment to six months. McFarlane and Castledine(7) state the need for careful planning for the termination of the relationship between Primary Nurse and patient. In the majority of cases, termination poses no problems for the nurse. However, it is important for her to recognise that difficulties may occur, particularly with the more intensive involvement, and the transfer of a patient is not always as smooth as one would wish. Terminations following any length of interaction can be an emotionally difficult and trying event. It is important, therefore, that the nurse prepares for it from the first interaction with the patient.

Conclusion

It is apparent that apart from some minor setbacks and worries Primary Nursing in this Unit is working well. The patients are happy in having someone with whom they can identify and feel secure in the knowledge that someone personally cares for them.

The nurses all feel more responsible and aware of themselves as professionals, and find the care of their patients both rewarding and satisfying.

It is obvious that the ward sisters role is vital. Syred(13) The ward sister has a key role to fulfil, especially in the area of teaching both staff and patients. She should also be able to encourage patient nurse interactions by her good ward organisation.

It was obvious that the success of Primary Nursing in this Unit was achieved by the motivation and hard work of the ward sister who continually encouraged and guided the staff to achieve their goals.

Discussion

Comparing the two types of nursing, one cannot fail to see the advantages of Primary Nursing. Although actual nursing care was excellent in both Units, the benefits of Primary Nursing to both patient and nurse cannot fail to be recognised in the two comparisons. Nurses in both areas agree that personalised care is by far the best for the patient and although it will require hard work and perseverance by all concerned, the benefit to everyone is apparent - Wright(8) The difficulties should not be seen as insurmountable obstacles in the pursuit of truly professional practice. Early reports show that nurses often stumbled in their early efforts. Clifford(14) The notion that Primary Nursing is just another way of organising work at Unit level is a dangerous one to hold and certainly is one that will not promote long term effectiveness of this or any other mode of nurisng. One reason for the lack of sustained success of other delivery systems may be that the approach to the development of such systems has focused upon finding an answer to the question "How can we organise THE SYSTEM TO GET THE WORK DONE" THE MORE APPROPRIATE QUESTION SEEMS TO BE " HOW CAN WE ORGANISE A SYSTEM TO PROVIDE OPPORTUNITY FOR PROFESSIONAL NURSING PRACTICE AND EFFECTIVE OUTCOMES OF THAT PRACTICE FOR THE PATIENTS

This study was carried out to show the need for, and nursing attitudes to,a change in the delivery of the style of nursing adopted by most areas in long term care, thus hopefully to improve the quality of nursing care and enhance the quality of life to the patient.

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The researcher would like to acknowledge the help of the following people: Colleagues and staff of the wards who kindly agreed to take part in this research, the Hospital Manager and staff of the General Office, Forest Hospital, Tutors, Mansfield School of Nursing.

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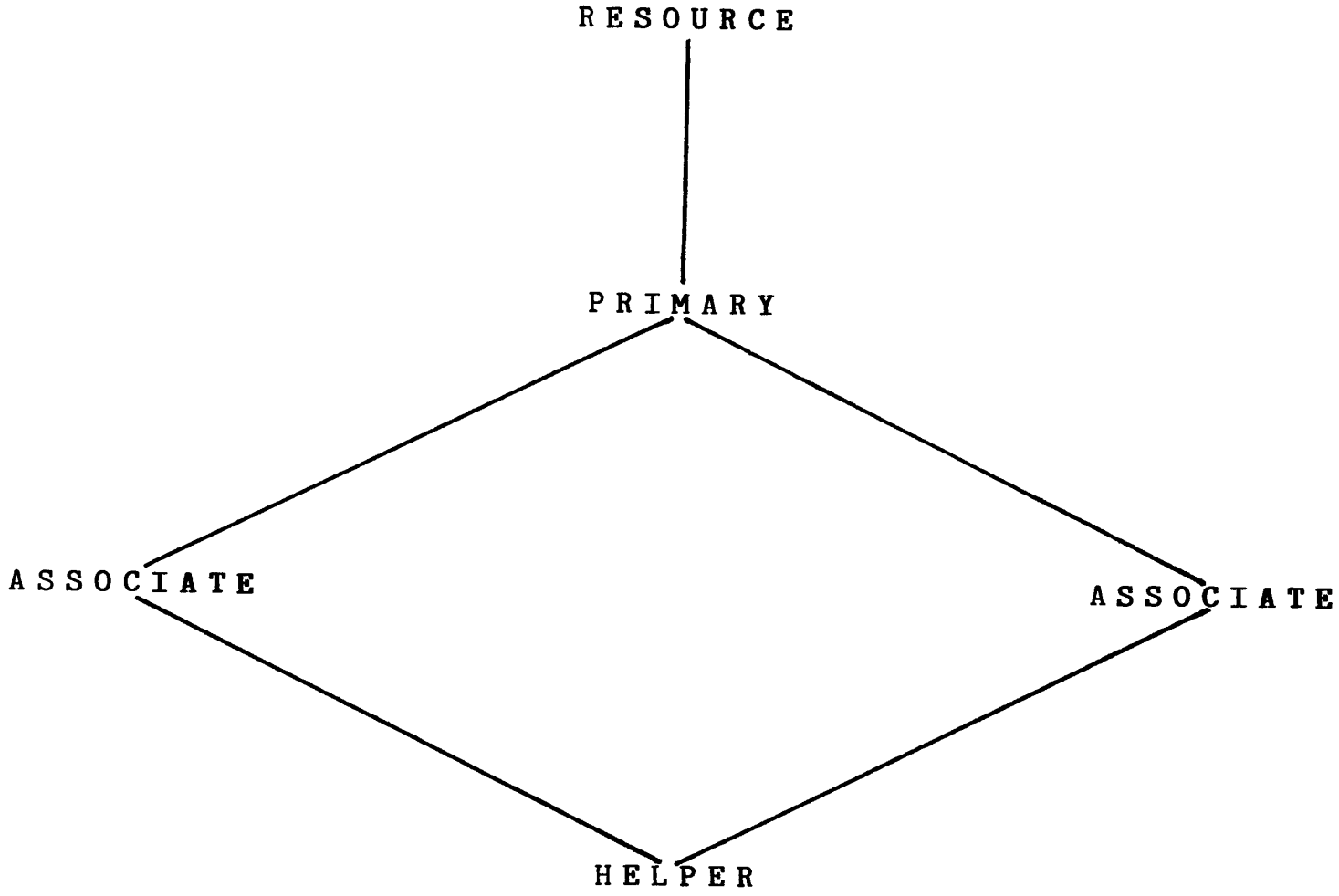
P R I M A R Y N U R S I N G



TRENT REGIONAL HEALTH AUTHORITY

UKCC PROJECT 2000

A. INTRODUCTION AND OVERVIEW OF KEY ISSUES

1. INTRODUCTION

1.1 Project 2000 is, at its core, a plan for reforming nurse education. An outline of the UKCC's proposals is contained in paper B (white sheets) attached.

1.2 Health Authorities have been consulted by DHSS about Project 2000, in a series of sixteen questions, each dealing with a major aspect of the proposed changes. These questions, and a summary of the responses by DHA's, together with comments of Regional Officers, are contained in paper C attached.

1.3 It is recommended that this review of key issues, together with paper C should constitute the Regional Health Authority's reply to the consultation, due to be submitted to DHSS by the end of September.

1.4 Paper D gives a broad outline of the composition of the nursing and midwifery staffing situation in the Region.

2. REVIEW OF KEY ISSUES

2.1 Over the years there have been a number of recommendations for changing the pattern of nurse education, covering, for example, the creation of colleges of health studies; common basic training; modular further training and higher post-registration certificates. (Briggs Report 1972).

2.2 Project 2000 represents the culmination of this protracted debate and is the most determined effort which has been made to set out an action plan for change.

2.3 It is suggested that the proposals can be viewed from three main perspectives:

a) From the point of view of a profession aspiring to an improved image for itself with higher standards of professional qualification, able to demonstrate its attractiveness as a vocation and career by recruiting and holding skilled and dedicated practitioners;

b) From a managerial perspective of cost and achievability, and;

c) From a shared concern for what is in the best interests of patients.

2.4 Dealing with the first of these it is recommended that the objectives of rationalising education, giving it a higher status and redefining upwards the competencies of the first level nurse and the specialist practitioner should be supported in principle, on the understanding that these can be relatively easily and economically achieved.

It is suggested that it is only reasonable to support these legitimate aspirations of a respected profession in wishing to enhance its standing, to improve the education and development of its members, and to expand their potential contribution to the health of the population. To fail to do so would be to deny to nursing that which is tacitly accepted for other self-regulating professions.

2.5 The remaining set of issues contained in Project 2000 is very complex - arguably too complex. It tries to deal, simultaneously, not only with an educational strategy, but with 'manpower' supply problems in response to demographic changes producing a decline in the number of school leavers with the requisite entry qualifications for nurse training.

2.6 Thus, Authorities were asked to consider :

- a manpower model involving demographic projections
- projections about NHS resources extending years beyond current strategic plans
- questions of skill mix within nursing and the substitution of other grades for the service contribution of learners and for enrolled nurses
- asssumptions about the motivations of school leavers, mature entrants and males in the future wishing to enter a new training scheme and remain in employment in a profession and in a public sector beset by social, technological and economic change and uncertainty.

In addition, the centrally-provided manpower model developed by management consultants, which was intended to help work through some of these issues, was flawed, rather simplistic, and contained some highly questionable and untested assumptions.

Authorities, in the face of all this complexity and uncertainty, were rightly hesitant and cautious about coming to firm conclusions on some of the more fundamental and far-reaching changes proposed.

2.7 What follows focusses on a few key issues from paper C, and represents a managerial assessment of what may be affordable and realistically achievable, set, it is hoped, in the common ground between managers and professional nurses on what is in the interests of patients.

2.8 <u>COST</u>

a) By using the Price Waterhouse manpower model, and applying standard costings to it, the estimated additional costs of implementing Project 2000 in the first 8 years would be £31.4 millions. This is judged to be a conservative estimate. It can only be regarded as a rough approximation, given the unsophisticated nature of the Price Waterhouse model. The model goes on to project a possible saving from year 9 and thereafter of about £1.8 million per annum.

b) If the proposed 20% service-contribution of students is reduced to zero by making students completely supernumerary (as we are suggesting) the costs will be substantially increased and the anticipated date of moving into savings will be put back appreciably. This is currently being evaluated in cost terms.

c) There will be additional costs arising from changing teacher : student ratios. These have only been estimated by five DHA's, but the total for the Region as a whole could be of the order of £10m. over the first ten years of implementing Project 2000.

e) Aggregating these imprecise costings gives an order of a gross cost for implementing Project 2000 of £40 to £50 millions in the first 8 years. It may be helpful to put this in context. On the one hand the annual nursing paybill for Trent Region is currently £318 millions. On the other hand the cost of Project 2000 represents around 50% of the Region's anticipated revenue growth over the same period.

f) Conclusion

Central funding support for implementing Project 2000 is essential.

2.9 CESSATION OF ENROLLED NURSE TRAINING

This is widely challenged throughout the service, not only in Trent Region.

Phasing out enrolled nurse training at a time when we cannot be sure of compensation in recruitment for a decline in numbers of school leavers qualified to enter the new educational scheme would be an act of folly. There does seem to be a conflict between the perceptions of health authorities in valuing highly the contribution made by enrolled nurses to patient care, and those of the professional body concerned about two tiers of practitioner. Doing away with enrolled nurse training would be the most drastic possible solution to professional concerns about the abuse and misuse of them and occasional or even widespread lack of clarity about their role and place in the nursing team. Other solutions to these problems could be found. It is widely predicted that the need for a second tier nurse will inevitably arise again if abolition of enrolled training is implemented.

2.10 THE ATTRACTIVENESS OF A NEW APPROACH TO NURSE EDUCATION FOR POTENTIAL RECRUITS

a) We cannot be sure that an approach to nurse education involving grants (whether means-tested or not, but which are lower than existing student salaries); a common foundation programme; and less patient contact will enable the service to attract recruits in adequate numbers and quality. The risk that this will worsen our recruitment prospects is a real one, and therefore a piloting and evaluation of a new approach is essential if we are to minimise this serious risk which could have a drastic effect on quality of care.

b) Nor can we be confident of achieving the reduced wastage in training; the reduced turnover and loss of qualified staff; the increased recruitment of inactive nurses; the higher recruitment of mature and male entrants to training which are key assumptions in the manpower model. These propositions need to be tested to the point at which we can be sure of achieving and sustaining them. This is a further argument for piloting and rigorous testing.

2.11 SKILL MIX

"Skill-mix" means the ratio of qualified to learners and other staff in the nursing labour force.

This skill mix varies substantially around the country and is clearly, therefore, elastic. For example in Acute services the % of trained nurses in the labour force averages 61% for England, Trent Region is 58.3%, the highest being 65% in North West Thames. Within Trent the range is from 50.8% in Rotherham to 64.4% in Central Nottinghamshire.

The achievement and attractiveness of Project 2000 may crucially depend on the profession and health authorities taking a much more critical and sanguine view of the demand for qualified staff and their role in relation to other grades. If the demand projections for qualified nurses were to be significantly reduced - achievability and reduced costs of implementation of Project 2000 would be brought much closer. Substituting unqualified staff from the local labour market to fill established vacancies for qualified personnel is always possible. It would be better to do this on a deliberate, planned basis than by default.

2.12 DEMOGRAPHIC FEASIBILITY OF PROJECT 2000

Chart B compares the required intakes to nurse education in the Region with a) the projected availability of suitably qualified 18 year olds, and b) likely "best case" total recruitment to nurse education given mature entry, more male recruits and other initiatives. This challenges the achievability of the projected numbers of qualified nurses and, if valid, necessitates a review of skill-mix and a reduction in demand for qualified nurses.

2.13 FEASIBILITY OF PROJECT 2000, GIVEN EXISTING SCHOOL CAPACITIES

Chart C (attached) compares the training intakes required to sustain Project 2000 with estimated capacity of existing schools. Clearly, more investment in training facilities is needed, with associated capital and revenue implications.

2.14 SUPPORT WORKERS

This is already a very important and large group of staff in the Region (8,000 WTE). We should support the definition of the skill and knowledge requirements for competent support workers, the provision of training (for which there will be a cost), and encourage people to achieve personal development and career progression. Erecting artificial barriers to progression in times of recruitment problems and a dwindling supply of learners should be opposed.

If enrolled nurse training were stopped, it is predicted by some that the recognition of the skills and contribution of support workers may be one route by which we eventually would be forced to return to the concept of a recognised second tier qualification.

2.15 CONCLUSION

In conclusion, it is possible to go on and on examining a whole range of other issues. However these are basically peripheral to the key factors outlined about dealing with the achievability, affordability and service implications of what is being proposed.

It is hoped that members of the RHA will support this analysis supported by the detailed response of DHAs to consultation which are summarised in Section C of this paper. It is recommended that these, in the light of RHA discussion, should constitute the RHA's response to the NHS Management Board.

JIM GEORGE
DIRECTOR OF PERSONNEL SERVICES & MANPOWER

JSG/mb
10.9.87

CHART A

TOTAL COST OF P2000 COMPARED WITH SERVICE PLAN

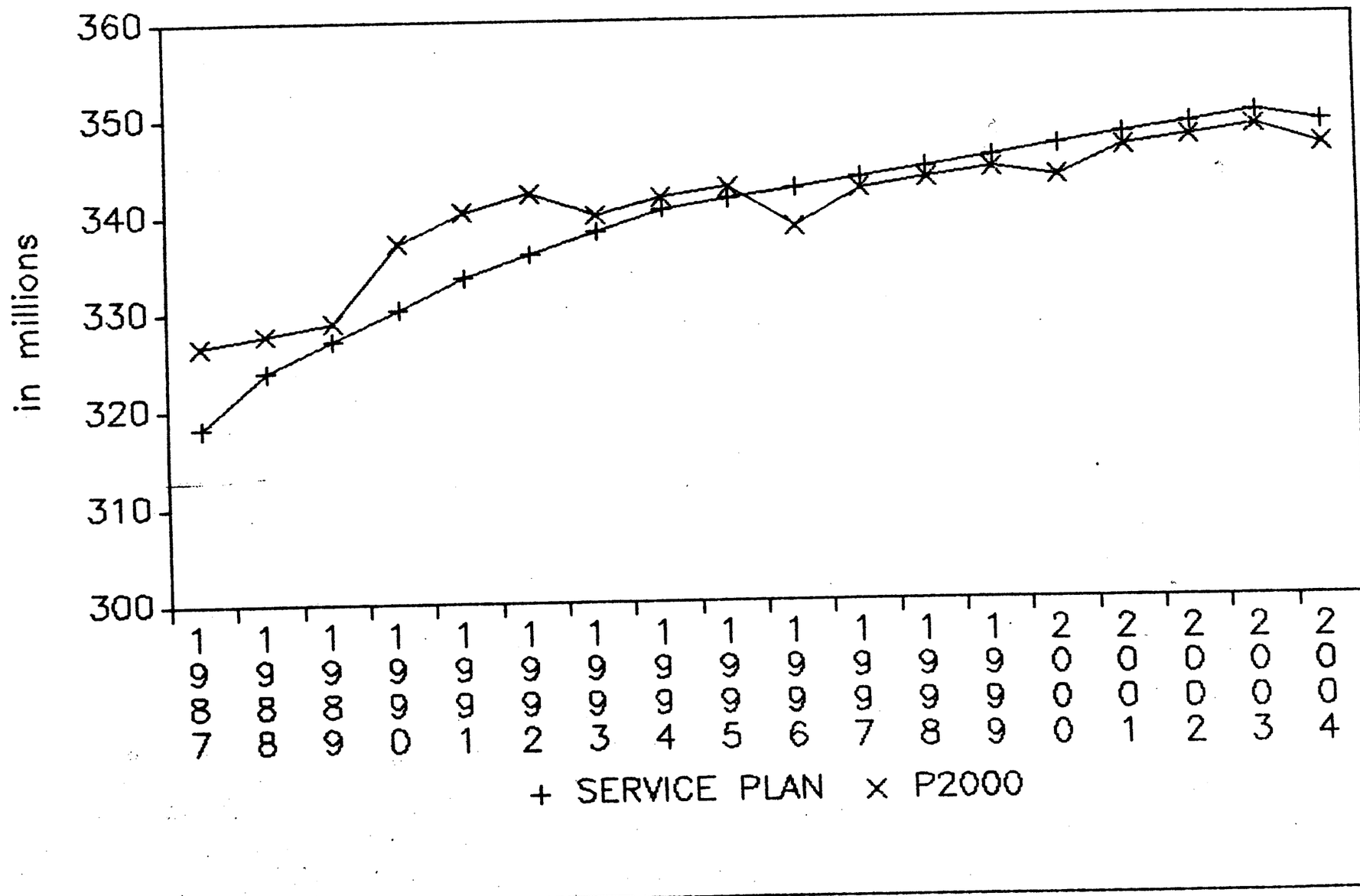


CHART B

DEMOGRAPHIC FEASIBILITY OF P2000

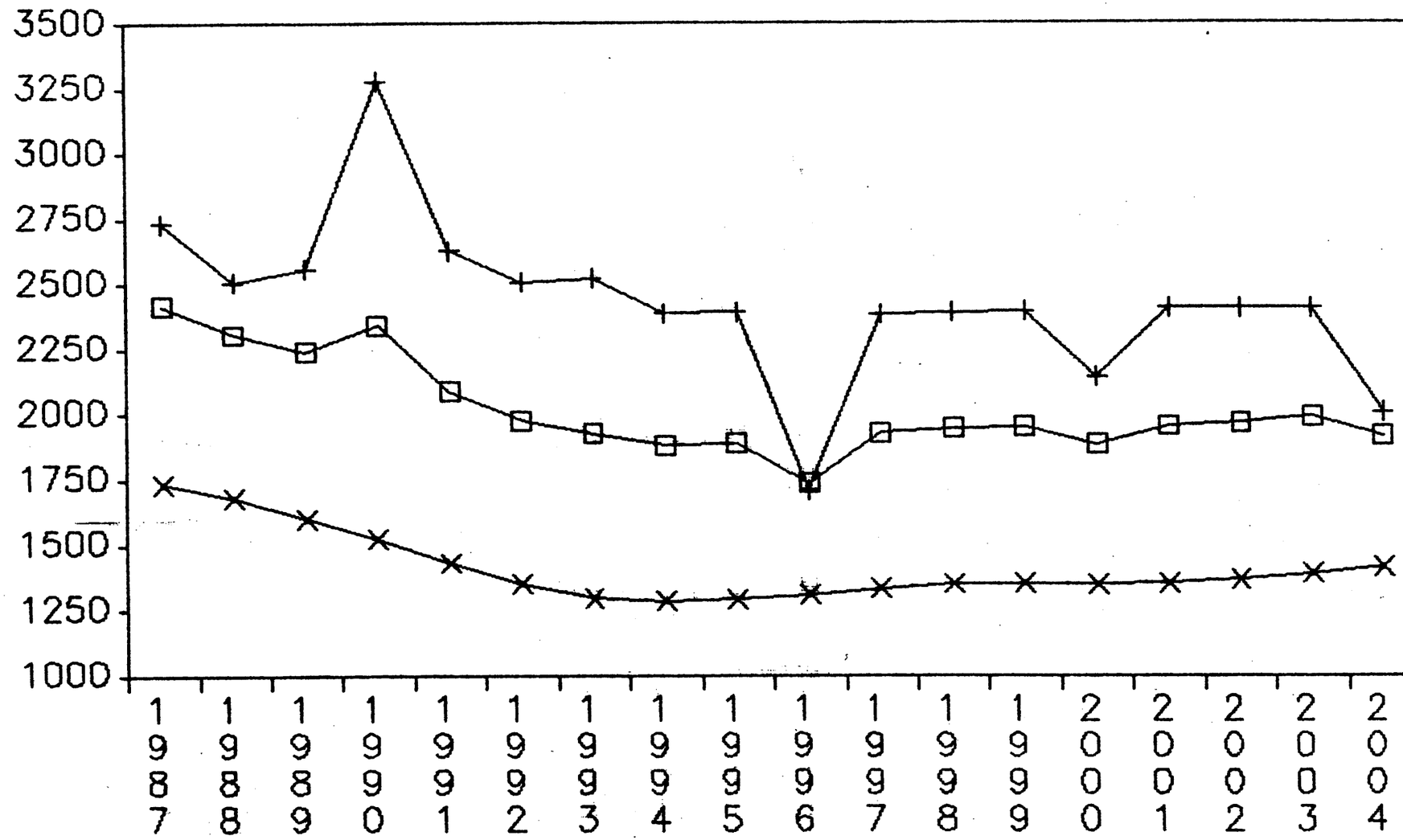
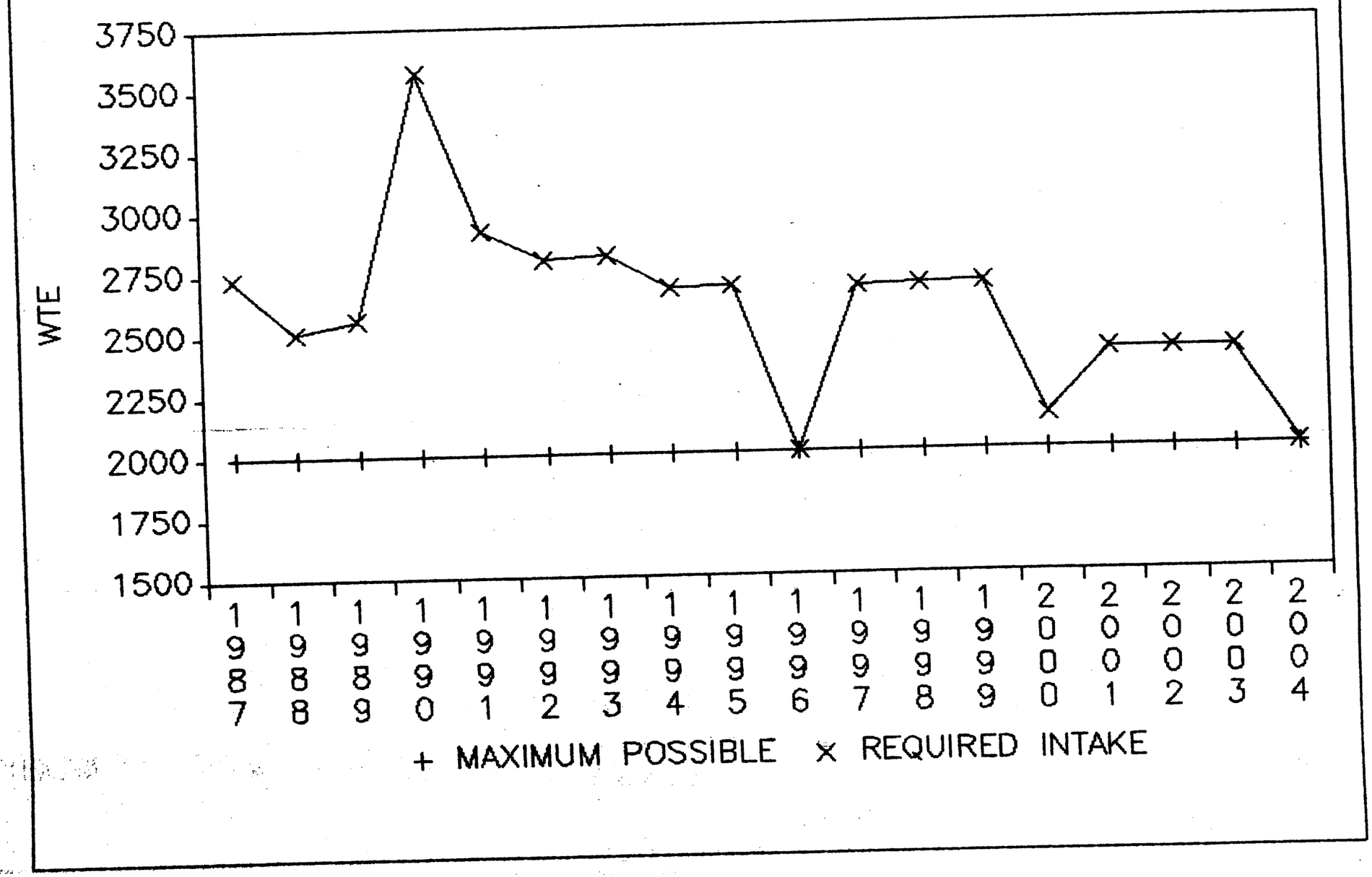


CHART C

FEASIBILITY OF P2000 : REQUIRED SCHOOL INTAKES COMPARED WITH MAXIMUM POSSIBLE



D. NURSE STAFFING IN TRENT REGION (ROUNDED WTEs)

	RGNs	SENs	UNQUALIFIED	STUDENTS	PUPILS	TOTAL
1987	17,400	5,800	8,700	5,300	820	38,020
1994 STRAT.PLAN	19,900	5,200	8,700	5,300	590	39,690
1994 PROJECT 2000	20,850	5,200	9,500	6,350	-	41,900

TRENT REGIONAL HEALTH AUTHORITY

UKCC PROJECT 2000

B. OUTLINE OF PROPOSALS ON WHICH HEALTH AUTHORITIES HAVE BEEN CONSULTED

The proposals submitted to Ministers are set out in Project Paper 9 entitled "Project 2000 - The Final Proposals". Briefly summarised, they are:

1. There will be a new ***single level of nurse***, whose role will embrace much of the work of present registered and enrolled nurses. The new nurse will be prepared to assess the need for care and to plan, provide, monitor and evaluate that care in both institutional and non-institutional settings. Once qualified, the new nurse will have the opportunity to continue working directly with patients and clients. An important result of this change will be to increase the amount of care given by qualified staff and to decrease the present dependence on a continually changing population of unqualified staff and those undergoing training.

2. A new ***specialist practitioner*** will undertake particular roles in the hospital and the community. The roles of some specialist practitioners will be focused in particular areas of practice; others will work in health promotion. Specialist practitioners will be people with considerable experience and will have completed additional education programmes.

3. All the care required cannot be given by qualified nurses, midwives and health visitors alone. Project 2000 proposes that ***helpers*** should be recruited to support nurses, midwives and health visitors. It is proposed that ***helpers*** should undertake specific tasks to help to provide care but be supervised by and work under the direction of qualified nurses, midwives and health visitors.

4. A new pattern of education and training should be introduced. This should consist of a common foundation programme to be taken by all nursing students to run for up to two years, followed by a further year in either the care of the adult, the child, of persons with mental handicap or in mental health.

5. Students should be supernumerary throughout their three year preparation and receive non-means tested grants. Because nursing is a practical profession, the courses will have a high practical content and students will have considerable contact with patients and clients. Inevitably, there will be some service contribution by students which Project 2000 proposes should be 20 per cent of their time, compared to the present proportion which can be as high as 60 per cent.

6. Education and training should be improved with more favourable teacher student ratios, and facilities comparable to the better standards to be found in tertiary education. It is proposed that stronger links should be developed with colleges and institutions of higher and further education.

7. Enrolled nurse training should end but increased opportunities be available to those enrolled who wish and are able to convert to registered status. Project 2000 also calls for more resources to be devoted to those enrolled nurses who do not convert to enable them to enhance their expertise.

8. For midwives, the following is proposed:

   - that separate and distinct competencies for midwives be maintained;

   - that the present eighteen months' post-registration and training should be maintained;

   - that support and encouragement be given to the extension and development of direct entry programmes for midwives. The UKCC hopes particularly that the opportunity for shared learning that such courses will provide will be developed to the full;

   - that education rules be so drafted so as not to preclude the development of experimental and new programmes in midwifery education.

Nurses working with persons with mental handicap

During the consultation, the UKCC was asked to look at its proposals again. This the Council has done and a Topic Paper on the nursing of persons with mental handicap has been issued. Its main points are:

1. Persons with mental handicap should be assisted to lead as normal a life as is possible within the limits of their handicap; with the same rights as any other citizen.

2. Many nurses currently working in this field are meeting changing demands, particularly as a result of the progressive development of community based patterns of living for mentally handicapped people.

3. A multi-professional approach, including the provision for further education and health care, is most appropriate. Shared learning opportunities for the different professionals involved should be continued and developed.

WHY IS PROJECT 2000 NEEDED?

Three important factors have made the need for education reform essential:

1. Demographic changes: From between the mid 1950s and 1964 the birth rate in the UK rose and then fell away. For the next two decades the number of young people available for recruitment to any career will reduce markedly. Nursing will be particularly affected because it has traditionally recruited large numbers of 18-year olds.

2. Value for money: Whatever the level of resources made available to health care may be, there is now and will continue to be emphasis placed on cost effectiveness in the delivery of that care.

3. Prevention is better than cure: It is government policy that there should be a shift towards the community provision of health care, and increased emphasis on the prevention of ill-health.

The proposals of Project 2000 address these changes, and provide programmes to develop the skills, confidence and commitment required to deliver the care which is needed. The proposals will give the future professions the flexibility to adapt and develop to meet changing demands on their skills; demands which cannot always be accurately predicted.

HOW DOES PROJECT 2000 TACKLE THE MANPOWER CRISIS?

The NHS currently needs to recruit about 30,000 additional qualified staff each year. 70% of these recruits are newly-qualified; 30% are returning to work. With the decline in the number of young people entering the job market, if these proportions remain constant, there would be a shortfall of 3,000 entrants to training in 1995 and a cumulative shortfall of 30,000 by the year 2000.

To prevent this serious situation, the demand for new entrants must be reduced, and recruitment increased.

Reducing the demand for new entrants

Increasing the levels of staff retention, and encouraging more qualified staff to return must be high priorities for all employers. The UKCC believes that this should involve an improvement in the flexibility of working arrangements, with greater support facilities for those with family commitments; improved reorientation and continuing education programmes. The proposals are also geared to reducing the wastage rates of those in training.

Increasing the supply of students

This could be achieved by diversifying the range of people currently entering nursing. The two major groups which are potential sources of new recruits are men and mature students. The UKCC is also committed to a critical assessment of the criteria for entry to initial programmes so that these can be broadened without sacrificing professional standards.

JSG/September 1987
and

TRENT REGIONAL HEALTH AUTHORITY

UKCC PROJECT 2000:

C. PROCESS AND OUTCOME OF CONSULTATION WITH DHAs

Introduction

To provide a clearer understanding of the Final Proposals of Project 2000 the RHA arranged several 'teach in' sessions for the nursing profession, Members, Chairman and General Managers and other personnel involved in the preparation of Health Authority responses.

In addition the Authority arranged for Price Waterhouse to give further information and to present their simplified manpower computer model which was designed to help evaluate the manpower implications of Project 2000. The model was issued to each District and further training sessions in the use of the model were run for District Officers involved in the consultation process. Although the aim of the model was to help Districts formulate a response to the questionnaire a number had difficulty in answering the questions in view of the late delivery inadequacy of the model, and several fundamental changes to it, the most recent being on 22nd August!

Comments have now been received from all District Authorities.

North Derbyshire Health Authority provisionally rejected Project 2000 and have set up a working party of members and officers to examine alternative systems. The Authority accepts that nurse training needs to be different, but does not accept that Project 2000 is the only answer. It is not persuaded that Project 2000 answers the manpower difficulty and it does not answer management problems. Many of its suggestions could be implemented by nursing schools and management without Project 2000.

Summarised below are key points raised in response to the sixteen specific questions put to the service by the Chief Executive of the NHS Management Board together with the views of Regional officers.

Summary of comments received from DHA on Project 2000 consultation

These comments are directed towards the 16 questions within Appendix A.

Question 1

What would your Authority see as the administrative implications of the introductory training in the proposed Common Foundation Programme of up to two years, to be followed by branch programmes?

District Response

The majority of Districts in principle were in favour of a Common Foundation Programme of 2 years. It was felt that the CFP would remove a lot of administrative duplication that occurs at present.

The four Branch Programmes however were seen to be a problem by several Districts, not all schools of nursing could provide training in all four areas of General, Paediatric, Mental Handicap and Mental Illness.

Table 1

FEASIBILITY OF THE FOUR BRANCH PROGRAMMES

DISTRICT	GENERAL	PAEDIATRIC	MENTAL ILLNESS	MENTAL HANDICAP
Barnsley	YES	NO	YES	YES
Bassetlaw	YES	YES	YES	YES
Central Nottinghamshire	YES	YES	YES	YES
Southern Derbyshire	YES	YES	YES	YES
Doncaster	YES	UNSURE	YES	YES
Leicester	YES	YES	YES	YES
North Lincolnshire	YES	UNSURE	YES	YES
South Lincolnshire	YES	UNSURE	YES	YES
Nottingham	YES	YES	YES	YES
Rotherham	YES	DOUBTFUL	YES	DOUBTFUL
North Derbyshire	YES	NO	YES	YES

Concern was expressed that the branch programmes for Mental Illness and Mental Handicap may be less popular, attracting fewer learners; an alternate view would be that learners might develop a preference for working in Mental Illness and Mental Handicap by way of introduction in the common foundation programme. However this would be curtailed if branch programmes were selected at the outset of the course as may be necessary for service demand planning.

Two Districts assumed that students would be admitted to Schools of Nursing on an academic yearly basis. This would create bottlenecks in clinical areas particularly in the community care placements where problems are currently being experienced.

The size of some Schools of Nursing would also have to be increased and would require more teachers and classroom facilities.

Regional Response

The Common Foundation Programme should be viewed as an important development in nurse education and the idea should be supported.

Whether the CFP should be of a two year duration or a shorter period of eighteen months should be questioned.

The concern that not all Schools of Nursing would be capable of providing all four branch programmes should not be seen as a serious problem as training "circuits" can be rationalised to overcome this.

The Administrative Implications as with any new curriculum will cause disruption to the service side, unless replacement staff for students can be recruited and employed in tandem with the changes being introduced.

Question 2

How does your Health Authority view the proposed change of status of the student nurse from salary to bursary and from the present arrangements to a lower service contribution during training?

District Response

Four Districts expressed the view that they did not anticipate any adverse effect on recruitment providing that bursaries were related pro-rata to the degree of student status. An added benefit would be to reduce conflict between service and education, thus enabling a more satisfactory learning environment to be created within practice areas.

However the remaining Districts were concerned at the prospect of introducing a bursary system as they felt this would have an adverse effect on recruitment.

The majority of Districts felt that if bursaries were introduced they should be non means tested with increased bursaries for mature students.

The view was also expressed that the NHS should control the bursary system.

Regional Response

The proposed change in status from salary to bursary is seen as a disastrous consideration at this time bearing in mind the recruitment difficulties we may face in the future.

If however a bursary system were to be introduced it should be means tested on the same basis as for other students in higher education.

The proposed 20% service contribution will create tremendous administrative difficulties; as are likely to outweigh any advantages of a student contribution and therefore total supernumary status is advocated.

Question 3

Would your Authority wish to encourage mature students into nursing and, if so, on what basis would you suggest that they should be remunerated?

District Response

All Districts were in favour of encouraging mature students into nursing.

All but one felt that mature students should receive an increased bursary allowance.

It was suggested that mature students pension rights could be in jeopardy as pension contributions would not commence until after the completion of training.

Several Districts are looking at the feasibility of running part-time courses for mature students but this would be reliant on the employing authorities ability to provide sufficient part-time jobs on completion of training.

Regional Response

Encouraging mature entrants into the Nursing Profession is fully supported along with the associated management initiatives that would support this view.

If a bursary system were introduced mature students should receive equal remuneration with younger colleagues.

Question 4

What are the main considerations you would have to take into account in establishing the proposed 20% service contribution?

District Response

The main concern of Districts was the ability to recruit sufficient qualified staff to replace the lost student contribution. One District stated that it would be unable to maintain a viable service particularly for the elderly care group.

Currently students form part of ward establishments and it should not be assumed that they can be replaced by untrained staff. If the correct skill mix is not achieved service reduction will become a reality. Added to this is the need for a higher proportion of trained staff to supervise in areas used for student training.

The Districts no longer training Enrolled Nurses will have no option but to replace students contribution with Registered General Nurses at greater costs of employment.

The majority of Districts felt that the 20% service contribution should be in the final year of training. If this were adopted there might be motivational problems for learners. It could also be argued that learners may be unable to gain sufficient experience commensurate with the responsibilities expected of a qualified staff nurse. Consideration should therefore be given to post qualification experience prior to formal qualification. Several Districts already offer a Professional Development Course.

Regional Response

The disadvantages of organising a "real" 20% service contribution from students would seem to outweigh the advantages to the service. Naturally it would be advantageous to the learner to have this type of experience but it should not be made part of the costing exercise.

Question 3

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District Response

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Regional Response

Encouraging mature entrants into the Nursing Profession is fully supported along with the associated management initiatives that would support this view.

If a bursary system were introduced mature students should receive equal remuneration with younger colleagues.

Question 5

Will the proposals generally meet the future needs for community care? What will be the effect of nurses trained under the proposed scheme proceeding directly to work in all specialties in the community?

District Response

Generally it was felt that the new training would prepare students more adequately for working in a community setting. Several commented that without full knowledge of the course content it was difficult to respond more fully to the question.

Presently many Districts have large numbers of learners allocated for community experience, not all are nursing students. This creates increased pressure on the community nurse. To prevent a reduction in the quality of service with the introduction of a new training course an increase in qualified community nursing staff would be required (this is not quantifiable at the present time) to:

a) Supervise learners on the new training course - assuming they will spend more time in the community setting.

b) Supervise the newly qualified nurse as it is suggested they may be unable to undertake a full range of duties initially.

Concern was expressed about using the clients home as a training area particularly as this is largely dependent on client goodwill. To prevent a breakdown of goodwill is dependent on a well planned and monitored allocation system to preserve client tolerance.

Regional Response

Without a full knowledge of curriculum content it is difficult to respond to this question.

It is felt however that community experience should be seen as an holistic approach rather than experience found merely in client homes.

Question 6

Although the proposals on the specialist practitioner are as yet only in general terms, does your Authority have any views in relation, for instance, to the way a specialist practitioner would be employed, to existing roles and grades and to any training implications?

District Response

All Districts supported the need for a specialist practitioner and saw certain ward sister/charge nurse and grades above as currently fitting this role.

It was felt necessary to encourage and reward the clinical specialist to remain at clinical level.

Regional Response

Expansion of the Specialist Role combined with improved remuneration is necessary to encourage the specialist practitioner to remain at clinical level and to develop a reasonable career structure for clinical nurses.

Question 7

What would be the implication for your Authority of the proposed cessation of enrolled nurse training? In particular your views would be welcomed on timing, training existing enrolled nurses to first-level standard, the role and career structure of those unable or unwilling to convert and the desirability and feasibility of the proposals.

District Response

Training of Enrolled Nurses within the Region (see Table 2).

Of the Districts continuing to train Enrolled Nurses all felt concern about the possibility of cessation of training, particularly before the new level of nurse joins the workforce therefore Enrolled Nurse Training should continue until there is an adequate supply of Project 2000 nurses.

Enrolled Nurses are said to be a stable part of the workforce and if training ceases this would worsen available staffing levels. Discontinuation of training at a time when all demographic projections show fewer school-leavers with educational qualifications for first level training will surely worsen the available numbers of trained nurses within the service.

Many regarded 'support workers' as a second level training of sorts and one District suggested continuing enrolled nurse training in place of support workers.

The argument for ceasing second level training because of abuse of the role, is managerial and not educationally based. Managerial remedies therefore should be applied to obviate, unacceptable abuse of the role. It was also felt that if Enrolled Nurse training ceased there would inevitably be some abuse of the support worker which may be more problematic.

The majority felt that conversion courses should commence as soon as possible; they were said to be expensive and low in productive terms.

Several schools were only able to train only ten learners per year and conversion could take upto twenty years in some instances.

The Price Waterhouse model specified an estimate of 40-50% Enrolled Nurses converting to first level training, this figure is thought to be unrealistically high although there is no strong evidence to support this view.

Conversion may be particularly difficult for Enrolled Nurses where local schools of nursing do not offer such courses. Motivation may be reduced in the light of having to train away from home. This will particularly effect women with children.

Part time conversion courses maybe necessary for the many part-time enrolled nurses in employment.

It was strongly argued that Enrolled nurses not wishing to convert must have protected conditions of service.

Regional Response

The cessation of Enrolled Nurse Training would be a disastrous step to take at this time unless replaced by a second level nurse of some kind. It is important to note that approximately one third of all trained nurses in hospital and community are currently SENs.

Question 7 Contd...

Project 2000 assumes that 40% of Enrolled Nurses will wish to convert to first level nursing this appears an over optimistic prediction for the Trent Region.

The District response is fully supported.

Table 2

Districts Training Enrolled Nurses within Trent Region 1986/87

DISTRICTS	ENROLLED NURSE GENERAL	ENROLLED NURSE MENTAL ILLNESS	ENROLLED NURSE MENTAL HANDICAP
SHEFFIELD	85.00	9.00	-
BARNSLEY	35.00	-	-
BASSETLAW & C. NOTTS	-	-	-
N. DERBYS	-	-	-
S. DERBYS	42.00	-	4.00
DONCASTER	-	-	-
LEICS.	78.00	16.00	12.00
N. LINCS	-	-	-
S. LINCS	20.00	-	-
NOTTINGHAM	-	-	-
ROTHERHAM	35.00	-	-
TOTAL	295.00	25.00	16.00

Question 9

Do the various targets set by the UKCC for achieving the necessary levels of manpower seem realistic for your Authority? A comment on each would be helpful.

Achievement of the targets proposed by the UKCC, namely, reducing qualified staff wastage by 1%; reducing educational wastage by 2%; increasing the number of returners by 2.5%; increasing the number of mature students by 33%; increasing the number of male recruits by 25% (existing levels of turnover and wastage would be relevant) - The effect of phasing out enrolled nurse training on the proportion of qualified staff in the nursing work force - The timescale of each of the manpower targets - the feasibility of increasing productivity by 5% - how quickly that increase would become effective.

District Response (See Table 3)

Regional Response

If there are committed management initiatives wastage could be reduced.

Greater flexibility will be required to attract mature and male students into the profession. Encouraging male recruits may be achieved by promoting a change of image in nursing and offering improved remuneration incentives. Part-time training of nurses and midwives needs to be given urgent consideration.

Whilst productivity in client areas is difficult to measure, it is felt that an increase in productivity by 5% may result in greater stress within the workplace and poorer quality of care.

Question 8

Based on local experience, what effect on recruitment and retention to nursing as a whole do you see stemming from the UKCC proposals?

District Response

This question received a mixed response as might be expected from districts with widely differing labour markets. It was a difficult question to answer.

Many Districts felt that Project 2000 may have an improved effect on retention but they were less positive about it being able to improve recruitment.

Again it was strongly stated that a bursary would have adverse effects on attracting people into the profession.

Regional Response

A difficult question to answer but it is felt that retention could be improved by management initiatives but the effect on recruitment may be more difficult to improve upon, particularly if remuneration by bursary were to be implemented.

Response

Table 3

DISTRICTS	REDUCING QUALIFIED WASTAGE BY 1%	REDUCING EDUCATIONAL WASTAGE BY 1%	INCREASING RETAINERS BY 2.5%	INCREASING MATURE STUDENTS BY 33%	INCREASING MALE RECRUITS BY 25%	INCREASING PRODUCTIVITY by 5%
SHEFFIELD	Unachievable Current wastage 17.9%	Unachievable	-	Diminishing pool		
BARNSLEY	Achievable within 1-3 years	Unachievable	May achieve 1% only	Unrealistic already at its peak	Realistic if there is a positive approach to reversing female image	Require more resources to achieve this would take 5 years
BASSETLAW	Has to be achieved	Achievable	Dependent on retraining available	Is required to meet service needs		May be achievable
CENTRAL NOTTS	Achievable	Achievable Have low educational wastage	Achievable	No room for significant increase		
SOUTHERN DERBYS	Achievable	Achievable	May be difficult needs flexibility	Requires flexibility		
DONCASTER	Has to be achieved	Achievable with new curriculum	Requires flexibility e.g. p/t work	Should be achievable National advertising would help	Wide variety in number of males in Mental Handicap/ Acute Services	
LEICESTER-SHIRE						
NORTH LINCS		Achievable		Would need to recruit additional 15 mature entrants	Would need to rectuit additional 8 male entrants	Difficult to quantify
SOUTH LINCS						
NOTTINGHAM	Unwise to speculate Detailed work on nurse manpower is now in progress					
ROTHERHAM	Unlikely to be reducable	Current 10% As low as possible		Is possible	Is possible but limiting due to mixed sex wards	Absurd projection

Question 10

Does your Authority envisage an increase in direct entry midwifery training? If so, to what proportion of total midwifery entry? Would your Authority continue to provide post registration (18 months) midwifery training? What are the implications of the proposals for midwifery services and for midwifery education?

District Response

One District in the Region already provides direct entry to midwifery training.

Although Districts agreed in principle to direct entry training, some smaller Districts anticipated difficulties in providing adequate training facilities. However it was suggested that amalgamating resources may be a useful way of overcoming difficulties.

One District is considering undertaking a feasibility study into direct entry training and are encouraged by the possibility of improving retention rates and attracting a more stable workforce; and several are in favour of Direct Entry to midwifery training.

Regional Response

The eighteen month post registration course should remain the predominant system of entry to the profession and part time training should also be considered. A comparative evaluation of District retention should be made for the course currently being run in Southern Derbyshire.

Question 11

What are the implications for your Authority of the proposals for ensuring all qualified hospital and community nursing and midwifery staff have an opportunity to be prepared for their new role?

District Response

One District runs a 15 day Professional Development course for all newly qualified nurses which could be extended to include preparation for the new role.

For the majority of Districts the implications of preparing staff for the new role had significant implications in both financial and manpower terms. It was suggested that to replace service loss whilst staff were being prepared for the new role would create a further burden on recruitment. One District commented that it could not meet the extra demand for training.

Regional Response

In preparation for the new role it is apparant that there will be significant manpower effects which are quantified by the manpower models. These have a financial implication.

Question 12

What are the implications of the proposals relating to teacher: student ratios and an all-graduate teaching staff?

District Response

The Present Teacher/Learner Ratio - Trent Region
(Excluding Director and Assistant Director, as at 31.03.87)

Barnsley	Sheffield	Bassetlaw & Central Notts	North Derbyshire	Southern Derbyshire	Doncaster	Leicester	North Lincoln	South Lincoln	Nottingham	Rotherham
1:16	1:22.3	1:19.5	1:17.6	1:19.6	1:22.5	1:19.3	1:13.5	1:17.3	1:18.8	1:17.6

To achieve a teacher/learner ratio of 1:12 would require an increase in teaching establishment and additional budgetary requirements for all Districts.

Table 2 - Costings of the Feasibility of Having a Teacher Learner Ratio - 1:12

DISTRICT	
BARNSLEY	Non-Recurrent 247.9 Man Years - £1,491,000 Recurrent 10.1 WTE - £ 145,000 Capital Spending - £ 50,000
BASSETLAW CENTRAL NOTTINGHAMSHIRE	
NORTH DERBYSHIRE	
SOUTHERN DERBYSHIRE	
NOTTINGHAM	
LEICESTER	
SHEFFIELD	40-54 extra teachers plus 3 support workers
ROTHERHAM	Extra £230,000
NORTH LINCOLNSHIRE	3 more teachers required
SOUTH LINCOLNSHIRE	
DONCASTER	8 more teachers at a cost of £116,000

Although many questioned the necessity for an all graduate teaching establishment several Districts had policies which positively encouraged staff to obtain graduate qualifications. It was suggested that an increase in teaching staff seeking graduate status may result in personal financing, if authorities were not allocated extra resources.

The eleven Districts with training schools wished to retain their schools within the National Health Service; many had links with higher educational establishments.

Regional Response

The teacher student ratio of 1:12 can be achieved but it will be costly unless learner intakes are reduced.

The need for an all graduate teaching staff is thought to be unnecessary in view of the excellent preparation already received by nurse/midwife teachers.

Question 13

What is the reaction of your Authority to the UKCC proposal for a new grade of helper to support professional practitioners in the light of the report on support workers from the group Chaired by the DHSS Chief Nursing Officer?

District Response

In principle many welcomed the proposal to introduce a grade of support worker with the provisor that a clear framework for training would be given.

To maintain standards of care the support worker would need adequate preparation and one District put forward a training plan that could be implemented in three stages.

Three Districts preferred to retain the Enrolled Nurse in place of introducing a support worker grade.

There was uncertainty that a National Framework for the support worker is desirable as: it was feared that eventually this new grade of helper would seek professional recognition, and that such recognition would be outside of the nursing profession. This would be seen as divisive and not conducive to a team approach.

Regional Response

The proposal for a new grade of helper is thought unnecessary as there seems no need to change from the existing system of using auxiliaries as support workers.

Question 14

The UKCC intends to examine the scope for widening the entry gate to training, without lowering standards. Has your Authority any views on how this may be achieved?

District Response

All Districts agreed with the idea of widening the entry gate to training.

To following proposals were made.

1. Develop Access courses. (To provide intensive study and qualifications enabling students to become more suitable candidates for nurse training).
2. Introduce Youth Taining Scheme
3. Develop B Tech. courses
4. Develop part-time courses

Regional Response

Widening the entry gate to training is fully supported by methods suggested in the District response.

Question 15

What are your views on the timescale for implementation of the proposals bearing in mind manpower and cost implications? Are there any aspects of the proposed timescale which could be modified to ease the transition process?

District Response

The timescale for implementation throughout the Region ranged from seven years (although it was said that this reduced time scale would be more expensive to achieve) to eighteen years.

The model assumed management action to reduce wastage would be achieved in year one and sustained thereafter - this was felt to be unrealistic.

One District suggested that transition periods beyond ten years would be more problematic due in part to at least two changes in UKCC membership, and at least two general elections. Such potential changes could result in new ideas and altered philosophies.

Regional Response

If Project 2000 were accepted it would be essential to pilot the scheme in selected areas. The Project should be introduced at the same time throughout the United Kingdom if the pilot schemes proved its feasibility and affordability. It would be interesting to pilot a Briggs type of scheme in addition to a Project 2000 scheme and compare the costs, benefits etc.

Question 16

Are there any other aspects of the proposals on which your Authority wishes to comment?

District Response

Several Districts did not respond to this question however, the majority of Districts who did respond made strong reiterations which are summarised as follows.

The consultation time was said to be totally inadequate and information received about Project 2000 lacked enough detail to enable better consideration to be given.

Although there was some support for the general philosophy of Project 2000; without increased financial investment, time and management initiatives, it was not believed practicable to proceed with the implementation of the project in its present form whilst maintaining services.

The management of a new grade of untrained helper resulting in the accommodation of larger numbers of trainers in clinical areas caused concern. This fuelled the argument that the Enrolled Nurse grade should be retained as the support worker to the first level nurse.

Prior to any adoption of Project 2000 pilot schemes in selected Districts should be introduced and evaluated; if following the evaluation of the pilot schemes, Project 2000 is to proceed there should be a fixed timetable for implementation.

If the project is introduced the various elements should be phased in, as total implementation at one time could jeopardize the implementation and the services provided.

Additional financial resources will be necessary with the introduction of Project 2000 and must be additional to existing funding at the time.

D. NURSE STAFFING IN TRENT REGION (ROUNDED WTEs)

	RGNs	SENs	UNQUALIFIED	STUDENTS	PUPILS	TOTAL
1987	17,400	5,800	8,700	5,300	820	38,020
1994 STRAT.PLAN	19,900	5,200	8,700	5,300	590	39,690
1994 PROJECT 2000	20,850	5,200	9,500	6,350	-	41,900