Rediscovering NURSING

A guide for the returning nurse

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Judith Morris • Denise Button

Springer-Science+Business Media, B.V.

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SPRINGER-SCIENCE+BUSINESS MEDIA, B.V.

First edition 1991

Originally published by Chapman and Hall in 1991

Phototypeset in 10/12pt Sabon by Input Typesetting Ltd, London

ISBN 978-0-412-34780-1

British Library Cataloguing in Publication Data

Rediscovering nursing.
1. Great Britain. Medicine. Nursing
I. Johnson, M. (Martin)
610.730941

ISBN 978-0-412-34780-1

Library of Congress Cataloging-in-Publication Data

Rediscovering nursing: a guide for the returning nurse/Martin Johnson . . . [et al.].
p. cm.
Includes bibliographical references.
Includes index.
ISBN 978-0-412-34780-1 ISBN 978-1-4899-2989-1 (eBook)
DOI 10.1007/978-1-4899-2989-1
1. Nursing—Handbooks, manuals, etc I. Johnson, Martin, 1953– .
[DNLM: 1. Employment. 2. Nursing—trends. WY 16 R317]
RT51.R43 1990
610.73—dc20 90–2350
CIP

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Acknowledgements

Our grateful thanks are extended to Trish and Julia Guest for painstakingly typing the manuscript and to Sue Dyke for creating such imaginative cartoons.

A special thank you goes to Alan Jackson and the Department of Medical Illustration at Bolton General Hospital for their diligent production of figures.

Martin Johnson
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Foreword

Learning to nurse is a little like learning to swim, ride a bike or speak a foreign language. It takes a long time to become a skilled practitioner, confident in your ability and assured that you understand what you are doing and know that you are doing it competently and safely. But, as everyone knows, lack of practice leads to loss of confidence and ability. To be as good as ever you were isn't easy, but neither is it impossible. All you need is time to adjust and adapt to all the changes that have taken place.

This book will give the once skilled, confident and competent nurse the knowledge needed to re-enter practice. It addresses the changes which have taken place in the delivery of care including the movement of care into the community, the growth in day-care and short-stay wards and, of course, changes in nursing practice. Such issues as nursing process, nursing models and primary nursing are described in detail, clearly helping you see how the profession has moved from the task allocation of my training into the individualized patient care of today. As ever, changes in medical and surgical practice affect nursing. The authors address these issues too, and explain such changes as U100 insulin, the use of scopes, fibre-optics and lasers to minimize invasive surgery and the tremendous growth in Health Education and Preventive Health Care. The book also suggests ways in which your new knowledge can be put to practical use. Details are given on Back to Nursing Courses, how to join a nursing bank or to work with the voluntary services.

Confidence, of course, is not just about your own confidence in yourself and your ability to nurse again. It's also about feeling comfortable about your family. Nurse managers today recognize your need for flexible holidays or for work shifts that mean you can be home for children. Health Authorities and Boards are beginning to

recognize that they should give assistance to nurses who value child-care and to accept that some of us also need flexibility to help care for elderly parents.

The need for managers to be aware of the importance of flexibility, of ensuring the nurses seeking to return to work have choice of placement and of making returning to work attractive is also being addressed by the Department of Health, the Royal College of Nursing and the private sector. All three have joined together in a major educational campaign beginning with a recently published series of videos, followed by Open Tech flexible learning programmes supported by Channel 4.

All-in-all you are very important. 'Your country needs you' isn't a new slogan, but it's truer today than it ever was. The number of traditional recruits to nursing (eighteen year old girls) is falling and our population is growing and ageing. Nurses – skilled, trained nurses – are essential if health care is to meet its demands for the 90s.

The fact you've opened this book shows you're interested and that you remember what nursing is like. Read the book. Ring up your nearest hospital and ask to speak to the person responsible for advising on returning to work and go along and talk. Remember, one thing hasn't changed: patients, and their families still need care. And isn't that what nursing is about and why you came into nursing all those years ago?

Betty Kershaw

1

How Can This Book Help Me? An Introduction

Welcome back to nursing! In choosing this book you have probably already made a decision to return to practise as a nurse. Hopefully you will find your new venture into nursing a rewarding and enjoyable experience.

This brief chapter aims to show you how this book can help you to achieve that experience.

WHAT'S NEW?

At the moment, returning to nursing may appear to be a challenging and daunting experience, rather than an enjoyable one. The excitement at the prospect of returning to work is possibly tinged with some apprehension about what to expect, what will have changed and how you will cope.

Anyone who has listened to news reports, read newspapers or even visited a hospital over the past five to ten years, cannot fail to have noticed that changes are occurring in nursing and the health service.

Nursing has had a high media profile recently. Issues such as pay, clinical grading and Project 2000 have received media attention, reflecting quite radical changes which have happened in the nursing profession.

The health service as a whole has seen major changes in management, structure and funding. 'Consumerism' has come to health care, as has the computer age and advanced technology.

Patient care has also altered. Lengths of stay in hospital are now much shorter, and advanced surgical techniques such as open heart surgery are more commonplace. Community care has increased drastically, especially for the mentally ill and handicapped.

WILL I COPE?

Faced with so much change, you may well be questioning the wisdom of your decision to re-embark on your nursing career. It would be naïve to assume that everything will be the same as when you left nursing. Even if it was, you might be anxious that you had lost your own skills.

Fear not! In amongst all that is new, one thing remains unchanged – the art of nursing. Those caring skills which you learned as a student or pupil nurse and which you used daily in your work as a nurse before, will still be there when you return to practice. Like the skill of riding a bicycle, your practical skills will also soon return. Whilst the technology and equipment may change, the underlying skills do not and the characteristics which made you an effective nurse before will remain.

So, whilst you will have to update your knowledge and your professional awareness, you will be building on firm foundations laid during your earlier career.

You will be amazed how quickly your skills return and enable you to feel competent to learn new ideas and to bring yourself up-to-date professionally. That is where this book will help you to cope.

HOW CAN THIS BOOK HELP?

This book is designed to help you to 'catch up' with what has been happening in nursing and the health service during the past ten years or so. It aims to help you cope once you have decided to return to practice by outlining areas where major changes have occurred.

It is beyond the scope of this book to update your practical skills. That can only be achieved by supervised practice, either as part of a Return to Nursing course or an induction or orientation programme. Nothing can prepare you totally for your return to practice. It would be presumptuous to suggest that this book could do that. It should be seen instead as a complement to a Return to Nursing course, or as an *aide-mémoire* once you are back at work.

WHAT DOES THE BOOK COVER?

This book considers first of all the changes that have occurred within the population. Trends in the type of patient you will encounter are explained, for example, the increasing number of elderly people.

The way in which care is delivered is discussed in the following two chapters. They describe how the role of various staff has changed in care delivery. The new approaches to delivery of nursing care are then outlined. Aspects such as the 'Nursing Process', 'Nursing Models' and 'Primary Nursing' are explained.

In considering the changes which have occurred in clinical practice, the emphasis is placed on a few examples such as wound care and insulin therapy. In this way the book highlights why changes have occurred, covering new equipment and technology, medical and nursing research. You are also given advice on how to find out and cope with other innovations in practice.

Major changes in the structure of the nursing profession, in the management of the health service and in nurse education are then explained. Reading these chapters may help to clarify some of those newspaper headlines on 'The White Paper', 'Project 2000' and 'The Griffiths Report'.

Finally there are two chapters which focus clearly on you as the returning nurse. Ideas to help you cope once you are back at work are given in Chapter 9, whilst the final chapter looks to your continuing career and opportunities in nursing.

You may wish to delve into different chapters as issues become

relevant to your work. The index at the end will guide you to areas of commonality between chapters.

Further reading lists are provided at the end of each chapter, so that you can follow up areas of particular interest. Very often the references given are to textbooks which should be available in most schools or colleges of nursing libraries or major booksellers. A list of useful addresses is also given at the end of the book.

SUMMARY

This chapter has answered the question posed in its title. It has shown that this book will help you to reorientate yourself to nursing and thereby cope with and enjoy your return to practice.

2

Who Will Be My Patients? A Review of the Changing Nature of Patients

You may be wondering what sort of people your patients will be when you return to nursing.

The short answer is that they are the same sort of people you come across in everyday life. The patient population is, after all, merely part of the general population and as such, is subject to the same changes taking place in society.

The aim of this chapter is to examine the effects some of those changes have had on the nature of the people who will become your patients.

HOW HAS THE STRUCTURE OF SOCIETY CHANGED?

Many of your patients will be elderly. Since the early part of this century, improvements in living conditions and developments in health care have increased life expectancy at all ages. The population as a whole is ageing and the number of people living into old age is continuing to rise.

In 1987 the number of people aged 65 years or over was 8.8 million, compared with 5.5 million in 1951. If this growth is projected into the future, it is expected that the elderly population will number 11.3 million by the year 2025, with 1.4 million of these aged 85 and over (Central Statistical Office, 1989).

As many of the current health problems of our society are degenerative and disabling by nature, such as arthritis and heart disease, it is likely that there will continue to be a high incidence of ill-health among the elderly population. This will result in a high demand for health care, not only in the geriatric area, but also in general medical and surgical wards where elderly people are often admitted with multiple pathologies.

This is not, of course, the only reason for the patient population growing older. Changes in family structure may mean that elderly relatives are less likely to be cared for at home. The large extended family who all lived within walking distance of each other is a thing of the past; families are now much smaller and moving away from parents to a different part of the country is common.

It must also be remembered that those people who are in their 80s and 90s, even if they do have families, are likely to have children who are themselves elderly. Given the high death rates due to coronary heart disease and cancer in middle age, some elderly people may even outlive their children, and it is not as easy to place the burden of care on the shoulders of grandchildren.

Some of your patients will have experienced other family changes.

Since the early 1970s, the chances of them having or of being an illegitimate child born outside marriage have increased. There have been changes too in marriage and family structure, with more people living with a partner as a married couple, bringing up children as a single parent, and getting divorced.

The traditional view of the family as a married couple with two children, although still the most common type of family unit, can no longer be taken for granted. This is particularly important for nurses who must try to understand the patient's relationships with others in order to care for the individual as a whole, and deal with problems which are often social in origin.

Your patients may have experienced mental, physical or sexual abuse within the family. While it is doubtful that these are new problems, they are now receiving much more publicity than in the past, so raising the public's awareness of them.

Your patients will have a variety of religious and cultural backgrounds. Over the last 30 years, Britain has become a multi-racial and therefore multi-cultural society. The figures for 1984–86 show that 4.5% of the UK population were from ethnic minorities, of whom the majority were from the West Indian/Guyanese, Indian or Pakistani ethnic groups. Many of the younger age groups of the ethnic

minority population were born in this country. (Central Statistical Office, 1989.)

Individuals from ethnic minority groups may have norms, values and beliefs that are significantly different from those of the majority population. Their concepts of health and their attitudes to health care may differ markedly from your own, yet it is important to accept and respect such differences when caring for patients from these groups. For example, an Asian lady who is admitted to hospital may find it extremely offensive to be examined by a male doctor, to have a bath rather than a shower, and to wear hospital clothes which she considers immodest. If you were caring for this lady you would probably be able to show greater empathy towards her if you understood the reasons for her attitudes. There are many useful books available on ethnic and cultural differences: you are particularly directed to the reference included in the further reading section at the end of this chapter.

HOW HAVE HEALTH AND ILLNESS CHANGED?

During the last few years, there has been increasing interest in all things related to health. Health issues such as diet, smoking, exercise and stress have become popular subjects for parliamentary debate, television and radio programmes and articles in newspapers and magazines. Health as a trend is fashionable, while 'healthy lifestyle' became one of the catchphrases of the 80s.

This intense media coverage has led people to have a greater understanding of what health is and what it means to them as individuals. For example, the publicity surrounding an event like the Para-Olympic Games has seen to it that many no longer regard all disabled

people as unhealthy. Similarly, people with chronic illnesses such as diabetes or multiple sclerosis, who can never be cured but who continue to lead full and active lives, have added weight to the argument that health is something more than simply the absence of disease.

Many of your patients will have views about their own health which will affect their perception of their treatment and care. Some may hold views which are completely at odds with your own and those of other health care professionals.

Since the pattern of ill-health in the UK continues to be dominated by two modern 'epidemics', namely heart disease and cancer, it is inevitable that many of your patients will be suffering from them.

Of all the types of heart and circulatory diseases, it is coronary artery disease that is the greatest threat to health and life. In 1987, the mortality rate from coronary heart disease for men was 359 and for women 270 per million population of the UK. The major or primary risk factors that predispose an individual to the disease have been identified by research as a raised blood cholesterol level, high blood pressure and cigarette smoking (see Figure 2.1). These and the other secondary risk factors have repeatedly been the targets of health education campaigns. The message is always the same: that if people adopt a healthier lifestyle they can significantly reduce their risk of developing coronary heart disease. One such campaign entitled 'Look After Your Heart' was set up by the Health Education Authority in 1987.

There has been some response by the public to health education in that there is now an increased awareness of the harmful effects of stress, lack of exercise and a high fat intake, and there has been a reduction in smoking, mainly among men.

Whether it is as a result of health education or of improved medical treatment, or a combination of both, the rates of death from coronary

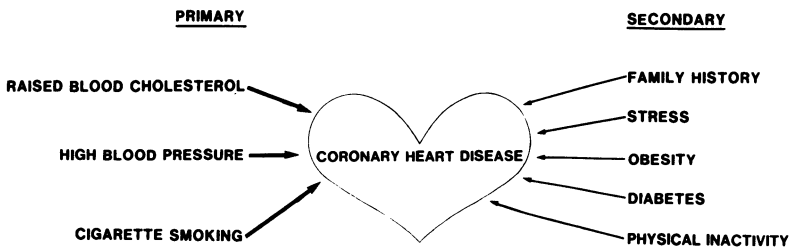


Figure 2.1 The risk factors in coronary heart disease.

heart disease, particularly among the younger age groups, have begun to fall over the last few years.

However, this decline has been very slow compared with that seen in other countries. An example is the USA where the rates of death from coronary heart disease have fallen quite dramatically since the early 1970s. There remains a lot of work to be done.

The second major cause of illness and death in the UK is cancer. Of all types, lung cancer continues to be the commonest cause of death with the majority attributed to cigarette smoking. Among men it is the greatest cancer killer, whilst among women it is second only to breast cancer as a cause of cancer mortality. However, this may be set to change.

Since the mid-1970s there has been a significant reduction in the rate of death from lung cancer among men; indeed, in the under-50 age group, it has dropped by 50%. This trend is thought to be due to an overall reduction in smoking and an increase in the use of low-tar cigarettes (Doll, 1988).

The picture for women is rather more gloomy: in the same period of time, their mortality rate has continued to rise, particularly in the over 55 age group, where the effects of long-term smoking have taken their toll. What is perhaps even more worrying, however, is the number of schoolchildren who smoke.

A survey carried out in 1986 found that among secondary schoolchildren in England and Wales 7% of boys and 12% of girls aged between 11 and 15 were regular smokers (Central Statistical Office, 1989). If these children continue smoking into adult life, then many will become your future patients as they succumb not only to lung cancer but also to other smoking-related diseases.

Both coronary heart disease and lung cancer are therefore prime targets for all those involved in health promotion and illness prevention, including nurses.

When you return to nursing, an integral part of your work will be aimed at increasing your patients' awareness of the factors affecting their health and helping them change their lifestyles accordingly.

This is not always easy: remember that it is difficult for people to fully appreciate the long-term benefits of a change in lifestyle when they feel well now, particularly if the change involves giving up something they enjoy.

Another disease of the 1980s and 90s that some of your patients may have is AIDS (Acquired Immune Deficiency Syndrome). Others may be infected by the virus which causes AIDS, Human Immunode-

ficiency Virus or HIV, but are not yet showing any signs and symptoms of the disease.

By the end of July 1990, the number of reported cases of AIDS was 3548 of whom 1925 had died. However, there are many thousands more infected with HIV who are expected to develop AIDS as a result.

AIDS poses a threat to anyone in society. For nurses, it demands not only the complex skills involved in caring for an individual with a distressing and fatal disease, but it also challenges many of our traditional assumptions about social and sexual behaviour. In your caring role you have nothing to fear from the AIDS virus since it has proved very difficult to catch in nurse-patient contact. For further information on procedures and policies regarding AIDS, you are referred to the reading list at the end of this chapter.

HOW HAVE PATIENTS' EXPERIENCES OF HEALTH CARE CHANGED?

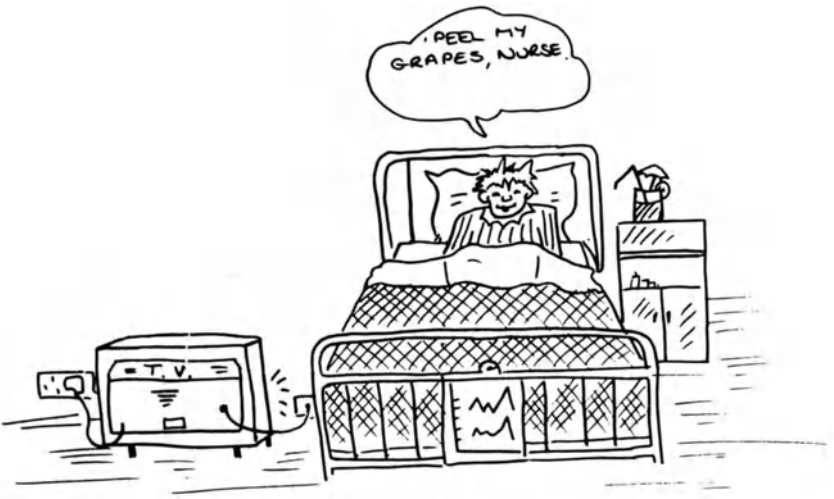
There have been changes in your patients' experiences of health care.

The growth in popularity of health-related issues discussed earlier has not only been responsible for heightening the public's awareness of health but also for increasing their understanding of health care. Because of this, it can no longer be assumed that people will automatically adopt the traditional role of compliant patient. Some of your patients may already know a lot about their condition and may question the necessity of traditional practices.

This increased understanding of health care, together with the growth of 'consumerism' in society has lead people to have much higher expectations of health care than, for example, ten years ago.

Perhaps as a result of this, people are now more likely to express dissatisfaction with the NHS. A survey done in 1987 shows that more people are generally dissatisfied with the running of the NHS than four years previously (Brook *et al.*, 1989) although this must also be linked to changes in the NHS during this time. While satisfaction was expressed about the general quality of medical and nursing care, particular sources of increasing dissatisfaction concerned the resources available to hospitals and the length of waiting times for both appointments and hospital admission for non-urgent surgery.

Many people continue to support the private provision of health care, but most feel that this should only be available outside NHS



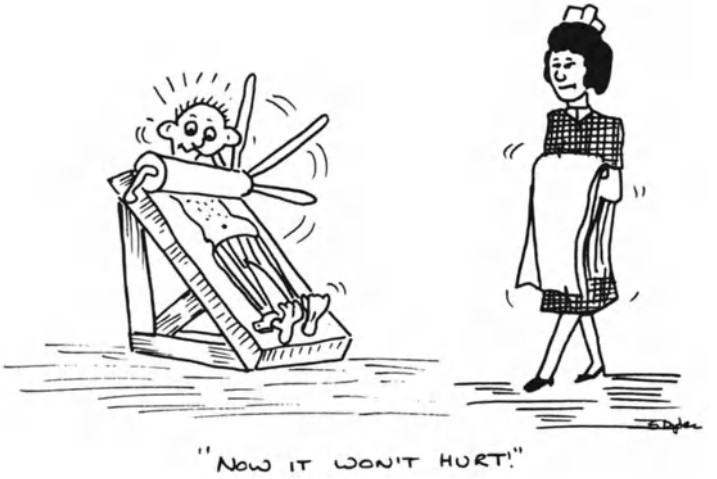
hospitals (Brook *et al.*, 1989). Some of your patients will have private health insurance, often arranged through their workplace, which may offer them financial support while an NHS hospital in-patient, or the opportunity to have their non-urgent surgery performed at a private hospital. Whatever your own views about the private health sector, it looks set to stay and continue to grow in the future.

When people are admitted to NHS hospitals, their stay as an in-patient is likely to be shorter than ever before. Since 1971, the throughput of NHS hospital in-patients in the UK has risen by nearly 26%. However, during the same period, the number of hospital beds available on a daily basis has fallen by 25%. (1987 figures, Central Statistical Office, 1989.)

This has meant that the average length of stay of patients in hospital has dropped quite considerably over recent years. For example, in 1971 a medical patient could expect to remain in hospital for an average of 14.7 days, while in 1986 a similar patient would stay only 8.5 days. (Central Statistical Office, 1989.)

The reasons for this are, in part at least, due to improvements in medical treatment, but they also reflect the increased drive for efficiency and cost-effectiveness called for in recent management changes in the NHS (see Chapter 6). Whatever the reasons, if you are returning to work in an acute hospital ward, the faster patient turnover will certainly affect the care you give to your patients. If you are returning to work in the community you may find yourself giving care that was once given in hospital, such as removing sutures from a patient's wound, or more advanced procedures.

While they are in hospital, some of your patients may have to undergo new types of treatment which they may find extremely frightening or just difficult to understand. For example, the increased use of lasers as an alternative to surgery, or the more widespread use of scanning machines to aid diagnosis. When you return to work you



may need to explain such treatments to your patients and reassure them about their use. Naturally you should receive proper training to do this and will need to ask your employer about this.

If you are returning to work in non-acute areas, then your patients will have experienced changes here too.

The last decade or so has seen a move towards increased care in the community for patients resident in long-stay hospitals for the elderly, the mentally ill and the mentally handicapped. This is not a new idea; indeed the majority of elderly people, mentally ill and mentally handicapped people are already cared for in the community by families and friends.

However, the term 'community care' tends to be used more widely to include a variety of elements, shown in Figure 2.2.

During the last few years there has been increasing pressure on local health authorities to close down many of the large, long-stay institutions and move former residents into some form of community care. This has resulted in a fall in the numbers of long-stay patients in hospitals for the mentally ill and mentally handicapped, and a growth of residential homes and hostels. However, the support services for those patients returning to their own homes have often been found to be inadequate, and a tremendous burden has been placed on their families and friends, and on the community health and social services.

Community care of course also involves all those people who have

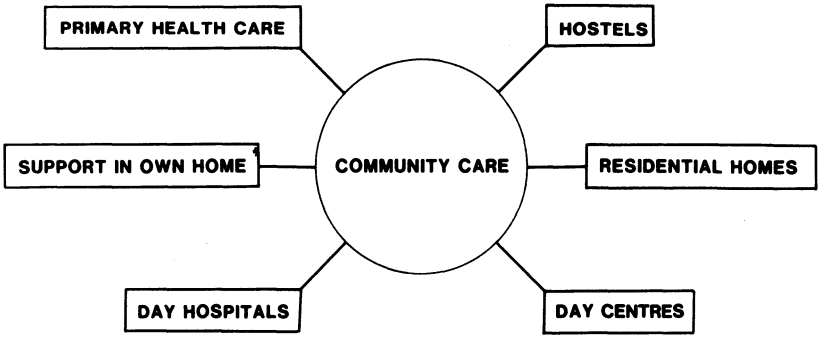


Figure 2.2 The elements of community care.

always lived in their own homes, including many who are disabled. Most care in the home is carried out by relatives and friends – lay or informal 'carers' who in 1985 numbered about 6 million in the UK. (Central Statistical Office, 1989).

It is important that, as nurses, we acknowledge the enormous and essential contribution that such carers make to health care, and that community nurses in particular are able to offer help and advice if necessary.

SUMMARY

This chapter has examined some of the changes that have affected people, and therefore patients, during recent years. The structure of society, the pattern of health and illness and attitudes towards health care have all been briefly considered. It is hoped that this will have encouraged you to do some further reading on some of the topics raised.

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3

Who Will I be Working With? Changing Roles in Health Care

If you have not worked as a nurse for a considerable time, it is possible that you may feel a little unsure of what to expect when you do return. By reading this chapter, you will gain an insight into the differing nursing posts and be able to identify other personnel involved in patient care. In addition you may find it useful to read about how some aspects of the nurse's role and working life have changed over the years.

You will find, when you walk into a hospital ward, department or community setting, that most of the clinical nurse titles are familiar to you. Sisters, staff nurses, enrolled nurses, student nurses and auxiliaries still form the usual nursing team. An increased number of your nursing colleagues (about 10%) may well be males.

The numbers of a particular nursing grade will vary from area to area and so will the ratio of trained to untrained nursing staff. The size and structure of the ward or department, the nature of the speciality, patient dependency levels (see Chapter 6) and many other factors are studied by the local health authority before deciding upon an appropriate 'skill' or 'grade-mix'. A high dependency unit will be staffed by a majority of trained nurses with very few unqualified staff and will have a high staff to patient ratio. In contrast, a less acute area, such as a long-stay ward, may be staffed by equal numbers of qualified to unqualified nursing staff. District nursing sisters continue to organize patient care in the community and are assisted by enrolled nurses with auxiliaries carrying out some aspects of care.

While it is difficult to generalize, on a general hospital ward, you may well be working in a team consisting of perhaps one or two ward sisters, three staff nurses, an enrolled nurse, an auxiliary and a varying number of student nurses. Nurses on the ward will receive additional training to suit the needs of patients in that area.

SHIFTS

Although hospitals generally have set shift patterns for staff, consisting of 'early' and 'late day' shifts and a night shift, there is a move towards more flexibility. Part-time nurses form a substantial proportion of a hospital work force and, as you will see, flexitime working patterns have been introduced in some areas. The normal full-time working week consists of 37½ hours at present and there is an annual holiday entitlement of five weeks plus bank holidays.

The duty rota should include a balanced grade-mix throughout the day and less staff should be on duty when the level of ward activity is reduced, for example some wards have less patients at weekends. Other factors taken into account by the nurse planning the duty rota include supervision of student nurses by trained staff, and requests from nurses for specific off-duty time.

A close look at the traditional duty rota in Figure 3.1 will reveal that there is a four-hour overlap of nursing shifts in the afternoon. This situation is now being studied closely and some hospitals are introducing flexitime. The aim of flexible hours is to increase the trained nursing hours available when patient care is needed most and also to reduce costs. Starting times and finishing times are varied in

	MON	TUES	WED	THUR	FRI	SAT	SUN
SISTER A	E	L	E	L	1/2	DO	DO
CHARGE NURSE B	DO	DO	E	E	L	1/2	L
STAFF NURSE C	L	E	L	E	1/2	DO	DO
STAFF NURSE D	E	DO	DO	L	E	L	1/2
STAFF NURSE E	ANNUAL LEAVE						
ENROLLED NURSE F	L	E	L	E	1/2	DO	DO
STUDENT NURSE G	E	L	E	L	1/2	DO	DO
STUDENT NURSE H	DO	DO	L	E	L	1/2	E
STUDENT NURSE I	E	E	1/2	DO	DO	L	E
STUDENT NURSE J	E	L	E	1/2	DO	DO	L
AUXI-NURSE K	L	E	DO	DO	L	1/2	E

E-EARLY SHIFT 7.45am-4.30pm

L-LATE-DAY 12.15pm-9.00pm

1/2-HALF DAY 7.45am-1.00pm

DO-DAY OFF

Figure 3.1 An example of a daytime duty rota.

a flexitime system and this may be useful to nurses returning to work who have family responsibilities.

The night duty rota is often planned by the night nurse manager and full-time staff usually work seven nights in two weeks. A number of hospitals have 'internal rotation' where all qualified staff spend some weeks on day duty followed by a period of night duty. This aims to increase continuity of care to patients and to produce a united team of nurses rather than separate day staff and night staff. A night shift usually spans the hours from 8.30 pm to 8.00 am. As with day duty, the number of nurses and grade-mix are apportioned according to the number of patients, the nature of the speciality, etc.

Having established who you are likely to be working with and the possible hours involved, the following look at the role of the nursing team members may serve to highlight, not only changes in recent years, but also familiar aspects of the nurse's work.

The role of the qualified nurse is complex and is shaped by the nature and needs of patients and clients (see Chapter 1). It is also governed by the Nurses' Rules which are part of the Nurses, Midwives and Health Visitors' Act 1979, and the UKCC Code of Professional Conduct – these are discussed in Chapter 7.

ROLE OF THE WARD SISTER

You will soon notice, on returning to nursing, that the ward sister is still the key to the standards of patient care achieved and to the atmosphere on the ward. She is the person to whom most enquiries are directed. Her main functions are to ensure that all patients receive the care and treatment required, that nursing is carried out in a caring environment and that staff gain job satisfaction.

So what is new about the role of the ward sister? As you will learn in Chapter 4, the organization of patient care has altered and this has resulted in changes in her role.

Communication is now probably the main element, rather than sister having direct control over patient care. She leads a group of qualified nurses by negotiating with them the philosophy of the ward, objectives to be achieved, ways of organizing care, standards to be reached and resources needed.

Liaison with other departments, other disciplines and the community nursing staff is part of the ward sister's role but equally may be devolved to an individual nurse if care of her patient is involved.

In addition, the ward sister communicates with managers about resources, manpower, budgets and during committee work. She liaises with nurse teachers about student education programmes and post-basic training and participates in planning meetings. Most wards have a clerk to assist with administrative tasks.

Guiding and advising the nursing team on nursing care is an important part of the sister's role. All qualified nurses are required under the Professional Code of Conduct (see Chapter 7) to improve their professional knowledge and competence. Therefore the ward sister communicates with the nursing staff to identify learning needs so that appropriate action (e.g. study days, courses) can be planned.

On wards used for the practical experience of student nurses, the ward sister ensures that students receive supervision and teaching and that their performance is assessed.

EFFECTS OF SCIENCE AND TECHNOLOGY ON THE NURSE'S ROLE

The role of qualified nurses has also expanded in line with medical and technological advancements. Nurses receive additional training when working in high-technology areas. This may include training in defibrillation procedure in coronary care units, the management of artificially ventilated patients or the care of patients receiving renal dialysis. (Information on post-basic courses are included in Chapter 10.)

Technological advances are evident on general wards too; the nurse returning to practice will soon gain experience of electronic monitoring of blood glucose levels, temperature and intravenous infusions. Once you are accustomed to these and other new devices, the advantage of their accuracy and time-saving will soon be appreciated.

Enrolled nurses form a valuable part of many clinical teams and their role has been made more explicit as a result of the Nurses' Act 1979. They assist registered nurses with assessment of patients, with planning care and with giving nursing care. Some enrolled nurses receive additional training to become competent in, for example, the administration of medicines.

The work performed by registered and enrolled nurses varies with their skills, training and the settings where they practise. However, even though the roles of qualified nurses in different areas may appear very different, they are all based upon the appropriate section of the Nurses' Act and are judged by the Code of Conduct. This applies whether they are caring for physically ill patients, mentally ill or mentally handicapped clients, school children or any of the diverse groups of people who may require the attentions of a nurse.

STUDENT NURSES IN THE CLINICAL AREA

As you will learn later in this book, pre-registration nurse education is undergoing fundamental changes. The majority of students on the wards and in community settings will prepare for first level registration. Although they currently form a substantial part of nursing manpower, there are plans for them to become supernumary in all training areas. This means that you will still be working alongside students and may be teaching and supervising them. However, they

Figure 3.2 Different but the same.

will be on the wards to gain practical educational experience by observing and practising nursing rather than being, as critics of the current system say, 'pairs of hands' to swell staff numbers. You may find that students have changed in subtle ways – they are encouraged to be questioning and analytical about nursing practice. Continuous assessment of practice and theory means that students take responsibility for attaining their own goals and seek help from qualified nurses in attaining these aims.

In anticipation of pre-registration nurse education leading to a single level of registered nurse and the phasing out of the enrolled nurse grade, many schools of nursing have ceased enrolled nurse training. However there may remain some pupil nurses gaining their practical experience in hospital wards and they require support and supervision from their senior colleagues.

Students on many other courses (see Chapter 10) will also be caring for patients in a variety of clinical placements. If you return to work on a teaching ward or in the community, you will soon have the satisfaction of assisting both pre- and post-registration students to achieve their educational objectives.

HEALTH CARE ASSISTANTS

Health Care Assistants continue to work under the direction of qualified nurses and assist with care of patients. It is important that they work within the boundaries set by their job description and receive training sessions on the aspects of care with which they are involved.

CLINICAL NURSE SPECIALIST

In recent years, a grade of nurse known as clinical nurse specialist has developed. She is a registered nurse who has developed her knowledge and skills about a particular aspect of patient care, such as stoma management, continence advice, diabetic care, management of pain or family therapy, or about care of a particular age group. She then applies her expertise to assist patients/clients and to advise the nurses involved in their care where appropriate.

Clinical nurse specialists are an acknowledged source of experience and expertise which is proving a valuable asset in improving patient care. Nurses and doctors in hospital or community settings can seek

the advice of the specialist nurse in the management of their patients. For instance, a stoma care specialist will be involved in counselling patients and relatives before surgery, perhaps in the out-patient department or on the ward. The nurse will continue this relationship in the post-operative period, giving advice on stoma management and appliances.

Following discharge from hospital, the specialist nurse will continue to guide and support the patients and relatives in the community. Thus she or he provides an important link between hospital and community for the patients in her care.

The development of the clinical nurse specialist grade has provided a career structure for clinical nurses which enables them to continue giving patient care. Their knowledge and expertise may be particularly useful to a nurse returning to practice.

JOINT-APPOINTEE

Another title which may be unfamiliar to you is 'joint-appointee'. These are nurses who are fulfilling a dual role (e.g. ward sister/tutor) and are accountable to two managers (e.g. nurse manager and education manager). The aim of this type of appointment is to bridge the gap between 'school' and 'nursing services'. The appointee shares time between organizing patient care and teaching students with the two functions relating and becoming interdependent, i.e. students and permanent staff are taught how to organize and give care both in theory and practice by the same person.

COMMUNITY NURSES

Those nurses returning to work in the community will notice an expansion both in the variety and number of nurses practising there. Early discharge of patients from hospital, the rising elderly population and closure of many long-stay hospitals has resulted in the need for increased nursing services and nursing expertise in the community.

In addition to general community nurses, there are now community-based psychiatric nurses and mental handicap nurses. They assist in the management and care of their clients, giving guidance and support to relatives and carers where appropriate. Liaison with other health professionals and other agencies forms an integral part of

"EARLY DISCHARGE FROM HOSPITAL".

the community nurse's role as the number of patients/clients with individual needs and problems rises.

As the nature and structure of society gradually alters, as people place emphasis on different values and as medical technology advances, so nursing reflects these changes. This glimpse at the nursing team reveals that new nursing grades have developed, the environment where many nurses practise has shifted, and the roles which accompany the traditional titles of ward sister, staff nurse, enrolled nurse and student have undergone discernible changes.

MULTIDISCIPLINARY TEAM

You will, however, when you return to nursing be part not only of a nursing team but also of what is known as the multidisciplinary team. Health care is provided by a whole range of disciplines and you will be familiar with most of the titles. The multidisciplinary team consists not only of doctors and nurses but also of physiotherapists, occupational therapists, dietitians, domestic staff, porters, chaplains, clinical psychologists, speech therapists etc.

Although the broad aim of all these groups is concerned with the well-being of patients, it is important that the nurse appreciates their

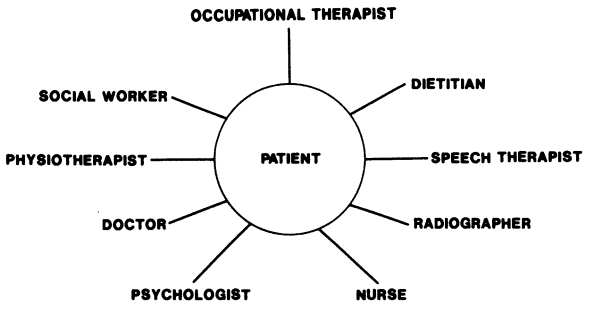

Figure 3.3 The multidisciplinary team

different perspectives and goals. Only by awareness and appreciation of each others' contribution can the team work well together.

Co-ordination of the contributions of all the team members is an important part of the nursing role as this is the only discipline to provide a 24-hour service. The size or importance of the contribution of a team member is perhaps dependent on the patient's problems. For instance, where a patient requires urgent surgery, the contributions of the surgical team are of major importance; where a patient is learning to walk again, the physiotherapist has an important role.

Because of the role as co-ordinator of care, the nurse needs knowledge of the therapies and treatments provided by other members of the multi-disciplinary team. The nurse may need to understand, for instance, the principles of rehabilitation techniques for stroke patients so that physiotherapist, nurse and other carers are working towards the same goals. This instance also emphasises the patient teaching role of the nurse – the patient must be working towards the same goals too!

You will be liaising with yet more disciplines through your role in caring for patients who are having diagnostic tests. These include radiographers, electrocardiographers and scientists and technicians working in pathological laboratories. There have been many advances in diagnostic procedures and some of these may be new to you. Luckily, some excellent books are available on the nurse's role in diagnostic procedures, rehabilitation programmes, patient teaching, etc. Relevant study days and courses are also organized by nurse education departments.

Many nurses feel that their role needs clarification amongst the

increasing number of specialities found in the health care field and this issue is picked up in the next chapter.

In conclusion, you will have noticed that many of the nursing and non-nursing personnel mentioned in this chapter are familiar to you but some new posts have evolved as society has changed and as technology has advanced. The work and working conditions of the nurse should now be clearer and you may have a better view of the role of the trained nurse in current nursing practice.

FURTHER READING

Kron, T. and Gray, A. (1987) *The Management of Patient Care – Putting Leadership Skills to Work*, W. B. Saunders, London.
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4

How is Care Organized Now? Changes in the Delivery of Care

You may have heard the terms 'Nursing Model' and 'Nursing Process' but perhaps be unclear about their use. This chapter aims to show the different ways in which patient care may be organized and how care is planned using a model and the nursing process.

Before we explore how care is organized, it might be wise to define what caring means. The 1972 Report of the Committee on Nursing identified nursing and midwifery as 'the major caring profession'. We have already discussed the other members of the multidisciplinary team who are involved with the treatment and therapies which patients receive. So what is this caring function which seems central to nursing?

Virginia Henderson (1977), says 'The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities . . . that he would perform unaided if he had the necessary strength, will or knowledge. And to . . . help him gain independence as rapidly as possible.' Assistance seems to be one of the key words in this statement – nursing is helping in many different ways. Nurses, you may say, have always helped their patients, so what is 'new' in the care given to patients today?

HOLISTIC CARE

The emphasis in nursing is on giving holistic care to individual patients or clients. Holistic nursing refers to the need to treat or care for the whole person. The physical functioning of the body is affected by the mental and spiritual state of the person and vice versa. An example of this might be found by examining the concept of pain: physical pain causes concern and anxiety to the sufferer; worry and anxiety

may result in muscle tension and thereby increase the degree of pain. Similarly, many nurses have marvelled at the effects of spiritual faith in restoring physical or mental well-being. In nursing today, there is therefore a move towards caring for the physical, psychological, social and spiritual needs of patients and recognizing the responses which occur when any of these needs are unmet.

Although nurses have always been aware of the need for more than mere physical care, you may notice that more emphasis is now placed on attention to all human needs.

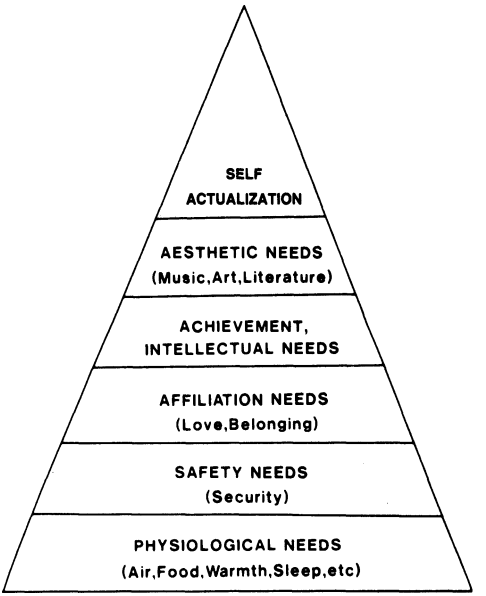

Figure 4.1 Maslow's hierarchy of human needs (Maslow, 1970).

Maslow (1970) suggests that the lower order physiological needs must be met before the higher levels can be accomplished, i.e. an individual who lacks warmth, shelter and food is unlikely to feel safe, secure or cared for. Relating this to nursing and health care, the function of the nurse is to help the individual meet the needs he or she cannot satisfy without assistance. Whilst assisting the patient to meet a physical need, e.g. helping an adult with food, the nurse will be aware of the effects that the situation may have on the patient's psychological state. The nurse will use interpersonal skills, verbal and

non-verbal, in an effort to counteract any adverse effects. This will be an holistic approach to nursing.

INDIVIDUALIZED CARE

Hand-in-hand with holism comes the emphasis on the patient or client as an individual. Each person is a unique individual being with their own personality, physical make-up, moods, strengths, weaknesses, beliefs, etc. Nurses need to be aware of the differences between patients and the varying effects that illness, hospitalization or any stress can have on different individuals. Most nurses will have noticed for instance the various ways in which two patients react to forthcoming surgery, even when the anticipated operations appear identical.

PATIENT INVOLVEMENT IN CARE-PLANNING

In nursing today, there is increasing importance placed on the rights of individuals and these include the freedom to choose and to be involved in decision-making. You will be aware that patients do not always have the knowledge to make informed choices. Nurses now spend an increased amount of time giving patients/clients, plus their family and friends where appropriate, information. This may be a matter of explaining nursing procedures and investigations, giving information about treatment or equipment which is to be used, or it may involve demonstration and teaching of skills which the patient or family will need in order to cope at home.

Once the patient or client is well-informed and has understanding, they may be in a position to make informed choices and to be involved in decision-making. For instance, a person who understands the need for and the components of a reducing diet may then choose their own meals, substitute part of the diet with suitable food brought in from home, and thus become involved in their own care. Similarly, you will find that nurses ask patients how they normally cope with particular stresses at home, e.g. pain, and then may include these coping strategies when planning the care with the patient. Although many patients are very ill, they too can often make choices if given the opportunity, i.e. which position is most comfortable, which fluid to drink or when to take a bath.

Where the sharing of knowledge and decision-making with the

"PATIENT INVOLVEMENT IN DECISION-MAKING"

patient occurs, the relationship between nurse and patient changes to a partnership. Instead of doing things for the patient/client, the nurse works with the patient. As the knowledge and skills of the patient increase, they can make more decisions and become less dependent on the nurse.

In many cases, the partnership does not only include nurse and patient but also family and friends. You may notice a big increase in the amount of family involvement in hospital care of patients. Flexible visiting times enable relatives to be present, to be consulted with the patient about care and, when appropriate, to give the care. In the case of a chronically sick person, the relatives may have been giving the majority or all of the care in the home and may either wish to continue their involvement in the care or may prefer to take a well-earned break.

The interpersonal skills of the nurse play a large part in determining the nature and effectiveness of the nurse/patient relationship. Nurses now receive increased training in communication skills so that they may feel equipped to cope with the demands of a close relationship with patients and relatives. They need an understanding of psychology and sociology in order to develop the necessary skills to teach and

motivate patients. Back to Nursing courses may well include sessions or workshops designed to improve interpersonal skills.

WHAT IS HEALTH?

Nurses, in recent years, have moved towards new definitions of health. The World Health Organization, as long ago as 1948, defined health as 'a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity'. Thus nurses may view a wheelchair-bound person who is managing a useful, satisfying, happy life as healthy. Alternatively a person who is free of any disease process but who feels unable to cope with unemployment may be seen as having a health problem – the needs for security and self-esteem, in a society which places high value on work, are unmet.

Now that we have examined some of the ideas that have emerged in nursing, we shall compare the various methods which can be used to deliver nursing care.

TASK ALLOCATION

Task allocation is the assignment of individual tasks to a nurse, e.g. Staff Nurse Evans to do all the dressings, Nurse Wright to do the blanket baths etc. Using this method, all the necessary work is divided into activities which are then assigned to one or more nurses. Thus a patient may be washed by one nurse, receive drugs from another, have their temperature taken by a third nurse and so on with no continuity of care. It may be thought that this method deters a nurse from building up a close relationship with a patient; the patient is seen as a series of unrelated tasks not as an individual with physical, psychological, social and spiritual needs. Added to this, the areas of nursing care where a nurse can spend time closely observing and communicating with patients, such as bed-bathing, are seen as junior tasks and are not performed by senior or qualified nursing staff. With this method, the ward routine can become so rigid that there is little scope for individualized patient care. You may remember bedpan rounds and bath books – unfortunately you may still come across them. Nurses may resort to task allocation when patient turnover is high and staffing levels are low.

PATIENT ALLOCATION

Patient allocation is where a number of patients are assigned to one nurse. That nurse is responsible for planning the care, often using a problem-solving approach (see Nursing Process, later in this chapter), but they can also break the care down into a series of tasks, i.e. attend to the hygiene needs of each patient, then take and record the temperature of each patient, etc. When the nurse requires help with a nursing action, e.g. lifting, this is sought from another nurse.

In this system, the allocation of patients can be done on a day-to-day shift basis, a weekly basis or on the length of stay of each patient. The planning of care can also be done in varying ways: the nurse can plan only the care she or he will give during the duty span or may plan for the next 24 hours or more so that subsequent shifts will continue with the care planned by someone else. Care is then discussed during the overlap period between shifts.

This system of organizing delivery of care can have advantages over the task-centred approach unless, of course, the nurse breaks down the care of patients into a series of tasks. The care the patient receives should be more continuous and should be individually designed for that particular patient. Where the same nurse assists the same patients, especially over a prolonged period, a better nurse/patient relationship has opportunity to develop. Patient allocation can give the nurse a keen sense of job satisfaction, by taking pride in providing help, comfort and teaching the assigned patients. Useful communication between nurses is increased when each nurse reports back on the care and progress of assigned patients, both verbally and by writing in the Kardex system or patient file.

Changes in the patient's condition may be noticed earlier when one nurse has responsibility for the total care of that patient and the relationship between signs, symptoms and treatment will be more easily identified. For instance, when one nurse is giving complete care to a patient, she or he will relate the rash that was noticed whilst assisting the patient with a bath to his or her raised temperature and perhaps to the drug that was administered earlier. If all these nursing activities had been performed by different nurses, the relationship may go unnoticed.

Although a certain amount of routine is required in giving care to assigned patients (hourly neurological observations, etc.), these repeated interventions will be performed by the patient's own nurse.

The nurse has the freedom to deal with patient's problems on a priority basis and in consultation with the patient.

There are disadvantages to this method as well. Patient allocation can carry a lot of responsibility for the nurse and may lead to student nurses working without close supervision. Equipment, such as hoists and sphygmomanometers, has to be shared. A nurse may find she or he has been assigned a patient with whom it is difficult to form a relationship, and vice versa. It may be difficult to allocate all patient care including drug administration and doctors' rounds. All these problematic areas require negotiation and planning between the ward sister and nursing staff.

TEAM NURSING

Team nursing is widely used in hospital wards. This consists of two or more groups of nurses led by a qualified nurse looking after a group of patients. On a ward of 30 patients, there may be two teams. The structure of a typical nursing team may be: Team Leader – Staff Nurse; Team Members – 1 Enrolled Nurse, 2 Student Nurses, 1 Health Care Assistant.

The team leader assesses the patients' needs and allocates team members. Within the team, a type of patient assignment system can operate with the team leader having the responsibility and freedom to plan the care of patients and allocate patients to nurses according to ability and experience. Alternatively, she or he may allocate tasks

to nurses. Many of the strengths and weaknesses of team nursing depend upon how the care is organized, i.e. patient allocated or task allocated. Additional benefits of team nursing are that:

1. The ward sister has two or more team leaders with direct responsibility for patient care and is therefore able to engage in policy making, overall planning and teaching clinical skills.
2. The team leader can supervise learners and health care assistants and this is an efficient way of utilizing the work force.
3. Equipment is more easily shared.

Experience has shown that the capability of the team leader, both as a clinical practitioner and as a leader, is crucial to the success of team nursing. The leader needs to be a good role model for junior colleagues, to allocate patients or tasks to appropriate levels of nurse and to recognize when to seek advice from the ward sister or clinical nurse specialist. The team leader liaises with other members of the multidisciplinary team and must communicate effectively with members of the nursing team. As with all nurses in a leadership position, she or he needs to be approachable so that junior nurses, members of other disciplines, patients and relatives will feel able to discuss, make suggestions, admit failures and seek advice. Qualified nurses returning to practice in the hospital setting are likely to be engaged in team nursing and, when confident enough, to function as a team leader.

PRIMARY NURSING

A final system of organizing delivery of care is 'primary nursing'. Although this system has been in use in the USA for about 15 years, it is not yet used widely in the UK but may be gaining ground. It involves giving one nurse complete accountability for the nursing care of a patient from admission to discharge. Each trained nurse on the ward is given responsibility for a number of patients (this can vary from three to six), and the skill and expertise of each nurse is considered when assigning them to patients. Associate nurses and helpers assist in the care and take over when the primary nurse is absent but do not change the care plan. The responsibility for the nursing care provided remains with the primary nurse. This means that a qualified nurse may be primary nurse to four patients, planning their care and

giving it whilst on duty, and may also be associate nurse to other patients whilst their primary nurse is off duty.

This system requires that direct nursing care is given by qualified nurses with students and auxiliaries acting as helpers. In addition, it necessitates each qualified nurse being given professional freedom to design care plans in conjunction with the patients. This means the ward sister acting as a facilitator and consultant rather than keeping direct control over patient care. Many nurses believe that primary nursing is the system which enables nurses to fulfil a professional role. It is not to be confused with the primary health care team or primary care.

The term 'planning care' has cropped up several times during this chapter and an explanation of how this is accomplished now follows. To understand how individualized patient care is planned, it is necessary to gain some knowledge of 'Nursing Models' and 'Nursing Process'.

WHAT IS A NURSING MODEL?

We meet models in everyday life – model cars, model aeroplanes, model buildings. A model is not the real thing but is designed to represent the reality. Nursing Models are sets of inter-relating ideas which nurses have described to represent what they feel nursing is. Models include the particular nurse's beliefs and values about nursing and identifies the aims of nursing.

All nurses have ideas about what nursing is and about the purpose of nursing, and these ideas vary from one nurse to another. A group of nurses, working together on a ward, consider some of the generally accepted Nursing Models and agree to use one model or adapt a model for their nursing practice. Thus all the nursing staff are sharing the same overall aims when planning and giving care.

The Nursing Process is used to carry the ideas, beliefs and aims of the Nursing Model into actual nursing practice. Later in this chapter you may go on to notice that the steps of the Nursing Process do not attempt to explain what nursing is, but provide a systematic way of planning and giving nursing care. Therefore a Nursing Model needs the Nursing Process to translate its ideas into practice and neither Nursing Model nor Process is of any practical use without the other.

Many Nursing Models have been described and there are some very readable books which explain them (see Further reading at end

of the chapter). Two of the most popular Nursing Models in the UK are the Activities of Living Model (Roper, Logan and Tierney, 1980) and the Self-Care Model (Orem, 1985).

Before illustrating the use of these two models of nursing, it must be said that on your return to nursing, you may find that many nurses are still guided by the Medical Model which has dominated nursing for a long time. This model views man as made up of separate parts, each viewed independently. Under the influence of this model, paralleling medical specialisms such as evolved coronary care nurses, orthopaedic nurses and psychiatric nurses. These divisions are still part of the nursing profession. The main aim of this model has traditionally been cure and control of disease. Now, nurses are increasingly emphasizing their role in holistic care and this has led to interest in and the adoption of models designed specifically for nursing.

ACTIVITIES OF LIVING MODEL

As the name suggests, the Activities of Living Model is based upon 12 activities which an individual must engage in throughout their life. It recognizes that there will be times when the individual cannot yet or is no longer able to perform one or more of these activities. In addition, certain circumstances may arise which restrict independent performance of activities of living, e.g. mental or physical illness.

The 12 activities of living are:

1. maintaining a safe environment;
2. breathing;
3. eliminating;
4. controlling body temperature;
5. mobilizing;
6. sleeping;
7. communicating;
8. eating and drinking;
9. personal cleansing and dressing;
10. working and playing;
11. expressing sexuality;
12. dying.

According to this model, the aim of nursing is to assist the individual towards independent performance of the activities of living, or

enabling the individual to cope with dependence where necessary. An example of a plan of care based on this model is given later in the chapter in Figures 4.2 and 4.3.

THE SELF-CARE MODEL

This model was developed in the USA by Dorothea Orem and is based on the belief that all adult individuals have the right and responsibility to care for themselves. Nurses who accept this belief and base their nursing practice on the Self-Care Model, aim to help their patients to meet their self-care needs. There is some similarity between the self-care needs of this model and activities of living. Self-care needs include air, water, food, elimination, activity and rest, balance between solitude and social interaction, prevention of hazards to human life and functioning, desire to be 'normal'.

In addition 'developmental self-care needs' are identified which vary with the age and changes in the life of the individual, e.g. a person who is retiring from work may have different self-care needs from a young student. When illness occurs, an individual may need to change their self-care behaviour, and develop 'health-deviation self-care needs'.

The nurse assesses the patient's usual and present ability to meet self-care needs. The nurse then deducts the present self-care ability from the 'therapeutic self-care demand' (what the patient needs to know or do) and the difference is the patient's problem or self-care deficit. Thus 'what the patient *needs* to know or do' minus 'what the patient *can* do' = Patient Problem. The use of this model in a care plan is shown later in Figures 4.4 and 4.5.

NURSING PROCESS

This is a problem-solving, systematic approach to nursing. Similar approaches are used in many fields including administration, industry and medicine. However the types of problems which are identified in all these areas are very different. The nurse is seeking to identify patient problems, i.e. things which the patient would do for themself if they had the necessary strength, will or knowledge, according to Henderson's (1977) definition of nursing.

Nursing Process consists of four steps:

1. assessment and identification of problems;
2. setting goals and planning nursing action;
3. carrying out the nursing action (implementation);
4. evaluating whether the nursing action was effective. (If not, alternative action may be adopted.)

It must be emphasized that these steps do not necessarily take place in the order suggested here – a nurse is assessing the patient and noting any new problems whilst carrying out nursing care. For this reason, Nursing Process can be described as a dynamic, continuous approach. In order to use this approach properly, patients must be allocated to nurses rather than tasks; it would be difficult to assess a patient on a continuing basis if the nurse is only responsible for part of the patient's care.

Assessment

The aim of assessment is to collect information about a patient/client and then, by examining the information, to identify the patient's problems. The remainder of the nursing process is based upon the assessment and therefore it should be carried out carefully and thoroughly.

Information about a patient/client is collected in several ways:

1. by interviewing the patient and/or relatives and obtaining a 'nursing history';
2. by observation;
3. by other means, e.g. reading the GP's letter, medical case notes, communication with community carers.

Assessment commences as soon as the nurse meets the patient. Although it may not be appropriate to take a nursing history immediately, for instance if the patient is dangerously ill, the nurse will be observing and noting. The assessment includes collecting information about the patient's physical, psychological, social and spiritual needs. Those needs that the patient is unable to meet are identified as the patient's problems. When assessing the patient, the nurse aims to establish previous ability (e.g. what the patient could do before their current illness), present ability (e.g. what they can do for themselves) and potential ability (e.g. what they may be able to manage in the future).

Nursing history

Obtaining a nursing history involves the nurse interviewing the patient and/or family and collecting personal data. The interview should ideally be conducted in as private a place as possible, either a side-room, office or in a curtained bed area. More emphasis is placed on communication skills and psychology in nurse education today and these are important if relevant information is to be produced from the interview. The nurse needs to remember that the patient is also the member of a family or community and should ensure that she or he collects information about the effects of illness on relatives, friends, job, finances, hobbies, etc. as appropriate.

Observation

This method of collecting information will be very familiar to you, as observation skills are fundamental to good nursing care. The nurse makes subjective judgements about the patients based on knowledge and experience, e.g. non-verbal cues from a patient who is in pain. Objective data is collected by measuring temperature, pulse, fluid input and output, weight, etc. The nurse uses all senses to obtain information; most nurses will appreciate the importance of the feel of the skin when assessing degree of shock and remember the distinct smell of pear-drops on the breath of a ketotic patient.

Collecting patient information from other sources

Although a medical assessment has rather different aims and is designed to identify medical problems, the notes and GP's letter may be used to expand the nursing assessment information. In some cases, additional information may be gained from community nurses or carers, or from the staff who have been caring for a patient in another institution prior to hospital admission.

For the returning nurse, it may be reassuring to know that guidelines are used by most wards so that the assessment and planning of care for patients follows a similar format even though the information collected will be individual to the particular patient. These guidelines are agreed following study of one or more Nursing Models.

Identification of patients' problems

After examining the data collected during the initial assessment and later during subsequent assessment, the nurse identifies areas where the patient requires help to meet his or her needs. The nurse does this in consultation with the patient who usually has most knowledge of his or her abilities, the effects of his illness and the areas in which he or she requires help. A simple definition of a patient problem is an unmet need, e.g. every human needs to breathe and if the patient is having difficulty (chest infection, bronchospasm) then he or she has a breathing problem.

Patients' problems can be 'actual problems' as just described, or can be 'potential problems' – for example, a patient who is confined to bed may be at risk of developing pressure sores.

The wording of patients' problems should be clear, concise and correct (as should all documentation of patients' care) and should include the patient problem, the cause of the problem and any behaviour in relation to the problem. Example: Mr Smith has chest pain due to angina, he is sweating and has a tachycardia.

Physical, psychological and social problems are identified and listed in order of priority on the care plan (see Figure 4.5), a life-threatening or safety problem coming before a longer term problem.

Setting goals and planning nursing action

A goal (or desired outcome) is agreed by nurse and patient for each identified problem. The goals should be realistic so that they can be achieved within a reasonable time span. You may find that short-term and long-term goals are set for patients who are receiving nursing care over a prolonged period. It is important that the goals are patient-centred and couched in positive terms whenever possible. Again goals should be clear and concise so that both patient and nursing staff understand the objectives of the nursing actions.

Well-written goals should include a subject (usually the patient), an active verb (e.g. say, walk), conditions necessary to achievement of goal and time span for achievement. By writing goals in this way, they will be measurable or observable. Compare the following two examples and decide which you would be able to evaluate as being achieved/not achieved.

Goal A: Mobility will improve.
Goal B: Mary will be able to walk to the toilet with walking frame and one nurse in seven days time.

The nursing action or intervention should also be planned with the patient. If a problem has been long-standing, the patient may have developed effective ways of coping when it arises, e.g. a particular relaxation technique for coping with anxiety. Nursing practice is likely to be more effective if the patient agrees with the proposed action.

The nurse/patient partnership may be very equal where a patient has clear understanding of his or her illness and treatment. Where a patient lacks knowledge to make an informed choice about the possible ways of resolving a problem(s), then the nurse discusses the options with the patient, giving a professional opinion and advice but the final choice should, where possible, rest with the patient.

The agreed nursing actions should be based upon sound scientific principles (see Chapter 5). They should also be realistic in terms of nursing time, resources and skills available; it is worthless to plan care for a patient which cannot be provided. The prescribed care must be appropriate so that the goal can be achieved, i.e. confining an elderly person to a chair all day is unlikely to achieve a desired outcome of independent mobility. Nursing actions must be specific and clear so that each nurse will interpret instructions in the same way. You may well recall the confusion that can arise over 'up and about' or 'encourage fluids'.

Carrying out the nursing action

This is the practical step of the Nursing Process where the written plan is converted into nursing care for the patient. As stated earlier, assessment continues during the giving of care.

The nurse returning to practice may notice that an increasing amount of time is spent in teaching patients, in providing psychological comfort and that patients are encouraged to retain their independence. Although pockets of resistance may always be in evidence, modern nursing care is geared towards helping patients to regain independence, to care for themselves or to adapt useful coping strategies.

As the number of diagnostic tests and treatments increase, it is important that nursing care is planned and co-ordinated so that important nursing care is not missed, e.g. '100ml fluid to be given

hourly' may not be possible if the patient is spending most of the morning in the X-ray department.

Evaluating nursing care

This step takes place when the time set for achievement of the goal is reached. The nurse and patient must decide if the goal has been achieved. Evaluation cannot easily take place unless the goal is written in observable or measurable terms.

If the goal has not been achieved, then the reason must be ascertained. It may be that more time is needed for the nursing actions to be effective or that the nursing actions need changing. For instance an anxious patient may remain so despite the prescribed nursing actions, in which case the patient is re-assessed in an effort to discover if there are other as yet unknown causes for this anxiety, and further nursing action is planned and implemented.

Progress notes should be written on patient care by the assigned nurse during each shift. This varies from hospital to hospital and there may be a hospital policy relating to documentation of patient care which will clarify this practice.

Student nurses assess and plan care under supervision but it is usual for a fully accountable registered nurse to check and countersign the care plan.

Some wards keep the care plan at the individual patient's bedside and he or she is encouraged to read and use it. It is desirable that the care plan is couched in terms that the patient, or family involved in his care, will understand.

You may find standard or core care plans in use where many patients are admitted with similar problems. Additional information is added and problems identified which pertain to each individual patient and care planned accordingly.

As stated earlier, the guidelines followed when planning care depend on the nursing model which has been chosen as most suitable for the patients in a particular area (community or hospital). Figures 4.2 and 4.3 show an assessment and care plan using an Activities of Living Model. The use of a Self-Care Model is shown in Figures 4.4 and 4.5.

Before leaving the subjects of Nursing Process and Nursing Models, it is important for the reader to be aware of the professional and legal implications. The nursing record is classified as a primary

NAME :- *Miss Mary Evans (wishes to be called Miss Evans)* **AGE** :- *82 yrs*

ADDRESS :- *23, Fern Road, Drayton* **TELEPHONE** :- *123 4567*

NEXT OF KIN :- *Sister, Dora Evans same address* **RELIGION** :- *C of E*

G.P. :- *Dr Brown* **HOSPITAL NUMBER** :- *5237*

HOSPITAL WARD :- *D9* **CONSULTANT** :- *Dr. Black*

DATE OF ADMISSION :- *1-1-90* **TIME** :- *10.00am.*

NURSE :- *Margaret Jones*

NURSING HISTORY AND ASSESSMENT

DATE 1-1-90

Understanding of need for Hospitalization

Patient says she has a bad chest and has been in bed at home for 3 days.

Maintaining a safe environment

Has had two falls in past week. Telephone installed two months ago.
Feels she may need her bed downstairs when she goes home.

Breathing

Chest feels tight and uncomfortable and patient is producing thick green sputum. No medication prior to admission. Respirations: 25 per minute.

Eliminating

Opens bowels every three days. Takes Senokot x2 daily. Is concerned about becoming constipated whilst in hospital. Is continent of urine, wakes during night to pass urine. Has used commode for the past 3 days.
Urinalysis: nil abnormalities.

Controlling body temperature

Temperature on admission 38.5°C. Skin feels very warm.
Home is centrally heated and kept warm.

Mobilising

Usually walks with stick around the house and garden, can manage stairs slowly. Feels weak and needs help to move at present.

Sleeping

Has slept very little since chest became tight but has short naps. Normally retires at 10.00pm, wakes at 2am to use toilet and then sleeps until 7am.
Takes no sedatives.

Communicating

Expresses herself clearly. Wears spectacles. Hears well.

Eating and drinking

Food prepared by her sister. Normally eats 3 small meals per day with cooked lunch. Wears dentures. Does not eat or drink after 6pm. Presently appetite is poor, has had only fluids for the past 2 days. Blood pressure: 140/90 Pulse: 88

Personal cleansing and dressing

Community nursing auxiliary visits weekly to help patient bathe. Can usually manage to wash and dress herself slowly. Sister has washed her hands and face for the past 3 days. Would like to be bathed daily whilst feeling so warm.

Working and playing

Enjoys television, radio. Normally assists with light housework. Has 2 cats.

Expressing sexuality

Has hair set once a fortnight, dislikes make-up, perfume.

Dying

Says she enjoys life but realises pneumonia can be serious at her age.

Figure 4.2 Assessment sheet based on Activities of a Living Model.

DATE	No	PROBLEM	GOAL	NURSING ACTION	REVIEW DATE
1-1-90	*1*	*Patient's chest feels uncomfortable due to a chest infection*	*She will state that her chest feels comfortable (7 days time)*	*1. Nurse patient in upright position* *2. Obtain sputum sample for laboratory testing* *3. Administer medication as precribed* *4. 4 hourly measurement of temp, pulse and respiration rate* *5. Change sputum pot at least daily and note colour and consistency of sputum*	*8-1-90*
1-1-90	*2*	*Patient's skin feels very warm due to pyrexia*	*Temperature will reduce to within normal limits in 3 days*	*1. Dress in light cotton nightgown and cover with 1 cotton sheet* *2. Record temperature 4 hourly Use electric fan to circulate air*	*4-1-90*
1-1-90	*3*	*Miss Evans is at risk of skin breakdown due to reduced mobility*	*Her skin will remain healthy whilst she is confined to bed*	*Assist patient to change position 2 hourly. Place sheepskin rug under patient report each shift*	*4-1-90*
1-1-90	*4*	*She is unable to wash without help due to weakness*	*Miss Evans will be able to wash and dress herself at her own pace (7 days time)*	*Daily bed bath until patient states she feels stronger. Then assist patient into bath using seat and step. Provide chair and give support whilst she dresses herself.*	*8-1-90*

Figure 4.3 Abbreviated care plan based on Activities of a Living Model.

document, that is, a record that will be of importance to a patient's care throughout his or her stay and during subsequent periods of treatment. It will be preserved, along with other notes, charts, documents, etc., for a period recommended by the Department of Health (DHSS Circular HC (80)7).

You will probably be able to obtain guidelines for safe recording practice from your nurse manager. These may include recommendations about care planning and progress notes, documentation of untoward incidents or accidents and responsibility for the content of the record.

ACCOUNTABILITY AND CARE PLANNING

The qualified nurse is required to be accountable for the decisions she or he makes and for the nursing actions she or he plans and implements. The nurse therefore needs to ensure that she or he has the necessary skills, knowledge and attitudes to plan effective nursing care for patients either as the leader of a team of nurses or as a primary nurse. The team leader delegates responsibility by assigning patients to junior colleagues and nurses in training but remains accountable for the care given. In the primary nursing system, each primary nurse is accountable for their patient's care. Accountability is difficult when tasks are allocated because the

NAME :- *Mr George Thomas* AGE :- *64 years* DATE OF ADDMISSION :- *1-1-90* TIME :- *10.00 a.m.*

ADDRESS :- *Birch Cottage, Alton.* NEXT OF KIN :- *Wife - Mary, same address* RELIGION :- *C of E*

G.P. :- *Dr Mills* CONSULTANT :- *Dr Milton* HOSPITAL NUMBER :- *7349*

UNDERSTANDING OF NEED FOR HOSPITALISATION :- *Knows that his blood sugar is high and that he requires insulin injections*

SELF CARE NEEDS	USUAL SELF-CARE ABILITY	PRESENT SELF-CARE ABILITY	THERAPEUTIC SELF-CARE DEMAND (WHAT HE NEEDS TO DO)
AIR	*No respiratory difficulties Has smoked 20 cigarettes per day for all his adult life.*	*Has read that smoking can damage your health, says he ought to 'give up'. Respiration rate: 18*	*Know specific hazards of smoking in diabetes*
FOOD	*Has been on diabetic diet for 10 years. Weight normally 91/2 - 10st Height 5ft 6ins.*	*On 15 line diabetic diet. Has lost weight recently now 9st 3lb wife prepares his food.*	*Take 16 line diabetic diet to restore weight and maintain blood sugar between 4 - 10 mmol.*
WATER	*Well-hydrated Environmental - mains water supply to farm cottage.*	*Increased thirst recently which he compensates taking extra fluids. Remains well-hydrated Blood pressure 140/80*	*Demand met by self-care ability*
ELIMINATION	*Micturation habit - before every meal but not during night. Bowel habit - once per day.*	*No change*	*Demand met by self-care ability*
ACTIVITY AND REST	*Fully active, works on farm and helps with household tasks. Sleeps 8 hours per night without sedation*	*Black, hardened area around right big toe has made walking slightly painful. Has satisfactory manipulative skills. No change in sleep pattern.*	*Know importance of foot care in diabetes. Apply dressing to toe.*
SOLITUDE/ SOCIAL INTERACTION	*Lives in remote cottage, has telephone. Attends village functions*	*No change in social activity at home. Feels worried about 'mixing' on ward.*	*Adjust to ward environment*
PREVENTION OF HAZARDS TO WELL BEING	*Has remained accident-free on farm. Complies with diabetic drug regime but only tests urine when feeling ill.*	*Temperature 37oC Pulse 90 Has associated numbness in feet with cold weather Can see small print with glasses*	*Know hazards of poorly controlled blood sugar levels*
BEING NORMAL	*Puts emphasis on self-sufficiency Reluctant to take medical advice of insulin injection as felt it would disrupt his normal life.*	*Has now become motivated to improve health so that he can continue farm work.*	*Know how to adapt insulin treatment into normal lifestyle*
DEVELOPMENT SELF-CARE NEEDS	*Retired from work as joiner at 60 to help brother on farm*	*No change from usual self-care ability*	*Demand met by self-care ability*
HEALTH DEVIATION SELF-CARE NEEDS	*Diabetic for 10 years controlled on chlorpropamide 200 mg daily and 15 line diet.*	*Feeling generally unwell for several weeks, increased numbness in feet sore area on toe. Knows that he must avoid sugary food. His demonstration of urinalysis had timing error - did not realise significance. States he is willing to learn about insulin injections. Has experienced both hypo- and hyperglycaemia and can describe symptoms. Wife is eager to be involved in care. Blood sugar on admission 22 mmol/litre*	*Know what diabetes is and relation between food, exercise, insulin, stress and blood sugar. Take insulin as prescribed. Perform BM stix test Perform Urinalysis Know what action to take in case of high or low blood sugar levels.*

Figure 4.4 Assessment sheet based on Self-Care Model.

DATE	NO	PROBLEM	GOAL	NURSING ACTION	REVIEW DATE
1-1-90	1	George feels anxious about mixing with other patients	Patient will demonstrate confidence with other patients (3 days)	Introduce staff and immediate neighbours, show around ward. When he feels ready, introduce to other diabetic patients. Allow him to express feeling.	4-1-90
1-1-90	2	Lacks knowledge about diabetes	Patient will correctly complete diabetic questionnaire by planned discharge date (5 days)	1. Assess present knowledge 2. Illustrate diabetes with diagram 3. Explain relationship between hyper and hypoglycaemic factors 4. Ask patient to fill in questionnaire	6-1-90
1-1-90	3	Lacks skill to self-inject insulin	Patient will be able to draw up and administrate correct dose of insulin accurately. Will be able to describe storage of insulin, need for changing sites, car of equipment. (5 days)	Day 1 Inject patient with prescribed dose of dose of insulin. Day 2 Demonstrate injection techniques to patient and leave equipment for him to practise. Day 3 Support and guide patient while he draws up insulin if he feels confident, encourage him to self inject. Day 4 Onwards - patient to give own insulin with advice as necessary.	
1-1-90	4	Patient and wife lack knowledge about diabetic diet	Patient and wife will be able to discuss constituents of well balanced diet, importance of fibre in giving more stable blood sugar level. They will demonstrate ability to "exchange" foods. (5 days)	Day 1 Show patient how to complete menu sheet. Liaise with dietitian so that individual 16 line diabetic diet can be produced. Day 2 Arrange teaching sessions for patient and wife with dietician. Ensure they have dietary exchange sheet before discharge.	
1-1-90	5	George lacks knowledge and skill to perform accurate urinalysis technique	He will demonstrate accurate technique and discuss significance of glucose and ketones in urine. (4.1.90)	Day 1 Perform urinalysis 4 hourly and record on chart. Day 2 Check patient has watch with second hand. Demonstrate procedure to patient, stress importance of following timing instructions. Explain need for fresh samples. Explain significance of glucose and ketones and that ketones present may indicate need for more insulin.	
1-1-90	6	George lacks knowledge and skill to perform blood glucose test	He will demonstrate accurate technique using BM Stix. Will identify importance of controlling his blood glucose level between 4-10 mmols per litre. (5.1.90)	Day 1 Perform 4 hourly BM stix test, explaining reasons for procedure. Day 3 Support and advise patient while he performs test. Arrange for family to see test.	
1-1-90	7	Patient lacks skills to apply sterile dressing to toe	Patient will apply dressing safely and can explain importance of foot care by date of discharge.	Arrange for chiropodist to excise hard skin around sore and explain free service. Using aseptic technique, apply dressing. Support and advise as necessary.	6-1-90
1-1-90	8	Patient & family lack knowledge about long term complications and about action necessary if blood glucose level is outside normal limits.	Patient & family will identify action to correct hypoglycaemia and hyperglycaemia	Discuss long term complications, explain controlled blood glucose, explain controlled blood glucose level will minimise these. Explain hazards of smoking. Discuss action to take in event of hypoglycemic attack and causes. Discuss symptoms of hyperglycaemia and how this may be prevented. Emphasise importance of balance between diet, exercise and insulin.	

Figure 4.5 Care plan based on Self-Care Model.

ward sister is in overall control and yet may have least contact with the patients.

To summarize, the qualified nurse carries out nursing assessment, identifies patients' problems, predicts desired outcomes of care, prescribes nursing actions and evaluates the results using a nurse model as a framework. The nurse produces recorded evidence of the care she or he has planned, the nursing actions that have been carried out and the results that have been achieved. In this way, the nurse is accountable to the employer and as a professional nurse is held accountable for her or his practice by the UKCC.

This chapter has given you an outline of how patient care may be organized when you return to nursing. You may now feel more confident about your ability to plan a patient's care or, at the least, should be aware of the concepts that underpin Nursing Models and Nursing Processes.

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5

What Will I Be Doing? Developments in Clinical Practice

Probably your biggest fears as a returning nurse relate to changes in practice in the clinical areas. Questions like, 'Will I still be able to nurse?' and 'Will all the equipment be different?' are most likely uppermost in your thoughts when the decision to venture back into nursing is finally reached.

Such concerns are perfectly normal and hopefully can soon be allayed. This chapter aims to help reduce these anxieties by outlining why changes have occurred and then giving specific examples of developments in practice. Most importantly it aims to reassure you that much will still be familiar and your nursing skills will soon return.

Obviously it would be impossible to describe every new practice or piece of equipment which you will encounter in your clinical area. Neither would it be possible for you to update your actual skills by reading. Therefore this chapter does not attempt to cover specific skills such as lifting and handling patients or cardio-pulmonary resuscitation. These are best revised in your own particular workplace with practical teaching and supervision.

However, this chapter can offer a guide to the type of developments which you may see in the clinical area. The examples chosen are relevant to various fields of nursing. They reflect different influences on nursing practice and will help you to understand the reasons behind new developments. In this way, the chapter aims to guide you through updating your own clinical experience.

WHY HAVE CHANGES IN CLINICAL PRACTICE OCCURRED?

Imagine that you have been asleep for the past ten to 15 years. If you now entered a modern kitchen just as a family were about to eat breakfast, what changes do you think you might notice?

Firstly, look at the kitchen equipment. There is a microwave oven, a convection oven, and the 'cooker' looks nothing like your old gas cooker – it appears to be a ceramic worktop. Even the kettle has changed to look like a plastic jug. Digital displays are everywhere and much of the equipment is programmable.

Now try and consider why these changes have occurred. Improved technology is one answer. 'High-tech' equipment is now commonplace as technology improves and can be produced more cheaply. Time-saving devices such as these have become increasingly popular in our fast-moving society. Some equipment such as the kettle/jug has been developed to be more fuel efficient and thus cost effective, while also being easier to use. Fuel efficiency and consumer satisfaction have been strong motivators for technological development. The microchip revolution has also enhanced the performance of equipment such as washing machines.

What about changes in the breakfast itself? Gone are the bacon and eggs with white bread. In its place are muesli, brown bread, decaffeinated coffee, low fat milk and sweeteners. Medical and nutritional research has shown that eating less fat and sugar and more fibre in the diet can reduce the risks of developing various diseases. Many families have now altered their diets quite considerably over the past few years in response to health education. The food industry has responded by developing new products such as decaffeinated coffee and sugar substitutes. They also give details on labels as to the exact ingredients in the product. These changes are therefore a response to medical research coupled with improved food technology.

The point of focussing on the kitchen is to highlight that changes in what we do and what we use are part of everyday life. The same is also true of nursing.

Nursing practice has changed and continues to change in response to developments in various fields. Figure 5.1 shows some of the factors influencing change in nursing practice.

Nursing practice will have changed from when you were previously working and you would be naïve to assume that all will be the same when you return. However, by examining why these changes have

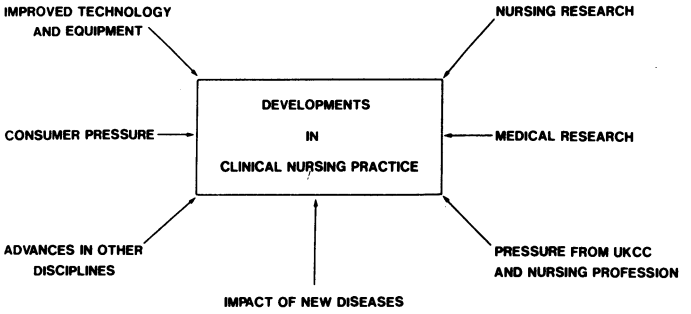


Figure 5.1 Factors influencing changes in clinical nursing practice.

occurred you will soon realize that in many ways nursing is just keeping up with advances in everyday life. As Figure 5.1 shows, nursing is also responding to improved technology and medical research. More importantly, nurses are examining their own practice and looking for ways of improving patient care, by research into nursing.

An example of each of these various types of change will be explored in more detail. This will help you to understand similar changes and the impetus for change in your own areas.

WILL I COPE WITH THESE CHANGES?

Think back to being in that modern kitchen. If you were asked to boil some water, you would know to use the kettle, but would need to find out how to switch it on. So the principle remains the same, but the equipment has changed. This may be true for many of the changes in nursing where new technology has been introduced. You will just need to familiarize yourself with the new equipment, such as electronic thermometers and infusion pumps. Just as in the kitchen, many of the new pieces of equipment are labour-saving devices and you may soon wonder how you managed without them.

Likewise, you would soon have picked up the principles behind the new diet at breakfast. However, the skills you would have needed to make breakfast have not changed. Making toast is the same, regardless of the type of bread!

Think of this example when you return to practise as a nurse. You will soon realize that the basic skills of nursing have altered little.

You will find that your skills will soon return, even though you may feel clumsy or slow at first.

Very quickly you will realize that you have not lost the art of comforting a distressed patient or relative, or of meeting a patient's hygiene needs. These and many other aspects of nursing are unchanged, so you need not fear that you can no longer nurse.

Remember that you are not starting from scratch as a nurse when you return to practice. You have a wealth of skill and knowledge at your fingertips which is waiting to be revitalized and put to use. In addition to this you have an advantage over other nurses – an immense amount of life experience. Whatever you have been doing since leaving nursing – an alternative job, having a family, travelling – each of these experiences will have given you important lifeskills which you should not undervalue. These may include self-confidence, the ability to communicate, a deeper understanding of life's problems, self reliance or maturity. On a practical note you may have acquired skills in areas such as childcare, languages, housework, or office skills. These will all assist you in coping with new experiences on your return to work.

Be reassured then, that given the chance to practise and revise your nursing skills, you will soon feel competent in the clinical area.

PRINCIPLES VERSUS PROCEDURES

One change that you will find useful is that nurses are moving away from following rigid procedures and towards applying principles of care instead. You may remember the 'Procedure Book', where set procedures were written out step by step. In many hospitals this remains a useful guide to practice, but you may find the rigidity of this approach constricting. Increasingly, health authorities are changing these 'bibles' of nursing practice to 'Principles of Care' manuals.

In these manuals, the procedure is still outlined, but usually less rigidly and accompanied by the rationale for each step with any relevant underlying research findings. Where hospitals have yet to update their own procedure manuals, you may find it useful to consult the Royal Marsden Hospital *Manual of Clinical Nursing Procedures* edited by Pritchard and David (1988). This hospital, a centre of excellence in the treatment of cancer patients, has published its procedure manual as a book. In fact some hospitals have bought one copy for each ward and adopted its procedures, rather than revise their own.

The effect of this move from procedures to principles of care for you, is that staff should be more tolerant of variations in the minutiae of techniques, as long as you do not contravene the principles involved. This has often been a problem in the past for nurses moving to work in a different hospital. For example, the 'dressing technique' learnt in one hospital was often very different from that in another and you felt you were doing it wrongly if you did not follow the technique of the hospital you were working in. Nowadays, as long as the principles of asepsis are not broken, it should not matter about the specifics of the technique. So if you are returning to a different clinical area you need not worry that you do not know their techniques.

It is now worth considering some developments which have occurred and the reasons for these. Once again, however, it should be stressed that it is not possible to explain all changes, and you should identify those relevant to your own area when you return to practice.

Advice on how to find out about such changes is given at the end of the chapter.

CHANGES DUE TO THE INFLUENCE OF THE UKCC AND THE NURSING PROFESSION

Drug administration is given as the first example of a change in nursing practice as it is usually one of the main causes of concern for the returning nurse.

You are probably concerned that there will be a great many new drugs in use and that you may not feel competent to administer them. These fears are understandable, since medicine and pharmacology are improving and new drugs are constantly appearing. Administering drugs carries a great deal of responsibility and so you may wish to have the chance to revise the relevant policies and procedures.

However, both these fears can be best allayed during your induction programme and on your return to work. You should ask for practise and supervision in administering drugs until you feel competent to undertake this yourself.

In order to update yourself on the drugs found in your clinical area, start with those most commonly in use. You would not be expected to know about all drugs on the market. Qualified staff are often very familiar with the drugs in use in their clinical area, but would be as unfamiliar as you with those used in a different unit. Therefore you should concentrate on learning about drugs as you come across them in your practice.

Find out about their mode of administration, side effects, storage and any precautions necessary. This information can be found in the BNF (British National Formulary), a book published annually and which is often available in clinical areas or from hospital pharmacies. The MIMS (Monthly Index of Medical Specialities) is a useful guide to drugs currently available, particularly the trade names. However, doctors are increasingly being encouraged to use the generic or approved names of drugs rather than trade names, in order to avoid confusion and to cut costs. Many doctors still carry a copy of MIMS in their pocket which suggest even they cannot retain the information on the thousands of drugs available to them.

Although these may be your main concerns, there are one or two changes which have occurred in drug administration which you may not have heard about. The changes have come about because of

pressure from the nursing profession itself, either to clarify rules regarding drug administration or because of other clinical developments.

Drug administration and the UKCC

When 'doing the drug round' in most hospitals in the past, two nurses were usually involved. As you may remember, one had to be either a qualified nurse or in some cases a student nurse who had passed a drug assessment. The other person could be a qualified or learner nurse, though occasionally auxiliary nurses were involved. Enrolled nurses were also allowed to administer drugs in many health authorities.

Drug administration errors were quite frequently a cause of nurses being brought before the UKCC professional conduct committee, even when two nurses had been involved in checking the drug. The UKCC therefore issued an *Advisory Paper on the Administration of Medicines* in 1986. It outlines the responsibilities of the qualified nurse in the administration of drugs. In doing so, the UKCC has clarified its

position in the event of a nurse being involved in a drug administration error. It is therefore important that you familiarize yourself with this document, which is available free from the UKCC.

Many important points are made, but two in particular have caused the biggest changes in practice. Firstly, the document states that:

> 'The UKCC is of the view that practitioners whose names are on the first level parts of the register, and midwives, should be seen as competent to administer medicines on their own and responsible for their actions in so doing . . .' (UKCC 1986)

It continues by suggesting that involving a second person in checking drugs is only necessary when teaching a learner, or if the local policy requires it. Under no circumstances are nursing auxiliaries or assistants to be involved in drug administration.

This has resulted in many health authorities revising their drug administration policies and allowing first level nurses to conduct 'drug rounds' on their own. It is most important, if this is the case in your area of work, that you feel totally competent in drug administration before taking it on. You should continue to ask for supervised practice until such a time.

The other important issue addressed in this document is the role of second-level (enrolled) nurses. The UKCC has stated that in line with the competencies of the second level nurse, she may only administer medicines under the direction of a first level nurse. This applies unless the second level nurse has had additional training on drug administration and been deemed competent to do so, by completing an assessment.

If you are a second level nurse returning to practice, you may find that you are given the opportunity to undertake such additional training. If not, you should check your health authority's policy on drug administration and be wary of taking responsibility for this task without fully understanding the implications, since the UKCC would not consider you competent to do so.

Other issues are clarified in this document, including the doctor's and pharmacist's roles in drug administration. Once again, you are strongly recommended to obtain and read a copy in order to understand the issues for yourself.

Self administration of drugs

This change in nursing practice has stemmed from nurses themselves, who have questioned their usual practice.

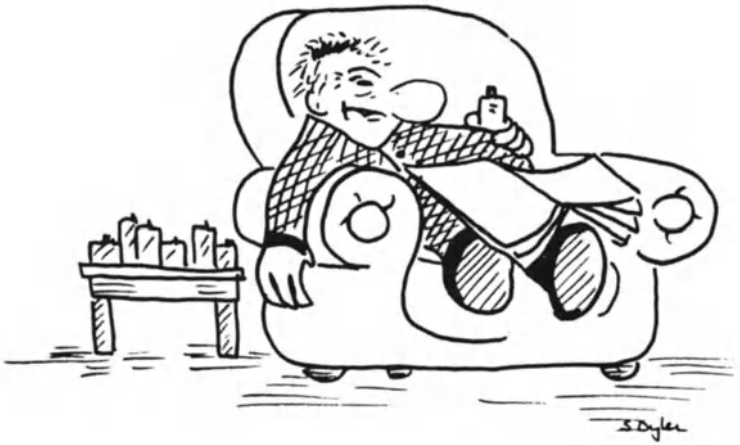
You are probably familiar with the scenario of an elderly lady being given six or seven different tablets, three times a day, from the drug trolley. The same patient would be discharged home on similar medication but often without any idea as to what the drugs were for, when to take them or what the side effects were. Such a lack of knowledge may well have resulted in the lady being readmitted with a drug-related problem.

Alternatively, you may have seen patients who are used to taking their own medication regularly at home having their drugs confiscated on admission to hospital. The patient is then dependent on the nurse to administer their drugs. Yet on discharge home the patient is suddenly seen as capable of managing their own medication again.

In both these situations, nurses have begun to question whether or not they are acting in the patient's best interests by denying them responsibility for drug administration.

You may therefore see on some care of elderly units and even on some general wards, patients being allowed to administer their own medication. It should be pointed out that this is done only after prior assessment of the patient's abilities, a teaching programme for the patient about their drugs, and adequate supervision.

In this way, elderly patients become familiar with their drugs in hospital and are less likely to have drug-related problems on discharge



home. It may allow the fitter, more able patient some control over their treatment and also saves nursing time. Nurses are then freed to spend time educating the patient rather than administering drugs.

Should you wish to know more about this innovation in practice, MacGuire *et al.* (1987) describe how it was set up on a care of the elderly unit.

Cytotoxic drugs

The use of cytotoxic drugs for the treatment of cancer, both in hospital and in the community, has increased drastically in the past ten years. Concern has therefore arisen about the effects on nurses of frequent exposure to these products since cytotoxic drugs can themselves be carcinogenic. Nurses may have contact with the drugs as they administer them to patients, particularly when mixing drugs for injection or infusion. Consequently, most health authorities have now drawn up policies which outline the precautions which nurses should take when dealing with cytotoxic drugs. It is important that as part of your orientation you find out what the procedures are for your area. Usually they involve the wearing of gloves, plastic aprons and possibly plastic goggles (to protect the eyes from splashes). If there are not specific guidelines in your area, then the Royal Marsden Hospital *Manual of Clinical Nursing Procedures* gives a good description of a procedure to follow.

CHANGES DUE TO THE IMPACT OF NEW DISEASES AND CONSUMER PRESSURE

You will doubtless have heard a great deal about HIV infection and AIDS over the last five years. This is a disease which has affected all our lives and which has had an impact on clinical practice. However, as a returning nurse, you can be confidently assured that you cannot contract this virus from normal nursing practice. No one world-wide with lots of day-to-day exposure through nursing care has managed to become infected. You would have to receive direct blood-to-blood contamination involving a substantial volume of blood, or have penetrative, unprotected sex with your patients in order to contract the virus! It is an extremely delicate and vulnerable virus which is destroyed by hot soapy water and all normal bleaches and detergents used in a 1:10 concentration.

You need not therefore have any great fears about nursing patients who are HIV positive or who have AIDS when you return to work. Each health authority will have guidelines for dealing with care in a variety of clinical settings.

However, the impact of AIDS has made all health professional, including nurses, reconsider some of their practices.

Resheathing needles

Many of the policies issued in relation to AIDS are proving to be more useful when dealing with patients with a far more infectious virus, namely Hepatitis B.

This virus has been around longer than HIV and constitutes a far greater risk to the practising nurse. It is transmitted via blood-to-blood contact and used needles causing needlestick injuries are one of the main ways in which nurses (and other staff) contract the disease.

One policy which has changed following concern about the transmission of AIDS and Hepatitis B is the resheathing of used needles.

Since syringes and needles are now disposable in almost all cases they are discarded after a single use. In the past, in order to prevent re-use by drug addicts, you may remember putting the plastic sheath back over the needle and then bending or breaking the needle before disposal.

There was obviously a risk of stabbing yourself with the needle as you attempted to replace the plastic sheath. The DHSS have now

Figure 5.2 A typical 'sharps' container.

issued guidelines stating that used needles should *not* be resheathed, but disposed of intact and uncovered into a sharps container. All clinical areas should have properly labelled, sturdy sharps containers, into which all sharp disposable waste can be placed (Figure 5.2). These bins can then be incinerated when full.

You should first find out what type of sharps container is used in your area and also familiarize yourself with policies regarding needlestick injuries should they occur.

Hepatitis B vaccination

There is now a vaccine available which protects against the virus causing Hepatitis B. Some health authorities are offering this vaccination free of charge to all nursing staff. Others are targeting those most at risk of contracting the disease. This includes those who come into contact with large quantities of blood in their work, such as those working in casualty, in renal units, or those who work with areas of the population where there are large numbers of carriers of the virus, for example mentally handicapped people.

If you are not offered the vaccination in your place of work, you can obtain it on prescription from your GP and most occupational health departments would then arrange to administer it. This involves three doses, one initially and then one month and six months later. A blood test is then needed within a year to check antibody levels and a fourth booster injection is provided if necessary. Another booster is always required five years later.

For more information you are advised to contact your occupational health department.

Confidentiality

The impact of AIDS on the general public has meant that consumer pressure has influenced nursing care. Total confidentiality and anonymity is now promised in respect of anyone requiring an AIDS test. The importance of confidentiality cannot be stressed enough in relation to all patients. However, the sensitive nature of the circumstances surrounding patients infected with the AIDS virus has encouraged nurses to become even more aware of this issue. It is important that you find out about the measures to be taken when dealing with patients in relation to AIDS in order to preserve their anonymity and confidentiality.

CHANGES DUE TO NEW EQUIPMENT AND TECHNOLOGY

Just as in the 'new' kitchen where there was a great deal of new equipment, so when you walk onto a ward you will find many new items to use. Even simple tasks like giving out the drinks may have altered as vending machines have replaced drinks trolleys in some areas. The following are a few examples of developments in commonly-used pieces of equipment. The list is by no means exhaustive. It could not be as equipment is updated all the time. However, you should remember that the best way to learn how to use a piece of equipment is in the clinical area, under supervision. So when you return to practice, do not be afraid to ask someone to show you how something works.

Beds

Many hospital beds are now of a design which allows them to be raised and lowered by use of a foot pedal. This makes lifting and handling patients much easier for the nurses as well as being more accessible for the patient. Such beds can also tilt at either end, thus removing the need for those old 'bed blocks' to raise the foot of the bed. Variable backrests are an integral part of beds and the heads of beds are usually removable, which is useful in the case of a cardiac arrest. Also helpful in that situation is that the beds nearly all now have hard bases, so there is no need to position boards under a patient who has arrested.

You will find the new beds lighter and easier to move. In fact in many areas patients are taken to and from theatre and X-ray in their beds, rather than on trolleys.

There are many developments in specialized beds for turning and positioning patients and for the relief of pressure. It is impossible to describe them all here. You could enquire in your clinical area whether any of these are available and if so, how they work.

Thermometers and sphygmomanometers

The mercury thermometer is still a standard piece of equipment in many clinical areas. However, some areas have now moved away from each patient having their own thermometer by the bed. As patients have become more ambulant, there is a risk of cross infection since it is more difficult to ensure that the patient gets the right thermometer. Furthermore, this system requires that the ward stocks many thermometers. Many nurses now use individual sheaths of disposable plastic over the thermometer which are discarded after each use. In this way one thermometer can be used for several patients.

Several nursing research studies have also shown that nurses were not recording temperatures for a long enough time, or in the correct position in the mouth (Gooch 1986). A minimum time of three minutes in the right or left sublingual pocket of the mouth is required. Using a mercury thermometer was found to give the most accurate reading. To leave a thermometer for that length of time is time consuming for nurse and patient. In order to achieve quicker, more accurate temperature recordings, electronic thermometers are being used in many clinical areas. Figure 5.3 shows an example of an electronic thermometer. Such thermometers may have an electronic probe, which is inserted into a disposable plastic sheath before use. The probe is inserted into the patient's mouth (the sublingual pocket) and is held in position by the nurse. A digital display shows the patient's temperature in a matter of seconds. The plastic sheath is then discarded and the thermometer can be used on another patient. The machine may also incorporate a timer, enabling the nurse to record a patient's pulse rate at the same time as taking the temperature.

Some thermometers have rechargeable batteries and so are quite portable. Most clinical areas using these would only have one or two per ward as it is possible to record several patients' temperatures in the time it takes to record one or two with conventional methods.

Figure 5.3 An electronic thermometer.

Other electronic equipment which would previously only have been found in Intensive Care Units (ICUs) is now finding its way into general areas. You may, for example, see electronic sphygmomanometers. These may inflate and deflate the cuff as well as record the patient's blood pressure which is displayed digitally. The nurse therefore only needs to position the cuff correctly and the use of stethoscopes is eliminated.

Whilst possibly appearing daunting to use at first, you will probably soon wonder how you managed without this equipment in the past.

Insulin therapy

There have been several changes in insulin therapy in the past decade. These have been due to improvements in equipment, standardization of strengths of insulin, technological advances in the types of insulin produced and consumer pressure. The developments will be explained here briefly in order to forewarn you of some of the changes you may encounter on your return to work. However you should contact the

diabetic nurse specialist in your area or the relevant clinical staff in order to get more information when you return to work.

The introduction of disposable syringes and needles has had a great impact on insulin therapy. It has negated the need for cleaning, oiling and sterilizing syringes and needles and provides sharper needles for the patients.

In hospital all insulin syringes are disposable and increasingly at home patients are also using these. The disposable syringes and needles are now available on prescription to patients at home. Although intended for single use, research has shown that it is safe for individual patients to reuse disposable syringes at home for four to six injections. This is only if the needle is resheathed and the syringe and needle stored in a clean container in a cool place. It is not necessary to sterilize the plastic syringes between use. Obviously patients using disposable syringes and needles have to have 'sharps' containers at home, for the disposal of same. Whether you work in the hospital or community you will come across this change.

Technology has also improved the administration of insulin. There are now various special types of 'injector' which make it easier for patients to administer their own insulin. Companies have responded to consumer pressure in producing products such as the 'Acupen' (made by Owen Mumford Ltd.). This appears from the outside like a fountain pen and can clip into a coat pocket just like a pen. However it is actually a syringe containing several doses of insulin. The patient on unscrewing the 'pen' can adjust the dose required by turning a dial. The other end of the 'pen' is the needle and so the patients can easily administer their insulin. This gadget helps diabetics to adapt the dose to their diet, administering the insulin close to mealtimes. Diabetics using this new pen type syringe can inject themselves in any convenient location needing only the minimum of privacy. It therefore allows a far more 'normal' and flexible lifestyle.

Another product is an automatic injector, which removes the need for a patient to push the needle into their flesh. The syringe and needle is placed into a container, the 'Injectomatic', and then a plunger is pressed and the dose administered. The patient cannot see the needle entering the flesh.

Other developments, such as an infusion pump planted into the abdomen which delivers a continuous amount of insulin, are constantly improving and will no doubt become more common in the future.

In relation to insulin and syringes, one of the biggest changes to

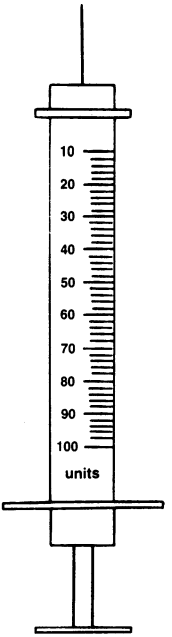


Figure 5.4 A 'U100' insulin syringe.

insulin therapy in the past ten years has been the standardization of strengths of insulin. In line with an international policy, the old strengths of 20 u/ml, 40 u/ml and 80 u/ml have all gone. Insulin is now produced in only one strength; 100 u/ml. This has required the production of new size syringes which are graded 100 u/ml (see Figure 5.4)

This development has made insulin administration far simpler for the nurse and the patient. Gone are the days of calculating how many marks on the syringe equals 60 units of insulin. Now you would just draw up to the 60 mark on the syringe. The whole process should now be much easier as patients will only ever receive one strength of insulin.

Finally, there has been a development in the type of insulin being produced. Previously, diabetic patients relied on insulin derived from pigs (porcine) or cows (bovine). Occasionally patients reacted to one or both of these insulins which are obviously 'foreign' to the human body. Technology has now enabled scientists to produce human insulin in sufficient quantities for it to be available to patients as an

alternative to porcine or bovine insulin. 'Humilin', as one brand of human insulin is known, is produced by the process of genetic engineering. This involves incorporating the genes which code for the production of human insulin into the genetic material of the bacteria Escherichia Coli. The bacteria then produces human insulin as if it were part of itself.

Human insulin is purer than the other insulins and less likely to cause allergic reactions. Increasingly therefore you will see patients prescribed this new type of insulin.

CHANGES AS A RESULT OF NURSING RESEARCH

In the past, if you asked a colleague the question, 'Why do we do it this way?' about an aspect of nursing care, the reply would often have been, 'Because we always do it this way,' or 'Because Sister says so'.

Increasingly, nurses have become dissatisfied with such answers and have begun to question their traditional practices. In doing so, nurses have undertaken research into many aspects of care, education and management. Consequently nursing is now building a body of research-based knowledge on which to base practice.

On your return to nursing you may therefore find that some traditional practices have changed due to the influence of nursing research studies. In order to be able to use this knowledge, nurses are being taught to read and understand research reports. In this way nurses should be able to answer the question, 'Why do we do it this way?', with 'Because research studies have shown that this is the most effective way'.

If you want to understand more about research and how to use research studies, some useful references are given at the end of the chapter.

One area in which nursing research has influenced care is in the prevention of pressure sores. The following is a brief outline of aspects which you may find have changed.

Assessment of risk of pressure sore formation

One major innovation has been the introduction of methods of assessing the risk of a patient developing pressure sores. Research by Norton

et al. in 1975 involved the testing of a risk calculator, now known as the Norton Score (Figure 5.5).

Physical Condition	Score	Mental Condition	Score	Activity	Score	Mobility	Score	Incontinent	Score
Good	4	Alert	4	Ambulant	4	Full	4	Not	4
Fair	3	Apathetic	3	Walk/help	3	Slightly limited	3	Occasionally	3
Poor	2	Confused	2	Chairbound	2	Very limited	2	Usually/urine	2
Very bad	1	Stuporous	1	Bedfast	1	Immobile	1	Doubly	1

Figure 5.5 The Norton Score (Norton *et al.*, 1975).

The use of the Norton Score involves the nurse assessing the patient in relation to five specific areas which were considered to be contributory factors in pressure sore development. Figure 5.5 shows the areas for assessment. For each factor a score is given and the total score is then calculated. This score represents the risk for the patient of developing pressure sores. A total score of 14 or below indicates that the patient is 'at risk' of pressure sore development. For patients found to be 'at risk' of developing pressure sores, preventative measures should be introduced.

In many clinical areas the Norton Score is used to assess all patients on admission and regularly thereafter, depending on the patient's condition. The Norton Score is often recorded in the nursing Kardex system.

Since the introduction of the Norton Score in the 1970s, several other nurse researchers have tried to refine the risk calculator by including other factors which may predispose to pressure sores. The Waterlow Risk Assessment Card is one such development. This tool considers more factors than the Norton Score, but still involves a numerical assessment of the risk of developing pressure sores. The factors include medication, tissue malnutrition and neurological deficit as well as age, sex, mobility, continence and appetite (Waterlow, 1985).

You may well come across either of these risk calculators, or one of the others in use, in your clinical area. They have been found to be very useful in predicting the risk of pressure sore development, thus allowing preventative measures to be directed to those patients most needing them.

If you want to know more about the use of such assessment tools, there are references to further reading given at the end of the chapter.

Methods used to prevent pressure sore formation

In many clinical areas until fairly recently the 'back trolley' was an essential part of the ward equipment. 'Doing the backs' was the synonym for pressure area care. You may remember massaging patients' pressure areas with soap and water.

This practice and several others designed to prevent pressure sores have been discredited by nursing research and are now out of date. It has been shown that massage may disrupt the microcirculation of the skin and tissues, thus encouraging tissue damage. Soap deposits left on the skin can alter pH, and so affect the bacterial flora of the skin. Rubbing spirit on to the skin to harden it has also been shown to do more harm than good. Treatments such as egg white and oxygen serve no purpose other than relief of pressure whilst oxygen is administered.

In fact, relief of pressure by regular repositioning of the patient has been found to be the most effective way of preventing (and treating) pressure sores. Patients should be 'turned' or their position altered at least every two hours. In some areas this is recorded on a special 'turn chart' so that everyone knows when the patient was last moved.

Pressure relieving devices may also be used, including special beds such as water beds, net beds and fluidized bead beds and cushions. You may see these devices in use in your area, if not you could enquire whether they are available from other units or on hire from manufacturers.

Pressure sores currently cost each health authority approximately a quarter of a million pounds per annum due to patients' extended stay, nursing time and treatments. In most cases they are preventable, so you can see why this area of nursing practice has received so much research attention. Indeed, it is now recommended that each health authority have its own policy on pressure sore prevention. You should find out what your authority is doing about this and try to ensure that your practice is research based.

CHANGES DUE TO MEDICAL RESEARCH

It is not just nursing research which has influenced practice. Obviously advances in medicine will affect nursing too, causing nurses to question their practice. In some cases nurses and doctors have collaborated on research projects, for example studies on catheter care.

The management of wounds is an area of nursing care which has changed drastically in the past ten to 15 years due to the influence of medical and pharmacological research. You will undoubtedly see these changes in your practice, so the major issues are outlined here.

Wound management – cleansing the wound

Traditionally the theory behind healing a wound was to keep it clean and dry, applying a dry dressing such as gauze, gamgee or a non-adherent dressing and letting nature take its course. Antiseptics were usually used to clean wounds daily as the dressing was changed. Large wounds were packed using gauze strips often soaked in Eusol (a hypochlorite solution) and liquid paraffin.

All this has changed as a result of research into tissue repair and factors affecting healing. Doctors and pharmacologists have also investigated the optimum environment for wounds to heal. They found that common methods of caring for wounds could well have a harmful effect on the rate of healing or on the appearance of the eventual scar.

The research showed that cleaning wounds with antiseptics was unnecessary in most cases. Antiseptics were found to have a harmful effect on healing tissue. In particular Eusol and other hypochlorites have been shown to damage granulating tissue and so should not be used for cleaning or packing wounds.

Normal, isotonic saline has been found to be best for cleaning wounds either by flushing or profuse swabbing. However, the need to change dressings and clean wounds daily has also been questioned. Clean, closed surgical wounds are generally left untouched until sutures are removed, unless there are signs of infection.

Dressing the wound

As the ideal environment for wound healing has been investigated, so recommendations for the type of dressing which would produce this environment have emerged. Table 5.1 shows the performance criteria for the ideal dressing (Turner, 1987).

Table 5.1 Performance criteria for dressings (Turner, 1987)

- Remove excess exudate and toxic components.
- Maintain high humidity at wound/dressing interface.
- Allow gaseous exchange.
- Provide thermal insulation.
- Protect against secondary infection.
- Be free from particulate or toxic contaminants.
- Allow removal without trauma at dressing change.

The biggest change has been the discovery that open wounds heal fastest in a warm, moist environment. So the principle of applying a dry dressing and allowing the wound to dry and form a scab may actually slow healing and create a larger scar.

The traditional dry dressings such as gauze and gamgee do not keep the wound moist and perform poorly on several of the other criteria too. They shed fibres in the wound, do not prevent the wound from cooling and tend to stick to it, causing trauma when removed.

Consequently pharmaceutical companies have developed a range of new dressing products which are designed to meet the criteria given in Table 5.1 and to provide the optimum healing environment. However, latest thinking on the need to allow gaseous exchange is that the wound gets its oxygen from the blood supply and not from diffusion through the dressing. Totally occlusive dressings which do not allow gaseous exchange have, in fact, proved very effective in promoting healing. New dressings are made from such a diversity of substances, including foams, gels, films and fibres, that you may not recognize them as dressings. Table 5.2 shows the main types of newer dressings.

Table 5.2 Examples of types of new dressings

Films e.g. Opsite, Tegaderm, Bioclusive.
Foams e.g. Silastic foam, synthaderm, coraderm, lyofoam.
Beads e.g. Debrisan.
Fibrous e.g. Kaltostat, Sorbsan
Hydrogels e.g. Geliperm, Vigilon, Scherisorb.
Hydrocolloid e.g. Granuflex, Comfeel Ulcus, Dermiflex.

Most of the new dressings are designed to be left in contact with the wound. Some will deslough wounds as well as promote healing, and can be used where Eusol would have been used in the past. Other

dressings incorporate charcoal for use on foul smelling wounds since it absorbs odours. Most new dressings are intended to be left in place for several days and some may even be worn in the bath, thus making it easier for the patient and saving nursing time.

Not all the dressings are yet available on prescription and so community staff may not have access to them all. Hospitals are tending to rationalize the use of new dressings to one or two brands per category. You can find out which are available to you by asking the pharmacy or stores.

Drug companies are constantly improving these products and producing new dressings. As this is such a radical change in practice it is important that you familiarize yourself with the theory behind it. Each dressing is different and requires different handling, so you need to understand how to use them.

Some authorities employ specialist nurses in wound care or tissue viability. In other authorities the infection control nurse may advise on wound care. You may find them useful in providing information on the new dressings, or there is plenty of literature available on the subject. Otherwise you could contact the drug companies directly and ask for samples and information.

CHANGES DUE TO ADVANCES IN BEHAVIOUR THERAPY AND PSYCHOTHERAPY

Just as advances in medicine have influenced nursing care, so the work of other professionals have affected our practice.

The discipline of clinical psychology has stimulated nurses in the mental health and mental handicap fields to develop a range of therapeutic skills. These include the facilitation of support groups, group and individual psychotherapy, and behaviour therapy techniques. Since 1982 the basic training of nurses in these fields has developed to focus much more upon communication skills and the nursing process. For a small but increasing number of nurses, advanced training in specialist techniques has become available.

Behaviour therapy is a term used to cover a range of treatments aimed at helping people to change inappropriate ways that they may have developed to cope with life's stresses, and to reduce the impact of unpleasant emotions. The assumption is made that much of the way we behave and feel is learned, which means that new and more helpful ways of coping can also be learned, if the right motivation is

there. An example of an area where such therapy has been successfully applied by nursing staff is the quite common problem of phobias. Generally the therapist aims to replace unpleasant feelings with more comfortable emotions. This can be done by patiently training the client to associate the feared object with a relaxed state of mind.

Whilst behaviour therapy has proved valuable for some problems, others are better helped by approaches which aim to change the way people think and feel rather than just their behaviour. Nurses are becoming more skilled in the various techniques of psychotherapy which aim to explore the origins of people's thoughts and feelings and to provide a forum for the safe venting of fears and emotions. Clients needing this kind of help are particularly vulnerable, so it is imperative that the nurse undergoes specialized training. Unfortunately this level of training is less widely available than is necessary, but new courses are continually being developed and some National Board courses such as that for community psychiatric nurses will include basic principles.

Some writers have suggested that these measures are the proper province of the doctor or the trained clinical psychologist, and that nurses taking on these skills is an unnecessary extension of the nurses' role. Certainly there is the possibility of overlap between the roles of the various professionals involved. However few of the nurses with experience in this field would doubt the major strides which have been made in moving from a custodial model of care to one where the nurse employs special human skills in managing a truly therapeutic relationship with his or her client.

References are given in the further reading list at the end of the chapter to books which will tell you more about these changes.

SUMMARY

This chapter has given you a taste of some of the changes you may see in clinical practice. Hopefully you will be able to understand the reasons behind the changes and to recognize other developments in your clinical area.

You may still feel a little daunted by the amount that has changed in practice. But remember what was said at the beginning of this chapter, that your skills will still be there. What you may need to do now is to spend some time reading around and asking questions about the new developments, in order to feel secure in your knowledge.

Keeping up-to-date by reading nursing journals is probably a good idea, and a worthwhile investment on your return to work. The librarian in any school or college of nursing library will help you to find literature on any of these developments as will the tutorial staff. References are given to books which you may find useful, in the further reading section at the end of the chapter, others will give an overview of developments in several areas of clinical nursing practice. Remember too that you can pick the brains of other nurses, the clinical nurse specialists, doctors or other professionals in order to help you get up-to-date. Chapter 9 will give you other ideas of ways to cope on your return to work.

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6

What's New in Management? Management Initiatives in the NHS

Returning to practice you are certain to find quite a number of changes in the way the health service is managed. Many of these changes seem to have made only a little difference to the work of most nurses. Indeed Salvage (1985) sums this up by saying that being a nurse is like being at the bottom of a large pyramid, looking up at 'large numbers of unseen senior people issuing orders which are passed down the line' (p. 80).

This view is very accurate and yet Salvage goes on to point out that by being better informed and more organized, the 'ordinary nurse' can have a considerable say in important decisions. This section aims to explain some of the main issues, ideas and changes that have shaped the health service in the last ten years or so.

WHO'S IN CHARGE?

In the late 1960s and early 1970s the nursing service adopted a very hierarchical career structure for nursing staff after the recommendation of the Salmon Report. Salmon suggested a number of grades through which the nurse could be promoted, and gave clear job descriptions for each level of authority. New titles such as nursing officer were created and hospital matrons became 'principal nursing officers' and 'chief nurses'. The system had some advantages and made opportunities for promotion which had not previously existed.

Several disadvantages soon became apparent, though, one of which was the lack of clarity about the roles of some of the grades. Nursing officers who were often responsible for several wards were often in an awkward position – not really in charge of the ward but wanting to exert some kind of authority over ward sisters. Attempts to improve

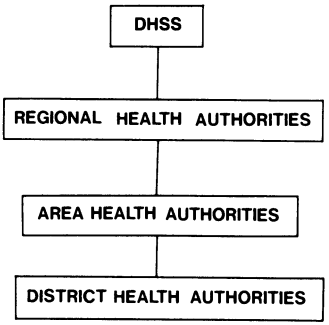


Figure 6.1 The NHS in 1979, before restructuring.

the nursing service by reorganizing management roles and functions have become increasingly common in the health service. This special focussing on management and managers has been termed 'managerialism' by historians and sociologists, but here we will explore only some of the practical issues raised by this approach.

When in 1979 a Conservative Government was elected it set out to improve the efficiency and cost-effectiveness in the NHS. It was felt that much could be learned from the very successful managers of certain private industries and businesses. Very quickly one of the tiers of the extensive NHS hierarchy – the area health authorities – was abolished so that decision-making could be concentrated at three main levels (see diagram).

In 1983 Roy Griffiths, the deputy chairman of Sainsbury's, was asked to look into the management of the health service. The report produced by Sir Roy, now known as the Griffiths Report, was unusually short – only a few pages, and was compiled in a very short time. One of his main conclusions was that no one person was prepared to make a decision when it was needed. At each level of the hierarchy there was a team of equals consisting of a doctor, a nurse, an administrator and perhaps a treasurer. None of these was officially in charge and disputes could only be resolved by referring to the full meeting of the health authority members, a very lengthy process indeed.

The solution, Griffiths argued, was 'general management'. This would give clear authority to one person who would make sure decisions were reached and action taken swiftly. He suggested an altogether more business-like approach proposing recruitment of the general managers mainly from business and industry. This did not happen as much as Griffiths had wanted perhaps because the 'high-

fliers' were attracting much better terms and salaries than the NHS could offer.

In your hospital or community the 'unit general manager' is the person you are most likely to meet. Units are sections of district health authorities often based on a hospital which are of manageable proportions. Typically there are three or four units but there may even be as many as nine or ten in very large districts based on a whole city.

Although some of these new managers were drafted in from industry and even the armed services the majority are now people whose career has been in the NHS. Many are trained administrators who were well-placed to win the posts when they arose. Some are medical staff who have decided to turn their hand to management and a relative minority are from other disciplines such as nursing. Unfortunately, nurses did not compete very effectively. They had often failed to prepare themselves for this level of management. This situation is slowly changing with improved staff development opportunities for highly motivated people.

Unit general managers have a great deal of authority to make decisions and control large budgets. In most units, there is still usually a nurse in a senior position, but he or she may have responsibility for other groups of staff and they are usually accountable to the unit general manager.

'General management' was not implemented without a fair degree of protest, because both nurses, doctors and other professionals were worried about erosion of their own authority. Some political parties complained that the new Conservative Government would use the new managers to implement radical changes such as privatization or selling off parts of the NHS. Some of this may be true, but the criticisms can with hindsight be balanced by the knowledge of distinct improvements in efficiency and cost-effectiveness which the 'crisper' new form of management allowed.

WHY DOES MANAGEMENT MATTER TO ME?

Often reorganizations do not seem to make much difference to the practising nurse – changes of title and job descriptions for senior managers can seem irrelevant. In one way, however, they have become much more important. The more effective management style of Griffiths and the new 1979 Government has meant that certain policies

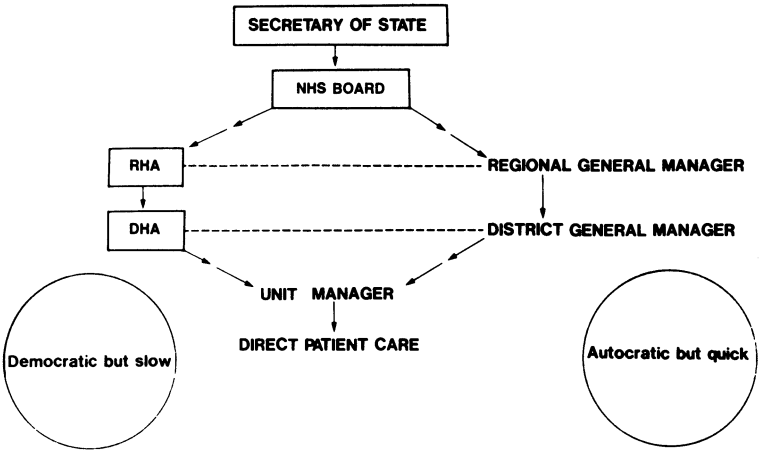


Figure 6.2 A typical Griffiths structure.

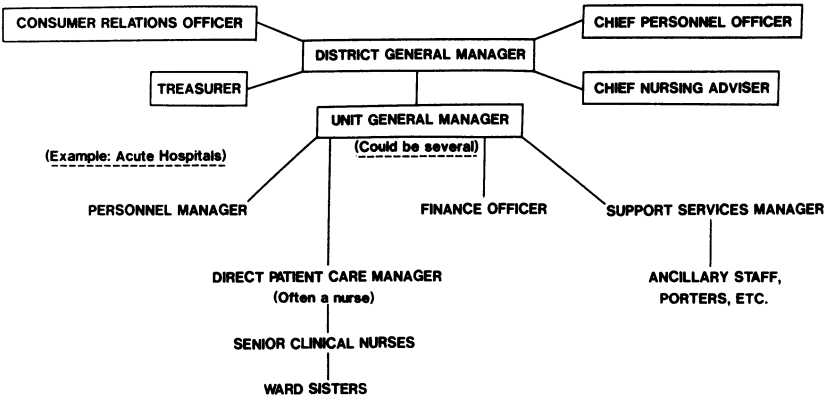


Figure 6.3 A Griffiths-type Health Authority structure.

reach the 'shop floor' much quicker. Some of the more important issues will be discussed in this section.

Who gets what?

A number of reports have examined the changing priorities in the management of the NHS. *Prevention and Health, The Way Forward, Patients First* and others are widely available in hospital libraries. Social changes such as the growing population of elderly people and a decrease in the number of younger people available to look after them have been mentioned in other chapters. These changes have forced us to think again about the strategy for nurse education and about hospital facilities.

For many years large city centre hospitals have had the lions share of financial and other resources, but now the Government has set about reallocating some of these resources to the less prestigious and more peripheral or smaller health care settings. Much of the allocation of resources had been led by what the media and the medical profession define as important. For example heart transplant surgery, intensive care and other acute specialisms have high prestige in the public mind compared with care of elderly people and the treatment of chronic conditions. Steps are now being taken to restore and balance however. Despite criticism of the Government for cutting some acute services in hospitals, it is fair to say that in many areas there has been expanded provision of high quality service for the elderly and particularly the elderly mentally ill. Much remains to be done, but these specialisms are not the neglected Cinderella services they once were.

In order to find the money for these developments, acute medical and surgical services have been reduced, in some cases quite noticeably, compared to the levels you would have seen in the late 1970s. You may recall however that patients often spent longer than was really necessary in hospital awaiting tests and visits from busy medical staff. In many conditions the need for surgery has been drastically reduced. For example the very common operations for duodenal ulceration have been almost abolished with the advent of new drug therapies.

The agreement of priorities is never easy and much hard bargaining goes on behind the scenes. Politics and professional self-interest occasionally become evident. Nevertheless, some steps have been

taken to satisfy the ever more discerning consumers of health care as pressure groups have increasing influence on the media and on the more formal decision-making channels.

How many staff?

For some years critics of the NHS have claimed that it is inefficient. In the early 1980s attempts were made to increase efficiency by encouraging higher 'productivity', that is the work done in a given time by a certain number of people. One way of doing this was to avoid filling vacancies so that the number of employees gradually fell.

For several years these 'manpower reductions' took place affecting mainly non-clinical staff. In many cases these reductions could be absorbed by a large department where skills were spread widely. Sometimes though serious problems resulted if the person leaving had key skills or a specific job to do. Ward clerks, for example, do a job which removes a considerable load of paperwork from the busy ward sister or staff nurses. If not replaced on leaving, the time available to skilled nursing staff for their true clinical role is soon eaten away. In some cases then crude application of the general principle led to even greater inefficiency, not least because a ward sister's time is much more expensive than that of a ward clerk.

Despite these problems in some areas, many departments which

were over-resourced (overmanned) did become leaner as Sir Roy Griffiths had wanted. As regards nursing staff there has actually been a net increase in numbers of staff employed. Where the public and political debate arises is upon the question of whether this rise in numbers has kept pace with the increased workload generated by the greater elderly population needing care and the many medical advances which require extra nursing support.

There are nearly half a million nursing staff of all grades working in the NHS. Deciding how many of each grade or skill level should be 'established' in each clinical area is a vexing question, and many efforts have been made to measure as accurately as possible the work to be done and the staff required. Most of these studies have drawbacks and considerable reliance is still placed on the professional judgment of experienced nurses.

The need for managers to have hard factual 'evidence' in order to win the fight for extra resources has led to increased popularity of approaches such as 'Monitor' which attempts to relate a measure of the quality of nursing care to staffing levels. You may therefore see nurses who are wholly employed to collect this sort of manpower information by means of questionnaires, observation of nurses at work and analysis of the results of other methods of recording nursing activity.

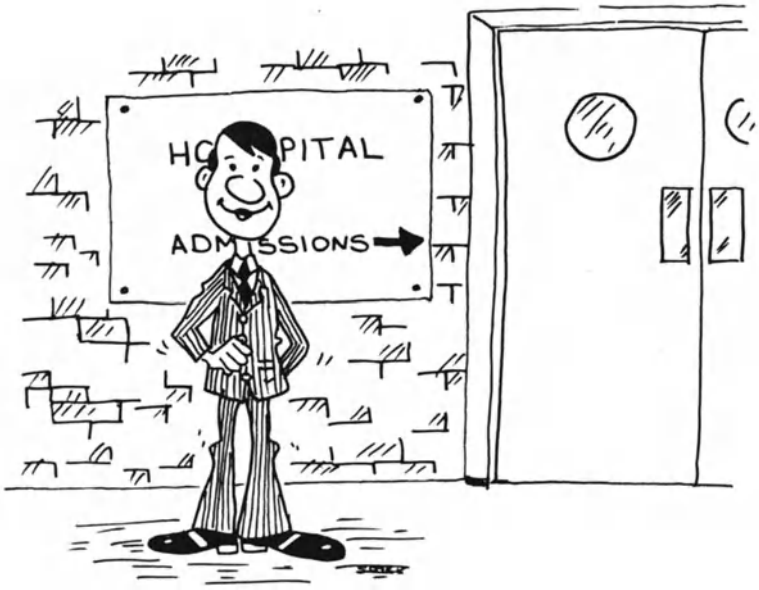
It must not be forgotten that human resources are any organization's greatest asset. Qualified nurses are particularly valuable as they are increasingly expensive to train and hard to recruit and retain.

Nurse managers are generally very keen to attract and keep you as part of their 'human resources'. Studies have shown that the factor most likely to assist in the ability of people like you to return to practice is flexibility. Managers are learning fairly quickly that flexitime arrangements, part-time hours, job-share opportunities and improved nursery facilities are important issues to address in solving the projected shortages of nurses in the 1990s.

MONEY MATTERS

Until the 1960s matrons and ward sisters were highly cost-conscious. Stories of student nurses counting pillow cases and having to report to matron for breaking a thermometer are all true.

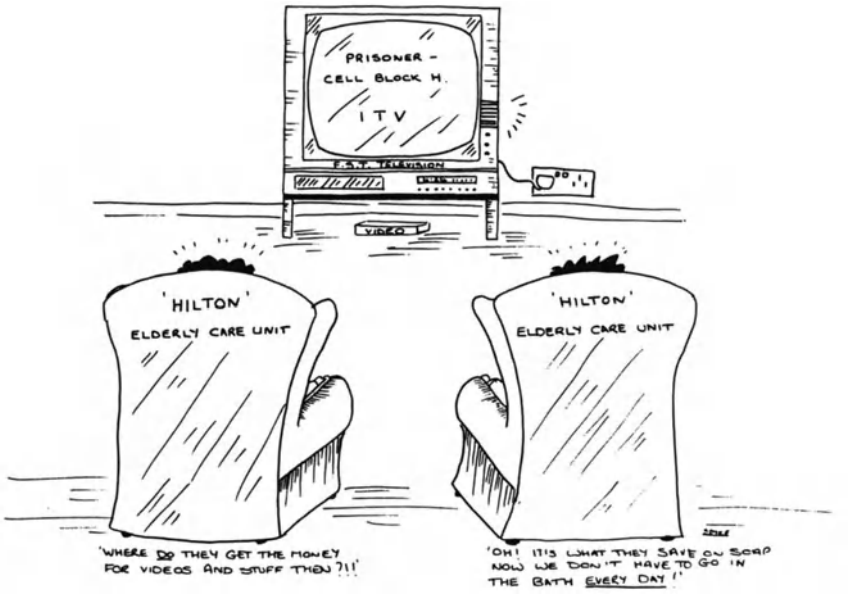
Then, however, the country and the NHS in particular became more wealthy. A reorganization removed much of the financial



accountability from nurses and gave it to administrators and supplies officers. Nurses naturally want high quality products for their patients so there was a trend towards using the best and perhaps much more expensive dressing or equipment just because it was available. Medical staff also, without proper information about how much things were costing, were rapidly developing new and expensive treatments in surgery, medicine and intensive care. Many of these advances had 'hidden' costs such as the extra nursing and technical staff needed to carry them out. Medical staff were, it was realized, the main determiners of the cost of health care for this reason.

There is little doubt that some efforts needed to be made to control spiralling costs of the health service. Where controversy arose was in the methods adopted first by the late 1970s Labour and then the 1979 Conservative Governments. The Callaghan Labour Government had attempted to limit pay awards in the public sector and probably lost the general election as a result after a 'Winter of Discontent'. The incoming Conservative administration decided upon a different strategy, aspects of which will be discussed here.

One approach was to make general managers run the services in their district with a small reduction in their allocation of money each year. A typical reduction was only one per cent, but as part of a



budget of £20 million it adds up to the manager having to find an extra £200,000 which is no easy task. Sometimes rather desperate measures were taken such as closing wards and even small hospitals. In some health authorities staff were even made redundant which was a new experience for NHS employees who had taken job security for granted.

Although this approach has seemed crude at times it has certainly stimulated a great deal of thinking about how to run services in a cost-effective way. Many schemes have been tried to raise extra cash for local health authorities: examples are selling off unwanted land, allowing shops to be built on hospital premises, and selling advertizing space on corridors and in hospital publications. Other approaches relate to the selling of skills such as laboratory expertise to other health authorities and private health care.

For you as a practising nurse, some of the main changes are as follows. First, many ward sisters now get regular statements of the amount their unit or ward has spent compared with their allowance (or budget). It can be very helpful to know what things cost and to

be able to compare equipment used as regards effectiveness and cost. This information can help us to use very expensive items only when really necessary, but of course the sister must be prepared to defend or explain 'overspending' when this is in the interest of patients.

Although nursing staff have often not received much training in accounting, 'managing' a budget is not very different from running a home and receiving regular bank statements. Many sisters have welcomed the extra information because it can sometimes mean that money saved by being less wasteful of expensive items can be used, at least partially, to buy items (such as video recorders) for their ward not normally covered by hospital finance.

At a national level, steps have been taken to reduce expenditure on items such as drugs. Sometimes drugs sold under a brand name can cost many times more than the same drug made by a different company. The rules have now been changed to allow hospital pharmacies to dispense the cheapest rather than conform strictly to the doctor's prescription. This 'generic' dispensing has cut the NHS drugs bill considerably, but with a consequent reduction in drug company profits.

An important White Paper produced by the Government recently has suggested among other things that some GPs should hold and manage their own budget for treatment and some hospital services. An initial anxiety about this is that some doctors may worry they are overspending and fail to give the best possible treatments to their patients. The idea behind this approach is to encourage sensible spending by giving accurate information but many doctors are unhappy about the scheme and it remains to be seen how it will work in practice.

This new White Paper also has important implications for the way hospitals in particular are managed and financed. Certain, usually specialist, hospitals are to be allowed to 'opt out' of the NHS. They will receive a grant from the government but will then be expected to be self-sufficient. They will charge for any services they provide to other health authorities and GPs and will be free to raise cash in other ways if they are able. Some hospitals already providing a service to a large number of patients outside their own district can easily see that they must gain from the new arrangements because they will be more effectively repaid for work they already do. The advantages for more 'ordinary' hospitals are far from clear and it is worth finding

out what your potential employer is doing currently about the White Paper's proposals.

PRIVATIZATION

Quite a number of NHS services have been privatized, for example, cleaning, laundry and catering. When you return to work you may find that the domestic staff are no longer employed by the health authority but by a private company which is under contract to them. Other services, perhaps even sections of the nursing care, may eventually follow. Arguments behind the benefits and costs of this approach are political and financial and whilst the political trend is to the right, these measures will no doubt continue.

ENSURING A GOOD SERVICE

Most people think of quality control in relation to engineering work such as making cars or possibly food hygiene inspection. Nursing sisters have long felt responsible for the quality of the nursing care on their ward or of the care they provide in people's homes. This quality was a matter of professional judgment of standards based on training and adapted through experience, and this method of quality control in nursing is still probably the most important. The public are beginning to be more consumer conscious and demand a good service. Consequently health service managers have developed approaches to the assessment of quality of care in order that comparisons can be made between units and hospitals, lessons learned, and the public's greater demands met.

In the health service generally, work has been done to assess the quality of various branches of the service. Many would agree that health service catering would benefit from feedback on the quality of food provided. Out-patient departments have sometimes improved dramatically when patients' opinions have been sought.

Much has been learned from the reports of the health service ombudsman (who investigates complaints from patients or relatives). However, many patients choose not to complain, being grateful for the help they are given, so that much can go wrong without complaints being received. In the USA, hospitals usually have to be licensed by a state authority to provide services. These licenses depend

on written proof of the standard or quality of service provided. Some of these ways of measuring quality of nursing care have been developed for use in the UK. All of the approaches have advantages and disadvantages as there are many difficulties in measuring 'good nursing care'. However, many managers and sisters are taking these measures as part of an increasing tendency to review standards and performance on a regular basis.

Ideally, information on the quality of care provided is fed back to the relevant nurses sensitively and constructively. Done in this way, quality assurance approaches can usefully help us recognize strengths and weaknesses in our nursing care. Like dependency or manpower prediction measures (with which they are sometimes combined), these techniques need to be balanced against sound professional judgment of experienced nurses before far-reaching decisions are made. More information about these sorts of measures is given in the further reading at the end of this section.

Performance indicators are currently being developed by some health authorities. As the name suggests, these are measures of their performance and usually include length of patient stay, infection rates, operations performed, etc. More sophisticated performance indicators are being developed with the intention of aiding comparison between units and authorities. These measures are usually statistical and should be seen as measures of quantity rather than quality.

THE MICROCHIP REVOLUTION

Information technology has had a major impact upon business and industry. The health service may have been a little more cautious in

its adoption of computers and rapid communication systems, but in many spheres of activity you will note their use.

Much personnel, financial and payroll data is kept on computer and when you commence employment you will probably receive a print-out of your employment record to check. Each year your employer should allow you to see this information to correct and update it. New laws protect this information so that only you or your manager will normally see it. It may not be released to, for example, companies who might like your address to advertise their products to you. This does happen with some of the non-public organizations to which you may belong since selling your address to advertisers saves money on subscriptions. It means you get junk mail though.

The use of computers in the clinical area is very variable at the moment, but it is unlikely you will require any kind of specialist knowledge and where computers are in evidence there will be specially trained personnel to operate them. Although it was once thought that all patient information would soon be on computer, in fact the ease of access and mobility of traditional 'notes' has made this unlikely for the present. Desk-top computers are increasingly common in offices because of the great efficiencies that exist to typists and secretarial staff when they can use a word-processor. Whilst computer literacy is going to be increasingly important for the younger recruit to all occupations, you need not fear that you are in some way behind. Most clinical nurses need never touch a keyboard.

BEING IN CHARGE

Earlier it was suggested that nursing is organized in a hierarchy or pyramid. This approach to management has been popular in large organizations for centuries because it can be efficient, particularly when large numbers of the staff need to be told what to do because they have had little training or because it is vital that dissent from the leader's view is kept at a minimum. The army is perhaps a good example of this idea.

In nursing at the ward level these ideas are being challenged with qualified nurses in some areas being given much more authority to make decisions with and for their patients without reference to, say, a ward sister. This primary nursing idea is discussed in more detail in Chapter 4.

Despite these moves there still remains a fairly strong view that on

major matters the 'top managers' make the decisions. These managers are often subject to business-like incentive schemes such as 'performance-related pay', where salary increases are linked to achievement of agreed aims or goals. Contracts are often temporary with reappointment dependent upon performance. Performance is reviewed regularly at special meetings for most health service managers so that individuals know where they are working well and where they need to improve.

Being so large and complex it is difficult to see how a less bureaucratic management system could be made to work, but individual managers of units and departments have some freedom to introduce flexibility. Indeed well-qualified and capable professional staff increasingly demand this.

IF THINGS GO WRONG

Previous inconsistencies in the way staff were treated by managers when they did poor work or behaved inappropriately have led to special procedures which must be followed by managers when things are so bad that formal disciplinary measures are necessary. Each health authority may vary slightly by local agreement, but usually there are four levels of action which may be taken. The manager must thoroughly investigate the problem and offer reasonable help to the erring individual wherever this is realistic. Eventually, a formal interview is arranged where the manager presents his or her case and the employee provides his or her view of the situation. Each 'side' is encouraged to have a witness to what is said. Managers will often have a colleague or personnel officer whereas the employee may have a friend or in serious cases a union representative. After the interview the level of action to be taken is decided and the employee informed in writing. Appeals against disciplinary action are made if wished to more senior managers or even to the health authority itself in serious cases.

The levels of action available to managers are as follows (but in cases of gross misconduct, such as theft or physical abuse of patients, dismissal may be the only option considered):

1. verbal warning;
2. first written warning;

3. final warning;
4. dismissal.

Other routes of appeal are open to those who remain aggrieved, such as industrial tribunal. Fortunately these situations are fairly rare and good managers should be able to help staff through difficulty without recourse to disciplinary measures.

Where staff have cause for complaint that they have been treated unfairly by managers, there are grievance procedures which should enable a fair hearing of the issue. Of course these too should be the last resort because professional staff ought to be able to resolve their differences without the polarized conflict that these formal mechanisms often produce.

These are not cheery subjects but it is important to be aware of them and the related mechanisms at national level – the UKCC Professional Conduct Committee and the ENB Investigating Committee. These bodies have powers to investigate and if necessary suspend the registration of nurses who for any reason are unfit to practise.

These mechanisms exist to protect the public and are a very necessary part of a profession. The fact that some nurses do fall foul of the system increases the responsibility upon us all to help colleagues under stress and to provide proper training in new techniques. It is particularly important never to take on new responsibilities until you feel ready.

MANAGEMENT IN THE COMMUNITY

Much of this discussion applies to the management of community services. Griffiths' first report led to many community services being put together as a unit of management. Nurse managers with a background in one discipline such as health visiting or district nursing are now often responsible for the whole community service. A report by Dame Julia Cumberledge (DHSS, 1985) emphasized this trend by suggesting a blurring of roles between nurses and health visitors but this has been slow to happen at the clinical level.

Community resources have been stretched by the increased population of elderly people and by earlier discharge of hospital patients who consequently need more nursing care in their own homes. In 1988 Sir Roy Griffiths was asked to make more observations, this time of resources in the community. His findings have not had the

same adverse publicity as his first report but they do have far reaching implications. These could include some services again becoming the responsibility of the local council and some nursing services being run privately.

SUMMARY

This chapter has tried to explain some of the current issues which face you in dealing with management in the new NHS. Much has changed with the advent of general managers, quality assurance and formalized disciplinary procedures. At the clinical level, however, there will be much that you can identify with and build upon to regain your confidence. Management, despite its limitations, can help you considerably to identify your training needs and take the right steps to keep up to date.

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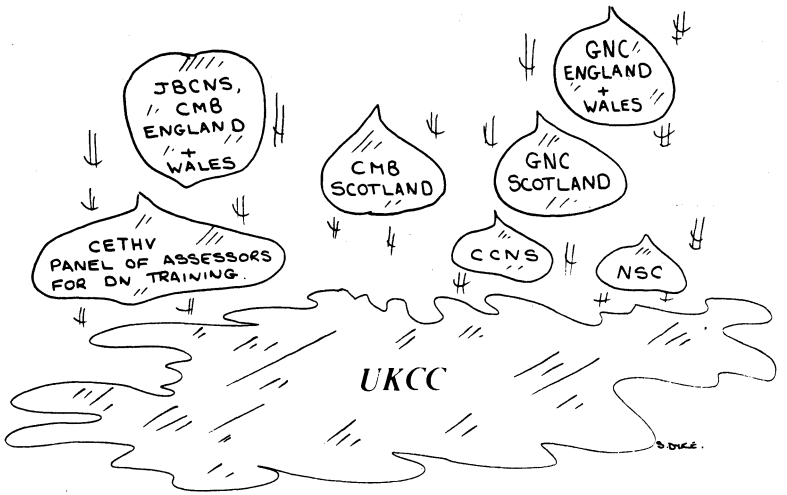
7

Whatever Happened to the GNC? An Update on Recent Legislation and the Statutory Bodies

You may have already heard something about the UKCC, or United Kingdom Central Council for Nursing. The aim of this chapter is to consider the role and functions of the UKCC and the National Boards which will affect you when you return to work.

The UKCC became the statutory body of the profession in 1983. Prior to this, nursing had been controlled by a number of different organizations, such as the General Nursing Councils for England and Wales, and for Scotland, the Central Midwives' Boards, and the Council for the Education and Training of Health Visitors to name but a few!

By the mid 1970s, it was clear that the vast number of statutory bodies, some of which had begun life in the early years of the century, had become too cumbersome to deal with the constantly changing face of modern nursing. The Nurses', Midwives' and Health Visitors' Act of 1979 enabled a single new organization to be formed



which assumed the functions of the nine bodies it replaced. This was the UKCC, which was established in 1980, but which functioned alongside the General Nursing Councils for three years before assuming full responsibility on July 1st, 1983.

WHAT EXACTLY IS THE UKCC?

The UKCC is made up of nurses, midwives and health visitors, and members of other allied professions. It is responsible for providing a framework for the development of the profession throughout the UK, but it acknowledges that things are different in England, Northern Ireland, Scotland and Wales, by having four National Boards (Figure 7.1).

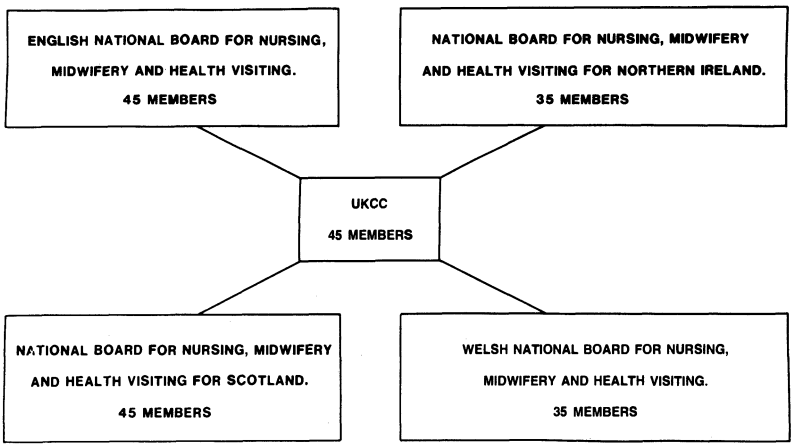


Figure 7.1 The structure of the UKCC and National Boards

The membership of the UKCC consists of seven nominated representatives from each National Board, with the remaining 17 members appointed by the Secretary of State for Health. The National Boards have a similar make-up, with the majority of their members elected by the profession, and the remainder directly appointed by the Secretary of State.

The appointments made by the Secretary of State include members of the profession who represent all the major specialties, plus representatives from general education, finance and medicine. However, the bulk of the UKCC and National Board members are elected by the profession itself. Elections to the National Boards are held every five years; the last ones were in 1988. Candidates are nominated from nursing, midwifery and health visiting and registered members of the profession may vote for one candidate from the field in which they are working.

For example, if you are returning to work as a registered nurse in England, you will be entitled to vote at the next election for one of the registered nurses standing for election to the English National Board. A registered midwife would only be entitled to vote for a registered midwife and so on.

The elected members of each National Board are made up of a certain number from each of the three main fields. For example, the 30 elected members of the English National Board include 20 nurses, five midwives and five health visitors. Within the nursing contingent, practising nurses, including enrolled nurses, are well represented.

The distinction between what the UKCC does and what the National Boards do is not always clear in practice, but broadly speaking, the UKCC lays down the 'bare bones' of professional policy, and it is then up to each National Board to add the 'meat' by interpreting such policy.

WHAT DOES THIS MEAN FOR ME?

The overall job of the UKCC is to: 'establish and improve standards of training and professional conduct for Nurses, Midwives and Health Visitors'. (Nurses, Midwives and Health Visitors' Act, 1979, Section 2(i), p. 2.)

In other words, the UKCC is responsible for establishing the framework within which all nurses work.

It carries out this responsibility in three main ways:

1. by maintaining an up-to-date register of nurses, midwives and health visitors who are entitled to practise in the UK;
2. by setting and improving standards of professional conduct;
3. by setting and improving standards of education and training.

The professional register

With the establishment of the UKCC, all the registers, rolls and records of the previous statutory bodies were replaced by a single professional register. Since it contains the names of all the nurses, midwives and health visitors entitled to practise in the UK, the register is divided into 11 parts to reflect the range of registered qualifications held (Table 7.1).

Table 7.1 The parts of the professional register

Part 1	– First-level nurses trained in general nursing (RGN).
Part 2	– Second-level nurses trained in general nursing (England and Wales) (EN(G)).
Part 3	– First-level nurses trained in the nursing of persons suffering from mental illness (RMN).
Part 4	– Second-level nurses trained in the nursing of persons suffering from mental illness (England and Wales) (EN(M)).
Part 5	– First-level nurses trained in the nursing of persons suffering from mental handicap (RNMH).
Part 6	– Second-level nurses trained in the nursing of persons suffering from mental handicap (England and Wales) (EN(MH)).
Part 7	– Second-level nurses (Scotland and Northern Ireland) (EN).
Part 8	– Nurses trained in the nursing of sick children (RSCN).
Part 9	– Nurses trained in the nursing of persons suffering from fever (RFN).
Part 10	– Midwives (RM).
Part 11	– Health visitors (RHV).

(Nurses, Midwives and Health Visitors Order 1983; Schedule 1)

The new register meant a change of professional title for everyone who qualified prior to 1983, so that if, for example, you trained to be a state registered nurse, you are now known as a registered general nurse.

Additional qualifications obtained after registration may also be recorded on the register. These 'recordable' qualifications include

those for district nursing, for teaching nursing, midwifery or health visiting, for occupational health nursing, and for a wide range of post-basic clinical nursing courses.

The register is computerized and holds the personal details of each individual entered, as well as the registered and recorded qualifications. Everyone whose name appears on the register is assigned a Personal Identification Number (PIN) which will be entered into employment records when starting work. It is the responsibility of every qualified nurse, midwife and health visitor to keep their entry up to date by informing the UKCC of any changes in their details. If a change is made, then the individual is sent a copy of their register entry to check that the information held is correct. For details on how to check your own entry, see Chapter 9.

The register is maintained in order to protect the public. Anyone with a legitimate reason may contact the UKCC and check on the registration of any nurse, midwife or health visitor. A small charge is made for this service.

In 1987 the UKCC introduced a system of periodic registration fees. Prior to this, only one fee was paid at the time of initial registration. Now you will be required to pay a fee every three years in order to keep your name on the register and thereby retain your entitlement to practise. As from September 1990, this will be linked with mandatory periods of updating or refreshment, such as that currently undertaken by all midwives.

Standards of professional conduct

The profession has a duty to protect the public from those whose conduct falls short of the required standards. These standards, established by the UKCC, are embodied in its Code of Professional Conduct, which every nurse, midwife and health visitor has a responsibility to read and act upon. The code sets out the standards expected of anyone engaged in professional nursing practice. The UKCC may also be approached directly for advice on professional conduct matters.

The UKCC publishes advisory guidelines on specific issues such as confidentiality, accountability, advertising and the administration of medicines. Copies of the code of conduct or any of these publications may be obtained free of charge by sending a stamped addressed envelope to the UKCC.

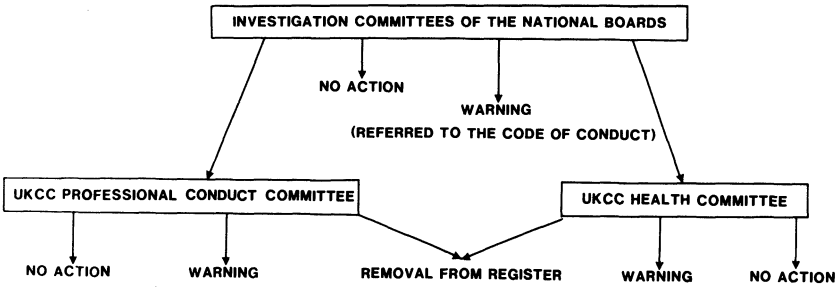


Figure 7.2 The system for investigation of alleged professional misconduct

In order to uphold standards the UKCC has set up a system to investigate cases of alleged professional misconduct (Figure 7.2). Through this system it has the power to remove, or indeed to restore, the name of a nurse, midwife or health visitor on the register.

Entry into the system is by way of the Investigating Committee of the appropriate National Board, whose members are themselves registered nurses, midwives or health visitors. These committees consider cases of alleged misconduct brought to their attention by employing authorities, the police, or concerned members of the public. After a full investigation they decide whether to refer the case to the UKCC Professional Conduct Committee. As an example, the Investigating Committee of the English National Board hears approximately 40 such cases per month, of which about ten warrant further investigation by the Professional Conduct Committee.

Cases of alleged unfitness to practise due to ill-health may be referred to the UKCC Health Committee. In addition, concerned members of the public may report cases of misconduct and unfitness to practise directly to the appropriate UKCC committee and so bypass the National Boards.

Both the UKCC committees may decide to remove the name of a person from the register and thereby their right to practise. However they also consider cases of appeal against such a decision and may restore names to the register.

Since this system is designed to protect the public, meetings of the Professional Conduct Committee are by law open to the public. If you would like to attend one of these meetings and get a better idea of how this aspect of the profession works, forthcoming dates and venues are usually printed in the professional journals, or are available directly from the UKCC. The committee meets all over the country

and not just at UKCC headquarters in London; however, places available at any venue are limited, so you would need to apply in writing to reserve one if you wish to attend. (The address is in the appendix of this book.)

Standards of education and training

The UKCC is responsible for establishing the overall rules governing the content and standard of education and training in the profession. These apply not only to the 'basic' training courses leading to registration, but also to the 'post-basic' or continuing education of nurses already registered.

The UKCC advises and collaborates with the National Boards through a series of committees, on, for example, educational policy, midwifery, health visiting, district nursing and research. It is the role of the National Boards to approve institutions to run courses of training which meet the UKCC requirements of content and standard. These institutions may be schools of nursing in hospitals or departments or nursing in colleges, polytechnics or universities. The National Boards also monitor the assessment and examination procedures used in such courses.

Training courses are no longer based on a rigid syllabus, but around a series of outcomes or competencies, which sum up what someone has achieved on completing the course. There are specific competencies for courses leading to entry to different parts of the register. Those which must be acquired by first-level (registered) nurses are listed in Table 7.2.

It is up to each training institution to plan courses according to the specific competencies; the appropriate National Board then approves such plans, for up to a maximum of five years.

Further information about nurse education can be found in Chapter 8.

SUMMARY

This chapter has focussed on the main aspects of the role of the statutory bodies in nursing. The maintenance of the professional register, and the establishment of standards of professional conduct

Table 7.2 The competencies which must be acquired by completing a course leading to entry to Parts 1, 3, 5, and 8 of the Register. (Nurses, Midwives and Health Visitors Rules Approval Order 1983; Part III, Rule 18 (I)).

1. Advise on the promotion of health and the prevention of illness.
2. Recognize situations that may be detrimental to the health and well-being of the individual.
3. Carry out those activities involved when conducting the comprehensive assessment of a person's nursing requirements.
3. Recognize the significance of the observations made and use these to develop an initial nursing assessment.
4. Devise a plan of nursing care based on the assessment with the co-operation of the patient, to the extent that this is possible, taking into account the medical prescription.
5. Implement the planned programme of nursing care and where appropriate teach and co-ordinate other members of the caring team who may be responsible for implementing specific aspects of the nursing care.
6. Review the effectiveness of the nursing care provided, and where appropriate, initiate any action that may be required.
7. Work in a team with other nurses, and with medical and para-medical staff and social workers.
8. Undertake the management of the care of a group of patients over a period of time and organize the appropriate support services related to the care of the particular type of patient with whom she is likely to come into contact when registered in that part of the register for which the student intends to qualify.

and education all directly impinge upon your work as a nurse. The UKCC does distribute a twice-yearly news-sheet called 'Register' to all nurses, midwives and health visitors on the register, and this is a useful review of current issues. However, if you would like any further information the statutory bodies may be contacted directly; the addresses appear in the Appendix of this book.

8

What's New in Nurse Education? A Review of Current Developments in Professional Training and Education

You may already be aware of some of the changes taking place in nurse education. The aim of this chapter is to examine the major developments taking place, both currently and in the near future, with particular emphasis on how they will affect you when you return to work.

The previous chapter describes how schools of nursing now plan courses to ensure that students achieve certain competencies. For first-level courses, the competencies centre upon the promotion of health, the assessment, planning, implementation and evaluation of care, and aspects of the management of patient care (see Chapter 7). The content of such courses reflects this with their emphasis on the concept of health rather than that of illness, the use of a systematic approach to individualized care, and the importance of interpersonal skills in nursing. When you return to work, you may find that students may try out their new-found communication skills on you. More time is

also given over to psycho-social aspects of health care, ethical and professional issues and the impact of research on nursing practice.

You may find when you talk to students that the teaching methods now used seem far more informal than in the past. Nurse teachers place a lot more emphasis on students actively participating in and directing their own learning. This is reflected in the growth of, for example, small group discussion and experiential workshops as teaching methods.

You may also come across changes in the examination and assessment system. The National Boards now allow schools of nursing to set and mark final examination papers for certain courses. For example, for the RGN course there is no longer a 'State Final' but a 'devolved' examination. Since each school devises its own, these examinations are likely to be more appropriate to the experience offered by the hospital and local community.

There has also been a recent increase in the use of continuous forms of assessment for students. In England it has been decided by the National Board that by 1992, all students in training will be assessed on a continuous basis.

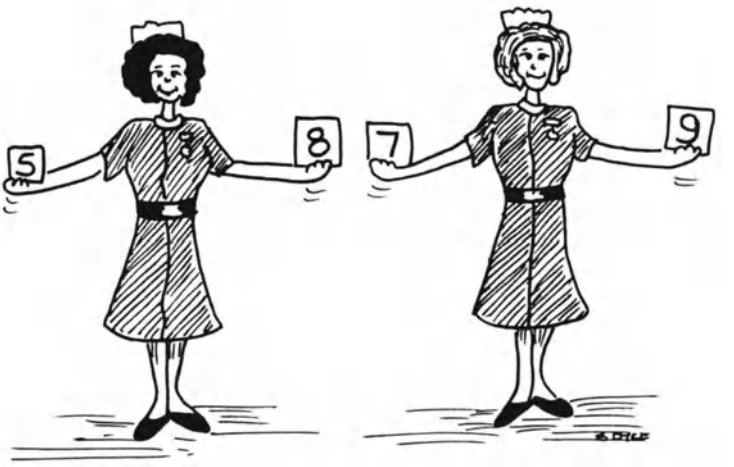
If continuous assessment of practice is used, the traditional ward-based 'one-off' assessments are replaced by sets of objectives to be achieved by students during their allocation to the clinical areas. If continuous assessment of theory is used, it replaces the 'final' examination and its pass/fail criteria by a series of assignments throughout the training period. These may include, for example, essays, nursing care studies, literature reviews, or indeed, written examinations, all of which are taken into account when assessing students' progress.

While it seems fairer not to rely on 'one-off' assessments, students may still feel nervous about being assessed continuously.

WHAT EXACTLY IS PROJECT 2000?

The changes described so far have taken place within the traditional framework of nurse education. You may already have heard something about 'Project 2000'; this report, published by the UKCC in 1986, proposed changes in the very framework itself.

Project 2000 is the latest in a long series of reports from various groups in the last 50 years which have called for major reforms in the way nurses have traditionally been trained. However, unlike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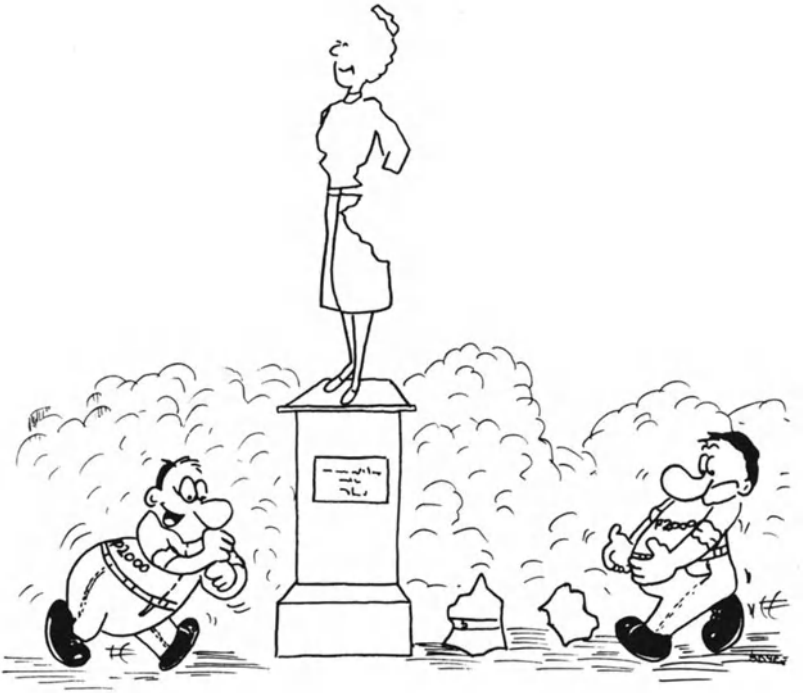


previous attempts, Project 2000 has been accepted in principle by the Government and is being put into practice.

The impetus for Project 2000 arose from three major issues affecting the profession: changes in the structure of the population, the inherent problems of the traditional system of nurse education, and the changing health needs of society. These issues will now be explored.

Demographic changes

During the 1970s the birth rate in the UK dropped quite dramatically; this has resulted in a shortage of teenagers which will be at its most acute by the mid–1990s. Nursing will be particularly affected since it has traditionally relied upon recruiting large numbers of school-leavers.

Traditional training

Most of the nurse training programmes in the UK are built on a system of student labour. Student nurses are employed by the NHS primarily as part of the workforce. For the patients this means that a large part of their care is given by unqualified staff, while for the students' research has repeatedly shown that learning in the clinical areas is often a 'hit and miss' affair (e.g. Fretwell, 1982).

Furthermore, students and teachers alike have long been isolated from their counterparts in other fields of higher education, not only in terms of philosophy and geography, but also in the educational value of their professional qualifications.

Changing health needs

The changing health needs of society are discussed in greater detail in Chapter 2. The pattern of health and illness is now dominated by issues such as the ageing population, community care, health promotion and illness prevention. Nurse education can therefore no longer be satisfied with turning out nurses whose experience is essentially rooted in hospitals and caring for sick people. Project 2000 has

attempted to address these issues and proposes a new framework for nurse education to take it into the next century.

WHAT DOES PROJECT 2000 MEAN FOR ME?

The main proposals of Project 2000, which were accepted by the Government in 1988, are being implemented gradually, with some schools of nursing already moving to the new form of training and others due to follow over the next few years.

The central focus of the proposals is a new form of nurse preparation leading to a single new level of nurse practitioner. This has implications for the role of the enrolled nurse, recruitment into the profession, the structure of training programmes, the role of the student nurse and the role of the 'support worker'. These issues will now be examined in more detail.

The role of the enrolled nurse

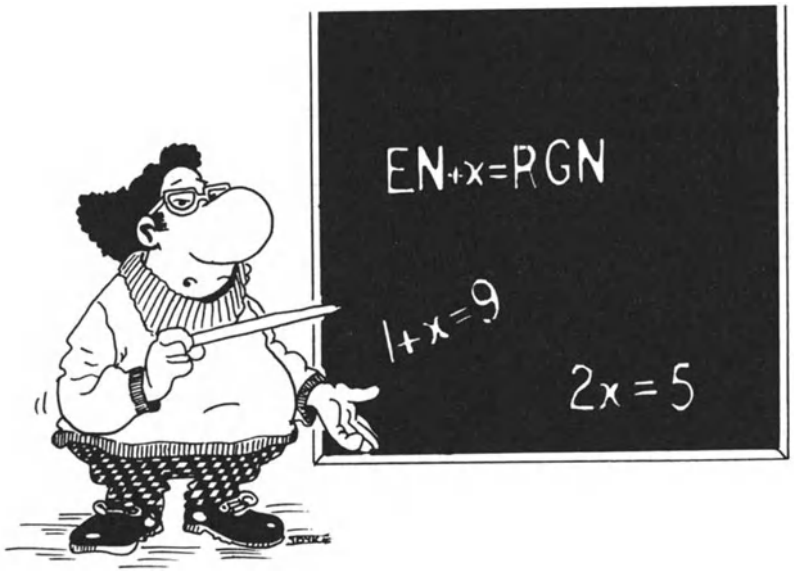
There currently exists a 'two-tier' system of nursing with first-level and second-level nurses (registered nurses and enrolled nurses respectively). According to the Nurses, Midwives and Health Visitors' Rules,

the first-level nurse is competent to manage all aspects of patient care, while the second-level nurse is competent to assist the first-level nurse, accepting delegated tasks and working as part of a team.

The role of the second-level nurse, however, has traditionally been beset by problems. Enrolled nurses have acted variously as first-level nurses and nursing auxiliaries, depending merely upon the mix of grades of staff in a particular area. Many have been denied the opportunities for professional development afforded to their first-level colleagues.

In an effort to correct this misuse, albeit in the long-term, Project 2000 recommends a single new level of registered practitioner to undertake the work previously done by the present two levels. To this end, enrolled nurse training is gradually being phased out. The enrolled nurse parts of the register will remain for as long as there are enrolled nurses. However, they will only remain open for entry until all pupil nurses currently in training have qualified.

Existing enrolled nurses may of course remain in their present posts and continue to fulfill their role at this level. However there are increasing opportunities for those who wish to become first-level nurses. Many schools of nursing now offer 'conversion courses', designed to enable second-level nurses to gain first-level knowledge, skills and attitudes.



Although many schools have adopted a flexible approach to entry requirements, the demand for such courses is great and many are over-subscribed. If you are an enrolled nurse and are interested in applying for a 'conversion' course, further information can be found in Chapter 10.

The proposal regarding the cessation of enrolled nurse training was accepted by the Government on condition that the entry gate to training be widened and the role of the support worker developed.

Recruitment into the profession

You may already be aware that the 'entry gate' to training has been widened. Because of the falling numbers of school-leavers entering nursing, there has been a move to attract a greater number of more mature recruits. Furthermore, there is a general recognition that many people who possess qualities necessary for nursing did not have the opportunity for whatever reason, to gain the traditional 'paper' qualifications during their time at school. With no enrolled nurse training, such people would have been lost to nursing without changes to the entry gate.

There has been a shift away from the standard entry requirements of five GCSE/GCE 'O' levels towards a greater acceptance of a much wider range of educational and vocational qualifications. Entry

requirements for first-level training courses are now stated as being 'five GCSE/GCE ordinary level passes at grade A, B or C, or the equivalent', as accepted by the UKCC. Information about the qualifications regarded as equivalent may be obtained from the UKCC.

One such alternative to 'O' levels is a pass in the DC educational test. (The initials are those of Professor Dennis Childs, an educational psychologist who devised the test.) This is set by the UKCC and offered by many schools of nursing to potential recruits. The test assesses a candidate's intellectual ability through a series of timed exercises. Like the traditional educational qualifications, the DC test must be used in conjunction with some means of assessing the personal and social attributes of a candidate, such as a personal interview, since intellectual ability cannot stand alone as an entry criterion for nursing.

The widening of the entry gate means that when you return to nursing, many of the students you meet will be older than 18, perhaps older than you. You will find that the mature students will have had a greater wealth of experience prior to training, both in other work and in life generally, than the students who have just left school.

You may also meet students who are undertaking different types of training programmes. For example, some schools of nursing now offer RGN training on a part-time basis, particularly for more mature students with young children, or for those who are single parents. Some schools are already offering the Project 2000 system of training, which is described in greater detail in the following section. There are also a number of nursing degree programmes, whose students are part of a university or polytechnic, but who gain practical experience in clinical areas. The number of such degrees available has risen dramatically during the last decade, so much so that nurses who trained in such a way are no longer as rare as they once were.

In England, all applications for basic nurse training courses are handled by the Nurses' Central Clearing House, which is run by the English National Board. It provides a centralized system for processing such applications, allowing each candidate to apply to up to six schools of nursing for nurse training. As yet, the clearing house system is not in operation in any of the other three National Boards.

The issue of recruitment is not only a matter of attracting new people into the profession but also of encouraging nurses to return to work following a break.

As you are no doubt acutely aware, the decision to return to practice often depends upon the availability of such things as flexible

working hours, crèche facilities and opportunities for professional development. If nurses are to be attracted back to work then it is these sorts of facilities that warrant close consideration by all concerned in recruitment.

For further information on back to nursing courses, see Chapter 10.

The structure of nurse education

The preparation programme for the new type of registered practitioner will still be three years in length, but otherwise will be vastly different to traditional nurse training courses.

It consists of two consecutive 18 month programmes: the Common Foundation Programme which is a general introduction for all nursing students, followed by a choice of four branch programmes leading to entry onto different parts of the register: care of the adult (RGN), care of the child (RSCN), care of people with a mental handicap (RNMH) or care of people with problems of mental health (RMN) (Figure 8.1).

Midwifery training remains separate; the traditional 18 months post-registration preparation still exists, but experimental direct-entry training courses have also been set up.

Prior to the implementation of the new preparation programme there is a need for schools of nursing to be rationalized in order to provide a common foundation programme and at least two, but

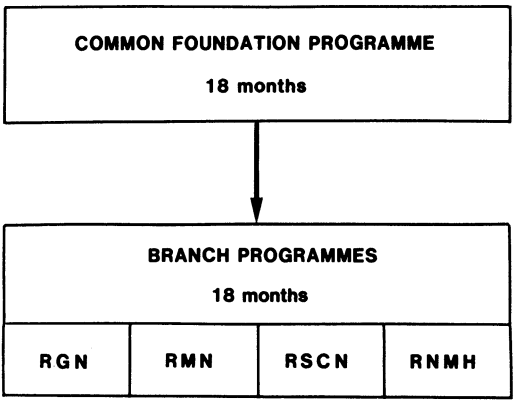


Figure 8.1 The structure of the preparation of the registered practitioner.

normally three of the branch programmes. This has lead, in many areas, to the amalgamation of schools so that together, they are able to provide the necessary teaching and experience for these programmes.

It is also recommended in Project 2000 that formal links are established between schools of nursing and higher education institutions. This would enable academic validation of nurse education programmes and greater academic recognition of professional qualifications.

Nurse education beyond registration is to be more comprehensive and more suited to particular specialities, thus enabling individuals to become 'specialist practitioners' in their own area of practice. Current examples of specialist practitioners are health visitors, occupational health nurses, and community nurses in general, mental health and mental handicap nurses all of whose specialist qualifications are recordable on the UKCC register.

However, the variety of such qualifications looks set to grow as registered nurses refine their skills in their chosen area of practice, and more courses are established to formalize such professional development.

The role of the student nurse

It was highlighted earlier in this chapter that one of the main factors affecting traditional nurse education programmes is the student nurse's overwhelming commitment to the needs of nursing practice. Therefore one of the key proposals of Project 2000 is that students are supernumerary to staffing establishment figures throughout their training. This was partly accepted by the Government: supernumerary status was granted for the duration of the common foundation programme, but during the branch programme students will be NHS employees and make a significant service contribution. Students will receive a non-means-tested bursary throughout their three years.

This implies true 'student status' during the common foundation programme, with the emphasis on clinical experience dictated by education rather than service needs.

Supernumerary status does not mean that students will simply observe nursing practice.

Nursing is such a practice-orientated profession that it is essential for students to learn the necessary skills by practising them under the supervision and direction of a qualified nurse. Despite its many critics,

the effectiveness of supernumerary status has been demonstrated repeatedly in the growing number of nursing degree programmes whose students have long held such status.

The removal of students from staffing establishments, and the cessation of enrolled nurse training, obviously leaves a huge gap in the number of nurses available to care for patients. While it is envisaged that care would and should be given by qualified nurses, Project 2000 proposes a new 'helper' grade, known as the 'support worker' or more recently, the health care assistant, to ensure that services are maintained.

The role of the support worker

The recommendations on the role of the support worker have been drawn up by a consortium of bodies including the Department of Health, the UKCC and the NHS Training Authority. (The NHS Training Authority was set up to co-ordinate and improve the efficiency of the training of all NHS employees, apart from medical staff.)

While Project 2000 provided the original impetus for the development of such a role, it is recognized that there is a need for competent support workers, not just in nursing, but throughout the whole range of health care services.

The role and training of support workers are closely linked to the framework of 'levels of competence' laid down by the National Council for Vocational Qualifications (NCVQ). This provides the opportunity for individuals to progress through levels of increasing competence and thus gain credits towards nationally recognized vocational qualifications.

For support workers to nurses, there are two main roles, each requiring a different level of competence. These are: environmental support, such as housekeeping and clerical duties, at the lowest levels of competence, and direct care support, demanding a slightly higher level. Both are well below the level of competence demonstrated by a registered nurse. However, there will be an opportunity for support staff to progress through the NCVQ framework and gain qualifications which would enable them to enter nurse training, thus enhancing recruitment into the profession.

There does seem to be a risk that progression to a level lower than that required by nurse training may lead to the development of some form of 'second level' nurse. However, the UKCC has stated very clearly that it will not allow a two-tier system to develop again, and it has reiterated the position of enrolled nurses as registered practitioners.

For both the nursing support roles outlined above, the support workers will work under the supervision of qualified nurses, forming an integral part of the nursing team. Training must, by nature of the work, be a combination of learning both 'on' and 'off' the job.

When you return to work you may well be involved in training support workers, either as a supervisor or as an assessor, but you should also receive appropriate training for your role.

The position of existing auxiliaries has yet to be finalised but they

are likely to be assimilated into the support worker scheme and given similar opportunities to progress.

SUMMARY

You are returning to work in a period of immense change in nurse education. This chapter has considered some of the current developments and, in particular, it has focussed on the implications that Project 2000 has for you as a nurse returning to professional practice. These include the roles of the enrolled nurse, the student and the support worker, recruitment issues and the structure of training programmes.

REFERENCE

Fretwell, J. E. (1982) *Ward Teaching and Learning*, Royal College of Nursing, London.

9

How Will I Cope? Support for the Nurse Returning to Nursing

Returning to work following a break may seem a daunting prospect. The following chapter aims to provide you with some strategies which will help to ease your path back into nursing. You may be assured that everyday life skills employed in running a home, in parenthood or in other types of work will be useful. Budgeting, for example, is not too different whether it is in the home or in the hospital ward. Comforting a distressed child and a sick patient require many of the same interpersonal skills.

ORGANIZATIONAL ASPECTS

Keeping in touch with what is going on

It would be helpful to enquire whether any clubs or groups exist in your area to meet the needs of like-minded people. Some hospitals run 'Keep in Touch' clubs for those nurses who are not ready, for whatever reason, to return to work straight away. The clubs may provide speakers who can lead discussions on subjects relating to nursing. There may be professional update sessions or just discussions centred around subjects of concern. It is usual for the topics to be chosen by the group members themselves.

The meetings are often held in the early evening to enable nurses to attend. The local school of nursing is a common venue for such activities and enquiries to the school are likely to be helpful. You might even think you could help to set up a club for your area if one does not exist.

Child care

Care of children is often a problem which needs to be dealt with before nurses who are parents can return to work. It would be wrong to suggest that crèche facilities are commonly available in hospitals but it is certainly worth enquiring about them. Who knows? Frequent enquiries may result in the development of more child care facilities for nurses. Otherwise it is up to the parent to make adequate child care arrangements in the community. Details of child-minders, nurseries etc. will be available via your local council or public library.

Working hours

Whether you choose to return to nursing on a part-time or full-time basis, there are usually several options open to you. More and more hospitals acknowledge that they need to provide help to those returning to nursing. Flexible working hours are becoming more commonplace, allowing nurses to select from a wider range of possible duty times. It is possible that you could join a Nurse Bank to be available at mutually agreeable times. These are quite popular and suit those nurses who can provide a limited number of hours per week.

Some nurses even return with a friend and negotiate to share a

job. Each one of the pair provide some of the total hours needed to fill the post.

Am I eligible to return to practice?

Before a qualified nurse can return to nursing practice, he or she must be registered with the UKCC (see Chapter 7). In order to fulfil this legal requirement you should complete a registration form available from the UKCC (the address is in the list of useful addresses in the Appendix of the book). In return, you will receive a plastic card embossed with your Personal Identification Number (PIN).

If you know that your name already appears on the UKCC register but wish to check your details, you should also contact the UKCC Registration Department.

What will I earn?

Perhaps one of the most pressing questions you may want to ask on your return is. 'What will I be paid?' You may well have heard about the clinical grading structure which came into operation early in 1988.

Clinical grading was designed to give financial reward to nurses according to their clinical skills and years of experience rather than simply by virtue of their post. It is based on nine grades, each of which has a number of incremental points (Figure 9.1).

To find out the actual pay scale for each grade, you will need to contact your hospital personnel department. As a result of the implementation of the grading system, every nurse's job has been re-graded. Nurses' pay is reviewed annually and pay increases awarded accordingly.

When you return to work, whatever your grade and corresponding salary, you will still be required to pay income tax and national insurance contributions according to your rate of pay. However as from April 1988, you are now able to choose your own pension scheme. This means that you have the choice of opting out of the NHS superannuation scheme and into a private pension scheme. The NHS scheme has the advantage of being index-linked and is recognized by the staff side of the Whitley Council – the group which agrees the pay and conditions of all NHS health workers.

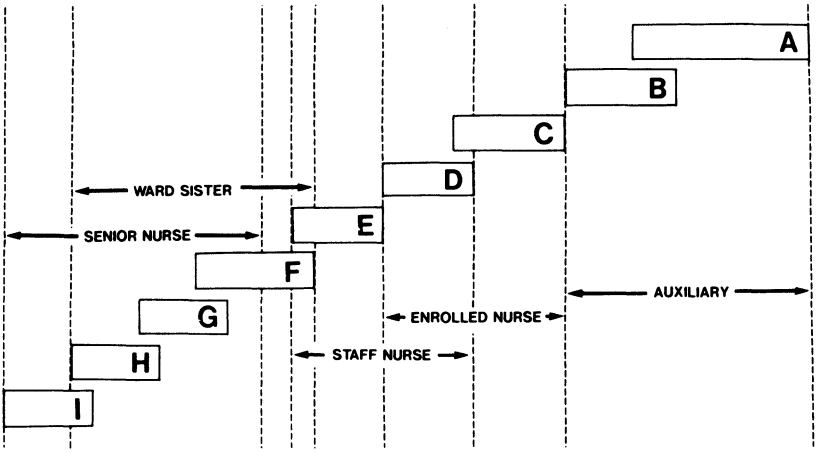


Figure 9.1 The clinical grading structure.

For further information, you are advised to contact your hospital personnel department.

Do I need to join a union?

Nurses still have the same choices with regard to membership of trade unions and professional organisations. The main bodies that represent the interests of nurses are the Royal College of Nursing, the National Union of Public Employees (NUPE) and the Confederation of Health Service Employees (COHSE). Most nurses are members of at least one of these and choose to pay their subscription fees on a monthly basis, deducted from their salary at source. You will doubtless be encouraged to join one of these organizations by your employer if you are not already a member.

PRACTICAL HELP

Having discussed some of the legal and organizational aspects of returning to nursing, let us now look at some practical steps which may ease your way back to the clinical area.

Where can I get help from?

You may find that the greatest help is to find a nurse who can act as your 'mentor', someone who can offer advice, give support and information, and suggest useful ideas. This may initially seem unrealistic but, before or after your return, a mentor will be very useful in supporting you. Nurse teachers and other staff such as recruitment officers are well placed to advise you and in particular to direct you to up-to-date information. In the clinical area, nurse specialists may be a useful source of support and information.

These people, along with senior nurse managers, can help you find a suitable return to nursing course or to locate other relevant opportunities such as study days. You may be encouraged to attend in-service training sessions which should boost your confidence. Even if you are not employed by the NHS, such courses are usually offered at minimal cost.

Your need for accurate and up-to-date information could also be helped by local public libraries. First, the local librarian will almost certainly help you find journals or recent books on nursing and associated topics. There should be lists of courses available as well as names and addresses of organizations who may be able to help you.

Membership of a hospital or college library often depends upon employment or attendance on a course in that institution, but you should be allowed to read and get advice from these sources.

The large increase in publications about nursing has made up-to-date information written by nurses, for nurses much more available. Methods of finding a book or article on what you want can easily be demonstrated by library or teaching staff.

Other sources of help and information include local colleges of education, some of which run up-date and advanced nursing courses.

On returning to nursing, you will find that the health authority automatically provides instruction on health and safety matters, on fire safety and other important developments.

SUMMARY

The information and advice contained in this chapter provides you with some useful ways in which you can prepare for returning to your previous occupation. By planning the resumption of your nursing

career in a careful and systematic manner, you should gain in confidence and feel ready to take your place within the nursing profession.

10

Where to Next?
Developing Your Career

Whether you are returning to nursing, or just reflecting on your present role, it is worth paying some attention to planning your future.

Everyone feels in a rut from time to time and wonders how on earth we get to the other side of the fence where the grass seems to be greener. With good planning and a little help, there are many opportunities available to you, some of which will be examined in this section.

In the past nurses assumed that the basic qualification was the end of their professional training and that career development or expertise in any field was gained by a mix of natural ability and experience.

The UKCC has clearly stated that the qualified nurse has a duty to take reasonable steps to maintain his or her skills and competence well beyond the basic qualifications. Indeed it has now undertaken a major review called the 'Post Registration Education and Practice Project' (PREPP) which it hopes will provide a structured system of continuing education for all qualified nurses and which may include mandatory updating.

The responsibility for keeping up to date and improving your knowledge and skills will therefore lie with you. Many health authorities are however increasingly committed to provide in-service or post-basic education for staff. They have to be because such continuing education may well have been made mandatory by the UKCC for all nurses (as it already is for midwives) before many more years pass.

You may be reading this book to help with your return to nursing course. Some health authorities regularly run such courses and charge a fee to cover costs. Individuals are then free to apply for positions in that or some other authority.

Other authorities will employ you first, then do their best to orien-

tate you by attaching you to a guide or mentor until you feel confident enough to assume greater responsibility. During this period you may be released for study sessions.

Return to nursing courses are to become mandatory very soon for nurses who do not practise for five years or more and are already compulsory for midwives.

KEEPING UP TO DATE

There are several key areas where clinical nurses need to keep up to date and avail themselves of local in-service training sessions.

The scale of tragedies, such as that at the Hillsborough Football Ground, has reinforced the point that all employees working with large numbers of people need to be constantly ready to deal quickly and efficiently with emergencies.

Other civil disturbances like the 'poll tax' riots and prison disturbances have all required effective responses from local health services.

Disaster planning is the responsibility of senior officials, but every nurse should familiarize him or herself with basic emergency plans such as fire escape routines. So often the ordinary person may save many lives by simple actions such as alerting the right services, shutting fire doors and enabling orderly escape. Sessions by health and safety experts and the District Fire Officer should form part of any orientation programme. Ask about them because they *are* routinely provided in all health authorities.

Many hundreds of nurses each year retire or seek alternative employment through injury to their bodies. Demanding physical work in nursing clearly requires a degree of physical fitness. Most difficult lifts and manoeuvres are achieved however by good technique, not strength.

You are wise to ask about lifting and handling techniques, and to attend study sessions in this area. Modern lifting aids have taken considerable effort and danger out of many lifting situations.

New health problems constantly challenge the health service: the most notable recently is the viral infection AIDS (Acquired Immune Deficiency Syndrome). The health risk to staff through professional contact with AIDS patients is, provided simple hygienic precautions are taken, absolutely *nil.* (See Chapter 2.) Other illnesses with less stigma in the past have actually been a greater menace to staff, such as serum hepatitis and tuberculosis.

Awareness training in precautions and issues in caring for AIDS patients is widely available and you should make sure you attend a session. Usually run by professional AIDS counsellors or experts in the field these sessions help to dispel myths and give practical advice.

Apart from training in these areas which is virtually compulsory, health authorities vary in the amount of provision of in-service training in other issues and skills. You should find out about in-service training in your area and ask to see a programme of courses. Release in work time to attend courses depends upon your manager, and in busy times can be difficult to obtain. Professionals however should probably be prepared to meet managers half way. You would certainly show enthusiasm if you are prepared sometimes to attend in your own time. Staff *should* have the right to be educated during their work hours, but sadly this goal will not be achieved overnight.

Many interesting and valuable short courses are run and attending some of them will help you re-establish useful contacts and relationships as well as your confidence.

Here is a list of courses often run by many continuing education departments:

1. stress and coping skills,
2. communication skills,
3. advances in drug therapy,
4. lifting and handling techniques,
5. nursing process workshops,
6. prevention of child abuse,
7. resuscitation techniques,
8. handling aggressive behaviour.

FURTHER CAREER DEVELOPMENT

Opportunities for diverse career development are greater than ever before in nursing. There has been an explosion of specialisms and courses of preparation about which we will say more later. Whatever your aim in returning to practice you will gain more in terms of job satisfaction, financial and other rewards if you pay some thought to planning your future. It is always wise not to be too specific about your goal. For example the roles of director of nurse education, clinical teacher and hospital matron have all changed and may be almost unrecognizable. New and equally challenging roles are being

developed however and you may wish to prepare yourself, over a period of years, for such an opportunity.

CLINICAL NURSING

Developments in clinical nursing are discussed in Chapter 5. These developments have led to new roles and increasingly there is a commitment to develop a clinical career structure. This will mean that nurses will be able to command promotion and higher rewards without leaving the bedside.

Traditionally promotion meant teaching or management, but this is slowly changing. The role of clinical nurse specialist is for example much more common and often commands the salary or grade of nurse tutor or senior clinical nurse.

To obtain such posts it will soon be necessary to supplement skill and experience with clinical or academic qualifications at, say diploma or degree level. Such things may seem unrealistic because as nurses we have tended to have a low estimate of our potential. You will however meet many nurses engaging in these aspects of career development.

Examples of new clinical roles are given in Chapter 3. Many of these new roles exist because they offer the possibility of flexible working arrangements and maximum independence or autonomy in making decisions.

TEACHING

The many changes facing nurse education have also presented golden opportunities for development of new roles for teachers. To work in the NHS as a nurse teacher in a school or college of nursing you will need to achieve basic entry requirements. The guidelines change from time to time but broadly the UKCC expect you to have the following:

1. You must be a first-level (e.g. RGN, RMN or RMNH) nurse.
2. You must have something like three of the last ten years (in total) experience at staff nurse or sister level in areas where basic and/or post-basic student nurses are regularly allocated.
3. To be eligible to register as a tutor you must have completed some advanced professional study and have undertaken a course approved by the National Boards for nurse tutor preparation.

Actual routes to registration have increased of late, but one example will be given.

Example

You have been out of nursing for nine years till your youngest child was settled at school. You are RGN and hold the Queens Institute Certificate in district nursing. Suppose you return to a post of 30 hours per week in your local hospital on a ward where you will be supervising student nurses. Once you get settled back to your post you should discuss your plans with the local College of Nursing Principal and preferably your line manager. You will almost certainly need their support because you will need to work for about three to four years in positions of responsibility with learners. During this time, although you possess an 'advanced' nursing qualification you would gain much by doing further study, such as part of a degree in a relevant subject or the Diploma in Nursing. This would aid both your teaching and your career prospects as a teacher.

On completing the clinical experience, your College Principal

should normally support you for a funded place on a tutors' course of which quite a number are now available, both full and part-time, most being the equivalent of one academic year.

A word of caution is that you will almost certainly need to possess a degree in order to achieve any career progression as a teacher. Do not be put off by this because there are many opportunities now for day release, and financial support, and gaining a degree is more to do with interest and motivation than any inherited ability.

You are strongly recommended to seek advice from education staff because courses may be available which combine both a teaching qualification and a degree. This obviously makes the whole process more efficient and less tedious. Such courses already exist in Manchester, Edinburgh, Huddersfield, London and an increasing number of other centres too.

The role of clinical teacher is becoming obsolete and courses preparing for this function alone have ceased. It has now been largely recognized that the ideal clinical teacher is the clinically-based nurse who had had some preparation in relevant skills.

It is possible to obtain a post as a nurse teacher in a school or college of nursing without the relevant qualifications but there are rules to prevent this happening for more than a year or so. Gaining some experience in this way can however help you to decide whether or not formal teaching is for you.

Finally, it is possible to hold the post of lecturer in nursing in a college, polytechnic or university without having formal nurse tutor qualifications. Almost without exception you would need to possess a university honours degree and recent clinical experience.

It would still be sensible in the long term to obtain registration as a nurse teacher so that the job opportunities throughout higher education *and* the health service will be open to you. Indeed increasing links between the two sectors strengthen this point.

MANAGEMENT

The chapter dealing with issues in management illustrates a number of changes in health service management. Many of these changes signalled, at least initially, a decreased role for nursing staff. Administration and many senior nurse management roles were changed beyond recognition or abolished altogether.

The sad fact was that despite some individuals having got to the

top on ability and drive, the preparation and education of most senior nurses for top management posts had been sadly lacking. Recently however, health authorities have recognized to some extent the key importance of the management of the largest occupational group in the health service – nursing staff.

Chances for management development are becoming available. Historically, women in particular have either failed to take or been prevented from taking these opportunities so that of the mere 7% of nurses who are men, considerably more achieve senior management positions (about 59%).

Academic qualifications are, rightly or wrongly, becoming more important in the field of management, with the Certificate in Management Studies and the higher level Diploma in Management Studies being important parts of individual career progression.

One of the changes brought about by Sir Roy Griffiths is that it is now much easier to achieve promotion across the boundaries of experience and grades. Previously many appointments panels took the view that it was wrong for people to reach the top too quickly and you certainly could not manage a mental hospital if you were a general nurse. Increasingly, appointments are made on 'ability to manage' and the apparent ability to do the job, irrespective of experience. This may seem unfair to those who have 'served their time' coming up through the ranks, but senior posts are really more about getting the job done than long-service awards. Certainly this change has increased the career prospects of able and motivated people who have chosen to slow their career progress down because of family or other commitments.

Whilst perhaps comparing unfavourably with private industry in salary and perks, top posts in the NHS are rather more secure (though not totally so!). Rewards can depend on performance. With the schemes of performance-related pay, middle and senior managers will be able to earn up to 20% more than their official salary if they opt into the scheme.

For advice about management you need to talk to middle and senior managers about both the experience you will need and the qualifications and training you would benefit from.

The private sector has expanded to some degree over recent years and may be worthy of consideration. Often units are smaller, competition less in terms of numbers, and with the right temperament you may progress rapidly.

The Royal College of Nursing has a Private Sector Nurse Managers'

Group and you may find its members able to advise you (see addresses in the Appendix of this book).

RESEARCH

There are two main routes into research for nurses.

Medical research

Quite a large number of nurses are employed, whole-time or often on very convenient part-time hours, collecting information for medical research. The work may be fairly routine but involves tact and sympathy in offering explanations or in carrying out interviews or medical investigations.

Sometimes the work is very interesting indeed. Contracts may be short-term so that you need to be clear about duties and conditions.

In a limited number of cases the work can be expanded so that the nurse may study for a degree, but when the work is very routine this is unlikely.

Nursing research

Research undertaken principally by nurses with nursing as its main focus is quite a different matter.

Some eminent nurse researchers began and gained valuable experience assisting medical colleagues before determining that there was a great need for nurses to put their own practice on a scientific footing.

Nursing research is an expanding field, despite relative difficulty in obtaining funds. Most degree courses in nursing have a research element, and whilst the information gained in small studies may have minimal scientific significance, such work often whets the appetite for deeper investigation into an area of practice. For reasons of convenience, much nursing research has studied health service personnel rather than patient problems. There is now a need to pursue clinical or patient-related nursing research in a vigorous but co-ordinated fashion.

To undertake sound research it is usual to have an academic supervisor who will normally be based in a university, a polytechnic or

one of the few nursing research centres. This will often mean registering for a higher degree (MSc, MPhil or PhD). In the 1970s it was possible to do this without necessarily possessing a first (BA or BSc level) degree. However the larger number of people with these qualifications now means that most likely you will need a degree or certainly an advanced diploma in a relevant subject.

A higher degree is usually the way that research skills are gained and achievement of this will give you considerably wider scope for employment in higher education or research generally.

Both the DoH and some regional health authorities allocate money for research scholarships each year. To obtain a scholarship of this type you will need to apply through a recognized academic department of nursing, of which the DoH Research Section publishes an up-dated list each year.

There is no doubt that establishing formal links with an academic department of nursing, perhaps as a student, is a sound first step in becoming a nurse researcher. You may prefer to study another subject of relevance to nursing such as sociology or psychology at basic degree level and go on from there.

There is great need of trained scientists from these disciplines to study nursing. You may find however that competition for post-graduate positions in these better-established disciplines is greater. For example, you may well need to have a good class (at least 2:1) honours degree.

Because of the problems with funding, nursing research is very often a rather temporary activity. Some health authorities fund nursing research posts but quite often the 'research' is small-scale and the individual's time is devoted more to product evaluation and undertaking surveys of a managerial rather than a clinical nature, such as dependency or manpower studies.

A number of challenges face the potential nurse researcher. None of these challenges will prevent the able and motivated individual from achieving their goal. One myth should be dispelled though. Researchers are not at all the super-intelligent mastermind characters you may believe. They are mostly nurses committed to difficult and sometimes tedious work with the goal of improving patient care or the quality of education or management to which we are all exposed.

ENROLLED NURSE OPPORTUNITIES

It is widely believed that enrolled nurses have been misused and abused since their creation in the 1940s. Many have been given responsibilities for which they have not been prepared and there have been very limited or non-existent opportunities for career development. The main opportunities available have been:

1. National Board clinical courses;
2. Conversion to the First Level of the Register;
3. Other courses, e.g. distance learning.

The availability of National Board courses is sadly limited for financial reasons. The longer (six months to a year) courses are very expensive to run. Many enrolled nurses have gained immensely from completing such courses, but it has always seemed, sadly, that many more of these courses are open only to the RGN level nurse.

The National Board careers advisory centre will give details of courses currently available (see the Appendix in this book).

Conversion courses

Since the UKCC suggested the cessation of enrollment training, enrolled nurses have naturally been concerned that their future employment and career prospects were poor.

Governing bodies have given assurances that the EN's future will be protected but they accept that many of those who feel capable of the further study necessary should be allowed the opportunity to 'convert'. Until 1989 three routes were open to the EN wishing to achieve first level registration.

First, she or he could apply to do a three-year training for RGN, RMN, RSCN, etc. Being already qualified, this is obviously wasteful and the very basic parts of the course would be boring or even insulting. It was 'legal' however and some schools of nursing allowed ENs to train in this way. Many nurses were so keen they were prepared to use this route.

Second, a two-year course was available in many schools where the EN would slot into various blocks of an established three-year training and complete the course instead in two years. This route was also a little unsatisfactory as it was often disjointed and the student

had to join several different groups of 'ordinary' students during the course.

In the mid 1980s, a new one-year course was approved and schools of nursing slowly began to adopt it as their preferred 'conversion course'.

Previously entry criteria had been kept strictly at a five 'O' level minimum with special references, but the UKCC then relaxed these criteria too. The problem remained that only 150 or so of these courses existed (1989 figures) and each course took a maximum of 15 students.

Many tens of thousands of enrolled nurses would probably wish to do these courses, so competition for places meant, sadly, that academic qualifications still meant a lot in getting a place despite the UKCC relaxation of the rules.

All is not so bleak, however. National Board initiatives have allowed new 'conversion' courses to be designed on an equally sound but more flexible basis so that they can be run much more cheaply. Students will not have to become full-time students and could perhaps do the course by day or block release from their present employment. Other changes include credit being given for previous study and experience so that individuals may do a shorter course if they have completed National Board courses, A levels, distance learning packs or have other such evidence of recent study or course completion.

Selection for courses may still be quite competitive so there is wisdom in discussing opportunities with your local College of Nursing Principal or the tutor or senior tutor responsible for this area of career development. They should be able to advise you of how to achieve criteria in a planned systematic way.

The UKCC have also allowed a change in the statutory rules to enable enrolled nurses who are at that level because they failed first level CRGN etc) examinations are to be allowed three further attempts. Local colleges of nursing are being encouraged to help individuals to achieve this wherever possible.

It is highly unlikely that enrolled nurses will ever be 'automatically' converted as the Royal College of Nursing has suggested. It is sensible to be realistic and have a goal that over a four- or five-year period you will gain new clinical experience, complete some further study of your choice (guided by your tutor) and work on your technique of applying for courses. Further study may not be officially necessary

(your ENG is enough), but it will make the course and its written assessments easier for you to cope with.

If you have recently returned to nursing after a break, and especially if you are part-time, you may feel at a particular disadvantage. This need not be so provided you plan to gain sound experience and increase your study skills in a systematic way. The new 'flexible' conversion courses may suit part-time employees better and should enable you to achieve your goal eventually. To find out about local conversion courses write to your National Board or a local school of nursing.

Finally, a number of recent developments in distance learning are of great use to the enrolled nurse. These are referred to later in this chapter.

FURTHER STUDY

This section is aimed primarily at first level nurses. Opportunities such as distance learning and some National Board courses are open to both levels of nurse. Nursing degrees and diplomas tend to be open only to first level nurses although this is not true of degrees and diplomas in other subjects such as sociology and psychology or studies with the Open University.

Whilst release and funding for career development can still be difficult to obtain, opportunities for personal and professional development by advanced study have grown immensely in recent years. It is possible here only to give an overview of opportunities so that not all those available will be covered. Your local college of nursing should be able to give you a comprehensive picture of local and regional opportunities and you should make your own enquiries.

Further statutory training

Courses such as these are now mandatory for the Health Visitor Certificate or National Certificate in District Nursing. They are run in colleges of higher education and last one academic year. To get on such a course you will need to apply to your local director of community nursing who will inform you of local entry criteria. You may be required to reach a minimum of five 'O' level equivalents and gain some practical experience in hospital or the community before you can be funded. If successful you will be paid at least a staff nurse salary during the course but you will be expected to work in that area for a period of time subsequently.

Psychiatric nurses do not have to undertake a mandatory qualification to work in the community but these are available both in full-time student form and by a newer distance-learning method. Again you may be required to gain some recent experience before being 'seconded' to such a course by your manager.

First-level nursing courses

You may feel that your return to nursing would be eased by undertaking a course leading to a different part of the Register. There is a great need of trained children's nurses and nurses in the mental handicap field, for example. Certainly your confidence would return much more easily in the role of student and you may find a new field much more interesting. Courses leading from one part of the register (say RMN or RGN) to another (say RSCN or RMNH) are usually of 12–24 months' duration. They are widely available and effectively double your career development opportunities having completed them.

Distance/open learning

New materials on nursing subjects have arrived on the market which have much in common with correspondence courses but have come to be known variously as open or distance learning. The packs can be bought, worked through and then discussed in tutorials at either a local college or school of nursing. Alternatively you can buy the packs and work through them with colleagues or friends.

Much of the material is very readable and up-to-date but completing it has gained little formal recognition. Some packs are now 'validated' by various academic institutions and bodies and this fact will encourage their use.

The Open University has developed a range of courses (not necessarily as part of a degree) which can be taken as home study or as group study in a local study centre. Recent titles include Child Abuse Prevention, Drugs Misuse and Caring for Elderly People. These courses are noted for their high quality and could be a first step toward higher levels of academic study if you wish.

Post-basic courses

A very wide range of National Board approved courses are available in both colleges and schools of nursing. Courses vary in length and content but are broadly in three categories.

1. Short clinical courses e.g. 'Care of patients with AIDS'. These last for two weeks and you will be given a statement of attendance on leaving.
2. Short professional studies courses, e.g. 'Teaching and assessing in clinical practice'. These last for 15–17 days and you will be given a statement of attendance on leaving.
3. Long clinical courses e.g. 'Neurosurgical nursing', 'Intensive care nursing'. These last from six to 12 months, and on completing you will be given a certificate of competence.

Details of all these courses and where they are held are available in your college of nursing or from your National Board.

Diploma courses

For many years the main advanced qualification in nursing was the London University Diploma in Nursing. This currently three-year part-time course may be taken at a large number of colleges of further and higher education throughout the country. The Diploma has been developed to cover important nursing issues, research and some basic social and biological sciences. It has suffered slightly in competition with degree courses since these confer higher academic status for often a very similar standard of work. Degrees are frequently of four years' part-time duration rather than three.

Colleges are also planning to offer the Diploma over a more manageable two-year programme but at the same standard or may offer a different two-year Diploma course (CNAA).

Some centres will soon be ready to offer a top-up course to degree level over one year full-time or two years part-time. (An experimental course in London is already running successfully.)

If you are thinking of this level of education then do also investigate degree opportunities and make a choice based on the advice your local college of nursing may give. Both levels have much to offer.

Degree courses

The most widely available degree courses are those offered by the Open University. Although some shorter courses are designed for nurses, there are no Open University degrees in nursing as yet.

Other highly relevant subjects are available however and you can build your degree in units called 'credits' from a number of different subject areas. Advantages are the flexibility of pace and the first-come first-served philosophy of the degree. That is, you do not need formal qualifications to get a place on the degree, but you need to apply early. Home study, 6 a.m. television and radio programmes and occasional summer workshops do not suit everyone as a method of study. The standard of work is however high and your degree will give you considerable critical and analytical skills.

A large number of part-time nursing degree courses have developed in recent years. Although officially you should have evidence of academic ability such as 'A' levels, students over 25 are often treated flexibly as mature entry candidates and allowed to demonstrate their potential by interview, aptitude test or written work.

Courses are usually of four or five years' duration but you may be exempted from certain elements if you possess other advanced nursing qualifications.

Some courses are very flexible, allowing attendance at lectures in evenings and afternoons to fit in with domestic or work commitments. In some cases degrees can be built up in modules or units so that you can proceed at your own pace. Examinations, as with the Diploma and an increasing number of basic nursing courses is usually by a mixture of course work (essays, projects etc.) and traditional written examinations.

As we have pointed out elsewhere, this level of higher education is virtually an essential part of advanced career development in teaching, management or in the clinical or research areas. Certainly nurses prepared at this level are better able to negotiate, liaise and if necessary compete with other health professionals who are now prepared on degree courses.

Full-time degrees are available in nursing which commonly last four years. Usually they include a course leading to registration, a degree and sometimes a community nursing certificate. Full-time degrees are available in other relevant subjects too, but secondment to any full-time basic degree course is unlikely. If you can manage to support yourself on a local authority mature students' grant you may enjoy the unique experience of going full-time to university for three years. You might even earn extra cash as a bank or agency nurse during the lengthy university vacations.

Whatever you do it is worth talking over your plans with an experienced local nurse teacher so that you do not waste time going down blind alleys or completing courses that may be less useful than others that may be available. You should also get good advice about the secondment, funding and other support that we briefly go on to discuss.

PRACTICAL POINTS

To pursue your career by means of courses of higher education you will need to:

1. be selected perhaps against competition;
2. identify the source of funds;

3. identify the time needed and domestic arrangements necessary to cope – release in work time may or may not be available.

Space prevents detailed discussion of these issues here but we will make one or two suggestions and refer you to useful reading.

Selection is a matter of presenting letters, application forms or a curriculum vitae in immaculate condition, beautifully set out with a page or two of good reasons why you ought to be doing this course or that job. Your piece of paper must stand out relative to others in order to avoid the selectors' 'unsucessful' pile. Talk an experienced manager or teacher into advising you on this.

Interview technique is also important and can be partly learned by practice and good feedback. The chapter on interview technique in Jill Baker's book (see Further reading) may be helpful. Going to see the course leader for an informal visit often helps. You can give a good impression in a less formal interview which the selectors may find hard to ignore when the real interview comes along. (Foot in the door technique.)

Funding is often hard to obtain, and indeed varies from place to place. Tutors' courses are partly or wholly funded centrally by National Boards, as are part-time degrees leading to tutor registration.

For other part-time courses funds and release in work time depend on availability, workloads, and perhaps the commitment of your managers to such things. Sometimes a bargain can be struck, with you offering to find fees if you can be released for the time off. Fees can be hundreds of pounds so you will need to budget for them each year. Help with fees can sometimes be gained from scholarships of which the Royal College of Nursing publish a list.

Many managers will endeavour to find funds to help with your studies provided they feel they get their money's worth from you. It's partly about establishing relationships.

National Board courses are usually funded by your employer so that provided you are awarded a place, all should be plain sailing. You need to check your contractual position if seconded to a course. Are you to return to your present post or a different one, or is your contract temporary and only for the duration of the course?

Despite the odd scare, very few nurses are or need remain unemployed for long. Career development by education can only enhance your prospects long-term. It is usually a sound investment.

FURTHER READING

Baker, J. (1988) *What Next? Post-basic Opportunities for Nurses*, Macmillan Education, Basingstoke.

Appendix

USEFUL ADDRESSES

National bodies

Department of Education and Science
Government Buildings
Honeypot Lane
Stanmore
Middlesex HA7 1AZ
Tel.: 081–952 2366

Department of Health and Social Security
Research Section
Alexander Fleming House
Elephant and Castle
London SE1 6TE
Tel.: 071–210 3000

English National Board for Nursing, Midwifery and Health Visiting
Victory House
170 Tottenham Court Road
London W1P 0HA
Tel.: 071–388 3131

National Board for Nursing, Midwifery and Health Visiting for Northern Ireland
RAC House
79 Chichester Street
Belfast BT1 4JE
Tel.: 0232 238152

National Board for Nursing, Midwifery and Health Visiting for Scotland
22 Queen Street
Edinburgh EH2 1JX
Tel.: 031–226 7371

The Open College (Marketing Services)
Third Floor
St James's Buildings
Oxford Street
Manchester M1 6FQ

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC)
23 Portland Place
London W1N 3AF
Tel.: 071–388 3131

Welsh National Board for Nursing, Midwifery and Health Visiting
Floor 13
Pearl Assurance House
Greyfriars Road
Cardiff CF1 3AG
Tel.: 0222 395535

Further education

Continuing Nurse Education Programme
26 Danbury Street
London N1 8JU

Distance Learning Centre
South Bank Polytechnic
PO Box 310
London SW4 9RZ

English National Board Careers Advisory Centre
PO Box 356
Sheffield S8 0SJ

Health Visitors' Association
36 Eccleston Square
London SW1V 1PF

Institute of Health Service Managers
75 Portland Place
London W1N 4AN

Open University
Walton Hall
Milton Keynes
MK7 6AA

Royal College of Nursing
20 Cavendish Square
London W1M 0AB

Royal College of Midwives
15 Mansfield Street
London W1M 0BE

Society for Tissue Viability
Wessex Rehabilitation Unit
Oddstock Hospital
Salisbury
Wiltshire SP2 8BJ

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