LEARNING CONTRACTS, THE TRAINED NURSE AND THE IMPLEMENTATION OF THE NURSING PROCESS: COMPARATIVE CASE STUDIES IN THE MANAGEMENT OF KNOWLEDGE AND CHANGE IN NURSING PRACTICE.

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Abstract

The adoption of a "nursing" model in practice and education is discussed in relation to the socio-cultural and organisational factors which have shaped the traditional care giver role. Issues arising out of this change in the "practitioner" role are identified. The changing roles of the nurse and the teacher are described and discussed. The move toward an autonomous role for the clinical nurse is seen to require a change in the nurse-teacher relationship. Learning contracts are perceived to be a vehicle for implementing the new roles of the nurse and the teacher.

The writer in the role of an observer-who-participates negotiates learning contracts with nurses working in four wards of four hospitals in one Health Authority. The clinical areas are described as one community hospital, one long-stay geriatric unit, one psychiatric rehabilitation unit and one psycho-geriatric assessment unit. Thus, community, general and psychiatric nursing are included in this study of the management of knowledge and change in nursing practice.

A variety of data collecting techniques are employed to give an illuminative evaluation of the outcomes of the learning contracts and the effect formal and non-formal education have on the implementation of the nursing process. The formal approach to education takes the form of the Diploma in Nursing (London University, Old and New Regulations) and the Joint Board of Clinical Nursing Studies Course in Care of the Elderly (940/941). The non-formal inputs are the clinically based learning contracts negotiated with the nurses in the four clinical areas.

The data are presented as comparative case studies which record the organisational policies adopted by the Health Authority and the outcomes of the learning contracts in the four clinical areas. From the case studies two "themes" emerge: that of role conflict and the problems of assessing the degree of change achieved.

A theoretical framework of "codes and control" is developed from that originally presented by Bernstein (1975) for general education and adapted to health care organisations by Beattie and Durguerian (1980). This framework is used to interpret the changing roles of the nurse and the teacher, and the division of labour between the professional nurse and the woman in her own home. It is argued that the implementation of the "practitioner" role demands a redistribution of power and control in favour of the patient and the nurse vis-a-vis the manager, the teacher and the doctor. Further, in addition to the teacher's and the clinical nurse's dependence on the manager for the resources required to implement the desired change in practice, nurse-practitioners are dependent on the knowledge held by doctors, clinical psychologists and occupational therapists to implement the nursing process. In the presence of an inadequate basic education programme and a limited access to continuing education, the data suggest that the literature on the nursing process and the key documents distributed by the R.C.N. (1981) and the U.K.C.C. (1982) are making demands upon the clinical nurse with which she is unable and sometimes unwilling, to comply.

It is argued that a "codes and control" framework identifies the complexities of the change toward the "practitioner" role and thereby, clarifies the existing role. In this way concepts of care held by the nursing staff are identified which in turn, can be utilised in model building to promote a "grounded" theory of nursing in the cultural and organisational context of nursing in the United Kingdom. Thus the use of learning contracts which

identify the nurse's need for continuing education, in conjunction with an action research mode utilising case studies, can assist in the development of a theory for nursing practice and education. In this way the theory for nursing has its basis in clinical practice, is refined through research, and is returned to practice through the education programme. It is therefore argued that learning contracts have a useful role to play in bridging the gap between theory and practice in the school of nursing and institutions of higher education.

The data recorded in the case studies suggest that in the absence of a redistribution of power and control and/or supportive education programmes during and after the period of transition between the old and new roles, the implementation of the nursing process will merely continue the existing Nightingale strategies. The formalisation of the present problem-solving approach to care in the form of care plans will not necessarily promote the "practitioner" role desired by the profession. Instead the clinical role will continue to be defined by physicians and management will consolidate its position in the hierarchy of the bureaucratic organisation of the National Health Service. This will not be challenged by nurses in that it will continue the existing strategy of "reifying" the presence of the "professional" nurse and in particular, her position in institutions of higher education. Such a strategy although satisfying in terms of status will lead to the clinical nurse being asked to implement a role with which she is unable to comply. This in turn will lead to role conflict and a greater division between the "theory" of the school and the "reality" of the ward.

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CHAPTER ONE

Towards a nursing model for care: implementing national, organisational and professional policies for change in practice and education

Introduction:

The present discussion on the changing role of the nurse stems from the key documents on nursing education and the structure of the nursing organisation presented by the General Nursing Council for England and Wales (G.N.C., 1977), the Royal College of Nursing (R.C.N., 1981) and the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (U.K.C.C., 1982). All of these documents have recommended the adoption of a more "patient-centred" approach to care as the basis for practice and education and the promotion of a clinical career structure based on the "practitioner" role of the nurse (G.N.C., 1977; R.C.N., 1981; U.K.C.C., 1982).

Both the R.C.N. (1981) and the U.K.C.C. (1982) acknowledged the gap between the existing and new roles of the nurse and the need for supportive education programmes in the period of transition between the present and future roles. This move toward an alternative mode of practice raises issues concerning the introduction of change in a highly structured and rigid bureaucracy such as nursing, as well as the changes in attitudes held by the nurse towards the patient and her colleagues (Ashworth, Castledine and McFarlane, 1978; Webb, 1981). These writers in their separate arguments have highlighted the need for "risk-taking" by managers and practitioners should an attempt be made to implement the proposed change in practice.

The ability to engage in "risk-taking" and the degree of success achieved in implementing change is linked by Towell (1975) to the manager's ability to create a climate of flexibility, in which open channels of communication permit the diffusion of the innovation throughout the organisation. Nursing organisations however, have in the past promoted a structure in which power has been positional, rather than personal (Towell, 1975), decision-making has been deferred upwards (Davies, 1976), and a dependency on the medical profession has been encouraged (Abel-Smith, 1960). Thus problems may arise if an attempt is made to introduce a mode of practice which challenges the existing social, organisational and professional relationships held by the nurse vis-a-vis the manager, the doctor and the patient (see Part Three, Chapter Ten, pp. 142).

In adopting the nursing process as the basis for practice and the curricula of existing education programmes the G.N.C. (1977), the R.C.N. (1981), and the U.K.C.C.(1982), appear to have underestimated the social, organisational and professional strategies which have shaped the traditional nursing role in society and the nursing organisation. Little attention has been paid to the control exerted by the medical profession over job content and the education programme, through the reliance on the medical model as the basis for practice and education.

Social issues arising out of the redefinition of the nursing role:

The role of the nurse is inevitably linked to the role and status of women, the role of medicine in society and hence, the division of labour between the sexes and between the nurse and the patient (Davies, 1979). Given that the sick role adopted by the patient is culturally and socially defined (Cox and Mead, 1975; Tuckett, 1977), it may be argued that the nurse is not in a position to redefine her role in isolation from a corresponding

redefinition of the patient's role by the society in which they live. Thus the introduction of the nursing process, in which the nurse redefines the patient role from that of "passive recipient" to that of "active participant", may be a source of conflict between the patient and the nurse and between members of the work group, if the individuals concerned, hold different perceptions of the nursing and patient roles than those persons wishing to implement the new mode of practice.

The social issues to which this study addresses itself and for which the conceptual frameworks presented in Part Three (Chapter Ten) offer an explanation of the complexities of the changes involved in the adoption of the nursing process by the nursing organisation, may be summarised as follows: the power and control exerted by central government over the availability of resources (Abel-Smith, 1960); the power the medical profession exercises over the patient, the role and education of the nurse, and its wider social role (Freidson, 1970); the strategies adopted by the Matrons of the major teaching hospitals and their dependence on a constant supply of cheap female labour, in the form of student nurses, to staff the wards (Baly, 1980); the allocation of roles and hence, employment to males and females by a dualist labour market (Greenleaf, 1978); and a division of labour between the nurse and the woman in her own home which appears to be founded on social, rather than technical factors (Davies, 1979).

It may be argued that the attempt to promote the autonomous "practitioner" role contained in the key documents presented by the G.N.C. (1977), the R.C.N. (1981), and the U.K.C.C. (1982), is an attempt to introduce organisational change from a position of social and occupational weakness and that this alone will influence the degree of success achieved.

Organisational issues arising out of the redefinition of the nursing role:

The literature on the nursing process highlights the problem-solving nature of the process. The implementation of this problem-solving process, as a means of redefining the patient and nursing roles, raises questions as to whether the introduction of formalised care plans will merely promote the existing routinisation of care and not the redefinition of roles (Kratz, 1977).

If the introduction of planned care is confined to the existing task allocated routinisation of care, then the hoped for patient participation and hence, improved standards of care may not occur, nor will the hoped for autonomous role automatically follow. The nursing process will merely become the successor to "total patient care" and as Bendall (1975) has argued,the schism between theory and practice will continue to disillusion both student and trained nurses.

It may be argued that in a rigidly structured bureaucracy such as nursing the degree of role redefinition required to implement the desired autonomous "practitioner" role, will be resisted by those in positions of authority when existing role boundaries are challenged. The R.C.N. Report (1981) already contains an example in its suggested future structure of the nursing organisation. The roles of the "Primary Nurse, Sister I and Sister II" appear to be replacing old organisational titles with new and not as the R.C.N. (1981) attempts to argue, devolving the power to control the work content down to the bed-side. This hidden strategy supporting the present investment of power (Webb, 1981) in the position held, is a possible source of conflict for any nurse attempting to implement the desired "practitioner"role.

Educational issues arising from the redefinition of the nursing role:

The R.C.N. (1981) and the U.K.C.C.(1982) in common with the earlier Briggs Report (1972) perceived the need for a continuing education programme to support the nurse at all levels of her career. However, no attention has been paid to the academic credibility of the content of the basic and post-basic courses comprising this continuing education programme. Further, no commment is available on the R.C.N. (1981) or U.K.C.C. (1982) perceptions of the priority of implementing one course over another, the sequence and/or level of each continuing education programme, or whether or not a nationally recognised academic validating body is to be approached to approve the curricula offered.

In order that the nurse-teacher can support the clinical nurse in her attempt to introduce the new mode of practice, the nurse-teacher must first understand that new role, how it differs from the existing one, and how it changes his/her own role vis-a-vis the basic and post-basic student. Further any redefinition of the practitioner's and teacher's roles necessitates a review of the tasks associated with these roles, as well as a renegotiation of the relationships held.

In the light of existing research data on the correlation of theory to practice in present schools of nursing (Dodd, 1973; Hunt, 1974; Bendall, 1975), the proposed change in the education of the nurse not only involves the content of what is taught, but also the context in which nursing practice is taught and the strategies used to teach the theory of nursing. In addition, the school of nursing must develop its curricula on an identified theory/ies of nursing, rather than the existing medical model.

The proposed change in practice therefore, raises questions about the preparation of the nurse-teacher for his/her new role as well as the preparation of new nurse-teachers in existing teacher training programmes. It is argued that the traditional teacher employed in the school of nursing will require retraining in programmes which offer a detailed study of the nursing role before they can help the clinical nurse in her adoption of the new role. Further, nurse-teachers are themselves the products of the traditional school of nursing and they themselves may share the traditional attitudes towards the patient, the distribution of the workload, as well as the schism in the student's perception of the relationship between theory and practice described by Bendall (1975).

It may also be argued that the limited education offered to student-nurses and their teachers has failed to develop in them the new skills required of the "practitioner" nurse. The handing over of the learning programme to other occupational groups such as clinical psychologists, who do have the requisite skills, may simply transfer medicine's traditional control over the development of the nursing role to yet another non-nursing group. Thus, the development of an educational programme to support the change from the existing to new roles requires the creation of a programme, in which the knowledge base and skills required to implement the "practitioner" role are presented as an integrated and applied course of study. Failure to achieve this might result in the recreation of the present dichotomy between theory and practice, in which the "idealised" role of the nurse is at variance with that experienced by the nurse in daily practice.

It may be argued that the G.N.C. (1977), the R.C.N. (1981), and the U.K.C.C. (1982), have discussed the implementation of the nursing process in too narrow and simplistic a manner. The social, organisational, and educational

issues arising out of this change in occupational strategy and contained in the definition of the "practitioner" role (Davies, 1977); the corresponding change in the role of the teacher and the emphasis on continuing education (U.K.C.C., 1982); together with the challenge to medicine's traditional power over the development of the nursing role, are those to which this study addresses itself and for which the conceptual frameworks developed in Part Three (Chapter Ten) offer explanations of the challenge to the existing distribution of power and control inherent in the implementation of the nursing process. As a teacher in the post-basic section of an Area School of Nursing, the writer was ideally placed to observe and assist the efforts made by a group of nurses employed in four clinical areas of four hospitals in one Health Authority. These clinical areas may be classified as one community hospital, one long-stay geriatric ward, one psychiatric rehabilitation unit and one psycho-geriatric assessment unit. All of these units provided institutionalised care to an ageing population. In the remainder of this chapter the writer records the overall strategy adopted by the Health Authority to implement the nursing process as the preferred mode of practice.

The study: one Health Authority's attempts to implement change in nursing practice:

The recommendations put forward by the G.N.C. (1977) and its policy for adopting the nursing process as the basis for education and practice, were discussed by the members of the senior nursing management team at a study day conducted by the Area Nurse (Clinical Practice) and three nurse teachers, including the writer, from the school of nursing. This seminar had been presented in response to an identified priority given to this topic (nursing process) by the members of the nursing hierarchy, the school of nursing and individual members of the clinical areas. This seminar was held on the 9th January 1981.

The purpose of this seminar was to convey to those nurses present the concepts underlying the nursing process (Discussion document, 5.1.81). Support for the change towards this "patient-centred" approach to care was given by the then Area Nursing Officer (now called the District Nursing Officer), the Director of Nursing Education and the Nursing Policy Group (Area level). This support was recorded in the minutes of a meeting held by the Nursing Policy Group (N.P.G.) on the 16th February 1981.

In the course of the seminar, the managers were asked to consult with the members of their clinical areas in order to identify those nurses wishing to implement the nursing process. In this way "pilot" areas in which the new clinical role could be implemented, were identified by the ward based nurses. It was also suggested that the seminar could provide an opportunity for the senior members of the management team to identify topics for future study days and so participate in the planning of an ongoing education programme based on their identified needs for continuing education.

This first seminar for senior managers was reinforced by a second one aimed specifically at the teachers from the Area school of nursing and therefore, was centred on the implications for the curriculum offered to students and contained in the adoption of a nursing model for care. Again this seminar was perceived by the Director of Nursing Education and the three nurse-teachers involved in the original seminar, as a means of initiating a continuing education programme for nurse-teachers.

A three day work shop for nursing officers had also been planned. This however, failed to attract much attention from this grade of nurse. Only three nursing officers bothered to submit topics for discussion and no record can be found to suggest that this grade of nurse perceived continuing education as a major prerequisite to working

as a nursing officer.

The response to the request for pilot areas fared better and the minutes of a meeting held by the Area Nurse (Clinical Practice) and the three nurse-teachers, including the writer, identifies the selection of twelve clinical areas wishing to implement the nursing process (Nursing Process Project minutes, 4.2.81).

These minutes also identify the creation of a "core resource team" consisting of the Area Nurse (Clinical Practice) and the three nurse-teachers involved in the seminars presented to the managers and the teachers. This resource team was presented as a central base to which nurses wishing to implement the proposed change could refer to for help and/or guidance.

The above mentioned minutes refer to the allocation of two general and two psychiatric wards to the writer. It was suggested by the core resource team members that the original strategy presented to the senior management team should be pursued. This strategy involved the establishing of direct contact between the member of the core resource team and the members of the clinical areas allocated to them. Each pilot area was asked to nominate a key member, who, together with the members of the core resource team, made up the Nursing Process Development Group (N.P.D.G.). The purpose of forming such a group was to establish a working relationship between members of different clinical backgrounds, in which problems met and progress made, could be discussed. This group met for the first time on the 18th March 1981. Although this group had the personal support of the District Nursing Officer, it did not have the organisational power to allocate or reallocate organisational resources to implement the nursing process. Thus the group did not form part of the organisational structure of the National Health Service and its authority stemmed from the District

Nursing Officer's personal, rather than positional power.

The records produced by the group (N.P.D.G. minutes, 25.6.81) outline the discussion held by members of the group and the District Nursing Officer and the Area Nurse (Manpower Planning). The focus of this discussion was the identified need for manpower, financial, material and educational resources to implement the nursing process. The minutes reveal the District Nursing Officer's recommendation that the Nursing Policy Group (N.P.G.) was the most likely source of funding. Thus she acknowledged the group's dependence on the management team for resources to implement national, organisational and professional policies. Again this dependency of the clinical nurse on the nursing hierarchy for resources to implement the preferred clinical role is the sort of issue involved in the change of occupational strategy contained in the move toward a nursing model for practice and education (Davies, 1976), to which this study addresses itself.

At the meeting held on the 25th June 1981, the group members reaffirmed their purpose to:

> "- advise, monitor and co-ordinate the changes effected by the nursing staff within the pilot areas.
> - identify the common needs of the pilot areas and to assist in meeting those needs.
> - develop a nursing record format appropriate for the particular areas.
> - develop skills including assessment skills, identification of nursing problems, writing nursing care plans and evaluating care.
> - provide a mutual support system for all learners involved in the project."
>
> (Comely, 1981, p. 3).

These same minutes identify the group's preoccupation with its lack of resources, a lack of commitment towards group goals, the creation of new nursing records and the production of a literature review for members of the clinical areas. The group also set "deadlines" for the implementation of a common format to be used throughout

the Health Authority. These deadlines were set at:

> "- initial local (pilot area) selection of a process format by the end of September 1981.
> - selection of a 'common' format which might be used in all nursing areas by the end of January 1982.
> - final trials of a standardised format which could be adopted by the Area Health Authority by April 1982."
>
> (N.P.D.G., 25.6.81, p. 2).

The allocation of four clinical areas to the writer facilitated his entry to these areas in order to describe the attempts to promote the practitioner role described by the G.N.C.(1977), the R.C.N. (1981) and the U.K.C.C. (1982). These pilot areas were located in four different hospitals in one Health Authority in the Midlands. All of these units provided institutionalised care to an ageing population drawn from a wide range of social backgrounds.

These clinical areas may be classified as: one community hospital, one long-stay geriatric ward, one psychiatric rehabilitation unit and one psycho-geriatric assessment unit. Thus the setting up of the Nursing Process Development Group (N.P.D.G.) as an attempt by one Health Authority to implement national policies for change, provided the writer with an opportunity to study the management of that change in both general and psychiatric nursing organisations.

As a member of the school of nursing's post-basic education team, the writer was responsible for the Joint Board of Clinical Nursing Studies (J.B.C.N.S.) courses in Care of the Elderly (940/941), Anaesthetic Nursing, Accident and Emergency Nursing, Special Care of the New Born, and the non-statutory › Opthalmic Nursing course. Further the writer had inputs to the Diploma in Nursing (London University, Old and New Regulations).

As the course co-ordinator for the Diploma in Nursing (London University, New Regulations), the writer was involved in the curriculum development of a course of study offering an integrated learning programme and presented by the school of nursing and the local College of Further Education. It also presented the school of nursing with an opportunity to create a learning programme based on a nursing model for care, in which the focus of the nurse's attention is the individual's needs for nursing care and the nurse's contribution to the overall goals of the health care team.

This change in the role of the nurse and the corresponding change in the role of the teacher raises questions which this study attempts to clarify and to which the theoretical frameworks presented in the third part of the thesis address themselves. Thus the writer's post of nurse-teacher not only included formal and non-formal educational programmes, but also provided the vehicle for creating a role for the teacher as a researcher into the continuing educational needs of trained staff, in order to support the clinical nurse's attempt to implement the nursing process.

At the beginning of this attempt to implement national and professional policies for change, the records produced by the Nursing Process Development Group identified the control exerted by the management team over the resources needed to achieve the preset goals. Further, there appeared to be a lack of support from nurse-managers for continuing education and that this lack of support might imply that these nurses did not perceive the need for continuing education to support the new role (Kratz, 1971).

At the beginning of the study there were a number of issues which could determine the outcome of the change process in favour of a maintenance of the status quo. To balance this apparently negative effect, there was

the positive enthusiasm of the individuals directly involved in the implementation of the nursing process, the active participation of the clinical nurses in selecting the pilot areas, and the support, albeit personal, of the Director of Nursing Education and the District Nursing Officer.

To support the change in practice and the role of the teacher, the writer adopted a teaching strategy based on a contractual relationship between the teacher and the student. This approach had been tested in an earlier study by the writer (Keyzer, 1980). The findings of this study suggested that trained nurses found learning contracts an acceptable form of non-formal in-service education. Factors which influenced the outcomes of the contracts were identified as follows: the ward sister's perception of the benefits of education for clinical nurses, group cohesion, the night shift worker's lack of access to continuing education, and the students' active participation in all aspects of the learning process. Thus it was argued that learning contracts facilitated the concepts underlying the nursing process and were a possible vehicle for its implementation.

The present study permitted the extension of an earlier one in order to clarify organisational variables which promote or inhibit the effect education has on the implementation of the nursing process. The writer therefore, negotiated group contracts with the clinical staff employed in the community hospital, the long-stay geriatric ward, the psychiatric rehabilitation unit and the psycho-geriatric assessment unit.

To maintain anonymity for those persons involved in the learning contracts and the change process, no reference will be made to the names of individuals, hospitals or clinical areas described in this study. It would be possible to identify the persons and places involved in this study of "real" groups working in their "natural"

surroundings and this, the writer believes, is sufficient reason to protect the identity of those persons involved in the implementation of the proposed change in practice.

The study is therefore, in the action research mode in which the writer in his dual roles of teacher-researcher negotiated learning contracts with the nurses employed in four clinical areas offering institutionalised care to an ageing population, as an attempt to implement national policies for changing the role of the nurse and the education offered to her. It is an attempt by one nurse-teacher employed in a school of nursing to record the implementation of a national policy aimed at a redefinition of the clinical role of the nurse and a corresponding redefinition of the role of the teacher.

CHAPTER TWO

The changing role of the nurse: a change in "occupational" and "organisational" strategies

Introduction:

In Chapter One it was suggested that the implementation of the nursing process demanded a redefinition of the nursing role. The R.C.N. (1981) and the U.K.C.C. (1982) appear to suggest that they are defining the role through the adoption of the Henderson concepts (1966). Although the present role may not have been stated in a written philosophy or concepts such as that given by Henderson, it does not follow that the role has not been defined. In this chapter the writer will argue that the implementation of the nursing process is an attempt to redefine the existing role, as well as an attempt to overcome the existing schism between "nursing as it ought to be" and "nursing as it is".

The Briggs Report (1972) described society's outward dependence on the service provided by nursing and midwifery as the major "caring" profession, but made no effort to define the role except to identify that the majority of care was carried out by women in their own homes. In doing so the Report drew attention to the close relationship between the "professional" role of the nurse and the role and status of women in society.

In the absence of an overt definition of the nursing role recognised by the profession at a national level, which in part is due to the variety of contexts in which nurses work (McFarlane, 1970), the G.N.C. (1977), the R.C.N. (1981), and the U.K.C.C. (1982), have drawn on the definition provided by Henderson (1966). She perceived the nursing role as one in which the nurse assisted the individual in daily living activities normally performed unaided if there was the will, or knowledge to do so. Thus the

role is described in terms which suggest that of a practitioner who diagnoses, prescribes, implements, monitors and evaluates nursing care based on the individual's perceived needs for care.

Central to this definition is the belief in the patient's right to be an active participant in all aspects of the therapeutic regime designed by the health care team. King (1971) supports this stance and she describes a multidimensional role for the nurse which involves individuals and groups in social systems. Nursing practice is she states, based on an understanding of man from conception to old age, in health and in illness.

Hence an understanding of how the family and other social systems impinge on health and health care are essential facts in the nurse's frame of reference. Davies (1979) argues that of the three major health care roles of the doctor, the nurse and the patient, an understanding of the patient role is central to the understanding of the two other "occupational" roles.

Tuckett (1975) in a general discussion on the patient role outlines an acknowledgement of a network of individuals that form the personal community of a given member of society. This implies that there exists for every member of the family, a multi-person care giving group in which the nurse is but one resource available to the patient. This concept is supported by Bauwens (1978) who draws attention to the changing patterns of care of self and others that accompanies the different developmental stages in the life of human beings.

It may be argued that the model for care has moved away from the "illness" based framework traditionally employed by nurses working in the hospital and community setting (Freidson, 1970). Orem (1980) underlined the individual's need for self care activities and the nurse's role in the provision and management of these activities

on a continuous basis to sustain health, to cope with illness and to aid recovery. To achieve this Orem suggests a contractual nurse-patient relationship in which the degree to which the nurse takes over these self-care activities is negotiated by the participants.

Roy and Roberts (1981) suggest that the goal of these nursing actions is to assist the individual to enhance his position on the health-illness continuum by bringing about an adaptive state in the patient which, in turn, frees him to respond to other stimuli. This, Roy believes, differentiates the roles of the nurse and the doctor who

> "focusses on stimuli which determine the patient's position on the continuum ... on the disease, and his goal is to move the patient along the continuum from illness to health. Nursing focusses on the patient because of his position on the continuum".
>
> (Roy Sr C., in "Nursing Outlook", Volume 18, Number 3, March, 1970, pp. 42-45).

This differentiation Roy argues, defines the role of the nurse as one of an independent practitioner contributing to the goals of the health care team.

In proposing a nursing theory for practice and education Roy identifies nursing's previous dependence on the medical diagnosis and treatment, including the study of localised pathology, as the framework for education and practice (medical model).

Thus this challenge to medical domination over the content of the nursing curriculum and job content (Davies, 1977) is one source which identifies the redefinition of the traditional nursing role contained in the concepts underlying the nursing process.

The "organisational" role of the nurse:

The adoption of the "practitioner" role and the nursing process as the vehicle for implementing it by the R.C.N. (1981) and the U.K.C.C. (1982), appears to be putting an emphasis on an aspect of the role hitherto ignored by British nurses. The Nightingale reforms which led to the creation of the present "organisational" nursing role as a transmitter of medicine's power in the management of the sick poor has been described and discussed by Abel-Smith (1960) and Davies (1980). Both of these writers identify the nursing role as that belonging to two distinct social classes. In the Voluntary and Poor Law hospitals the clinical role was given over to members of the "domestic servant" classes and that of Matron was confined to the upper "middle" class. Abel-Smith has argued that the clinical role has continued to be given over to untrained staff. Davies supports the hypothesis that the initial strategies implemented in the Nightingale hospital have continued to the present day and can be found in the recommendations of the Salmon Report (1966).

Further, Abel-Smith has argued that nurses have used their patients and through emotive arguments, have maintained their social and organisational status. To support this, he cites Bedford-Fenwick's rationale for registration.

The maintenance of the nursing role as one belonging to women is also identified by Abel-Smith and he outlines the discrimination against males taking up the role. Anderson (1973) similarly describes the stigmatisation of male nurses by their nursing and medical colleagues. These writers and the Briggs Report (1972) cited earlier, appear to support Davies (1979) in her hypothesis that the organisational role of the nurse is determined by social, rather than technical factors.

As a predominantly female role, nursing is disadvantaged when compared with the mainly male occupation of medicine.

The traditional apprenticeship training offered by schools of nursing provide the student nurse with an education programme that has, as its only standard of performance, a professional certificate of proficiency, rather than an academic award. The only academic qualification open to basic nursing students are those degree programmes offered by Polytechnics and Universities. This, however, creates an even greater confusion in that, there exists in the United Kingdom a continuum of basic qualifications preparing the first line practitioner ranging from a non academic qualification to an honours degree. Further, the presence of a second level of basic nurse, the enrolled nurse, whose role in practice overlaps that of the registered nurse (McFarlane, 1970; Anderson, 1973), merely adds to the confusion.

The high turn over of staff in the ward area as student nurses move from one clinical area to another creates an unstable environment, in which the trained nurse is prevented from gaining the sort of clinical expertise that would give her power in the ward on par with that of the medical consultant (Baly, 1980). Within the clinical areas the bedside care is, as has already been stated, given over to the untrained student nurse and the nursing auxiliary (Abel-Smith, 1960; Davies, 1977).

The recommendations of the Briggs Report (1972) for a continuing education programme to support the nurse throughout her career and the repetition of that call for further education by the U.K.C.C. (1982) ten (10) years later, all point to the low priority given to the educational needs of a predominantly female profession. Further, unlike male professions there is a limited career structure in nursing and that which does exist has only been available since the Salmon Report in 1966. This limited career structure is confined to management and unlike their medical colleagues, nurses do not enjoy the opportunity to develop their clinical skills in nursing specialities to become clinical nurse specialists. Although

the R.C.N. (1981) perceived this to be a desirable role, the existing preference for the managerial role may inhibit the realisation of the clinical practitioner role (Davies, 1977).

Theory and practice: the schism between nursing "as it ought to be" and nursing "as it is":

Previous attempts to introduce change into the nurse-patient relationship and the greater involvement of the patient and his relatives in the provision of care, have not always met with the degree of success hoped for by the innovators. An example of this is contained in the study carried out by Stacey et al (1970) into the care of children in hospital after the implementation of the recommendations of the Platt Committee (1959). The Report suggested that the parents of hospitalised children should be given an active role in the care of these children during their period of hospitalisation. These writers state that:

> "... it is not simply that the nurse needs to be retrained for these new arrangements. Her whole role and the tasks she is expected to perform must be redefined... special training courses... had they preceded the attempt to implement Platt it is possible that the resistance to meet the new arrangements might have been less great".
>
> (Stacey, Dearden, Pill and Robinson, 1970, p. 152)

Thus the writers perceived the need for supportive education programmes in an attempt to implement change in the organisational nursing role when that change challenged existing role boundaries. Similarly, they draw attention to the need to ensure that all of the members of the nurse's role set understand the new roles of the patient, his relatives and the nurse, and how that new role differs from the old one. It may be argued that the supportive education programme not only includes all members of the clinical nursing staff, but extends to include the

managers and the school of nursing.

The need for education to support the proposed change towards a more patient orientated mode of practice is obtained from the studies into the nurse-patient relationship carried out by Main (1956), Menzies (1970) and Miller and Gwynne (1976). These authors in their separate studies have shown how the tensions and conflicts involved in nursing lead to the collusive generation of nursing behaviour that is marked by its defensive nature, its avoidance where possible, or denial, of the emotional demands of the task at hand. Thus it may be argued that the traditional task-orientated approach to care was a deliberate attempt to protect the clinical practitioner from the emotional trauma of having to work in an environment that created risks to her own emotional well-being (Menzies, 1970).

It may be argued that to change the existing work practices requires a corresponding change in the defense systems which protect the staff from these emotional trauma and that failure to give the staff new means of coping with these incidents may impede the success of the change process. It may be argued as Towell (1975) and Towell and Harries (1979) do that the success of any change involves the creation of an organisational climate where openness and experience is valued and decentralisation of control is present. In a rigidly structured bureaucracy such as nursing, such change requires a degree of "risk-taking" by the participants. This issue is discussed in greater detail in the following chapter, with particular reference to the choice of strategy most likely to achieve the desired change in practice and attitudes (see Chapter Three).

The nursing process: theory and practice:

In order to translate the theory for practice underlying the nursing process, the nurse must be able to apply her knowledge and skills to patient care in a systematic and

organised manner. Within the traditional routinsation of care, the planning of care has been given little attention by practitioners, managers, or teachers of nurses. Clarke (1978) in a review of the research studies carried out by Goddard, McFarlane, Schurr, Anderson, and Cormack, concluded that it was difficult to detect any reference to the planning of care at ward level in traditional nursing units.

McFarlane (1975) appears to support Little and Carnevali (1976) who suggested that the planning of care in which the identification of problems and the setting of objectives to meet the identified problems, created a "scientific" process which allows the nurse to involve the patient in all aspects of the therapeutic regime and thereby enhance the effectiveness of the care given (Marriner, 1975). This implies that the adoption of the nursing process will demand that the nurse-practitioner will have to develop skills which have not been taught during the basic programme and which have not been given any great importance in the clinical area. Lelean's study of the traditional record keeping system in the Nightingale ward (1973) revealed the inadequacy of these records together with the often confusing prescriptions for care. Miller (1978) in a study of the planning of patient care suggests that traditional nurses have no clear goals for care and that written policy and communications regarding the patient were deficient and without any attempt to individualise that care. It may be argued that any attempt to reverse this state of affairs without the support of an educational programme aimed at helping the nurses to gain these new skills, will result in the sort of change achieved in the implementation of the Platt Committee recommendations on the care of hospitalised children as reported by Stacey et al (1970). Thus the introduction of nursing care plans into the clinical area may simply reflect a change that is more apparent than real. One of the issues to which this study will address itself is therefore, that although nurse-theorists such as McFarlane

(1975) perceive a problem-solving approach to care as a means of obtaining optimum levels of work activity, education and clarification of the professional role, the implementation of care plans into the clinical area may only promote the existing problem-solving approach and not the redefinition of the role suggested.

Not all nurse-theorists approve of the problem-solving approach as the most appropriate method of providing individualised care. Orlando (1961), and Daubenmire and King (1973) perceive the nursing process as the interaction of the nurse, the patient and the nursing action. For these writers the accent is on the ongoing dynamic interpersonal relationship between the nurse and the patient. Thus the nurse-patient relationship is viewed as the vehicle through which nursing is practised.

Altschul (1978), and Stuart and Sundeen (1979) also reject the mechanistic problem-solving approach in favour of the interactional one in psychiatry. Regardless of the approach adopted, the nursing process describes the actions nurses take in the organisation and delivery of patient care. This focusing on the patient and his individualised needs is a change in the priorities for the nurse's time and energy.

In a study of elderly hospitalised persons, Norwich (1980) concluded that the allocation of the nurse's time was determined by her perceptions of the priorities for care and that these priorities acknowledged that not all the patient's needs for care could be met. In this she supports Baker (1978), whose study of the care received by elderly patients suggests that staff perceive these patients as less than fully rational human beings for whom the minimum level of physical care is appropriate if not inevitable. Baker argues that although this level of care contrasts with official policy, it received the explicit and implicit approval of both the nursing and medical hierarchies. It may be argued that this schism between

the practice of nursing in the reality of the hospital and that officially supported in the theoretical policies, is a potential problem facing any nurse attempting to introduce the nursing process as the means of overcoming the barriers between theory and practice. The study of the implementation of the nursing process and the use of learning contracts as the vehicle for an in-service education programme to support that change must therefore, address itself to the issues raised by this discrepancy between "nursing as it ought to be" and "nursing as it is".

The implementation of an education programme aimed at the in-service training needs of nurses raises further questions about the effect education has on practice. Wells in a study of geriatric nursing (1980) came to the conclusion that the staff's inability to meet the needs of the elderly person stemmed from their lack of understanding of the elderly and their lives and that this resulted from inadequate educational opportunities, as well as the inappropriateness of present educational programmes open to nurses.

The negative correlation between the level of observed practice and the level of knowledge held on which the performance was based, was recorded by Dunn (1970). In her study of the trained nurse's practice, Dunn suggests that this schism stems from the initial training programme offered to student nurses. Dodd (1973) identified the student nurses' problems in correlating theory with practice. Dodd argued that a closer integration between theory and practice would be necessary before this dichotomy was overcome. Hunt (1974) found a similar dichotomy between the theory of wound dressing technique taught by the school of nursing and that practised in the reality of the ward. Bendall (1975) argued that this negation of the school in favour of the "real" world of the ward was a direct result of the G.N.C.'s intervention in the education of the nurse. This curriculum based on a theory of "total patient care" which had never been

practised in the ward, was identified by Bendall as the major source of conflict in the student's perception of the relationship between theory and practice. This concept of "total patient care" although satisfying in terms of status for the trained nurse, caused conflict and disillusionment in the student, but was not challenged by the nurse since it "reified" the existence of the professional nurse and in particular the nurse-teacher.

It may be argued that the implementation of the nursing process in clinical practice demands a reorganisation of the workload and a reorientation of the nurse's attitudes towards the patient. In the event that this redefinition of the role does not take place, then there is a real danger that the present schism between theory and practice will be magnified. This in turn will not improve the quality of care received by the patient, but will continue the present strategies of promoting the status of the professional nurse in her "organisational" role, in the school of nursing and those tertiary educational institutions offering further/higher education to nurses. In the following chapter the writer discusses the changing role of the teacher in response to the identified need for a closer integration between theory and practice. Further, it will be argued that this new role could facilitate the changing role of the nurse as well as develop the teacher's clinical credibility through a clinically based learning programme.

CHAPTER THREE

The changing role of the teacher: using learning contracts to support change in bureaucratic organisations

Introduction:

In the preceding chapter the need for supportive education programmes for nurses involved in the move toward the implementation of a nursing model for care was identified. This need for further education was perceived to come from the gap between the existing level of practice and that expected of the new role of the nurse-practitioner described by the R.C.N.(1981) and the U.K.C.C. (1982). One of the major issues arising out of this perceived need is the major focus on education to support change in a bureaucratic organisation that has traditionally placed little emphasis on continuing education and/or change.

The data recorded in an earlier study by the writer, suggested that little value was placed on in-service education by members of the hierarchy, nor were the majority of the nurses working in the clinical area very active in supporting their personal learning needs through the use of journals. However there were individual nurses who read journals, discussed the contents with their colleagues and perceived a change in the care given to the patient as a result of this non-formal education programme (Keyzer, 1980).

It was argued in that earlier study that the use of learning contracts by nurse-teachers in the school of nursing, could facilitate the development of a non-formal in-service education programme based on the individual or group needs for further education. In this way it was suggested that the schism between nursing "as it ought to be" and nursing "as it is" could be overcome. It was further suggested that the concepts

and philosophy underlying the contractual nature of the teacher-student relationship in an adult education programme facilitated the integration of a theory of nursing and education based on a humanistic concept of care and education (Keyzer, 1980).

Attention was drawn to the close similarities between the model for practice presented by King (1971) and the adult education model presented by Faure (1972) and Dave (1978) in their arguments for life-long education to support the individual cope with the stress of modern life, including the rapid changes in private and professional life (Keyzer, 1980).

As argued in the previous chapter, this emphasis on education and a change toward a new "practitioner" role for the clinical nurse poses problems for the nurse-teacher. In order to support the nurse in her new role, the teacher must rethink his/her role, the tasks involved as well as the priorities for his/her time, in addition to re-examining the learning theories on which his/her teaching strategies and practice are based.

The resources of any school of nursing are finite. In order that the school of nursing can support the changes demanded by the R.C.N. (1981) and the U.K.C.C. (1982), additional resources will have to be found. This suggests that a closer co-operation between schools of nursing and instititions of further/higher education will be necessary to expose trained staff, including the teaching staff, to the knowledge and skills of other disciplines, whose expertise the nurse now needs to implement the nursing process.

This change in the education offered to both basic and post-basic nurses also includes the adoption of a theory of nursing as the basis for practice and the curricula of the courses presented by the school of nursing. Riehl and Roy (1974) differentiate between a theory and a

conceptual framework and argue that in the absence of a universal theory of nursing, the frameworks for practice presented by such writers as King (1971), and Orem (1980), act as a guide to practice and a theoretical basis for the education programme. Stevens (1979) refers to the conceptual frameworks presented by King (1971), Orem (1980) and Roy and Roberts (1981) as theories and notes that a theory can be at different levels of development. She suggests a classification in terms of broad categories of descriptive and explanatory theory. Stevens argues that nursing theory, whether assumed or identified, is the subject matter in the curriculum since the curriculum purports to teach what nursing is by virtue of the content selected for study. Nursing theory is therefore, the matrix which binds together the theoretical content of the lecture and the practice of nursing in the ward or the home. If this is so, then the studies carried out by Dodd (1973) and Bendall (1975) clearly identify the lack of a unifying nursing theory underlying the present education programmes offered to student nurses.

Adult education: social and organisational issues in implementing change in nursing education

The recent developments in the field of adult education suggest that the meaning of such education is being discussed in terms of reviewing the availability of resources and the reconstruction of the current educational system (Faure, 1972). Central to Faure's argument is the belief that education should be freely available to all persons throughout their life span. This concept of education stresses the importance of education as a process which can be initiated and completed at any time of life. The drawing of neat boundaries between education and training, between vocational and general, between formal, non-formal and informal education systems in nursing, is too narrow and restricting to facilitate the changes in practice envisaged in the implementation of the nursing process. The continuation of the existing

limited access to nursing education experienced by nurse-managers, educationalists and practitioners in the past, would result in difficulties of applying theory to practice when attempting to meet the varied learning needs of an adult nursing population (Briggs Report, 1972; the National Staff Committee for Nurses and Midwives, 1981).

To meet the demands for further education outlined in the discussion document distributed by the U.K.C.C. (1982) and the implementation of the practitioner role desired by the profession (Davies, 1980), nursing education must be viewed as an integral part of a comprehensive continuing education programme, not as yet another department specialising in vocational training. To achieve the optimal levels of continuing education required to overcome the deficit in the present level of practice, nursing education must be seen as a conjunction of social and professional educational policies, funding and attitudes which are designed to promote changes in the education of the nurse, the organisation of the health care offered to the population and to achieve the changes desired in the literature on the nursing process.

The concepts underlying Faure's perception of "life-long" education define such education as a process which enables the teacher and the nurse to break down the barriers which have isolated the majority of practising nurses from the existing educational system (Suchodolski, 1978). Gelpi (1979) argued that the role of education in modern society was to promote the full and favourable development of the individual in his/her collective life, in his/her family and in him/herself. In order to achieve this, nursing education cannot continue to isolate itself from other sources of learning, nor can it continue to concern itself solely with learning programmes linked to the study of localised pathology, medical diagnosis, medical treatment and/or

investigation as the basis for determining the patient's needs for care (medical model) at the expense of the patient's psycho-social needs.

Unlike Illich (1978) who advocated the "de-schooling" of society to achieve the abolition of adult education programmes linked entirely to productivity, Gelpi suggested that current educational institutions have a vital role to play in the provision of continuing adult education programmes. However, Gelpi does stress the involvement of the workforce and its representatives in the running of these institutions of further/higher education. This he suggests, will ensure the equal distribution of resources throughout the population.

This highly idealistic concept of education may be perceived as an attempt to promote the learner as an active participant in the acquisition of knowledge and the abolition of an educational system which has confined the total formal and non-formal learning experience to the individual's youth (Suchodolski, 1978). In contrast to the traditional system of basic and post-basic nursing education, this new role for education views learning as a normal, constant dimension of the nurse's entire life and a component varying in explicitness and importance for each person. As a philosophy of education for nursing education and the teacher faced with the challenges of the proposed change towards the nursing process, this concept of nursing education would require the redesigning of the present field of nursing education on the basis of a break with traditional attitudes (McFarlane, 1980), if it is to produce practitioners, teachers and managers who value education and the benefits it holds for them in a changing world.

Independent learning contracts:

Earlier in this chapter it was argued that the student-centred approach to in-service education adopted by the

writer differed from the traditional programmed learning approach of the school of nursing (Keyzer, 1980). It is therefore, necessary to define the term "independent" learning and to differentiate it from "individualised" learning.

Mitchell et al (1975) argued that the best way to integrate theory and practice in nursing education was to take a problem-solving approach in which the student played an active role. These writers defined such an approach as individualised learning.

Jourard (1972) on the other hand viewed independent learning as a problem-solving activity and he suggested that individuals have the need or the capacity to assume responsibility for their own continued learning. Lewis (1978) defined independent learning as a process in which the student attempts to meet his various goals and objectives. Lewis goes on to differentiate between independent and individualised learning by defining the latter as a process in which the teacher and student collaborate to create a learning programme in which the teacher has a greater degree of control over what the student should learn and how the success of that learning is to be assessed. Independent learning and individualised learning would therefore, appear to be complementary to each other, but the terms are not synonymous.

The essential difference between the two processes would appear to lie in the locus of control over what is learned, how it is learned, how it is assessed and the role of the teacher. The implementation of the nursing process in the clinical area, where the patient's needs for care and the skills in meeting these needs form the basis for the learning programme, requires a flexibility of approach which utilises the resources of the clinical area, the school of nursing and the collective expertise of the work group. It may also be argued that the

pressures of the trained nurses' workload will to a greater or lesser extent determine the progress made by the clinical nurse in achieving the preset goals or objectives. Hegyvary and Haussmann (1976) and Hegyvary (1982) argued in separate studies that the effect education had on the process of nursing was the most difficult variable to assess. They argued that the quality of care received by the patient can be influenced by variables over which the nurse has little or no control.

It may be argued on the basis of this evidence that any learning programme aimed at implementating the nursing process and therefore, attempting to promote a quality care programme, must involve self evaluation by the nurse and the peer group; and similarly, that the objective evaluation of the change in practice may be influenced by organisational factors. The degree of success in the learning programme may therefore, not be reflected in a corresponding success in implementing the nursing process.

Learning contracts: a vehicle for change

Much of the literature on the implementation of independent learning programmes refers to the attempts made by individual teachers and institutions to promote independence in the students following higher education programmes. It is argued that the student should take responsibility for planning his own work and for pursuing his own learning objectives. Many terms have been coined to describe such an approach to adult education and the following are a few of these terms: independent study, self-directed learning, student-centred, student initiated and project orientated cited by Boud (1981).

Alexander and Vynce (1967) underlined the active involvement of the student in their definition of independent study and describe such study as any activity that is

motivated by the individual's own aims to learn and largely rewarded in terms of its intrinsic value. Such a definition de-emphasises those traditional nursing practices which diminish the control exerted by the student over the development of the learning programme (Lamond, 1974). Thus independent study as the vehicle for implementing the learning programmes needed to bring about the changes in education and practice desired by the R.C.N. (1981) and the U.K.C.C. (1982), may be the means whereby nursing education moves toward comprehensive and unifying programmes which include formal, non-formal and informal learning.

The strategies adopted to foster these independent learning activities has been described and discussed by a number of educationalists in terms which reflect their individual perceptions of how "independent" such learning is (Rogers, 1969; Rudock, 1978; Bridge and Elton, 1977; Knowles, 1978; Goldman, 1979; Percy and Ramsden, 1980). Percy and Ramsden (1980) suggest that it is unwise to generalise about the most effective means of achieving student independence. This, they argue, is best perceived as a means of promoting student motivation, or adjusting the pace of work so that it takes into account the different student's abilities to engage in problem-solving.

In an earlier study (Keyzer, 1980), it was suggested that learning contracts were an acceptable form of in-service education and a vehicle for implementing the nursing process. The use of contracts as an integral aspect of the nursing process was described by Orem (1980) and Mayers (1978) who perceived the contract as an agreement between persons regarding the purpose of their association for a specific period of time.

Donald (1976) viewed this agreement in a formal manner and suggested that the contract should be a document drawn up by the teacher and the student in which they

specify what the student will learn, how this will be achieved, within what time frame and the criteria to be used to measure the success of the venture. Langford (1978) viewed the contract in a broader, more informal manner and defined only the carrying out of specific actions, or the taking of actions to reach an agreement.

The learning contract may therefore, be an informal verbal agreement between the participants, or it may take the form of a formal document which is signed by the teacher and the student. Esbensen (1969) indicated that a variety of contracts were required and that the type chosen greatly influenced the learner's motivation and progress. Hence a variety of contracts are available to the participants engaged in the implementation of the nursing process from "teacher made and assigned" to "student made and initiated".

The flexibility of the contractual nature of these learning programmes gives support for the individual and group needs of the ward staff. In these small groups, it may be found that some nurses will be happier with informal discussion whilst others might prefer a more structured approach (Boud, 1981). The learning contract may therefore, be used to create a climate of informality and ease, or to support a framework of proceedings with firm definitions of roles and responsibilities. Rogers (1969) acknowledged that the "freedom to learn" included the student's right to demand didactic, classroom-bound teaching.

Very little has been written about the use of learning contracts in nursing education. Knowles (1978) discussed their use in industry, Ottaway (1976) in relation to worker participation in change and Goldman (1979) as a means of supporting fulltime students in higher education programmes. Both Knowles and Goldman perceived the contract as a vehicle for meeting the internal needs of the student and the external needs of the organisation.

Goldman described how the contract could be used to support those students who fail to adopt effective methods of study despite a desire to do so. In this instance the contracts were used to support students who lacked confidence in their own ability and adopted an unstructured approach to their work. This lack of self-confidence leads to confusing and self-defeating behaviour. The student therefore, finds it difficult to give commitment to the desired change, to take risks and hence, fails to achieve the preset goals.

Searight (1976) negotiated contracts with student nurses in an attempt to satisfy the students' needs and interests through a flexible and yet demanding course of study. Crancer et al (1977) used contracts to share accountability for learning between the teacher and the student. Bouchard and Steels (1980) suggested that formalised contracts improve teacher-student communication and enhance the student's expressiveness. The resulting creativity in the outcomes of the learning programme are linked to the security offered by the contracts to those students involved in the risk-taking of problem-solving within the broad framework of the course objectives. Bouchard and Steels underline the contracts protective nature which ensures that the student is not asked to take on the responsibilities which belong to the teacher.

Regardless of the approach taken by the teacher in the negotiation of the contract, it is the handing over of the control over learning to the student that challenges the basic assumptions underlying the traditional approach to nursing education (Rogers, 1969; Freire, 1978; Bernstein, 1975). The unquestioning nature of the traditional nursing student and trained nurse suggests that any attempt to promote independent study will be met by resistance from the organisation. Similarly, some students may hesitate to accept the freedom to become more self-directed in their learning activities and

insist that the old tried relationships be reinstated. Freire (1978) argued that the threat to the control over the access to knowledge inherent in any attempt to involve the student in the learning process will result in pressure from the teacher's peer group to conform to the traditional methods and relationships. Independent, non-formal learning contracts are therefore, not only a different way of presenting data to the trained nurse, they reflect a redistribution of power and control which challenges the traditional teacher-student relationship and attitudes. Thus, the implementation of the nursing process in the clinical area and the negotiation of non-formal learning contracts between the writer and the nurses engaged in the change process, may be regarded as risk-taking ventures which are likely to be opposed by colleagues in the ward and the school and by members of the learning group.

Implementing change in nursing organisations:

Much of the literature on the implementation of change in the behaviour and attitudes of individuals and groups refers to the work carried out by Lewin (1947). Lewin's work established the importance and strength of group decisions in changing behaviour. This, Lewin believed, originated in the group standard acting as a social attraction for the group's behaviour; that is, the group norm has a positive valence for the individual's behaviour. Kogan and Wallach (1967) disagreed with Lewin's conclusions that group decisions were important in creating a lasting change in behaviour. These writers concluded from their experiments on risk taking in groups, that different components of group experience might account for the "risky shift" phenomenon. They suggested that group discussion contains three major components: information about the decisions of others; verbal social interaction; and achievement of consensus. Kogan and Wallach concluded that group discussion is necessary and the sufficient condition for the production of the risk shift, and that

consensus after discussion adds little to the shift.

Vinokur (1971) developed models of decision making drawing on the work carried out by Lewin, and Kogan and Wallach. The assumption made by Vinokur is that in making a decision between two or more courses of action, it is optional or rational to seek the maximise benefit to oneself. When no risk is associated with the alternatives, the rational individual chooses the alternative with the most desirable outcome. Vinokur concluded from the findings of the study on risk taking, that the willingness to take risks produced during group discussion is accompanied by a rational change in the assessment of the utilities. Thus, the information generated during group discussion leads to changes in the utilities of the outcomes. This reassessment leads to a change in preferred minimum probability of success, a change which is now perceived to be rational. These findings suggest that in group discussion in which utilities are discussed, and probabilities not mentioned, a shift in risk taking will be demonstrated.

In the light of Vinokur's theory, it may be argued that if the choice presented by the writer to the organisation favours the risk involved in the change towards the nursing process, then there is a probability that the risk to implement change will be taken. However, should the writer argue for conservation of the traditional approach to care, then the move towards the new mode will be cautious. Hence, the changes in individual decisions may be perceived to be a function of the increased information made available during group discussion (Vinokur, 1971).

Chin and Benne (Bennis et al, 1976) in a discussion on the general strategies for implementing change in schools, identified how the problems of such change centres on the human problems dealing with the resistances, anxieties, threats to morale, conflicts, disrupted

interpersonal communications, which prospective changes in patterns of practice evoke in the people affected by the change. Hence, when the change involved in the adoption of the nursing process or life long education, brings changes in the work group, in the relationships held between colleagues and students, and in the relations of teachers and practitioners, a framework to guide the innovator's actions is required.

Chin and Benne identified three types or groups of strategies. These are: empirical-rationale, normative-re-educative and power-coercive. The writer must therefore, choose from these three different modes of intervention one approach which will achieve the desired change. It may be argued that in a hierarchical bureaucracy all three options may be used simultaneously to achieve the implementation of the nursing process. However, the study carried out by Stacey et al (1970) indicated that an awareness of the benefits to the patient through the implementation of the recommendations of the Platt Committee (1959) to the care of children in hospital, did not in itself ensure the change in the nursing role. The empirical-rationale approach to change would not appear to be the most appropriate method of implementation of the nursing process. Scheff (1961) has shown how staff can prevent the implementation of a change in practice, when the decision to carry out the change is made by those in positions of authority, that is, power-coercion. It would appear that the strategy most suited to the needs of the teacher attempting to influence the change towards the accepting of the nursing process, is the normative-re-educative approach to change (Chin and Benne, in Bennis et al, 1976).

Hall (1977) argued that the introduction of a new role should be considered from two points of view: from the client's new behaviour and as an example of innovation in the organisation. In this way, information may be gathered on the process of innovation and on the nature

and functioning of the organisation and its members. Hall defines innovation in terms of its discontinuity with past behaviours and the subjects' perceptions of the nature of that discontinuity. He similarly distinguishes between innovation and innovativeness.

While innovation is held to refer to a material technology as well as the idea justifying that technology, innovativeness describes a set of attitudes or values that are open to change (Hall, 1977). In the light of this definition, innovation in nursing education refers to the teacher (the material technology) and to the learning resources available to the organisation, as well as to the concept of education as a process of accomplishing personal, social and professional development.

Hall goes on to suggest that innovation implies communication in a social system and that it is more realistic to think of a social order which provides a climate for inventions and discoveries. This, Hall suggests, permits the study of change at both a personal and organisational level. Hence, innovation is characterised as taking place within a social system over a period of time. This permits the diffusion of new knowledge throughout the system. This diffusion model perceives the process of innovation as five inter-related stages: awareness and interest, evaluation and trial, and finally adoption (Hall, 1977). This process may be halted at any stage by rejection, or be discontinued after adoption. However, Hall points out that the implicit model of diffusion is one of spread of an innovation through channels of communication in a relatively open social system, biased neither for nor against the innovation. Thus, innovation is seen as overcoming barriers of resistance that are not organised and are likely to crumble in the face of the self-evident advantages conferred by the innovation (Hall, 1977).

Stacey et al (1970) in their study of children in hospital, commented on the closed communication between nurses and their clients:

> ".. it is also clear that although the extent to which parents are prepared to accept the hospital authority varies, statements made by hospital personnel, even the most junior, are perceived as authoritative. Doing what the hospital says is quite an ingrained habit. Alongside this is a reluctance felt by many to challenge this authority in any way."
>
> (Stacey, Deardon, Pill and Robinson, 1970, p. 157)

These researchers conclude that the responsibility for opening up channels of communication rests with the staff involved. It is also noted that staff may feel threatened by questioning outsiders. Education therefore, has a vital role to play in presenting new knowledge and skills which it is hoped, will permit the staff to appreciate how much power and authority they possess in the nurse-patient relationship and thereby help them feel less threatened and more willing to communicate (Stacey et al., 1970).

The implementation of the nursing process demands more than just a training programme aimed at the nurse's role as a collector of data. Her whole new role as an autonomous practitioner needs to be re-defined, including the tasks she is expected to perform. This includes the roles of the ward sister, the unit manager, the clinical teacher, the nurse-tutor, and the clinical practitioner as well as those they are expected to supervise. For example, the role of the student-and-pupil nurse and the nursing auxiliary will have to be re-defined in the light of the practitioner role described by Henderson (1966).

Not only do the staff require retraining in their roles and tasks, they must be supported in their teaching roles in the nurse-patient-relative relationships. Stacey et al

believe that:

> "... it must fall to the lot of the nursing staff to teacher the mothers the new role of mother-in-the-ward. This being so nurses must themselves first accept and understand it... and are aware of the new strains and new responsibilities her presence puts upon themselves".
>
> (Stacey, Deardon, Pill and Robinson, 1970, p. 152)

Education in all aspects of the new role should include not only discussion of the new role nurses must play in the implementation of a more patient centred approach to care, but also include the knowledge from disciplines such as psychology and sociology, and how this information is at variance with common practice. In the school of nursing, similar retraining of all grades of teachers will be necessary to help the teacher adjust to his/her new role and thereby assist them in establishing their new relationships with students, trained staff and members of the management team (Stacey et al, 1970).

Towards a model for continuing nursing education: education and change in bureaucratic organisations:

The structuring of an organisation on bureaucratic lines was first described by Weber (1947), who perceived it to be the most efficient form of organisation. The strength of this form of organisation was seen to lie in its use of specialists, whose knowledge base and ability to work with precision and direction, following rules and regulations, would minimise the personal, the irrational and the emotional factors in decision-making (Weber, 1947). The characteristics of the bureaucratic organisation which may be recognised in present day nursing establishments include a well defined hierarchy of authority in which high officials supervise lower ones; a division of labour based on functional specialisation and full-time trained officials; a system of rules, policies, regulations and bye - laws covering the duties and rights

of officials; a system of procedures based upon written documentation of particular work situations; a fundamental impersonality in dealing with work situations; a system of promotion plus selection based solely on technical competency (Abel-Smith, 1960; Baly, 1980; Davies, 1976, 1977, 1979; Main, 1956; Menzies, 1970; Jourard, 1972).

Although the Briggs Report (1972) recommended an ongoing education programme to support the nurse for her responsibilities in each level of professional practice, neither Abel-Smith (1960) nor Davies (1980) identify that a higher educational background is a prerequisite for promotion to higher managerial posts. Further, the post-basic educational programmes available to nurses offer a confusion of different levels of academic and non-academic awards in the form of certificate, diploma and degree courses and in which some certificates hold higher merit than diploma and yet other diploma are seen as equivalent of a degree. Examples of this include the post-registration certificate awarded to registered nurses following a course in orthopaedic nursing and the award of a diploma to an enrolled nurse; the Diploma in Advanced Nursing Studies awarded by Manchester University to post-registration students is acknowledged by that university to be an equivalent of the basic degree and students obtaining "credit" level passes are able to apply for entry to a taught Masters level course. Further the courses presented for the preparation of the first level practitioner range from a non-academic professional certificate of proficiency to a university validated degree in nursing studies. These are only some of the problems to which the profession must address itself when the redefinition of the clinical role is recommended. In the present nursing organisation, it is possible for a nurse or nurse-teacher to hold a degree/higher degree and at the same time to be subordinate to a manager who has completed the basic school of nursing programme only.

Davies (1979) in a review of the literature on the development of organisational theory, draws attention to its hybrid nature and suggests that in the sociological analysis of health care organisations there exists a "paradigm crisis". In a later paper (Davies, 1979) she identifies two lines of enquiry that offer possible solutions for this crisis: the politics of occupations and the division of labour. Of these two approaches Davies argues that the "division of labour" holds greater attraction for those persons studying the nursing role by its departure from the normal structuralist-functionalist approach. It is argued that this new route of enquiry permits the study of the nursing role as one of process within the cultural/social setting and which focusses on the organisational role as one linked to the role of medicine in the wider social setting and the social, rather than technical factors which divide the role of the nurse from that of the woman in her own home.

The reorientation in the teacher's and the organisation's attitudes towards continuing education as prescribed by the Briggs Report (1972), the R.C.N. (1981), and the U.K.C.C. (1982), suggest that considerable problems exist in any attempt to revalue the previously debased clinical role of the nurse. Indeed the very existence of the call for a continuing education programme by the R.C.N. (1981) and the U.K.C.C. (1982) indicates that the implementation of the recommendations of the earlier Briggs Report (1972) has not been achieved. Further, the data collected in the earlier study by the writer (Keyzer, 1980) indicates that not only were the staff inadequately trained for the task at hand, there was a lack of access to a continuing education programme.

It is argued that in addition to the new knowledge required to implement the nursing process, trained nurses will also require access to further education presently not provided by the school of nursing or the employing authority. To

gain this new knowledge nurse-teachers must integrate what present nursing knowledge there is with that held by other health care workers such as, clinical psychologists. These occupational groups not only hold higher academic, organisational and social status than the traditional nurse, their present position in the tertiary educational institutions nurses are trying to gain entry to, gives them an advantage over those nurses seeking to establish nursing courses in Polytechnics and Universities. There is therefore, a possibility that in their attempt to provide the nurse with a broader educational base for practice, nurse-teachers are forced to hand over control of the learning programme to these non-nursing groups. This would defeat the move towards the autonomous role the profession seeks and hand control over the education programme and hence the role, to yet another group.

In the following chapter the writer describes the negotiation of the learning contracts with the staff employed in four clinical areas offering institutionalised care to an ageing population. The study therefore, not only records the attempt to implement change, it is also a new role for the teacher in a school of nursing. This new role involved the writer as a researcher into the effectiveness of learning programmes in terms of change and was used to keep the trained nurse's practice up to date.

CHAPTER FOUR

Negotiating in-service education for trained nurses: an action research approach

Introduction:

The present chapter focusses on the negotiation of learning contracts to support change in education and practice. These contracts were negotiated between the writer and the nurses employed in one community hospital, one long-stay geriatric ward, one psychiatric rehabilitation unit and one psycho-geriatric assessment unit. At the beginning of the study ninety-three (93) nurses were employed in all four wards. The writer's access to these clinical areas was through the decision taken by the Nursing Policy Group (N.P.G.) to support the implementation of the nursing process (Chapter One, page 17).

In Chapter One (pages 20-23) the writer recorded the setting up of the Nursing Process Development Group (N.P.D.G.) and the allocation of four clinical units to the writer. The contents of pages 23-24 outline the action research mode adopted by the writer to support the nurses' attempts to implement the desired change in practice. The present chapter extends that outline and records the attempt made by the writer to negotiate an in-service education programme with the nurses involved with the change toward a nursing model for care.

An action research approach to in-service education:

The utilisation of an action research approach to support the educational needs of nurses involved in the implementation of the nursing process, facilitated the integration of the writer's dual roles of teacher and researcher. Thus the writer adopted a role of an "observer-who-

participates" in the activities of the clinical nurses in the wards and the classroom. The time period covered was from 27th January 1981 to 31st August 1982. In total five hundred and thirty-three hours were spent in contact with nurses in the ward and in the classroom. The formal courses supporting the change in practice were the Diploma in Nursing (London University, Old Regulations) and the Joint Board of Clinical Nursing Studies (J.B.C.N.S.) in care of the elderly (number 940/941). Out of these five hundred and thirty-three (533) hours, three hundred and eighty (380) hours were spent in the clinical areas.

In addition to these inputs the writer's job description outlines his participation in "planning educational programmes" which in the terms of this study relate to the other post-basic courses offered by the school of nursing. These courses are as follows: ten (10) J.B.C.N.S. courses, the Diploma in Nursing (London University, Old and New Regulations), the post-basic course in Opthalmic nursing and the contributions to in-service study days related to the implementation of the nursing process (Comely, 1981). As a member of various organisational groups such as the N.P.D.G., the writer was in contact with a variety of managerial and clinical staff from other areas of the Health Authority.

Aspects of the proposed implementation of the nursing process were discussed by the writer and these nursing colleagues in formal and informal meetings. The time involved in these meetings is difficult to assess, since the conversations were often carried out at informal gatherings involving social activities such as coffee breaks and lunches, or to social gatherings outside the normal work environment. Examples of formal inputs were: the currciulum development of the J.B.C.N.S. programmes and the new Diploma in Nursing (London University). This may be regarded as hidden time, in that the input to the nursing process was subsumed within the discussion on some aspect of curriculum development involving any or all of

the post-basic educational activities offered by the school of nursing. The N.P.D.G. minutes record that the writer's inputs to the clinical areas had to be curtailed because of the priority for his time given to the submission of the curriculum for the Diploma in Nursing (London University, New Regulations) (N.P.D.G. minutes, 15.4.82).

Part of this "hidden" time given to the implementation of the nursing process is the day-release given to the writer by the school of nursing to attend London University for the supervision of the present thesis. The time spent on the literature review helped the writer to develop insights into the nursing process and the complexities of change. Throughout the study, this information was fed back to the groups and formed part of the learning programmes offered to the students in the formal courses. Thus the writer's own learning programme formed part of the teaching programme offered to the nurses and the implementation of the nursing process in the clinical areas.

The study had the support of the then Director of Nursing Education and the then Area Nursing Officer (Appendix A). Since the 1982 reorganisation of the Health Service the latter's title has become "District Nursing Officer". The study was self-financed with the exception of the first year's fees to London University which were provided by the Area Nursing Officer from locally held funds. In total from the beginning of the study to the presentation of the thesis to London University, the study took four years to complete.

Strategies for supporting change: the teacher as participant in change:

The use of participant observation as a valid research method in nursing has been described and discussed by Abdellah and Levine (1965). These writers define participant observation as the collection of data by a member of a group who takes part in the group activities. Gold is

cited by Altschul (1972) and his differentiation between the roles of the "observer-as-participant" and the "participant-as-observer" is as follows:

> "The observer as participant is restricted in his participaation by the overriding necessity to observe his subject's responses and behaviour. The participant as observer is restricted in his observation by his perspective as a participant and by the overriding need to maintain continued participation."
>
> (Gold, cited in Altschul, 1972, p. 42)

The role of participant observer was adopted by Towell in his study of psychiatric nurses (1975). He suggested that this approach was ideally suited to the study of the complexity of the social processes involved in nursing. Similarly, he contended that it permitted the collection of data on the actual behaviour of the individuals involved, as they carry out their daily activities in the organisation.

Altschul (1972), however, favoured the role of observer as participant. In her study of nurse-patient interaction, she discussed the problems relating to the role and concluded that the adoption of the role of an observer who participates completely with the subjects was difficult, but not impossible. However, drawing on her experience from a previous study, Altschul suggested that such a role necessitates a place in the hierarchy, and this, it was argued, would inhibit the success of the participant's role.

The role of the teacher employed by the school of nursing, although not always viewed as that of a member of the hierarchy, is in relation to the ward staff, that of a power relationship based on position in the bureaucratic organisation and the acquisition of knowledge (Freire, 1978). Thus, a decision was taken by the writer to reduce the effect this power relationship would have on the

negotiated contracts. This was achieved through a limiting of the writer's contact between himself and the ward staff to normal working hours and to enter all clinical areas, including the duty room only with the permission of the nurse in charge.

An assumption was made by the writer, that as a visitor to the ward access to the clinical area was by invitation of the staff. To have assumed otherwise would have been an acknowledgement of the writer's right to enter the ward area by virtue of his status within the organisation. As in Baker's study (1978) of geriatric nursing, all social activities such as coffee breaks were taken in areas used by the staff.

The advantages of adopting the role of observer as participant were those of the 'outsider role' (Gold, 1958). This permitted the subjects to talk freely to the observer, without having to take him into their private lives, nor was there any need to withhold information (Gold, 1958). There were limitations on the relationships the observer could establish with individual members of the group and the group as a whole. These arose from the observer's status within the organisation as discussed by Altschul (1972).

The relationships established by the writer during the study, suggested that this need not always be so in that some of the data volunteered by the staff during the learning activities, were highly critical of individual members of the hierarchy with whom the writer was known to have contact. It may be argued that such comments would not have been made if the subjects felt there would have been any risk to themselves, as a result of these comments reaching the person concerned. The choice made by the writer not to attach himself to any member of the hierarchy, or to any specific member of the ward staff was an advantage. The disadvantages of this choice were related to the lack of information of the motivations underlying

the outward social behaviour of the hierarchy, in adopting the nursing process as the basis for education and practice.

Sociograms: an attempt to understand the power relationships within the nursing group:

To assist the teacher measure the flow of two-way conversation during the clinical meetings, an attempt was made to construct diagrams of the flow of conversion between members of those clinical groups. Treece and Treece (1977) defined such a device as a schematic drawing used to visualise data resulting from observations and interviews. Thus, the schematic drawings of the flow of conversation during the meetings were used to record and analyse data relating to leadership, pairing or grouping of members and the authority structures within the group (Altschul, 1972; Treece and Treece, 1977).

Douglas (1976) suggested that the only way to analyse what is happening in a group was to observe the process of the group dynamics. He made use of the sociogram to show the flow of communication within the group. Altschul (1972) utilised sociograms to show the flow of communication in nurse-patient interactions during group meetings. In addition, schematic drawings were used to show the number of persons involved in the discussion and hence, the decision-making process; the contributions or lack of contributions made by individual members; and when used in conjunction with seating plans, the relationships between members and authority figures. An attempt was therefore made to engage in socio-metric evaluation of the two-way flow of conversation between group members. No attempt was made to measure the number of interactions between individuals. The schematic diagrams represent the flow of two-way conversation during the entire time frame of the meeting and were constructed by the writer during the meeting. In addition, to describe the undercurrents and feelings during these meetings, a brief outline of the

topics discussed will be given and where necessary, data collected from individual and group interviews will be used.

Learning contracts: strategies for supporting change:

In the previous chapter (Chapter Three, pages 43-44) the writer discussed the use of learning contracts as a means of negotiating change in practice. In the earlier study (Keyzer, 1980), an attempt was made to negotiate learning contracts with nurses working in a general hospital. The data obtained from that study suggested that nurses find these learning contracts helpful in meeting their individual learning needs. The information recorded during that study also suggested that the nurse's access to continuing education could be influenced by such variables as working on night duty, the ward sister's perception of the priorities for the nurse's time, group cohesion, and the senior manager's attitude towards education. Hence learning contracts were used in the present study to clarify data of this nature.

The type of contract used during this study is similar to those utilised during the earlier study (Keyzer, 1980). That is, the formal document identified the nurse's learning objectives, the resources available, the learning strategies used, the time frame in which the contract was to be completed, the type of evaluation used to determine the success of the contract. Examples of the contract designed are included in the appendices (Appendix B). Early in the study, it was discovered that the use of structured contracts was inhibited by pressures of the workload on the staff. However, Esbensen's study (1969) of learning contracts suggested that there are a wide variety of contracts that may be used to meet the student's needs.

Thus, the majority of the contracts negotiated between the writer and the groups observed, were flexible verbal

agreements, based on day to day clinical learning needs of the staff as they attempted to introduce the nursing process. Each contract and the outcomes, are discussed in the relevant case study. Similarly, the writer describes the effect the organisation had on the negotiated contract in these case studies. Examples of the contracts negotiated are included in the appendices (Appendix B).

Data reflecting on the organisational variables effecting the implementation of the nursing process and the learning contracts were also collected from organisational memoranda such as the minutes distributed by the (Area) Nursing Policy Group (N.P.G.) and the Nursing Process Development Group (N.P.D.G.) and the formal evaluation of the Diploma in Nursing (London University, Old Regulations) and the J.B.C.N.S. course in care of the elderly (J.B.C.N.S. course 940/941). Similarly, information of the progress made is collected by informal and formal individual and group interviews.

Case studies:

Fox (1982) defines a case study as a survey in which the researcher:

> "seeks to obtain the widest variety of information about each case and to obtain the kind of depth which cannot usually be obtained about large numbers of respondents because of the difficulty and time involved in obtaining such data.... This type of saturation of data and this level of analysis can, under the proper conditions, provide a research answer for a problem available to no other way."
>
> (page 165)

Thus the case study approach was considered to be the most appropriate method of recording data in a study of the implementation of change in the clinical environment, in which the writer had no control over the work content of the work group, the variables effecting change were unknown

and the proposed change in practice and education had no precedent.

Fox (1982) stresses the appropriateness of the case study in research on the caring of the whole person and the teaching of nurses to consider the multiple aspects of behaviour and personality in planning care. The evaluation of the case study should focus on its depth of data about the individuals and groups involved that would not be possible by any other means. It may be argued that this approach to data collection is the one most suited to the needs of the writer in his capacity of nurse-teacher , when the time available to the writer in his role of researcher was limited to the normal working conditions of a teacher in the school of nursing and the collection of data was confined to normal work activities. The case study method therefore, permitted the researcher (the writer) to integrate his dual roles and to collect data whenever and wherever that data presented itself. In this way the writer gathered data on the change in practice and the effect of organisational variables on the educational programmes from a wide variety of sources including the care plans used by the nurses in the clinical areas and his personal observations of the groups and individuals in their working environment.

Part Two: Implementing the nursing process in one Health Authority: comparative case studies

CHAPTER FIVE

Organisational policies and strategies for change: a background to the implementation of change in nursing practice

In Chapter One (page 17) the creation of the Nursing Process Development Group (N.P.D.G.) as an integral part of the organisational policy for implementing the nursing process was recorded. The outward aim of that strategy was to support the clinical nurses in the ward and the school of nursing in their attempts to implement the nursing process as the official mode of practice throughout the Health Authority. The time period set by the N.P.D.G. for the implementation of the new mode of practice was between sixteen (16) and twenty-four (24) months (Chapter One, page 20).

However, in Chapter One the issues arising out of the implementation of the new role of the nurse and in particular, the challenge to existing social and organisational relationships with the medical profession and the nursing hierarchy were discussed (Chapter One, pages 12-17). It may be argued that the setting up of the N.P.D.G. as an organisational group based on the "personal" power of the Area Nursing Officer and its lack of organisational authority to allocate or reallocate resources, was part of a hidden strategy to maintain the status quo, rather than to promote change.

In this chapter the writer records the organisational strategies employed by the nursing hierarchy and the effect on the implementation of the desired change is recorded in the case studies contained in Chapters Six, Seven, Eight and Nine. The purpose of the present chapter is to provide an organisational background against which the implementation of the nursing process in the clinical areas

can be viewed.

Organisational strategies: implementing change or maintaining the status quo?

The following data are gathered from the minutes circulated by the Nursing Policy Group (N.P.G.) and the Nursing Process Development Group (N.P.D.G.). The N.P.G. minutes dated 23 August 1980, identify this group's notification by the Director of Nursing Education of the recruitment of two nurse-teachers, whose brief it would be, to develop in-service education programmes for nurses working in the General Division of the Health Authority and in particular, the major teaching hospital. This policy was never implemented but formed the basis for the writer's access to the clinical areas described in the following case studies. One reason for the non-achievement of the original strategy to link individual nurse-teachers with specific clinical areas was the resignation of the first teacher from her post in the post-basic education team. This highly qualified member of staff, had specific expertise in post-basic education and had carried out a research study into the educational needs of registered and enrolled nurses working in the Health Authority. This nurse-teacher left her employment in the school of nursing to take up a post in an institution of higher education.

The writer therefore, had to take on this first teacher's commitments to the formal post-basic education opportunities offered by the school of nursing. It was in this way that the writer became involved with the post-basic course in care of the elderly (J.B.C.N.S. 940/941) and the Diploma in Nursing (London University, Old Regulations). Although subsequent teachers were employed to replace the first teacher, these teachers were confined to the formal J.B.C.N.S. courses and did not involve themselves with the in-service education component as envisaged in the original N.P.G. minutes.

Insight into the support available to persons initiating new clinical posts is obtained from the N.P.G. minutes dated 9 September 1980, in which the then Divisional Nursing Officer (General) reported the resignation of a clinical specialist in care of the dying and their relatives. The records of the meeting note that:

> "she did not feel that the job had developed as she would have wished."

The group are recorded as believing that this was an "important" post which needed to be reviewed and discussed at a future date when the incumbent's report was submitted. At the end of the study in September 1982 no further mention of this "important" post was found in these organisational records. It may be argued that the failure of this clinical post which reflected the clinical specialist role envisaged by the R.C.N. (1981), implies that the top level managers were unable to support the innovation they encouraged. Further it was suggested by the Divisional Nursing Officer in an informal conversation with the writer that one of the prime reasons this clinical specialist role failed, was the lack of support for the post from members of the nursing staff at ward level and in particular from members of the medical profession.

It may be argued that before the N.P.D.G. had even been formed, support for the nurse attempting innovations in clinical practice was poor. In particular, there appeared to be little support from managers, doctors and members of the peer group for the type of innovation leading to the establishment of clinical specialists as envisaged by the R.C.N. (1981).

In the light of this data the attempt made by a group of enthusiastic nurses who did not have the organisational authority to allocate resources (see Chapter One), may be viewed as an attempt to implement change from a position of organisational weakness. The presence of the N.P.D.G.

was acknowledged by the N.P.G. in the minutes of their meeting dated 10 February 1981.

The official status of the N.P.D.G. was questioned and reference to the incident leading up to this is made in the case study of the psychiatric rehabilitation unit. The incident recorded in the minutes of the N.P.D.G. meeting dated 30 June 1981, indicates that the writer had been challened by members of the Psychiatric Division on the legitimacy of the N.P.D.G.'s organisational power. As stated earlier in Chapter One, the group's power source stemmed from the "personal" power of the then Area Nursing Officer and the Director of Nursing Education. The response given by the Area Nurse (Clinical Practice) to the questioning of the group's status by the senior staff in the psychiatric hospital referred these senior managers to the Area Nursing Officer's support of the group and the recording of that support in the N.P.G. minutes. Issues such as this are discussed in the conceptual frameworks for practice and education presented in Part Three of the thesis.

To add to this questioning of the organisational power of the group, a ward sister in charge of one of the geriatric units involved in the implementation of the nursing process and forming part of the pilot areas allocated to the writer, identified the problems related to the constant changes in staff and its effect on her attempt to implement change (N.P.D.G. minutes, 30.6.81). This was only one factor involved and the minutes draw attention to the group's identification of the pressures of the workload and its effect not only on the implementation of change, but also to the inability of some of the key members to attend the meetings and the effect this had on their contribution to the change process.

The group minutes dated 28 August 1981, reveal that the Area Nurse (Clinical Practice) had been asked by the group to approach the then Divisional Nursing Officer (Psychiatry)

to discuss the problems of the nurses working in the Rehabilitation unit and the Psycho-geriatric unit and their inability to attend the group's meetings. The members of staff from these clinical areas allocated to the writer as a resource person, identified the problems as relating to staff shortages and the pressure of the work-load. A request by the writer for information on the establishment: in-post staffing levels of the units involved, was not answered. The following table (Table 1) represents the staffing levels of one geriatric ward (General) involved in the study. The time period covered is one month and exemplifies the fluctuation in the daily levels of staff.

The minutes of the N.P.D.G. meetings also reveal the constant changes in the membership of this group as individuals left to take up new posts and other members joined in their places. The records dated 28 August 1981 identify the setting up of learning packages under the direction of two of the original members of the core resource team involved in the original study days for managers and teachers (see Chapter One). These study days were created in response to the clincal areas identified needs for skills concerned with "interpersonal relation-ships" and "problem identification". Further data to support the need for this type of in-service education programme and the lack of such skills held by trained nurses, is provided in the following case studies.

These learning activities were to be conducted in the classroom and not, as the original N.P.D.G. strategy had advised, in the ward area. The rationale behind this change of strategy was identified by the group members as the pressures of the workload and the constant distractions of teaching in the ward during normal working hours. Further data to support these reported statements is given in the case study on the implementation of the nursing process in the community hospital.

Table 1: Staffing levels in one geriatric ward

DATE	MORNING STAFF	AFTERNOON STAFF	ALTERATIONS IN STAFF
1.12.81	4	4	3 sick, 1 study, 1 on holiday, 1 on course
2.12.81	5	3	2 sick, 1 study, 1 on holiday, 1 on course
3.12.81	5	4	1 sick, 1 on holiday, 1 on course
4.12.81	6	4	1 sick, 1 on holiday, 1 on course
5.12.81	5	2	2 sick, 1 on holiday, 1 on course
6.12.81	4	4	4 sick, 1 on holiday, 1 on course
7.12.81	6	4	1 sick, 1 on course, 2 on holiday, 2 study days
8.12.81	6	2	1 sick, 1 course, 2 on holiday, 2 study days
9.12.81	7	3	1 sick, 1 on course, 1 on holiday
10.12.81	5	4	2 sick, 1 on course, 1 on holiday
11.12.81	5	3	2 sick, 1 source, 1 on holiday, 1 'snow bound'
12.12.81	6	4	1 sick, 1 on course, 1 on holiday
13.12.81	4	4	3 sick, 1 on course, 1 on holiday
14.12.81	4	4	3 sick, 1 on course
15.12.81	6	2	3 sick, 1 on course, 1 study day
16.12.81	6	4	2 sick, 1 on course
17.12.81	7	3	2 sick, 1 on course
18.12.81	6	3	2 sick, 1 on course, 1 Lieu day
19.12.81	4	3	2 sick, 1 absent, 1 on course
20.12.81	5	3	3 sick, 1 on course
21.12.81	7	5	3 sick, 1 on course
22.12.81	6	4	3 sick, 1 on course, 1 Lieu day
23.12.81	6	3	3 sick, 1 on course

contd...

Table 1 contd.

DATE	MORNING STAFF	AFTERNOON STAFF	ALTERATIONS IN STAFF
24.12.81	4	4	3 sick, 1 on course
25.12.81	7	3	2 sick, 1 on course
26.12.81	5	4	2 sick, 1 on course, 1 Lieu day

The minutes of the meeting held on the 28 August 1981, go on to indicate that although the need for resources to support the implementation of the nursing process had been identified some six months earlier (N.P.D.G. minutes, 18.3.81), these vital resources were still not available. Originally the Area Nursing Officer had directed the group to the N.P.G. (see Chapter One) for these funds, but the records show that this group were unable to provide the financial, manpower, material, or educational resources needed to support the pilot areas. Instead a renewed attempt to raise funds for the implementation of the nursing process was made to the major teaching hospital's "Operational Group" and the "Area Management Team". The impression given by the minutes of the N.P.D.G. and the N.P.G. is that of a group of nurses, lacking in organisational power and support, going from one organisational group to another begging for resources to implement national, professional and organisational policies for promoting the practitioner role in order to improve the quality of care provided to the patient. These attempts met with little or no success, although every group approached supported the ideas involved in the change, but could not provide the necessary resources to achieve these goals. The N.P.D. group meeting's minutes dated 3 November 1981, record an attempt made by the Area Nurse (Clinical Practice) to involve the Divisional Nursing Officers in the direct funding of the pilot areas in their

specific divisions. This attempt, like the others, failed and the N.P.D.G. were advised to submit a research proposal to the Area Research Committee.

The minutes of the N.P.D.G. meeting dated 29 October 1981, reveal that an earlier attempt to secure funds through the submission of a research proposal had met with little success. These minutes state that:

> "the request for funding from the Area Research Committee had been refused on the basis of a postal vote, the voting being 8-2 against. Dr. Sharp, the chairman, has expressed his regret..."

It should be noted that only one nurse is a member of this research committee and that the remaining members are physicians. This data would appear to support the arguments that the medical profession continue to define the nursing role (Davies, 1980). Further evidence to support this argument is provided in the case study on the long-stay geriatric unit and the dependence on funds for an innovation in clinical practice on the medical profession.

The requisite resources did not materialise until 21 January 1982, that is one year after the initial agreement to implement the nursing process had taken place. The resources were obtained through the offices of the Area Nursing Officer and her intervention with the Area Research Committee. The total sum made available to the N.P.D.G. group was one thousand, one hundred pounds (£1,100.00). The possibility of further funding was dependent on the submission of a Report on how these resources had been spent. This second allocation of money totalled no more than nine hundred pounds (£900.00). This was barely enough to cover the stationery required to create process records for the twelve pilot areas. Most of the funding for the implementation of the process was therefore, obtained by the individual charge nurses/sisters from existing funds by various hidden means.

It may be argued that this data reflects the low status of the clinical nurse and the lack of attention paid to needs for adequate resources to support her changing role. Further, that in the absence of these resources the organisation can maintain the status quo. The records of the N.P.G. reveal the lack of support given to the in-service educational needs of trained nurse (N.P.G. minutes dated 2.3.82). The total amount of money allocated to the in-service education services in the Health Authority were set at five thousand and seven hundred pounds (£5,700.00) for all non-statutory courses. In reality this allocation provided the school of nursing with some five hundred pounds (£500.00) for in-service education. Thus in contrast to the R.C.N. (1981) and the U.K.C.C. (1982) recommendations for a greater emphasis on continuing education, the reality of the organisation is one of little or no real commitment to further education.

The effect of this inability to supply necessary resources on the individual clinical areas involved in the implementation of the nursing process is recorded in the following case studies. The conceptual frameworks presented in Part Three offer guidelines to the interpretation of the data presented above.

CHAPTER SIX

Towards a community based model for nursing: implementing the nursing process in a community hospital

In Chapter One (pages 17-18), the writer described the seminar in which the senior managers were asked to nominate pilot areas for the implementation of the nursing process. The unit presented by the Divisional Nursing Officer (Community) was a newly commissioned community hospital. This offered an opportunity to implement the nursing process in a clinical setting which appeared to be ideal for a "health care" model for practice, rather than an "illness" model as presently practised in hospitals.

Gaining access to the Community hospital:

The writer gained access to the unit on both the formal and informal organisational levels. The first approach to the teacher was made by the Senior Nursing Officer and the Nursing Officer from the Community hospital. Their initial request for help centred around the design of the nursing record to be used in the unit. The final format adopted by these managers was based on that presented by Mayers (1978). This discussion coincided with the meeting of the N.P.G. in which they accepted the implementation of the nursing process as the preferred mode of practice (minutes 10.2.81).

In the discussion between the writer and the Senior Nursing Officer and the Nursing Officer, these managers expressed their intention to create a clinically based role for the Nursing Officer along the lines of the structure proposed by the R.C.N. (1981), so that the role of the staff nurse would resemble that of the primary nurse described by the R.C.N. (1981). To achieve this objective, they removed the role of ward sister on day duty. The Nursing Officer

therefore, assumed the role model function described by Pembrey (1980).

Negotiating the contract for change:

Three days before this newly established hospital opened, the Senior Nursing Officer and the Nursing Officer, held an orientation day for the staff to which the writer and an in-service education teacher were invited. In the course of the orientation programme the Senior Nursing Officer outlined the philosophy the unit would attempt to implement through the adoption of the nursing process as the mode of practice. The nursing process was explained by the teacher and the format designed by the Senior Nursing Officer and the Nursing Officer, was presented to the staff by the Nursing Officer.

The staff were not involved in the decision to implement the nursing process, nor were they party to the creation of the format used. None of the staff had experience in using the format, but all had worked in traditional nursing organisations offering institutionalised care to the elderly.

Following the initial introduction to the proposed format and mode of practice, the staff were asked by the Senior Nursing Officer to participate in role play, group discussion and simulated case studies, in order to give them some indication of what a more patient-orientated approach to care involved in the way of new skills and application of old ones. The ethos of the group suggested that many of the new skills were already present, but not fully utilised.

The responses of the staff during the meeting suggested that they were fairly positive about the emphasis on the clinical aspects of care. The contents of the discussions held with the writer suggested that whereas he had discussed the professional nursing role in terms of the

registered nurse, the participants had viewed the tasks associated with this role as common to all grades of nurse. Further, in their arguments that: "we all do the same job" the staff appeared to perceive the role of the trained and untrained nurse as one and the same thing. This lack of clarity between the roles of the different grades of nurse has been recorded by McFarlane (1970) and Anderson (1973) in their separate studies of the nursing role. Thus this organisational strategy of overlapping the roles of trained and untrained nurses might be a possible source of conflict when the practitioner role was put into practice.

In their proposals for implementing the nursing process the R.C.N. (1981) made reference to the concept of "Primary Nursing". Since the role of the staff nurse in this unit had been perceived in this way, a definition of this concept is included at this point. Primary nursing is defined as:

> "a modality of nursing care subscribing to a distinct set of objectives and philosophy that, in turn, support a unique distribution (assignment) of nurses to patients in a hospital setting... so that the total care of an individual patient is the responsibility of one nurse, the primary nurse."
>
> (Marram et al, 1979, page 1)

Hegyvary (1982) concurs with this definition and states that primary nursing is both a philosophy of care and an organisational design which emphasises the essential elements of accountability and autonomy in the role of the professional nurse. Hegyvary perceives the role of the professional, that is primary nurse, as comparable in principle to that of the attending physician. She defines a professional practitioner as follows:

> "A professional practitioner has received extensive, specialised education to provide a client with a unique, autonomous

> service based on scientific knowledge and methods and standards and ethics of the professional group."
>
> (Hegyvary, 1982, page 5)

In adopting the primary nursing role as the basis for the staff nurse in the community hospital, the Senior Nursing Officer and the Nursing Officer appear to have adopted a concept of the professional nursing role which was at variance with that expressed by trained and untrained staff in their conversations with the writer during the induction course. This conflict of role activation might be a source of frustration for the nurses involved and is an issue to which the themes presented in the third part of the study address themselves.

At the end of the orientation programme, the Senior Nursing Officer and the Nursing Officer negotiated a contract with the writer in which they suggested a six weeks "settling in" period for the staff. This, they argued, would allow the staff to familiarise themselves with a new work environment, new colleagues and new patients. At the end of this period, that is March 1981, the writer returned to the hospital in order to discuss with the staff their perceived needs for in-service education. In addition to the writer, the staff had access to an in-service training teacher and the study days presented by the Nursing Process Development Group cited in the previous chapter. As a serving member of the N.P.D.G. the Senior Nursing Officer was ideally placed to advise this group on the clinical nurses' needs for further education. The N.P.D.G. minutes referred to in the previous chapter also identify that the Nursing Officer deputised for the Senior Nursing Officer at these meetings.

The location of this community hospital in a small market town on the outskirts of a large industrial city in the Midlands, the staff's reliance on public transport and their family commitments, were factors which determined

the staff's access to the available in-service education programmes at the major teaching hospital. This need to centralise the learning programmes in the teaching unit was related to the resources, such as classrooms, available to the school of nursing. The N.P.D.G. minutes dated 29 July 1982, reveal that those nurses who did attend these in-service education programmes found them of great benefit in helping them to implement the nursing process.

The in-service education teacher also arranged study days each Wednesday and again, because of the centralisation of the school's resources, these study days were held in the major teaching hospital. At first these study days were infrequent and changes in the teaching team contributed to this. Once the in-service teacher had established herself within the post-basic team, these study days became a regular feature of the educational facilities offered by the school of nursing. Any member of the nursing staff had access to these study days at which a variety of topics, such as the key documents on practice and education presented by the R.C.N. (1981) and the U.K.C.C. (1982) were discussed. This particular seminar was presented by the writer and formed part of the feedback from this study to the participants from the general hospitals.

Implementing the learning contract and assessing the success of the attempted change in practice:

The role of the writer in the clinical area had been defined by the staff as that of a resource person, who would present the staff with the information needed to implement the nursing process in their clinical unit. As stated earlier, the staff did have access to other educational resources, such as the workshops on "interpersonal skills" and "problem-solving" arranged by the N.P.D.G. (minutes dated 24.9.81).

It may be argued that such a learning programme based on

the nurse's identified learning needs and over which she exerts some control, could help the nurse overcome the schism between theory and practice described in Chapters Two and Three. Although this approach holds advantages for the student, it has major disadvantages for the teacher.

These clinical based learning periods did not permit the writer to prepare for the teaching session in advance. The writer therefore, went into each session "blind". This implies that the clinical teacher needs to be flexible and have a sound knowledge base and understanding of the problems likely to be found in the specific clinical area. Thus, the focus of the clinical teaching sessions was the nursing problems of "real" patients and not hypothetical patients in a theoretical discussion in a classroom. In this way the writer and the clinical staff attempted to overcome the dichotomy between theory and practice.

The nurses in the community hospital requested the writer's presence in the clinical area on a full-time basis. This was verbalised by one staff nurse who stated: "you show us and we'll do it". The writer's commitments to the formal education courses and his inputs to the other pilot areas did not permit him to implement this request. This does not detract from the writer's belief that in another situation this might have assisted in the establishment of closer working relationships between the writer and the clinical nurses and perhaps a more in-depth learning programme.

Conflict between the writer's roles of clinical teacher and his inputs to the formal education programmes offered by the school of nursing, was therefore, a variable which was perceived by the writer and the nursing staff to inhibit the staff's ability to implement the new mode of practice. Although the Director of Nursing Education had given the implementation of the nursing process his

personal support (see Chapter One), the writer had to put the needs of the formal courses before those of the non-formal education of the trained nurses in the clinical area. The conceptual frameworks for practice presented in Part Three of the thesis discuss this issue in greater depth.

In their evaluation of the first six months of attempting to implement the nursing process, the trained staff, registered and enrolled, full-time and part-time, stated that it had been, as one staff nurse described it: "sheer hell". This they felt was the result of having to implement a completely new mode of practice in a new unit with new staff. The general consensus of opinion expressed by the trained staff suggests that they believed it had been worthwhile. They identified that the implementation of the nursing process was different from that previously practised under the heading "total patient care" (N.P.D.G. meeting dated 29.7.82).

Each clinical teaching session conducted by the writer lasted a complete working day from 9.00 am to 16.30 pm. Each session began with the writer reviewing the care plans with either the Nursing Officer or the Senior Staff Nurse-in-charge. The format chosen by the staff was similar to that presented by Mayers (1978) and a copy of that format is contained in Appendix C. The first clinical meeting between the writer and the staff revealed that the nurses had some difficulty in completing all aspects of the process, that is assessment, planning and evaluation. The data collected in the first step of the process, the nursing history, reflected that recorded in the medical notes and the contents of the "evaluation" sheet were identical to those of the nursing history. This data was similar to that recorded by Lelean (1973). Entries under the headings of "assessment" and "evaluation" might read as follows:

> "this pleasant elderly gentleman has
> been admitted for a short stay to

> relieve the family while they go away on holiday."
>
> "big bath faecal incontinence."
>
> "Walked with help."

As recorded by Lelean in her study (1973), these nursing observations and prescriptions were open to interpretation and often did not make sense until viewed in the context of a specific patient. The writer discussed these statements with the staff who described their need for an "aide memoire" rather than detailed prescriptions to remind them of the specific patient. It was only when the prescriptions were read by a non-participating observer, as in this case, the writer, that these comments on the patient's behaviour did not describe specific problems or objectives for care.

The staff nurses and the enrolled nurse went on to describe to the writer their need to write something about the patient at the end of each shift. This was held to be true even when the patient's problems were long term and in the case of the elderly person might never be resolved. This problem was discussed at the N.P.D.G. meeting on the 30 July 1981. The records of that meeting suggest that the Area Nurse (Clinical Practice) stressed:

> "the need for adequate documentation of nursing actions and the nurse's responsibilities to the patient in regard to care."

In spite of this discussion and the reassurances by a high status nurse, the clinical nurses continued to write the traditional "end-of-shift" report as recorded by Lelean (1973). Further, much of the evaluation data could be found elsewhere, that is there was duplication of existing records. Examples of this duplication include the patient's temperature, pulse, respirations and blood pressure which were already recorded on the appropriate chart. Similarly, daily living activities which had not been identified as potential or actual problems (Mayers,

1978) were often included in the evaluation of care. Statements such as "slept well" exemplify this sort of recording, even when inability to sleep was not an identified problem.

The staff's problems with the concept of "evaluation of care" appeared to stem from their difficulty in identifying the origins of patients' problems. The first recorded incident defined the patient's need for nursing care as "mobility". The care plan had been written thus:

PROBLEMS (ACTUAL & POTENTIAL)	DESIRED OUTCOME	TARGET DATE	NURSING ACTION
Mobility	Increased mobility	Ongoing	Encourage mobility
Immobility	Prevent pressure sores	Ongoing	Frequent P.A.'s
Obese	Reduce weight	Ongoing	Reducing diet

From such a care plan which reflected the sort of plan and nursing actions found in the traditional Kardex, a learning contract was negotiated as follows:

LEARNING OBJECTIVE	STRATEGY	RESOURCES	TIME/ DATE	EVALUATION
To define what is meant by the term 'mobility'	Group members will discuss with each other and find a consensus of opinion as to the meaning of the word 'mobility' in this patient's care	The patient. Other members of the staff. Library	Six weeks	The care plan will contain a description of the patient's needs for care, the nursing actions to meet those needs, and a standard of care which will discriminate between satisfactory and unsatisfactory achievement

At the end of the six week period stipulated in the contract, the teacher returned to the unit to review the

success or failure of the staff's attempts to clarify their intentions set out in the care plan. The new care plan read as follows:

PROBLEMS (ACTUAL & POTENTIAL)	DESIRED OUTCOME	TARGET DATE	NURSING ACTION
Poor mobility, just able to stand for a short while	To encourage and improve mobility as much as possible	Ongoing	Patient to be encouraged to stand with two nurses at least three times per day, especially when transferring from bed to chair/commode. Patient to feel secure when standing and not to feel as if she is likely to fall. PHYSIOTHERAPY where possible

By repeating the same contract, the staff continued to improve on their ability to write the plan as follows:

	PROBLEMS (ACTUAL & POTENTIAL)	DESIRED OUTCOME	TARGET DATE	NURSING ACTION
30.6.82	1. Actual: Unsteady on feet following operation. Lack of confidence	To gain full mobility, and confidence when walking	16.7.82	To mobilise at least four times daily under supervision of a nurse to instill confidence so that she is able to walk independently, with or without aids.
	2. Unable to get in and out of a bath unaided	To maintain social cleanliness	16.7.82	Patient to be offered a bath at least three times a week (Mon., Wed., Fri.). Needs help and supervision to get into and out of bath. Can wash independently on other days.
	3. Prolonged bed rest	Maximal functional mobility	Review daily	1. Change position at least four times per day and three hourly at night. Two persons required.

	PROBLEMS (ACTUAL & POTENTIAL)	DESIRED OUTCOME	TARGET DATE	NURSING ACTION
30.6.82 (cont'd)				2. Passive movement of arms and legs; at least two times per day am and pm. 3. Encourage active exercises.

These examples are provided to show how the contracts were used to help the staff clarify their written communications with each other. The plans are not used as a means of showing the scientific basis for these nursing actions. The data contained in these sample care plans suggested that the nurses at the beginning of the study had difficulty in writing the care plans and in identifying the underlying causes of the outward manifestations of the patient's needs for nursing care.

Evaluating the implementation of the nursing process

To assess the staff's ability to apply the steps of the nursing process to patient care and to evaluate their ability to prescribe care for the patient's bio-psycho-social needs, Henderson's fourteen daily living activities were used to identify critical incidents.

Table 2: Identified patient needs - the Community Hospital

	CRITICAL INCIDENTS	NUMBER OF RECORDED INCIDENTS (N = 144)
1.	Hygiene	48
2.	Elimination	31
3.	Mobility	29
4.	Communication	8
5.	Nutrition	11
6.	Safety	1
7.	Clothing (Regulate temp.)	00

contd...

	CRITICAL INCIDENTS	NUMBER OF RECORDED INCIDENTS (N = 144)
8.	Sleep and rest	1
9.	Recreation	9
10.	Select Clothing to be worn	1
11.	Breathing	6
12.	Religion	00
13.	Education/Learn	00
14.	Work/achievement	00
	most frequently recorded incident: maintaining an intact skin	11
	(date: 30.6.82)	

To validate the categorisation of the recorded incidents, the identified patient problems were written on plain white cards. Each critical incident described by Henderson's listing of daily activities were written on a second separate card. The patient problem cards were then mixed and a tutor was selected to arrange these cards under the daily living activities named on the second set of cards. The distribution of the identified patient problems matched that of the categorisation carried out by the researcher.

Both the observer and the tutor noted the difficulty in allocating some of the identified problems to the appropriate category. This was due to the manner in which the problems had been written. Both evaluators agreed that the main difficulty resulted from the staff's inability to identify the underlying cause and the interrelationship of one or more problems from a common cause.

This appeared to have its basis in the original training programme. The staff in this unit and their colleagues in the other units observed during the study, agreed that the basic training programme provided by the school of nursing had not prepared them for this new role. It may be argued that not only had the standard of education programme not

prepared them for the new role, it had failed to provide them with the skills necessary to identify the patient's needs for care under the existing approach. The number of recorded incidents in Table 2 suggests that the care received by the patients reflected the routinisation of care in the Nightingale ward. The main emphasis in the care plans appeared to be: hygiene (48 incidents), elimination (31 incidents), communication (29 incidents), and safety (11 incidents) as the main focus of the nurses' attentions. This was one year after the introduction of the nursing process to the unit.

It may be argued that the routinisation of care continued in a unit supposedly implementing the nursing process, because the basic organisation with its traditional distribution of power and control continued to exist. The problems encountered by the Nursing Officer, the obvious maintenance of the existing hierarchy and the staff nurse's concerns about the power of the auxiliary nurse at the bedside where the care was implemented, all point to the use of the traditional work patterns by the staff.

The main contribution the learning contracts and the nursing process had made to this unit and to the patient care, was the conscious application of problem solving to patient care in an area where such activity had not been openly used before. At the end of the study when the staff were asked to evaluate their experiences in working with the nursing process, their answers were fairly positive. When categorised into satisfying and dissatisfying incidents, the distribution was as follows (see over).

The comments indicate that the use of a problem solving approach to patient care and the handing over of responsibility of that care to the trained nurse, were satisfying to the qualified nurse. How satisfying it was to the patients cannot be judged from these comments. An attempt was made by the writer to take a base-line recording of patient satisfaction with the quality of care provided,

SATISFYING	DISSATISFYING
"More patient contact"	"Some nurses are territorial with their patients"
"Continuity between staff"	"Initial difficulty with new approach"
"Get to know patients better"	"Difficult"
"Teams you know where you are through better patient relationships"	"Personality of some of the staff not suited to this approach"
"Feel closer to patients"	"Afternoon - could be more patient participation"
"More pride in patient care"	"Lay out of documents needs to be revised"
"Being with the same group of patients for longer periods"	"Lack of full-time staff means that there are only three people who can do the plan"
"Like to know all that's going on"	"No organised meetings to discuss the care"
"Helpful"	"Part-time nurses do not use the plans"
"Not having a Sister is a benefit, but initially it is stressful"	"Lack understanding of the term 'Evaluation'"
"Enjoy working in teams"	"Work day needs to be reorganised so that there is continuity of the teams from shift to shift"
	"The design of the ward is wrong for this allocation of patients to specific nurses"
	"High dependency on auxiliary nurses"
	"Some auxiliaries have a higher status in the running of the ward than some staff nurses"

but the staff's perceived threat from such a quality control programme made such a measurement impossible. The feedback from the Senior Nursing Officer following the initial attempt to implement a 'Slater-Walker Rating Scale' (Wandelt and Stewart, 1975), suggested that both trained and untrained staff had been threatened to the extent that the implementation of the nursing process was endangered. The comments made by the staff in their evaluation of the progress made by June, 1982, suggested

that to implement the nursing process and primary nursing, the organisation of the nurses' day had to be rearranged to accommodate the continuity of the team from shift to shift. Similarly, that the present reliance on part-time trained and untrained staff militated against such a reorganisation.

The writer's evaluation of the contract negotiated with this unit indicated that one of the primary difficulties in setting up a clinical based programme, was the reliance on part-time staff. It was difficult for the teacher to arrange a time when these part-time workers were available to attend the study day. In the event, it was the same group of nurses who attended each session. For one nurse a time period of one year elapsed between her attendance at the session. Each of the study periods had to be held in the nursing station. This was to facilitate the running of the ward. The teaching sessions were constantly interrupted by telephone calls, whilst nurses were called away to discuss patient problems with doctors or relatives. Similarly, disruption was caused by the change of shift reports (see previous chapter).

One of the advantages of these interruptions was that it permitted the teacher to observe the change of shift reports and the content of these reports. As in Lelean's study (1973), the contents reflected the traditional Kardex type of information characterised by statements such as:

> "Has had a big bath. Still some incontinence. She seems happier today."

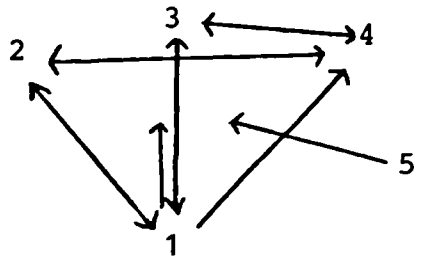
Despite the amount of time and effort put into the compilation of the care plans, not one nurse referred to them in these change of shift reports. The nurses continued to give the traditional, ambiguous reports associated with the routinisation of care.

There was no evidence in either the verbal report or the written plan to suggest that the patient had contributed to the plan of care, or that the nurse had a clear scientific rationale for care. It may be argued that in this unit, like the other units observed during the study, the use of the nursing process was viewed as a success by the staff involved because they believed that a change in practice had taken place (Hall, 1977), even though this change could not be verified by an objective means.

Group meetings

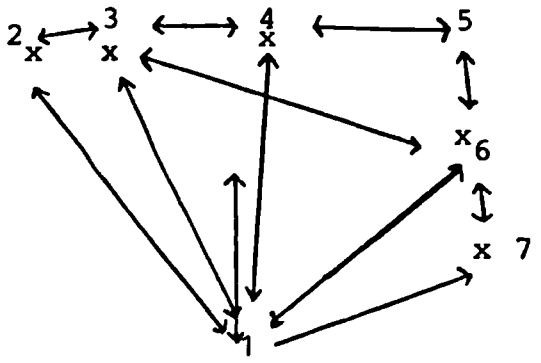
As in the psychiatric unit, the teacher attempted to monitor the flow of conversation between members of the learning group. Unlike the psychiatric unit, no doctor nor other occupational group was present during these meetings. Only three such groups were observed, that is, there were only three occasions in which it was appropriate to monitor the flow of conversation due to the size of the group and the number of interruptions.

Group 1: Five members present.



In this group, the writer discussed with the members of the unit and a clinical Nursing Officer from another unit, the problems encountered in implementing the nursing process. From the seating plan, it can be seen that these two members of the nursing hierarchy were the most favoured persons (numbers 1 and 4). Within the group, a sub-group consisting of the teacher, the clinical based Nursing Officer from outside the unit and a staff nurse were the principal participants in the debate.

Group 2: Seven members present, three from another geriatric area wishing to implement the nursing process.

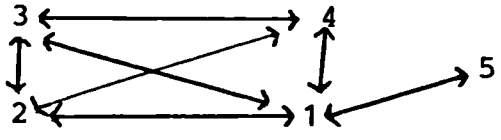


In this group the topic for discussion was the other unit's wish to implement the nursing process. The Nursing Officer may be identified from the seating plan (number 2). In the course of the discussion it was revealed that a previous attempt to implement the nursing process by a Ward Sister in this unit had failed because of the outright hostility of the auxiliaries and the trained members of staff. Indeed the unit enjoyed a certain notoriety amongst members of the unit staff because of the 'power' exerted by these untrained members of staff over their trained colleagues. In the course of the discussion, the writer was asked by these trained nurses to

> "speak to the auxiliaries so that they would allow the nurses to go ahead with the nursing process".

This request was not accepted. It was stated that the writer could only become involved once the staff had decided to implement the change in practice and a need or further education had been established. Within the group several sub-groups are seen to be functioning, each with the writer as the central focus (seating plan 1).

Group 3: Number of persons present: five.



The topic for discussion in this meeting was a review of the progress made by the staff in the nine months since the unit opened. The main flow of conversation is between the writer (seating plan 1) and a group of staff nurses. The staff nurse in the seating plan numbered 5 appears to be the social isolate. In this group all members appear to be contributing to the debate except the social isolate.

These groups illustrated the control the writer had over the nurses' access to knowledge relating to the nursing process. The freedom given to the group reflected the power holder's perception of the amount of clinical autonomy required to implement the role. Evidence was found to support the argument that the traditional medical model for care was being used in the clinical area. Each meeting included a discussion on the willingness of the nursing staff to extend their role into that of the doctor. During the discussion, group members asked questions about the allocation of venepuncture to the nurses by the General Practitioners. The argument put forward by those nurses willing to take on this extra responsibility implied that they believed it was in the patient's interest for the nurse to take blood for routine tests such as "Fasting Blood Sugar" in those cases of suspected Diabetes Mellitus of late onset.

The legal aspects of such procedures are not clear and they are not taught in the basic programme. As stated earlier, the minutes of the N.P.D.G. meetings had contained a statement by the Area Nurse (Clinical Practice) underlining the trained nurse's legal and professional responsibilities in terms of patient care. It is of interest to note that a group of trained nurses who were afraid of the legal consequences of not writing a statement about the patient at the end of each shift, were prepared to take on a clinical procedure for which they were not trained and the legal status of which was uncertain at that point in time. The conceptual frameworks presented in the third part of

the thesis provide a framework for analysing this apparent willingness to engage in role extension.

It is argued that although the management team and the clinical nurses openly adopted a nursing model for care as the preferred mode of practice, the traditional strategy of taking on tasks the medical profession no longer wished to carry out still prevailed. In the presence of this continuing strategy the issue which arises relates to the possibility of implementing the practitioner role, when the power of the medical profession over the development of the clinical role is still as great as it ever was. Again the frameworks presented in the third part of the thesis offer an explanation of this apparent limited autonomy of the clinical nurse.

CHAPTER SEVEN

New homes for old: implementing the nursing process in a long-stay geriatric unit

Gaining access to the long-stay geriatric unit:

Access to the long-stay geriatric unit was obtained through the decision taken by the Area Nursing Policy Group (N.P.G.) to support the nursing process as the preferred mode of practice and the office of the Senior Nursing Officer (Chapter One, page 17). Contact with the wards of the Geriatric unit had been established by members of the post-basic team (N.P.D.G. minutes 4.2.81). The clinical teacher responsible for the J.B.C.N.S. course in care of the elderly had established open communications with members of the clinical areas and the management team. Further, a post-basic education teacher had organised in-service education programmes for the ward staff (N.P.G. minutes 5.8.80) and the teachers of the basic education programme were involved in the promotion of the care received by the elderly person in hospital. Inputs to the clinical area were therefore, well established before the setting up of the N.P.D.G. in January 1981.

Negotiating the contract for change:

The initial contract for change had been negotiated by the writer and the charge nurse of the long-stay unit. Following this charge-nurse's promotion to the rank of Nursing Officer, the contract was renegotiated with the sister appointed in his place (N.P.D.G. minutes 4.2.81). The minutes of the N.P.D.G. meeting of the 25.6.81 identify that the Nursing Officer continued to function as the key resource person representing this unit in the Nursing Process Development Group (N.P.D.G.).

As with the other units, the writer's role was negotiated with the unit staff and defined by them as a "resource person". Thus the writer functioned as a "change energiser" and the unit Sister assumed the role of "change agent" (Ottaway, 1976). It was agreed that the writer would meet with the staff to discuss their attempts to implement the nursing process and to assist the staff in designing a format suited to the needs of the patients and the skills of the staff.

The contents of the first meeting with the staff centred around the distribution of the workload. The writer referred to the concept of "primary nursing". Marram et al (1979) define "primary nursing" as a model for nursing care which supports a unique distribution (assignment) of nurses to patients in the hospital setting. This, they state, is achieved through the continuity of assigning one nurse who is responsible for a given patient's care, which in turn results in effective and efficient care planning, care giving and care evaluation. Thus there is one designated nurse who holds the accountability, autonomy and authority for decision making in the assessment, planning, implementation and evaluation of the care given and received. This role is given only to the "professional" nurse, that is, the Registered nurse (R.C.N., 1981).

Hegyvary (1982) reports on a cross cultural study of the attempts to introduce this "primary nursing" model in Europe, North and South America. In the course of this study, Hegyvary concurs with the definition given by Marram et al (see Chapter Six).

The staff agreed to attempt to implement the basic concepts of this approach to ward management. However, the "professional" role was discussed by the staff in terms of one that could be adopted by students and auxiliaries as well as the enrolled and registered nurse. The practical realities of the ward dictated the interchangeability of roles between the trained and untrained nurse.

The student nurses reported considerable satisfaction with the greater control over their work content. The allocation of responsibility for patient care, especially those associated with "primary nursing" to the student nurse raises many questions. For example: did the greater control over their work result in a higher standard of care, or was the patient placed at greater risk since the nurse's knowledge base and skills had not been added to by simply changing the distribution of the workload, and was the role of the nurse redefined in relation to the patient, his relatives and their peer group?

Implementing the contract:

In the course of the implementation of the nursing process, the staff designed a format for the collection of data and a care-plan suited to their abilities. This format was not dissimilar to that devised by the Community hospital. This format was not suited to the needs of the other wards in the unit. The staff from each ward in the geriatric unit argued that the social factors underlying the patient's admission to the ward, regulated the type of data elicited by the history sheet. Each ward admitted different types of patient, that is those in need of assessment, treatment for acute illness, rehabilitation and long stay. The staff argued that each ward required a different 'Kardex'. They argued that standardised care-plans would result in standardised care. To ensure individualised care, each ward required a different type of nursing process format (Nursing Process Workshop, 17.4.82).

This need to reflect the individuality of the patient in the format chosen, was not to be tolerated by the organisation. Reference to this was made in a meeting held by the Nursing Policy Group at Area level. The minutes of this meeting stated:

> "... different staff groups had designed different forms for use in their particular area, many of which had common elements.

> In order to economise and achieve rationalisation, it was agreed that any staff group who wished to introduce the nursing process should get in contact with the secretary of the Nursing Process Development Group."
>
> (Nursing Policy Group Minutes, 2nd March, 1982)

This need to economise and achieve rationalisation was consistently used by the organisation to defend its inability to support the innovation it had encouraged.

An attempt to introduce an individualised clothing scheme for the patients housed in the geriatric unit was a direct result of a project completed by an Enrolled Nurse following a J.B.C.N.S. course in care of the Elderly. This nurse was concerned about the lack of care and attention to clothing brought into the unit by the patients. She suggested that a personalised laundry system should be initiated to ensure that the patient's clothing was not only clean, but was not being used by other persons in the ward.

The Senior Nursing Officer was enthusiastic about this attempt to improve the care received and to protect the individual patient's clothing. The management team, although giving verbal support, could not find the finance to implement a six month trial of the proposed scheme. Finance for this scheme was provided by the medical staff from research funds held by a Consultant Geriatrician. Thus, an innovation in clinical practice was dependent on the medical profession for its implementation and success.

Implementing the nursing process:

The contract negotiated with the original ward dealt with the needs of patients in that ward. That is, the staff discussed the use of such terms as "mobility", "reassurance", "encourage" and "communicate" as they were used in the context of the care plans. In addition, the staff

identified the need to adjust the organisation of the nurse's day. Like their colleagues in the Community hospital and the psychiatric wards, the staff concluded from their experience with the attempts to utilise a "primary nursing" model, that the shifts worked by the teams had to reflect the composition of those teams. These rearrangements reflected the reliance on part-time trained and untrained staff.

The staff were especially concerned about the lack of continuity of care over the twenty-four hour period. As with the population described in the previous study (Keyzer, 1980), the day staff in the ward identified the problems of the night staff in relation to their lack of access to the continuing education facilities offered by the school of nursing. This lack of access to learning resources, reflected the unsocial hours worked by the night staff and the constraints of family commitments on the hours worked by individual part-time nurses (Keyzer, 1980). Attempts were made by the day staff to work an internal duty rota which included the night shift. To replace those nurses on day duty during their spell of night duty was too expensive. The day staff continued to complain about the 'backwardness' of the night staff. During the J.B.C.N.S. course 940, the ward sister discussed this problem with other nurses (N.P.D.G. minutes dated 15.4.82).

The consensus of opinions expressed by these nurses identified the lack of educational facilities offered to night staff and the negative effect on their abilities to keep up to date with attempts made by the day staff to implement change. This does not mean that all night nurses were opposed to change, nor does it mean that all night nurses were obsolete. All that this data suggest are that in the units observed during this study, the night staff experienced great difficulty in gaining access to continuing education programmes and were unable to contribute to the implementation of change as well as they might have done (N.P.D.G. minutes dated 15.4.82).

The clinical meetings attended by the teacher in the original ward were based on a group approach to education. One of the needs expressed by a staff nurse during one of these meetings referred to the utilisation of her time. She commented that:

> "now I have time to think about the patient as an individual, I need time to think about his special needs... and I need time to think what I am going to do about them."

In this way the staff nurse described the need to create a period of time during the working day, when the staff could sit down and think about the care required by the individual patient. When asked to explain how she had organised this aspect of her working day before the change to a process model, she replied:

> "I guess I just got on with the work."

Thus, she identified the difference in the organisation of the nurses' day between the routinisation of care and care that is individualised. These statements made in the presence of her colleagues did not appear to have an unsettling effect on the group as might have been expected.

It may be argued that by the time the teacher and the staff negotiated the contract, the staff had already acknowledged that the traditional approach to care was no longer acceptable. Therefore, any statement made by the teacher or staff member criticising the traditional method would be accepted as valid. The new norms, styles and values must have been internalised before the teacher became involved with the change.

Like the rehabilitation ward involved in the implementation of change in psychiatry, the introduction of the teacher to the ward occurred at a point in the change process when the staff were ready for further education. It would appear that there is a specific point in the change process when the teacher should become involved with the group.

It is suggested that this point occurred when the group themselves perceived the need for education and the need to involve external sources in the implementation of change.

Evaluating the progress made:

In June 1982, one year after the contract had been negotiated, the writer reviewed the staff's ability to implement the nursing process. This was achieved through an examination of the care plans recorded in the patient documentation. In all some eighty-nine (89) problems were identified in the care plans.

Using a critical incident technique, each problem was written down on a separate card. A second set of eight cards was made out, only three of which identified the categories to which the problems could be linked. These categories were: physical, psychological and social problems. A further five cards were left blank, so that the nurses could create other categories into which they would allocate the various identified problems.

A random selection of staff on duty was made. The Enrolled nurse selected to categorise the problems was used to the format developed by the ward and was accustomed to taking charge of the ward. In addition, she was involved in teaching student nurses in the use of the format in the unit.

The additional categories created by this nurse for the identified problems were: psycho-social, physical-social, physical-psychological, physical-psychological-social and "other". Thus, eight different categories were created into which the nurse was asked to fit the identified patient problems listed in the care plans and used by her in daily practice. The attempts made by the nurse are listed in Table 3.

Table 3: Categories of problems listed in the care plans

N = 89

NURSE	PHYS.	PSYCH.	SOC.	PSYCH/ SOC	PHYS/ SOC	PHYS/ PSYCH	B.P.S.	OTHER	TOTAL
1	25	8	3	14	-	14	-	25	89
2	39	7	-	3	2	29	-	9	89
3	31	7	-	-	3	34	4	10	89
4	37	7	-	3	-	18	4	20	89
5	33	6	-	-	-	18	2	30	89
6	45	4	-	1	1	13	10	15	89
T	37	-	-	9	-	14	29	-	89

LEGEND - PHYS = Physical Problems
PSYCH = Psychological Problems
SOC = Social Problems
PSYCH/SOC = Problems that contain both psychological and social elements
OTHER = Those problems that the nurse could not categorise
PHYS/SOC = Problems that contain both physical and social elements
PHYS/PSYCH = Problems that contain both physical and psychological elements
B.P.S. = Problems that contain biological, psychological and social elements
T = Teacher

To validate the categorisation of the problems, five Enrolled nurses chosen at random from the twelve wards in the two hospitals, were asked to allocate the same eighty-nine (89) problems to the same categories by the first Enrolled nurse. In addition, a nurse tutor was asked to categorise the same problems. The results of these attempts are set out in Table 3.

The contents of Table 3 suggest that the six Enrolled Nurses categorised the same eighty-nine (89) problems differently. Some of these problems could not be classified according to the categories created by the original nurse. Only the tutor categorised all of the problems according to the selected classification. It should be noted that this tutor held a Master of Science degree and had experience in the use of the nursing process.

All of the subjects stated that it was difficult to decide which problems belonged to which category. Thus, after a year of working with the process, the ward staff still had difficulty in writing clear, concise statements of their patients' needs for nursing care. The difficulty in classification was also thought to be caused by the individual nurse's inability to recognise certain problems. For example, categories such as 'vomiting', 'mood swings', 'pyrexia and anorexia' created problems for some of these nurses.

The conclusion drawn was that either the nurses did not understand the terminology they themselves used, for example, "psycho-social", or that the categories were not helpful in identifying the patient's problems.

An alternative method based on Henderson's fourteen "daily living needs" (Henderson, 1966) was used to categorise the patients' needs for care contained in the care plans. To validate the writer's categorisation of these needs for care, a teacher from the school of nursing was asked to assign each problem to the appropriate "daily living need".

Both the writer and the teacher allocated the problems to identical categories. The outcome of this categorisation is shown in Table 4.

Table 4: The identified patient needs in a long-stay geriatric ward

	CRITICAL INCIDENTS	NUMBER OF RECORDED INCIDENTS (N = 89)
1.	Hygiene	26
2.	Elimination	19
3.	Mobility	15
4.	Communication	11
5.	Nutrition	10
6.	Safety	5
7.	Clothing	2
8.	Sleep and rest	1
9.	Recreation	-
10.	Select clothing to be worn	-
11.	Breathing	-
12.	Religion	-
13.	Education/Learn	-
14.	Work/achievement	-
	Most frequently recorded incident: maintaining an intact skin	11

It would appear that like the Community hospital, the nurses in the long-stay geriatric unit, focussed their attention on the patient's needs for care as reflected in the routinisation of ward work. The problems identified were mainly physical problems and were contained in the subject matter taught in the traditional curriculum. Indeed, it may be argued that the problems identified reflected the traditional Nightingale approach of 'ward hygiene'. Like the nurses in the Community hospital, the most frequently recorded incident was related to maintaining an intact skin.

Closer inspection of the problems and prescriptions for care relating to this one aspect of care revealed the need to improve the education of the nurses. The identified

patient's needs relating to maintaining an intact skin and the nursing prescription were divided into three categories. Those in "category one" pertained to the prevention of developing a pressure sore. "Category two" were those persons with a high risk of skin damage, that is, those persons whose skin was red, but not broken. "Category three" was mainly curative, that is, those persons whose skin had broken and where a pressure sore was known to exist.

For "category one", the treatments prescribed in this ward were mainly concerned with the prevention of pressure and the use of nursing aids such as sheep skins. Similarly, these prescriptions referred to the use of frequent changes of position. To assist the nurse, this ward used the Norton Scale, as was the official policy of the Area Health Authority. When asked by the teacher to identify the score at which the patient became 'at risk', the nurses using the scale were unsure of the answer. A copy of the "Norton Scale" used by the ward is included in the Appendix D. Similarly, a copy of the guidelines for the care of the skin from the 'procedure book' kept on the ward is included in the Appendix D.

It was noted that the Norton Scale used by the ward, contained guidelines which suggested that if the skin was broken, it was the role of the physician to prescribe treatment. The ethos in the hospital suggested that this aspect of patient care belonged to the nurse. A dichotomy therefore existed between the official role of the nurse and that implemented by the nurse.

If the role of the nurse included the prescribing of 'cure' as well as care, then the nurses would be expected to have specific knowledge relating to the measures used. In the care plans reviewed in the long-stay geriatric ward, it was noted that there were as many as eight different prescriptions for the care of a pressure sore. In addition, it was noted that the prescriptions for preventive care

no longer appeared once the patient's skin became red, or when a pressure sore was known to exist. Once the skin became red and after it had become a pressure sore, the prescribed care reflected the 'folk lore' of the cultural medicine described by Bauwens (1978).

It may be argued that the studies carried out by Wells (1980) and Baker (1978) suggested that the care received in the geriatric wards might be inferior to that received in the general wards. Isaacs and his co-workers (1972) argued that the most highly qualified staff were located in the general wards and that the most up to date equipment was to be found there. An attempt was made to compare the prescriptions for skin care contained in the care plans of the long stay ward with those of the staff in the major teaching hospital.

The wards chosen were those described by a newly qualified staff nurse as 'real' wards, that is, medical-surgical wards. Data were collected by clinical teachers attached to these wards. These teachers were not in contact with the geriatric unit, nor were they directly involved in the attempts to implement the nursing process in the Health Authority. Data were collected from the nursing orders given to the students with whom the teachers worked and were carried out by the students under direct supervision of the clinical teachers.

Table 5: Nursing Prescriptions (Category 1)

N = 6 wards

NURSING PRESCRIPTION	WARDS (Frequency)	RATIONALE
1. Drapolene Cream	1	Usage
2. 3 hourly turns	5	Usage
3. 3 hourly turns and a sheep skin	1	Usage
4. Sheep skin only	2	Usage
5. 3 hourly turns and the application of cream	1	Usage

NURSING PRESCRIPTION	WARDS (Frequency)	RATIONALE
6. 4 hourly turns and 2 hourly turns at night	1	Usage
7. Sheep skin in bed Kyle Sheet Wash & dry each A.M. Apply Conotrone cream	1	Usage

These prescriptions for care are acceptable, in that they can be verified by referring to nursing literature such as "Community Outlook", March, 1982. However, in each ward the rationale for practice was one of usage. That is, the reply was of the 'we always do it that way' type of answer.

For category two, the prescriptions identified greater diversity between the types of cream used. The different types of prescription are:

Table 6: Nursing Prescriptions (Category 2)
N = 6 wards

NURSING PRESCRIPTION	WARDS (Frequency)	RATIONALE
1. Canesten Cream	1	Usage
2. Drapolene Cream + sheep skin	1	Usage
3. Dermolex & Drapolene Cream	1	Usage
4. Arachis Oil	1	Usage
5. Drapolene Cream	6	Usage
6. White Paraffin	1	Usage
7. Oilatum in bath water	2	Usage
8. Arachis Oil + Emulsifying Ointment	1	Usage
9. Savlodil + Jelonet + Melonin	1	Usage
10. Emulsifying Ointment Soap and Water + Tinc. Benz. Co. + Talcum Powder	1	Usage

NURSING PRESCRIPTION	WARDS (Frequency)	RATIONALE
11. Emulsifying Ointment	4	Usage
12. Sheep Skin only	2	Usage
13. Conotrane Cream	1	Usage
14. Nystantin Cream + Sterzac Powder	1	Usage
15. Egg White + Oxygen	1	Usage

It is not the purpose of this study to argue which treatment was the best approach to care. The use of these prescriptions is to show the wide variety of lotions and creams used by the nurses to treat the same condition and the lack of a scientific rationale to guide that practice. The use of a wide variety of creams contained in this collection of nursing prescriptions can be viewed as a "belief in powerful objects", in that, the individual nurse prescribing the actions believed they would work (Bauwens, 1978). No attempt has been made to discover the actions of these creams, nor was there any attempt to supply scientific evidence to support their use in the context of pressure care.

Table 7: Nursing prescriptions (Category 3)

N = 6 wards

NURSING PRESCRIPTION	WARDS (Frequency)	RATIONALE
1. Oilatum in bath + Drapoline Cream	1	Usage
2. Cicatrin Powder	1	Usage
3. Conatrone Cream	1	Usage
4. Thovaline Cream	1	Usage
5. Steridrape	3	Usage
6. Emulsifying Ointment	1	Usage
7. Egg white + oxygen	6	Usage
8. Egg white + oxygen + Insulin	2	Usage
9. Iodine Spray	2	Usage

NURSING PRESCRIPTIONS	WARDS (Frequency)	RATIONALE
10. Opsite	5	Usage
11. ½ strength Eusol	2	Usage
12. Poviodine	3	Usage
13. Zinc and Cator Oil	3	Usage

As with the category two prescriptions, the category three nursing actions identified the use of a wide range of substances with no clear rationale for practice other than that the nurses believed they worked. In terms of the prescriber role and the need for education, this data suggest that there was a deficit in the trained nurse's knowledge.

No difference was found between the knowledge held by the nurses working in the geriatric wards and those who worked in the general wards. That is, neither group could give a clear rationale for the prescribed action. It may be argued that these data indicate that the basic education programme had failed to give the nurse a scientific basis for one of the most common nursing actions, that is care of the skin.

A review of the curriculum offered by the school of nursing indicated that the General Nursing Council had not approved the allocation of student nurses to the Dermatology Unit. Similarly, the prescription for care outlined in the 'procedure book' made no reference to the relevant research on skin care. It is suggested that this prescription of care based on a "belief in powerful objects", reflected the type of care that might be found in the home.

The data support the hypothesis that the division of labour between the organisational role of the nurse and that of women in their own home is social, rather than technical. Similarly, the prescriptions reflected what the nurse will

do for, or to the patient. None of the prescriptions for care reflected an increased participation of the patient in his daily living activities. Thus, just as the hierarchy continued to exist, so also did the division of labour between the nurse and the patient remain unchanged. That is, the distribution of power and control in the organisation remained in the status quo.

It is suggested that the contract between the teacher and the staff may have developed the staff's ability to develop a new Kardex but it did not automatically follow that the power relationships between the nurse, the manager and the patient had changed. It is suggested that this case study implies that the introduction of the nursing process, like the attempts to implement the recommendations of the Platt Committee on the care of children in hospital (Stacey et al, 1970), may appear to give the patient a greater say in his care, but the change may be more apparent than real.

CHAPTER EIGHT

Towards a new model for rehabilitation: implementing the nursing process in a psychiatric rehabilitation unit

Gaining access to the rehabilitation unit:

Access to the unit was gained at two interrelated levels, that is the formal and informal organisations. The decision taken by the N.P.G. to support the implementation of the nursing process (see Chapter One, page 17) is taken to represent the formal organisation and the informal organisation took the form of the invitation from the charge-nurse to the writer to help the staff to implement the nursing process in his unit. In terms of change theory, the latter may be viewed as the more important, in that it reflects the group's perceived needs for a change in practice and its recognition of the place of education in the change process. The support of the hierarchy is also recognised in that, resources are needed to implement change and to support the educational needs of the trained staff (Bennis et al, 1976; Towell and Harries, 1979).

The minutes of the N.P.D.G. meetings dated 4.2.81 identify the Rehabilitation unit's participation in the change toward the nursing process and its status as a pilot area. By the middle of 1981 however, the minutes of the N.P.D.G. (25.6.81) reveal that the representatives of the psychiatric wards, including the Rehabilitation unit, had difficulty in attending these meetings. The minutes of the same group dated 30.7.81 report the writer and the charge-nurse from the Rehabilitation unit as identifying the problems relating to the staff's inability to keep to the deadlines set by the N.P.D.G. These problems in part, resulted from staff shortages and are recorded in the N.P.D.G. minutes of 28.8.81 and are repeated in the minutes of 24.9.81. The minutes of the 24.9.81 quote the

writer as reporting that little progress had been made in helping the nurses from the psychiatric unit in their attempt to participate in the N.P.D.G. activities and his request that the psychiatric nurses should not be excluded from the innovation in practice.

The progress made by the members of the Rehabilitation unit is acknowledged in the N.P.D.G. minutes dated 15.4.82, and which report the Rehabilitation unit's attempt to set up a weekend workshop for nurses interested in the implementation of the nursing process on the 16 and 17 April, 1981. Reference to this workshop is made later on in the discussion on the assessment of the success achieved by the units in the psychiatric Division. The N.P.D.G. minutes also record the Rehabilitation unit staff's inputs to a study day presented by the N.P.D.G. on the 23.6.81. Reference to the staff's evaluation of their success will be made later in Chapter Twelve. Similarly, reference is made to the paper published by the charge-nurses, based on that evaluation, throughout the thesis (see Hicks and Tutt, 1982).

The mode of entry to the clinical area and the above data recording the need to involve the hierarchy in the provision of resources, indicates that although the staff had some control over the mode of practice adopted, the final decision rested in the hands of the hierarchy. Thus, the clinical nurse in psychiatry, like his colleague in general nursing, has only a limited control over his work environment and the mode of practice adopted.

The first meeting held between the writer and the members of staff from the Rehabilitation unit was held in a "general discussion" room in the main ward of the unit. The members of staff present at this meeting were a Senior Nursing Officer, a Nursing Officer, three Charge-Nurses, Staff nurses, Enrolled nurses, Student and Auxiliary nurses. In addition, a Consultant Psychiatrist and a member of the Medical Social Work department were present.

The group were seated in a circle and this, it was emphasised by the charge-nurse, reinforced the staff's belief that their's was "an open system in which each finds his or her own role". In this "open system" symbols of power and control were on display. The initial impression was given by the quality of clothing worn by the group members. The different styles and quality of clothing worn by the medical and nursing staff represented the divisions of social class and wealth between these two occupational groups. Similarly, the division of labour was reflected by the "professional" image of the doctor's clothing and the more utilitarian nature of the nurses' casual clothing. The nursing staff had discarded the traditional uniform in order to overcome the barriers it represented in the nurse-patient relationship.

The nurses did, however, display symbols of power and control in the form of the "bleep" and the ward keys. Since the "bleep" identified those members of the hierarchy with the organisational power to engage in decision making, it invested its temporary owner with that power vis-a-vis other members of the work group. Similarly, individual members of the group displayed bunches of the ward keys in a variety of ways. Even when these keys could not be seen, they could be heard as the nurse walked across the room. These keys opened the duty room door, the drug cupboard and other locked containers including the access to food and beverage. Thus, they represented the power and control invested in the charge/staff nurses vis-a-vis the junior nurses and the patient.

<u>The content of the discussion and the group dynamics:</u>

The topics discussed by the group included the role of the nurse, the stages of the nursing process and primary nursing as the modality for implementing the change in practice. The most striking aspect of the debate was the group's inability to define the nursing role, especially that of the professional nurse. It was with some pride

that they argued "we all do the same work". Thus, like their colleagues in the long-stay geriatric ward, these nurses appeared to have confused democratic management with the traditional strategy of keeping boundaries between the different grades of staff ill-delineated and an interchangeability of roles.

At the end of this first group meeting the staff had not reached a concrete decision about their future course of action. Within the group, two leaders appeared to be in conflict with each other. It is suggested that this conflict stemmed from the charge-nurse's challenge to the power of the medical staff over the clinical role. Therefore, the influence those power holders had over the loyalty of individual members of the group and group cohesion, were sources of possible barriers to the proposed change. Similarly, it was argued that individual members of the group were using the change to promote their own status within the unit, the hospital and the Health Authority.

The absence of a member of the school of nursing was noted by the group members. To quote one member of the staff

> "you never see them in the ward - they pop their heads round the door and ask if you're okay - then they're off."

It should be noted that the shortage of psychiatric nurse-teachers created acute problems for all those teachers involved in the basic programme. The possibility of involving a member of the psychiatric nursing teaching team could only be achieved at the expense of the basic learners.

Evaluation of the first group meeting:

At the beginning of the study the variables influencing the group's ability to implement the proposed change were identified as follows: the support of their senior managers and strong leadership from at least one charge-

nurse; a resource person in the nurse-teacher who was willing to act as a change energiser; support from within the group for a clinical based T-group approach to education. The variables which might inhibit the group's progress were identified as follows: a lack of support from a clinical specialist well versed in the implementation of the nursing process; the conflict between the charge-nurse and the psychiatrist resulting from the challenge to medical supremacy over work content and education; and the non-participation of the silent members of the group. Similarly, there was always the chance that individuals inside and outside the group, were using the proposed change to enhance their own professional status.

A contract between the teacher and the charge-nurses was negotiated in which the role of the teacher was defined as that of a change-energiser and that of the charge-nurses as change-agents (Ottaway, 1976). In common with their general nursing colleagues, the group requested the presence of the writer in the clincal area throughout the change process. Thus, both general and psychiatric nurses perceived the need to initiate clinical-based learning programmes to support the change in practice.

In-service education in the Rehabilitation unit:

The initial education programme for this change in practice was mainly in the form of visits to other units outside the boundaries of the Health Authority. The nurses acknowledged the medical profession's contributions to the arranging of these visits. No attempt had been made to set up a formal or non-formal nursing education programme. One charge-nurse had gained entry to the Diploma in Nursing (London University, Old Regulations) offered by the school of nursing.

In his evaluation of the Diploma in Nursing course, the charge-nurse identified the negative influences of the ward environment on his attendance at the day-release study

days. In particular, the charge-nurse identified the effect of the nurse:patient ratios on his ability to attend the course. In this he supported the data from the previous study (Keyzer, 1980). When the nurse:patient ratios were low, the nurse was discouraged from leaving the ward to attend the educational programme.

The main benefits of the course for this particular nurse were identified by him as the chance to meet with members of the peer group to discuss the present service offered to the population. He suggested that the review of common problems contained in these peer group discussions, clarified his own ideas and concepts of what constituted good patient care. The preferred learning environment was identified as informal group discussions in the coffee room or the "pub" at lunch time. This preferred learning mode was supported by other members of the study group. This suggests that informal group discussions is a preferred learning strategy for post-basic nursing education (Moran, 1977).

Further insight into the organisational factors which influenced the student's access to education, was provided in the students' evaluation of the Diploma in Nursing course. The participants described the negative attitudes of ward staff members towards the learning programme and its relevance to practice. They also identified the nursing officer's inconsistent support throughout the course. To quote one student during the course evaluation:

> "It is as if they give their support, then try to make it as difficult as possible to attend."

This supports data collected by the previous study (Keyzer, 1980), in which the respondents suggested that their immediate supervisor's attitude to continuing education was "indifferent".

From the "end-of-course" evaluation records held by the

writer as the course co-ordinator for the Diploma in Nursing - Part A (London University, Old Regulations), the following comments from seventeen (17) student questionnaires (session 1980/81/82) reveal the type of support nurses involved in this post-basic course can expect from their colleagues in the clinical area:

Nurse "A": "My clinical responsibilities resulted in divided loyalties between a busy ward and the course. The course is well worth doing, but needs support and backing from the clinical areas."

Nurse "B": "I would have gained more from the course if it had been full-time as the feeling of isolation by virtue of a one-day release for twelve months seemed obvious from work colleagues. I found that working in a busy A/E unit was not the ideal medium for ongoing study. Initially written assignments were good when one had the enthusiasm to battle on against: 1 isolation from work, 2 certain hostile vibes from colleagues. Finally, I would not wish to appear unduly critical, but I lost much of my ideal for doing this course by the concentrated effort of having to study for the examinations at the expense of attending to the lectures. Also not once was I approached by the education department of.... supposedly my sponsors to see how I was getting on!"

Nurse "C": "I would have benefitted from a full-time course because the clinical responsibilities would be completely relieved and therefore all time can be spent towards the course and a routine of study could be beneficial. I felt my clinical commitment to the ward came first and for that reason, combined with the fact of doing frequent night duty on internal rotation, affected my studies considerably. I had insufficient time to complete the written assignments as a result.... just to emphasise the fact that having gained a tremendous amount from the course - to get to exam standard, I feel it is unfair on top of the clinical commitment and night duty I would rather a full-time course, or if it is to stay on day release then the exam standard set is reviewed. I found it frustrating that although I knew I was capable of attaining the exam standard,

time and my responsibilities to the ward came uppermost in preventing this."

Nurse "D": "I'm sure that if the course is full-time then there are fewer distractions from work and more continuity in the course. Particularly, if I had lectures to prepare in my own time and marking prior to settling down to study in the evenings."

Nurse "E": "I feel that I would have felt more.... (student's writing unclear at this point). Also for research/study, a full-time course would have taken me away from the pressures of my work. Especially colleagues' attitudes to 'part-time' work. I feel that I had to work twice as hard at work."

Nurse "F": "My clinical responsibilities inevitably reduce study time as I'm usually too tired to study after a day's work. Ideally I would like this course to be full-time but realise that the staffing difficulties may be insurmountable."

Nurse "G": "My clinical responsibilities affected my ability to study. Working as a Sister on a busy A & E department is extremely tiring - sometimes difficult to study in free time."

Nurse "H": "My clinical responsibilities affected my ability to study particularly irregular hours so no pattern for studying could be followed."

Nurse "I": "It is very difficult switching from full-time clinical work to studying from one whole day, and then back again. When the working load is heavy, I am too tired to sit and study and therefore my study has to take the lower priority."

Nurse "J": "Working as I do in a hospital where the turn-over of staff from Sister grade and upwards is very slow, I feel that the opportunity for staff to leave their work place for a full-time study course would result in refreshed outlooks to work and would benefit the patients. I wonder if there is enough awareness amongst nursing management of the benefits to be gained by the H.S. from post-basic education. Support and encouragement from that source might be more forthcoming if those benefits were more widely appreciated."

Nurse "K": "Freedom to pursue studies away from clinical cares, "academic" atmosphere, continuity of discussions, ect, ect, ect. Probably outway the advantages of Day-release. Dichotomy = 1) passing the exam 2) offering better nursing care."

Nurse "L": "When the ward was very busy my studying was the first thing to suffer."

Nurse "M": "Being on night duty my concentration power for study was limited and I did feel that my work should not suffer due to study. Very difficult to study after a days work."

Implementing the learning contracts in the Rehabilitation unit:

The contracts negotiated by the writer, the staff and the consultant psychiatrist in the Rehabilitation unit, was implemented in a series of clinical meetings held each Friday morning in the unit staff room. This room was an integral part of the unit floor plan and was housed on the second floor of the main hospital building. Each meeting was attended by the consultant psychiatrist, his junior doctor, a medical social worker, all the members of the unit nursing staff including those student nurses seconded to the hospital in part fulfilment of their General training programme. On rare occasions, individual patients were asked to attend these meetings. The writer was invited to attend these meetings and when his commitments to the formal post-basic courses permitted him to do so, recording of the topics for discussion and the flow of two-way conversation was made (see Chapter 4). In all, the writer attended thirteen meetings between the 18.7.81 and 5.2.82. The meeting held on the 2.12.81 was convened for the purpose of a discussion between the writer and the unit staff on the observations made by the writer in each meeting.

Each meeting started at approximately 10.30 am and lasted for about ninety minutes (90). Immediately before and directly after each meeting the teacher held informal

interviews with the charge-nurses and any other member of the team wishing to discuss the implementation of the nursing process. During these interviews, individual students and staff nurses would air their opinions on the progress or lack of progress made. The writer observed that during the meetings neither the medical social worker nor the general nursing students made any contribution to the debate.

Each group meeting observed by the writer, commenced when the consultant joined the group. The charge-nurses only assumed the leadership role when the consultant was on annual leave. In those meetings observed by the writer, the discussions did not begin until the consultant had taken his seat and his consent to commence the proceedings had been obtained. This consent was usually signalled to the charge-nurse by the consultant nodding his head in an affirmative manner.

Similarly, each meeting finished when the consultant rose from his seat. The point reached in the discussion and the degree of decision-making achieved, appeared to be of little consequence. It may be argued that in terms of patient care, it was the consultant's decisions which really counted (Freidson, 1970). Any decision made by the group would therefore, be of secondary importance. However, since it was the nursing staff who had to carry out these decisions, there was always the possibility that these objectives for care might be modified to suit their perceptions, or that the medically approved approach to care might be discarded. One staff nurse consistently stated, in private and in the group, that no real change ever occurred in the care received because no real decisions were ever made.

The diagramatic representatives of the flow of two way conversations during the meetings are contained in Appendix E. A conclusion is drawn from these sociometric studies

that the initial meeting between the writer and the group had identified the power structure in this unit. It was the same members of staff who controlled the flow of information in the group and between the different grades of staff in the nursing and medical hierarchies. From the topics discussed, from the anxieties expressed and from the patient's greater involvement in the management of their daily lives including the stopping of the old work routines, it appeared that some changes had taken place.

From the individual informal interviews held by the writer with the four charge-nurses, two staff nurses and four student-nurses (psychiatry), a conclusion is drawn that there is a lack of readily available nursing knowledge to replace the traditional reliance on medical data. In particular, these nurses identified the over emphasis on general nursing in the post-basic courses offered by the school of nursing. Psychiatric trained nurses (3) attending the Diploma in Nursing course (London University, Old Regulations) supported this belief in their course evaluation (June, 1982). Thus a lack of specific nursing knowledge and technology, together with a limited access to further education, forced these nurses to rely on the one source which had never failed them: the medical profession.

CHAPTER NINE

Towards an integrated model for nursing care: implementing the nursing process in a Psycho-geriatric Assessment Unit

Gaining access to the Psycho-geriatric Assessment Unit:

The access to the unit was facilitated by the offices of the Divisional Nursing Officer (Psychiatry) and the Director of Nursing Education. This was supported by the decision taken by the Nursing Policy Group (N.P.G.) to adopt the nursing process as the basis for education and practice in the Health Authority (N.P.D.G. meeting minutes dated 4.2.81, see Chapter One). The Psycho-geriatric assessment unit was therefore, a pilot area and since it formed part of the same hospital as the Rehabilitation unit, many of the problems met by that unit were also faced by the Assessment unit.

The initial appointment to introduce the writer to the staff was arranged by a teacher from the school of nursing (psychiatry). A nursing officer and that teacher were the vehicles used to establish the contract between the writer and the nursing staff from the unit. Thus, although in theory any member of the nursing staff had free access to any member of the school of nursing staff, the boundaries between the school of nursing and the clinical areas were tightly controlled by managers at middle and top levels.

The need to involve management, especially middle management, indicates the importance of the facilitator/enabler role of the Nursing Officer in the implementation of change (Cropley, 1980). Baker (1978) identified management's implicit and explicit acceptance of low standards of care. Pembrey (1980) suggested that the role model

provided by senior staff had a lasting effect on the professional role adopted by the trainee. It may be argued that the manager's attitudes towards education and standards of practice, are extremely important in the attempts made by the ward staff to implement the nursing process.

In both the assessment and rehabilitation unit, much of the direct patient care was carried out by student nurses. Bearing in mind the low organisation status and knowledge base held by these nurses, any attempt to implement the nursing process must be viewed as an attempt to introduce a change from a position of weakness. Although this grade of nurse carried the responsibility for the quality of care received by the patient, her inputs to the decision-making process were negligible.

Introducing the teacher to the ward staff

The first meeting between the writer and a member of the ward staff was convened in the "sitting room" of the ward. Those persons present were the Nursing Officer, a teacher from the school of nursing (psychiatry), the senior charge-nurse and the researcher. This was the only occasion that the Nursing Officer or a member of the psychiatric teaching staff ever participated in a meeting related to the implementation of the nursing process. In common with the rehabilitation unit, the decision to implement the change in practice was taken by a small group of elites.

This position of weakness was compounded by the charge-nurse's educational background. As a graduate of the school of nursing, she was still in the student role when confronted by the teaching staff (Bennis et al, 1976). Thus, organisational power and authority by virtue of rank and sapiential authority based in academic achievement, combined to maintain the status quo, between the organisational roles of the practitioner, the manager and the teacher.

Throughout the meeting the observer noted the charge-nurse's discomfort when spoken to by the teaching staff. This she later confided, was in part due to her feeling of "being grilled" by the hierarchy. In particular, she identified the researcher's academic background as a barrier to establishing a trust relationship. It was only after a considerable length of time had elapsed, during which the writer had to prove his understanding of the pressures of the workload on the staff, that this barrier was overcome. It is difficult to state exactly when the barriers to communication were dropped by the staff, but it was certainly not within the first six months of the contract. The enrolment of the senior charge-nurse into the J.B.C.N.S. course 940/941 was a major factor in the formation of a closer relationship. This course was initiated six months after the first meeting between the writer and the members of the psycho-geriatric assessment unit's staff.

Toward the end of the study an incident occurred which suggested that the nurse's academic background might have an influence on the acceptability of a nursing prescription for care. This incident concerned the writer and the senior Charge-nurse. During a review of the care plan for a specific patient, the senior Charge-nurse asked the writer to approve a specific course of nursing action to meet an identified patient need for nursing care. When the writer asked the Charge-nurse why it was necessary to have his approval for a nursing action which she personally had prescribed, she replied:

> "if ..... (nurses name) ..... says this should be done everyone will question it, but if I say Dirk Keyzer said it was alright no one will question it. Even the medical staff."

Thus she identified the staff's use of the writer's name to back up prescriptions for care, even when they themselves had clinical experience which the writer, as a

general trained nurse, did not have. This state of affairs was acknowledged by the junior staff in the unit and when discussed with other nurses in the geriatric wards, which formed the other pilot areas in this study, they also admitted to this strategy.

Although this study has not attempted to analyse the effect of individual personalities on the implementation of change, it might be that in this instance the personalities of those involved could have been a factor. The Director of Nursing Education consistently referred to the three teachers associated with the Nursing Process Development Group as "mavericks". This suggests that these people were perceived to be "different". However the senior Charge-nurse was also acknowledged by the school of nursing, her Nursing Officer, her Divisional Nursing Officer, and her colleagues in the unit as a strong personality who was:

> "a real go-up-and-getter who stands no nonsense"
>
> (Unit Nursing Officer)

This data is limited and further study is necessary to clarify the effect higher education has on the nurse's clinical credibility and her attempts to implement change.

Contents of the first meeting:

The topics discussed during the first meeting concerned the staff's attempts to create and use a nursing history and evaluation sheets. In common with the Rehabilitation unit, the nurses in the Psycho-geriatric Assessment unit had adopted a model for care which emphasised the patient's active participation in his/her activities of daily living. Thus, the framework most suited to the needs of the patients as perceived by the nursing staff, appeared to be that described by Orem (1980) in her contractual relationship based on self-care activities.

When asked by the writer to define the role of the professional nurse in the unit, the senior Charge-nurse stated:

> "we all do the same job here. I don't ask any one to do a job I cannot do myself."

Like her colleagues in the other pilot areas described in this study, she appeared to believe that in an organisation in which the traditional Nightingale structure and its over lapping of organisational roles existed, the interchangeability of the roles of the trained and untrained nurses represented "democratic" management. The rationale for this belief was discussed by the Charge-nurse and the Nursing Officer for the unit and they identified the need for all members of the trained staff in the unit to take turns as the "nurse-in-charge" of the ward. Thus an interchangeability of roles between the roles of the registered and enrolled nurses was essential to the smooth running of the unit.

It may be argued that the traditional strategies of the Nightingale hospital and the realities of the workload in this unit combined to demand the routinisation of care, the ill delineated boundaries of the clinical nurses and that any attempt to introduce an alternative mode of practice might result in not only role conflict, but also diminished levels of supervised practice for student nurses.

The nursing officer and the teacher from the school of nursing (psychiatry) acknowledged the unit staff's inputs into the education of basic and post basic student nurses. If the staff acknowledged their own lack of education for the task at hand, then the content and the quality of their teaching programmes for the student must also be open to question. However these nurses are entitled to credit as they were as Lamond (1974) pointed out in her study of nursing education, those clinical

nurses who were willing to share their knowledge with the students in the ward.

In an attempt to clarify the role played by nursing staff in the student's gathering of knowledge during their allocation to the Rehabilitation and Assessment units, the writer held informal conversations with the students seconded to these two units by the school of nursing (psychiatry). Like their role models, the trained staff, the students identified the medical staff as their major source of information to define and explain patient's needs for care and their behaviour patterns. The students also expressed their gradual realisation that towards the end of their training programme their introduction to the staff nurse role identified their lack of preparation for their managerial responsibilities (Vaughan, 1980). In doing so they described the discrepancy between the curriculum model offered by the school of nursing and the practice model offered by the daily activities of the trained nurse in the clinical area.

When viewed in the light of the research studies carried out by Dodd (1973) and Bendall (1975) into the dichotomy between the theory and practice of nursing and discussed in Chapter Two of this study, the apparent lack of understanding of the organisation in which they worked and expressed by members of the Assessment unit staff, together with their lack of access to further education, suggests that the attempt to implement the nursing process in this unit was an attempt to introduce change from a position of organisational weakness. On the other hand it might be that the staff had, as they believed they had, an open system based on democratic management lines and that this alone would ensure the success of the venture.

Negotiating the contract for change:

At the end of the first meeting, the writer and the senior Charge-nurse negotiated a date and time for the writer

to meet the other members of the unit staff. The topic for discussion was identified as the nursing process. The meeting was held in a ward side room. Those persons present included the writer, a charge-nurse and a staff nurse. The senior charge-nurse remained in the patient areas to supervise the work of the student nurses. The discussion between the nurses present did not proceed further than a resume of the contents of the first meeting. The second charge nurse denied any knowledge of the proposal of change or any knowledge of the meaning of the term "nursing process". It was therefore necessary to involve the senior charge-nurse in the discussion.

The senior charge-nurse recalled the staff meeting at which the group had decided to adopt the nursing process as the basis for practice. The conflict between these two charge-nurses reflected that recorded in the previous study (Keyzer, 1980). In that study, two sisters had disagreed about the implementation of the nursing process and as a result there was a barrier to the implementation of the learning contract. Unlike the previous study, the senior charge-nurse in the assessment unit was able to overcome the resistance of the second charge-nurse and the staff nurse. This was achieved through the retrieval of the minutes in which the agreement to implement the nursing process was recorded.

This conflict between members of the ward hierarchy was thought to be related to the divisions in the work team. These divisions were decided by the shift worked by the team members. The senior charge-nurse identified her lack of authority over the "late" and "night" shift teams. This, she believed, was the result of having one charge-nurse for each shift worked. Thus, the ward team consisted of three independent work groups, each with its own charge-nurse and staff-enrolled nurses.

Although in theory the staff had agreed to implement the

proposed change, each individual work group had not necessarily supported the change in practice. The second charge-nurse was quite open in her disagreement with the decision made. She stated that she

> "was just the housewife of the unit ... did not want to be involved with the hassle of change ... would not oppose it, but don't want to be involved."

In common with the "silent" members of the rehabilitation unit's staff, this senior nurse did not object to the change per se, but she did not wish to be involved in the risk-taking or the decision-making inherent in the change.

It is suggested that the lack of co-operation from this key member of the team (Pembrey, 1980) was a major variable in this unit's failure to progress in the change process. Similarly, that resistance to change need not be hostile, but can be just as destructive when it takes the form of non-participation. This senior nurse made no particular attempt to promote the change in practice and full responsibility for the plan was given to the other two charge-nurses on day duty.

At the end of the meeting the nurses and the writer negotiated a learning contract which identified the second charge-nurse's learning needs as follows:

> "to read the literature on the nursing process and to be able to discuss those concepts in relation to the needs of the staff and the patients in the assessment units."

The time frame for the completion of this contract was set for six weeks. The learning strategies adopted by the nurses included the selection of journal articles and books from the school of nursing's library.

The staff employed in the psycho-geriatric assessment unit,

unlike their colleagues in the rehabilitation unit, emphasised their need for a structured learning programme. This shifting of the responsibility for learning on to the teacher was perceived by the teacher as a manifestation of the second charge-nurse's low risk-taking. Further it may be argued that the staff's perception of the proper goals for patient care were influenced by the traditional models for care. The attempt made by the group-as-a-whole to legitimise the change in practice was not supported by this second charge-nurse.

One of the arguments put forward by the second charge-nurse in support of the structured learning programme, was the low staff:patient ratios and the heavy workload carried by all members of staff. At the beginning of the study, the unit was understaffed, but even as the staff:patient ratios improved, no obvious change in the staff's ability to implement change occurred (N.P.D.G. minutes, 28.8.81).

This would appear to support Wells' study (1980), the findings of which suggested that it is not that the staff do not mean well, nor that they do not work hard, rather it was the goals for care that were inappropriate. Similarly, as Baker (1978) argued, the present inferior levels for care are supported by both medical and nursing hierarchies.

It may be argued that it is not unreasonable for members of staff to be unsupportive of the proposed change. It is exceptional that they do perceive the need for change and are willing to tackle the potential opposition of the power holders that is, the nursing hierarchy, the school of nursing and the medical personnel.

The evaluation of the first learning contract

At the end of the six weeks' time frame set by the learning contract, the writer returned to the unit to discuss the

staff's progress. On entering the patient area the teacher was met by the second charge-nurse, who claimed that the staff were too busy to discuss the proposed learning programme. The teacher therefore had to withdraw from the clinical area and to arrange a new date for the review of the contract.

This inability of the staff to meet their negotiated commitments was a specific feature of this unit. This led to frustrations in both the teacher and individual nurses. It did not appear to upset the second sister, who perceived the pressures of the work load as a justification of the traditional work patterns. Apart from the construction of new nursing process documentation formats, no real progress was made in this unit's attempts to implement change in practice. At the end of the study, the same work books and Kardex system as described by Lelean (1975) and used at the outset of the contract, were in use. The Nursing Process Development Group's minutes record the assessment unit staff's inability to attend meetings and to contribute to the development of the change process.

It may be argued that the lack of group cohesion was a major factor in this apparent lack of progress. The most junior of the three day-shift charge-nurses claimed that the staff played games with each other. In particular, he suggested that individual members of the team purposely blocked the effects of their more progressive peers. The major breakthrough in this unit's attempts to implement the nursing process was the senior charge nurse's admission to the J.B.C.N.S. 940/941. Continuity between the ward based contract and the formal learning programme was ensured by the writer's involvement in both programmes.

In-service Education in the Psycho-geriatric Assessment Unit

The use of the medical model for practice was enhanced through the physician's control over the nurses' continuing

education. In the absence of formal post-basic education specifically aimed at the needs of the psychiatric nurses, the staff turned to the medical profession for the knowledge required to guide practice. Only one of the twelve post-basic education courses offered by the school of nursing, was related to the specific needs of the Registered Psychiatric nurses. The staff did have access to the Diploma of Nursing (London University, Old Regulations) and the J.B.C.N.S. course in care of the elderly. The nurses commented on the heavy bias towards general nursing in these courses and hence, the limited value to the psychiatric nurse.

In common with their general and psychiatric colleagues, the staff identified their preference for informal, peer group discussion as a means of acquiring new knowledge (Moran, 1977). The medical staff's inputs to these informal/non-formal educational programmes were mainly through the use of seminars and group visits to centres of "excellence" outside the boundaries of the Health Authority.

Following each of these non-formal educational activities, the staff resolved to implement the desired change in practice. In spite of their good intentions, the staff never realised the proposed changes. In their evaluation of their past failures, the staff identified the following variables: the inadequacy of the basic training programme in preparing them for their new roles, the preference for "custodial" care in the organisation of the psychiatric services and low staff:patient ratios.

The dissatisfaction expressed by the staff towards the basic training programme, reflected the attitudes of the other nurses involved in this study and the recommendations by the Briggs Report (1972). Not only had the education programmes at basic and post-basic levels failed to provide the nurses with a framework for practice, it had also

failed to support the nurse with adequate knowledge for the level of expertise required for the position held. This gives grounds for questioning not only the nurses' ability to implement change, but also their ability to meet their patients' needs for care under the existing system (Keyzer, 1980).

The control exerted over the nursing role by other health care workers

In addition to the medical staff's control over the nursing role, there was evidence which suggested that other health care workers exerted an influence over the development of nursing. In common with the data contained in the case study of change in the Community Hospital, this control was founded in the occupational strategy related to the taking on of care activities which other workers such as clinical psychologists, physiotherapists and doctors, leave out, as a rationale for comprehensive nursing care (Davies, 1976, 1977).

At the beginning of this case study, the nursing staff had elaborated on the traditional Kardex and designed assessment and evaluation formats. The staff identified their dependence in the clinical psychologist and the occupational therapist in the construction and use of these new nursing formats. Both of these health care workers had provided the knowledge and the framework required to construct the nursing history and evaluation sheets. This dependency on other professionals' expertise not only underlined the inadequacy of the basic programme, but also the low status held by nurses vis-a-vis other occupational groups in the hospital.

Further evidence to support this data was obtained during the evaluation of the learning programme by students following the J.B.C.N.S. course 940/941. The students complained that members of the other occupational groups

such as Occupational therapists, "talked down" to nurses in the ward and the classroom. In addition, the students claimed that they were unable to implement essential nursing care and to improve the standard of nursing care, because of the demands made on their time by other occupational groups. These occupational groups were identified as doctors, physiotherapists-occupational therapists and clinical psychologists. Thus, the nurses themselves identified the menial, ill delineated role of the clinical nurse and the debasement of their specific contributions to patient care vis-a-vis other occupational groups.

It may be argued that unlike the prescriber role suggested by Henderson (1966), the role experienced by the nurses in the assessment unit and the other wards involved in this study, was that of implementing other health care workers' orders. The lack of specific nursing knowledge and technology together with the dependency on other workers' knowledge, suggested that this organisational role and status of the nurse reflected the role and status of the woman in the home and society. Similarly, it may be argued that the division of labour between professional nursing and "mere" mothering is based on social rather than technical factors. The value placed on the organisational role vis-a-vis the domestic role, is based on the nurses' close proximity to and use of "scientific" medicine in the hospital setting (Davies, 1979). In the home and the ward, the care giving role is allocated to low status females for whom few or no educational opportunities exist.

Evaluating the effect of formal education on the implementation of the nursing process:

At the end of the J.B.C.N.S. course in care of the elderly (940), the writer, the clinical teacher for the course and the senior charge-nurse from the psycho-geriatric assessment unit, held a formal interview as part of the course requirement (January, 1982). The interview was held in a classroom belonging to the Community school of nursing.

Only these three persons were present. The interview lasted forty-five (45) minutes. From the official records kept by the writer and the clinical teacher, and which form part of the student's official course record, insights were obtained of the effect education has on the nurse's mode of practice. In her verbal evaluation of the course, the senior charge-nurse identified the following learning strategies as important aspects of adult education: the use of peer group discussion, the opportunity to meet colleagues from other clinical areas involved in the care of the elderly and the opportunity to engage in self evaluation. The records kept by the writer and the clinical teacher also reveal that the charge-nurse stated that the peer group discussions had enabled her to assess her clinical skills as being "special" or "different" from those described by her peers in the classroom.

The records kept by the writer and the clinical teacher involved with the charge-nurse throughout the course, quoted her as saying during the interviews:

> "I used to feel that I had been put in charge of the unit because I could cope with it ... now I realise that I have got special skills which other nurses don't have. I was surprised to see an occupational therapist carrying out what I consider to be my job (reality orientation), but what really surprised me to see the way which the nurses accepted a bed making, drug pushing role."

In this statement the charge-nurse identified the effect of the course in raising her level of consciousness in relation to the patient's needs for and her contribution to the care required. She also referred to a visit paid to a "specialist" unit outside the Health Authority, which was reputed to be "a centre of excellence". During this visit, the charge-nurse had discovered another occupational group (occupational therapists) implementing an aspect of care she considered part of the nursing role (reality orientation).

This observation supports Davies' arguments (1976, 1977) that the ill delineated role of the clinical nurse, has disadvantaged that grade of nurse when attempts are made to develop the practitioner role. It also underlines the need for nurse practitioners to define their role more clearly in the face of pressure from other occupational groups. In particular, those groups who are also engaged in the process of professionalisation, for example: social workers, occupational therapists-speech therapists and physiotherapists.

At the end of the J.B.C.N.S. course in care of the elderly (940/941), a group evaluation meeting was held in a classroom in the Community school of nursing. Those persons present in addition to the students, the writer and the clinical teacher, were as follows: a Senior Nursing Officer (Community Division), a Senior Nursing Officer (General Division) and a Senior Tutor (Post-Basic Education) from the General school of nursing. The meeting lasted ninety (90) minutes. The topic for discussion was the effect of the course on the participants' clinical practice.

The following statements are taken from the records kept by the writer throughout the ninety (90) minutes of the meeting. These comments give insights into the effect formal education has on the nurse's daily practice:

Nurse A: "I was more aware of getting hold of further education, for example the library... spending the odd days in various wards refreshed my ideas of ward work. I realised it was up to us nurses to demand release from work, this opinion I voiced at our meeting as my mind was made up to fight for it ... but once I got involved in my routine work I got physically tired again and realised that for day release one of my colleagues had to do my work as well as hers. Unless my N.O. is willing to help and encourage us, we will just continue in our safe old way."

Nurse B: "Due to closure of the hospital and the subsequent transfer of staff and patients to other hospitals, I have found it impossible to put into practice any information, ideas, etc. gained from the

course ... On arrival at my new destination I knew I had to tread carefully, it could not be a case of a new broom sweeping clean ... however, whenever possible I introduced the idea of nursing process to all grades of staff ... hoping at least to sow the seeds of change."

Nurse C: "With the co-operation of the other sister, I managed to introduce 'patient allocations' ... this has been well accepted by staff and patients and has at least provided a base for progressing with the nursing process."

Nurse D: "I think there will be problems ahead because of staff levels and the large number of part-time staff involved ..."

Nurse E: "I have told the S.N.O. and N.O. that with the present staff levels I think it is impossible to fully implement the nursing process. I'm afraid their answer was ... 'there is little we can do about staff levels ... you will need to adjust the degree of process ...'"

Nurse F: "I have been encouraged by the S.N.O. and N.O. to obtain copies of books on process to be available to all staff interested."

Nurse C: "Since the course I have found it much easier to explain my ideas to other people. Now all I want is the opportunity to put it all into practice."

Nurse D: "A complete change of working system to patient allocation ... find that in the afternoon the system does not work well ..."

Nurse F: "Course 940 has given a good background start to the nursing process and I have found colleagues a good back up and source of encouragement. The N.O. is keen to help."

Nurse E: "New stationery is kept by the N.O. and because of printing difficulties is sometimes in short supply ..."

Nurse A: "Documentation? ... previously nil ... apart from fragments in referral notes. Immediate action: Kardex type documentation ... minimum information plus what is easily acquired ... information now available shows how much more is needed. Communication: staff already in post agreed with changes suggested, but so far have not shown much action. Medical staff vary in their reaction. N.O. sounds enthusiastic on request for discussion and meetings."

Nurse D: "Some night sisters are unhelpful ..."

Nurse E: "Shortage of process stationery ..."

Nurse D: "Movement of staff a problem ..."

Although these nurses worked in a variety of hospital and community services, many of the above comments reflected the problems and lack of progress made by the nurses in the assessment unit. For example, the staff identified the chronic shortage of trained staff, the need to revise the documentation of care needed and given, the need to reorganise the work load, the renegotiation of the shift system, the lack of co-operation from the night staff originating in their isolation from available learning activities, the open hostility of some colleagues to the proposed changes, the lack of support from the nursing hierarchy including their inability to supply needed resources and their apparent lack of understanding of the complexities of the change process.

The comments made during the course evaluation supported the assessment unit staff's claims for practical and emotional support from the Nursing Officer and the importance of this organisational role in the implementation of change. It may be argued from such data that nurse-managers cannot expect staff members to implement change on the basis of secondment to a post-basic course, nor should these managers request the setting up of a specific course if they do not intend to supply the support required by the implementers of change. The staff's ability to translate theory into practice would appear to be related to their manager's perception of his/her role in the provision of a quality care programme (N.P.D.G. and N.P.G. minutes, 1980-1982).

Relating theory to practice

The provision of a day-release course which attempted to integrate theory and practice through the use of group

discussions, seminars, clinical visits and ward based assignments had, in the students' evaluation, little or no effect on the group's work practices.

One positive outcome of the course (J.B.C.N.S. 940/941) was the transfer of group relationships from the classroom to the work environment. It is to the credit of the students that following the J.B.C.N.S. course, the ward charge-nurses from the geriatric unit (general) and the assessment unit (psychiatry) continued to meet with each other for the purpose of promoting the change in practice. These nurses attempted to build up a nursing referral system between the general and psychiatric units. This continuity between the course and the ward facilitated the setting up of a self-help education group. Thus, all of the staff from the units described in this study, were provided with an opportunity to engaged in a self-directed study programme. The writer's role in this group was one of a resource person, but his position was considered to be of equal status to all other group members.

The charge-nurses from the rehabilitation and assessment units took the initiative to organise the initial study day, which was held in a meeting room in the main building of the psychiatric hospital. This meeting was attended by three trained nurses from the rehabilitation unit, two trained nurses from the assessment unit, the writer and a trained nurse from a geriatric ward in the general hospital. The meeting lasted two hours, during which time the members discussed their needs for a supportive in-service education programme. A decision was taken by the group members that the focus of these meetings should be clinical problems faced by the group members in daily practice (N.P.D.G. minutes dated 15.4.82).

The second meeting attended by the writer was held in a meeting room in the school of nursing. Unlike the first meeting the group included two representatives from

the long-stay geriatric ward and two representatives from a psychiatric hospital hitherto not involved in the change process. In addition to those persons, two representatives from the trained staff in the assessment unit and three members of the trained staff in the rehabilitation unit were present. The meeting was held on a Saturday and lasted from 9am until 4pm. Thus, the members had utilised their own time to attend the meeting. In this meeting the group members shared their experiences in implementing change in their respective units.

The third meeting witnessed by the writer, was held in a meeting room attached to the assessment unit. Like the second meeting it lasted all day but was held on a normal working day. One member of the geriatric unit (General Division) had given up one of her days off to attend this meeting. The writer observed that those members present were the same people who had attended the previous two meetings. This raises several questions, for example, were the members of this group keeping the learning activity within a small select group, or were those persons the true energy sources for the change process in their respective areas and therefore, the individuals who were prepared to give up more of their own time to the implementation of change? Certainly, those members present did not include the second charge-nurse from the assessment unit, nor the nurses who argued against the proposed change in the geriatric unit, nor were the silent members of the rehabilitation unit present.

The N.P.D.G. minutes dated 29 July 1982, in which the group members reviewed the study day presented on the 17 April 1982, reveal the realisation that the members of the group and the pilot areas "were highly motivated toward the nursing process", but this may not be true of others. These minutes also identify the use of the members own time to implement the nursing process.

The setting up of these self-help education groups asks questions about the effect of the nurse's own perception of the need for further education*, the effect it has on the identification of the need for an alternative mode of practice and the chance any attempt to implement that change has in a rigidly structured bureaucratic organisation (see Chapter Three).

The charge-nurses of the Community hospital, the long-stay geriatric ward and the Assessment unit had attended the J.B.C.N.S. course 940/941, two of the charge-nurses from the Rehabilitation unit had attended the Diploma in Nursing - Part A (London University, Old Regulations) and the junior charge-nurse from the Assessment unit was following an Open University course in his spare time. Were these people truly representative of all of the staff employed in the general and psychiatric divisions? The records held by the school of nursing's post-basic education department and the evaluation of the courses by the students following them, would suggest otherwise.

It may be argued that the attempted implementation of the nursing process in the units described in this study owed much to the personal commitment of these key members of staff. This is in line with the data provided by Pembrey's study (1980) of ward sisters. However, unlike that study the data supplied by this present study suggests that several members of the staff, including the "junior" members of staff, play important change-energiser roles.

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* Footnote: In October 1984 the writer met the junior charge-nurse from the Psycho-geriatric Assessment Unit. In that meeting he revealed that he was now working in the school of nursing as a teacher and that he was attending a day-release programme at Surrey University. It is therefore, argued that the key members of the clinical areas were themselves continuing learners and that this influenced the implementation of the nursing process and the setting up of the self-help learning groups.

Part Three: Challenging role boundaries: conceptual frameworks for understanding the division of labour in nursing practice and education

CHAPTER TEN

Theoretical frameworks for understanding conflict in practice and education: a "codes and control" model

In Part One it was argued that supportive educational programmes would be necessary to help the clinical nurse in her attempts to implement the nursing process as the desired mode of practice. The issues arising out of the proposed structure of future nursing organisations and the education of the nurse presented by the R.C.N. (1981) and the U.K.C.C. (1982), were perceived to be: the apparent underestimation by the R.C.N.and the U.K.C.C. of the control exerted by cultural, social and organisational strategies over the status of female occupations; the ambiguous nature of a problem-solving process which could merely formalise the present routinisation of care, rather than the redefinition of the role sought by the proponents of a "nursing" model for care; the need to not only provide supportive educational programmes during the period of change, but also the problems of overcoming the schism between theory and practice inherent in the present education of the nurse (Chapters Two and Three).

In order that the nurse-teacher can assist the practitioner in her attempt to implement the new role, the nurse teacher must first understand that new role, how it differs from the old one and how it changes the traditional relationships between the nurse, the manager, the teacher, the doctor and the patient (Chapters Two and Three). Bearing in mind the hierarchical bureaucratic nature of the traditional nursing organisation, the control exerted by the medical profession over the job content and the development of the role, and the control by central government of the allocation of resources (Chapter Two), the framework most suited to the task at hand would appear to

be one which concentrates on the organisational structures which maintain role boundaries and the strategies which support the maintenance of the status quo between the social and organisational roles of the doctor, the nurse and the patient.

In Chapter Two reference was made to Davies' argument (1979) that the role boundaries between the professional nurse and the woman in her own home were maintained by social, rather than technical factors. Davies argued that a study of the division of labour within the provision of health care would permit a study of the roles of the doctor, the nurse and the patient. In this way it was suggested that a study of the nursing role and the nursing organisation could be carried out in which the health care organisation was perceived to be an integral part of society, rather than the closed "box" approach traditionally followed by the "structuralist-functionalist" view of the nursing role as part of the organisation and separate from the wider social roles of the patient and the care-givers (Davies, 1979).

In this Chapter, it is the writer's intention to expand upon Davies' suggestion to examine the division of labour in the provision of health care and to apply a theoretical framework of "codes and control" formulated by Bernstein (1975) for general education and extended by Beattie and Durguerian (1980) to health care organisations. It will be argued that the application of the "codes and control" framework to nursing practice and education will assist in understanding the problems involved in the redefinition of the nursing role.

Bernstein's theory of "codes and control" in general education and its application to nursing practice and education

Bernstein's theoretical formulation (1975) is an attempt to understand the inter-relationships between symbolic orders,

forms of social organisation, and the shaping of experience in terms of codes. Using this approach, changes in the organisation, transmission and evaluation of educational knowledge may be viewed as the reflection of the social distribution of power and the principles of social control.

Educational knowledge codes are defined as the underlying principles which shape curriculum, pedagogy and evaluation. It is argued that the form this code takes depends on social principles which regulate the classification and framing of knowledge made public in educational institutions. The concept of classification refers not to what is classified, but to the relationships between contents. Where classification is strong, the contents are well insulated from each other by strong boundaries. When classification is weak, the boundaries between contents are blurred. Therefore, classification refers to the degree of boundary maintenance between contents. Classification focusses on the boundary strength as the critical distinguishing feature of the division of labour of educational knowledge. The basic structure of discourse is the curriculum.

The concept of "frame" is used to determine the structure of the message system, pedagogy. Frame refers to the form of the context in which knowledge is transmitted and received. Thus, "frame" is concerned with the specific pedagogical relationship of teacher and taught. Just as "classification" does not refer to context, so "frame" does not refer to the contents of pedagogy. Frame is therefore defined as the strength of the boundary between what may be transmitted and what may not be transmitted. When framing is strong, there is a sharp boundary, where framing is weak, a blurred boundary exists between what may or may not be transmitted. Framing focusses on the range of options available to the teacher and student in the control of what is transmitted and received in the context of the pedagogical relationship. Strong framing reduces the options available, weak framing increases the range of options. Frame therefore refers to the degree of

control teacher and student possess over the selection, organisation and pacing of the knowledge transmitted and received in a pedagogical relationship. The concept of framing also includes the boundary inside and outside the school or the degree of penetration of the informal learning, that is, the activities which occur during the everyday life of the teacher and students, into educational knowledge.

The basic structure of the message system is given by variations in the strengths of classification and the strength of frames may vary independently of each other. Bernstein (1975) illustrated this by suggesting that programmed learning involved weak classification (C^-) when the boundaries between educational contents may be blurred, but the pupil has little control over what is learned (strong framing F^+). The power component of this analysis may be stated as follows: strong classification reduces the power the teacher has over what he transmits, as he may not overstep the boundary between contents. Strong classification reduces the power of the teacher vis-a-vis the boundary maintainers. Similarly, strong frames reduce the power of the student over what, when, and how he receives knowledge and, therefore, increases the teacher's power in the pedagogical relationship.

Any organisation of educational knowledge which involves strong classification gives rise to what Bernstein (1975) terms a collection code. If however, there is an attempt to reduce the strength of the classification an integrated code is said to exist. Integrated codes shift from closed contents (strong classification C^+) to open contents (weak classification C^-) and thereby lead to a disturbance of existing authority structures, existing specific educational identities and concepts of property (Bernstein, 1975).

Collection and integrated codes have different organisational

outcomes. With a collection code, knowledge is organised and taught in tight, well-defined boundary subjects such as, anatomy, pharmacy and physics. The teaching staff work within horizontal relationships with their peers in other subject hierarchies. For example, a senior tutor in general nursing education is in a peer relationship to a senior tutor teaching in psychiatry, and work in vertical relationships with junior members of staff. Thus, the hierarchical bureaucracy of the traditional school of nursing may be viewed as having a collection code.

With an integrated code, teachers have to enter into social relationships with each other arising from their shared educational task. The conditions of work relationships exist through a common work situation instead of through insulated subject hierarchies. This may lead to a weakening of the separate hierarchies and the new horizontal work relationships between teachers may alter the structure and distribution of power. Teaching and administration are likely to undergo a change from relative invisibility to visibility (Bernstein, 1975).

Bernstein (1975) suggested that social order in collection codes arises out of the hierarchical authority relations, out of systemic ordering of the differentiated in time and space, and out of an explicit examining procedure. Strong classification and framing therefore create predictability in time and space. Collection codes are stated to create insulation through strong framing between every day knowledge and the knowledge of the school. This insulation creates areas of privacy and reduces the penetration of the socialisation process into the self (Bernstein, 1975).

This relationship between educational codes and the structure of power and principles of social control has implications for any attempt to change the model for care, the change in the status of the practitioner and the teacher-student

relationship. It may be found that attempts to change or modify educational codes will meet with resistance at a number of different levels irrespective of the intrinsic educational merits of a particular code (Bernstein, 1975).

Organisational "codes and control": a theoretical framework for understanding health care organisations and occupations:

Beattie and Durguerian (1980) applied Bernstein's framework of "codes and control" to the education and practice of "Family Planning" nurses. In doing so they illustrated the conflict between the "curriculum" model of the nursing role presented in the theoretical content of the course and the "discipline" modelcontained in the practice of the nursing role in the "real" world of the clinic. The writers also identify the "colonisation" of a self-help group by professionals and the subsequent loss of control over the service by the social group for whom the service was initially set up and who were responsible for the organisation and delivery of that service. It is argued by these writers that the effectiveness of any service organisation depends on the wider social, professional and organisational factors which shape that service and that an understanding of this aspect of health care was essential for the planning of the service provided in terms of available resources, technology and trained staff.

Beattie and Durguerian (1980) draw attention to the use of "organisational" and "occupational" models in the past to account for the social tensions and conflicts within organisations, to understand the creation of role boundaries and the division of labour within the organisation and between the different occupational groups. The writers go on to create two frameworks for understanding the "rules of discourse" in the "institutional context of Family Planning". These models emphasise the difference between the distribution of power and control in two models for health care, one of which is "patient-centred" and the

other which is "professional personnel centred".

The following Table 8(Beattie and Durguerian, 1980, p. 15, Table 1) illustrates Beattie and Durguerian's framework for understanding the tensions between different role boundaries and the division of labour.

It may be argued that such frameworks suggest that the move toward a more "patient-centred" approach to patient care challenges existing role boundaries and the division of labour between the professional groups engaged in the organisation and delivery of health care. Webb (1981) utilised a similar approach and argued that a "codes and control" framework outlined the need to redistribute the power and control between the present nurse-manager and the practitioner, in any attempt to implement the nursing process. Whereas Beattie and Durguerian (1980) utilised a two dimensional plane, Webb draws only a continuum between "personal" and "positional" power in the traditional nursing organisation. In the following Table 9 Webb (1981) draws a comparison of "task-centred" and "patient-centred" nursing practice.

A "codes and control" framework for General Nursing:

In Chapters One and Two attention was drawn to the development of the "organisational" role of the nurse and its basis in the gender division of labour in the home and the hospital. Similarly, it was argued that the initial strategies founded in the Poor Law and Voluntary hospitals of the last century had survived to be included in not only the managerial structure of the Salmon Report (1966), but were also to be found in the new structure for nursing put forward by the R.C.N.(1981).

Dimensions / Rules	Scientific/Academic Expertise or structure of knowledge	Structure "Roles" and Social "Relations" F.P. Nurse Role	Structure "Roles" and Social "Relations" F.P. Client Role	Institutional Context or Control	Social-Political Order
C+F-	"Medical" Biopatholotical	"Clinical" Prescriptive	"Comply" Obey	"Professioalism" Collegiate Autocratic	"Conservative" Consensus
C+F+	"Ecological" Epidemiological e.g. Public Health	"Pedagogic" Educative Inform, explain risks, teach	"National Understanding" Risk Estimation decision making	"Bureaucratic" Consultative e.g. NHS	"Progressive" Reformist
C-F-	"Biographical" Social-Psychological Personal Humanist	"Pastoral" Interpret Comfort Counsel	"Coping" Resolving Individual self help	"Negotiated" Democratic Benevolent e.g., private	"Liberal" Tolerance
C-F+	"Cultural"	"Interrupt" Reconstruct	"Engagement" Co-operative action Collective reconstruction e.g. Women's groups	"Participative" Syndicalist e.g. start of F.P. services	"Radical"

Table 8 Rules of Social Relationships versus Dimensions of Institutional Analysis
(Beattie and Durguerian, 1980)

Table 9 A Comparison of Task-Centred and Patient-Centred Nursing (Webb, 1981)

	Task-centred mode	Nursing process mode
Legimitation and perpetuation	Theory not explicit taught via practice	Theory explicit formally taught
Boundary maintenance between categories	Task allocation	Patient allocation
	Hierarchy of tasks	Total patient care
	Brief visits to patients	Extended period with patients
	Little interaction	Great interaction
	Fixed timetable	Flexible timetable
Boundary maintenance between hospital and life outside	Outside not relevant	Outside deliberately brought in
	Patients and family passive	Patients and family involved
	Little knowledge shared	Much knowledge shared
	Fixed ward routine	Personalized routine
	Relationships undesirable	Relationships necessary
Organization and pacing of work	Sister plans timetable	Nurses plan own timetable
	Nurse has little control	Nurse has much control
	Nurse satisfies sister	Nurse satisfies patient
	Patient not involded in planning	Patient involved in planning
	Limited definition of nursing	Wide definition of nursing
	Work books ticked	Reports written
Relations between sister and student nurse	Rank important	Ranks de-emphasized
	Explicit hierarchy	Implicit hierarchy
	Sister checks	Sister advices and teaches
	Sister accountable	Sister accountable
	Personality not highly visible	Personality highly
	Sister is manager	Sister is colleague, professional nurse
Assessment of a) patient	Privacy of information	Full history taken
	Verbal information	Written information
b) nurse	Stereotyped reports	Personalized reports
	Protection of person	Exposure of person

contd. next page.

	Task centred mode	Nursing process mode
Power and communication	Medicine dominates Relative autonomy of nursing Interpositional control Explict control Vertical communications Order and reports Brief reports Problems referred to hierarchical superior	Medical dominates Relative autonomy of nursing Interpersonal control Implicit control Horizontal communications Discussion and teaching Increased written communication Problems are responsibility of nurse

It is now argued that the division of labour in general nursing and in the education offered to the student and post-basic nurse, reflects the distribution of power and control in the organisation and society as a whole. Thus the adoption of the nursing process and a model for education which encourages independent learning in the nurse (see Chapter Three), will not only disturb the power relationships held by the nurse vis-a-vis the patient and her colleagues in the health care organisation, but also the division of labour between the nurse, the manager and the patient.

The changing models for nursing practice and education:

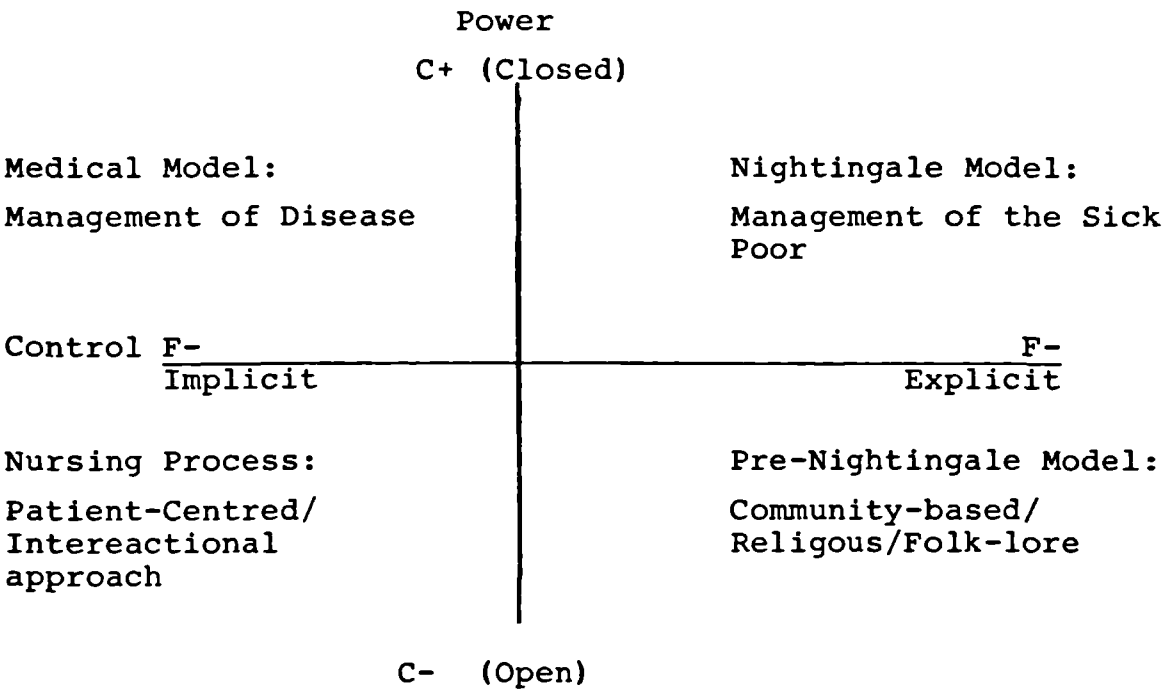

Figure 1: Models for Nursing Practice (General) (After Bernstein, 1975; Beattie and Durguerian, 1980).

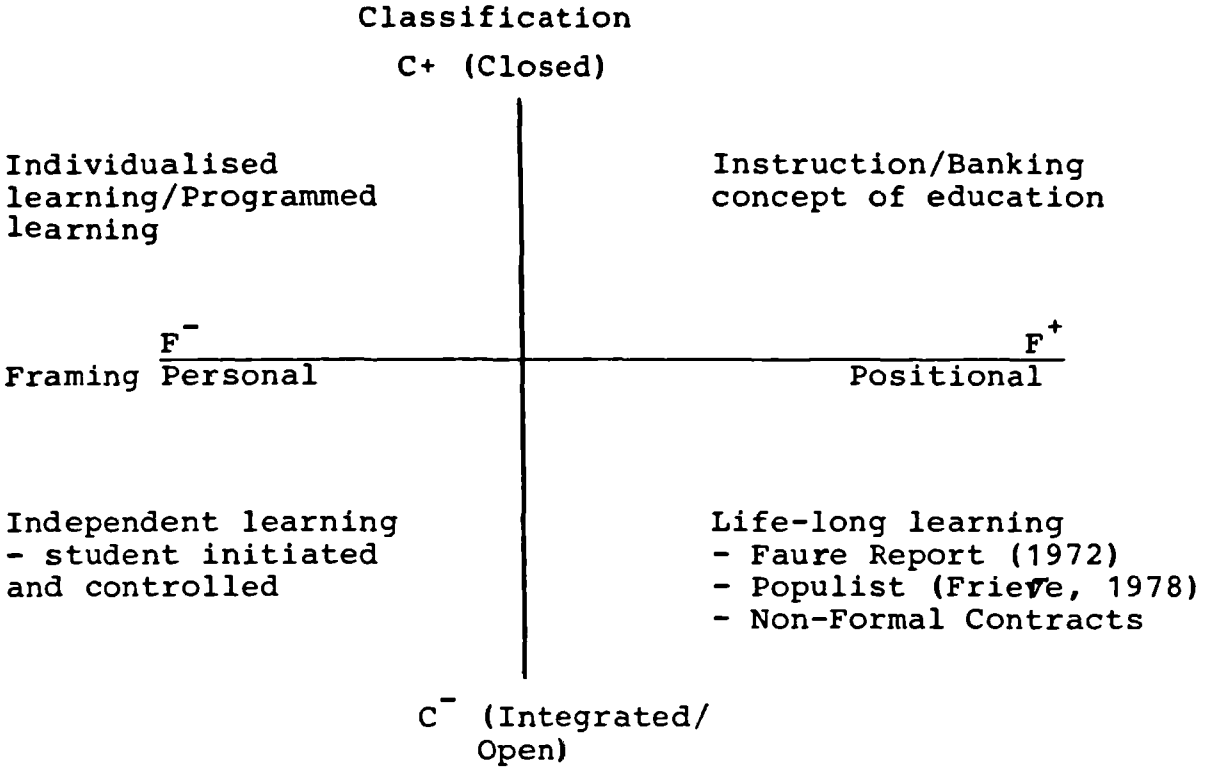

Figure 2: Models for Nursing Education (After Bernstein, 1975; Beattie and Durguerian, 1980).

In the pre-Nightingale model (Fig.1), the boundary between what is, and what is not nursing, is open and blurred (C-) (Abel-Smith, 1960). No selection criteria existed to limit the recruitment of clinical nurses to a specific strata of society. The nurses in both the Poor Law and Voluntary Hospitals were responsible to the nursing hierarchy for the management of the ward and the patient, but the doctors' sapiential authority over the clinical care was acknowledged by all grades of nurse. The patient was viewed as the passive recipient of care, dependent on the charity of others for the care received under the Poor Law (Abel-Smith, 1960).

With no demands for specific academic or "professional" qualifications or experience, the pre-Nightingale nurse was not called upon to perform the wide range of tasks

which are now regarded as the role of the nurse. In many of the teaching hospitals, surgical dressings and the general comfort of the patient were regarded as the province of the medical students and residents (Abel-Smith, 1960). While it was not unknown for a nurse recruited from the ranks of the 'domestic servant' classes to be promoted to the rank of sister, it was more common for these sisters to be separately recruited from the middle classes. Matrons were often of a still higher social class and fulfilled a function similar to that of a housekeeper in the homes of the wealthy (Abel-Smith, 1960; Davies, 1976; Baly, 1980).

The nursing hierarchy that staffed the Voluntary hospitals before the Nightingale reforms found no reason to suppose that any kind of special training or experience was required to nurse the sick. Neither the Matron, nor any other nurse, had the qualifications to teach learner nurses the contents of the task at hand. This does not mean that the pre-Nightingale nurse had no knowledge or skills, nor that she had no access to education. In addition to the informal learning of her everyday life, the nurse had access to the information passed on by her medical colleague and the prescriptions/proscriptions for healthful living defined in the culture of her society. Indeed, it was to the doctor's benefit that the nurse at the bedside should be able to carry out his orders and report on the patient's progress. Consciously or unconsciously, the medical staff defined the nursing role through its control over the nurse's access to the knowledge required to implement the medical orders. The medical staff therefore, controlled what, when and how the nurse should learn that aspect of patient care he decided was the nurse's domain (Abel-Smith, 1960).

Although helpful to the medical profession in its attempts to establish itself as a major institution of social control, this informal system of nursing education was

haphazard. In terms of Bernstein's theory of 'codes of control' in general education (1975), the model for education may be defined as "weak classification, strong framing" (C-, F+), and the model for practice likewise "weak classification, strong framing" (C-, F+). It may be argued that in a social system where access to nursing care is open, and the nursing role is defined by the patients' cultural definition of health and illness, then the model for nursing education will reflect the view of life-long education contained in the recommendations of the Faure Report (1972) and the model for adult education put forward by Freire (1978).

With the advent of the Nightingale school, the selective recruitment of pupils and probationers, limited the available care givers to those who had received some form of officially recognised training (Abel-Smith, 1960; Baly, 1980). The role of the nurse and the education of the recruit now became a major concern of the medical and nursing hierarchies. To maintain their boundaries, the medical profession controlled what the nurse could practice at the bedside and so became involved in the formal education of the nurse. In the ward the traditional sapiential authority of the doctor over the nursing practice was re-inforced in the acknowledgement of medical supremacy by Nightingale herself (Davies, 1976, 1977).

In this way, the respective roles of the doctor and the nurse were now maintained through strong classification (C+). Similarly, control over the nurse as a student, and as a practitioner, was invested in the sister and the matron. That is, in the nursing hierarchy power was positional, rather than personal. The Nightingale model may be said to have "strong classification, strong framing" (C+, F+) (Fig. 1, p. 150). In this model both the patient and the beside nurse were subject to the control of the medical profession and the nursing hierarchy, with the nurse being held responsible to the doctor for

carrying out his orders, and to the nursing hierarchy for the running of the ward. As a result, professional-bureaucratic conflict was an integral part of the 'organisational' role adopted by Nightingale (Davies, 1976, 1977). Similarly, the patient was the passive recipient of care. At no point in the nursing process did he exert any control over the therapeutic plan, nor did he contribute to its execution other than doing what he was told to do by the doctor or the nurse (Davies, 1980).

In the Nightingale model both patient and bedside nurse were restricted to the limited freedom given by the medical and nursing hierarchies. Davies (1980) cited several nurse authors, for example: Williams and Carpenter, to describe the management of the sick 'poor' in the Poor Law and Voluntary Hospitals. In the discussions cited by Davies, both medicine and nursing were viewed as institutions of social control in the hospital and the community.

The model for education inherent in this system was one of "instruction" with strong classification of contents (Fig. 2, p. 151). The boundaries between what knowledge belongs to nursing and what belongs to everyday life, was controlled by the medical profession as the definers of the nursing role. The teacher-student relationship, because it was confined to members of the work group, had the power over learning invested in the teacher. Therefore, when related to Freire's model for education (1978), this may be defined as a 'banking concept', in which the teacher as the active participant, deposits knowledge into the passive, listening student. The student in the classroom, like the patient in the ward, has no active input to the acquisition of knowledge, and assessment of the learning is carried out by external evaluation such as examinations. The seal of approval of the student's internalisation of the distribution of

power and control in the nursing organisation was the awarding of the hospital's certificate or badge (Abel-Smith, 1960; Baly, 1980) (Fig. 2, p. 151).

As medical knowledge and social conditions improved, the role of the nurse gradually changed until the medical model became the accepted framework for practice and education. The Nurses Act (1919), and the subsequent setting up of the G.N.C.'s examination, resulted in a more formal approach to nursing education (Fig. 2, p. 151). The standardisation of the training programme constrained the teacher in what could be included in the curriculum, and re-inforced the belief that the medical staff were the ideal teachers of nursing students. As with the Nightingale model, the distribution of power and control was maintained in the status quo. The student did, however, exert a little more control over the pace of learning when programmed learning was adopted as the preferred learning strategy by the school of nursing for the learner. Here the classification remains strong, but the frame is weak (C+,F-) (Fig. 2, p. 151).

Similarly, the formulation of teacher-selected objectives for a learning contract, would permit the student to exert some control over the pacing of the learning, but not the assessment of his needs, nor the evaluation of the learning achieved. The presence of the G.N.C.'s final examination, as the only means of evaluating the outcomes of the learning programme, constrains both the teacher and the student in the freedom they have to deviate from the officially controlled content of the course.

The freedom given to both student and teacher to implement change reflected the limited freedom given to their colleague in the clinical area by the medical staff, the nursing hierarchy, and with the introduction of the G.N.C., the Government (Abel-Smith, 1960; Davies, 1977; Baly, 1980). It may be argued that throughout its development

as an occupational group, nursing has preferred to have the role of the nurse defined by others. Anyone attempting to introduce the practitioner role defined by Henderson (1966), may find that nurses are unable to take such a step independent of the control exerted by others over the development of the present role.

The models for practice containing "strong classification" and "weak framing" (Fig.1, p. 150) may be found to co-exist with those based on "strong classification, strong framing" The amount of personal power, that is limtited autonomy, given to the individual practitioner lies in the discretion of the power holder (doctor or nurse-manager). It is argued that the degree of autonomy given to any grade of nurse is contained by the structure of the organisation and by the practitioner's perception of power sharing with the patient and his relatives. Similarly, within one school of nursing, one teacher may be prepared to give the student some control over learning by negotiating a learning contract, whereas another teacher may prefer to contain all learning to formal didactic, classroom-bound teaching. This is made possible through the strong classification in both models and hence, the maintenance of the status quo in terms of power relationships and boundaries.

If, as has been suggested (G.N.C. Ref. 77/19/A), the balance of power would be disturbed through the implementation of the "practitioner" role (Henderson, 1966), then conflict may be experienced by practitioners, students, teachers, and managers. The students observed in the studies carried out by Dodd, Hunt and Bendall (see Chapter Two and Three) may be viewed in the light of the theory of 'codes and control'. Thus, the conflict in the students' perceptions of the relationship of theory to practice, may be said to exist because the knowledge gained in the clinical area, lies outside the boundary of what is considered to be bonafide nursing knowledge.

The "strong classification" code curriculum upheld by the G.N.C.and the traditional pedagogical approach to nursing education (strong framing), ensure that only teacher-taught knowledge is acceptable in the examination. Whereas, if the knowledge gained by the student in the clinical area, could be accepted by the teacher as legitimate nursing knowledge, then it may be found that the reported conflict ceases to exist. The weak boundary between the informal and non-formal educational systems no longer inhibits the integration of that knowledge. That is, the theory of nursing taught would no longer be unrelated to practice (McFarlane, 1980).

The current move towards the implementation of the autonomous practitioner role, where power of decision-making is invested in the individual, rather than the position held, together with the emphasis on the nurse-patient relationship as an open system, suggests a reciprocal change in educational practice. Although the models for care suggested by Orlando, King, Altschul and Stuart and Sundeen (see Chapter Two) appear to fall within a framework of "weak classification, weak framing", the distribution of power still favours the nurse over the patient. As with the problem-solving approach advocated by McFarlane, King's conceptual framework emphasises transaction, rather than the actions taken by the patient. It is the nurse who assesses the patient's needs for care and selects that aspect of care in which the patient may, or may not, participate. Similarly, the power relationship between the nurse, the doctor, and the hierarchy need not necessarily be disturbed. The nurse must defer to the medical and nursing hierarchies for the resources required to implement her plan of care. Hence, any attempt to implement the nursing process may be defeated by either power source (medical or nursing hierarchy), or subsumed within the medical model. It would not be impossible to engage in problem-solving within the medical model. Problem-solving is not the sole property of a nursing

model for patient care. Similarly, it would be possible for the patient to become involved in his care programme using the medical model. It would be possible for some clinical practitioners to exercise some form of autonomy in their daily work, providing they were carrying out some task other health care workers did not wish to include in their role (Davies, 1977). If, as Stevens (1979) has suggested, conflict in the learner may be the result of a lack of interplay between the conceptual framework for practice, and the philosophy for education held by the school of nursing, then the implementation of the nursing process demands a change in the student-teacher relationship as well as the curriculum.

As stated earlier, the nursing process is based on a humanistic concept (Chapters Two and Three), that is, the individual is believed to be self-directing in all aspects of his life. Translated into educational terms, it follows that in such an approach the learner is perceived to be capable of defining his own learning needs, setting his own objectives, planning learning strategies, and evaluation his progress towards his pre-determined goals (Rogers, 1969). The model for education may therefore, be defined as "weak classification, weak framing" (C-, F-), (Fig. 2, p.151). Peters (1969) suggested that students have a generalised expectancy of control or lack of control over their environment and are more likely to engage in learning activities if allowed a greater chance of controlling their environment. Lamond (1974) in a study of student nurses' expectations of the teaching role of the nurse-practitioner, indicated that nurse-learners expect to have little or no control over their learning in the clinical area. The findings of this study suggested that the student was not encouraged to develop a constant expectation that the trained staff will adopt the role of teacher in the ward. Lamond states:

> "... in one ward she may soon learn to anticipate that the trained staff will

> share their knowledge and expertise with her, and in the very next ward to which she is allocated, she may have rapidly to incorporate an entirely different set of expectations."
>
> (Lamond, 1974; p. 77)

To assist the student develop flexibility, the capacity to learn and thereby cope with change, Bouchard and Steele (1980), and D'Asleven (1981) suggested that nursing education should move away from the narrow, prescribed role towards a broader education which prepares the nurse for her future role. Hence, any attempt to implement the nursing process without a response to these requirements will lead to a continued adherence to a curriculum unrelated to practice, and unacceptable standards of care (McFarlane, 1980).

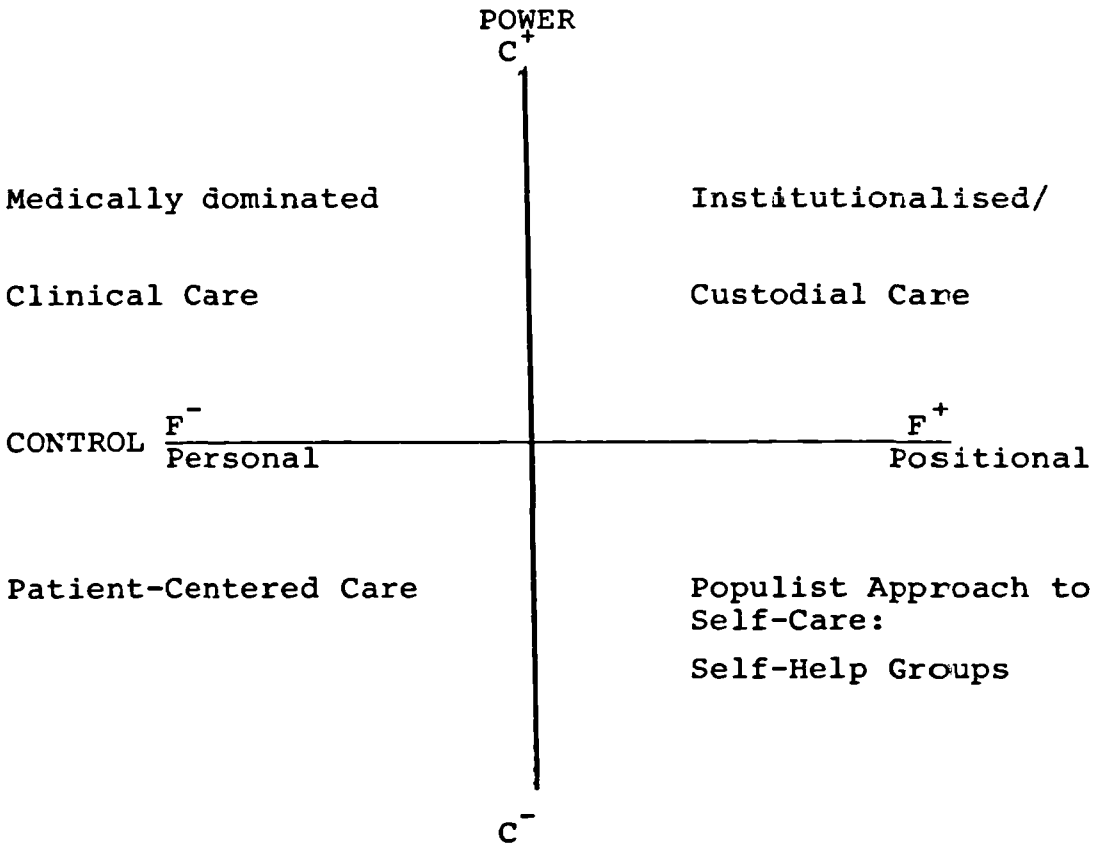

Figure 3: Models for the division of labour in the nurse-relationship and the distribution of power and control

(After Beattie and Durguerian, 1980)

As argued earlier in this Chapter and Chapter One and Two, the power and control exerted by the medical profession and the Matrons of the Voluntary and Poor Law hospitals not only inhibited the development of personal power of the nurse practitioner, it also constrained the active involvement of the patient in the decision-making process. In Figure 3, this model for practice is represented by "Institutionalised/Custodial" care. The division of labour between the physician and the nurse is controlled through the doctor's professional expertise, and between the different grades of nurse by the investment of power in the position held in the bureaucracy. Thus, there existed a hierarchy of tasks between the different grades of nurse. In the nurse-patient relationship, the division of labour between professional nursing and "mere mothering" was tightly controlled by the G.N.C. In this model for care the locus of control lay in the hands of the doctor, the manager and the nurse. The focus of the nurses' attention was on the disease, the routinisation of care, obedience to the hierarchy and the denial of self on the part of the practitioner nurse. The patient in this model for care exercised little or no control over the therapeutic plan and his individual needs were placed secondary to those of the organisation.

The "organisational" role developed in these hospitals maintained the boundaries between the roles of the physician, the nurse and the patient, and between the roles of the manager, the practitioner and the patient. This is represented in Figure 3 by "strong classification, strong framing" (C^+, F^+). Any attempt to introduce a model for care in which the locus of control is shifted towards the individual practitioner and the patient will not only upset the balance of organisational power, it will also disrupt the division of labour between the nurse, the patient, the manager and the physician. It may be argued that such an attempt might be resisted by the existing power holders and perhaps individual nurses and patients,

who have internalised the existing distribution of power and control.

In Figure 3 the model for care representing "strong classification, weak framing" (C^+, F^-) is referred to as "Medically Dominated Clinical Care." Here the division of labour is still maintained through the power of the professional expertise of the physician and the nurse. Even in those instances where the patient has direct access to a nurse, for example: wound dressing or vaccination, the control exerted by the patient is limited by the nurse's power over his access to treatments and aids to recovery.

It may be argued that the patient can exercise some control over the therapeutic plan, in that, he can decide whether or not to follow the instructions given, take the drugs prescribed, or come back to the Health Centre for continuing care. His control over the therapeutic plan is however, limited by the power of professional expertise invested in the doctor and the nurse, and their power to control his access to the formal health care system. They do not control the influence of the patient's cultural beliefs about health care, nor the influence exerted by members of his family. The patient does therefore, exercise some control over the decision to seek professional help and whether or not the therapeutic plan is implemented. He cannot bypass the physician and seek specialist expertise present in the formal health care system.

The model for care representing "weak classification, weak framing" (C^-, F^-) in Figure 3 is referred to as "Patient-centred " care. In this model for practice the focus of nursing attention is the patient's needs for care as perceived by him. This model may be said to reflect the nursing process described by King (1971). Here the patient and his family are active participants in the decision-making process and the nurse is one of many

resources persons (See Chapter 2). Thus, both in the hospital and the community setting, the locus of control and the power of decision-making is invested in the client and the individual practitioner. An early example of such a group would be the original "family planning" organisations (Beattie and Durguerian, 1980). The "professionalisation" of these groups by physicians has created "strong classification, weak framing" in which the power is invested in the medical profession, rather than the client. Similarly the nurse's role as "client advocate" is diminished by this "strong classification" (Beattie and Durguerian, 1980). The care system defined in Figure 3 as "Populist Self-Help", perceives the distribution of labour between the nurse and the patient as "weak classification, strong framing" (C^-, F^+). Here the boundaries between what tasks are carried out by the client and the nurse are ill defined, the role of the nurse being one of applying professional expertise to the client's perceived needs. In this model the nurse is perceived to function in the practitioner role in a community based "self-care" programme, where the emphasis is on health care, rather than the illness orientation of the hospital based medical programme.

Current examples of self-help groups are "Help the Aged", and "Mencap". These organisations function as pressure groups to help the elderly and the mentally handicapped person monitor the quality of care provided by the formal care system, and to promote the well-being of the client group through support services. This model does not negate the contributions made by the formal health care system, rather it seeks to reinforce the effectiveness of these services through the promotion of the client as an active participant. The weakness of this concept centres round the individual/group's ability to engage in "self-help". Tuckett (1977) cites research data which suggest that those persons in reduced social circumstances are perhaps the least able to engage in "self-help". Likewise

Tudor-Hart (1971) indicates in his "inverse care law" that those who are least "in need" have the educational, financial and social resources, to utilise the existing welfare amenities to their advantage and thereby engage in "self-help".

It may be argued that if such a model for practice, with its emphasis on a sharing of labour is implemented, it will be resisted by the medical and nursing professions. The "weak classification, strong framing" of this model reduces the power base of the doctor and the nurse-manager.

Beattie and Durguerian (1980) have described and discussed the colonisation of self-help groups such as, "family planning" run by women's groups. The introduction of the present health care professional into one of these groups, may result in the application of a problem-solving approach to care, but not necessarily the full participation of the client in **all aspects** of the process.

A model for practice and a division of labour which reflects "weak classification, strong framing" demands a reorientation in the nurse's value of the importance attached to working in close proximity to doctors. Similarly, the attitudes of doctors towards nurses as their assistants, militates against the adoption of such a model for practice (Anderson, 1973).

The initial reaction of the medical profession to the introduction of a practitioner role by nurses, which rejects the supremacy of medicine in the clinical area, has not been too favourable. The article titled "Doctors and Nurses" published in the British Medical Journal (Volume 283, Number 6293, pp. 683-4) presented the traditional paternalistic attitudes of the medical profession to nurses, and the perceived threat to medical power by the introduction of the practitioner role by nurses.

In the light a theory of "codes and control" in nursing education, it may be argued that the control exerted by the nurse as a member of the organisation (Stacey et al, 1970) is a major factor in determining the degree to which the patient is allowed to participate in the planning of nursing care. Although the literature on the nursing process suggests a model for practice based on "weak classification, weak framing" (Fig. 1, p. 150), the control exerted by the nurse over the patient's access to the material and knowledge required to implement the plan, suggests that this participation may be limited to the nurse's perception of the priorities for her time. For example, the patient's physical needs for care will be attended to, but not his psycho-social needs, especially if another patient's physical needs are viewed as being of greater importance by the nurse.

The control exerted by the medical and nursing hierarchy over the nurse's access to the financial, material and manpower resources required to implement the plan of care, will determine whether or not the plan can be implemented. It may be argued that the limited control exerted by the nurse over her work content, will be reflected in the limited control exerted by the patient over the care received. The application of a problem-solving approach to care in a traditional hospital setting, will result in a distribution of labour between the nurse and the patient, which reflects the distribution of power and control in the organisation. In terms of the "codes and control" theory, this may be defined as ranging along a continuum from "strong classification, strong framing" to "strong classification, weak framing" for the traditional hospital setting (Fig. 1, p. 150).

CHAPTER ELEVEN

Clarifying role conflict and supporting role change

In Part One (Chapters One, Two and Three) it was argued that the introduction of a more patient-orientated approach to care and a more student-centred education programme, would disturb existing role boundaries in the clinical areas and the school of nursing. Further the existing conflicts between the "idealised" and "real" roles of the nurse might be magnified by the implementation of planned care in an organisation that had hitherto paid little attention to this aspect of the organisation and delivery of care.

A theoretical discussion can only speculate on the source of potential conflict and the subject's response to the proposed change. It raises questions about the content of the learning programme supporting the proposed change and about the strategy adopted to implement the new role, as well as the problems of presenting research data which are at variance with present practice (see Chapters Two and Three). Similarly questions arise when the innovators are faced with colleagues who cannot, or will not, contribute to the change process. This is in addition to the conflicts already contained in the traditional role of the nurse (see Chapters One, Two and Ten).

The following chapter deals with the probems of role conflict as experienced by the participants engaged in the introduction of the nursing process in the clinical areas described in Part Two of this study.

Role conflict between the roles of the trained and untrained nurse: organisational relationships in the community hospital:

In the official handout distributed by the Health Authority to patients using the community hospital, the hospital was described as:

> "a small friendly local hospital where family doctors can look after patients with the support of nurses and other professional staff, many of whom will already know the patients."

In this community based health care system, the supremacy of the medical staff in the "care" role as well as "cure" was acknowledged. The role of the nurse was viewed in terms of supporting the doctor, rather than the patient. The information defined the role of the hospital in the community thus:

> "The hospital caters for a balance of short and long stay patients. These include people who are ill and need medical treatment, people who are recovering from an operation and patients who come for a short stay while their families are on holiday as well as the care of elderly who need to be looked after on a long term basis."

Again the medical model for care was identified and confused with a model for care which suggested that the patients' needs resulted from social, rather than medical problems.

The unit contained a day hospital where up to 30 patients came from mid-morning until tea time, to take part in shared activities and received specialist advice and treatment. It provided all types of remedial and rehabilitative care for elderly and disabled people. It was the only centre for such care in a small market town on the outskirts of a large city. In adopting the "care" approach, this hospital appeared to be ideal for the implementation of a

"self-help" (Fig. 3, p.159) orientated model for practice. However, the acknowledgement of the nursing role as one of supporting the doctor implied that access to nursing was through the traditional medical diagnosis of "disease", rather than "health care". Thus, the model for practice may be defined as ranging along a continuum from "strong classification, strong framing" to "strong classification, weak framing", in which the power and control exerted by the doctor over the patient and nurse, maintains the "strong classification" (Fig. 1, p. 150).

The adoption of the traditional approach to care in the Community hospital was re-inforced by the official hand-out's description of the health care team. The team were introduced as follows:

> "The family doctor is a key figure in the life of a hospital. He cares for his patients when they are in hospital or attending the day hospital, consulting with specialists where necessary.
>
> Nurses form part of a combined service that involves hospital nurses, district nurses and health visitors. They all keep in touch with other professional groups to make sure that patients get help they need both in the hospital and at home.
>
> Physiotherapists, occupational therapists and speech therapists work with other staff to provide services for the day hospital and on the wards. They play a major part in planning the courses of treatment to help patients recover from illness or overcome handicap.
>
> Visiting consultants will continue to operate a wide range of clinics at the nearby Nuffield Health Centre. These include opthamology, psychiatry, surgery, gynaecology, orthopaedic, chest and diatetic clinics at which specialists will see patients referred by their family doctor. X-ray and physiotherapy facilities are also available at the Nuffield Health Centre, following referral from your doctor.
>
> A medical social worker is based at the new hospital and is available to give help and advice to patients.

> Other hospital staff play an important part in keeping the hospital running smoothly. These include domestic staff, catering staff, porters, maintenance staff and administrative and clerical staff."

It may be argued that in this description of the "team", the role of the doctor was the only one identified as "caring" for the patient. He also controlled the patient's access to other health care facilities. The role of the nurse on the other hand was less clearly defined. She was viewed as:

> "... keeping in touch with other professional groups to make sure that patients get help they need in the hospital and at home."

This was hardly the professional, practitioner role defined by Henderson (1966). It may be argued that this description reflected the menial role identified by Davies (1976, 1977), in which the nurse was perceived to be taking on the work other health workers left out under the rationale of providing comprehensive care.

Unlike the role of the nurse set out in this booklet provided for the patient, the roles of the physio-therapist - speech-therapist and occupational therapist were viewed as important, professional practitioners. The literature stated that these workers played "important roles" in planning therapeutic programmes for the patient.

It may be argued that the nurse-managers responsible for defining the nursing role perceived it to be inferior to those of the doctor, the physiotherapist, speech therapist and the occupational therapist. In contrast to these health-care workers, the nurse was not seen to be involved in a systematic approach to planned care described in the literature of the nursing process; and contained in the nurses' adoption of that process as the model for care in this hospital (Chapter Six, case study on the Community

Hospital). The information pamphlet clearly stated that the doctor controlled the patient's access to the therapeutic plans designed by these health care professionals. The same literature also perceived the roles of the nurse at the bedside to be inferior to those of the therapists.

It is suggested that this subordinate role reflected the division in the social status given to the educational establishments in which the students were prepared for their professional roles. The therapists described in the literature were trained in tertiary educational institutions such as Polytechnics, whereas the nurses were by tradition restricted to the school of nursing. The untrained nurse on whose shoulders the burden of providing bedside care fell (McFarlane, 1980), received little or no training other than the informal learning that is part of her daily life.

It may be argued that even before the hospital opened its doors to the public, the role of the trained nurse had been defined as that of a manager and at the bedside, one of implementing other health care workers' orders. The bedside nurse was viewed by the organisation to be subordinate to medicine and other health-care workers such as physiotherapists, speech therapists and occupational therapists. It is suggested that in a Community hospital, which was ideally suited to the implementation of a "health care" approach to care, the conflicting ideologies and expectations underlying the subordinate role of the bedside nurse, were a source of frustration which would inhibit any attempt to implement the practitioner role defined by Henderson (1966). The hospital was built to provide a service for 78 in-patients, and up to 30 day patients. Although the patient literature identified the hospital's role in providing post-operative care, the main emphasis was on the needs of an elderly population. The hospital was not equipped to deal with acute emergencies or accidents, nor the needs of maternity cases, paediatrics,

psychiatry and mentally handicap. It may therefore, be viewed as a community based geriatric hospital.

As stated earlier, the staff consisted of both trained and untrained nurses. The unit was not part of the training circuit used by either the basic or post-basic education programmes. The use of students as part of the work force was not a major variable in this unit's attempts to implement the nursing process. Within the division of labour in hospital work this placed the community hospital at a lower social level vis-a-vis the major teaching hospital (Tudor-Hart, 1971).

Table 10: Staffing levels for the Community Hospital

	Day		Night	
Staff	Estab.	In Post	Estab.	In Post
Nursing Officer	1.0	1.0		
Sister/Charge Ns.	0.4	0.0	1.0	1.0
Staff Nurse	7.48	6.68	Internal	rota
Enrolled Ns.	1.33	1.33	Internal	rota
Nurs. Aux.	14.31	13.89	Internal	rota

	TOTAL			
Staff	F.T.	P.T.	Estab.	In Post
Nursing Officer	1.0		1.0	1.0
Sister/Charge Ns.	1.0		1.4	1.0
Staff Nurse	4.0	2.68	7.48	6.68
Enrolled Ns.		2.0	1.33	1.33
Nurs. Aux.	4.0	14.0	14.31	13.89

Estab. = Establishment.

Number of Patients in ward = 27

The above figures indicate that the traditional Nightingale strategy of having large numbers of untrained staff, supervised by a small elite group of trained staff, was the norm for this unit (Davies, 1976, 1977). It is suggested that in this unit the bedside role had been given over to the untrained nurse. It would have been physically impossible for some eight trained members of staff to give the requisite care to twenty seven patients on a day and night basis.

The allocation of the clinical role to auxiliaries and the attitudes of the medical and nursing professions towards this discrepancy, has been described and discussed by Baker (1978). Although this division of labour was out of line with the practitioner role described by Henderson (1966), it reflected the strategy of the Nightingale hospital. Abel-Smith (1960) argued that the bedside role had always been given to the untrained nurse.

It may be argued that the low status given to the nursing staff in the official handout reflected this allocation of the clinical role to the auxiliary. The description of the "team" in the handout made no reference to the differing roles of the trained and untrained nurse. The only indication that there might be a difference was an explanation of the different types of coloured uniforms worn by the nurses. Thus, for this unit there was a hidden definition of the nursing role which blended the role of the trained and untrained nurse into one, within which the trained nurse carried out both bedside nursing care and managerial roles. The untrained nurse was the active participant in the bedside care received by the patient. The organisational role therefore, reflected the social role of care-giver in the home. The role of care-giver in the hospital, like the female role of "mere mothering" in society, was given over to low status persons without the education and the "expert" knowledge demanded of a professional. It is held that for this unit the

"unique" role of the nurse did not exist and that nursing, as it was practised, was nothing more than "common sense" based on the trained and untrained nurses' daily living experiences.

Role conflict and the introduction of new roles:

The smooth running of the Nightingale ward demanded the interchangeability of roles between the different grades of nurse (Davies, 1976, 1977). The means of coping with the upheaval caused by the introduction of a new practitioner role, by the auxiliaries was to blame the writer for creating a division between themselves and the trained staff. When the literature on the nursing process was discussed in the presence of Enrolled nurses and untrained staff, the hidden strategy of traditional organisations in using both these groups as the need arises, was opened up and the conflict resulted.

A comment made to the writer by an auxiliary summed up the feelings of this group best of all. She stated that:

> "You downgrade us the whole time, but you would not be able to run this place without us."

For the writer this caused a dilemma. As a teacher there was the obligation to provide all grades of staff with the knowledge, skills and attitudes required to function in their respective roles. Alternatively, as a member of a professional group, there was a responsibility to promote the group through the education programme. When the interests of these two groups clashed, conflict arose in the writer.

In this case study (Chapter Six, Case study of the community hospital), the conflict arose early in the contract, when it became clear to the writer that the ill-defined roles meant that he was being asked to provide

untrained staff with the same knowledge and skills as the trained staff. The contract was renegotiated and it was stated that the writer would function only in relation to the needs of the trained staff. The trained staff provided the inputs to the auxiliary staff according to how they defined the contributions this grade of nurse made to the care of the patient.

Throughout the study, the ill delineated roles of both the trained and untrained nurses continued to be a source of conflict. This may be exemplified by the words of one staff nurse:

> "I may be the staff nurse, but she (the auxiliary) has more say and is given a higher status than I am."

This, and other incidents observed by the writer, together with comments made by the in-service education teacher to the writer, suggested that the allocation of the care-giver role to the untrained nurse, gave the nurse power in the ward. This was in addition to the power invested in her organisational relationship with the patient and his relatives (Stacey et al, 1970).

In each discussion period held during the study, the staff consistently voiced their concern over the power invested in the untrained nurse. The in-service education teacher had occasion to remark to the writer that during one training session, an auxiliary had given counter orders about the care the patient should receive. This was carried out in the presence of the in-service training sister. It may be argued that this represented an attempt on the part of the auxiliary to maintain her power base in the clinical area, when threatened by the presence of a nurse-teacher. It also underlines the weak power base of the teacher in the clinical areas when prescriptions for care become issues of controversy.

Conflict in implementing new clinical roles

The conflict of roles was not contained to those of the trained and untrained nurse. It was also noted in the roles of the staff nurse and the Nursing Officer. For the staff nurse the problems related to the concept of "primary" nurse. One staff nurse defined the conflict in terms of the problems stemming from the distribution of power and control in the unit. In terms of Marram et al (1979) and Hegyvary's definitions (1982) of this role, the power to control the care received by the patient was invested in one specific staff nurse because of her specialist knowledge and skills. However, as the staff nurse pointed out:

> "I am just a staff nurse. The staff nurse on the late shift does not have to implement my plan if she does not feel she has to. After all, we are both the same rank."

Thus, this nurse described the power relationships between members of the same grade.

In their attempt to introduce the nursing process and primary nursing, the Senior Nursing Officer and Nursing Officer were unaware of the need to redefine the roles and tasks performed by each grade of nurse, nor had they redistributed the power and authority to control both work content and patient care in the unit. It may be argued that since this unit was part of the wider organisation of the National Health Service, these individual managers were not at liberty to carry out such a drastic redistribution of power and control.

It may be argued that the role conflict experienced, resulted from the attempt to implement a model of practice based on "weak classification, weak framing" in an organisational setting that had, in the official patient handout, been defined as one founded in "strong classification, strong framing" (see Figures 1 and 3, pp.150 and 159). Further evidence to support this argument came

from the conflict experienced by the Nursing Officer in her attempt to create a "clinical practitioner" role based on "weak classification, strong framing" (see Figure 3, p. 159).

The Nursing Officer: the need to redefine an existing role

The Nursing Officer observed during this case study had been selected for her role because of her training and experience as a District Nurse in the geographical area in which the new hospital was located. Her knowledge of the local population and their cultural definitions of health and illness was extensive and in depth. She had personal relationships with many of the elderly using the resources of the health centre. She understood their relationships with near relatives and the local community. As such, this nurse seemed to be the ideal person to head a community based hospital. Furthermore, her interest in clinical nursing suggested that she had the potential qualities required to implement a clinical-based Nursing Officer role.

The Nursing Officer's main deficit was her lack of higher education. Higher education was not viewed as a pre-requisite when the candidates were interviewed for the post. If it had been, then some of the problems faced by this nurse might have been better understood by the hierarchy. Similarly, if the hierarchy themselves had been given the opportunity to engage in the objective study of the concepts underlying the nursing process, then some of the demands made by them of this nurse and other members of her peer group, might not have been made. The experiences of this nurse serve to illustrate that meaning well and working hard, were not in themselves substitutes for knowledge.

In the course of her duties as a clinical based Nursing Officer, the nurse was supposed to act as a clinical

advisor to the staff and to take on the role and tasks of clinical practitioner. This suggested that her role was one of assessing, planning and implementing clinical care, in addition to helping the staff nurse implement the nursing process. Since the unit did not have a Ward Sister on day duty, the role normally given to this grade of nurse was automatically transferred to the Nursing Officer by the other members of the work group.

Because the planning team responsible for setting the establishment of this unit had not redefined the tasks associated with the new role of clinical specialist, the Nursing Officer found herself having to fulfil two roles: that of the clinical specialist and that of the ward manager. After all, the patient literature had defined the role of the Ward Sister in terms of ward management. In addition to these confused rules, the hierarchy complained to the Nursing Officer that she was not carrying out her duties as a nurse of this grade should. Thus, the hierarchy expected this nurse to simultaneously carry out inconsistent and conflicting roles.

It was not the purpose of this case study to evaluate this nurse's ability to function as a manager, only to point out the ambiguity of this nurse's position. In the patient literature, the role of Nursing Officer was defined in the traditional terms of a unit manager. This role was completely different from that expected of a clinical specialist. It may be argued that the conflicting demands made on this nurse resulted from the senior managers' lack of understanding of the new roles they were implementing. It is suggested that they did not understand the need to ensure that the tasks associated with this new role had to be redefined in relation to other occupational roles in the organisation. The Nursing Officer readily admitted her lack of knowledge and expertise in management, but the hierarchy were

responsible for many of the problems encountered. This may have stemmed from their limited exposure to higher education and hence, the conflicting ideologies in the models for practice initiated by them. Thus, the "strong classification" of the traditional Nightingale hospital and exemplified in the control over the new role as exercised by the nursing hierarchy, inhibited the development of the new role based on "weak classification". Similarly, the "weak framing" inherent in the "personal" power of the new role was in contrast to the "positional" power of the nursing hierarchy and its ability to change the implementation of the new role back to the traditional "managerial" role outlined in the patient booklet.

It may be argued that the implementation of the new roles associated with the nursing process and primary nursing require the renegotiation of the relationships held by the nurse vis-a-vis her colleagues and the hierarchy. In particular, when a decision is made to change the role of the Nursing Officer to that of a clinical specialist, such a change involves the whole organisation's perception of the new role and that of the role of "nursing officer" as it now exists. This in turn, demands the renegotiation of the "strong classification" of the present "organisational" role to one of "weak classification" inherent in the "practitioner" role (Fig. 1, p. 150).

Klein (1966) suggested that initially the threat to existing roles may not be perceived until the planned change has been implemented and achieved. Evidence of such events in the past is supplied by Baly (1980) and Lancaster and Lancaster (1982). These writers in their separate accounts of the implementation of new roles in nursing practice suggested that nurses as individuals and as a professional group, have historically experienced difficulty in supporting each other. The success of the adoption of new roles depends on nurses being socialised in higher education programmes to accept the responsibility for developing and

demonstrating role-models.

It is argued that in this study the role conflict experienced by the participants had its origins in the direct challenge to the "organisational" power, that is "strong classification", inherent in the managerial roles of the nursing hierarchy and the power invested in the nurse's role as an employee of the organisation vis-a-vis the patient. Thus, the degree of "freedom" experienced by the nurse and the patient depends greatly on the individual perceptions of the power holder, manager and practitioner, when the attempt to implement the new mode of practice, and hence the new power structure, is made. As Stacey et al (1970) have pointed out the degree of success achieved in the redistribution of power and control in the nurse-nurse or nurse-patient relationships, depends on the understanding the nurse has of the power invested in her position as an employee of the organisation and her position in the hierarchy. It is therefore, argued that to implement the nursing process as the desired mode of practice, the nurse must first understand the nature and structure of the present institution and how the present distribution of power and control limits both her own and the patient's freedom to redefine their roles. It is further argued that the present attempt to implement the nursing process and its attendant role redefinition, will be maintained within the boundaries of the existing structure of the nursing organisation. That is, it is in the interests of the present power holders, doctors and nurse-managers, to limit the freedom of the nurse-practitioner and the patient to one of "strong classification, weak framing", rather than one of "weak classification, weak framing". The latter would severely diminish the power exerted by the doctor and the manager over the job content and the control exercised by nurse-practitioners and patients alike.

The Wednesday meetings: conflict between the "idealised" and "real" roles of the nurse

Further insight into role conflict associated with the implementation of the nursing process was obtained as a result of the original contract with the Long-stay ward being widened to include the other units in the geriatric sector. Feedback from ward, managerial and teaching staff indicated that the nurses working in the other wards of the unit were keen to implement the nursing process. The teacher agreed to negotiate the contract with the whole of the geriatric unit. In all the writer had contact with some three hundred (300) nurses in twelve (12) different wards, in two (2) different hospitals. Thus, the original contract negotiated with the long-stay ward lasted from March, 1981 up to December, 1981 and the contract with the unit as a whole from January 1982 up to and including August, 1982.

The inputs to the education of the staff were the formal post-basic courses in the Care of the Elderly (U.B.C.N.S. 940/941) and the non-formal contracts negotiated with the unit. These non-formal inputs were in the form of seminars on the nursing process. These seminars were held every Wednesday afternoon, each hospital taking alternative turns in hosting the seminar. In addition to these seminars, the ward staff had access to the in-service education programme run by the post-basic education department. The original ward staff had access to the seminars held by the Nursing Process Development Group (see Chapter Four).

The topics discussed in the Wednesday meetings included the role of the nurse; the Henderson definition (1966) of the nursing role; the research studies carried out by McFarlane (1970) and Anderson (1973) into the existing role; the development of the nursing role as described and discussed by Abel-Smith (1960) and Davies (1976, 1977);

and the nursing process and the concept of "primary nursing". In addition to the staff employed in the two hospitals, members of the Community hospital staff joined in these discussions. The writer drew on the experience of the staff from two "pilot" wards to introduce the realities of the change. It was hoped that by bringing in these "real" problems for discussion that the schism between theory and practice would be overcome (Bendall, 1975).

In retrospect these meetings were a mistake, in that the feedback to the writer from all levels of the organisation had been over-enthusiastic about the readiness of the staff to discuss and analyse their role in the organisation and delivery of care.

It would be impossible to describe and discuss the reaction of every single nurse with whom the writer came into contact during the period of the contract with the two hospitals. Generalisations are therefore, necessary to convey some of these reactions. It is suggested that further research be initiated to examine the categories of reaction described in this study, before future attempts to implement change take place.

One of the first factors influencing the nurses' access to education was the lack of continuity of attendance at the seminars. This was a direct result of the unit's reliance on part-time staff and the constraints on the time available to them by family commitments. Management needed to ensure that the care of the patient was carried out. Hence, there was a need to keep a certain number of staff on the ward. The managers therefore, divided the staff into groups to ensure that the staff could attend the seminars. This resulted in individuals being directed to the study day who would not have come on their own initiative. Not all members of the nursing profession are interested in the implementation of change, nor do they see a need for it.

Reactions from these individuals were hostile to the change process. In this group's perception, the existence of an alternative approach to care implied that they were "bad" nurses. These nurses were noted to talk in terms of "good" and "bad" nurses. The suggestions of a change in practice caused these nurses great discomfort.

These general nurses may be compared to the psychiatric nurses who felt "obsolete". Unlike their colleagues in psychiatry, these general nurses did not have the counselling facilities available to the psychiatric nurse. In addition, the lack of continuity in attending the seminars prevented the teacher from fulfilling a supportive role.

The nurses attending the seminars viewed the nursing process as something they had always done (Kratz, 1977). The nursing process was perceived to be something they had been taught to do in their training, only it was now called something different. The nurses saw no need to implement change, nor did they see the need for further education in this new role. Attendance at the seminars was in their own words "a waste of time". This attitude was expressed by both Enrolled and Registered nurses. Both those who had trained within the preceding five years and those who had trained in the 1960's believed that the concepts of "total patient care" and the nursing process were one and the same thing.

When the debate on the implementation of change involved the need for education, especially higher education, then there was a decided hostility towards 'nurse academics'. The majority of staff attending the discussions on the nursing process argued that higher education was not required to nurse. Both Enrolled and Registered nurses argued this point of view. It is suggested that the nurses felt threatened by the emergence of a graduate nurse and hence, a threat to their livelihood. The group

members were firm in their belief that nursing was "common sense" and all "this talk of degrees" was unrealistic.

The staff verified the arguments put forward by Bendall (1975). In their arguments against the need for higher education, they described the schism that exists between the school and the clinical area. For these nurses who did not believe in higher education, the people who worked in the school were out of touch with the reality of nursing. Similarly, the nurses suggested that those engaged in higher managerial posts were simply using the process, and them, to maintain their own status in front of other nurses. For the clinical nurses, the only "real" nurses are those who work in the ward.

Conflicting ideologies in nursing care of the elderly

It is suggested that the discomfort experienced by the nurses and their resistance to change was a result of their exposure to data contradicting their self image, before they themselves had recognised the need for a change in their self concept as 'nurse'. Similarly, it may be argued that the nurses adopted the defender role because they perceived the upheaval the nursing process would cause in the existing status quo within the organisation.

Getzels and Guba (1954) defined role conflict in terms of the individual being asked to perform two or more roles at the one time. It may be argued that the nurses who resisted the change suggested by the teacher, did so because they were being asked to fill simultaneously two roles that were inconsistent and contradictory. That is, they were being asked to implement a nursing model based on "weak classification, strong framing" in an organisation supporting a "strong classification, strong framing" model. It is argued that in the light of the "codes and control" theory, the challenge to the existing "strong

classification" of the traditional model for practice by the "weak classification" of the nursing model, provoked expectations of the staff which they were unable or unwilling to comply with.

This questioning of the expectations arose from the setting out of the role of the "professional nurse" in specific terms in the literature on the nursing process and primary nursing. Pugh (1966) argued that staff legitimise their roles in general terms, hence the opposition to a new role which sets out the boundaries of that role in clear, concise terms.

It is argued that the staff did not perceive the "practitioner" role as a legitimate role of the nurse in the context of the wards in which they worked. The nurses identified the ill-defined role at the bedside in terms which support the hypothesis that the organisational role reflects the social one. The division of labour between "mere mothering" and the "professional" nursing role as it now exists, is more social than technical (Davies, 1979). The staff did not perceive the need for higher education to prepare the nurse for her role or to keep her knowledge up to date.

Resistance to change need not always reflect an irrational response. Klein (1966) suggested that resistance to change is more likely to be an attempt to maintain the integrity of the group to real or perceived threat. Hence, the arguments against the need for higher education from an occupational group who had identified their need for further education. Similarly, it may be argued that the resistance to the improvement of the practitioner role and the more active involvement of the patient suggested by,Henderson (1966), reflected the real and perceived threat to the managerial authority these nurses aspired to in their careers, that is "strong classification".

In the case of the Enrolled nurse, this threat was mainly to the power relations held by her vis-a-vis the patient (Stacey et al, 1970) and to the power inherent in the Sister's role which she was asked to perform in the absence of that grade of nurse. It is suggested that the resistance to the information transmitted during the seminars, reflected the real and perceived threat to the existing status quo of the distribution of power and control in the organisation. The implementation of a model for practice based on "weak classification" threatened the organisational power base of the Staff and Enrolled nurse vis-a-vis the patient and subordinates. Hence the resistance to a role which would have, in an "ideal" situation, given them greater control over their job content and improved the quality of care received by the patient.

Further insight into how these nurses perceived their present role was obtained from a study carried out by a post-basic student following the J.B.C.N.S. Course in Care of the Elderly offered by the school of nursing. Redmond (1982) in a study of attitudes expressed by the staff towards the patients in their care, revealed the low regard in which these nurses held their patients and the care givers. The data collected by Redmond suggested that the majority of staff employed in the geriatric unit had not applied for these posts, but had been directed to these posts as a result of a need for trained staff in the respective wards. The respondents perceived this move as detrimental to their careers. Those who were prepared to care for the elderly did not perceive that commitment in the long term.

All of the nurses in Redmond's study agreed that the care of the elderly was hard, physical work. Similarly, the most appropriate approach to the care of the elderly was perceived to be one of "firmness". Redmond drew attention to the fact that not one of the respondents thought that

"kindness" was a pre-requisite in caring for the elderly person. Thus, not only did the subjects of this study have a negative self concept as "nurse caring for the elderly", they also expressed an equally negative attitude towards the patients in their care.

Redmond concluded from her findings that the data supported the studies carried out by Wells (1980) and Baker (1978). Thus, the low standard of care received by the elderly is related to the lack of education available to the staff involved and that this state of affairs is implicitly and explicitly supported by management and the medical staff. Similarly, that a lack of education resulted in the staff setting inappropriate goals for care and this, rather than low staff/patient ratios, is responsible for the heavy workload and resultant low standards of care.

One comment made to the writer by a newly qualified staff nurse illustrated the low regard in which care of the elderly was held by the organisation. She stated:

> "I am not really worried by my allocation to a geriatric ward for my first post. My tutor said that I was a good student and that I should not have to wait too long for a real ward."

Thus, the low status given to the care of the elderly was reflected in the attitudes of the school. This newly qualified nurse perceived the geriatric ward as being not a "real" ward. Further she felt secure enough in this belief to verbalise it to a high status member of the organisation (the writer) in front of her peer group. It may also be argued that such values merely reflect wider social attitudes and hence,the stigma attached to the organisational care-giver has its origins in society.

Role conflict in psychiatric nursing:

At the beginning of the contract, conflict between individual group members had been identified (Chapter Eight). This conflict was further increased by the contradictory demands on the writer's time from the group and the school of nursing. The writer had to resolve this conflict in favour of the formal post-basic education programmes offered by the school of nursing. As in the other units described in the present study, conflicting ideologies undermined the attempts to promote a clinical role for the teacher. In a change programme involving "risk-taking" and a challenge to the traditional distribution of power and control, the clinical staff could not depend upon the physical presence of an educationalist to support their new role. It therefore fell to the Nursing Officer to provide the organisational and emotional support in times of dispute.

The first incident involving the conflicting ideologies held by the traditional organisation and the nurses in the change process occurred within the first six weeks of the contract. In their initial attempts to construct and use a nursing history format, the nurses in the Rehabilitation unit identified their need for education in terms of interviewing and counselling skills. One charge-nurse solved this problem by joining a J.B.C.N.S. course in "psycho-dynamic techniques" offered by the school of nursing. For those nurses remaining in the clinical area, the teacher suggested the utilisation of a learning programme developed and used in the basic education of medical students (Maquire et al, 1977). This approach utilised audio-visual recording techniques in which the students evaluated their own performance. The contribution from real patients was central to the success of the programme.

The use of the patient in this exercise necessitated the

patient's, his relatives' and the consultant's consent to use the confidential data contained in the interview. Since the patient's access to professional nursing is through the medical staff, the consultant held considerable power over the patient's and the nurse's activities. In this instance the consultant used his power to stop the learning activities. In doing so he maintained his professional boundaries (strong classification), his traditional right to define the nursing role and the education of the nurse. To support this control over the patient and the nurse, the consultant argued that he had a duty to protect the patient's civil liberties. This was perceived by the nurses to be an emotive argument in view of the denial of civil liberties inherent in the traditional medical model for psychiatry.

Unfortunately this opening up of the conflict between the concepts of the nursing role held by the medical and nursing personnel, occurred at a point in the change process when the ward nurses were still unsure of their new independent role. The risk involved in challenging the consultant was perceived by the silent members of the group to outweigh the advantages of gaining their independence from medical domination. This data supports Davies' argument (1976) that part of the nurses' occupational strategy involved a dependency on medical decision-making in times of conflict.

Through their acceptance of the physician's right to interfere with the learning programme, the nurses acknowledged and re-established the consultant's control over the development of the clinical role. The consultant therefore, diminished the effect the writer had on the education of the nurse. This unfortunate state of affairs did have a positive effect. It forced the dominant charge nurses and staff nurses to take a stance and challenge the medical staff in an open rather than in a hidden manner. It was suggested to the writer by a student nurse

that the ward staff had tried to make the writer assume responsibilities for change which really belonged to the trained staff in the ward.

The Friday Meetings

The open challenge to the medical profession's traditional right to direct nursing practice occurred mainly in the weekly meetings held to discuss the implementation of the nursing process. These meetings were held to discuss progress of individual patients and the staff's application of the nursing process to patient care. The consultant persuaded the group to accept these meetings as the vehicle for the education programme. In this way he maintained his control over the transmission of knowledge and information he considered to be appropriate to the role of the nurse. Outwardly, the model for practice appeared to be one of "weak classification, weak framing", but the control exerted by the medical staff over the nursing establishment ensured that it remained one of "strong classification, weak framing" (Fig. 1, p. 150).

The conflicting ideologies underlying these meetings ensured that the hidden agenda for each discussion was the nurses' attempts to gain control over their practice, rather than the patient's progress. The freedom given to the nurse was limited to what the consultant believed was appropriate to the role of the nurse.

The maintenance of traditional work practices was further emphasised by the exclusion of the patients and their relatives from these clinical meetings. Marriner (1975), Ashworth, Castledine and McFarlane (1978) in their separate accounts of the nursing process stressed the need for the full participation of the patient in all aspects of the nursing process. By excluding the patient from a meeting in which vital "knowledge" about his wellbeing

and future was discussed, both the medical and nursing staff ensured that the "closed" boundaries (strong classification) between the roles of the patient and the staff were maintained. This contrasted with the accepted policy of an "open system" (weak classification) model for practice (see Chapter Eight).

It is suggested that the concepts of the nursing process were being subsumed within the traditional models for care. The nurses and the patients had only limited control over their environment and functioned within the boundaries of traditional organisational relationships. The development of nursing records which attempted to set out the client's needs, the objectives for care and an evaluation of that care once it has been given, did not ensure that a more equal relationship had developed in the case of the doctor, the nurse and the patient in this psychiatric rehabilitation unit.

The emotional needs of the staff

The nurses observed in this study worked in "live" groups, rather than controlled "laboratory" situations. In these natural surroundings the membership constantly changed as new nurses joined and established members resigned. These constant changes in the group membership introduced new ideas and concepts of care into the unit. Occasionally, these new members of staff provided the stimulus to continue with the proposed plan of change. Further, the constant turn-over of student nurses ensured that the staff reviewed their progress, clarified their thoughts and defended their choice of categories. The introduction of new staff also brought anxieties into the unit over and above those already present in the daily practice of nursing (Main, 1956; Menzies, 1970; Millar and Gwynne, 1976).

Throughout the time frame covered by this case study, the

staff relied heavily on the support of the Nursing Officer and the peer group in the hospital. Their need for peer group support from colleagues working in other units within the hospital was identified as important by the staff, especially when the reorganisation of care challenged the traditional power structure within the ward and the hospital. In particular, it was noted that individual members of the work groups experienced anxieties when the traditional routinisation of care and the use of work groups were challenged. It was not unusual to hear individual nurses express concern over their lack of control over the patient and their inability to adjust to a less structured work regime. On at least one occasion one member of the team openly complained of feeling "obsolete" and requested to be transferred to another, more traditional, unit.

It is argued that these data support the arguments that the literature on the "idealised" role of the nurse and in particular that circulated by the R.C.N. (1981) and the U.K.C.C. (1982), are making demands upon the trained nurse which he/she cannot or will not comply with. This is particularly true when the change demanded of the nurse challenges the traditional distribution of power and control in the relationships held vis-a-vis the doctor, the manager and the patient.

It is argued that the data presented in the case studies of the attempted implementation of the nursing process in the psychiatric units recorded in this study, uphold the suggestion that the "practitioner" role is a direct challenge to the "strong classification" of the existing hierarchical bureaucracy of the nursing organisation and in particular, to the control exerted by the medical profession over the job content and the education of the nurse. It is further suggested that conflict in role enactment may result when the model for practice adopted by the nursing staff is different from that embraced by

the medical team. For example: if the nursing staff adopt the psycho-dynamic model underlying the nursing process, for example the contractual approach suggested by Orem and adopted by the nurses in this study, and the medical staff continue to utilise some other approach involving external assessment and evaluation as the basis for their practice, then conflict between the nurses and the medical staff is inevitable. Thus, the basic philosophies and concepts underlying the practice of each occupational group are in opposition. Likewise, as Beattie and Durguerian (1980) and Webb (1981) have argued, the implementation of the nursing process challenges the role boundaries and hence the division of labour between the doctor, the nurse, and the patient.

In the psychiatric nursing units recorded in this study, some nurses appeared to be unable to renegotiate these role boundaries with the patient, whilst others welcomed it. However, regardless of the degrees of role negotiation achieved by the individual members of staff, they were not able to renegotiate actual tasks laid down by the bureaucratic structure of the organisation. Thus the "strong classification" between the roles of the nurse and the patient were maintained through the social and organisational status of the patient. The actual changes achieved by the staff vis-a-vis the patient were in those areas of daily living such as bed making, which did not challenge or change the structure of the organisation and therefore, the status of the nurse and the patient within the organisation or society. Thus the distribution of power and control in the wider society is reflected in the type of "codes and control" model adopted by the organisation. Where social attitudes change and the patient is permitted a greater freedom to participate in the organisation of his daily living routine, this freedom does not extend to the redefinition of the patient's social status or role, or the wider social role of the medical profession as a major institution of social

control.

It is argued that so long as medicine continues to function as an institution of social control, the status of the patient and the nurse will be limited to what society and the medical profession deem them to be. Thus the distribution of power and control in the wider social context is reflected in the distribution of power and control in the organisation. Further, the factors which determine the division of labour between the nurse and the woman in her own home, the patient and the physician, are based on social factors, rather than technical expertise.

CHAPTER TWELVE

Learning contracts and the evaluation of change: self-assessment in education and practice

Introduction:

In Chapter Three the writer discussed the use of independent learning contracts and the change in the teacher's role as an external assessor of the student's achievements. In particular, it was argued that this new role for the nurse-teacher required him/her to rethink their role in the evaluation of the success achieved by the learner and indeed, to rethink his/her ideas of what constituted success and failure when the learning objectives were based in the student's perceived learning needs. Further it was suggested that in terms of Bernstein's "codes and control" framework for general education (1975) this sharing of power and control in the learning experience offered to the student and the assessment of the degree of success achieved, challenged the traditional role of the teacher and the "strong classification" of the traditional "collection" code curriculum. It was also argued that the "strong classification" of the traditional G.N.C. dominated curriculum was in part responsible for the schism between theory and practice found in the present school of nursing. One of the arguments put forward by the writer in support of the independent learning contract was its apparent usefulness in bridging the gap between theory and practice, especially when the nurse's learning programme was based on her perception of the knowledge and skills needed to implement her role (Keyzer, 1980).

The need for a rethinking of the teacher's and the student's roles in the evaluation of the learning programme is further supported by the studies carried out by

Hegyvary and Hausmann (1976). These writers argued that the effect education had on clinical practice was the most difficult variable to assess. This they believed, stemmed from the organisational variables which influence patient-outcomes and over which the nurse exercises little or no control. Further, it may be argued that when the change involves attitudes, the observer may not be in the best position to determine the degree of change in each individual or the group as a whole. Thus, as Hall (1977) argues, the external assessor may not be able to verify that the staff's perception of the change that has, or has not, taken place.

In this chapter the outcomes of the learning programmes negotiated by the writer and the clinical staff are described by the participants and interpreted by the writer utilising the frameworks devised in Chapter Ten based on the "codes and control" framework for nursing education (Figure 2). It is argued that since the nursing process consists of both actions and attitudes, that the outcomes of the contracts can not be measured in strictly behavioural terms, and must therefore, take into account the participants' perceptions of the degree of change.

The Rehabilitation unit:

The contract negotiated between the writer and the charge-nurses in the Rehabilitation unit (see Chapter Eight), identified the trained nurses' needs for continuing education in both their managerial and clinical roles. In terms of the nursing process, these learning needs were overlapping and may be represented in a learning contracts as follows:

Learning Objective	Strategy	Resources	Criteria for Evaluation
To complete a nursing record which can be used by all members of staff	Self study (non-formal education)	School of nursing Library-Psychiatry -Main teaching hospital	The record will contain a nursing history, a plan of care and an evaluation sheet
	Charge-nurse (formal education)	Diploma in Nursing course	The data gathered will identify the patient's strengths and weakness, his priorities for care, his contributions to the plan of care
	Visits to other units in this and other Health Authorities	Compare and contrast other attempts	The format must be acceptable to both staff and patients
		to implement change	The redistribution of the workload will: utilise the individual expertise of group members
The staff will discuss with each other and experiment with the suggested plan for re-organising the workload, i.e., change in shift-work, named nurse for a set group of patients, link up a trained nurse with specific students and patient group for duration of students' stay in unit	Peer group discussion	Unit staff	Facilitate the professional development of the nurse
		Colleagues in other wards	
	Individual and Group discussion	Medical staff	Promote a democratic management style, enhance the staff's job satisfaction upgrade the quality of patient care
	Individual and Group discussion	Nurse-tutors	
			Stimulate a learning environment in the ward for staff and patients

The staff were aware of a previous strategy employed by nurses which ensured that only members of the hierarchy were normally sent on educational visits to other hospitals. A deliberate strategy was activated to ensure that all grades of nurse had an equal opportunity to participate in the learning activities. It was argued by the staff, that the previous strategy employed by the hierarchy ensured that the status quo was maintained.

The writer did not attempt to direct the staff toward one particular nursing framework, nor was the literature selected for the staff. Complete control over the sources of information, the time-frame for change and the framework for practice, was given to the staff. In this way, the writer and the charge-nurses overcame the constraints laid down by the consultant and created a student-centred approach to education.

This "open" approach to education was possible because it did not involve the patient and did not threaten the occupational boundaries of other professional groups. Thus, the maintenance of "strong classification" between the roles of the physician and the nurse was not endangered. In terms of the organisational relationships with the nursing hierarchy, these learning activities did not disturb or alter the formal organisation, nor could they be implemented without its consent.

It may be argued that the steps and stages of the nursing process and the re-organisation of the workload were being subsumed within existing relationships. Within these structures, the distribution of organisational power and control remained unchanged; that is, the "strong classification, weak framing" of the traditional "organisational" role based on the medical model (Figure 1, p. 150) remained intact.

The framework for practice chosen by the staff was based on Orem's concept (1980) of self-help. This problem-orientated and contractual approach to care was viewed by Altschul (1978) as too mechanistic for psychiatry. Altschul recommended King's interactional approach (1971). The staff argued that a problem-solving approach offered a more practical solution to the nursing problems of an elderly population who had both psycho-social problems and multiple pathology.

The factors isolated by the staff to support their choice of framework were as follows: there was an acknowledged lack of education to support a psycho-dynamic model; the patient's obvious needs to be involved in the very basic activities of daily living; the effects of prolonged institutionalisation on the patients and their variable ability to care for themselves from day-to-day. It may be argued that the patients' inconsistent ability to care for themselves and the nurses' need to ensure a minimum standard of social cleanliness, encouraged a model for care ranging along a continuum from "strong classification, strong framing" to "strong classification, weak framing" (see Figure 3, p. 159).

Reorganising the workload

Initially the group recognised that they would have to assess the patients' total needs for care and the individual roles they could be given within the structure of the organisation. It was agreed that with a patient population exhibiting such a wide variety of abilities and disabilities, some form of "streaming" would be necessary (see Hicks and Tutt, 1982).

The staff decided that the best plan of action would be to house the patients in three geographical locations. The initial move concentrated on the creation of an "upper" and "lower" level. These terms referred to the

geographical location of the wards in relation to each other, rather than a stigmatisation of the patients on some grading of their abilities. The "lower" level patients were housed on the second floor of the hospital and the "upper" level patients on the third floor. Towards the end of this study a third component was added to this unit. This third unit was a former doctor's residence within the grounds of the hospital. This "half-way" house was established towards the end of the study and a separate research project will be required to assess its success or failure. In terms of this study, this attempt to provide sheltered accommodation for the more able patients, was considered to represent a self-help approach to care (weak classification, strong framing) through the patients' greater control over all aspects of their daily lives (see Figure 3, p. 159). Initially the staff attempted to establish two separate groups of patients: one consisting of the younger, more psychotic patients and the other formed by the older, more physically dependent patients. This grouping left a third group of middle-aged persons, whose needs for self-care varied on a daily basis depending on their mental status.

It was found that organisational variables such as: acute shortage of bed space and low staff-patient ratios militated against the successful achievement of this strategy. Similarly, it was found that the staff were occasionally over-optimistic about individual patient's abilities to achieve the pre-set goals. Thus attempts made by the staff to involve thier patients in the organisation of their daily living activities failed because of the elderly, institutionalised patients' physical rather than mental resources. It was therefore necessary to review the overall aims for the unit and the individual objectives for the patients.

The new approach to care was essentially the same for both

"upper" and "lower" patients. Each individual was encouraged to assume responsibility for their own living space and for their own personal and social hygiene. Unlike past practices, no time limit was set by the staff in which the patient had to complete these tasks. The more able patients were encouraged to take on community responsibilities such as, the budgeting of the group's food allowance money, shopping for food in the local supermarkets and in preparing food for the group's meals. Further, it was noted by the writer that the patients from the "upper" level group had free access to tea and coffee making facilities throughout the day. Previous strategies of assigning patients to "work groups" were discouraged by innovative members of staff and were eventually disbanded. More attempts at helping the patient to integrate into the external world were introduced, for example: groups of patients were taken to the local swimming pool where it was discovered that one elderly patient had been a keen swimmer in his youth, a fact that had not been known to any member of staff. With this reappraisal of the staff's attitudes towards the patients, it was discovered that individual patients previously allocated to work groups involving heavy manual labour, were over the official retiral age of sixty-five (65) years. These persons were now acknowledged to have "retired" and no future demands were made of them in terms of engaging in heavy manual work.

Although the staff believed they had created an "open system" approach to care, they still controlled the selection of patients to these groups, rather than the patient's personal decision to join or leave a particular group or to identify him/herself with either the "upper" or "lower" group. If it is accepted that nursing care involves both attitudes and actions, then the nurses's perceptions of a change in practice which distinguished between the old and new model in practice,

could be considered as evidence that an attudinal change toward the patient had taken place. Thus the change was conceptual in nature and therefore, more difficult to assess from the outward behaviour towards the patient, or the way in which the patients were selected to the membership of each group.

The boundaries between the roles of the different grades of nurse remained unchanged that is, ill defined, but there was still the clear demarcation between the roles of the doctor and the nurse. There may have been a renegotiation of roles between the nurses and between the nurse and the patient, but there was little or no possibility of role negotiation between the doctor and the nurse. Similarly, within the official structure of the organisation, the roles of the clinical and managerial nurses continued as before.

The time frame for the implementation of change:

The period of time covered by the case study of the Rehabilitation unit (January, 1981-September, 1982), may be viewed as relating to the action stages of the change process. The initial discussion on the change in practice originated two (2) years before the actual changes described in this study. Thus, two (2) years of debate and discussion and of selective recruitment had preceded the introduction of the new nursing formats and the non-formal education programme. The unit nurses identified the value of the discussion with members of their peer group and meeting other nurses from other hospitals, in clarifying their ideas and introducing them to different approaches to rehabilitation.

The outward success of the learning contracts cannot therefore be viewed purely in terms of the introduction of a nurse-teacher into the clinical area. The data presented in the case study (see Chapter Eight), suggest

that there is a significant point in the change process at which the educationalist should be introduced to the group. In this study, it appears that this point occurs when the members have committed themselves to the change process and have acknowledged their need for further education (see Chapter Four). The data also suggest that there is a limit to what a teacher can achieve in the presence of the medical staff's control over the patient and hence, the nursing role.

In addition to the recognition of their needs for education, the group leaders acknowledged an open strategy of selective recruitment. This strategy had been initiated to bring together highly motivated, like-minded individuals and to create a nucleus of co-workers who would initiate innovative approaches to care. As stated earlier in this chapter, the introduction of such persons caused anxieties and tensions when existing group practices and attitudes were challenged. Throughout the period covered by the case study and the preceding two years, the staff relied heavily on the support of the Nursing Officer. The data therefore, support the arguments put forward by Hall (1977) and Towell and Harries (1979), that the outward success of the change programme and the time taken to implement new roles and relationships, depends on the involement of all grades of staff and an openess in the channel of communication between members of the organisation.

The learning programme

The success of this learning contract should not be viewed in terms of the change in clinical practice, but in the promotion of the group's learning skills. The handing over of control to the group facilitated flexibility and promoted the nurses' ability to seek out information appropriate to their needs in the clinical

area. It also encouraged the setting up of a self-help learning programme within the hospital (see Chapters Five, Eight and Nine). This data support the findings of an earlier study (Keyzer, 1980) and indicate that trained nurses are interested in further education and self-directed learning. The impetus fór the setting up of this self-help group, like the energy for the change in clinical practice, came from the charge nurses. This outward display of leadership by these individual nurses was perceived by their colleagues to reflect the charge nurses' personal concepts of nursing and their commitment to a more egalitarian way of life.

The nurses described their perceptions of the implications for psychiatric nursing contained in the recommendations of the Briggs Report (1972) and the setting up of the U.K.C.C. in 1979. It was suggested that the recommendations put forward by these committees, would spell the end of psychiatric nursing as they knew it. The staff were under pressure and perceived threat from two sources of change within and outside the hospital setting. The threat from these external sources of change involved the nurses' perceptions of the relationship between general and psychiatric nursing. It was suggested that the proposed changes contained in the Briggs Report (1972) would result in psychiatric nursing becoming a post-basic speciality of general nursing. This, the staff argued, would result in the selection and recruitment of nurses whose attitudes would not be sympathetic with the needs of the patients. It may be argued that these attitudes are prejudices rooted in the historical development of the nursing service. However, future research may well discover different attitudes towards patients and therefore, different concepts of care in those persons presenting themselves for general and psychiatric education. If this were found to be so, what would the future of an integrated basic programme be?

There was also open hostility towards the senior management at Area and Regional levels of the hierarchy. These managers were perceived by the staff to be "General Nurses" who had little or no understanding of the needs of psychiatric nurses or their patients. Thus, not only was there a wide schism between the managers and the practitioners; it was suggested by the staff that there was a deliberate bias towards general nursing (Carpenter, 1980). It is argued that this data indicate the lack of cohesion between the different branches of nursing and a possible source of weakness in the attempts to promote a practitioner role; and similarly, that this lack of cohesion and the lack of priority given to nursing education enhances the medical profession's hold over the development of the clinical role (Abel-Smith, 1960; Davies, 1980).

External influences on the change process

The external factors influencing the success or failure of the planned change were identified by the staff as stemming from the involvement of central government in the provision of care (Abel-Smith, 1960; Davies, 1980). The 1982 reorganisation of the National Health Service had a direct effect on the morale of the staff in this and other units described in this study. In particular, the reduced resources available to the nursing organisation was frequently used as an excuse by the senior managers when requests were made by the ward staff for more financial, material, educational and manpower resources to meet the daily needs of the patient and the proposed plan of change (see Chapter Five). Conflict between the individual manager's desire to promote a change in practice and his organisational role as an agent of central government, was a significant variable in the nurse's ability to promote the practitioner role. It should be noted that the degree of conflict varied considerably between individual managers,

depending on their commitment to the proposed changes.

The staff's requests for extra resources referred mainly to the financial aspects of obtaining new stationery for the development of the nursing process formats and to release the staff to attend meetings and seminars held by the Nursing Process Development Group (Minutes of the Nursing Process Development Group Meetings, 1980-82). The nurse's ability to apply theory to practice was influenced by the practical support offered by the hierarchy. This, in turn was influenced by their access to the requisite resources and government policy towards the health services. Similarly, the nurse's access to educational activities was influenced by their manager's attitudes towards staff devlopment.

It may be argued that in periods of economic recession, the reduced funding of the health services ensured that nursing education was the "constant casualty" (Davies, 1980). The quality of the learning experiences offered to the student is of little consequence when the managers give low priority to staff development and the nurse is denied access to the learning programme. Similarly, the involvement of a nurse-teacher in the implementation of change has a limited value when the staff are denied access to needed resources.

The Psycho-geriatric assessment unit:

In Chapters Eight and Nine, the writer described the setting up of the self-help study days organised by the charge-nurses in the Rehabilitation and Assessment units. In the second of these study days held in the Psychiatric hospital, the writer recorded the Assessment unit charge-nurses' evaluation of their progress in implementing the nursing process. The following information is taken from the notes made by the writer during the study day. The time covered by

the discussion was approximately one-and-a-half hours. Both general and psychiatric nurses were present (see Chapters Eight and Nine).

The topic for discussion in the second of the self-help study days was the degree of change achieved by the nurses in the assessment unit. The senior and junior charge-nurses described how it had taken four years to implement the nursing history and evaluation formats. They justified their adoption of a nursing model by drawing attention to the name of the unit, that is a "Psycho-geriatric Assessment Unit". The charge-nurses acknowledged the inputs from other health care professionals and the benefits gained from visiting other units outside the Health Authority.

The charge-nurses calculated that it had taken them eighteen months to produce the formats in use at the beginning of the study. From the first meeting at which the need for change was discussed up to the end of September, 1982, four years had been spent in the development of a nursing history, a care plan and an evaluation scale. In common with their colleagues in the rehabilitation unit, the staff had requested the involvement of the teacher once they had recognised their needs for education.

The senior charge nurse stated that the staff had tried not to use medical terminology and to overcome the problems of perceiving patient behaviour in terms of "normal and abnormal". This approach, she believed, had brought the ward nurses more in line with the model for care utilised by the community psychiatric nurses. The application of the elements of the nursing process to patient care, had, in this charge-nurse's opinion, fostered closer relationships between ward and community based nurses.

The charge-nurses stated that the nursing history format had been designed to assist the staff in the planning of care for patients admitted for a six week hospitalisation programme. In reality, some patients had been hospitalised for as long as thirteen months.

The charge-nurses stated that the problems encountered in the move from a "sickness" based model to one founded on "functional disorders", underlined the inadequacies of the basic education programme. The resulting needs for further education were perceived by these nurses to include both general and psychiatric nursing concepts. In their arguments, the charge-nurses suggested that the staff required a deeper understanding of the principles of general nursing care as well as psychiatric nursing. The provision of holistic care was linked to the closer integration of the current basic nursing education programmes and the creation of a programme based on an understanding of individuals, their interpersonal and social relationships with others and how these are disrupted by what is now called "mental illness". In this way, the nurses believed a greater understanding of the client's problems would follow and then, an improvement in the care received.

The charge-nurses illuminated the differing models for practice by drawing attention to the redefinition of terms used in daily practice. These terms included such patient states as "incontinence" and "aggression". The presence in the ward of post-basic students following the J.B.C.N.S. course in care of the elderly, was viewed by the charge-nurses as a stimulus to the change process. These students not only brought new concepts into the unit, but their questioning of current practices ensured that the staff had to clarify their thoughts and ideas.

In their evaluation of the progress made, the charge-nurses

stated that the initial attempts to use the new nursing formats had been hampered by low staff:patient ratios. Similarly, the need to maintain the traditional Kardex in tandem with the new records had doubled the administrative tasks in the unit.

The new nursing formats were initially designed by the nursing staff in conjunction with the clinical psychologist to provide a semi-structured questionnaire using headings (see Appendix C). It had been found that the staff had tended to use only these general headings instead of their initiative and observations. The charge-nurses also underlined the need for a different type of nursing knowledge and expertise to assess, plan and evaluate the patient's need for care.

The staff had continued to use medical terminology and to gather data recorded in the medical notes. This was perceived to be a direct result of the nurses' use of the medical model, that is, they continued to assess the patient's needs in terms of the physician's diagnosis and/or the malfunction of some body system (see Chapter One).

In the process of adopting a nursing model for care, the staff reported that they had realised that their relationships with each other, the patient and his/her relatives, the doctor and other personnel, would have to change. In particular, they singled out their relationships with the medical profession.

The charge-nurses believed that any change in the nursing role would require not only an education programme for the nursing staff, but also a programme aimed at the general public and their perception of the prescriber role. The staff suggested that members of the public perceived the nurse as a "doctor's assistant". Thus, any move towards the 'prescriber' role described

by Henderson (1966) would have to be explained to the general public.

One of the positive aspects of adopting the nursing process was identified by the charge-nurses in relation to their teaching role. It was suggested that the use of a nursing history, a care plan and an evaluation scheme, facilitated the teaching of both basic and post-basic students. This, the charge-nurses emphasised, was satisfying to staff and students alike. In particular, the allocation of nurses to specific patients for the entire duration of the patient's hospitalisation, had made it "easier" for the trained staff to teach the students.

The charge-nurses' perception of the staff's reaction to the implementation of the nursing process

In their description of the progress made, the charge-nurses reported that initially there had been an identifiable difficulty in getting the staff to agree to the proposed changes (see Chapter Nine). The charge-nurses reported that the staff believed any change in the organisation and delivery of care would involve a reassessment of staffing levels. The need for further education in "getting the staff to understand the process" was acknowledged by all members of the group.

The charge-nurses admitted that although the new nursing formats had been in use for more than a year, they were still experiencing difficulty in persuading the staff to accept and utilise them. This problem, it was stated, could be overcome by an education programme tailored to the specific needs of the psychiatric nurse.

The charge-nurses acknowledged the writer's inputs to the

change process. The main benefits of the writer's inputs were viewed by the charge-nurses in terms of the relationships formed. In particular, they identified the positive effect of knowing that some one expected them to achieve their preset goals. When asked to clarify this statement, the charge-nurses explained that it was important for the staff to know that they were expected to achieve, otherwise it would have been easy to abandon the attempts in times of adverse conditions. Thus, it would appear that the benefit of the negotiated contract was the statement of commitment, rather than the format of the agreement. Further, the charge-nurses acknowledged their use of the tutor's sapiential authority to coerce the organisation to make available necessary resources (see Chapter Nine).

In a general discussion with group members, the charge-nurses stated that they felt like pawns in a game. In particular, they suggested that their attempts to implement the nursing process enhanced the senior staff's reputation within the hospital and the Health Authority. The staff perceived their seniors' support for the change in practice as a form of self-aggrandisement rather than a genuine concern for they patient's well-being. The nurses present agreed that they had used a strategy of:

> "Well, if you (the hierarchy) want us (the staff) to implement process then ..."

to obtain resources which would have been essential irrespective of the model used.

The nurses present at the study day agreed on the need for open communications between all grades of staff. All persons present had experienced the disruptive effect on the proposed change, caused by one member's resistance

to the plan of action. Group cohesion was perceived to be essential for the success of the venture.

Although commitment to change was deemed to be central to the success of the venture, individual nurses stressed an opinion that resistance to change was in some way an indication of the need for change. Again, the need for a continuing education programme was stressed and perceived to be essential if patient care was to be improved.

In a general discussion on the risks inherent in the adoption of the practitioner role, the nurses from the rehabilitation and assessment units stressed the importance of psychological support and the anxieties experienced by all members of their respective groups. These anxieties were classified as follows: anger at each other for not having explained the purpose of the proposed change; conflict in the staff when medical decisions had to be made by members of the nursing staff; the forcing of decision-making downwards especially when the Enrolled nurse was made responsible for the admission or discharge of patients; the lack of clarity of the clinical role; the need for the planning of change, rather than a reaction to enforced change; the need to reorganise the workload to include discussion time for nursing staff.

The assessment unit charge-nurses supported their belief that a change in the nursing role necessitated a change in the organisation of the workload and the shift system as a means of distributing the staff over a twenty-four hour period. Too much emphasis, they suggested, had been placed on the benefits of the nursing process in terms of patient care, with a disregard to the upheaval of working relationships vis-a-vis colleagues and other professional groups.

It was suggested by the senior charge-nurse that the belief held by some nurses in the inter-changeability of the terms "total patient care" and "the nursing process", had its basis in the literature published by "The Nursing Times" and "The Nursing Mirror". Little or no attention had been paid to the change in the work patterns or how the process could be implemented, by these magazines. Similarly, the needs of the staff as people had been ignored by the articles published. Thus, the available nursing literature was perceived by the charge-nurses to be inadequate in meeting their needs for new nursing knowledge.

In a general discussion on the needs of the staff, the psychiatric nurses voiced their support for the use of T-groups and sensitivity groups. The general nurses present appeared to support, or at least give verbal support, for an "authoritarian" approach to dealing with staff problems. The question posed by the psychiatric nurses to their general colleagues was "what happens to those people who cannot or will not change?" The reply given by a general Nursing Officer was "Get rid of them".

The conclusions drawn by the psychiatric nurses stressed their perceptions of the general nurses' "mechanistic" concepts of care. These general nurses agreed to disagree and restated their belief in their sole right to be called "nurses".

The charge-nurses from the assessment unit concluded their review of the attempt to implement a more "patient-centred" approach to care in their unit. They restated their personal belief in the need to provide a more "human" environment within the hospital setting and suggested that the quality of care received by the patient was a direct reflection of the staff's feelings and morale. Both patients and nurses were people they stated,

and therefore the needs of both groups had to be taken into consideration when a change in practice was planned.

Summary:

In the terms of this study this self-evaluation by the staff and their complete control over the context, content and methods of conducting the study day can be perceived to fall within a "weak classification, weak framing" model of education (Figure 2, p. 151). In the light of the "codes and control" framework, the lack of active intervention on the part of the teacher and the staff's freedom to run the study day as they pleased, all point to the rejection of the traditional roles of the teacher and student, and the power invested in the school of nursing over the learning programme. As in an earlier study (Keyzer, 1980), the students engaged in the study day indicated that given the opportunity to take control over the learning programme, clinical nurses can produce constructive critiques of the progress made in the implementation of the nursing process. Both groups identified negative and positive aspects of their innovations and no attempt was made to imply that either group had implemented the "idealised" role.

The staging of such a study day and the opportunity for the staff to take control over all aspects of the learning programme did not signify that the "strong classification" of a "collection" code had been changed to that of an "integrated" code curriculum. Indeed the participation of the teacher, the use of the school of nursing's premises and the involvement of the clinical staff could only happen within the limits tolerated by the official organisation. Since the permission to conduct the study day and the staff's participation required the consent of the hierarchy, this freedom to participate in self-directed learning

could only take place within the limited freedom tolerated by the managerial and educational staff. Thus although the teacher and the learners appeared to have created a model for continuing education based on "weak classification, weak framing", the overall control of the nursing hierarchy as the employing authority of both the teacher and the learners has to be taken into account. In the terms of a "codes and control" framework the model of education may be said to lie within a "strong classification, weak framing" (Figure 2, p. 151) model in that, the hierarchy still maintained control over the nurse's access to education even if the study day had been set up by the participants as some sort of challenge to that power base.

The contents of the self evaluation do however, raise several questions. For example, in identifying that not all nurses support the change toward a "nursing" model for care, were the charge-nurses implying that those who did support the change had different qualities from those who opposed it? and could those qualities be said to be related to a more clearly defined concept of their part in the provision of health care? If so, then it may be argued that the student-centred contracts assisted those persons in their attempts to put these concepts of care into practice.

The evaluation carried out by the charge-nurses underlined the lack of knowledge and expertise held by the traditionally trained nurse and the need to expand the present continuing education programmes available to both general and psychiatric trained nurses. It is also argued that the traditional development of these services has favoured the general nurse over those employed in psychiatry and that existing educational opportunities appear to be biased towards the general nurse. Both groups advocated the use of the nursing process in their respective clinical areas and proclaimed

the advantages it brings to the teaching of nursing practice to students in the clinical area. This raises questions as to the content of these teaching sessions. If as the staff claimed and the care plans indicated, the trained nurse is inadequately prepared for the task at hand, then the contents of their teaching programmes for student nurses are also open to debate. Further it is not clear from the data provided whether or not the trained staff permit their students the degree of freedom to learn that they believe is their due as trained members of staff.

The continued use of the student as an integral part of the workforce and the R.C.N. (1981) and the U.K.C.C. (1982) concept of them as "protected employees" suggests that the "strong classification" of a "collection" code curriculum will continue to form the basis of the education offered to basic and post-basic students. Until the central issue of the ambiguous status of the learner is resolved it is unlikely that an "integrated" code curriculum based on "weak classification" will be implemented. Thus the distribution of power and control in the organisation not only reflects that of the wider society, but also the school of nursing and the education of the nurse.

It is therefore, argued that the division of labour between the doctor, the nurse and the patient is based on the distribution of power and control, especially between gender roles, and any attempt to disturb the status quo will be resisted at all levels of the organisation. Resistance to the proposed change may even come from those persons for whom the intended change could bring a greater control over their own environment and their lives.

CHAPTER THIRTEEN

Reflecting on an action research approach: theoretical illumination and practical intervention

Introduction:

The first part of this study outlined and discussed the potential problems facing nurse practitioners and tutors engaged in the implementation of the nursing process in practice and education. It was argued that the introduction of the Henderson definition (1966) of the nursing role in British nursing organisations, would require a redefinition of the roles of the manager, the doctor and the patient. It was further suggested that a corresponding change in the role of the teacher would be necessary to support the change in clinical practice.

It was argued that this redefinition of the teacher's role opened up new opportunities to promote research and thereby develop nursing theory and through the negotiation of clinically based learning contracts, to facilitate the integration of theory, practice and education. Frameworks for understanding the changing roles of the nurse and the teacher were developed from the application of a conceptual framework of "codes and control" to the changing models for practice, education and the division of labour between the nurse and the patient.

The second part of the study described and discussed the writer's attempt to put the suggested strategies for change into practice and the problems arising out of the redefinition of the organisational role of the nurse. The implementation of change carries with it a certain amount of risk for the participants. In this study

there was always the chance that the group would reject the proposed change, or that the implementation of the nursing process in the United Kingdom might not mean the same as in the United States where the concepts originated.

The data recorded in this study are discussed under the following headings: "codes and control" models; action research strategies; and practical implications. Conclusions are drawn and recommendations for further study are put forward. It is suggested that the data support the arguments developed by Stacey et al, (1970), Towell (1975), and Hall (1977), that the implementation of a new role requires supportive education programmes, the involvement of all grades of nurse, together with an open communication system which permits the diffusion of the innovation and change throughout the organisation.

Towards a theory of nursing: a "codes and control" model

The conceptual frameworks of "codes and control" developed for this study have proved useful in examining the changing role of the nurse, her education in the school of nursing and the division of labour between the nurse and the patient. A "codes and control" framework draws attention to the distribution of power and control within the present nursing organisation and the strategies which have kept the clinical nurse and the patient in positions of weakness, relative to the power invested in the roles of the doctor and the manager. The education programmes developed and controlled by the hierarchy and through the adoption of the medical model, the medical profession, have supported this distribution of power and control through the professional socialisation of the student nurse. Thus, the traditional training programme is itself part of an overall strategy which maintains the status quo of the

present hierarchical bureaucracy of the nursing organisation.

The data gathered by this study, especially that concerned with role conflict, suggests that the implementation of the nursing process challenges existing role boundaries and that managers and doctors are in positions of power to defend these boundaries. The existing decision-making strategies ensure that the trained nurse has only limited freedom to redefine her role within the parameters set down by the power structure of the organisation.

When applied to the concepts underlying the models presented by Henderson (1966), King (1971), Orem (1980), and Roy and Roberts (1981), the "codes and control" framework indicates the redistribution of power and control between the doctor, the nurse and the patient from that inherent in the traditional model for care. The process of nursing contained in these frameworks for nursing have different degrees of power sharing between the nurse and the patient. The model advanced by Henderson continues to stress physical care and imbues the nurse with greater power than the patient. That proposed by Orem offers a contractual approach to the nurse-patient relationship and like the learning contract, provides for a variety of power-sharing relationships. The adoption of the Henderson model by the nurses working in the "General" division of the Health Authority and the preference shown for the Orem model by those employed in the "Psychiatric" units, suggests that the adoption of a specific model by a particular group is a reflection of the distribution of power and control in the clinical area and the freedom the clinical nurse has to redefine her role.

It is also argued that the close resemblance of the Henderson model to the traditional medical model does not necessarily change the role of the nurse and hence,

the division of labour between the nurse, the patient, and the doctor. Thus the division of labour between the "professional" care giver and the woman in her own home is maintained in the status quo.

It is therefore, argued that the adoption of the Henderson model by the general nurses permitted the formalisation of the problem-solving inherent in the traditional model for care, without the disruption of the existing power relationships and within the organisational limits to implement change in the clinical role. It is concluded that the adoption of the Henderson concepts of the nursing role in British hospitals is possible, but that the implementation of planned care need not necessarily lead to a redistribution of power and control between the nurse, her patient, or her colleagues in the nursing and medical profession. Thus the Henderson model for care does not automatically create the "autonomous" role presented by its author, or desired by the R.C.N. (1981) and the U.K.C.C. (1982).

The application of the "codes and control" framework to the historical development of nursing identifies the debasement of the clinical role in favour of the managerial one. The introduction of a framework in practice which values this previously less favoured role demands a change in the attitudes held by nurses as well as a reorganisation of the workload. This, in turn, requires an organisational climate in which the nurse feels secure to take the risks associated with change and in which management can support the change desired with the appropriate resources.

The nurses working in the Rehabilitation unit appeared to enjoy the support of their managers in times of role conflict, especially from the Nursing Officer. This contrasts with the general hospitals where the nurses appeared to be constrained to the more rigid "positional"

relationships of the traditional hierarchy and support for the nurses was lacking. Thus, the emotional security offered to the nurse in her work environment and the freedom she has to redefine her role, appear to influence the model for care adopted, or whether a redefinition of the role takes place instead of the formalisation of the present "problem-solving" approach to the routinisation of care. If this argument is accepted, then it follows that the introduction of a specific framework for practice and the autonomous "practitioner" role cannot be achieved without the full support of the workforce, nor can it be chosen and implemented by external power sources. However, external power sources are in a position to promote or inhibit the successful implementation of the proposed change.

Regardless of the model chosen by the clinical nurse, the new power relationships held by the nurse and the patient differ from that in the traditional model for care. It is argued that in the light of the "codes and control" framework, the adoption of a nursing model in practice and education is an attempt to redefine the role of the nurse and not as the key documents distributed by the G.N.C. (1977), the R.C.N. (1981), and the U.K.C.C. (1982) suggest, a clarification of the existing clinical role. This role has already been defined and incorporated into the structure of the present National Health Service. The role of the nurse in the United Kingdom is that of a manager of care and the organisation of that care in the formal institution, as witnessed by the career structure in management and not clinical practice. Even the educationalists employed in the school of nursing are viewed as managers of learning and hence, the subservience of education to line management and service.

The lack of commitment to a policy of continuing education by the organisation has denied the clinical nurse the

opportunity to develop specific clinical expertise and thereby, to enhance her organisational power to control her job content and work environment. Thus, the present educational programme and the organisational strategies adopted by managers, have conspired to maintain the distribution of power and control in favour of the manager. Hence the role conflict experienced by those nurses who attempted to imbue the clinical role with some of the power of decision-making traditionally held by doctors and managers.

The "codes and control" framework offers a theoretical guide to help the nurse to understand the nature of the organisation in which she works and the constraints it imposes on the development of her role. The framework offers the nurse clearer insights into the explicit and implicit definition of her role as contained in the organisational relationships held by her vis-a-vis the patient, the manager and the doctor, and the difference between that role and the new roles contained in the nursing models for care. By understanding her role more clearly, the nurse is more likely to comprehend the complexities of the change toward a nursing model in practice and education.

The attempt to introduce the nursing process, recorded in this study, suggests that the staff and their managers did not fully understand the new roles they were trying to create. This may in part have been caused by the lack of access to post-basic education for managers and clinicians, or the inadequate preparation of nurse-teachers and therefore, the curricula supporting the nurse in her basic and post-basic education. Alternatively, it may have had its basis in the literature presented by such nursing journals as: "The Nursing Times" and "The Nursing Mirror", which have presented the practitioner role described in the nursing models as "role extension" and "role expansion", rather than as

"role redefinition". If the introduction of the "practitioner" role is to be viewed as "role expansion or extension", then the aspect of the role to be extended or expanded, would be the managerial one and not the clinical. The role of the nurse in the United Kingdom is that of a manager and not a clinical specialist. Hence the ineffectiveness of the literature in supporting the psychiatric nurses in their attempt to change their clinical role and the role conflict experienced when that new role challenged existing role boundaries.

It has been argued that the existing managerial role has been explicitly and implicitly stated in the division of labour within the hierarchical bureaucracy of the nursing organisation. The uncritical application of frameworks for practice which have their origins in an other country and therefore culture, is a source of difficulty for those nurses wishing to improve the care received by the patient.

The nurses observed in this study had clearly defined concepts of their roles and the service they could offer the patient. Individual nurses expressed negative self-concepts as "nurse-caring-for-the elderly", whilst others tried to implement their more positive concepts through the adoption of the nursing process as the mode of practice. It is suggested that these positive concepts of the nursing role be studied and utilised to develop a theory of nursing in the United Kingdom, rather than the carte blanche acceptance of the American literature.

The concept of the nursing role shared by both general and psychiatric nurses stated that the role of the nurse was one of assisting the elderly person to live as complete and full a life as is possible within the confines of their physical, psychological and social conditions. The implementation of this role not only

suggests that the nurse will have to be educated in the physical and social/behavioural sciences, but also that the learning experiences offered, permit the study of the normal living patterns of elderly people in their own homes and in the community. Similarly, the present strategy of caring for elderly people in general and psychiatric hospitals is questioned and the future role of the "nurse-caring-for-the-elderly" appears to be more community- than hospital-based.

The nurses engaged in this study adopted a strategy of finding a framework for practice which reflected their personal and group concepts of the nursing role. It is suggested that further study should be directed to the description of these concepts held by nurses in every clinical area and the development of a theory of nursing which reflects the cultural and institutional context of British society. In this way, a theory of nursing can be developed from clinical practice in the hospital and community setting, can be refined through research and returned to clinical practice through the education programme.

The contribution made by the "codes and control" framework to the development of a theory of nursing in the United Kingdom, is to draw attention to the complex nature of the nursing role and its relationship to the distribution of power and control in society, the organisation and the school of nursing. The isolation of social, cultural and organisational issues surrounding the definition and redefinition of the traditional care giving role, leads to role clarification which in turn, identifies concepts of care on which future nursing theories can be built.

Action research strategies: benefits and disadvantages for nurse teachers supporting change

The decision to use an action research strategy to support change in practice was in part dictated by the nature of the study and in part by the writer's belief in the need to include a research component in the role of the teacher in the school of nursing. Thus the role of the teacher as a researcher into the educational needs of trained nurses was used to support the change in practice. The adoption of such a role permitted the integration of the writer's dual roles of teacher and researcher within the normal boundaries of the school of nursing.

The utilisation of a case study approach was dictated by the writer's lack of control over the clinical areas in which the change was implemented. It permitted the collection of data when and where it occurred, did not involve expensive or extensive printed questionnaires, did not require computerised analysis, or involve the participants in work additional to their daily practice of nursing. It permitted the observation of the participants in their "natural" surroundings and therefore, facilitated the study of the organisation in which the change was to be implemented.

It is argued that the action research mode together with the use of case studies, is appropriate to the clarification of the role of the nurse and the development of nursing theory. Nurses handle a wealth of data throughout their working day. Nurse-teachers in particular have access to data in the form of student assignments, curriculum development meetings, organisational memoranda, individual and group meetings with colleagues concerning the present nursing role and the attempts made to improve the performance of the student and trained staff. Thus research data documenting the

nursing role is to be found in the desks, filing cabinets and classrooms of every nurse teacher.

It is argued that the presentation of this thesis is itself support for the integration of the roles of the teacher and the researcher.

At the beginning of this study it was stated that the study was in part an attempt to create a new role for the nurse-teacher. It is suggested that this objective has been achieved and support for those teachers wishing to develop the research aspect of their roles has been obtained.

The disadvantages of the approach taken, are the need to extend the time to prepare for and to present the study, into the writer's own time. The time taken to present this study cannot be contained in the normal thirty-seven-and-a-half hours (37.5) of the teacher's working week. Thus the writer's commitment to the development of the nursing role must be taken into account. It would be unrealistic to assume that every nurse teacher had the motivation, time, or money to engage in a study of this nature. It is therefore, suggested that within the school of nursing there should be created the post of educational researcher, or that in co-operation with institutions of higher education joint-appointments between the school of nursing and these institutions be set up to facilitate the development of such posts. This will ensure that the effectiveness of present curricula and teaching strategies are monitored to support the change in practice.

In addition to promoting a new role for the teacher in the school of nursing and the clinical area, the action research mode facilitated the personal and professional development of the writer. It is argued that the research study was in part a self-directed education programme and

represents a learning contract between the writer and his supervisor. Thus the study may be viewed as a learning contract which meets the internal needs of the learner and the external needs of the organisation. It is argued that in addition to promoting change in clinical practice, the action research mode used in conjunction with a learning contract, in both the clinical area and the tertiary level educational establishment, facilitated both formal and non-formal continuing education for trained nurses.

It is argued that learning contracts whether in non-formal or formal education, have a valuable part to play in the professional and personal development of the nurse. Through the use of the action research approach, the writer's own learning programme was reflected back into his role as teacher in the school of nursing and the clinical area. The development of the "codes and control" framework and the data collected, were used as feedback to the clinical areas, to assist in the development of the curricula of the school of nursing's submission for the Diploma in Nursing (London University, New Regulations) and the J.B.C.N.S. course 940/941. Further, this thesis will provide an evaluation of the teacher's role as researcher in the school of nursing and can be used to develop the role of the tutor in the basic and post-basic education departments.

The utilisation of an action research mode and case study as research methodology, may be said to be an effective and efficient means of promoting research "mindedness" in clinical practice and education, to support change in practice and education, to develop insights into the nursing role, and thereby assist theory and curriculum development. In this way the advancement of the profession is assured through the clarification of the clinical role and the greater effectiveness of the education programme at both basic and post-basic levels.

Practical implications: learning contracts as a vehicle for change

The data recorded in this study and the presentation of this thesis, indicate that learning contracts can be used to facilitate the personal and professional development of the nurse, in formal and non-formal education, and at school of nursing and tertiary levels. Regardless of the setting, the actual format used appears to be of lesser importance than the negotiation of an agreement between the teacher and the learner. In the presence of the pressures of the workload and the variable commitment of colleagues to the change towards a nursing model in practice and education, it is unwise to be too rigid as to which format is more likely to facilitate the learning programme. It falls to the teacher to be as flexible as possible in accepting the constraints of the clinical environment, instead of expecting the learners to change their work patterns to suit the demands of the course of study. It is also argued that the teacher cannot expect to have clinical credibility purely on the basis of his/her organisational rank. This is gained thorugh his/her understanding of the demands of the clinical area on the nurse's time and the strains of trying to carry out the tasks at hand as well as implement change. The successful negotiation of the learning contract depends on the mutual respect the participants have for each other. The essence of the contract is the co-operation between equal partners in the learning experience.

The data recorded in this study support the previous one (Keyzer, 1980), that the use of learning contracts can be used in an in-service education programme to the satisfaction of the student and the teacher and as a bridge between the school and the clincial area. The data suggest that the trained nurse is ill prepared for the advanced clinical roles expected of her in the key documents on the future of nursing presented by the

R.C.N. (1981) and the U.K.C.C. (1982). The nurse therefore, finds herself in a position where she is unable to comply with the demands made of her by nurse-theorists and nurse-leaders. To meet these demands on the nurse's time and skills, the data suggest that all grades of nurse are in need of further education in all aspects of the nursing process. It is argued that the use of learning contracts in the present study has identified the need for further education to support the proposed changes in clinical practice.

The schism between "nursing as it ought to be" and "nursing as it is" may be said to lie in the discrepancy between the "curriculum" and "discipline" models for care. The contents of the traditional school of nursing curriculum emphasise the direct care giving role of the nurse, but pay little attention to the managerial role the trained nurse is expected to perform on graduation from student to trained nurse status. Further, little attention is paid to the change in the tasks or relationships associated with the change from student to staff nurse status. On graduating from the basic education programme the newly qualified staff nurse has to negotiate new relationships with those persons who once formed part of her peer group. The "weak classification" of her relationships with fellow students and pupils, and with the nursing auxiliary, now become "strong classification" in her new role of staff nurse and hence, a member of the hierarchical bureaucracy. Similarly, the "weak classification" of her peer group relationships with fellow students is converted into a "strong classification" as she adopts the teaching role expected of her new managerial role of staff nurse.

The bedside role contained in the school of nursing curriculum is at variance with the managerial role experienced in the clinical area where the student witnesses the career structure in management. This division

between the model for practice presented by the school and that experienced in the clinical area is further enhanced by the value placed on the managerial role by the "positional" power over decision-making held by members of the managerial team.

It is therefore, argued that the "practitioner" role desired by the profession and representing "nursing as it ought to be" is unrelated to the "organisational" role experienced in the clinical area, that is "nursing as it is". Thus the newly trained nurse experiences difficulty in adapting to her new role as manager and the experienced nurse has difficulty in supporting the clinical aspects of the role. The present basic education curriculum requires drastic revision whether or not a nursing model for care is adopted. The contents of the care plans recorded in this study indicate that the trained nurse's knowledge base is inadequate not only to assess the patient's needs for care, but also to prescribe the requisite nursing care to meet those needs. The learning contracts therefore, support the view that the division of labour between the professional nurse and the care given by women in their own homes, is based on a social divison of labour, rather than technical knowledge and expertise. It is argued that to promote the clinical role, the school of nursing and the organisation need to devote a greater amount of their time, energy and money to the development of in-service continuing education.

The data recorded in this study suggest that trained nurses prefer the action orientation of the learning contract to the more didacted classroom-bound traditional "chalk and talk" approach to nursing education. Thus the learning contract is one method of providing an effective continuing education programme based on the nurse's perceived needs for education, both in the clinical area and the school of nursing at basic and post-basic levels. It would be unrealistic to suggest that one

teacher working alone in the clinical area could meet all of the staff's needs for further education. It is argued that both formal and non-formal education will be required to assist the clinical nurse in her attempts to improve the quality of care provided and to support the change toward a nursing modelfor care. This will require the active involvement of all grades of staff and the recognition by nurse managers that the decisions they take, can inhibit or promote the changes they outwardly support.

In an attempt to improve the present curricula offered at both basic and post-basic levels, it is suggested that an integrated programme of learning based on the physical and social/behavioural sciences will facilitate a greater understanding of the nurse's part in the provision of an effective and therefore, efficient health care programme. In the presence of the present inadequate preparation of nurse-teachers in the courses available to them, it is suggested that a closer co-operation between the school of nursing and external tertiary level educational institutions be negotiated. This will ensure that the school of nursing will be able to offer a broader education to its students, through their exposure to the wider clinical expertise held by the staff of these institutions of higher education. It is further suggested that nursing education be removed from the control of line management and placed in insitutions of higher education. The manipulation of the traditional education programme by nurse managers together with their use of it as a strategy of social control, has had an undesirable effect on the education offered to the student and the trained nurse, and the role of the clinical nurse.

It has been argued that to support the desired change toward a nursing model in practice, the present education offered to nurses, the manager's commitment to the changes

they outwardly encourage, and the roles of each grade of nurse, need to be researched and redefined in the light of the social, organisational, professional, and educational issues surrounding any change in the role of the clinical nurse. Learning contracts can be used to assist in the definition of the role through a description of the knowledge the trained nurse identifies in her learning objectives. Thus, when combined with an action research mode and case studies, the learning contract can assist in identifying concepts of care and the nursing role in general and specialised areas of patient care, and thereby contribute to the development of a "grounded" theory of nursing founded in the practice of nursing in its social and organisational context. It is argued that learning contracts are a vehicle for change and that they should be used in future studies on the nursing role, the implementation of change and in-service education. It is also recommended that further study be directed toward the use of learning contracts in the basic and post-basic education programmes available to nurse-learners. In particular, it is recommended that the use of learning contracts as a bridge between the school and the clinical area be clarified through further action research studies.

In conclusion it is argued that in bureaucratic organisations such as hospitals in which social, organisational and occupational strategies have maintained the role boundaries between the doctor, the nurse, the patient and the manager, it is unlikely that without additional resources and support from the managerial team, the desired "practitioner" role will not materialise. If the U.K.C.C. really believe in the "practitioner" role and are not merely paying lipservice to a fashionable concept, then it must resolve the issue of student status for its learners and provide the financial, material and educational resources to support the changes it outwardly promotes.

In the absence of the requisite support there is little the teacher or the clinical nurse can do to implement the change in the role as stated in the key documents distributed by the R.C.N. (1981), and the U.K.C.C. (1982). There is an established need for an expansion of existing in-service continuing education programmes and the extension of the present nurse-teacher's inputs into the clinical area, to meet the trained nurse's needs for further education.

It is argued that without the support of managers and educationalists, the implementation of the nursing process in the United Kingdom will merely continue the existing Nightingale strategies, through the formalisation of the present problem-solving approach and that the creation of care plans will become yet another aspect of routinised care. This may improve the quality of care received by the patient, but it will not necessarily promote the autonomous practitioner role. Instead the clinical role will continue to be defined by the medical profession and management will consolidate its "positional" power base within the structure of the National Health Service. This will not be challenged by the nurse, since it will continue to "reify" her existence and in particular, her place in institutions of higher education. Such a strategy although satisfying in terms of status will lead to the nurse being expected to implement a clinical role that she is either unable or unwilling to comply with. This in turn, will lead to role conflict and a greater division between the "theory" of the school and the "reality" of the ward.

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APPENDICES

Appendix A: Letters to the Area Nursing Officer, and the Director of Nursing Education requesting support for the study.

School of Nursing
Phase II

XXXXX 817475

DMK/SG

Miss M Davis
Regional Nursing Officer
Oxford Regional Health Authority
Old Road
Headington
Oxford

4th June 1981

Dear Miss Davis

Further to our conversation on the 1.6.81 concerning the need for a nursing research project in geriatric nursing.

The proposed study has become necessary for the following reasons:

a) The current work being carried out in the geriatric wards of the O.A.H.A.(T) will require to be validated through research.
b) To assist nurse-teachers and managers plan effective in-service education, a study of the clinical nurse's preferred learning behaviours is essential.
c) To determine the financial aspects of in-service education, a study which can identify the learning resources available in the work environment is an important contribution to the allocation of nursing education funds.

I enclose a copy of the initial draft of the research proposal submitted to the Institution of Education, London University. The study will be supervised by Dr. A. Beattie as a Ph.D. thesis.

I would, therefore, be obliged if you would consider the said project for funding. The monnies would be used to offset fees due to the University, books and incidental expenses.

Yours sincerely

Mr. D.M. Keyzer
Tutor
Post Basic Education/In-Service Education

School of Nursing
Phase II

XXXXX 817475

DMK/SG

Mr. J. MacDonald
Director of Nurse Education
School of Nursing
JRII

4th June 1981

Dear Mr. MacDonald

I am at present planning a Ph.D. thesis concerned with the learning needs of a group of nurses as they attempt to demonstrate their unique function as one of care complimentary to the medical profession's function of treatment in caring for the elderly.

The study is to be supervised by Mr. A. Beattie, London University, Institute of Education.

The study is an evaluation of my normal work activities concerning the implementation of the nursing process in the geriatric wards of your hospital group.

I would, therefore, be grateful for your permission to use the data gathered as the basis for the proposed study.

I would be willing to discuss the project with you at any time.

Yours sincerely

Mr. D.M. Keyzer
Tutor
Post Basic Education/In-Service Education

School of Nursing
Phase II

XXXX 817475

DMK/SG

Ms. J. Flindall
Area Nursing Officer
Manor House

4th June 1981

Dear Ms. Flindall

I am at present planning a Ph.D. thesis concerned with the learning needs of a group of nurses as they attempt to demonstrate their unique function as one of care complimentary to the medical professions' function of treatment in caring for the elderly.

The study is to be supervised by Mr. A. Beattie, London University, Institute of Education.

The study is an evaluation of my normal work activities concerning the implementation of the nursing process in the geriatric wards of your hospital group.

I would therefore, be grateful for your permission to use the data gathered as the basis for the proposed study.

I would be willing to discuss the project with you at any time.

Yours sincerely

Mr. D.M. Keyzer
Tutor
Post Basic Education/In-Service Education

School of Nursing
Academic Centre Level 4

Tel: Oxford (0865) 817450
Ext.....

John Radcliffe Hospital
Headington
Oxford
OX3 9DU

Your Ref:

Our Ref: JM/SFC

10 June 1981

Mr. D. Keyzer
Nurse Tutor
Post Basic/Inservice Education
School of Nursing

Dear Dirk

Thank you for your letter of 4 June informing me of your success in obtaining a place to complete your PhD studies. I am writing to confirm that the School of Nursing is willing to enable day release for you to complete studies.

It is well established in the School that staff can be released for further study but I must of course point out that your primary responsibility must lie within your job description, (this has not proved to be a major problem for staff in the past).

With best wishes for your study,

Yours sincerely

John MacDonald
Director of Nurse Education

Appendix B: Examples of the contracts used during the study.

In the beginning of the study, formal contracts based on those used in the previous study (Keyzer, 1980) were introduced into all of the units. These contracts although some what primitive and lacking in the form of the 'objectives', were of use to the staff involved. Knowles (1978) argued that the student's learning objectives should reflect the individual's perception of a particular competency. It is held that no matter how crude or subjective the model of the competency is, it gives the learner a clearer sense of direction.

Early on in the implementation of the contracts, it became obvious to both the students and the teacher that the use of formal contracts were inhibited by: the pressures of the workload, the Off-Duty and the dependency on part-time staff, and the hostility of some members of the work team. Hence, for the rest of the study, the contracts used were verbal, flexibile agreements between the teacher and the staff involved.

CONTINUING PERSONAL DEVELOPMENT PLAN

For		Date	
Subject	Sources/Resources	Strategies and Time Frame	Evidence of Attainment

CONTINUING PERSONAL DEVELOPMENT PLAN

For

Date 2.10.81

Subject	Sources/Resources	Strategies and Time Frame	Evidence of Attainment
Kardex - revise care plan: Review use of care plans by trial use of 'Banbury' Kardex.	Stationary Office for A4 holder, N/O McCarthy - Secure use of Kardex	Staff members will obtain & use Banbury Care Plan Kardex. Staff will use care plans in daily practice and evaluate their use in ± 1 month, i.e. 3.10.81	Completed care plans which state identified problems reflected in N/history - assessment. Nursing actions ie Rx. Outcomes in terms of patient behaviour. Time Frame.
Staff will attend In-service training programme as stated in N.P.D.G. meetings	Staff members Libraries	2 members of staff will attend 1 session on interpersonal skills; and 1 session on problem identification	2 members of staff will report back to group and explain contents of programme to other members of staff.
9.10.81 Sean to visit Witney on 26.10.81			

CONTINUING PERSONAL DEVELOPMENT PLAN

For			Date 28.8.81
Subject	Sources/Resources	Strategies and Time Frame	Evidence of Attainment
1) Using N. Process Formats	1) Staff members 2) Patients 3) Tutors	1) Staff will use new format in practice. 2) Comments re benefits and/or problems encountered to be discussed in unit conferences. 3) Review with tutor on 25.9.81	1) Completed plans. 2) Comments on use of format. 3) Amendments noted.
25.9.81 New S/N wishes to know more about "the Nursing Process"	1) Sister and staff 2) Tutor 3) Library	Staff Nurse will accompany Tutor to Witney on 28/9/81. Tutor will give clinical instruction on use of process recordings by review process notes held on in-patients.	Staff nurse will be able to contribute towards the development of process recording in his clinical area and be able to demonstrate the ability to implement the process in his daily work.

	21.8.81 The implementation of the Nursing Process: a) Planning & evaluation of patient care. 1) Problem-identification 2) Nursing prescriptions	1) To implement all stages of the nursing process using new format with at least one patient. 2) To clarify nursing problems as opposed to medical problems. 3) To clarify nursing Rx, e.g. mobilise at least 2 x day to walk unaided with Zimmer frame in ward area.	Each member of the team will contribute to the planning, implementation and evaluation of at least one patient's care as described in the nursing process. Time frame: 28.8.81	1) The group will provide at least one patient's plan of care together with an evaluation of progress to date. 2) The group will discuss any benefits or problems encountered in the use of the new format.

CONTINUING PERSONAL DEVELOPMENT PLAN

For

Date 25.2.81

Subject	Sources/Resources	Strategies and Time Frame	Evidence of Attainment
1) To implement the Nursing Process. a) Utilising their present patient assessment sheet to compile a care plan, and evaluation format	1) Libraries: a) Hospital's own library. b) Cairns library c) Regional library d) Public library Recommended books: 1) M. Mayers 2) Hunt & Marks-Marram. 3) C. Kratz Journals: 1) Nursing Times 2) Nursing Mirror	Each member of the group will read at least one of the recommended books, and conduct a literature search of the journals held in the library for articles on the nursing process written within the last 3 years. Time: 25.4.81	1) The group will produce: a) at least one completed nursing care plan reflecting the problems identified by the current nursing assessment format. b) an evaluation of the care given to at least one patient based on planned care. 2) The group will be able to discuss and describe the benefits and problems of the above care plan.

Not achieved 25.4.81
Postponed DMK

CONTINUING PERSONAL DEVELOPMENT PLAN

For			Date 12.3.81
Subject	Sources/Resources	Strategies and Time Frame	Evidence of Attainment
1) The implementation of the nursing process. a) Data collection b) Problem identification c) Priority setting d) Planning care e) Evaluation of care	a) 1) S.N.O. 2) N.O. 3) Tutor 4) In-service training sister. b) Recommended books: 1) M. Mayers 2) Hunt & Marks-Marram 3) C. Kratz c) Recommended reading: Articles on the nursing process in the Nursing Times and the Nursing Mirror	1) S.N.O. will discuss with the group: a) The reason for introducing the Nursing Process in this new hospital. 2) N.O. will describe the format to be used in the hospital. 3) The tutor will present a lecture/discussion on the four steps or stages of the nursing process. Utilise an O.H.P. 4) S.N.O., N.O., Tutor and In-Service training sister will role play at least 2 simulated patient interviews. 5) Group will identify and discuss strong & weak points of the interviews	1) Each group member will have completed at least one nursing history sheet, one care plan and one evaluation sheet.

CONTINUING PERSONAL DEVELOPMENT PLAN

For			Date 12.3.81
Subject	Sources/Resources	Strategies and Time Frame	Evidence of Attainment
Continued...		6) Group members will participate in role-playing nurse-patient interviewing using nursing process format. 7) Small group discussion on planning and evaluation of care. 8) Groups will provide feedback from lecture, discussion, role-play. Time 13.3.81	Achieved 13.3.81 DMK DM

CONTINUING PERSONAL DEVELOPMENT PLAN

For

Date 13.3.81

Subject	Sources/Resources	Strategies and Time Frame	Evidence of Attainment
1) Implementation of the Nursing Process.	1) Patients 2) S.N.O. 3) N.O. 4) In-Service Training Sister 5) Tutor	1) The group members will implement the nursing process in the clinical area, using the pre-designed format. 2) The S.N.O. & N.O. will avail themselves to the group members as required to give guidance and help as needed. 3) The in-service training sister will visit the unit for one day/week to instruct staff in clinical care as necessary. Time limit 31.3.81. 4) Tutor will revisit unit 17.8.81 to evaluate group members' progress in utilising the nursing process formats.	1) All patients will have their needs for nursing care documented, together with a complete plan of care listing nursing actions, review dates, and an evaluation of the patient's progress to date.
		Achieved 17.8.81 DMK DM	

CONTINUING PERSONAL DEVELOPMENT PLAN

For Date 17.8.81

Subject	Sources/Resources	Strategies and Time Frame	Evidence of Attainment
Identified problems from random selection of Nursing case notes. 1) Problem identification 2) Evaluation of progress 3) Nursing Prescriptions	1) Tutor-model care plans provided for 4 patients, each plan identifies: a) problems related to daily living needs b) nursing prescription and criteria for evaluation c) evaluation of patients' progress based on review date and identified problems	1) Group-members will re-plan all patients' care plans using tutor's models as guide lines. 2) Group members will discuss with each other the identified problems and recommended changes 3) These discussions will take place at the change of shift report. Time 3.9.81 DMK	a) All care plans will contain 1) identified problems, 2) nursing prescriptions, 3) review dates, 4) evaluation of progress to date. b) Tutor will carry out Qual. pac. evaluation of 4 case notes selected at random. DM
4.9.81 Define: "Reassure" in terms of nursing behaviours	1) Staff members 2) Tutors	1) Each member of staff will write down their own interpretation of the term "reassure" and compare with each other to define the common behaviours recognised by the team Time 28.9.91	1) Care plans will reflect nursing behaviours inherent in the term "reassure" the patient.

CONTINUING PERSONAL DEVELOPMENT PLAN

For Date 3.9.81

Subject	Sources/Resources	Strategies and Time Frame	Evidence of Attainment
The Nursing Process: 1) Evaluation of the quality of care received by 2 patients	Slater Nursing Competencies Rating Scale (Wandelt & Stewart)	1) Tutor will observe the care received by two patients over a period of 2½ hours. 2) Quality of care received will be rated on the Slater scale. 3) The care given to the two observed patients will be administered by two separate teams. Time 0800 - 1600 3.9.81	The observer will present two completed rating scales.
28.9.81 Improved care plans: need to review assessment & evaluation components	Tutor, Library, Staff Sister (course 940)	Tutor will conduct In-Service training programme on Assessment and Evaluation components of N. Process. Staff will attend training session and report back.	Improved nursing assessment data. Improved recording of evaluation of progress notes.

Appendix C: The Nursing Process Formats Developed by the Staff in the Psychiatric Rehabilitation Unit, the Psycho-Geriatric Unit, and the Community Hospital.

The following nursing process formats reflect the staff's ability to correlate theory with practice. Assistance from other health care workers was acknowledged by the staff involved. A copy of the previously used, and officially appointed Kardex, is included as a comparison. The format developed by the geriatric unit is not included, because the wards involved could not agree on the most suitable lay out. In addition, there were no resources available to have any of the formats printed. Reference should be made to the article by Lowe (1981). The format used in this article, and the content of that article, refers to one of the wards involved in the study.

Reference: Lowe, K., (1981): "Hospital care of the elderly", Nursing, 1981, pp. 1099-1101.

SURNAME (BLOCK LETTERS) CHRISTIAN NAMES FOLDER No

WARD DATE OF ADMISSION

ADDRESS

NEXT OF KIN & ADDRESS (GIVE TELEPHONE No.)

AGE RELIGION OCCUPATION

DIAGNOSIS DATE OF DISCHARGE

DATE	NURSING REPORT	SIGNATURE
738		

BED No. NAME CONSULTANT

NAME

CHRISTIAN NAMES

FOLDER No

AGE

RELIGION

NURSING

ORDERS

DIAGNOSIS

DATE ORDERED		DATE DISCONTINUED

786

COMMUNITY HOSPITAL

Name	
Address	Ward
	Reg. No.
	Reg. No.
	G.P.
Tel. No.	N.O.K.
Date of Admission	Address
Date of Discharge/Transfer	
Age/DOB/Sex	Tel. No.
Valuables	In Emergency Contact

NURSING HISTORY

Social History		Previous Medical History
		Chronic Health Problems
Living Accommodation		
Occupation		Disabilities
Community Services/	✓	
Social Worker/Other		
Agencies notified of		
Discharge		
		Allergies
Expected Duration of Stay		Has anyone explained your
		illness to you Yes____ No____
Arrangements for		Who
Discharge		
		Is the Patients understanding
		of his or her illness adequate
		Yes_____ No_____

RELATIVE'S INTERVIEW

Date	Relative	Interview	Signature

NAME G.P.

Daily Living Activities

Smoking	Hygiene
Drinking	Bowel Habits
Sleep	Bladder Habits

Nursing Assessment

General Condition and Appearance	Mobility (Norton Scale)
	Weight
	Urine
Psychological State	SG ALB
	PH SUG
	Temp
Pain	Pulse
	B.P.
	Respiration
	Type
Sight	
Hearing	
	History Obtained From
Mouth	
	History Obtained By
Skin	

NAME G.P.

Referral

Referrals	Date	Reason
Medical Social Worker		
Physio/Occ. Therapy		
Consultant		
Others		

Special Tests

Date	Requested Test	Date Completed	By Whom

NAME G.P.

NAME _____

CARE PLAN

Date	Problems (Actual & Potential)	Desired Outcome	Target Date	Nursing Action

NAME _____ G.P. _____

NAME _____

CARE PLAN

Date	Problems (Actual & Potential)	Desired Outcome	Target Date	Nursing Action

NAME _____ G.P. _____

Date	Daily Report/Evaluation/Changes	Signature

NAME G.P.

Date	Daily Report/Evaluation/Changes	Signature

NAME G.P.

REHABILITATION UNIT PATIENT:

PEOPLE SEEN:

UPPER LEVEL

CONTACT:

PLACE:

DATE: REPORT:

REPORTED PROBLEMS (Including reasons for concern of visiting. Problems may be diagnostic, behavioural or related to follow-up treatment).

OBSERVED PROBLEMS (Problems seen or reported by others at the time of visiting).

PLAN (Actions taken or advice given at the time of visiting and any future suggestions).

Signature:

INDEX CARD 1

PATIENTS NAME / Personal History	Social and Interpersonal Information	Additional Information
Information on present illness	Medical nursing and Social Care	Observations
Personal lifestyle	Physical, Mental & Functional Assessment	Summary of main points

REHABILITATION UNIT

UPPER LEVEL

Surname:

PROBLEM LIST

First Names:

Date of Birth:

No.	CURRENT AND ACTIVE PROBLEMS	DATE		INACTIVE PROBLEMS
	Any problem of actual or potential clinical significance requiring immediate action, on-going management or investigation	First noted or changed	Resolved or date of past problem	Past, resolved or dormant, may have bearing on current problems or become active.
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Notes:

REHABILITATION UNIT UPPER LEVEL

INITIAL PLAN

Problem Number	Problem	Initial Goal	Plan (Therapeutic, Rehab, Educational & Preventive Elements

Name: Date: Review Date:

REHABILITATION UNIT | REVIEW NOTES | UPPER LEVEL

No.	PROBLEMS	SUBJECTIVE (S) Accounts from patients or hear-say evidence reported by others	OBJECTIVE (O) Observations by staff, results of investiga-tions and factual events	ASSESSMENT (A) Interpretation and evaluation of S. & O.	PLANS (P) Further inves-tigations, therapeutic rehabilitative and educational plans

Surname: First Names: Date of Review: Date of Next Review: Previous Reviews:

REHABILITATION UNIT A S S E T S L I S T	UPPER LEVEL Surname: First Names: Date of Birth:

No.	Any factors which may hasten recovery, speed re-integration with the community, increase self reliance or enhance quality of life.	Date first seen or recorded
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		

Notes:

ASSESSMENT UNIT

HISTORY

RAC

Information from: Patient/Relative/Other:-

NAME

ADDRESS

Date of Birth

Date of Admission

Type of Admission

Reason for Admission

Transfer from

Previous Admissions

Hospital Status:

Age:

Marital Status:

Religion:

Consultant:

Diagnosis:

SPECIAL INSTRUCTIONS:

Suicidal Risk?

Wandering?

Other:-

Next-of-Kin

Relationship to Pt.

Address

Tel. No.

Medical History/Physical Disabilities:-

Care at Home:-

Community Nurse

Social Worker

Social Service

Day Centre

Home Help

Meals-on-Wheels

G.P.

SOCIAL HISTORY

Previous Occupation:

Spouse
Children
Grandchildren
Other dependants

Visiting problems?

HOUSING (House/Bungalow/Flat/Other:)

Bathroom
Toilets

Lives alone/shares/with family (who):-

Family Problems/Attitude

Patient's Previous Personality

Person Referring:

Reason for admission:

Treatment(s) required:

Full General Assessment

Assessment of Specific Areas

Nursing

Occupational Therapy

Other

Objective of Treatment

Approximate length of treatment

Discharge planning/follow-up (please tick)

Community Nurse_____	Day Care (where)
G.P. _____	
Social Worker _____	
Meals-on-wheels_____	
Home Help _____	

DAILY LIVING

DIET	MOBILITY
Special	Walks alone?
Dislikes	Uses sticks?
Appetite	Uses Zimmer Frame?
Remarks	Has falls?
	Any disability?
SLEEP	**COMMUNICATION**
Sedation	
Other comments	

ELIMINATION

Bowels - any problems Yes No

If yes, describe:

Incontinence?

Urinary	No problems	_____	Incontinence	_____
	Nocturia	_____	Dysuria	_____
	Frequency	_____	Urgency	_____

Remarks

HEARING Right:- Good / Poor / Deaf

Left:- Good / Poor / Deaf

Hearing aid?

Remarks

VISION Right:- Good / Poor / Blind

Left:- Good / Poor / Blind

Glasses?

Remarks

TEETH Own teeth?

Dentures: Yes / No / Upper / Lower

Problems

ASSESSMENT CHECKLIST

		Week 1	Week 2	Week 3	Week 4	Week 5
AROUSAL						
1 No undue difficulty in getting off to sleep	1					
2 Does not show pattern of early waking	2					
3 Sleep usually unbroken	3					
4 Does not wander around ward continually	4					
5 Does not wander off ward	5					
6 Shows interest in activities	6					
7 Talks about happenings on ward	7					
8 Able to relax at least for short periods	8					
TOILETING						
9 Dry by day	9					
10 Clean by day	10					
11 Dry at night	11					
12 Clean at night	12					
13 Indicates need to use toilet	13					
14 Does not use inappropriate areas as toilet	14					
15 Goes to toilet without prompting	15					
16 Accepts and responds to prompting	16					
17 Has established regular toileting habits	17					
18 Not unduly preoccupied with toilet needs	18					
19 Finds own way to toilet	19					
20 Pants down unaided	20					
21 Does not miss	21					
22 Pants up/dress adjusted, unaided	22					
23 Cleans self correctly	23					
24 Flushes toilet after use	24					
HYGIENE						
25 Changes soiled underwear correctly	25					
26 Washes hands and face without prompting	26					

		Week 1	Week 2	Week 3	Week 4	Week 5
27 Accepts bath	27					
28 Shaves self without prompting	28					
29 Puts rubbish in right place	29					
30 Does not hoard	30					
31 Does not explore anus	31					
COMMUNICATION						
32 Talks	32					
33 Talks coherently	33					
34 Talk not bizarre in style or content	34					
35 Talk does not have depressive content, not since ECT course	35					
36 Does not shout/scream/swear continually	36					
37 Shows appropriate feeling	37					
38 Does not assume strange expressions/postures/movements	38					
DRESSING						
39 Dresses self appropriately without prompting	39					
40 Dresses self appropriately with prompting/ aid	40					
41 Does not appear undressed on ward	41					
MOBILITY						
42 Walks specified distance	42					
43 Gait satisfactory	43					
44 Manages stairs safely	44					
45 Transfers from chair to standing	45					
46 Realistic awareness of any limitations to mobility	46					
47 Negotiates different types of door	47					
48 Does not have falls	48					
49 In and out of bath (with aids) by self	49					

		Week 1	Week 2	Week 3	Week 4	Week 5
SOCIABILITY						
50 Gets on with others	50					
51 Volunteers to help staff and/or patients on ward	51					
52 Helps out when asked	52					
53 Does not verbally/physically attack others (unprovoked)	53					
54 Shows reasonable consideration for others property	54					
55 Joins talk without taking over conversation	55					
56 Has no antisocial habits - exposing/spitting/masturbating	56					
FEEDING						
57 Sits appropriately at table	57					
58 Accepts food without undue fuss	58					
59 Eats adequate amount	59					
60 Eats unaided	60					
61 Uses cup unaided (without spilling)	61					
62 Uses eating utensils correctly	62					
63 Does not spill food	63					
64 Does not take others food/utensils unasked	64					
65 Eats reasonable mouthfuls	65					
66 Swallows without spitting out/ holding/bringing back food	66					
ORIENTATION						
67 Does not have to be reminded of what to do	67					
68 Does not continually ask for information	68					
69 Orientated for time (the date)	69					
70 Can tell time on clock	70					
71 Knows own name and address	71					
72 Recognises own name and address	72					
73 Can write own name and address	73					
74 Understands and follows oral instructions	74					

		Week 1	Week 2	Week 3	Week 4	Week 5
75 Understands and follows written instructions	75					
76 Differentiates between friends and strangers	76					

NAME _____

ADMISSION DATE _____ DISCHARGE DATE _____

DIAGNOSIS (on discharge) _____

_____

_____

SUBJECT	WEEK 1	WEEK 2	WEEK 3	WEEK 4	WEEK 5	WEEK 6
AROUSAL						
TOILETING						
HYGIENE						
COMMUNICATION						
DRESSING						
MOBILITY						
SOCIABILITY						
FEEDING						
ORIENTATION						
A.D.L.						

A.D.L. SUMMARY

72 HOURS OBSERVATION CHART RAC

DATE/TIME	NAME:	SIGN

RAC. NAME:-

Date:-	AIMS / OBJECTIVES / GOALS
WEEK No.	
Arousal	
Toiletting	
Hygiene	
Communication	
Dressing	
MOBILITY	
SOCIABILITY	
FEEDING	
ORIENTATION	
OTHER	

Rivendell Assessment Centre

PROBLEM SHEET (Day / Night)

Action / Evaluation

Patient's name:-

Week commencing:-

Date	Problems reported	Problems observed	Action	Patient's attitude to action

Reviewing date:-

No Value	RESPONSE Slight imp.	Marked imp.	Notic. imp.	EVALUATION Problem remains	Problem solved	Adverse reaction	Frequency of Evaluation	Person(s) Responsible

REHABILITATION UNIT

Surname:

First Names:

A S S E T S L I S T Date of Birth:

No.	Any factors which may hasten recovery, speed re-integration with the community, increase self reliance or enhance quality of life.	Date first seen or recorded
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		

Notes:

	Patient Problem	Nursing Prescription
1	Contraction of limbs, makes dressing difficult, also washing under arms. Pt. does not wash self.	Blanket bath <——> bath alternate days if poss. ensure clothes all well fitting and not too tight. (Bath use ambulift with leg ext).
2	Transfers with 1 support nurse, walks 2-3 steps with frame.	2 nurses to transfer, patient to walk 2-3 steps with frame daily. Walk ½ length of corridor.
3	Unsteady gait - prone to falls.	Observe pt. remove obvious hazards and obstacles. Do not discourage activity during day.
4	Lack of confidence when transferring.	Nurses to transfer. Explanation from nurses prior to procedure. Position feet against these nurses. Ensure adequate room use oxford hoist prn.
5	Unable to wash or dress self.	Weekly bath, Blanket bath daily, needs to be dressed.
6	Cyanosed feet.	Inform Dr., keep feet down fleecy and keep feet warm. Urine spec. for glucose and ketones.
7	Anorexia and pyrexial.	One hourly turns whilst in bed. Sheepskin pad between legs. Encourage hourly fluids. B.D. T.P.R.
8	Patient unable to wash and dress completely.	Pt. to wash hands and face. Nurse to assist with rest and with dressing. Bath on admission once patient has settled.

	Patient Problem	Nursing Prescription
9	Reduced mobility, will not walk of own volition.	Pt. to walk length of ward with 2 nurses during afternoon. 2 nurses to transfer.
10	Unable to wash and dress herself completely.	Help with wash. Put on shoes & stockings. Help with buttocks as pt. unable to see them.
11	Potential soreness of pressure areas.	Apply Drapolene cream.
12	Red, sore heels.	Sheepskin in bed at night.
13	Patchy dry skin on buttocks. Scratches arms and legs.	Apply emulsifying ointment B.D. Avoid use of soap on these areas.
14	Rash in groin.	Wash area B.D. Emulsifying ointment.
15	Occasionally has a sore groins.	Careful washing of patient as needed, applying dry gauze to groins when necessary or canestan cream as prescribed.
16	Dry scalp or ears.	Genisol shampoo x 1 weekly. Oilatum in washing water.
17	Dry skin.	Oilatum in washing - bath water.
18	Delicate area R. buttock.	Wash area B.D. and apply emulsifying ointment. Ripple cushion in wheel chair. Wash soap and water. Tinc. Benz. Co. applied, sealed with talc. powder.

	Patient Problem	Nursing Prescription
19	Dry scaly scalp.	Arachis oil/emulsifying ointment to be rubbed into scalp.
20	Tends to have dry crusty eyes.	Apply white paraffin to both eyes at least B.D. prn.
21	Sacrum tends to become pink.	Sheepskin in chair and in bed. Wash sacrum B.D. prn. Apply Drapolene cream.
22	Sore penis.	Wash when wet. Apply Drapolene.
23	Sore groins.	Wash well B.D. Apply Drapolene.
24	Groins a little red.	Wash well B.D. with soap and water, apply Drapolene to groins.
25	Both breasts slightly red.	Wash and dry areas carefully - apply Drapolene and gauze if necessary between breasts.
26	Prone to sore skin folds especially under breasts and in groins.	Soap and water, wash at least B.D., Drapolene cream to be applied and gauze squares if necessary.
27	Sacrum and groins prone to soreness.	Wash B.D. at least. Dermolex/ Drapolene to be applied. Ensure penile sheath on securely.
28	Pt. tends to have a dry scaly scalp.	Apply arachis oil to dry patches. Ensure that only small amount of shampoo used when hair is washed and that it is rinsed off thoroughly.

	Patient Problem	Nursing Prescription
29	Area of excoriation both buttocks.	Persuade bathing daily. Clean broken area with savlodil. Apply Jelonet then Melonin dressing. Cover with dressing.
30	Sacral sores - skin red and broken in 2 places.	Change position 2 hourly in chair or bed - to be encouraged to stand and walk when uncomfortable. Thoraline cream to sacral area 2-3 hourly.
31	Dry, cracked skin.	Oilatum in baths. Drapolene to legs.
32	2 small broken areas on L. hip.	Steridrape applied 2 hourly turns when in bed.
33	Two small broken areas on R. buttock.	Steridrape applied.
34	Small broken area on L. buttock.	Steridrape applied.
35	R. heel looking dry & cracked.	Apply emulsifying ointment to heel B.D. Sheepskin in bed.
36	Pt. unable to support weight properly.	Pt. to sit in wheel chair & be transferred by 2 nurses.
37	Movement from bed to chair or commode and vise versa.	Patient if lifted straight up can lock his knees then he can stand for a short time while holding onto the hand rail or bed. While nurse steadies him another can move chair or commode into position and arrange clothing.

Patient Problem	Nursing Prescription
38 Unable to toilet self.	Offer commode on rising. After lunch and before supper.
39 Potential urinary incontinence.	Commode on rising, after lunch & tea, and on return to bed.
40 Incontinence of urine at night in spite of offer of commode.	2 hourly turns wash patient and change draw sheet prn.
41 Incontinence of urine.	To wear penile sheath and leg bag during day. Uses urinal only when in bed.
42 Incontinence of urine when in bed.	Offer urinals at regular intervals. Wash sacral area as necessary. Apply Drapolene prn.
43 No consistent pattern of self help re hygiene.	Supervise and encourage patient with washing and dressing. Allow patient to do what he wants to do at the time of procedure.
44 Potential pressure sores.	Change position 4 x daily and at least two times in the night. Sheepskins in bed. Conatrane cream to sacral area. Wash each morning. Kylie Sheet.
45 Patient has had (L) big toe nail removed.	Observe toe dressing for signs of oozing and discharge. Patient to wear sock only as needed.

Patient Problem	Nursing Prescription
46 Embarrassed by facial hair, but often resistive to actions dealing with it.	Shave pt. when she is in the mood to co-operate.
47 Large bruising and slight swelling observed on fore arm ? as to cause.	a) Dr. to see. b) Observe for change. c) Very careful handling when patient is moved.
48 Vision limited to light-dark only.	Clear unhurried speech and care. Tell patient where she is and where she is going.
49 Poor vision.	Ensure patient wears glasses.
50 Tends to eat anything put in front of her.	Ensure patient always has a drink or light snack in front of her.
51 Tremor.	Ensure patient is given cup with handle. Dycem mats to be used under crockery. Plate collar, cope with ordinary cutlery. Has own adapted pen.
52 Elimination - periods of faecal fluid - constipation.	To give medication prescribed and diet.
53 Incontinent of faeces.	To ensure patient taks all meal time fluids. Requires disposable phosphate enema prn. Fybrogel to be given as per chart. 2 tbs bran on porridge mane. To sit on commode on getting up and return to bed.

	Patient Problem	Nursing Prescription
54	Incontinent of urine.	Penile sheath and leg bag during day.
55	Indwelling catheter - patient prone to "tugging" at it.	1. C.S.U. as indicated. 2. Bladder wash outs as per chart. 3. Fluids. 4. Discourage and distract patient from catheter tugging.
56	Indwelling catheter.	1. Bladder wash outs prn. 2. 180 mls. fluid hourly. 3. Swab around catheter.
57	Constipation.	1. Give aparient as charted. 2. Do not give bran. 3. Disposable phosphate enema prn.
58	Potential constipation.	1. Fluids as prescribed. 2. Disposable phosphate enema every 4th day prn.
59	Potential constipation.	1. Offer 180 mls. fluid hourly. 2. Medication as per chart.
60	Potential constipation.	1. Ensure patient drinks all fluid (180 mls.) at meal times and 180 mls. extra am and pm. 2. 2 tbs. bran on porridge. 3. glycerine suppositories prn. 4. ½ Disposable phosphate enema.
61	Urinary incontinence: erratic pattern.	Offer patient commode on getting up; or toilet before, after lunch, after tea, before supper and on return to bed.

Patient Problem	Nursing Prescription
62 Urinary incontinence.	Toilet on getting up and 11 am and again after lunch. Prior to supper and return to bed. When incontinence occurs savlon concentrate wash prevents odour. Offer 180 mls. fluid hourly to prevent conc. of urine.
63 Faecal incontinence - constipation.	1. Disposable phosphate enemas. 2. Ensure patient drinks all fluids at meal times. 3. 2 tbs. bran on porridge. 4. Encourage eating fruit and veg in normal diet.
64 Potential constipation - incontinent of faeces.	1. Encourage fluids. 2. Meal time drinks.
65 Restless and Agitated. Ambulent at night.	Observe and reassure. Return to bed when necessary.
66 Tires easily.	Pt. to rest on bed and after lunch if wanted. Likes to retire before tea.
67 Poor appetite.	Encourage him to choose own diet sheet - and advise when necessary.
68 Potential hypo/hyper glycaemia.	Give insulin as prescribed. Urinalysis 0.600 hours.

	Patient Problem	Nursing Prescription
69	Anorexia	Give build-up drinks as often as tolerated and offer other drinks hourly. Observe urinary output inform doctor of any change in condition.
70	Unable to feed self. Sometimes reluctant to eat.	Patient needs feeding and encouragement
71	Unable to feed self	To be fed by nursing staff.
72	Vomiting	Observe eating habits, give anti-emetic.
73	Dysphagia - Oesophagal stricture.	Medication crushed. Bougie passed prn. Soft diet.
74	Potential constipation. Dietery intake poor.	Ensure meal times fluids. Fybrogal, as per chart 2 Glycerine supps. prn. Needs to sit on commode for at least 2 minutes.
75	Patient cannot accept his diabetic diet. Likes to eat chocolate.	Explain (constantly) reason for diet. Remind patient that chocolate gives him diarrheoea (tactfully). Monitor extras, carefully avoid confrontation.
76	Becomes agitated if not up by 9am.	Patient will cope with problem.
77	Tends to become agitated after tea.	Take pt. away from situation and if necessary put to bed after tea.

	Patient Problem	Nursing Prescription
78	Patient becomes "moody" if he is not up early in the morning.	All new staff to be aware that patient likes to be up early to go to work.
79	General "aches & pains", headaches.	Give analgesia per chart. Prevent constipation. Keep comfortably warm limbs.
80	Anxiety and Parkinson's Disease.	Explain when necessary that we understand her feelings and condition.
81	Unable to wash and dress self.	Blanket bath daily. Bath x 1 fortnight. Needs to be dressed.
82	Mood swings.	Pt. prefers plain talking, lots of T.L.C. Responds to an early night.
83	Incoherent speech.	Pt. has wide, non-verbal vocabulary: very skilled in indicating views and requests. Encourage signing and counting.
84	Mood swings, communication difficulties.	Often linked with communication problems. Pt. will indicate needs on pre-printed board. Will also use pad and pencil which should always be at hand. Will answer yes or no. Has extensive non-verbal vocabulary.

Patient Problem	Nursing Prescription
85 Variable mood. Occasionally resistive to care. Communication unresponsive.	Care explanation prior to procedure. Avoid sudden movements (startle pt.). Unhurried care lots of patient conversation.
86 Partial deafness.	Ensure patient wears hearing aid. Slow, calm speech.
87 Speech restricted.	Observe patient has wide non-verbal vocabulary, easily understood, noise of protest.
88 Misperception - particularly nocte.	Tell patient where she is. Tell patient who we are.
89 Apparent confusion.	Slow unhurried conversation. Allow patient time to make herself understood.
90 Unable to understand requests, often appears confused.	Calm approach to patient. Repeat instructions or requests. Avoid sudden noise or movement, encourage patient when he does appear to understand.
91 Pressure area.	Sheepskin. Nurse - side to side.
92 Potential pressure sores.	3 hourly turns.
93 Hygiene - unable to bathe unaided - hair scruffy and greasy - potential pressure sores.	3 hourly turns.

	Patient Problem	Nursing Prescription
94	Potential pressure sores.	3 hourly turns.
95	Potential pressure sores.	3 hourly turns.
96	Potential pressure sores.	3 hourly turns.
97	Potential pressure sores.	3 hourly turns.
98	Potential pressure sores.	Sheepskin in bed.
99	Pressure areas.	Sheepskin.
100	Sore heels.	Sheepskin in bed.
101	Sore groins and under breast.	Wash well and dry, Nystantin cream. Dust with Sterzac Powder.
102	Sore groins.	Twice daily inspection of scrotum and groins, wash and use conatrone cream.
103	Persistent rash on lower back.	Wash B.D. and prn. with oilatum in water. Apply emulsifying ointment. Kylie sheet.
104	Pressure sore.	Apply cream.
105	Pressure sores.	Going to bed - use Kylie sheet at night and 3 hourly turns. Kanga pants to be used during the day. Wash skin and keep dry. Apply conatrone cream regularly.

	Patient Problem	Nursing Prescription
106	Pressure sores.	Change position when in bed or chair. 3 hourly turns at night.
107	Heal small broken area.	Dress daily with Cicatrin and dry dressing.
108	Insecure and anxious.	Reassure.
109	Very agitated and aggressive.	Reassure.
110	Frustration due to inability to communicate.	T.L.C. and reassurance.
111	Hygiene.	Bed bath daily.
112	Oral hygiene.	Mouth care prn.
113	Graze on fore arm.	Daily dressing.
114	Sutures in situ.	Daily dry dressing.
115	Needs help with hygiene, especially bathing.	Support in bath daily.
116	Scalp complaint.	Good hygiene.
117	Incontinence.	Offer commode 2 hourly.
118	Hygiene.	Bed bath daily.
119	Old ulcers on both lower legs.	Apply tubegrip to legs daily.

	Patient Problem	Nursing Prescription
120	Hygiene - unable to wash without help.	Daily bed bath.
121	Personal hygiene.	Daily bed bath.
122	Eye infection.	Good hygiene.
123	Unable to attend to personal hygiene.	Daily bed bath.
124	Oral hygiene.	Mouth care prn.
125	Poor personal hygiene.	Daily bed bath.
126	Hygiene - needs help to wash & bath.	Assist with big bath daily.
127	Waxy ears - hard of hearing.	Clean ears at least once per day.
128	Hygiene - unable to bathe unaided.	Bed bath daily. Big bath 2 x per week.
129	Toe nails in poor shape.	Cut nails weekly.
130	Needs help with bathing.	Assist with big bath. Ambulift.
131	R. hip sinus.	Daily dressing. Pack with gauze and eusol. Notify Dr.
132	Unable to bathe by herself.	Daily bath. Use Ambulift. Assist where necessary.
133	Mouth infection.	Oral hygiene B.D.

	Patient Problem	Nursing Prescription
134	Poor hygiene.	Bath daily. Help patient in bathroom.
135	Poor personal hygiene.	Daily bed bath.

Appendix D: The Norton Scale used by the Area Health Authority, and the prescription for skin care set out in the Procedure Book issued by the School of Nursing.

THE CARE OF PRESSURE SORES

The root cause of pressure sores is prolonged pressure on a localised area of the body. The most vulnerable areas are the sacrum, ischial tuberosities, heels, shoulders, greater trochanters, malleoli of ankles and elbows. Aggravating causes include incontinence of urine or faeces, loss of sensation and poor general nutrition. The most significant measure in the prevention of pressure sores is the relief of pressure. It is also essential to keep the patient clean and dry. The emphasis should be on PREVENTION of pressure sores, for by the time the skin appears abnormal severe damage may already have been done to subcutaneous tissues. If a pressure sore is already present and occasionally in other circumstances, special measures may be required.

Relief of pressure may be achieved in the following ways:-

1) Frequent changes of position - the frequency of changes of position and the positions used should be determined by the nurse in charge of the ward. The use of turn charts may prove useful and the scoring system (found on the reverse of the chart) may help in assessing those patients at risk. Chair patients are also at risk.

2) Utilization of devices to relieve pressure, e.g. ripple mattresses, sheepskin rugs, heel pads and elbow pads, foam pads, water beds and bed cradles to allow greater freedom of movement.

Special Points in Prevention of Pressure Sores:-

1) Cleanliness - the areas which become soiled by an incontinent patient or are damp with skin moisture must be gently washed and dried. This should be done as often as is required to keep the patient dry and clean.

2) A good lifting technique by an adequate number of nurses

to avoid dragging the patient.

3) A good diet and adequate hydration also play a part in the prevention of pressure sores.

Ref. Assessment of a patient's risk of forming pressure sores (From Exton-Smith, A.N., Norton, D. & McLaren, R. 1962)

Physical Condition		Mental Condition		Activity		Mobility		Incontinence	
Good	4	Alert	4	Ambulant	4	Full	4	Not incontinent	4
Fair	3	Apathetic	3	Walks with help	3	Slightly limited	3	Occasionally incontinent	3
Poor	2	Confused	2	Chair-bound	2	Very limited	2	Usually - urine	2
Bad	1	Stuporous	1	Bed-fast	1	Immobile	1	Doubly incontinent	1

ROTA FOR 2 HOURLY CHANGES OF POSITION

Suggested Rota and Key;

1 – LEFT SIDE
2 – SITTING UP
3 – RIGHT SIDE
4 – PRONE (i.e. LYING ON TUMMY)
5 – SUPINE (i.e. LYING ON BACK)

SPECIAL INSTRUCTIONS:

RISK SCORE		
Date	Score	Signature

DATE																												
TIME	Pos.	Signature	Pos.	Signature	Pos.	Signature	Pos.	Signature	Pos.	Signature	Pos.	Signature	Pos.	Signature	Pos.	Signature	Pos.	Signature	Pos.	Signatue	Pos.	Signature	Pos	Signature	Pos.	Signature	Pos.	Signatur
02.00																												
04.00																												
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AREA HEALTH AUTHORITY (TEACHING)

Identification of patients 'at risk' to incur pressure damage.

In recent years much research has been carried out in factors which predispose to bed sores. After a major survey of available research findings, Miss Doreen Norton has evolved a method of assessing those patients who are at risk to incur pressure damage.

The Area Nursing Policy Group, having studied Miss Norton's work, has agreed that all patients admitted to hospital in the Area Health Authority, or nursed at home by the community nursing staff, are to be assessed to identify those at risk, so that preventive measures can be introduced early enough to be effective.

The Area Nursing Policy Group recognise that, with the application of any policy, ward sisters must be allowed to exercise their professional judgment to apply preventive measures to patients who do not appear to be at risk within the terms of this scoring system, e.g. patients undergoing surgery that necessitates them being on a theatre table for a prolonged period.

The following scoring system is to be used.

A		B		C		D		E	
PHYSICAL CONDITION		MENTAL CONDITION		ACTIVITY		MOBILITY		INCONTINENT	
Good	4	Alert	4	Ambulant	4	Full	4	Not	4
Fair	3	Apathetic	3	Walk/help	3	Sl lim ted	3	Occasionally	3
Poor	2	Confused	2	Chairbound	2	V lim ted	2	Usually/urine	2
V bad	1	Styporous	1	Bedfast	1	Immob le	1	Doubly	1

Each patient will be assessed by the nurse in charge.—

1. On admission, or on the nurse's first visit in the community.
2. The next day, or the next visit as appropriate.
3. At weekly intervals, or on the most appropriate routine visit in the community, or *when any change takes place.*

The scores across A to E inclusive for each section are added together, and the total score is entered on the position change chart and in nursing records, i.e. kardex or community nursing record card and patient's home notes.

e.g.	Date	Score	Signature
	20.7.77	12	M. Bloggs

A SCORE OF 14 OR BELOW INDICATES THAT THE PATIENT IS 'AT RISK'

All patients found to be 'at risk' must have their body position changed every two hours, day and night, using every position unless there is any medical written instructions limiting the use of certain positions. Each change of position must be recorded on the chart, and signed by the nurse.

It is recognised that there are difficulties in implementing two hourly turnings for patients nursed at home. The District Nurse should try to ensure that the policy is followed as closely as local circumstances permit, by teaching relatives/friends of the patient the preventive techniques of lifting, turning and sk'n care, and use of equipment, i.e. sheepskin pads, ripple beds, etc.

When no additional home support is ava'lable, the patient should be turned or ambulated on each visit, and this recorded in home notes. The GP should be informed when patients are seriously 'at risk', and adequate preventive methods cannot be maintained.

The Position Time Rota Chart should be used for patients whose position is changed routinely, and relatives or friends should be encouraged to use the chart also.

General hygiene attention is given to the pressure areas at each turn, if required, and should follow the instructions laid down in Procedure Books for the routine treatment of pressure sores.

The state of the skin must be noted and reported on.

Spirit is NOT to be used on the skin.

Brisk massage is to stop.

Any lesion developing on a pressure area must be reported and noted in the kardex or community notes. The doctor in charge must be informed, and shou d prescribe treatment.

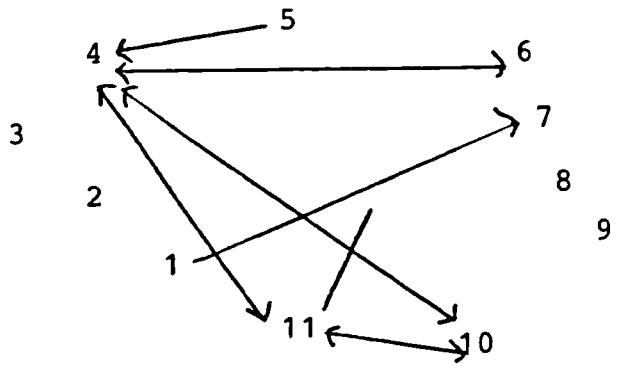
NB If the integrity of the skin surface is lost, the area is treated as a wound in an aseptic manner to prevent infection, and aid healing.

Appendix E: The sociometric evaluation of the group interactions in the Rehabilitation unit

Diagram number: 1
Venue: Rehabilitation unit.
Date: 18.7.81.
Topic: Review of patients.

Occupational groups present: Consultant psychiatrist and junior doctor, medical social worker, unit nursing staff.
Total number of persons present: 11.

Time frame: Ninety (90) minutes.

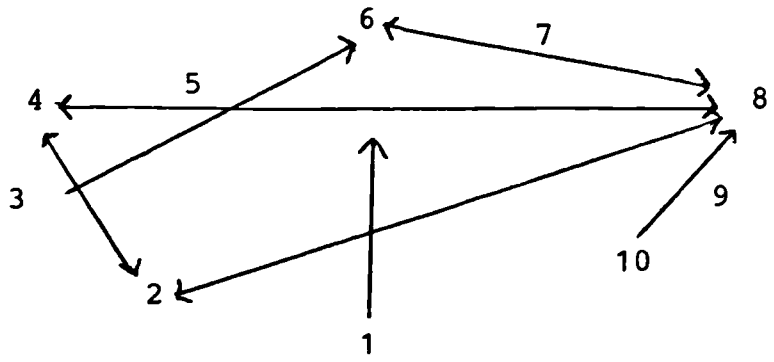


Most favoured person: Consultant psychiatrist (Number 4).

Diagram number: 2
Venue: Rehabilitation unit.
Date: 24.7.81.
Topic: Patient review.

Occupational groups present: Junior doctor, medical social worker, unit nursing staff. Total number of persons present: 10.

Time frame: Ninety (90) minutes.

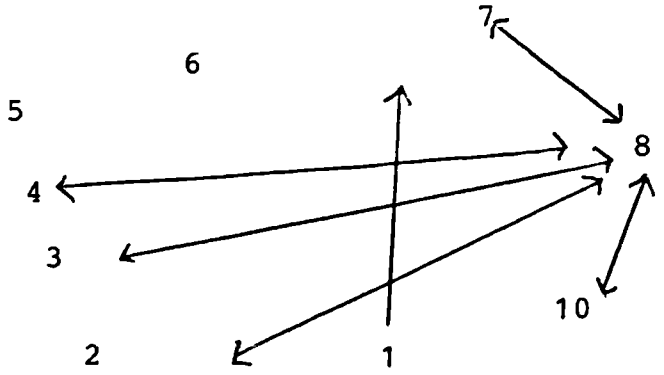


Most favoured person: Charge-nurse (Number 8).

Diagram number: 3
Venue: Rehabilitation unit.
Date: 31.7.81.
Topic: Patient review.

Occupational groups present: Junior doctor, medical social worker, unit nursing staff. Total number of persons present: 10.

Time frame: Ninety (90) minutes.

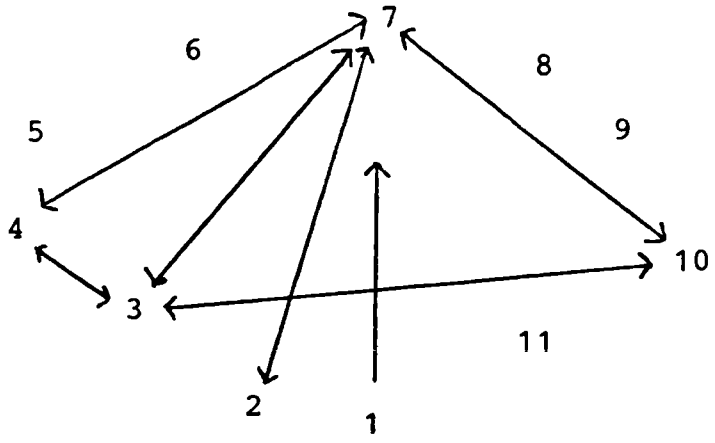


Most favoured person: Charge-nurse (Number 8).

Diagram number: 4
Venue: Rehabilitation unit.
Date: 21.8.81.
Topic: Patient review.

Occupational groups present: Consultant psychiatrist, junior doctor, medical social worker, unit nursing staff.
Total number of persons present: 11.

Time frame: Ninety (90) minutes.

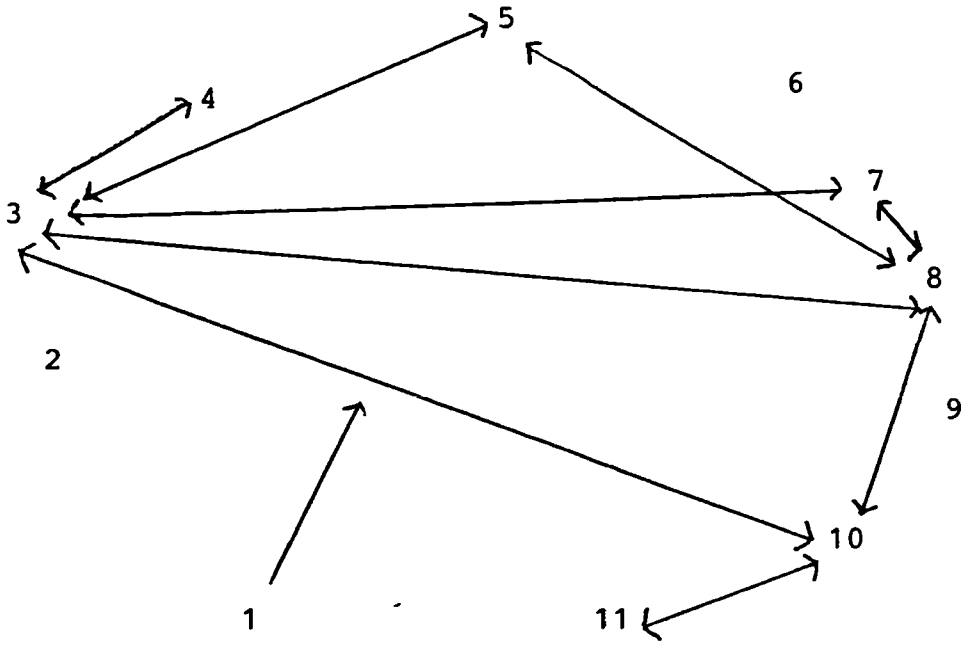


Most favoured person: Consultant psychiatrist (Number 7).

Diagram number: 5
Venue: Rehabilitation unit.
Date: 4.9.81.
Topic: Patient review.

Occupational groups present: Consultant psychiatrist, junior doctor, medical social worker, unit nursing staff.
Total number of persons present: 11.

Time frame: Ninety (90) minutes.

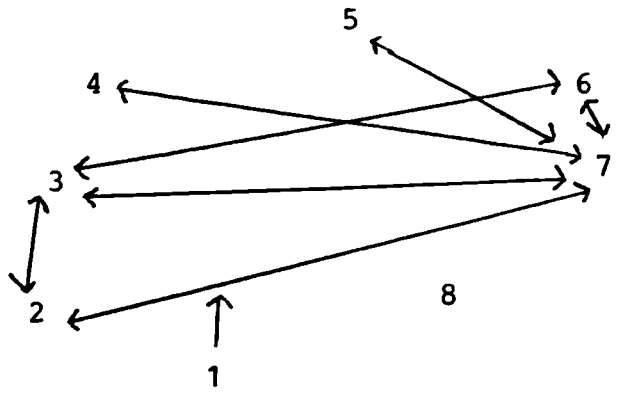


Most favoured person: Consultant psychiatrist (Number 3).

Diagram number: 6
Venue: Rehabilitation unit.
Date: 26.9.81.
Topic: Patient review.

Occupational groups present: Consultant psychiatrist, junior doctor, medical social worker, unit nursing staff.
Total number of persons present: 8.

Time frame: Ninety (90) minutes.

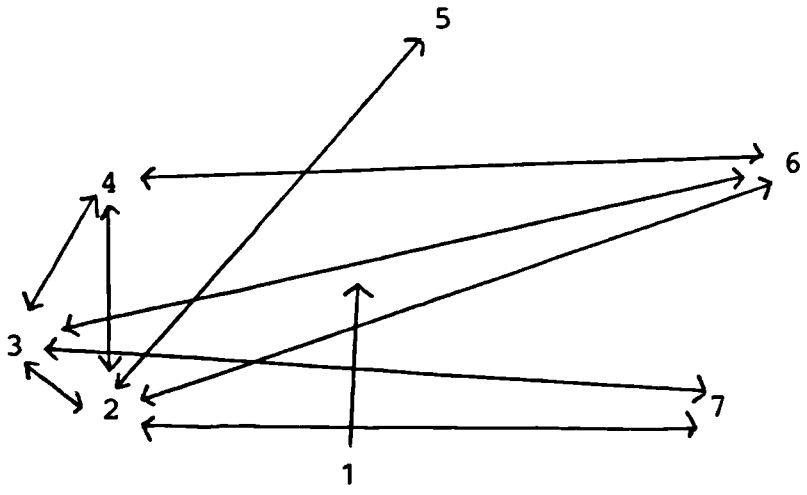


Most favoured person: Consultant psychiatrist (Number 7).

Diagram number: 7
Venue: Rehabilitation unit.
Date: 2.10.81.
Topic: Patient review.

Occupational groups present: Consultant psychiatrist, junior doctor, medical social worker, unit nursing staff.
Total number of persons present: 7.

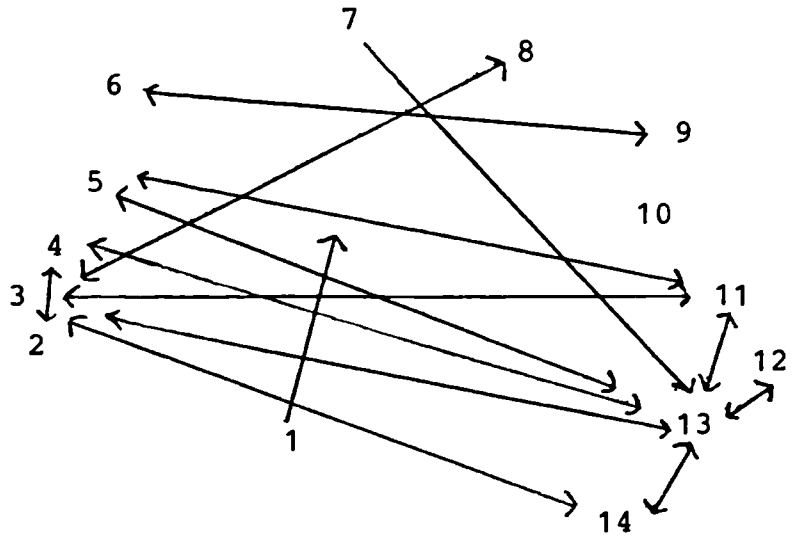
Time frame: Ninety (90) minutes.



Most favoured person: Charge-nurse (Number 2).

Diagram number: 8
Venue: Rehabilitation unit.
Date: 9.10.81.
Topic: Patient review.

Occupational groups present: Consultant psychiatrist, junior doctor, medical social worker, unit nursing staff.
Total number of persons present: 14.

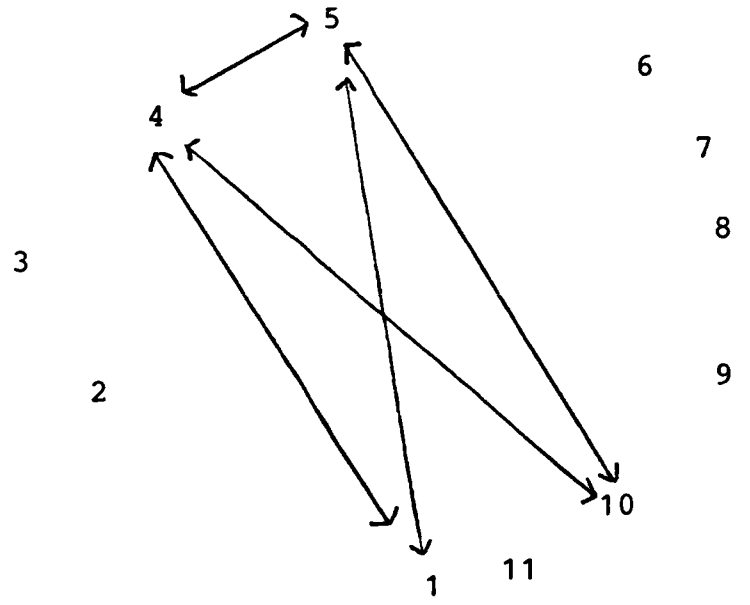


Most favoured person: Charge-nurse (Number 13).

Diagram number: 9
Venue: Rehabilitation unit.
Date: 16.10.81.
Topic: Patient review.

Persons present: Consultant psychiatrist, junior doctor, medical social worker, voluntary worker, unit nursing staff, patient (day-patient). Total number of persons present: 11.

Time frame: Ninety (90) minutes.

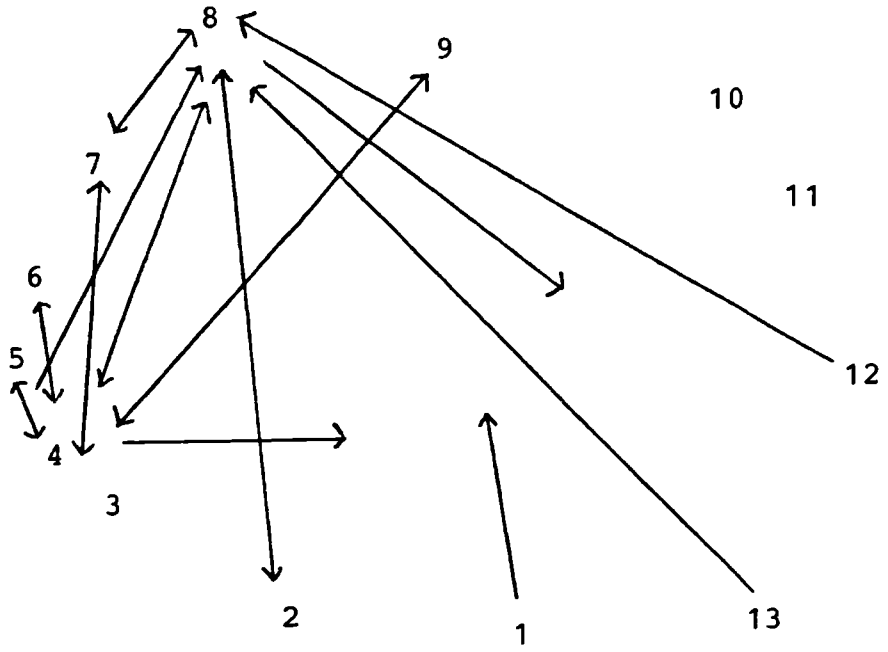


Most favoured persons: Consultant and Patient (Numbers 4 and 5).

Diagram number: 10
Venue: Rehabilitation unit.
Date: 20.11.81.
Topic: Patient review.

Occupational groups present: Consultant psychiatrist, junior doctor, unit nursing staff, medical social worker.
Total number of persons present: 13.

Time frame: Ninety (90) minutes.

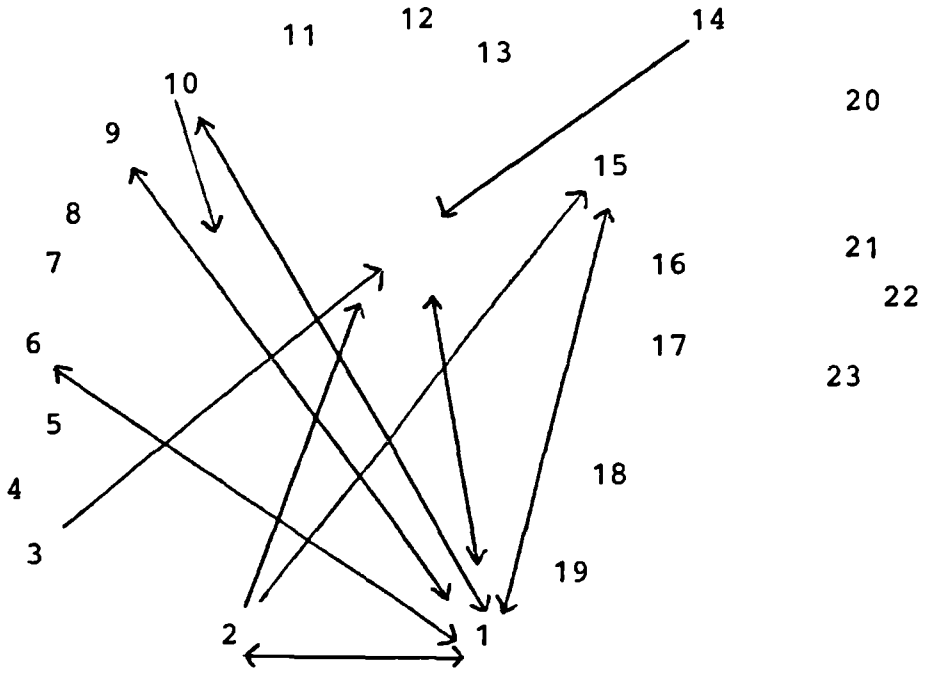


Most favoured person: Charge-nurse (Number 8).

Diagram number: 11
Venue: Rehabilitation unit.
Date: 2.12.80.
Topic: Feedback from writer to group on data collected during study.

Occupational groups present: Consultant psychiatrist, junior doctor, unit nursing staff, medical social worker.
Total number of persons present: 23.

Time frame: Ninety (90) minutes.

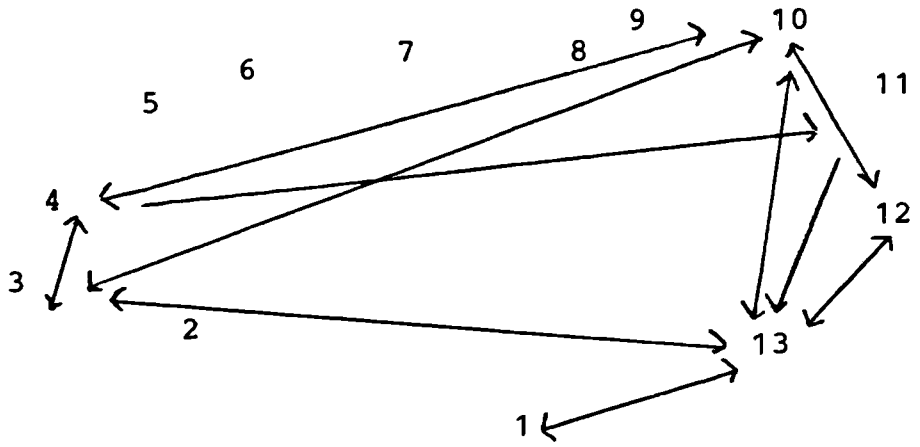


Most favoured person: Writer (Number 1).

Diagram number: 12
Venue: Rehabilitation unit.
Date: 4.12.81.
Topic: Anxiety expressed by one student nurse re patient contracts.

Occupational groups present: Consultant psychiatrist, junior doctor, medical social worker, unit nursing staff.
Total number of persons present: 13.

Time frame: Ninety (90) minutes.

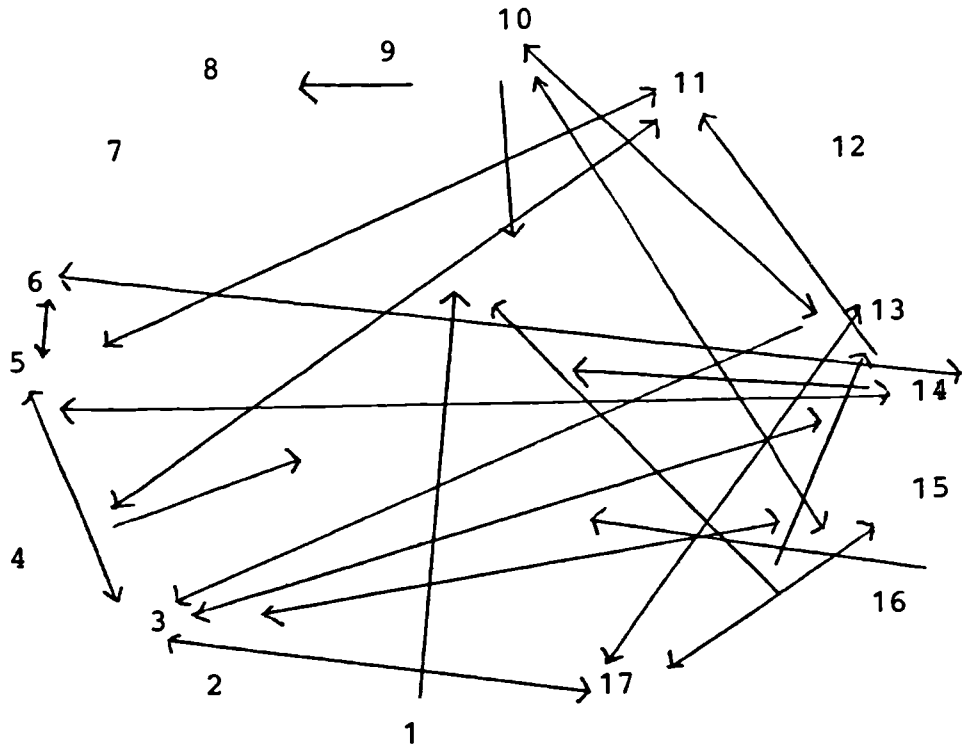


Most favoured person: Student nurse (Number 13).

Diagram number: 13
Venue: Rehabilitation unit.
Date: 5.2.82.
Topic: Trained staff's anxiety over complaints from members of the general public re patient's access to community life outside the boundaries of the hospital grounds.

Occupational groups present: Consultant psychiatrist, junior doctor, medical social worker, unit nursing staff.
Total number of persons present: 17.

Time frame: Ninety (90) minutes.



Most favoured persons: Doctor and Charge-nurse (Numbers 3 and 14).