

# **What makes a good nurse?**

A study conducted for WDGH NHS Trust  
by Bournemouth University to identify nursing practice and care  
within the Trust

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## Executive Summary

The aim of the project was to identify for the Trust Board of WDGH NHS Trust, Dorset County Hospital, the activities and functions staff and members of the public valued most from registered nurses. A qualitative research methodology was used and a series of focus groups took place with various staff and public participants. The participants were self-selected volunteers.

A potted history relating to context is provided and areas such as the evaluation of British nursing and the role of nurse leaders, including Nightingale, are discussed. The evolution of the health care system within the UK is also addressed with common themes and key points identified. For example, recognition that nurses need to be educated for their roles and that there is tension between meeting their learning needs and the service provision to patients. Lack of investment in nurse education and a view that nursing is a 'doing' rather than a 'thinking' activity prevails, corrupting the ideology and philosophy of nursing.

Nurse leaders have battled with medical and hospital authority to establish their view of standards and quality. Nursing has struggled to be recognised as a health care profession contributing to the benefit of society. Understanding the practice of nursing requires employers and government to provide appropriate conditions of service, welfare, investment and development so that the craft of nursing can flourish. Failing to do this impairs the ability of nurses to meet the changing needs of patients and the health care system.

The emergence of hospital systems has brought challenges and conflict for nurses and nursing practice. In many ways hospital practice, dominated by medical hegemony, shaped the role and position of nurses. This raises questions about whether health/hospital care requires general hospital workers or health practitioners and who should hold the title of 'nurse'.

The impact of the NHS and its funding is raised but not fully explored. This is done in other texts that discuss nursing as a nationalised industry and the issues this raises.

Nurse education is considered by reflecting on the recommendations of the various committees that have looked at nurse education and its role in preparing nurses for a proper role and function. Clay (1987) wrote that a succession of reports over the past 50 years have either been

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misunderstood, ignored or only partially implemented. This is reflected in the view that the difficulties which doggedly pursue nursing lie as much within parts of the profession as they do with external factors. A general lack of consensus and consistency continues to be a major stumbling block for the development of appropriate education and other issues.

The challenge for nurses in the 21<sup>st</sup> century must be for them to find their voice; to decide unanimously who they are, where they are going and the education they require to meet their personal and professional goals and the health needs of people. This must be set in a thorough understanding of the modernisation agenda.

Reflecting on all the key points raised in the first part of this report, there are various repeating themes that seem to reveal no real long-term solutions. It is against this background that this study was commissioned.

The report highlights the context and methodology exploited to achieve the findings. These findings suggest the following as areas of consideration when exploring what makes a good nurse and what the important activities and functions are that registered nurses should be involved in:

- Patient care;
- Co-ordinating care;
- Creating and maintaining a safe environment;
- Teaching and promoting learning in patients, carers and others;
- An advocacy role;
- Being a role model;
- Report writing/patient assessment notes;
- Dealing with relatives;
- Working in a variety of patient care settings;
- Providing leadership for nursing practice and standards.

The findings also explore how nursing practice is affected by the demands of today's health care system. Many nurses find that, because of the demands put on them, they are:

- Not giving patient care;
- Not spending time with patients;
- Not teaching;
- Not making decisions;
- Not practising autonomously;
- Not involved in budget decisions;
- Not involved in improving systems.

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The findings also show the blocks to nursing activity in the form of:

- Bureaucracy;
- Poor system design;
- Other responsibilities;
- Technology;
- Managerial emphasis;
- Perceptions;
- The demanding reality of work places;
- Poor communication systems.

These themes are further explored in the report, highlighting barriers to effective functioning, views about extended roles, quality measures and, importantly, the humanistic aspect of nursing and being a nurse.

Overall three key themes emerged from the study:

- Nurses doing a range of non-nursing work (aggravated by reduced numbers of registered nurses);
- A lost sense of the patient (and family) as people, a generalised loss of respect in professional and other relationships (for many different reasons);
- The loss of the one(s) in charge, few 'captains' remain, particularly at ward level.

Each of these three elements has implications for patients and their care. They also impact on the culture and capability of staff, particularly for those working in hospital wards, to provide care.

## Rationale for inclusion

During the process of constructing this report it became evident that a lot of other factors and actors played their parts in shaping and developing nursing. They affected how nurses and nursing came to be facing the challenges they do at this time. Some of these include the history of health care development, historical aspects relating to Florence Nightingale and other nurse leaders and the challenges they faced, the development of nurse education and nursing practice, the formation of health policy and the National Health Service (NHS). In more recent times NHS reforms and modernising agendas have played their part in shaping nursing into the forms found today.

This report attempts to give readers a historical overview up to and including some recent developments, as well as providing what was required in terms of the report. It has been presented in a way that is intended to be accessible, with links made between some of the different important events, so that readers can gain a sense of the whole.

The report focuses on the activities and functions of registered nurses. It is acknowledged, however, that many other people, health care workers, administrators, support workers, professionals, specialists and managers are also involved in the provision of care.

The range of inclusions (although there were still many omissions) meant that depth of critique was sacrificed. No particular point of view has intentionally been presented. All conclusions drawn were believed to be true at the time of writing but further study and analysis could lead authors and readers to different conclusions in the future.

It is hoped that readers will enjoy the report and find something interesting and useful, as well as learning about issues relating directly to this report.



## Introduction and Background

Nursing and its various branches have developed over many years in response to different needs being identified within the population. Specialised needs, as identified within children's nursing, lead to that branch of nursing developing its own knowledge and technical base.

This report focuses on the work of hospital nurses, often seen as the 'Cinderella workforce', because their specialised knowledge and technical base remain largely unrecognised and/or disregarded. In acknowledgement of the continuing shortage of hospital nurses, it was the intention of this project to identify the nursing roles and activities most valued by patients/clients and staff so that they could be retained and developed.

## Context

Before the mid-19<sup>th</sup> century, health care was very different to today. Following trauma, patients rarely survived. People admitted to hospital with skin conditions like open ulcers, or people who were weak or disabled, generally responded well to the diet and rest they were given. Anyone who was obviously infected or terminally ill was not admitted (Dingwell & Allen 2001). It is easy to forget that germ theory was not understood until mid-Victorian times. People believed that sickness was spread by bad smells, 'miasmas'.

Cholera was a prevalent and devastating disease. In 1853, outbreaks of cholera in Newcastle, Gateshead and London killed 10,675 people. In 1854, the Soho area of London was a filthy, smelly place and a serious outbreak occurred here. Dr John Snow, an epidemiologist and anaesthetist, speculated that the source of the cholera outbreak was contaminated water from the local well. He arrived at this assessment through careful deduction. As an experiment, he asked for the pump handle to be removed. It was, and the spread of the disease dramatically stopped. A few outlying cases were investigated and all led back to the pump being the source of the infection. Dr Snow published his findings with considerable evidence, but people remained sceptical for a long time (Summers 1989).

In Britain before 1860 there was little public or professional recognition that nurses needed any training. Nursing was seen as domestic service at best, or at worst, just a way to earn a living. It was only after the Nightingale reforms of 1860 that nursing became established as a

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respectable career for middle-class women. These women were expected to have a good education so that, once trained, they could move immediately into leadership positions and spread the nursing movement. Even after this time, hospital patients were usually poor people. The wealthy were cared for at home well into the 1920s. This pattern only changed as surgery developed and home conditions could no longer support treatment and care.

Interestingly, midwifery remained the domain of women until recent times. Obstetrics did not really develop in England as it did, for example, in the United States. It was in 1902 that the Midwives' Act was successfully passed – a testament to the diligence of interested groups. The act provided the mechanism for the organisation and registration of midwives. However, by 1918 one in five state-registered midwives in England still had no training (Oakley 1983). But it would be unfair to dismiss the experience of lay midwives. There was a long tradition of apprenticeship for midwives, and skills were acquired through experience. The passing of the Midwives' Act (1902) helped nurses to gain recognition for their work and was regarded as an important precedent by those who sought registration for nurses (Abel-Smith 1960).

The reasons why midwifery remained under the control of women for such a long time is open to speculation. One theory relied on the traditional belief that anything to do with menstruation and childbirth was dirty and a danger to society. This belief is still evident even today in some parts of the world. Childbirth was regarded as 'women's business' (Oakley, 1983, p32). Men were only brought into midwifery when there were complications. Only men were allowed to use surgical instruments to overcome obstructed delivery. These men usually belonged to the Barber-Surgeons Company (later to become the Royal College of Surgeons<sup>1</sup>). Surgery was at that time an unrecognised and disreputable branch of medicine. This is why surgeons are called 'Mr' rather than given the honorary title of 'Dr'. Women continued to take care of 'normal' births and men-midwives were called for problems. These men were to become the obstetricians of today (Oakley 1983).

Life for most people was unbelievably difficult and it was risky for all. Many babies and children died and many women did not survive childbirth. All had to face disease, under-nourishment, squalor and ignorance. It was not until the mid-20<sup>th</sup> century that things significantly improved. The introduction of the first antibiotics, powerful weapons

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<sup>1</sup> Surgeons and barbers became united under Henry VIII in 1540. At that time surgery was limited and treated with suspicion. During the 18<sup>th</sup> century, surgery began to develop its own knowledge and practice base. The surgeons broke away from the barbers in 1745 to form the Company of Surgeons, which was granted a Royal Charter to become The Royal College of Surgeons in 1800 (RCS 2003).

against infections, better housing, improved water supplies and sanitation all helped people to be healthier and live longer. Immunisation, improved nutrition and, more recently, technological advances mean that fewer people now die young. The combination of these and other factors, together with declining birth rates in the western world, have led directly and indirectly to a shift in the age of the population and the demographic changes we are seeing today.

## Myths

Medicine has built its reputation on curing the sick. As a result, society has become dependent on medicine and this dependency has subsequently provided the medical profession with much of its power.

Medicine's roots are to be found in the early Church. In 1512, the English Church authorities passed an Act that was the first attempt to regulate medical practice. Doctors were forbidden to treat patients who refused confession (Oakley 1983). All doctors were men because only men could enter university. While there, medical students studied the works of Plato, Aristotle, Christian theology and the Hippocratic physicians of ancient Greece (Oakley 1983). Medical education relied on astrology, theology and superstition (Illich 1976). Throughout the 19<sup>th</sup> century it was believed that sickness was spread through bad smells (even though evidence supporting germ theory was starting to emerge towards the end of that century). Links with science developed later. Many of medicine's early successes could equally have been attributed to other factors, like improved cleanliness and sanitary conditions, and better nutrition.

Many diseases left untreated follow specific patterns of growth, peak and decline, as was recently demonstrated by the SARS epidemic:

The main reason for the decline in infectious diseases was not to be advances in medical science, but developments in the system of public health. It was these developments which provided an effective counterweight to the sorts of urban living conditions created by the industrial revolution and within which infectious diseases could flourish. (Ham 1999, p5)

It is worth considering that there may even be considerable risks associated with hospitalisation (Hogg 1999, Illich 1976) and medical intervention (Illich 1976). Risks include infections, complications and sometimes death. This is not to decry the contributions made by medicine; rather it is an attempt to put things into perspective. Some authors suggest that science may not have the answers to all the

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problems. In a review of the progress made in the treatment of cancer, Hogg (1999) cited Lesley Doyal and Samuel Epstein (1983) to say that:

[They] have argued that the problem of the rise in cancers may not be so much scientific as political and economic. Causes that lie in the individual are exaggerated at the expense of researching hazards that lie in the environment (p162).

Perhaps scientists and doctors are sometimes looking in the wrong places for answers.

These days, where health care is necessarily controlled by economics and escalating costs, it must surely be worth re-evaluating the nature of health expenditure. We need to examine whether or not we are getting the best value for money by ploughing more money into medical research, at the expense of environmental and sociological research, all of which influence health.

Medical progress is not straightforward and treatment is not always beneficial. Sometimes treatment can cause more problems for patients than the original illness. (Hogg 1999, p162)

There must be other approaches to health and healing worth considering.

## Science

Our confidence in science is amazing. When we get sick we want to believe that we will be diagnosed, treated and cured, and that science will provide all the answers for us. This may not be the truth. The health service is free and available to everyone; it is an ideal and a treasure and must not be compromised. However, it is not perfect. Hogg (1999) reminds us that:

There is little certainty in medicine and many common treatments are not scientifically proven to be effective. Even for routine conditions and with the most expert staff, it is not always possible to predict with certainty the outcome of treatment. Some people may not get better even though the prognosis was good. Others get better when they were expected to die (p159).

There is much that is still unknown and misunderstood. Great strides have been made but there is a wealth of knowledge still waiting to be discovered. It is foolish to trust in science completely and it is not without its contradictions (Chalmers 1999).

### A medical myth

A medical myth is that patients arrive at the hospital sick, they are treated, they recover and are discharged home to continue with their lives. This is a myth because, increasingly in the modern world, this does not happen. Patients may or may not be treated, they may or may not recover, and they may or may not be discharged. They then may or may not go home and they may or may not be able to continue with their lives as increasingly patients may need extended, often complex, aftercare.

Having unrealistic expectations gives people a false sense of security. They may be reluctant to take steps to care for their own health, trusting instead in 'the system' to take care of them when they get ill. This optimism may lead to frustration and disappointment in the health service when expectations, however unrealistic, are not met (Hogg 1999).

### A nursing myth

A popular nursing myth is that in the past hospital wards were staffed by trained nurses. This has never been true (Salvage 1985, Dingwall & Allen, 2001). Learners, with varying degrees of competence, have always staffed hospital wards. The role of trained nurses was largely to oversee and guide learners and auxiliaries. In 1985, Salvage reported that approximately one quarter of the ward staff complement would be learners and another quarter would be auxiliaries. From the remaining number, some registered nurses would hold managerial positions, which meant that less than 50% of ward staff were likely to be trained nurses.

### Non-myths (truths)

One thing that has changed is the nature of hospital patients. They are frequently older, more often seriously ill, and are likely to have a complex range of disorders. These patients are less stable and need significantly more expert care than patients did in the past.

A second change is more subtle. In the past, nurses were very clear about their place in the ordered hierarchy but their roles have now changed. A range of people who work differently are replacing nurses. Nurses are no longer sure what their place is or the extent of their responsibilities. Many nurses have moved away from nursing, often pressured into administrative, organisational and other non-nursing roles, far removed from patients.

## The evolution of British nursing

### Foundations of nursing

Since the dawn of civilisation, people have responded to the care needs of the young, the sick and the elderly. Priests and their acolytes originally provided this service at a time when medicine and religion were closely linked. During the 1<sup>st</sup> century, the rise of Christianity reinforced this trend. Christian men and women cared for those in need. The Churches organised women called deaconesses to provide this service (Baly 1980, The Lancet Commission 1932). The Crusades (11<sup>th</sup>-13<sup>th</sup> centuries) saw the continued development of nursing as a service in both religious and secular settings, caring for the sick across Europe. Later, as the religious side of nursing became accentuated, recognition and support was only given to those who had taken vows. This association was later identified as one of the factors that undermined the ability of nuns to be successful nurses. In England, the demands of the two roles eventually proved too great and were abandoned (The Lancet Commission 1932).

The 17<sup>th</sup> and 18<sup>th</sup> centuries saw a decline in nursing. Growing populations, too few hospitals and deplorable management led to a significant decline in standards compared with those in society. England had lost the influence of nurses following religious orders, and nothing significant had taken their place. In Europe this had not happened so they fared better, but nowhere had hospital services kept up with the advances made by society (The Lancet Commission 1932).

### Kaiserswerth movement

The growth of the Kaiserswerth movement in Germany in the early 19th century is noteworthy because of the impact it had on nursing in ways that are recognisable today.

Nursing as a calling was at its lowest level by the beginning of the 19<sup>th</sup> century, nowhere having shared in the general development of social amenities. But in 1822 the Kaiserswerth movement preluded real advance. Theodore Fliedner, the Protestant clergyman of the small town of Kaiserswerth, near Dusseldorf, visited England to obtain financial help for his poor parish, and with his initiative the modern period opens. He became interested in the work of prison reform, inaugurated by John Howard<sup>2</sup> and carried on by Elizabeth Fry<sup>3</sup>.

On his return home, and with the co-operation of his wife Friederike, as able and as charitable as himself, Pastor Fliedner

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decided to institute a refuge for the care, physical and moral, of women who had been discharged from prison. Out of this idea, and by rapid stages, Kaiserswerth developed as an institute for the training of a supply of nurses for the sick poor, using the example of the Order of Deaconesses of the early Church. The movement in this shape developed rapidly, with Caroline Fliedner, the second wife of the founder, being also an outstanding character.

The organisation was a religious association, but not seeking the support either of the Church or the State. The women whom the Fliedners enrolled took no vows, but were expected to remain five years in the service, when they could if they wished return to their homes or marry.

The work before the Institute was divided into four branches – nursing, poor-relief, care of children, and succour of prisoners and fallen women, the last heading representing the original design.

Nursing was arranged under three heads – institutional, private, and district – and a system of training was arrived at in which we can recognise much that is with us today, such as a course of preliminary training, a classification into probationers, nurses, head-nurses, and superintendents, and a recognition of the authority of the head-sister. The head-sister was working under a clergyman, the Pastor, so that religious authority was present, but without the obligation on the nurses of taking the vow and surrendering all property to a community. This was an important difference from conventional example, for it allowed the Deaconess to cease from her work, when she chose, and live an independent life (The Lancet Commission 1932, pp16-17).

At the start of the 19<sup>th</sup> century there was no organised nursing in this country. Nursing was non-existent for the poor and in hospitals it was rudimentary at best, in the hands of the unskilled.

The horrors of goal [prison] and asylum life had begun by this time to make a strong appeal to the compassion of the public, not on the grounds of unjust incarceration, but because of the miserable plight of the incarcerated; but the fate of the sick poor, especially in hospitals, aroused no such pity. An awakening of the public conscience did not come about until some 20 years after the Kaiserswerth example had been set. Then the need of

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an organised supply of nurses became recognised by many, but not in any general manner by the medical profession, who, save for certain, notable exceptions, appear to have regarded the quality of nursing as of secondary importance. How this could have come about seeing the condition of things in hospitals is difficult to understand (The Lancet Commission 1932, p18).

Standards were appalling, and nurses required courage or callousness to cope. However, The Lancet Commission (1932) reminds us that:

It is not the failings of women placed in such circumstances that should be wondered at, but their virtues (p20).

These women often fell through no fault of their own; they were frequently uneducated, so were ill equipped to change conditions. At this time, nurses' lives were lives of great hardship and self-sacrifice.

## Key points

- Although caring for the sick originated through the priesthood, nuns and other women gradually became the main carers.
- As populations increased, there were too few hospitals to keep up with the demand and this, combined with poor management, led to a significant fall in standards.
- Formal education for nurses did not exist. With some exceptions, care was usually basic, given by uneducated, unskilled people. The quality of nursing care was not considered important by the medical profession.
- Nurses had no means of changing conditions even if they recognised a need.
- At Kaiserswerth in Germany, nursing was gradually becoming divided into different branches: nursing, poor-relief, care of children, and help for prisoners and fallen women. Care was given under three main groupings: institutional, private and district.

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<sup>2</sup> John Howard (1726-1790), High Sheriff of Bedfordshire and staunch Baptist, first became interested in prison reform when he visited prisons in Bedfordshire. He appealed for improvements which were refused, and in 1777 undertook a journey to tour prisons across England, and later Europe, comparing the conditions he found. Through this work, Howard became interested in the spread of infections (before germ theory was understood) and advocated separating the sick from the well, bathing, the treatment of infected clothes, and access to medicines. As an authority on penal reform and hygiene, Howard then turned his attention to hospitals. These, for the most part, he condemned, vigorously supporting practical improvements to diet, cleanliness, and the use of fresh air. Howard's records, collected over 20 years, provided 'the foundations for a new science of social study' (Baly 1980, p47).

<sup>3</sup> Elizabeth Fry (1780-1845) was an early reformer who became associated with nursing although she was best known for her work with prison reform. Motivated by her Quaker faith, Mrs Fry visited prisoners (sinners) for them to repent and be saved from eternal damnation. She was appalled by the atrocious conditions she found and despaired at being able to save prisoners when they were forced to live in such conditions. Despite opposition, with a group of sympathisers she organised improvements for female prisoners, which were recognised by reformers throughout the world. Mrs Fry was less successful in England where the American system of large buildings with single cells was being adopted. Her prison reform work brought Mrs Fry into contact with Pastor Fliedner and she visited Kaiserswerth. Mrs Fry was impressed by the deaconesses and, in 1840, attempted to establish a similar system of



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nurse training in England. However, with her ongoing commitment to prison reform, Mrs Fry was unfortunately unable to dedicate sufficient time and energy to this new project and so it was not successful. Historians also suggest that perhaps England in 1840 was not yet ready to engage with the idea of systematic training for nurses (Baly 1980).

## Nursing Reformers

### Florence Nightingale 1820-1919

#### The founder of British nursing

Florence Nightingale was a well-educated, intelligent and accomplished woman who, in the manner of the times, led what she considered to be an empty life. Distressed by the poverty and misery she saw as she travelled in England and Europe, and influenced by her religious beliefs, Miss Nightingale believed her destiny to be somehow linked with caring for the 'poor and miserable' (Baly 1980, p116). In 1845, she decided she wanted to be a nurse. She visited hospitals across the country and in Europe, formulating her ideas. Miss Nightingale was particularly influenced by Kaiserswerth, which she visited in 1849. It is usually reported that Miss Nightingale received training when she returned there shortly afterwards, although later in life she denied this, saying that:

'The nursing was nil and the hygiene horrible' but she was impressed by the atmosphere of devotion...and she learned that good nursing cannot be achieved by devotion alone (Baly, 1980, p117).

However, following this experience, Miss Nightingale was now committed to nursing in a large hospital. In a bid to leave home, her first appointment was arranged. In London in 1853, Miss Nightingale was appointed as 'Superintendent for the Institution for the care of Sick Gentlewomen in Distressed Circumstances' (Baly 1980, p117).

While waiting to take up this appointment, Miss Nightingale worked with the Sisters of Mercy in Paris where, at her own expense, she conducted a survey using questionnaires, eliciting information from all the hospitals across Germany, France and England, which she then collated. On her arrival back in London, armed with all her factual information, Miss Nightingale finally had the opportunity to put her ideas into practice. Her reforms included proposals for lifts, piped hot water and other labour-saving devices, described by Baly (1980, p117) as 'exacting and revolutionary'.

Miss Nightingale continued to visit hospitals and collect information. She recognised the need for hospital nursing reform and urged her political friends to support her. The following year, destiny took a hand. The Crimean War (1854-1856) began and through reports published in *The Times*, the public were able to read about the horrors of war and the lack of hospital care for the first time. Miss Nightingale was contacted and

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within six days (21 October 1854) she and a team of 38, non-sectarian nurses headed for Scutari. She saw this as an opportunity to prove to the world the benefits of good nursing.

The barracks themselves were built round a vast courtyard, and everything was filthy and dilapidated; the courtyard was a refuse dump, equipment and sanitation were non-existent and the building was over a dammed-up cesspool from which came a frightful stench; in the cellars below lived two-hundred prostitutes and around the walls lodged a filthy rabble.

Across the Bosphorus, in great splendour lived the British Ambassador, Lord Stratford de Redcliffe, who had orders to equip the hospital but in fact had never even visited it until compelled to do so by Miss Nightingale herself, and whose excuses she countered with the famous, 'Mr. Ambassador, I never gave an excuse, I never take one'.

The arrival of the Nightingale party was greeted with sullen opposition; the doctors received the news with disgust, but because of the government backing and the power of the press they dared not show open hostility; they simply refused the help offered by Miss Nightingale and her nurses (Baly 1980, p119).

Miss Nightingale would not let her nurses nurse until the doctors requested it. She had funds raised by public subscription so she and the nurses spent their time 'Buying equipment, stuffing mattresses, making bandages, and cleaning the place' (Baly 1980, p199).

On 9<sup>th</sup> November the situation changed. The battle of Balaclava over in the Crimea was a disaster; stupidity and ineptitude brought catastrophe; the harbour heaved with dead bodies, and in the chaos and confusion the sick, the wounded and the dying began to pour across the Bosphorus to Scutari. The hospital filled, the doctors were overwhelmed and they turned to Miss Nightingale.

Out came the mattresses and the bandages, and although 'the doctors worked like lions' it might be two weeks before they could see a patient; at one stage there were four miles of patients on mattresses on the floor; there were over a thousand cases of diarrhoea and the privies had become useless. In the confusion it was realised that someone had the power to spend money without army red tape; Miss Nightingale had at her

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disposal £30,000. A visiting member of parliament Mr Augustus Stafford, and Mr MacDonald, the administrator of 'The Times' Fund, were pressed into service as quartermasters and the main requirements were bought in Constantinople. Now the opposition collapsed (Baly 1980, pp199-120).

This had been an extraordinary effort and by the spring of 1855 Miss Nightingale was exhausted. She had become famous, she was adored by her charges, and it is suggested that her greatest contribution may have been

...that she was one of the first people who regarded the British soldier as having a dignity of his own and not 'the scum of the earth enlisted for drink' [as was the popular opinion] (Baly 1980, p120).

There continued to be many trials and challenges for Miss Nightingale. She became ill and was expected to die, but she recovered and worked on, continually trying to improve the conditions for soldiers. In 1856 there was peace and Miss Nightingale returned to London. A fund had been established to thank her for her work and this money was used to found the first nurse training school in England, at St Thomas' Hospital in 1860. There was considerable opposition and so it became necessary for the pupils to be beyond reproach. Once trained, these nurses were expected to go out into other hospitals and set up similar training schemes (Baly 1980).

## Key points

- Although Miss Nightingale was a person of exceptional ability she was still constrained by the norms of her time.
- Even with government backing, at the hospital in Crimea, Miss Nightingale and her nurses were powerless to help with caring for the sick in the face of opposition from the doctors.
- Miss Nightingale and her nurses were educated women who had received nursing training.
- The British soldier was treated with dignity for the first time.
- The need for nurses to be educated was recognised as important and the first nurse training school in England was established at St Thomas' Hospital in London.
- Nursing became formally recognised as a respectable occupation for women.

## Historical context

The period before the first World War saw increasing unrest spread across Britain. There was conflict in Ireland, both men's and women's suffrage movements were gaining momentum and there was industrial

upheaval. Workers who had never before challenged employers were forming trade unions to demand fair treatment. Women were particularly disadvantaged but they were finding ways to be heard. People from all walks of life were engaged in activities that challenged the status quo (Rowbotham 1977).

Between 1880 and 1930, many people besides Florence Nightingale were involved in nursing reforms. McGann (1992) gives interesting accounts of eight notable reformers, three of whom are featured below. There were protracted battles both for and against professionalisation and nurse registration.

## Eva Charlotte Luckes 1854-1919

Miss Luckes trained as a nurse at the Westminster Hospital, completing in 1878. From there she became a night sister and then Lady Superintendent before clashing with the authorities and resigning.

Like many matrons at the time, she tried to raise the standard of nursing in the hospital and her reforms were regarded by the medical staff and hospital authorities as a threat (McGann 1992, p10).

In 1880, Miss Luckes, although still young, impressed the hospital board with her enthusiasm, and was given the position of matron at The London Hospital in Whitechapel, an area 'notorious for its poverty' (ibid). Here Miss Luckes was challenged with reforming nursing. She quickly identified grave shortages in the quality and quantity of nurses. With the committee's support, she was successful in obtaining more nurses, and she reformed the system of training by introducing both practical and theoretical instruction. Miss Luckes was also responsible for introducing the first nurses' home, which provided nurses with better food and accommodation. She also started a private nursing service and the hospital gained financially from this arrangement.

Miss Luckes however still had her critics. She was required to defend her decisions on numerous occasions. Under-funding was an issue even then, but the hospital grew as the patient population increased with many new services being offered. Midwifery training for qualified nurses was introduced in 1900 and it was only then, with midwives going into people's homes, that the full extent of the local poverty was revealed. The hospital authorities responded appropriately and set up a fund to provide milk for mothers and baby clothes for those in need. Miss Luckes cared especially for the children of the poor, and she taught:

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The nursing of children requires special care, special training and special study. It needs infinitely more knowledge, more skill, more observation and more patience to become a really good children's nurse than it does to attain an average amount of efficiency in nursing adult patients.

It is essential for nurses to recognise that when they enter a children's ward, they find themselves in a new world, of which the inhabitants are 'little people', with a different language, different manners, different feelings and different thoughts (McGann 1992, p24).

Miss Luckes, like Miss Nightingale, believed that nursing should be taken up, not for personal gain, but to serve. (The Victorian context and the position of women in that society should be acknowledged here.) This shared view meant that Miss Luckes and Miss Nightingale became firm friends. Believing that nursing should be purely vocational in nature put Miss Luckes and Miss Nightingale into conflict with their contemporary Mrs Fenwick (see below), who was championing registration and the professionalisation of nursing. Registration required nurses to be examined on theoretical knowledge before their names could be entered on a register. It was this point that Miss Luckes and Miss Nightingale objected to, arguing that only the training school and its matron could know

...if a nurse was a good nurse and therefore competent. If the certification of nurses were removed from the training schools and vested in an independent body, such as a general nursing council, certificates would become meaningless. The examination could only be of the nurses theoretical knowledge and this gave no value to the nurse's personal characteristics which were the difference between a good nurse and an indifferent nurse McGann 1992, p25).

World War I (1914-1918) led to an increase in patients from the battlefields and also an increase in applications from women wanting to become nurses. (The war caused society to radically change and these changes were permanent.) During this time, the activities of trained nurses brought them into contact with other nurses from all over the country. From their discussions, many of them realised that the disorganised state of nursing and the disparity in training was not helping them or their patients. Much of the training was mediocre. There followed a public and professional swing towards registration, which was eventually successful in 1919.

## Key points

- Miss Lukes wanted to raise the standards of nursing but experienced opposition from the medical staff and hospital authorities who perceived the reforms as a threat.
- She identified shortages in both the quantity and quality of the nurses.
- Miss Lukes introduced a system of training that used both theory and practice.
- She introduced the first nurses' home with food provided, to improve conditions for nurses.
- She introduced a private nursing service which benefited the hospital financially.
- Midwifery training was introduced, which revealed the extent of local poverty, and other services for mothers and children were subsequently introduced.
- Miss Lukes identified the need for special training to prepare nurses to work with children.
- Miss Lukes and Miss Nightingale were like minded in their belief that nursing should be vocational. They challenged the fight for registration believing that only the matron could adequately assess the personal characteristics of each nurse, as these characteristics were believed to make the difference between a good nurse and an indifferent nurse. Miss Lukes and Miss Nightingale believed that centralised registration could only measure theoretical knowledge, and not the character of the nurse.
- WWI brought nurses together from different backgrounds and training schools. The disparity in training, much of which was mediocre, became evident. The result was a strong public and professional swing towards registration as a means of developing a standard.

## Mrs Bedford Fenwick née Manson 1857-1947

Miss Ethel Gordon Manson began her nurse training when she was 21 years old. She worked first at the children's hospital in Nottingham then moved to Manchester where she worked for a time in surgery. When she qualified in 1879, Miss Manson was offered the post of Sister on a women's medical ward in London, which she readily accepted. Miss Manson showed an early aptitude for management. She was hard working, popular with patients and staff, and got on well with the physicians. The work was hard, and she worked long hours, but she enjoyed it. In 1881, Miss Manson applied for the post of matron at St Bartholomew's Hospital. She was successful even though she was only 24 years old.

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Miss Manson extended the period of nurse training to three years and reorganised it to include both practical and theoretical instruction. She also took paying probationers whom she felt were a good influence on the staff and started a private nursing department. Miss Manson had high standards and expected the same from her staff. She improved the food for nurses, their off-duty hours and their holidays. She took a professional interest in the health of her staff and kept reports cataloguing their infections and illnesses. These provided Miss Manson with an illustration of the risks associated with nursing at that time.

While Miss Manson was matron at St Bartholomew's Hospital, she became aware of the need for nurses to have professional independence. There were two issues that concerned her. The first was the lack of protection for trained nurses and patients from people who called themselves nurses but who were untrained. The second issue concerned the exploitation of nurses sent out to do private work. Usually, the employing institution took the fee and Miss Manson fought for the fee to be paid directly to the nurses. The need for nurses to have a professional standing became her life's work. In 1887 she married a well-known physician, Dr Bedford Fenwick, and resigned from her position as matron, but she continued to work for nurses and began the campaign for registration. Shortly after her marriage, Mrs Fenwick, with 30 like-minded matrons, founded an organisation that they called the British Nurses Association (BNA) in 1888, as a means of organising the future of the nursing profession.

The aim was to raise the standard of the profession as a whole by uniting all trained nurses in membership of an association which would support and protect their interests and provide their registration (McGann 1992, p37).

The founders considered that the best way to protect the trained nurse was to establish a register of trained nurses similar to the register of doctors. They decided that the minimum qualification for registration should be three years training in a hospital. Mrs Fenwick was determined to set the standard of the 'trained nurse' as high as that of the best nurses. She considered that nursing was a worthwhile career and she wanted to make sure that it had professional standing which would attract intelligent women (McGann 1992, p38).

The BNA was well received and attracted large numbers of nurses and physicians as members. However, there were opponents, primarily among the medical profession and hospital managers. Criticism was



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raised in the journal *The Hospital*, which had a new nursing section called *The Nursing Mirror*, and was the journal read by hospital managers. *The Nursing Record*, a journal 'written by nurses for nurses' (McGann 1992, p39) supported the BNA and the fight for registration. This journal attacked the critics and opponents to registration, especially Eva Luckes (matron of The London Hospital), who had written questioning the need for registration. (Dr and Mrs Fenwick both contributed articles to the journal and in 1893 they became editors.)

Mrs Fenwick was active both nationally and internationally between 1892 and 1912. She met Lavinia Dock, Assistant Director of Nursing at the John Hopkins Hospital in Baltimore, and found they were:

...Kindred spirits, sharing a dream of a nursing profession, well organised and independent (McGann 1992, p40).

With Mrs Fenwick's involvement, the International Council of Women (ICW), founded by Mrs May Wright Sewell in Chicago, held a congress in London in 1899 where:

...Distinguished nurses from America, Denmark, Holland and the Cape Colony attended (McGann 1992, p41).

This was the first time international nurses had been able to gather together. As a result of this meeting, the following year The International Council of Nurses (ICN) was established:

...To promote international co-operation between nurses of all countries and to provide them with opportunities to meet and discuss professional issues (McGann 1992, p42).

In 1902, the Society for the State Registration of Nurses was launched. Two Bills for nurse registration were drawn up and presented in 1906 and 1907 but they did not have government support and were unsuccessful. In 1908, a Bill was presented to the House of Lords by the Central Hospital Council for London (which represented the London general hospitals):

The Bill proposed the establishment of an official directory of nurses, to be maintained by an official registrar. No provision for the self-governing of nurses and no minimum standard of training was made. Mrs Fenwick called it "the Nurses' Enslavement Bill" and urged all nurses to protest against this piece of reactionary legislation (McGann 1992, p44).

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This Bill was also unsuccessful at the second reading, not because of the content, but because nurse registration still lacked government support.

Registration for nurses had already been adopted in New Zealand, South Africa in the Cape Colony and Natal, and in ten of the United States. Mrs Fenwick continued to pursue registration for nurses in the UK, achieving some support as well as strong opposition from the Central Hospital Council for London. In 1909 the Central Committee for the State Registration of Nurses was formed to try and get a new joint Bill (with representatives from the trained nurses' associations) presented to Parliament. Mrs Fenwick was one of the joint honorary secretaries. Between 1910 and 1913 the joint Bill was introduced to the House of Commons every year, but still lacked government support and so was not heard. With the outbreak of war (1914-1918) presentation of this kind of Bill was not allowed, and so the battle for registration was suspended.

The British Red Cross was given responsibility for organising nursing services and the government was duly criticised for not preparing for a serious shortage that could have been avoided if nursing had been given appropriate recognition and authority through registration.

In 1916 the College of Nursing was launched to promote a standard training for nurses. It gained support among matrons (but not Mrs Fenwick and the professional lobby) and in 1918 the College drew up a Bill for the registration of nurses. This Bill was condemned by Mrs Fenwick who called it:

...An 'employers' Bill, because it failed to give nurses the degree of self-government which she regarded as essential for professional independence (McGann 1992, p48).

Heated debate between the College of Nursing and the Central Committee for the State Registration of Nurses followed as they each haggled for position. Eventually The Nurses Registration Act was passed in 1919 and the General Nurses Council (GNC) was formed to maintain the register.

Mrs Fenwick was at first optimistic, having been promised a nursing majority of two-thirds on the council. However, when the council was complete, the supporters of the College of Nursing outnumbered Mrs Fenwick and her supporters. The old disputes were carried forward into the new council and it was just a matter of time before Mrs Fenwick became isolated and was removed from the council.

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She continued to write and reproach nurses for not maintaining their fight for professional independence. She criticised nurses for not paying attention to what was happening to them:

Had the majority of nurses taken an intelligent interest in their own affairs, acquainted themselves with the privileges granted to them by Parliament...acted for themselves, instead of allowing themselves to be manipulated by a company of lay men, there would have been a very different tale to tell.

(British Journal of Nursing, Editorial, Dec 1922; cited by McGann 1992, p50).

Mrs Fenwick continued to be a strong supporter of nurses with an ongoing interest in their professional development, even though in her opinion, 'Nurses constantly demonstrated their lack of foresight and political awareness' (McGann 1992, p56). McGann (1992) records that perhaps Mrs Fenwick's greatest achievement was:

...The creation of the International Council of Nurses. She developed the idea of a world-wide organisation of nurses from her experience of the meetings of the International Council of Women. At these meetings she absorbed the optimism of a new century and the belief that women could regenerate the world. These feelings matched her own inclinations and, with her abilities as an orator and as a journalist, she inspired a generation of nurses to realise their part in international peace and progress (p56).

## Key points

- Miss Manson (who became Mrs Fenwick) was committed to raising the standard of nurse training. She introduced a longer training period with both practical and theoretical instruction.
- She improved nurses' food, off-duty hours and holidays.
- She started a private nursing service and fought for nurses to be paid the fee rather than the hospitals.
- She had two main areas of concern. Firstly, the need for nurses and patients to be protected from people who called themselves nurses but who were in fact not trained. Secondly, as above, she identified the exploitation of nurses doing private work. Following her marriage she committed herself to the establishment of registration and the development of nursing as a profession.
- She founded the British Nurses Association and was influential in the founding of the International Council of Nurses. She thus established nursing both nationally and internationally.

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- She wanted nurses to have self-government and professional independence so that they could shape and determine their own future and not be continually at the mercy of physicians and hospital authorities. Mrs Fenwick was not well supported by the people she was trying to protect and over time became isolated. She reproached nurses for not taking an interest in their own affairs and for not fighting for professional independence. The battle for registration took 30 years and in the end the result was weak, and nurses have been at the mercy of stronger authorities ever since.

## Isla Stewart 1856-1910

Miss Stewart was born and raised in Scotland, daughter of soldier and journalist John Hope Johnstone Stewart. She started her nurse training at the Nightingale School for Nurses, St Thomas' Hospital, London in 1879 aged 23. Miss Stewart was strongly influenced by the emphasis the school put on discipline, the importance of practical nursing experience, and the moral values displayed, which she believed helped shape the character of the nurse.

After nine months as a probationer Miss Stewart was appointed a sister of Alexandra Ward, a women's surgical ward of 20 beds. Many years later, looking back, she remarked that she was ill equipped for the post with only nine months' experience, 'After I had been a Sister for a couple of years I realised how much I had learned as a Sister at the expense of my patients. I do not like to remember how much my inexperience must have cost them (McGann 1992, p59).

In 1885 Miss Stewart was invited by Sir Edmund Currie to become matron of the smallpox camp near Dartford, Kent, established in haste to cope with the smallpox epidemic of 1884-5. All were housed in tents, and with unusually wet weather when she arrived, Miss Stewart described the scene as chaotic. Despite the terrible conditions and the lack of trained nurses, nurses were not attracted to this site, Miss Stewart reorganised the nursing and achieved high standards, which were officially recorded. She said of her achievements,

...Sir Edmund's dictionary had not contained the word 'impossible' and he helped me to erase it from mine, for which I have every reason to thank him (McGann 1992, p60).

In 1887 Miss Stewart took over the post of matron at the prestigious St Bartholomew's Hospital. This job was described as 'the biggest

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appointment in the nursing world', which acclaimed the successes of the previous matron Miss Ethel Manson when she resigned to marry Dr Bedford Fenwick (ibid.).

Miss Stewart and Mrs Fenwick became friends and they worked together towards establishing registration for trained nurses and many other innovations. They shared a common interest in developing nursing nationally and internationally.

Miss Stewart was involved in the establishment of a military nursing service. She was a member of the Army Nursing Board, Queen Alexandra's Imperial Nursing Service, 1906-1910, and Principal Matron, Territorial Force Nursing Service, 1908-1910.

Miss Stewart was also a leading educationalist. It was her achievements over 23 years as Superintendent of St Bartholomew's Training School for which she was admired throughout the world. Miss Stewart developed nurse training to meet the increasing and changing demands of medicine, the hospital and the nursing profession. As her reputation and that of the hospital grew, Miss Stewart was in frequent demand to speak at conferences until her death in 1910.

The American Federation of Nurses made her an honorary member and the French government presented her with a special silver medal in recognition of her contribution to nurse training in France (McGann 1992, p78).

## Key points

- Miss Stewart was strongly influenced by her training school, which emphasised discipline, practical nursing and moral values to shape the character of the nurse.
- She managed a smallpox epidemic and was acknowledged for reorganising the nursing workforce and achieving high standards.
- With Mrs Fenwick, Miss Stewart influenced the development of nursing nationally and internationally.
- Miss Stewart was involved in the development of the military nursing service and became principle matron.
- Superintendent of St Bartholomew's Training School for 23 years, Miss Stewart was a leading educationalist who developed nurse education to meet the changing needs and demands of the profession. She was in frequent demand to speak at conferences until her death.

## Summary

These extraordinary people, with their amazing achievements, could be an inspiration to nurses today, but nurses rarely hear about them. Nurses do not ordinarily learn about the history of nursing and the people who have contributed, in many different ways, to the development of their profession.

Nursing remains predominantly female and suffers as a result. The contributions of women tend to be ignored by historians (Achterberg 1990, Miles 1988). When men went to war it was their achievements that were celebrated, not the roles of the wives and families who supported them and often travelled with them onto the battlefields.

Nurses play an essential part in providing care. Neither doctors nor hospitals could function without them. Given the opportunity, nurses have always been creative in their approach to practice. For example, nurses were the first people to identify a need for hospice care and to provide this service. Hospitals and communities need nurses. They are needed to care for the sick, and to advise so to keep people well.

## Poor Laws and Voluntary Hospitals

The Poor Laws are a collective term for Acts of Parliament that governed assistance to the poor in Britain. From the 16<sup>th</sup> century, parishes were responsible for providing for their poor and from 1572 they levied taxation for poor relief (Isaacs et al. 1987). However, it seems that farmers came to exploit the Poor Law as a means to pay very low wages to workers whose income would then be made up by the poor rate. This increased costs and put an unnecessary burden on taxpayers. The Poor Law Amendment Act 1834 was introduced to abolish this 'outdoor relief', which meant that labourers were no longer able to claim relief on top of their very low wages. The change solved the problem for taxpayers, but not for the labourers who needed more money. After this Act, if anyone wanted help they were forced to go to the workhouse (Dingwall et al. 1988).

The workhouses were institutions set up in 17<sup>th</sup> century Britain and elsewhere to provide employment and shelter for paupers. The changes in the Poor Law Amendment Act 1834 made it necessary for anyone seeking any kind of assistance to enter a workhouse. They became overcrowded and unhygienic and had such inhuman rules that they soon became dreaded places (Isaacs et al. 1987).

It was not intended that the sick and the elderly would be affected by this Act but in practice the workhouses gradually filled up with these people, as the able-bodied, including the carers, migrated to the cities in search of work. The economic upturn of 1844-6 was followed by a downturn, and payment of outdoor relief had to be reintroduced because the workhouses were now full (Dingwall et al. 1988). The Poor Law system was not abolished until 1947.

### Poor Law hospitals

In the early 19<sup>th</sup> century, if people became sick most would be cared for in their own homes. If they did not have homes and became destitute, they had no choice but to enter the dreaded workhouses. The Poor Law hospitals were the infirmaries of the workhouses. It is hard to judge the nature of the care that people received in the workhouse. It would seem that for some it was the elderly inmates (often sick themselves) who provided care for no wages, but others did make the system work and care of a reasonable standard was given (Dingwall et al. 1988).

Into the 20<sup>th</sup> century, these infirmaries grew and developed services with funding from central government. The Poor Law hospitals continued to house mainly the chronically sick and the elderly (Rivett 1998).

## Voluntary hospitals

The voluntary hospitals were originally monastic depending later on voluntary contributions and income from investments for finance. They were the most prestigious of the early hospitals. These hospitals had complete autonomy. Some of the voluntary hospitals were well-established, like the teaching hospitals in London, whereas others were more recent developments, established to commemorate towns or individuals (Rivett 1998).

There are few records to indicate the nature of patients and their illnesses but it is suggested by Dingwall et al. (1988) that patients in these hospitals during the early years were not particularly sick or poor. This is reflected in the nature of the funding mechanisms. Contributors would not want to be linked to hospitals perceived as killing people. They would also likely expect favours in return for their donations and, although the hospitals were 'charitable', most prospective patients would have to pay or be sponsored for their treatment.

With the development of medicine these hospitals expanded and were able to offer more services to greater numbers of people, but they remained selective, focusing on the acutely ill, which meant that the Poor Law hospitals continued to receive the elderly and people with infectious diseases and chronic illnesses (Ham 1999).

The voluntary hospitals were well run and maintained a strict discipline. As such they became the dominant model for the National Health Service in 1948. All services became centralised. Medicine was always fiercely independent and habitually opposed to government, but the centralisation of services into hospitals gave medicine the base from which the medical profession could further develop its authority and power. This central base also provided the right environment for scientific study and allowed for technological advances to take place. These same advances have now made it possible for people to be treated at distances away from hospitals and so there is currently a shift to try and decentralise services back into communities. Decentralisation is also a response to consumerism, improving patient involvement, and widening access and choice. These changes in thinking are reflected in the new Health and Social Care Act currently before Parliament, which could show in time a shifting of power bases away from the big general hospitals.

## Key points

- Two types of hospital systems developed. The different funding mechanisms meant that the Poor Law hospitals mainly cared for the elderly, the chronic sick and the poor. The voluntary hospitals' funding system meant they were able to concentrate on acute care, the development of surgical techniques and scientific study, which



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provided scientists and physicians with a growing power base. These hospitals were to become the models for centralised NHS services.

- More recently, technological advances have led to the possibility of decentralising services again. Consultations can be conducted from a distance and information is widely available, which means that more conditions can be treated locally. These changes, in combination with rising consumer expectation and choice, could mean that decentralisation of services occurs. Decentralisation could shift the balance of power away from the big general hospitals back into communities.

## Founding the National Health Service

It would be a mistake to think that the National Health Service (NHS) came about by a process of natural evolution. It actually took years of painstaking work by many people to achieve even small measures of success and the result reflected what was possible rather than what might have been desirable (Ham 1999).

As recently as 1920 when the Dawson Report was published, most of the population were found to live in conditions described as 'Dickensian squalor' (Webster 1998, p4). Some men may have had access to health care through their employment (after the National Insurance Act 1911), but their wives, families and elderly relatives had nothing. Working class women were identified as particularly disadvantaged. They were dependent, were unable to access what medical provision there was, had too little money even for food, and their troubles were compounded by repeated pregnancy.

The UK health services had fallen behind those of other western societies. The next 20 years saw little improvement. The existing services were fragmented, wasteful, inefficient and chaotic. There were two rival hospital services, the voluntary hospitals and the private sector hospitals, which operated in conflict and without co-ordination.

As Webster (1998, p6) reported that:

It took the second world war to shatter the inertia of the established regime. In anticipation of likely air raid casualties amounting to at least 300,000, with remarkable speed and efficiency an Emergency Medical Service was set in place. The Luftwaffe achieved in months what had defeated politicians and planners for at least two decades.

The threat of war and large numbers of casualties motivated people to work together at last.

Difficulties arose when plans were initiated to design the post-war health service. The old animosities resurfaced. The different groups were inflexible, each wanting to maintain their own positions of power. The most successful of these were the voluntary hospitals and the medical profession, which had gained ground but were ready to fight for more. Three years of fierce negotiation (1942-1945) achieved little.

The Labour landslide victory of 1945 presented a new opportunity. Labour had long been committed to providing a government-operated, comprehensive health service for its citizens. Aneurin Bevan was appointed Minister of Health with the huge responsibility for housing and health. Bevan was a young ex-coal miner from South Wales. As a backbencher he had acquired a reputation as a maverick. Many people doubted his abilities, especially in such an important role, but Bevan quickly dispelled their doubts and proved to be a gifted and talented politician. Against resistance he used pragmatism and common sense to forge ahead. Instead of revisiting old battlegrounds, Bevan proceeded into new territory by choosing nationalisation as an alternative route to success. He regained control over the policy-making process (which had previously been given away through repeated, unfruitful negotiations with the voluntary hospitals and the medical profession, who wanted that control for themselves) and translated policy into legislation within a year (Webster 1998).

Once the plan was revealed it took a further two years to work out the detail of how the health service would be administered and run. Each of the groups still battled to try and maintain as much authority as possible, but in the end there was a smooth transition and the National Health Service was introduced on 5<sup>th</sup> July 1948.

## Key points

- In 1920 most of the population were living in squalor. Some men had access to health care but their wives, children and the elderly did not. Working class women were identified as particularly disadvantaged.
- UK health services had fallen behind those of other western societies.
- The two rival hospital systems operated in conflict and without co-operation.
- One particularly talented and gifted politician, Aneurin Bevan, was able to take the idea through to fruition.
- The process was challenging and the resulting NHS service represented what was possible rather than what might have been desirable.

## An overview of nurse education

The history of nurse education has always been one of compromise; the aspirations of nurses to raise the status of their work, set against the need for large numbers of nurses to do the work. Mrs Fenwick argued (at the beginning of the 20<sup>th</sup> century) that nursing wanted to attract 'the pick of the basket, not the leavings' (cited by Abel-Smith 1960, p123). But each time standards were raised, improvements were undermined. The relentless demand for more nurses to do more work has continued.

### The Lancet Commission 1932

The Lancet Commission on Nursing was published in 1932. The work was commissioned (due to the initiative of one female member) in December 1930 to investigate the reasons why there was a shortage of nurses, trained and untrained, throughout the country, and to offer suggestions for making nursing 'more attractive to women suitable for this necessary work' (The Lancet Commission 1932, p7).

The language suggests that nursing was seen as an appropriate occupation for 'suitable women', although suitable was not clarified, and that nursing work was 'necessary'. The word necessary is defined in two separate dictionaries as 'indispensable', and 'absolutely needed to accomplish a desired result'. The doctors recognised that they needed nurses if they were to accomplish their goals.

Data were collected using questionnaires distributed to all the General Nursing Council approved training schools and a sample of hospitals not so approved. Subsequent questionnaires were completed by selected groups of trained nurses, probationers and two different age groups of girls. The commission only claimed to report the views of female nurses in England and Wales. It was decided that there was not adequate information to draw conclusions on the conditions for male nurses or for those nurses working in Scotland and Ireland.

By the middle of 1931, the impact of the great depression was beginning to be felt and people were attracted into work that offered food and accommodation. This change relieved some of the acute nursing shortages but the commission believed that if nursing numbers were to be maintained, and future shortages were to be avoided, the recommendations had to be made.

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The recommendations of 1932 included aspects such as allowing nurses to live off the hospital site. This is not really relevant today, but other aspects are more pertinent. The commission referred to nurses' pay and their lack of freedom. A modern interpretation could suggest that an appropriate salary is still important to attract and keep registered nurses. Freedom could refer to aspects within and outside the work environment. These freedoms could be things like the freedom for nurses to be creative when caring for and managing patients or it could mean being able to manage a family or maintain important social contacts as well as working. One-dimensional nurses will not stay happy or effective for long.

The commission also recommended that the workload between nurses and ward-maids be redistributed. This would then relieve nurses of tasks that did not relate to patients. Again it may be possible to draw comparisons with today's nurses – it may not be domestic work that they become engulfed in but paperwork. It may be appropriate for someone else to do this important work so nurses can be free to concentrate on caring for patients.

## The post-war years

In the years after World War II, nursing and teaching were seen as ways for young women to improve their lives. Nursing provided young women with a means to earn a living, move away from home and create a life for themselves. This development boosted nursing numbers for a time but there remained a shortfall. The expansion of higher education in the post war years had given women many new employment opportunities.

To encourage more recruits to take up nursing, it was proposed by The Wood Report (1948) that nurse training should be taken out of the control of the hospitals and put into the hands of powerful regional committees. It was believed that under the control of the hospitals, the need to staff the hospital wards would always serve to undermine the education of, and therefore the needs of, the nurses (Abel-Smith 1960, Clay 1987). The Wood Report also recommended that more married nurses, part-time staff, and male nurses and male orderlies (but not enrolled nurses) be employed (Clay 1987). The reasons for the exclusion of enrolled nurses in this recommendation are not clear.

The government gave serious attention to the recommendations and in 1949 the Nurses Act achieved some success, but the matrons retained their power and nurse training stayed in the hands of the hospitals. It was opposition from the Royal College of Nursing and the General Nursing Council that prevented these early reforms, not government intervention (Clay 1987).

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The recruitment of nursing staff remained problematic. In the years following the founding of the NHS, the recruitment of nurses was in competition with other occupations. Sufficient nursing numbers depended on a supply of young, unmarried students and a core of unmarried qualified staff. It was recognised that:

If the nurses were rushed, it was hard [for them] to give good care and to supervise the clinical training of students (Rivett 1998, p186).

Advances in treatment compounded the demand and the difficulties.

In 1961 the Royal College of Nursing commissioned a complete reappraisal of nurse education. The outcome of the review (The Platt Report 1964) recommended that nurses should be educated along two different pathways. The recommendations were that student nurses should meet an educational entry standard of five 'O' levels and have two years' academic study before gaining clinical experience. Student nurses should also take an examination at the end of their education. Enrolled nurses should have less academic focus; they would instead follow an apprenticeship type of training with more emphasis on clinical experience. These were standards recommended to try and improve the quality and uniformity of nurse education (Rivett 1998).

Over the same period, discussions were taking place to improve the working hours and conditions for nurses. The recommendations would also make it possible for married women to become nurses. Improvements in nurses' pay did not follow these discussions and it was only much later that this was achieved.

The Platt Report (1964) had similar objectives to those of The Wood Report (1948) some years earlier, but had even less impact. According to Clay (1987) this latest report was quickly killed off by people who prioritised staffing the wards and maintaining the status quo over nurse education.

The enlightened reformers Sir Robert Wood and Sir Harry Platt proposed:

Real educational change that would give both students and patients the deal to which they were entitled (Clay 1987, p73).

But they were perceived as the villains rather than the heroes of nurse education.

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Just six years later in 1970 the Briggs Committee was set up, against background of industrial unrest, to again address how best to educate nurses and midwives. The Briggs Report was published in 1972, and Professor Briggs was of the opinion that gradual change could no longer be tolerated. He recommended radical proposals for structural reform, with only small changes to education (which Clay (1987) said were still unrealised). However, the structural reforms led to the Nurses, Midwives and Health Visitors Act 1979, which created the UKCC statutory body, with responsibility:

To establish and improve standards of training and professional conduct for nurses, midwives and health visitors (Clay 1987, p73).

The creation of the UKCC was a sweeping change. Old structures gave way to new and presented the opportunity for educational reform. The development of Project 2000 followed in 1986.

White (1988) referred to the ongoing ambiguity surrounding the education of nurses. She identified that entry gates to nursing in the UK are constantly being modified. When entry requirements are raised, changes only last until the next nursing shortage, which leads to entry gates being lowered again to boost nursing numbers. It could be argued that quality is repeatedly sacrificed in favour of quantity. Paradoxically this is happening again now, at a time when nurses are expected to function at levels that require them to have higher education and more, to be effective. The juggling act with numbers may have led to some of the disparity found within the nursing profession. Some nurses are educated to PhD level while others do not recognise any need for higher education (Clay 1987).

Nurses remain a diverse group with different goals and aspirations. The professional bodies should perhaps be taking the lead to determine standards and clarity for nurses and patients so that the best interests of both can be protected. Other professions have successfully achieved this.

Over many years the education of nurses has remained a challenge. In 1987, Clay wrote:

A succession of reports over the past 50 years have either been misunderstood, ignored, or only partially implemented. Crystal clear, far sighted recommendations such as those in the Wood Report (1947) were watered down, not primarily by the government but by the profession itself – or sections of it –

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anxious to preserve the system, nervous of radical change and determined to move only as far as they were pushed (p70).

This view illustrates that the difficulties which doggedly pursue nursing lie as much within parts of the profession as they do with external factors. The general lack of consensus and consistency within nursing continues to be a major stumbling block for the development of appropriate education and many other issues.

Clay (1987) cites Dr Harry Judge, who was involved with the development of Project 2000, as saying when interviewed in 1985:

I do believe that when nurses say what they want in terms of the education they require they will get it, until they do, they won't (p70).

People may think that nursing is currently at a cross-road, but Clay (1987) reminds us that nursing seems to be ever at a cross-road unable to get beyond it, choosing instead to bear the burden and continue to live 'The subservient role under the patriarchal system rather than taking a new road that can lead beyond patriarchy' (p117).

The challenge for nurses in the 21<sup>st</sup> century must surely be for nurses to find one voice, to decide unanimously who they are, where they want to go, and the education they require to achieve their personal and professional goals and meet the health needs of the people.

## Key points

- In 1930 a commission was launched to investigate the reasons why there was a nursing shortage throughout the country.
- The recommendations made in 1932 included more freedom for nurses with improved pay and conditions.
- In 1948 the Wood Report recommended that nurse training should be taken out of the control of hospitals, fearing that the need to staff the wards would always dominate local decisions and undermine the development of nursing. The matrons, the Royal College of Nursing and the General Nursing Council, not the government, defeated this move.
- As other roles and professions have opened up to women, nursing numbers have continued to fall.
- Each time nurse education has been improved and entry gates raised, the need to staff the wards has undermined these improvements and entry gates have been modified.
- The creation of the UKCC in 1986 offered the potential for real reform with Project 2000.



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- Ambiguity persists and quality of nurse training is repeatedly sacrificed in favour of quantity (the production of nursing numbers).
- Nurses remain a diverse group with little parity, which further defeats efforts to raise the profile of nursing.

## The modernising agenda

The modernising agenda for the NHS arguably began in January 1988 when Mrs Thatcher announced that the NHS was to be reformed. The announcement was made against the backdrop of attempts to avoid financial crisis in the NHS. New words entered the vocabulary of the British people, such as hospital Trusts and GP fund-holding, internal markets, competing for contracts and the purchaser/provider divide. Health services became pseudo businesses. This was a good idea except for the fact that people are not commodities and they should not be treated as if they are.

However, White (1986) perceived the changes and the Griffiths reforms as an opportunity for nurses. Where general managers were in charge of budgets White believed there were opportunities for nurses. She encouraged nurses to concentrate on developing quality assurance tools and for nurses to become re-focused on their ideological claim to be there for their patients. White called for nurses to re-establish patients at the centre of care, instead of bowing to the agendas of the service. In 1992, *The Health of the Nation* (DOH 1992) was the first document to have a real health focus.

The newly elected labour government of 1997 produced *The New NHS: Modern, Dependable* (DOH 1997). It promised a modern and dependable health service, giving high quality treatment and care wherever it was needed: at home, in the community and in hospital. The internal market was scrapped and replaced by the concept of integrated care. Nurse-led services were endorsed and NHS Direct was created. There was talk of multi-agency health centres and of professionals working in partnership.

In this document there was recognition that:

Old centralised command and control systems...stifled innovation and put the needs of institutions ahead of the needs of patients (DOH 1997, p10).

*The New NHS: Modern, Dependable* (DOH 1997) was designed to drive change in the NHS, by recognising the need to develop quality and efficiency, and introduced standards. This approach was called 'The 'third way' of running the NHS – a system based on partnership...driven by performance' (p10).

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This document spells out the need for high quality treatment and care. The vision of this document relies on nurses to make it happen, to make it become a reality; it gives nurses permission, it practically begs them, to become involved.

In *Making a Difference* (DOH 1999), the forward was written by The Rt Hon Frank Dobson MP, the Secretary of State for Health in 1999. He said:

Wherever I go in our country most people have nothing but praise for nurses, midwives and health visitors. Their jobs are very demanding (DOH 1999, p2).

He promised to see that nurses, midwives and health visitors would be properly rewarded and looked after. This goal was to be achieved by improving recruitment, education and training, introducing family friendly policies, and the development of career pathways. It was as a result of these proposals that the roles of consultant nurse, consultant midwife and consultant health visitor, were created.

In *The NHS Plan* (DoH 2000), the government identified that the NHS was the public service most valued by British people. The government supported the fundamental principles of the NHS as being, 'A universal service for all based on clinical need not the ability to pay', and that the NHS would provide, 'A comprehensive range of services' (DoH 2000, p3). To achieve this, the government promised more money and the modernisation of the health service.

An organisation could be described as a place where individuals are systematically united to achieve some end. The hospital could fit into this description. But most importantly, organisations are made up of people with values and belief systems that have often been formed over many years. These values and systems give rise to the activities and functions of different groups within organisations and form a cultural web (Johnson & Scholes 1999). A cultural web is a powerful thing constructed of many taken-for-granted aspects relating to rituals and routines, stories and symbols, controls and rewards, and reinforced by the traditional holders of power. A document like *The NHS Plan* (DoH 2000) challenges many of these aspects. It calls for people to work differently, for different rituals and routines to be created and for new stories and symbols to replace the old ones. This document also challenges the traditional holders of power to surrender their hold and allow other people and other groups to thrive.

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For the objectives of *The NHS Plan* (DoH 2000) to be achieved, nurses and others within NHS organisations are required to work differently than in the past. This means that the culture must change but this will not be achieved without considerable negotiation as people try to hold on to their traditional power bases.

The new roles for nurses outlined in *The NHS Plan* (DoH 2000) are:

Chief Nursing Officer's 10 key roles for nurses:

- To order diagnostic investigations such as pathology tests and x-rays.
- To make and receive referrals direct, say, to a therapist or a pain consultant.
- To admit and discharge patients for specified conditions and within agreed protocols.
- To manage patient caseloads, say for diabetes and rheumatology.
- To run clinics, say, for ophthalmology or dermatology.
- To prescribe medicines and treatments.

(DOH 2000, p83)

The supporters of this document may say that it is at least a start. The critics may say that it does not go far enough. Statements like those in the document give nurses a legitimate claim to work differently, but presented in this hesitant way, unsupported by any real government monitoring, they fail to give nurses the necessary authority or power. Cultural change will not come easily or quickly.

*The NHS Plan* (DoH 2000) has been the driving force for the current reforms in the NHS, and the new Health and Social Care Act, currently before Parliament, is set to be the driver for even more radical changes.

*The NHS Plan – an action guide for nurses, midwives and health visitors* (DoH 2001) contains a message from the Chief Nursing Officer, Sarah Mullally. This document highlights the things patients want nurses, midwives and health visitors to be involved in. These are:

- Improving the quality of care;
- More staff more time – see Improving Working Lives Standard, nurses actively working to improve conditions for staff in their Trust [www.doh.gov.uk/iwl/](http://www.doh.gov.uk/iwl/);
- Strong nursing and midwifery leadership from all levels of staff;
- Working in new ways – innovative nursing practice;
- Clean and pleasant environment for patients and staff;

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- Involving patients – forming new relationships with patients, allowing patients to have more say in their treatment and more influence over the way the NHS works, shaping care around their needs and convenience;
- Prioritising cancer, coronary heart disease and mental health  
[www.doh.gov.uk/cancer/cancerplan.htm](http://www.doh.gov.uk/cancer/cancerplan.htm)  
[www.doh.gov.uk/nsf/coronary.htm](http://www.doh.gov.uk/nsf/coronary.htm)  
[www.doh.gov.uk/nsf/mentalhealth.htm](http://www.doh.gov.uk/nsf/mentalhealth.htm);
- Older people – developing services that promote independence. Inclusive partnerships with them and their carers, and anticipating their needs while in hospital – food, drink, hygiene, skin care, maintaining continence. Be aware that older people are often reluctant to ask for help. [www.doh.gov.uk/olderpeople](http://www.doh.gov.uk/olderpeople).

## Key points

- The modernising agenda was proposed to try and avoid a financial crisis within the NHS.
- Managing the money and budgets became the focus of attention.
- Business culture dominates.
- Bold attempts to challenge traditional roles and ways of working.
- Patient/user involvement.

## Agenda for change

Agenda for change refers to the new salary framework that came into effect from April 2004. It is a system of pay and conditions that aims to reward NHS staff fairly for the roles they perform while at work. It affects all NHS staff, nursing, allied health professionals and service support staff. Medical staff have made separate arrangements but they will also experience changes in pay and conditions.

Under this system pay is linked to responsibility, accountability, competency, ability, knowledge and skills. These elements are contained within the National Service Frameworks. More information and detail about the agenda for change can be found on the web at: [www.rcn.org.uk/agendaforchange](http://www.rcn.org.uk/agendaforchange)

The agenda for change is also about transforming centralised services that have been in place since the introduction of the NHS in 1948. Centralised services meant that, as technology developed, it could be incorporated into existing systems. However, technology has now moved on. It has become even more sophisticated and is not large and cumbersome anymore. In fact technological applications are increasingly small and portable. This means that services can now be decentralised, moved back again into communities, making it easier and more convenient for staff, and easier and more convenient for patients to access care.

The changes are designed to support the new Health and Social Care Act currently before Parliament.

## Health Service Development

The development of health services and health policy is not accidental or evolutionary. It comes about in part due to the efforts of dedicated and committed people, but these people are acting under conditions over which they have little or no control. Any resulting policies are therefore the end product of long negotiations and bargaining among many people with differing agendas.

The second half of the 18<sup>th</sup> century saw the beginning of the industrial revolution. People began moving from farms and villages into the towns for work. The factories with their power-driven machines were reshaping the economy and the way people lived. Where people had once lived in small open communities they were now forced to live in overcrowded and increasingly squalid conditions in the towns. These places provided the perfect conditions for the spread of infectious diseases such as cholera, which was spread through water contaminated by infected sewage. In cities across the land outbreaks of cholera erupted regularly, with devastating consequences and loss of life.

The public health movement led by Edwin Chadwick and his supporters identified the need for clean water and effective sewage disposal to tackle cholera in particular and other infectious diseases. The Public Health Act 1848 aimed to establish the construction of systems to provide clean water and effective sewage disposal. It appeared to be a straightforward plan to implement such a policy, but this was not the case. The Act was opposed by people who made money out of the insanitary conditions and by taxpayers who were anxious about the costs being passed on to them. It took considerable jostling before the Act was eventually passed and several more years and subsequent legislation before effective changes were made. The most significant of these was the Public Health Act of 1872, which called for the appointment of a medical officer of health to specifically tackle infectious diseases and to campaign for better health (Ham 1999).

Struggles like this, apparently straightforward but instead infused with difficulty, are commonplace in history. They serve to illustrate the negotiation and re-negotiation process of the positions of interested parties, each striving to keep their own area of authority and power, which are not unique to health care.

Government, groups or individuals may initiate the formation of policy. It necessitates the gathering of ideas and discourse with interested parties

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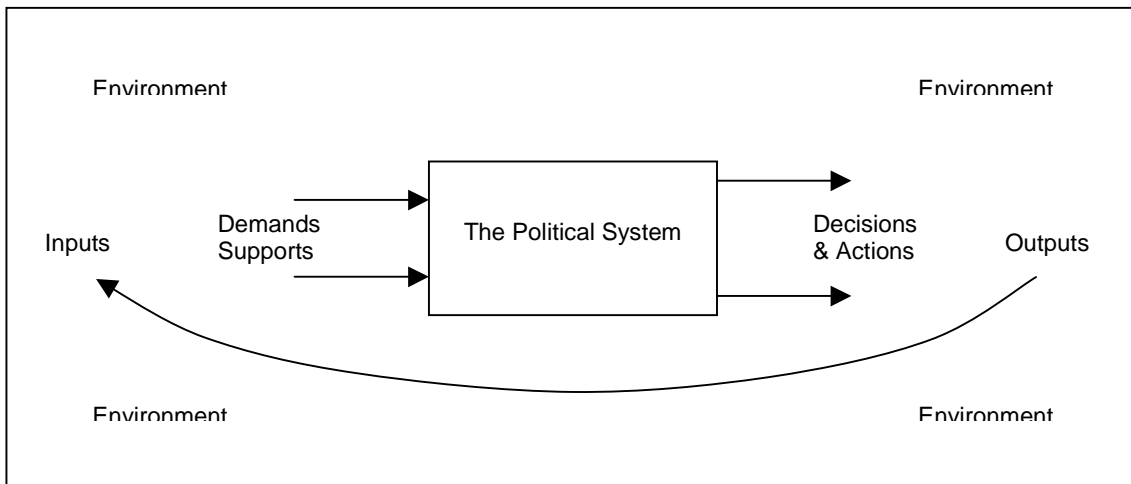
who may be apparent or who may show their interest and point of view in a variety of ways. The signing of petitions, the formation of pressure groups and strike action are all ways ordinary people can make their views heard by the elected government who will be wanting to extend their time in power. (No position is value free; everyone has their own personal and/or public slant on a proposal.) One person or a panel of people may be appointed to lead the process, which may take a considerable time or be brief depending on the issues and people involved. Because of the nature of the process, policies are usually a compromise position, negotiated and re-negotiated with interested parties and powerful groups.

Nurses are increasingly encouraged to become politically minded and be active in the debate rather than, as they have been criticised for, just accepting policies produced by others (Clifford 2000, Conn & Armer 1996, Des Jardin 2001, Northway 1996, Nottingham & O'Neill 1996). Nurses should be aware of and be involved in national and international issues, but they should also become involved in local issues. Nurses can develop a strong voice, using their positions to advantage on at least two fronts. Firstly, nurses hold a unique and highly regarded position with patients and families. They are the ones who know how they should be functioning to serve their patients best. Nurses have not been articulate in the past but they owe it to their patients and themselves to become so in the future. Secondly, nurses need to be involved in professional debates, or their roles and activities will continue to be determined (and perhaps undermined) by others.

Policy formation is a far from perfect system but it may be considered to be comparatively sound in the UK, providing everyone with the opportunity to contribute and be heard. Whether their views will be taken into account can be debated but opportunities exist. It can also be argued that some policies when implemented have unanticipated consequences. These consequences may be useful or they create more problems requiring further legislation.

Policies are a necessary part of the constitution. They are needed to provide proposals and plans of action, which then provide a forum for further debate. Following agreement, they can be implemented. Ham (1999, p100) cites Easton who gave this simple illustration of a political system:





**Figure 1. An illustration of the political system**

This illustration is useful even though it is recognised to be a very simple representation of a complex political system. For more detail see Ham 1999, Chapter 5.

## Analysis of key points and repeating themes

### Factors relating to nurses and nursing

Throughout the history of nursing, many similar themes keep recurring:

- Education for nurses is generally not valued as illustrated by the lack of support from employers (service needs versus nurse education).
- Educational standards are not consistent over time (entry gates and final qualifications vary – driven by service needs).
- Nurses lack real authority in workplaces.
- Falling numbers of nurses, nurses replaced by non-nurses, lack of quality and quantity of nurses (nursing shortage/falling standards?).
- Nurses are a diverse group. Different sub-groups have different aspirations and abilities. Parity is needed so that the title 'nurse' means the same to everyone (public and professionals/nurses and non-nurses). Mechanisms must be found to achieve parity. Lack of parity inhibits the development of nurses and nursing.
- Nurses are needed to work at high levels of skill in a range of workplaces. Hospital settings dominate the thinking of planners (and many professionals).
- The challenge of accurate assessment of learning.
- Nursing as a predominantly female occupation, issues of socialisation and gender;
- Ethical issues related to care.

All of these points continue to pose concerns. In the last hundred years, much has been achieved but many of the same fundamental issues remain unresolved. The current government has responded with sweeping proposals, but local hospitals and communities interpret the proposals within the existing frameworks.

### Worrying trends

As populations increased in the mid-19<sup>th</sup> century there were too few places to care for people who needed some kind of hospital care. Poor management of the demand led to falling standards. Today we are seeing similar patterns developing even though the causes and solutions may be different. Today's challenges include increased demand and also the increased usage of resources for a number of commendable reasons. Users include a range of survivors, people who in the past would have

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died as a result of their cancer, heart disease, diabetes or trauma. These people, and others who live longer than in the past, may develop chronic conditions which again boost the numbers of people needing treatment and care in hospitals and community settings.

Solutions include the introduction of a range of workers who are not registered nurses. Fewer people year on year are choosing nursing as a career. The increased demand on services, combined with fewer registered nurses to look after them, is a worrying and potentially dangerous trend for patients. This is because good patient outcomes are directly linked to the numbers of qualified nurses looking after them. Once you go beyond a certain point, balance becomes unsustainable, and standards and safety inevitably fall.

## The Project for WDGH NHS Trust

This study was commissioned by Mrs Elaine Maxwell, Director of Nursing, Dorset County Hospital, West Dorset General Hospital (WDGH) NHS Trust, Dorchester.

### Background to this study

#### Nursing shortage

Against the background of a worsening national and international shortage of nurses, the Board of WDGH NHS Trust requested this study to identify the work that registered nurses should be engaged in, the aspects of their role most valued by patients, and the health care teams that nurses work alongside. The Board wanted to identify these activities and functions so that they could support the necessary education and training requirements of nurses to help build a strong nursing workforce for the future, in ways most valued by patients and carers.

#### Who are the patients?

Over the last few years, the nature of hospital patients has changed. Patients are frequently older, more often seriously ill, and they are likely to have a complex range of disorders in addition to the condition for which they are currently being treated. This means that today's patients are often less stable and need significantly more care than patients in the past.

#### Implications for nurses and nursing

It is apparent that the daily challenges facing hospital nurses are far greater than the challenges of the past. Nurses tend to respond in two significant ways: they either stay on hospital wards as essentially generalists or they leave the wards to become specialists. Nurses who stayed on the wards have become divided again into those who continue to practice hands-on care and those who have become managers of the complex system. Both aspects are needed but there exists increasing tensions between the different demands currently being put on nurses.

When nurses are few in number they tend to be drawn into activities that many say they do not want to perform, in particular, administrative roles. Many nurses still claim that they want to be working with patients, to be giving them the time and care they need, but that administrative duties and other activities increasingly prevent them from performing this primary function of nursing.

#### Implications for patient care

Nurses, whether they are performing nursing functions or not, need to be in charge of, and responsible for, the overall care patients receive. If nurses are drawn into other activities, for whatever reason, and they are

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no longer able to perform this crucial role, then patient care will suffer. But nurses should not be expected to carry out this important function on their own. Mechanisms must be in place to support and enable nurses to fulfil it.

## Literature Review

### Literature related to this study

**Who are the nurses?** There is a tendency to think of nurses as a homogenous group, with shared values and goals. The reality is more challenging as registered nurses form a complex group both within the profession and outside in organisational structures. White (1988) identified three main groups of nurses:

- The managers – who want to control the nursing staff and budgets. The managers support the existing structures that maintain their positions in the hierarchy.
- The generalists – who are in their jobs mainly to earn a living. There is nothing wrong with this but again it is in their interests to support the existing systems and resist change.
- The professionally minded – this group may include specialists. These nurses look to higher education and specialist knowledge to develop practice. They tend to challenge existing structures and working practices, so come into conflict with the other two groups.

Nurses are individuals with some common ground, but with many different aspirations as well. They often have to function within well-established peer groups, which exert strong pressures to conform. Nurses are not a uniform group; they do not have a clear focus and so lack the strength they could have if consensus was possible.

**What do nurses do?** As described previously, nurses fall into three main groups: the managers, the generalists, and the professionals including some specialists. Arguably, all three groups should undertake nursing practice, but frequently it is the last two groups that have most contact with patients and the care they receive. Care has to be managed, standards of care maintained, the education and support of staff co-ordinated – these are all activities nurses should be involved in. Nurses also carry the responsibility for the care given to patients in their area. This is particularly true for sisters and charge nurses but the team of nurses supporting these people carry a share of the responsibility.

In recent years, nursing practice has become blurred with the practice of medicine. In some areas the use of technology and the tasking of procedures have begun to take priority and status away from nursing care. A shift in emphasis like this can make care a dehumanising activity for the nurse as well as the patient, instead of the therapeutic relationship it should be (Dean 1998).

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Nursing care remains hard to define although many people have tried (Webb 1992). One way to identify nursing care is to look from the position of the patient. Virginia Henderson's 1960s definition of nursing (cited by Clark 1998, p39) still stands firm today:

The unique function of the nurse is to assist the individual sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. This part of her function she initiates and controls, of this she is the master.

Nursing work is about meeting the needs of patients until they can do it for themselves. Nursing work may not be glamorous but it is always important (Lawler 1991). Here is one nurse's description of nursing activity (RCN 1992, p10):

I was a student nurse and I was being taught by the enrolled nurse how to pass a nasogastric tube on a patient. The lady we were working on was quite poorly. She had lung cancer and had had fluid drained from her pleural cavity twice that week. It was very painful and nauseating for her. She couldn't keep anything down, and she retched a lot. The nasogastric tube was to let us drain off some of the foul bile stained fluid that she brought up each time she was sick.

The enrolled nurse explained to her exactly what we were going to do, and how much better she would feel. He was quite clear about how unpleasant the tube could be when it was going over the back of her throat. He then explained it again to me, and she watched like a hawk, holding the tube he had given her in her hand. After all the preparation, he proceeded to put the tube up to her nose, and lifted her two hands and wrapped them around his. 'At any time when you want, you can stop this,' he said. So she did, three seconds later. The second time, he was just as patient. Eventually, with tears pouring down her face, she pushed at his hand to 'help' the tube going right down her throat. After she was all tidied up and settled, and some of the bile had been drained off, we all held hands for a second, and he made her laugh by inviting her to help with the intubation of any other patient who might need it. (Staff Nurse)

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The nursing task was to pass a nasogastric tube. What makes the task described special are the nursing ingredients of knowledge, understanding, sincerity, patience and humour. Such elements could be called the art of nursing.

Nursing care in the 21<sup>st</sup> century should still be about achieving these same fundamental ends. In 1995, Sibbald published 'A scenario from the future' (cited by Clark 1998, p41), which brings a possible future nursing reality to life:

The computer hums gently to life as community health specialist Rachel Muhammat logs into NurseNet. She asks a research partner, a cyberware specialist in London, England, for the results from a trial on neurological side effects of ocular biochips. Rachel, as part of a 61-member research team in 23 countries, is studying six clients with the chips. Then it's down to local business. Rachel e-mails information on air contaminant syndrome to a client down the street whose son is susceptible to the condition, and tells her about a support group in Philadelphia. She contacts a Quigong specialist to see if he can teach the boy breathing exercises, and schedules an appointment with an environmental nurse specialist. Moments before her 9.45 appointment, Rachel gets into her El-van and programmes it to an address 2km away. Her patient, Mr Chan lost both legs in a subway accident and needs to be prepared for a bionic double leg transplant. Together they assess his needs and put together a team of health workers. The surgeon, physiotherapist, acupuncturist and home care helpers are contacted. Rachel talks to Mr Chan about the transplant and they hook up to his virtual reality computer to see and talk to another client who has undergone the same procedure. Before leaving, Mr Chan grasps her hand and thanks her for helping him. Rachel hugs him and urges him to e-mail her if he has any more questions.

What do nurses not do?

Many nurses want to give patients 'individualised holistic care' (Tonuma & Winbolt 2000, p214), as championed by nurses for patients in the 1970s and 1980s (Pembrey 1980). But nurses find their daily reality to be very different. Hospital ward work in particular seems to have been reduced to a series of rituals and routines provided by a range of different people, from technicians to various assistants, which makes care unsatisfactory for both patients and nurses. Relationships between the different groups can become stretched to the point of hostility (Marsden 1995, Snell 2000), which benefits no-one.



In ward situations, nurses seem to have been manoeuvred into isolated positions where they carry all the responsibility but have little or no authority. A multitude of administrative and other tasks, while undeniably important, seem to have taken nurses away from their fundamental role of providing care.

## What are the barriers?

The medically dominated culture found within hospitals can be reductionist, turning people into conditions or disorders, rather than treating patients as human beings with a health problem. The managerial focus concentrates efforts on cost reduction and minimalist approaches. These different tensions serve to undermine the activities of nurses.

Nurses claim to be people-centred, but many nursing roles have become blurred, their expertise eroded and their skills undermined. Nurses have become marginalised, which reduces their authority and power.

Redfern (1996) reminds us that authority and power are similar but not the same. In hospitals many people are given authority (the 'right' and responsibility) to make decisions, but they are not also given the power. Other people can then overrule their decisions and nothing is achieved. If this happens repeatedly it can seriously undermine enthusiasm and effectiveness. Power may also be given through job titles but real power is associated with knowledge and influence. Nurses need to build their power bases by developing knowledge and influence in the organisation. However, many nurses remain uncomfortable with notions of power (Keighley 1996). Nurses seem to believe that power will undermine their fundamental values and beliefs, when really the opposite may be true.

Many specialist nurses, nurse practitioners and others, recognise that without power they remain in subservient, unsatisfactory positions that make nonsense of their expertise. Marsden (1995, p949) reports that,

From a job satisfaction point of view, experienced nurses, particularly in specialised areas, spend a good deal of time teaching new medical staff and it seems paradoxical that they can instruct and supervise doctors undertaking care and treatments that they are unable [not allowed] to carry out themselves.

This scenario may have changed in some areas, but many nurses are familiar with experiences like the one described.

So where do feelings of powerlessness really come from? Benner (1984) registered alarm when she heard that nurses believed their caring

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qualities were the source of their powerlessness. She retaliated by insisting that feminine qualities were just as important as those usually associated with male sources of power: competitiveness, domination and control. Benner (1984, p207) pointed out,

The disparagement of feminine perspectives on power is based upon the misguided assumption that feminine values have kept women and nursing subservient, rather than recognising that society's devaluing of and discrimination against women are the sources of the problem. The former view – the misguided assumption – blames the victim and promises that discrimination will stop when women abandon what they value and learn to play the power games like men do.

It is sad to note that some nurses do adopt masculine approaches to gain power, but Benner (1984) offers a glimpse of an alternative view. From the results of her study Benner reported that nurses developed their power by empowering patients, helping patients take control of their own situations. Through their caring, nurses were able to develop respectful relationships with patients, which released them both from the tyranny of the organisation.

Nurses remain reluctant to stand up for what they claim they believe in. Crouch (2003, p22) says that,

As a result people don't take nurses seriously when they make constructive suggestions about patient care. Too often we are tokenistic, and other people begin to expect us to be tokenistic.

Crouch encourages nurses to take opportunities and become involved:

Nurses have great opportunities in the present climate to lift their eyes up from the here and now and look at the bigger picture – we need to get out and make an impact. (2003, p24).

For nurses to have a strategic influence, they have to put themselves into positions where they will be heard, for example as part of the management team, and then they must commit to the challenge.

Too often, Trust chief executives and chairs still look to nurses for quick fixes to fill the gaps left by junior doctors or GPs, but that's hardly going to inspire nurses to feel valued and part of the team, they need to be part of system changes (Crouch 2003, p25).

What makes a good nurse?

Roberts (2000, p71) explains that,

Powerless groups have difficulty taking control of their own destiny because internalised beliefs about their own inferiority lead to a cycle of self-hatred and inability to unite to challenge the inequality of power. Empowerment of these groups involves the development of a more positive self-image through understanding of the cycle.

Roberts (2000) encourages nurses to understand the real sources of their oppression (society's devaluing of and discrimination against women) and for them to develop positive identities instead.

What do sisters and charge nurses do?

Most nurses are promoted into the role of sister or charge nurse with little or no training. This role requires good clinical and management skills, but good people skills and leadership qualities are also needed. Girvin (1996, p20) cites Hempstead who claimed that,

Nurses are prisoners of their own past, steeped in tradition, comfortable in hierarchical structures and management in a conventional, controlled environment.

Nurses were socialised not to take risks but to maintain the status quo. A nurse's authority, when needed, came from association with medical colleagues, rather than his or her own standing.

Girvin (1996) stresses how important it is for nurses to learn the skills to become effective leaders so that they can influence and refocus care on the welfare of patients, rather than, as currently happens, on management agendas.

The role of the sister and charge nurse is essentially to be 'in charge'. This person must supervise and know what is going on and what is happening to whom. They are responsible for every person, patients and staff, for all the care given while they are on duty and for giving a complete and detailed hand-over to the next person in charge (Armstrong 1981, Pembrey 1980).

The sister or charge nurse must also provide support for everyone while on duty. Nurses need support to do their work properly, as do other care staff including the medical team. A good sister or charge nurse will also be the one person the consultant can turn to in times of crisis. When consultants feel vulnerable, they have few people they can confidently confide in (Armstrong 1981). This is an important role for the sister once confidentiality is established.

What makes a good nurse?

A good working relationship with the medical team is essential for good patient outcomes. Nurses need to develop their own authority, as this example from the Royal College of Nursing (1992, p46) shows:

When you develop a good working relationship with your medical colleagues, you know you can rely on them in a crisis, and they know you won't bother them with trivial details when they are busy. Having said that, there are some people at some times who constantly do not respond. There was a big X-ray meeting on Mondays where the juniors presented cases and you just did not disturb that meeting. On one occasion when I bleeped the houseman out of there, he came so fast that he was out of breath. He knew that he was needed badly, and he was right. (Ward Sister)

However, to become a good ward sister or charge nurse, he or she needs a good team of people they can rely on. The ward sister or charge nurse should also be 'part' of a team, giving support to those below (receiving authority from them), while also receiving support and authority from above (from senior nurses, assistant matrons and matrons). Authority refers to the right to make binding decisions (Obholzer cited by Redfern, 1996). Without real authority and the corresponding power, sisters and charge nurses cannot be effective. They cannot be expected to function effectively if they are left in isolation.

The health outcome of insufficient numbers of registered nurses working with patients

Nurses say they want to give patient care but are prevented from doing so by other, predominantly administrative responsibilities. However, there is much evidence to support the need for registered nurses to be the ones giving patient care. Registered nurses have more knowledge than less educated colleagues and as a result they are more able to analyse issues, think critically, evaluate situations and solve problems as they arise (Swindells & Willmott 2003). This means that patients receive more responsive, high quality care, with lower mortality rates, as demonstrated by the magnet hospitals in the United States (Aiken 1998, Eckardt 1998). These hospitals were called magnet hospitals because of the way they were able to attract and keep nursing staff (Buchan 1997). When nurses were allowed to work in rewarding ways, ways that satisfied them and allowed them to give the best possible care to patients, nurses became committed to the hospitals and stayed. One of the key features of the success of the magnet hospitals was the ability to recruit and maintain adequate nursing staff levels and therefore build a mature workforce. The higher levels of nurses in the workforce were directly linked to lower mortality rates (Aiken 1998).

## Cost implications of having more registered nurses in hospitals

The cost implications of employing more (or fewer) registered nurses could sometimes be considered a matter of 'weighting'. Nursing costs measured only from the front of the equation will make their replacement by other, cheaper workers appear cost effective. However, taking into account costs acquired further down the line in the patient journey from infections, complications, re-admission, even death, these equations look less convincing.

In the UK, Pembrey (1984 cited by Clay 1987), the Royal Marsden Hospital in London (Clay 1987), and the Magnet hospitals in the United States, support the belief that, for the best patient outcomes, qualified nurses should be looking after patients. They support this position using cost-effectiveness as evidence. They report that having more registered nurses reduces costs in the longer term by reducing the numbers and types of complications (even death) experienced by patients.

This real example taken from the Royal College of Nursing (1992, p47) illustrates the kind of difficulties that can occur if there are not enough registered nurses on duty:

As a senior night sister I was called to the receiving room of casualty. The staff nurse and casualty officer were with a patient in the resuscitation room, leaving a nursing auxiliary in main casualty. She was experienced in the department and trying to sort out an order of priority for a group of youths who had come in together from a knife fight. One was bleeding profusely from facial lacerations, other had various lacerations to hand and arms. One was fairly quiet and only had a nick in the skin in the area of his stomach. As he was quiet and with little apparent bleeding she had placed him last in line. Although experienced, she did not have the depth of knowledge to know that the very quietness of the man was ominous and that the nick was the entry point of a stiletto stab wound that needed rapid surgical exploration. Within the hour the young man had been to the theatre and had his spleen removed. Any delay could have resulted in his bleeding to death quietly and cleanly, possibly unnoticed in the fracas that was going on. (Night Sister)

This example is not unique; many nurses are able to relate similar stories. It serves to illustrate the importance of having enough suitably qualified staff to safely cope with the patients they are responsible for. If there are too few nurses, even when they are appropriately trained and experienced, they may not be able to provide the care needed if they are stretched too thinly, and patients may die. As Aiken (1998) reported,

higher levels of nurses in the workforce are directly linked to lower mortality rates. Employing more registered nurses provides the opportunity to build a reliable and committed workforce, which is then able to provide high quality care. The long-term effect of this is to reduce costs and build the reputation of the organisation.

In *The Future Health Worker* (2003, pi), Kendall & Lissauer acknowledge that under investment in the NHS, compared with other European countries, means that 'too many health workers have to struggle to provide care in difficult and challenging circumstances'. They predict that although these pressures are likely to increase in the future, health workers need to keep care patient-centred. Patient-centred care is defined below:

#### **Patient-centred care for hospital inpatients**

- Respect for patients' values, preferences, and expressed needs (including impact of illness and treatment on quality of life, involvement in decision-making, dignity and autonomy)
- Co-ordination and integration of care (including clinical care, ancillary and support services and 'front-line' care);
- Information, communication, and education (including clinical status, progress and prognosis, processes of care, facilitation of autonomy, self-care and health promotion);
- Physical comfort (including pain management, help with activities of daily living, surroundings and hospital environment);
- Emotional support and alleviation of fear and anxiety (including clinical status, treatment and prognosis, impact of illness on self and family and financial impact of illness);
- Involvement of family and friends (including social and emotional support, involvement in decision-making, support for care-giving, impact on family dynamics and functioning);
- Transition and continuity (including information about medication and danger signals to look out for after leaving hospital, co-ordination and discharge planning, clinical, social, physical and financial support).

(Gerteis et al. 1993 cited by Kendall & Lissauer 2003, p11)

Kendall & Lissauer (2003) refer to the work of the US Institute of Medicine's Quality of Health Care in America project which identified the need for a patient-centred approach to care achieve improvements and meet the needs of patients in the future. These findings are equally valuable to British health care and the NHS as they are to the American health care system. The elements the project identified as important are illustrated here:

### **Establishing aims for the 21<sup>st</sup> century health care system**

- *Safe* – avoiding injuries to patients from the care that is intended to help them;
- *Effective* – providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit (avoiding under-use and overuse respectively);
- *Patient-centred* – providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions;
- *Timely* – reducing waits and sometimes harmful delays for both those who receive and those who give care;
- *Efficient* – avoiding waste, including waste of equipment, supplies, ideas and energy;
- *Equitable* – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socio-economic status.

(Institute of Medicine 2001, cited by Kendall & Lissauer 2003, p12)

Health care workers need to understand the importance of remaining patient-focused to work in patient-centred ways. All of the elements described above are fundamental and there is nothing revolutionary about any of the recommendations. They are all features that health workers would hope to find for themselves and their families if they should ever need to access the NHS, but pressures and challenges of recent years have led to a loss of focus. Now is the time for health workers to re-identify and value these fundamentals of care for the 21<sup>st</sup> century.

### **Do nurses need educating?**

There is a common perception that nursing is easy and anyone can do it – it is even supposed to be a 'natural' activity for some. The facts do not support this view. Swindells & Willmott (2003) conducted a study that compared the abilities of graduate nurses with those of diploma educated nurses. They found that in the areas of cognitive ability, reflective practice and professional practice the graduates all performed better than the diplomates.

Nurses are the acknowledged detectors of complications – doctors rely on nurses to do this for them. They have the knowledge and ability to put together early indications of deterioration in a patient's condition and take appropriate action. Aiken et al. (2003, p1617) found that:

In hospitals with higher proportions of nurses educated at the baccalaureate level or higher, surgical patients experienced lower mortality and failure-to-rescue rates.

What makes a good nurse?

Nursing is a highly complex activity, which remains under-rated. As a result, nursing is commonly regarded as a marginal occupation, with the education of nurses perceived as low priority. Exceptions to this perception include nurses who, although they are highly educated, remain aware of how much there is still to know, as illustrated by this example from the Royal College of Nursing (1992, p48):

As students, we worked alone on night duty with only our common sense and a small amount of knowledge to help. Patients survived sometimes in spite of, not because of us. Then we became trained and built up experience. I found myself thinking, after I had acquired the diploma in nursing why did they not tell me that before? We study and realise that some of our experiences lack validity. We examined the mistakes we made through lack of knowledge and the inadequacies of our training. We have become more supportive to our patients and our juniors as we gain insight and confidence. This professional development takes time and it takes a professional commitment. Reason, knowledge and understanding give commitment. If nursing is simple, why do I have two degrees and five nursing qualifications and still feel that I am scratching the surface?  
(Nurse Manager)

Benner (1984) supported higher education for nurses. She recognised the complexity of nursing practice and that time alone (experience) is not enough. Time must also be combined with knowledge and reflection for nurses to develop their expertise and give patients the care they deserve.



## Themes emerging from the literature

Who are the nurses and what do they do?

### Who are the nurses?

The people called nurses should be *registered nurses*, who make up a fairly uniform group of people, who hold similar values and practice to similar standards of competency. This is not the reality. Registered nurses are not a homogenous group. The reality is that registered nurses form a diverse group of people with very different values and abilities. The repeated adjustment of entry requirements and the trend for care workers to call themselves nurses aggravates this problem.

Nurses need to develop strategies to regulate standards of education and practice so that they can develop into a more unified group able to give 21<sup>st</sup> century standards of care.

### What do nurses do?

Registered nurses may perform a range of activities. They may be:

- Managing large, busy communal areas or hospital wards;
- Giving direct care in specialist areas or areas with a specific focus;
- Giving individual, one-to-one care in the home or private setting for individuals and/or families.

Barriers to care giving

Nurses report many barriers that prevent them from giving quality care to patients. The barriers include:

- Reduced numbers of registered nurses to care for patients;
- Increased nursing and non-nursing work loads, fed by the expectation that nurses can and should spread themselves to do everything: administrative duties, deal with human resource issues, advanced/extended practice providing treatment and care traditionally given by doctors;
- Lack of authority and nurses' concerns and difficulties not listened to or not addressed;
- In hospitals, the dominant managerial culture seems to prefer monetary unit cost as the determinant, rather than quality outcomes – a short-term focus.

Leadership in hospitals

Leadership in hospitals, particularly on the ward, seems largely missing:

- Role models lost during the 1980s' reforms need to be reinvented;
- Strong leaders as sisters and charge nurses are needed to actively supervise and manage complex work areas;
- There is a need for sisters and charge nurses, people with real authority, skilled and able to do the job; experts in the field, expert at managing people and using conflict resolution skills;

## What makes a good nurse?

- Leaders need to demonstrate and inspire professional identity and high standards of care;
- Structures and people in the hierarchy need to support leaders and leadership development.

### Quality registered nurses giving quality care

Quality and 21<sup>st</sup> century standards cannot be achieved without investment in people, education and practice. Investment is needed to:

- Keep experienced nurses in ward areas;
- Keep the experienced nurses who can then develop the learners in the field;
- Produce 'quality' staff rather than just increasing 'numbers' if patient outcome disasters are to be avoided. (Not a short-term measure but investment works out cheaper, with better results in the long-term.)

### Patient/carer involvement

The 21<sup>st</sup> century brings with it a new public culture. People increasingly know what they want from the health service and will use political and other pressures to achieve their objectives. The NHS must cultivate involvement and develop strategies to improve standards and give the public what they want.

### Education for nurses

Education is linked to improved nursing practice and patient outcome. Advanced education for nurses produces even better results. Small investments in education reap large rewards for patients. Closer links and improved relationships between service areas and educational establishments could lead to more creative environments and greater scope for teaching and learning.

## Methodology

### The study objective

- To identify the activities and functions that registered nurses employed by West Dorset NHS Trust should be involved in.

The informants were the staff of West Dorset NHS Trust and local people served by Dorset County Hospital. The study was approved by the local ethical authority and guided by the steering group.

### Study design

#### Recruitment of staff

Staff were invited to take part in the project by responding to 'information packs' distributed across the Trust with salary slips (total number: 2,850). The information packs contained background information and a description of the project, a contact questionnaire and a pre-paid address sticker. An information article was also published in the staff newspaper *Headlines* at the same time. Staff were asked to respond using either approach and thus volunteer to be contacted by the researcher at Bournemouth University. This contact between the staff member and the researcher formed the initial consent to take part in the project. A formal consent was obtained later. Everyone who responded remained a volunteer and was able to withdraw from the project at any time if they wished.

The researcher used the contact details to reach the volunteer and place them into a focus group. The original intention was that people could be placed into groups where every member had one purpose and a common identity through self-selection. In the event, through people's limited availability, this was not possible and so mixed groups were formed. However, care was taken to arrange groups where people felt themselves to be with peers, and were not therefore overwhelmed by other perhaps more senior members within the Trust. It was an important consideration that everyone should feel comfortable and thus able to contribute fully to the discussion.

There were 18 groups available for self-selection, and 17 of these were used. The groups chosen by the volunteers are listed below with the number of people who self-selected into each indicated in parentheses:

- Administration/secretarial (10)
- Allied health professional (12)
- Consultants (3)

## What makes a good nurse?

- Directorate (1)
- Doctor (4)
- Executive (1)
- Experienced nurse (43)
- Leadership role (4)
- Manager (9)
- Mental health professional (3)
- Newly qualified nurse (7)
- Non-executive (2)
- Nursing support staff (10)
- Other (details given) (2)
- Pharmacy (2)
- Service support staff (6)
- Speciality (12)

### **Volunteers**

There were 131 volunteers forming 4.6% of the staff at West Dorset NHS Trust. From these, 59 staff (45%) were able to take part in focus groups. To maintain anonymity, people are referred to as either nurses or non-nurses. The project was designed to consider the activities and functions of registered nurses and so any reference to nurses includes all registered nurses, newly qualified staff and more experienced nurses who may also be managers, specialists and midwives. References to non-nurses include health care support workers (although they have nursing roles, they cannot be called nurses for the purpose of this study), non-nurse managers, administrators, ward clerks, allied health professionals, physiotherapists, therapists, pharmacists, radiographers, service support staff, consultants, doctors, executives and non-executives.

### **Focus groups**

Focus groups were used to try and give staff at West Dorset NHS Trust the greatest opportunity to take part. Specific dates were selected in conjunction with the availability of rooms in the Thomas Sydenham Education Centre. The aim was to hold up to three focus groups on each of those days: one in the morning, one in the afternoon and one in the evening, to give participants a choice. A total of ten focus groups were held: five in the morning, four in the afternoon and one in the evening. All were well attended. Staff were enthusiastic and contributed thoughtfully to the discussions.

### **Limitations to focus group attendance**

Many more people wanted to take part in the focus groups but there were difficulties with availability. Some people found it hard to get away from

ward and clinic situations, others worked different shift patterns, and some had commitments to patients and families that prevented them from taking part. There were also unexpected emergencies and problems that prevented people from attending.

## Recruitment of the public

An advertisement (see Appendix 1), aimed at attracting and recruiting local people to the project, was placed in two newspapers available across Dorset and Wiltshire: *The Blackmore Vale* and *The [Dorchester] Echo*. Distribution included the towns of Dorchester, Weymouth, Bridport, Sherborne and many villages. Five people responded to these advertisements with four indicating that they wanted to take part in the project.

The disappointingly small number of people responding to the advertisement was taken as an issue to the steering group. The members of the steering group made sound suggestions (lessons learned for the future) but in the event it was decided to follow up the four volunteers. One person could not be reached but three people were contacted and took part in individual tape-recorded interviews.

Many of the staff participating in the focus groups had either been patients themselves or had close family members as patients in hospital in the recent past. As a result, staff could give their views as both staff working for the organisation, and as members of the public.

All contributions were valued and much appreciated by those involved in the production of this project.

## Managing the data

Data were collected by tape-recording the focus groups (staff contribution) and by tape-recording the individual interviews (public contribution). The tapes were then transcribed and analysed. The volume of data collected was organised into tables, providing clear and easy access to the emerging themes and issues raised.

## Findings

The findings have been presented in tables to show easily and clearly the issues raised and the emerging themes. Some of the points made were aspirations rather than facts. None of the findings was intended to be in any way critical. Participants were simply highlighting issues they identified as important.

Different people conducted the focus groups, so some variations occurred. Some of the questions were not given to every group. A lot of interesting and useful information was collected. To clarify what nurses should be doing, see Table 1.

**Table 1: What are the important activities and functions registered nurses should be involved in?**

| Themes  | Main points   |
|---|---|
| Patient care (1)                                | <ul style="list-style-type: none"> <li>- Giving hands-on holistic patient care</li> <li>- Assessing needs/making relevant referrals</li> <li>- Care-planning</li> <li>- Spending time with patients/listening</li> <li>- Identifying anxieties/problem solving on patient's behalf</li> <li>- Giving medication/infusions/dressings</li> <li>- Taking ECGs/bloods (screening)/cannulation (out-of-hours)</li> <li>- Admissions/history taking (out-of-hours)</li> <li>- 24 hour carers/one constant</li> <li>- Patient as a person not a diagnosis</li> <li>- Nursing focus</li> <li>- Using special nursing skills/multiple layers of skills</li> <li>- Supporting medical team; providing extra detail about patient; reporting subtle changes</li> <li>- Stabilising influence (in roller-coaster of treatment, the one there for them, to help them through)</li> </ul> |
| Co-ordinating care (2)                          | <ul style="list-style-type: none"> <li>- Conduit of care/pulling all the different specialists and treatments together at the appropriate times/central person</li> <li>- Forward planning</li> <li>- Discharges (planning)</li> </ul>  |
| Creating and maintaining a safe environment (3) | <ul style="list-style-type: none"> <li>- Clean and dry environment, patients able to eat appropriate food</li> <li>- Safety measures (security, cot sides, special mattresses, isolation, barrier nursing)/comfort</li> <li>- Appropriate equipment used/well maintained/properly trained staff (competent and compassionate)</li> </ul>  |

What makes a good nurse?

|   |  |
|---|--|
|   | <ul style="list-style-type: none"> <li>- Staff appropriately qualified and trained</li> <li>- Infection control (high standards)</li> <li>- Oversee whole ward/maintain high standards</li> </ul>  |
| Education (4)   | <ul style="list-style-type: none"> <li>- Working alongside nursing colleagues</li> <li>- Providing more formal teaching</li> <li>- Mentor and preceptor for nurse learners</li> <li>- Educating other groups</li> </ul>  |
| Advocacy role (5)   | <ul style="list-style-type: none"> <li>- Providing support in challenging circumstances (for staff, patients and relatives)</li> <li>- Explaining treatment and choices</li> <li>- Making sure patient voice heard</li> <li>- Defending patient choice</li> </ul>          |
| Role model (6)  | <ul style="list-style-type: none"> <li>- Practice in ways that inspire and give confidence (staff, patients, relatives), staff wanting to copy standards of behaviour, trustworthy</li> </ul>  |
| Legal documents/report writing/paperwork (7)                | <ul style="list-style-type: none"> <li>- To see that all appropriate forms/referrals/letters/records are completed to the right standard</li> <li>- Audit information</li> <li>- Admissions/discharges/care plans/diets/phone</li> </ul>                                   |
| Relatives (8)   | <ul style="list-style-type: none"> <li>- Keeping relatives informed</li> <li>- Providing information</li> <li>- Giving support</li> </ul>  |
| Working in a variety of different patient care settings (9) | <ul style="list-style-type: none"> <li>- Nurse-led centres – decision-making, autonomous practice</li> <li>- Specialist roles – decision-making, autonomous practice</li> <li>- With GPs, in schools etc.</li> </ul>   |
| Leadership (10)   | <ul style="list-style-type: none"> <li>- Person in charge of patients and their care should be a registered nurse</li> <li>- Nurses should be making decisions about treatment and care</li> <li>- Nurses should be involved in professional issues, leadership</li> </ul> |

Themes 1 and 2 refer to the direct care that registered nurses should be involved in. Themes 3, 5, 6, 7, 8, 9 and 10 refer to issues of responsibility and accountability. Theme 4 refers to registered nurses' responsibility to support colleagues and provide education. Table 2 tries to identify what areas of practice nurses have given up.

**Table 2: Are there important things nurses should be doing that they are not doing at the moment?**

| Themes  | Main points   |
|---|---|
| Not giving patient care (11)                                | <ul style="list-style-type: none"> <li>- Delivering the system instead of delivering patient care</li> <li>- Other work perceived as more important, takes priority</li> <li>- Not using nursing skills in patient care (touching, rolling without pain, doing the private things)</li> <li>- Task focus not patient focus</li> </ul> |
| Not spending time with patients (11)                        | <ul style="list-style-type: none"> <li>- Not a priority</li> <li>- Not letting patients talk</li> <li>- Not able to listen or explain things</li> <li>- Can't anticipate needs</li> </ul>   |
| Not teaching, supervising/ supporting nurse colleagues (12) | <ul style="list-style-type: none"> <li>- Not teaching, supervising nurses (HCSW) learning new skills</li> <li>- Not supporting/de-briefing following traumatic events</li> <li>- Not role modelling</li> </ul>  |
| Not making decisions (11)                                   | <ul style="list-style-type: none"> <li>- Only able to take some decisions in some areas</li> </ul>  |
| Not practising autonomously                                 | <ul style="list-style-type: none"> <li>- Only functioning autonomously in some areas</li> </ul>   |
| Not involved in budget/ expenditure decisions (12)          | <ul style="list-style-type: none"> <li>- Decisions about staffing, skills mix, equipment</li> <li>- No voice</li> </ul>   |
| Not involved in improving systems (13)                      | <ul style="list-style-type: none"> <li>- Screening services</li> <li>- Systems for patients (e.g. one-stop medications)</li> <li>- Making best use of satellite hospitals</li> <li>- Presenting patient point of view</li> </ul>  |

This situation does vary however. Different areas across the Trust have different organisational cultures. Some areas allow nurses to have more authority and others give nurses less authority. This is not a criticism but an attempt to highlight problems. It would seem that nurses on the wards have a largely dependent function.

The themes from Table 1 and Table 2 can also be grouped into:

- Issues of direct care: 1, 2, 5, 8, 11, 12
- Issues of governance and control systems: 3, 7, 13
- Issues around the preparation and support of others: 4, 6, 9
- Issues of accountability: 10, 11, 12

All the issues in Table 1 have been identified as important. Tables 2, 3 and 4 illustrate problems currently experienced by registered nurses which prevent them from functioning as they would like, with patients at the focus of care. Tables 3 and 4 try to identify what it is that prevents nurses from doing the things they should be doing.



**Table 3: What stops registered nurses from doing these things?**

| Themes                       | Main points   |
|------------------------------|---|
| Bureaucracy (1)              | <ul style="list-style-type: none"> <li>- Lengthy negotiation to obtain treatment or equipment for patients when it should be straightforward (exhausting)</li> <li>- Conflict between professional decisions and local policies</li> <li>- Constant fighting with managers (different priorities)</li> </ul>  |
| Poor systems/poor design (2) | <ul style="list-style-type: none"> <li>- Systems too rigid and narrow to allow effective use</li> <li>- Protocols and procedures lack flexibility</li> <li>- Identifying a problem but not having a system to resolve it</li> <li>- Having to tackle every problem from the beginning point every time</li> <li>- No opportunities for staff to be together to discuss problems and sort out solutions/improve systems</li> </ul>   |
| Other responsibilities (3)   | <ul style="list-style-type: none"> <li>- Running the organisation instead of giving care</li> <li>- Doing non-nursing work (lots of 'paperwork'), administration, writing letters, audit information/chasing results/provision of adequate staff numbers and skill mix/patient admissions/dealing with discharge difficulties). Believe nursing care important but so is paperwork – legal documents, patient safety, litigation</li> <li>- Responsible for the education and support of other groups of staff not just nurses</li> <li>- Some groups constantly changing so becomes a treadmill of responsibility for nurses</li> <li>- Filling the gaps when other staff not available (as messengers), out-of-hours nurses perform all roles</li> <li>- Picking up work left by others</li> <li>- Doing what no-one else will do</li> <li>- Running errands (often 'has to be a nurse' – unclear why)</li> <li>- Serving food (some believe this a positive exercise/others negative)</li> </ul> |
| Technical emphasis (4)       | <ul style="list-style-type: none"> <li>- Technical/equipment skills valued over nursing skills</li> <li>- Completing charts and ticking boxes</li> </ul>  |
| Managerial emphasis          | <ul style="list-style-type: none"> <li>- Managerial requirements given priority over nursing</li> </ul>   |
| Perceptions                  | <ul style="list-style-type: none"> <li>- The belief that nurses have to take responsibility for things other than nursing</li> <li>- Nurses have always filled the gaps – they and others expect nurses to continue to do this</li> <li>- Believing nurses are <u>not allowed</u> to do certain things (a belief which may be false)</li> <li>- Needing <u>permission</u> to perform as they would like</li> <li>- Belief that nurses have to do the paperwork</li> <li>- Lack of trust in nurses</li> </ul>  |

What makes a good nurse?

|  |  |
|--|--|
| Reality of the work place                                  | <ul style="list-style-type: none"> <li>- High turnover of complex patients</li> <li>- Staff shortages/lost continuity/bank and agency staff filling gaps-not familiar with area, treatments, routines (extra pressure)</li> <li>- HCSW expected to work to different levels in different areas</li> <li>- Technicians fragmenting the care of patients</li> <li>- Dealing with difficult relatives</li> <li>- 'Fire-fighting'</li> </ul> |
| Incomplete hand-over/has to be quick/communication systems | <ul style="list-style-type: none"> <li>- Only told about allocated patients not the whole ward</li> <li>- Little detail given at hand-over</li> </ul>  |

**Table 4: What are the barriers that prevent registered nurses from functioning effectively?**

| Themes                             | Main points   |
|------------------------------------|---|
| Loss of hand-over time and overlap | <ul style="list-style-type: none"> <li>- Fragmented report – only hear about allocated patients (not the whole ward, not very much detail)</li> <li>- Lost opportunities for teaching, team-building</li> </ul>   |
| Staff shortages                    | <ul style="list-style-type: none"> <li>- Ward work unrelenting/hard physically, mentally, emotionally</li> </ul>  |
| Burden of paperwork (5)            | <ul style="list-style-type: none"> <li>- Many different sources, overwhelming</li> </ul>  |
| Other people's work                | <ul style="list-style-type: none"> <li>- Supporting many other people and other roles in different ways – filling the gaps left by others</li> </ul>  |
| Loss of focus (6)                  | <ul style="list-style-type: none"> <li>- Nurses unsure about what their focus should be (many demands all have validity)</li> </ul>   |
| Lack appreciation/respect          | <ul style="list-style-type: none"> <li>- Between/across different groups of workers (on occasions)</li> <li>- Some groups reject/ignore advice given by experienced others</li> <li>- Verbal instructions later denied</li> <li>- Telling patients they can go home but not telling nurse</li> <li>- Nurse as hand-maiden</li> <li>- Nurses blamed when things go wrong</li> </ul>                |
| Organisational culture             | <ul style="list-style-type: none"> <li>- Different areas across the Trust have different organisational cultures. Some areas allow nurses to have more authority and others give nurses less authority</li> <li>- Lack of belief/faith in nurses' abilities</li> <li>- Lack awareness of nurses' potential</li> <li>- Deference to physicians</li> <li>- Dependent function (on wards)</li> </ul> |
| Perceptions                        | <ul style="list-style-type: none"> <li>- Lack of self belief by nurses</li> <li>- The need for permission (nursing belief)</li> <li>- Lack personal and professional authority</li> </ul>   |

## What makes a good nurse?

The themes from Table 3 and Table 4 could be grouped into:

- Direct care: 4
- Governance and control systems: 1, 2, 3, 4, 5
- Supporting other staff: 3
- Accountability: 6

These blocks and barriers must be addressed because they are having a huge negative impact on staff capability and morale, and quality patient care. Table 5 looks at the issue of extended roles for nurses (these views sometimes include specialist roles).

**Table 5: Extended roles – how do these fit in?**

| Themes                            | Main points  |
|-----------------------------------|--|
| Open to different interpretations | <ul style="list-style-type: none"> <li>- Generally good, if have the time to do the work and if its done as part of the nursing role and not as 'added on' tasks</li> <li>- Usually employs technical skills</li> </ul>  |
| Opinions for:                     | <ul style="list-style-type: none"> <li>- Increased knowledge and expertise/autonomy/accountability</li> <li>- Using nurses' abilities to good effect</li> <li>- Senior roles and specialist roles (more prestige)</li> <li>- Increased job satisfaction (opportunity to do roles as aspire to – this view was voiced as particularly true for specialist nurses)</li> <li>- Better for patients</li> </ul> |
| Opinions against:                 | <ul style="list-style-type: none"> <li>- Other people's jobs off-loaded on to nurses</li> <li>- Often task orientated</li> <li>- Nurses filling gaps left by others</li> </ul>   |

Table 6 tries to clarify issues from the patient's perspective. Many staff, nurses and non-nurses had experience as patients themselves, and experience of close relatives and friends as patients, so they were able to give comments from the patient's point of view even though they were also staff.

**Table 6: What do patients most remember about nurses? What do they most value?**

| Themes           | Main points   |
|------------------|---|
| Quality time (1) | <ul style="list-style-type: none"> <li>- Nurses listening, answering questions/explaining, giving time</li> <li>- Seeing the same person daily/nightly (continuity/a familiar face)</li> <li>- Helping with problems, provision made for pet/home concerns</li> </ul> |
| Quality care (2) | <ul style="list-style-type: none"> <li>- Being clean, dry, fed</li> <li>- Nurses giving strength, reassurance, explanation</li> <li>- Nurses being kind</li> <li>- Being treated with respect</li> </ul>  |

What makes a good nurse?

|                             |  |
|-----------------------------|--|
|                             | <ul style="list-style-type: none"> <li>- Making the family feel like partners in the care of a child</li> <li>- High quality care given by highly skilled nurses</li> <li>- Knowing whether they have been cared for by nurses or others</li> <li>- That Sister is 'in charge' (gives confidence)</li> </ul>   |
| Overwhelming experience (3) | <ul style="list-style-type: none"> <li>- Feeling a fish-out-of-water, frightened, everyone rushing around</li> <li>- Not wanting to be a burden – not asking for/not getting pain relief, help, etc.</li> <li>- Being told things would happen but they did not</li> <li>- Being told someone would come back but they did not</li> <li>- Not knowing who different people are (uniforms confusing)</li> <li>- Being asked the same questions over and over</li> <li>- Being left alone, not told what is happening</li> <li>- Discharged inappropriately</li> </ul> |
| Conflict (4)                | <ul style="list-style-type: none"> <li>- Being told different things by different people</li> <li>- Operations cancelled</li> <li>- Not being washed (one example given was of a patient who had not been washed for five days)</li> </ul>   |
| Watching and listening (5)  | <ul style="list-style-type: none"> <li>- Patients able to quickly assess the different personalities of staff</li> <li>- Listening to talk/observing what is happening to other people</li> </ul>  |
| Nursing station (5)         | <ul style="list-style-type: none"> <li>- Nurses 'busy' but apparently standing/sitting at the nurses' station</li> </ul>   |
| Reassurance (5)             | <ul style="list-style-type: none"> <li>- The first five minutes are most important: how they are greeted/are they bombarded with questions?</li> <li>- Knowing that someone is in charge</li> <li>- That someone knows what is happening to them</li> <li>- The sense that staff are competent and compassionate</li> </ul>  |

Table 6 highlights many of the personal attributes registered nurses, sisters and charge nurses should have in themes 1 and 2.

As reported in theme 3 it is easy (and understandable to some extent) for nurses to forget what an overwhelming and frightening environment the ward can be when they are so familiar with the ward and its challenges. However, staff must not forget and they must remain vigilant. Nurses must also stay aware of the issues in theme 4 and improve systems to overcome these unacceptable problems.

Theme 5 reflects the importance of a welcoming environment. Many organisations currently place a great emphasis on hospitality issues, and in various examples given, it would seem that the NHS has fallen far below expectations on this issue. This could be an on-going, in-house educational priority, to highlight the special nature of WDGH NHS Trust and its employees. Tables 7 and 8 are attempts to clarify certain terms.

**Table 7: When you and others use the term ‘nurse’ who do you think of most readily?**

| Themes                      | Main points – perceptions   |
|-----------------------------|---|
| Nurse                       | - The most usual expectation is that this person is a registered nurse  |
| Health care support workers | - The most usual care giver (may also be called nurses)   |
| Sister/charge nurse         | - A nurse, the one ‘in-charge’ who may or may not give hands-on care  |
| Problems                    | - Uniforms were reported as confusing – patients, doctors and others who make up the care teams reported being unable to tell who is who/who is giving the patient care/who is ‘in-charge’. Who are the nurses, who are they speaking to/who will be answering their questions? |

**Table 8: Sisters and charge nurses – are they nurses or something else?**

| Themes      | Main points   |
|-------------|---|
| Role        | <ul style="list-style-type: none"> <li>- Difficult balance</li> <li>- Many responsibilities</li> <li>- Challenge stereotypes</li> <li>- Develop own style</li> <li>- Managing/developing own staff</li> <li>- Loss of control: beds admission/discharges: cleanliness left to contractors</li> <li>- Constant interruptions</li> <li>- Too many patients to deal with (when complex situations develop, it was reported that sometimes it’s impossible to get round to everybody even once on a shift)</li> <li>- Staffing shortages, having to ‘make do’ with bank and agency staff</li> <li>- Should be good role model/leader</li> <li>- Should be positively influencing the environment/developing systems/patient pathways</li> <li>- Should be developing junior staff to support them in the role</li> <li>- Staff (and patients) remember (and talk about) ‘good’ sisters/charge nurses</li> </ul> |
| As nurses   | Partly personality dependent (partly other things, situation etc.) – if valued, more likely to keep aspects of nursing in the role/others may have different focus (different situation) and more administrative role   |
| As managers | Administrative work, organising, co-ordinating  |
| Uniform     | Important for patients and other staff to know who this person is   |

Table 8 highlights many of the difficulties experienced in this senior role; but this is a senior role which is crucial to effective patient care. The service exists to care for patients. Their needs must take priority. The sister or charge nurse needs to be the ‘captain of the ship’, the one

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responsible for all the care given (and not given). Anxieties expressed in Tables 6 and 14 reflect the failings of this person, and the failure of systems to support and enable the effective implementation of this important role.

It is acknowledged that sisters and charge nurses cannot be expected to be effective in isolation. They need to be leaders of the ward culture, as well as part of an effective team. There should be real support given from above (Matrons, Assistant Directors of Nursing, Director of Nursing) and from below (the registered nurses and other staff) to enable them to deal with the complex problems within their areas. Sisters and charge nurses need to be proactive in this development; patient care depends on them, they are the ones who carry the responsibility.

Table 9 tries to clarify the most important things registered nurses should do – and possibly suggests things that could be delegated to others to perform, and systems that need to be improved or changed.

**Table 9: What are the most and least important things that nurses do?**

| Most important duties                     | Least important duties                  |
|---|---|
| Provide a safe, secure environment        | Administration: paperwork               |
| Listen to patients                        | Negotiate (do battle with) the system   |
| Effective communication                   | Struggle for staff cover                |
| Professionalism – working to best ability | Clean up behind others                  |
| Negotiating care – giving advice          | Administration: off-duty, staff records |
| Turning up for work!                      |   |

Table 10 identifies perceptions about the modernising agenda.

**Table 10: What is the impact of the modernising agenda on nurses and nursing?**

| Themes                                   | Main points  |
|--|--|
| Housekeepers                             | - Good addition, highly valued, some control given back to ward sisters/charge nurse   |
| Using registered nurses more effectively | - Special roles, different roles   |
| Working in new ways                      | - Can be difficult to achieve, volume of work, needing to keep on top of things<br>- More machines<br>- Loss of skills<br>- More assessment<br>- Higher standards<br>- More data collection<br>- Keep the good but recognise that change is needed |

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|---------------------|--|
| Patient involvement | <ul style="list-style-type: none"> <li>- Welcome move, need to know what patients think, what they want</li> <li>- Service to be more responsive</li> </ul>  |
| Nurse expectations  | <ul style="list-style-type: none"> <li>- Non-traditional expectations</li> <li>- Nurses who want to be managers</li> <li>- More opportunities</li> <li>- Nurses/nursing to determine own future</li> </ul> |

Tables 11 and 12 aim to highlight issues important for the recruitment and retention of nurses in the Trust. It includes significant comments, suggestions and observations made by staff who took part in the focus groups.

**Table 11: Questions answered by nurses about their job at WDGH**

| Questions                        | Main points   |
|----------------------------------|---|
| What do you enjoy about nursing? | <ul style="list-style-type: none"> <li>- Patient contact, real people, caring for them and family</li> <li>- Different every day</li> <li>- Helping with patient's/family's problems</li> </ul>   |
| What keeps you in your job?      | <ul style="list-style-type: none"> <li>- Enjoyment, security, confidence in doing a good job, job satisfaction, comfortable in role</li> <li>- Team working, team spirit, nice people</li> <li>- Challenge, excitement, learning new things</li> <li>- Seeing people get well or have peaceful death</li> </ul>   |
| Why do you stay working at WDGH? | <ul style="list-style-type: none"> <li>- Live locally, family close by, nice area</li> <li>- Like the building, art, gardens, proud of hospital, friendly colleagues, good social life</li> <li>- Like local people/nice patients</li> <li>- Nice size (not too big), offers variety</li> <li>- (Some people) feel well supported by line managers</li> <li>- Loyalty to Trust</li> <li>- Consolidation before possibly moving on</li> </ul>  |
| Why would you leave WDGH?        | <ul style="list-style-type: none"> <li>- Expensive area to live – pay is an issue</li> <li>- Retirement</li> <li>- Take up new challenge</li> <li>- Lack of opportunities for advancement, poor prospects, few rewards</li> <li>- Frustration when complete courses but unable to implement change, roles lack authority</li> <li>- Lack of support and too much responsibility for newly-qualified nurses</li> <li>- On-going hassles</li> <li>- Not feeling valued/feeling abandoned/organisation taking advantage of goodwill</li> </ul> |

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|  | <ul style="list-style-type: none"> <li>- Unable to meet personal standards of care (due to factors beyond personal control)</li> <li>- Inadequate cover giving rise to dangerous situations.</li> <li>- Too much pressure</li> <li>- When treated badly by seniors</li> <li>- Fear of academic study, too much responsibility (consider leaving nursing)</li> <li>- Dealing with difficult/aggressive relatives</li> </ul> |
|--|--|

Table 12 identifies other issues from the focus groups not specifically related to this study but considered sufficiently important by staff for them to be raised in this forum for discussion.

**Table 12: Other issues raised by staff during the focus groups**

| Themes                              | Main points  |
|-------------------------------------|--|
| Leadership                          | <ul style="list-style-type: none"> <li>- Highlighted the importance of the person in charge being the right person with the right personality</li> <li>- Recognising that strong leadership creates a strong team</li> <li>- Practitioners need to meet on a regular basis to discuss issues and thrash out difficulties</li> </ul>  |
| Staff shortages                     | All areas across the Trust have too few workers, nurses, doctors, administrators, radiographers, messengers. No slack in the system. Too few staff on duty at the weekend  |
| Lack of support                     | Nurses, (newly-qualified nurses in particular), HCSW, junior doctors – concerns not being heard  |
| Working extra hours without payment | Nurses and administrators in particular (largely administrative type of work) done in own time   |
| Lack of effective career structure  | Nurses, HCSW, administrators. People with real talent not identified and nurtured, get frustrated and leave. Their talent is then lost to the organisation. Lack of pay parity for equivalent work across roles. Many staff not paid for the level of work they give.  |
| Special helpers                     | <ul style="list-style-type: none"> <li>- Handyman/engineer (rehabilitation areas in particular) to help adapt equipment for better use (by patients/clients and staff)</li> <li>- Social workers (on wards) needed to help with complex discharges (financial aid/funding issues/special expertise)</li> <li>- Observer person – someone (perhaps in training/shadowing) who is able to identify where efforts are being duplicated/help to streamline activities. (People are too bogged down/actively fire-fighting so unable to identify different ways of doing things)</li> </ul> |
| Recruitment                         | Lots of obstacles. Convoluted system. Slow. In-house moves could be stream-lined (many aspects not necessary/unnecessary duplication)  |



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| Unrealistic expectations                             | <ul style="list-style-type: none"> <li>- Many patients expect a hotel service which cannot be supplied</li> <li>- Health/disease/responsibility, not perceived as the individual's problem/the system there to put things right</li> </ul>   |
| Government interventions                             | <ul style="list-style-type: none"> <li>- TV for every bed makes giving care and keeping areas clean more difficult for staff</li> <li>- Targets mean unequal access to money for funding services</li> <li>- Money targeted to 'treatment' (easy to count/short term effect) instead of prevention (hard to count/long term investment)</li> </ul> |
| Menus  | Do not necessarily reflect healthy eating, health promotion, source of amusement   |
| Nurse education – some staff perceptions as reported | <ul style="list-style-type: none"> <li>- Entry gate too high</li> <li>- Learners lack the right attitude (many not interested in basic care)</li> <li>- Lack commitment (some just do not turn up for work)</li> <li>- Too little clinical experience when qualified</li> </ul>  |

These issues were considered important by the staff attending the focus groups. They need to be acknowledged and addressed within the Trust.

Tables 13 and 14 reflect the views and experiences of people served by this and other hospitals.

**Table 13: Overall views about a nurse's role and attributes required**

| Themes                       | Main points   |
|------------------------------|---|
| Role of the registered nurse | <ul style="list-style-type: none"> <li>- To give care as role permits, but to always supervise care being given</li> <li>- The ones responsible for care being given correctly – which includes patient's bathing, taking to toilet, able to access food/water, able to eat properly, teeth clean – as well as dressings, medication and technical aspects of the role</li> <li>- To remember the patient in a room on his/her own and go in to them frequently (reported as very frightening to be left in a room alone for long periods)</li> <li>- To prioritise nursing work over other work, e.g. a nurse dealing with one patients domestic problems (perceived as low priority) instead of giving pain relieving care to other patient(s) (perceived as high priority)</li> <li>- To keep clear and legible records</li> <li>- Oversee and be responsible for all care given to patients</li> <li>- Work with and educate colleagues</li> <li>- Develop protocols</li> <li>- Improve systems (patient care/record keeping/in wards and out-patient departments)</li> </ul> |

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|   |   |
|---|---|
| <p>Personal qualities:<br/>Good nurses, good sisters, charge nurses and good care staff</p>   | <ul style="list-style-type: none"> <li>- Good communicator</li> <li>- To be kind, to keep patients and relatives informed, to make them feel 'human' not just a 'case'/insignificant</li> <li>- To develop an aura to inspire confidence</li> <li>- Clear thinking, lateral thinking, organised</li> <li>- Knowledgeable, confident</li> <li>- Able to speak up in meetings, able to deal with difficult ward issues and people, including monitoring the performance of all staff (nurses, physicians, consultants, others) – able to take issues to sister/charge nurse/able go higher when appropriate</li> <li>- Not using terms of endearment unless invited to do so – patients in very vulnerable position, made worse by being called 'love'/'dear' – shows lack of respect</li> <li>- Good with patients, able to be sympathetic, reassuring, kind</li> <li>- Hard working</li> </ul>  |
| <p>Good image:<br/>To give reassurance and confidence in care</p>   | <ul style="list-style-type: none"> <li>- Distinguishable uniforms (patients want to know who is who)</li> <li>- Clean hands, tidy short nails</li> <li>- Tidy hair, worn up if long</li> <li>- Well fitting dresses/trousers and tops</li> <li>- To look like a 'health professional'. Looking as though he/she takes care of self so can be trusted to look after patient, relative, friend, should look good, smell healthy</li> <li>- To have clean and tidy shoes and tights</li> <li>- Involvement of someone like Richard Branson to sell nursing as a career (we all need nurses at some stage in our lives)</li> </ul>  |
| <p>Role of sister or charge nurse:<br/>Perceived as crucial to good organisation and care<br/><br/>Need able, supportive staff nurses, to help them to do their ward jobs effectively<br/><br/>Also need support from above to enable them to make necessary changes and be effective</p> | <ul style="list-style-type: none"> <li>- Must have a clear overview</li> <li>- If 'job sharing' should be sharing the role and information (mechanism built in to role) and not become two separate part time roles</li> <li>- Should know/meet/talk to all the patients every day and know what is happening to each one</li> <li>- To give care as role permits, help out nurses, work with them and patients, educating, guiding</li> <li>- Provide a welcoming environment</li> <li>- Supervising over all</li> <li>- Support consultant/medical teams (aide memoir, confidante – can be a powerful and rewarding relationship)</li> <li>- Ability to discipline nurses and other staff when necessary</li> <li>- To support nurses and other staff as needed</li> <li>- Ensure good, detailed, hand-over – the more care is broken up, the greater the risk of communication breakdown – the person in charge is the one to hold it all together with the aid of capable staff nurses</li> </ul> |

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|--|---|
|  | <ul style="list-style-type: none"> <li>- Able to speak up in meetings, able to deal with difficult ward issues and difficult people</li> <li>- Responsible for monitoring the performance of all staff (nurses, physicians, consultants, others) and able to deal with the issues</li> <li>- To develop protocols, improve systems (is all the paperwork really necessary?)</li> <li>- The ones responsible for all care being given correctly – which includes for patients: bathing, escorting to toilet, able to access food/water, and able to eat appropriately (should be monitoring patient's nutrition); for nurses: should be working with nurses to make sure these things done/educating/overseeing</li> <li>- To oversee and be responsible for all care given to all patients</li> <li>- To be a good 'captain of the ship'</li> </ul> |
|--|---|

**Table 14. When things are not as they should be...**

|  |  |
|--|--|
| Things nurses are not doing that they should be doing – where this happens ... | <ul style="list-style-type: none"> <li>- Nurses have lost sight of the whole picture</li> <li>- Lost sight of/ value of the basic things – these are important to patients/important to get right</li> <li>- Food/water must be where patients can reach it – nurses should be responsible for seeing that it is</li> <li>- If unable to do everything themselves nurses should be teaching and supervising others, taking responsibility for the care given to patients even if not doing it themselves</li> <li>- Working with computers instead of with patient and relatives/friends</li> <li>- Not treating people with respect, terms of address/treating them as 'cases' not as sensitive human beings</li> </ul> |
| Changed perceptions  | <ul style="list-style-type: none"> <li>- Nursing work not seen as important/not glamorous – but it is very important to patients</li> <li>- Changed perceptions of self – nurses as managers/technicians/busy doing 'other things' but should not lose sight of (or the importance of) their nursing focus</li> <li>- Role models lost (unforeseen casualties of 1980's sweeping reforms) and managerial/business focus replacing patient focus</li> </ul>   |
| Changed focus  | <ul style="list-style-type: none"> <li>- Focus changed from patient-centredness to managerial responsibilities/business speak (organisational focus/numbers/tick boxes)</li> </ul>   |

These people wanted to stress that usually they found care to be good but that sometimes things did go wrong. When this happened, it was a source of distress for them, their relatives and friends. From the research perspective, the staff of the Trust and the public were invited to give their views so that improvements could be made. To have received only

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compliments would have been comfortable but not useful, so all views, including criticisms, were welcomed.

Although many experiences were good, the most important deficits were identified as:

- Nurses doing non-nursing work (aggravated by reduced numbers of registered nurses);
- A lost sense of the patient and family as 'people' (a loss of respect in relationships for many different reasons);
- The loss of the one(s) in-charge, the 'captain(s)' – particularly at ward level.

Each of these three elements has massive implications for patients and their care. They also have an impact on the culture and capability of staff to provide care, particularly for those working in wards.

## 21<sup>st</sup> Century Treatment Forum

The need for a 21<sup>st</sup> century treatment forum was an issue raised through the process of this project. It was considered important by a participant who had regular contact with members of the medical profession and other professionals. She had witnessed and been part of difficult treatment decisions, difficulties that arose through advanced technology and new treatment options. This issue was raised because, in the 21<sup>st</sup> century, life-preserving treatment can be available in situations where it may not be the best option for the patient. In the current climate these decisions were seen as predominantly medical/physician dilemmas, but other health professionals would necessarily need to be involved in complex treatment decisions in the future.

It was proposed that the issue of whether active treatment was the most appropriate action was a dilemma likely to become more commonplace as technology and other advances continue to be made. The need for a forum, where professionals can thrash out treatment options in private (and therefore confidentially) before meeting with families, was identified. The view was raised that, while the rights and wishes of families would always be honoured, the rights of patients and the most appropriate treatment option(s) for them should always take priority.

When patients were able to speak for themselves and make their own treatment decisions, it was believed that there would be no need for discussion. Where this was not possible, doctors in particular voiced the need for help from professional colleagues. Clarke (2000) suggests that hospital ethics committees and legal specialists should be involved with

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difficult cases. It was proposed that a place easily accessible by all care professionals should be established in the local area for this purpose. The need to get decisions right was seen as paramount. Appropriate treatment choices would benefit doctors, health care teams, the organisation and most importantly patients and their families. The development of some kind of accessible forum was thought to be the best way to tackle this difficult issue.

## Discussion

### Issues raised

What are the important activities and functions registered nurses should be involved in?

Staff working for the Trust were able to readily identify activities and functions they thought nurses should be involved in. Table 1 covers an extensive range of activities including direct (hands-on) care as well as lots of managerial and organisational aspects.

White (1988) identified three types of nurses who showed different preferences across this range of activity. The nurses in the study clearly identified the need for all of these functions but many of them reported that the demands of managerial and organisational activities took them away from direct nursing and meaningful contact with patients and families.

Members of the public had very clear requirements about what they wanted from nurses (see Table 13); for nurses to be giving care but more importantly for them to be supervising all aspects of care and setting the standards on the wards. While many experiences reported were good, some were not (see Table 14), with examples of poor care, poor management and supervision, and poor interpersonal skills, which caused distress.

Gertis et al. (1993 cited by Kendall & Lissauer 2003, p11) highlighted respect, co-ordination and integration, information, communication and education, physical comfort, emotional support, involvement of family and friends, transition and continuity as being the main aspects of patient-centred care that nurses should be providing.

It would be convenient to blame nurses for the failings but that would not be fair. History has shown that nursing is a complex activity. Lots of powerful groups have an interest in controlling nurses and nursing expenditure, while maintaining their own positions of power within organisations. Nurses are required to do, and be responsible for, a range of activities, but they frequently have little or no authority to make changes that would enable them to do their work effectively.

Nurses should be the ones designing and controlling nursing agendas but they are frequently excluded from decision-making arenas. Benner (1984) and others have persistently encouraged nurses to find their identity and authority through their ability to focus on patient-centred care. 21<sup>st</sup> century service users demand high quality care and nurses say

they want to give such care. If nurses really believe in this goal and remain focused on this objective, they must be able to find a way through traditional bureaucratic mechanisms to find a new place for pursuing their ideals for patients.

**Who are the nurses?** For this study it was necessary to focus on the work of registered nurses within the organisation, but it was also respectfully acknowledged that other groups contribute significantly to the nursing care patients receive.

Through the course of the study it quickly became evident that, as described in the literature, registered nurses within WDGH NHS Trust were not a uniform group. The three types of nurses described by White (1988) were evident, with each group showing different motivations and different approaches. Differences in terms of values and orientation mean that consensus views are not possible.

The specialist nurses were largely a self-contained group that managed their own clients and workloads. Many had moved into these roles so that they could practice high levels of skill with more freedom than was currently possible in ward situations. The specialists found their work rewarding but on some occasions they could feel isolated and distant from the organisation. There did not appear to be mechanisms in place to encourage them to feel part of the greater whole of the organisation. They were also subject to many barriers within hospital systems. Specialist nurses reported spending precious hours 'negotiating the system' to gain legitimate equipment and/or medication for their clients. In a recent study conducted by Graham & Keen (2003), a different group of specialist nurses reported similar difficulties. These barriers frustrated specialist nurses' efforts and diffused their enthusiasm, thus wasting energy and expertise that could have been better channelled towards patient care.

Many of the generalist nurses saw their roles more as jobs they enjoyed, which provided them with a salary and a measure of security. These aspirations were viewed as equally valid. The generalist nurses were concerned for their patients and they performed to the best of their ability, but they had busy lives and other commitments, preventing them from becoming too involved with issues in the workplace.

There were also many nurses who became managers. As with the specialist nurses, some of them had moved into management roles to have more control over their working lives. Some of the management roles were in ward situations, some were not. Ward management roles were roles like ward sister or charge nurse. Other management roles

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involved higher levels of service management or different types of service development management. Sisters and charge nurses were seen as crucial to the effective running of the ward (by nurses, doctors, members of the public, physiotherapists, administrators and others), but how sisters and charge nurses performed this important role seemed to be dependent on personality and attitude. As a result, there were many different interpretations of the role. Whether sisters and charge nurses received preparation and support in their roles was not asked and was not evident. For them to be effective it would seem that both preparation and support would be necessary.

When considering nursing roles it is important to remember that nurses are not a static workforce. At different times nurses may focus their attention on different aspects of their lives. Although for some, home and child-care may take priority at the moment, at a different time they may want to change roles, take up educational opportunities or even opt out altogether for a while. All of these choices are positive and can be viewed as plus factors for nursing. Nursing as a profession continues to offer flexibility and opportunity for those who want it.

Many nurses and others considered nursing to be a professional role. Some conformed to White's (1988) description of professional nurses as those who looked to higher education and specialist knowledge to develop their practice, while others did not. Many nurses working across the Trust were, however, able to identify with White's (1988) description of the three groups of nurses. Within the Trust, nurses were working as specialists, generalists and managers. Constraints reported within ward situations could make life difficult and challenging for nurses who did identify with White's (1988) description of the professional nurse. They reported wanting to use professional knowledge and education within ward situations and beyond, but that organisational structures and traditional ways of working prevented this.

Aiken (2003) and Swindells & Wilmot (2003) highlighted the advantages of having educated nurses looking after patients. The examples from the magnet hospitals and examples given by the Royal College of Nursing support this and research conducted by Swindells & Willmott (2003, p1102) endorsed this view. They found that nurses educated to graduate level were able to perform, in terms of *cognitive ability, reflective practice ability and professional practice*, even better than diploma educated nurses, making them more effective in their practice while working for patients. Post-graduate education was found to enhance decision-making abilities and clinical skills development even more, making the whole treatment process safer for patients. However, there must be



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opportunities for nurses to use their knowledge and skills. If opportunities do not exist, as in many ward situations, nurses may become disheartened and move to other areas where they can be more autonomous, or perhaps they may leave the organisation altogether.

It is important to retain skilled and educated nurses at ward level. These nurses are much needed to supervise and educate staff, while using their talents to benefit patient care. It would appear that many nurses and other health professionals find ward situations difficult and challenging places to work in at this time (Kendall & Lissauer 2003). Nurses, and others, seemed to be under constant pressure. They want to give high quality care but are constantly being drawn into other work away from patients.

## What prevents nurses from working this way?

Nurses reported that bureaucracy, poor systems and non-nursing responsibilities were the main causes for being unable to care for patients. The volume of work seemed to be a real issue. There is much research to support the notion that adequate numbers of registered nurses are essential to provide safe, quality care (Aiken 1998, Buchan 1997, Clay 1987, Eckardt 1998, Kendall & Lissauer 2003, Lawler 1991, Pembrey 1984 cited by Clay 1987, RCN 1992). Nurses reported that they spent much of their time 'fire-fighting' and dealing with non-nursing crises of different types. This was unsatisfactory and patient care inevitably suffered.

Nurses regretted the loss of hand-over time, which is now non-existent in many circumstances, and the accompanying advantages. Losses include: the detail about patients and their care, knowledge of the whole complement of the ward (now nurses just hear about their allocated patients), the loss of team building and ward culture development, and crucially the loss of informal education, which was an integral part of the detailed hand-over. These things just don't happen now and the service suffers greatly as a result. Cost-cutting measures have come at a high price.

Nurses seemed to have no way of communicating what was important to them (high quality care) and no way of influencing people within organisations to make this possible. Nurses should be in positions where they can influence and implement necessary changes.

## What do patients want from nurses?

When staff commented on what patients wanted from nurses, they told stories of their own personal experiences, stories of fear and of feelings of being overwhelmed while in hospital. There were also issues of conflict. Patients were told different things by different people, and that

## What makes a good nurse?

certain things would happen but they did not happen. All of this undermines patients' confidence and makes them afraid. There were also reports of neglect, unacceptable at any time.

Kendall & Lissauer (2003, p12) cite the Institute of Medicine (2001) which identified that the 21<sup>st</sup> century health care system should be safe, effective, patient-centred, timely, efficient and equitable.

Members of the public expressed traditional values when referring to what they wanted from nurses. They wanted nurses to be kind, to address them respectfully, and to be inspiring both through how they looked and how they behaved. These are simple values easily achieved but readily forgotten. Competence to do the job was expected and taken for granted.

The ward sister role was seen as crucial (Armstrong 1981, Pembury 1980, RCN 1992). The public wanted to know that this person, (someone specific and identifiable) was in-charge, and that he or she would be responsible for their safety and well-being throughout their stay.

Health care seems to have become locked into special jargon, the perception of commodities rather than people, with much of it adopted from the business sector. But all that patients really want is to be treated well and reliably looked after while they are in hospital. How is it possible that such simple, understandable and important goals have so often become lost?

### Different groups of staff within the Trust and their different perceptions

Some historical perceptions are still held by some doctors and managers in particular. They continue to believe that nurses can 'fill the gaps' and hold the system together as they have always done. Many nurses themselves also wanted to be able to perform this function, recognising that if they did not hold things together patient care would suffer. But as Girvin (1996) found, many nurses remain prisoners of their past. The traditional socialisation of nurses has moulded them into roles as dutiful followers. This socialisation has left many nurses ill-prepared to rise to the particular leadership challenges they face today.

As a group, nurses are skilled and resourceful. With the needs of patients in mind, nurses at WDGH acknowledged that doctors needed blood and other results to make important treatment decisions, families needed to be informed, medication had to be ordered and arrangements for discharge must be made. Nurses at WDGH found themselves caught up in all of these functions; important functions but ones which often take lots of time, taking them away from patients and preventing them from

giving care, which they recognised should be their primary role. Many nurses reported this type of scenario and that the overly demanding environment prevented them from working effectively and receiving the job satisfaction normally associated with their work. Nurses reported overall feelings of being pulled in too many directions, unable to do any of them well.

Nurses are used to responding to the needs of the environment. They are not accustomed to standing back and looking for other alternatives. They need to begin to do this. They have to learn how to form their own ideas. They can then take these ideas to doctors and managers to gain their support for implementing change. Everyone in health care wants the same outcomes. They want quality, patient-centred care. This can only be achieved when teams listen to and support each other.

The adoption of the business culture into health care has had a significant impact. Resources are finite and must be effectively managed but there are many contentious issues, and cost-cutting for its own sake is not necessarily the best measure. Everything is open to different interpretations and should be discussed fully. There is the perception that replacing registered nurses with other less educated workers is a cost-effective measure. The perception is that you will get 'like for like' but for less cost. The reality is very different. Aiken (1998, 2003), the magnet hospitals in the United States, Pembrey (cited by Clay 1987) and the Royal Marsden hospital in London all report that having higher numbers of registered nurses leads to fewer complications, fewer re-admissions and fewer deaths. These all are important factors to take into account when considering costs. Hospital-acquired infection alone contributes hugely to the NHS bill, as do costs for re-admission, complications and death, where costs are perhaps less quantifiable but of enormous consequence to patients.

## The modernising agenda

According to Kendall & Lissauer (2003), and in common with other people working in health care organisations, staff at WDGH NHS Trust did not have particularly clear ideas about the Government's modernising agenda. (To help staff gain access to information about the modernising agenda and agenda for change, some details have been included in this report.) Staff rightly identified that roles need to change and that nurses need to be working in new ways. Extended roles were seen as a good thing unless they were used as a way of giving junior doctor responsibilities to nurses without providing extra nurses to do the nursing work as well.

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Members of the public could see the potential of having extensive de-centralised services available to them out in the community. This was seen as a positive development.

Kendall & Lissauer (2003, p5) report that:

Professional organisations, trades unions and Government all agree that further changes to working practices will be required in the years ahead. Yet there is little agreement about what the overall shape of the future health workforce should look like.

The British Medical Association has called for a hugely expanded role for nurses...but it does not envisage non-professionally qualified workers taking on more responsibility as nurses' roles expand.

Clearly there are incompatible demands identified here. The same number of nurses cannot continue to take on extended roles if they are also responsible for nursing care. If nursing care is to be no longer given by nurses then sufficient numbers of appropriately educated individuals must be developed to step into this role, or patient safety will be sacrificed. Difficult decisions have to be made and appropriate numbers of suitably qualified staff have to be prepared for the future.

How should nurses  
be working in  
WDGH NHS Trust?

Nurses need to be working more effectively within the Trust. This is what both doctors and nurses want. Doctors want nurses to expand their roles but organisational structures do not support this. Higher education is one aspect of preparing nurses to work more effectively but learning must be supported by education within ward situations as well. Also, a different group of people perhaps needs to be prepared to take over some of the nursing responsibilities. Organisational structures and systems need to be developed to allow this to happen.

Substituting nurses for other less educated health workers may look like a bargain. There is the perception that you get 'like for like' but according to the research, as previously stated, this is not the case. Qualified nurses, through education, knowledge, experience and constructive reflection, are able to perform in ways unachievable by their less educated colleagues. The more education and experience nurses have (hence the notion of lifelong learning for all professionals), the better they are able to perform. One of the classic nursing texts, *From Novice to Expert* (Benner, 1984), clearly illustrates this extraordinary development process.

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Nurses need to be the ones to spearhead the pursuit of improved quality of care and improved standards. They can do this from their philosophical position of being patient centred. This approach is in contrast to the existing popular culture within hospitals, which focuses on fulfilling the needs of the service.

In deciding the future service of the Trust, the Trust Board needs to decide how it wishes to invest in the future. By reducing the number of nurses looking after patients and replacing them with substitute less-educated workers may save money initially but research has shown that this approach, as a cost-cutting measure, does not add up. Patients are more likely to suffer complications following treatment, which will cost the organisation more money to put right. These costs are shown in terms of more emergencies, repeated surgery, more hospital care perhaps requiring intensive care, and even death.

## Recruitment and retention of staff within the Trust

Staff predominantly reported being satisfied with their work. Most gave examples of good relationships with colleagues and real pleasure being able to work with patients and other members of the public. They were happy with the environment, the clean building and beautiful grounds, but there were areas of concern that should not be overlooked.

Health care support workers, administrators and those working in different hospital departments, all reported that there were insufficient staff numbers to properly do the work required of them. They experienced feelings of disorganisation in their work and reported episodes of *'fighting the system'* instead of having systems to help them do their work effectively. Poor systems were usually reported to be the sources of problems, rather than individuals.

There were a few episodes of disrespect between individuals, which had caused unnecessary distress. Some people also experienced confusion in their roles, with a lack of uniformity across the Trust about what they were 'allowed' to do in the course of their work. This issue was a real stumbling block, and appeared to be based on perceptions and assumptions about what people could do rather than their abilities. This approach held people back, stopped them from being creative, and produced anxiety instead of rewards.

Different groups also raised the problems they had in gaining promotion and/or recognition for the level of work done. Systems seemed to be designed to keep people in the same place financially. They were often allowed to do more, but their efforts went un-rewarded. This made people feel unhappy and in some cases seek employment elsewhere. The

tragedy of this is disappointment for the individual, and excellent people are continually being lost from the organisation. Can the organisation afford to let this happen?

## Other issues raised

- The recruitment process for staff in WDGH was seen as unnecessarily laborious and long-winded. There were perceptions that delays were a mechanism to reduce costs, where reality demanded that staff be replaced as quickly as possible to maintain levels of care. Some sisters and charge nurses reported that they felt unnecessarily encumbered with human resource responsibilities that should be done by people employed in the human resource department.
- It was reported that while some sisters and charge nurses were undoubtedly very good, highly effective and supportive of staff and patients, some were not. Again it would be easy to blame individuals for their failings but as already discussed these people rarely receive preparation for their roles. Success seemed to be more reliant on personality and luck rather than good systems. It may be that through necessity some people are appointed when they do not have the necessary skills, which serves a purpose in the short term at the expense of the individual. It may be preferable to keep a position vacant when appropriate people cannot be found rather than masking the problem by appointing someone who is unable to do the job effectively. Better systems could be developed to prepare people in advance so that when positions become vacant, a ready supply of suitable applicants is available.
- The lack of support for learners and staff in all roles and at all levels appeared to be a problem across the Trust. This issue should be addressed because many people, with appropriate support and education, are then able to do well. If this need is not addressed staff could leave, develop illness, or become bitter and ineffective if left to cope on their own.

## Recurring themes

Throughout the history of nursing three recurring themes remain:

- The education of nurses is not recognised as important. Service organisations do not adequately support nurses in education. Many nurses themselves do not recognise the advantages of education for their own personal and professional development. Professional

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colleagues do not usually recognise the advantages of having educated nurses and the ways in which these nurses could help provide better services for patients.

- The lack of recognition for nurses' abilities leads to a lack of real authority. Even in these marginally enlightened times, the majority of senior nurses, many of whom hold leadership positions within organisations, do not have sufficient authority to make any kind of change within their work environment. They are required to take their concerns to a higher authority every time. Evidence from this and similar studies confirms that higher authorities rarely take the concerns of nurses seriously so senior nurses have to be persistent in the extreme to achieve anything. This is a waste of their time, energy and commitment.
- Because nurses are not valued or rewarded in financial or other ways, there are few incentives for people to choose nursing as a career so shortages are inevitable. Nursing roles are also being eroded. Other less educated care workers do not usually have sufficient knowledge or experience to keep patients safe. Hospitals are dangerous places. When people are sick they may die. Registered nurses are needed to establish and maintain standards in hospitals. They are needed to set an example, to teach learners, to oversee the care patients receive and to keep patients safe. Only the nurses have sufficient knowledge and experience to do this. There must be continuity and stability in the workforce. If there are too few nurses able to provide this, patient safety will be put at risk.

Professional issues need serious attention if a nursing crisis and subsequent impacts on patient care are to be avoided.

## Conclusion

While much about the Trust appeared to be good and working effectively, there were areas of concern. Nurses (and other staff) seemed to be struggling to cope with the many and extensive demands placed on them. Staff were feeling overwhelmed.

There appeared to be many complex reasons for this, including staff shortages across the Trust, fragmented care-giving, too few 'captains' leading teams, and many poor systems. Nurses seemed to be at the brunt of the difficulties. None of the reported issues could easily be fixed but they could be improved. Staff need to be aware that their concerns are being heard and will be addressed.

The challenge for the Trust at WDGH is perhaps to recognise that difficult decisions have to be made. If important issues are left unattended, the Trust runs the risk of losing many of its staff, perhaps the best staff. People who have good qualifications and experience are able to go elsewhere. However, many staff also expressed tremendous loyalty to the organisation, to colleagues and to patients. Loyalty is a special quality that should not be squandered. Once lost it is difficult to rebuild and replace.



## Recommendations

### Systems to value staff

While a lot of loyalty and commitment exists within the Trust, many staff were suffering from the complex effects of changes that have taken place within the NHS over the last ten years and more. It is not surprising if some have become battle-weary.

All staff need to be adequately rewarded for the work they do. Agenda for change aims to rectify financial aspects of this discrepancy, but for some time the reality is likely to be more upheaval and uncertainty. All staff across the Trust need to be supported through this difficult time and beyond, or the service and patients will suffer.

Financial gain is not the only way to reward staff. To give their best, people need to feel valued and many staff across the Trust did not feel valued by the organisation.

### Leadership positions

Ward sisters and charge nurses need to be given and be able to take real authority to manage their clinical areas. They need to be supported from below by registered nurses, and from above by matrons and managers. They need real authority to take decisions and make the changes they need to in their clinical areas.

Clinical nurse specialists and consultant nurses have less linear but equally important roles to provide leadership and service development. They should be able to do this without spending time arguing with those who hold the real authority within the organisation.

It is assumed that nurses are given senior roles because they are considered to be experienced and trustworthy. But these same people are not usually given the authority they need to function. This behaviour tells senior nurses that although they are in senior positions they are not really trusted after all. This is an impossible situation. Senior people cannot do their work effectively without the corresponding authority.

### Recruitment

Recruitment systems need to be improved to make it easier for staff to move within the organisation. The process of bringing in new people must also be speeded up. Staff report that they already struggle to meet daily variations in staffing numbers – being without staff makes managing care and patient safety almost impossible.

## Education and leadership development

Education is important if nurses and others are to function more effectively. Research has shown that education equips nurses to work more effectively. However, education is not the responsibility of one individual or organisation. Education needs to be provided from a variety of sources, both university and hospital based. Education needs to be supported in the workplace by nursing and other colleagues, and through mechanisms of continuing professional development, so that learners at all levels can reach their full potential. The concept of lifelong learning was introduced for exactly this purpose. Learning is not about short episodes, it is about the development of an organisational culture that values staff, a culture that gives them opportunities to develop and contribute to the overall values and goals of the organisation. All staff would benefit from the development of a more open and supportive educational culture.

Some nurses do not necessarily have a clear identity at the moment. There are lots of different types of nursing roles and this can be confusing for learners especially, in the early days. In an interprofessional world, each professional needs to hold core values about their own profession to recognise and appreciate what other professions have to offer. Curriculum development could perhaps address this issue. There should also be the development of strong nursing role models across the organisation through the development of sisters and charge nurses.

For nursing to change and take an active partnership role in caring for patients, nurses need to recognise the recurring difficulties they suffer and address those difficulties. Many of the same problems have burdened nurses and their development for at least a hundred years. There are fundamental flaws in the organisation of nurses and nursing. Nurses have to find new ways to resolve recurring problems and difficulties, which should be approached from the perspective of providing high-quality care for patients.

Only nurses can make real and lasting changes to their profession. They need to be aware of the problems, aware of what has been tried before and failed, to find new and lasting solutions. Only nurses can shape their profession in ways nurses themselves have declared they want to work. Nurses want to be able to give high-quality patient care, and they want to contribute meaningfully to the development of services. Only they can make that difference. Personal and professional development can help them to this. They will then be in much stronger positions to bring about lasting change to the nursing profession.

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## Appendix 1

### Advertisement for the *Dorset Evening Echo* (Dorchester) and the *Blackmore Vale* newspapers

(Bournemouth University Logo)

(WDGH NHS Trust Logo)

#### What makes a good nurse?

Have you got an opinion on this subject?

Bournemouth University and Dorset County Hospital are looking for volunteers to take part in a group discussion.

#### **We want to find out what you value in our hospital nurses**

If you live in the local area and are served by Dorset County Hospital you can help us by attending one discussion group for just two hours. Reasonable travelling and/or caring expenses will be met (following application).

If you are over 18 and interested in taking part, please write in giving your name and address (for the postal information sheet), your telephone number (with dial code) and email (if you have one) so that we can contact you, to the address below. If you are chosen from the replies (random selection method used) you will be contacted during the next few months.

Contact person: C. Partlow  
IHCS Bournemouth University  
1<sup>st</sup> floor Royal London House  
Christchurch Road  
Bournemouth BH1 3LT

## Appendix 2

### Information sheet June 2002

You are being invited to take part in a research project. Here is some information to help you to decide whether or not to take part. Please take time to read the following information carefully and discuss it with friends and relatives. Take time to decide whether or not you wish to take part. Thank you for reading this.

#### What should nursing practice and care in WDGH NHS Trust be?

##### **Background to the study and brief overview of the project**

Nursing has changed a lot in recent years. The old models of nursing have become eroded and new roles are taking their place. Many of the changes have been beneficial, but so many changes have given rise to a loss of focus about what nursing really is and what it is that nurses are trying to achieve.

The aim of this study is to re-identify what activities and functions people most value from registered nurses. Your views will then be used to inform the Dorset County Hospital Trust Board to help them plan the professional development of registered nurses and to channel the scarce nursing resource in the most effective ways. The study will be in two stages:

- Stage One: Local people served by Dorset County Hospital will need to respond to local advertising (and be prepared to complete a small questionnaire later). For hospital employees Stage One will be this initial contact and they are asked to complete the enclosed questionnaire if they are interested in becoming involved.
- Stage Two: Local people and employees will be invited to attend one of a series of focus groups (to be held on the hospital site) to try and establish what they most value or think is most valuable about nursing, nursing practice and care.

The questionnaire asks general demographic details, and WDGH employees are asked to select the group they most readily identify with. That will be the group they become part of for this study. Up to ten people will be randomly selected from each group to take part in one, 2-hour focus group, which will be part of a series of focus groups to be held over the next few months on the WDGH hospital site.

## What makes a good nurse?

For effective communication focus groups need to be quite small, no more than ten people, so if more than ten returns are obtained from one group then a random selection of ten names will be made. They will then be contacted to check on their availability. So if you have responded and have not been contacted it will be because you were not randomly selected from the replies but your group will be represented.

To include as many people as possible reasonable travel and/or care expenses will be met by WDGH NHS Trust. (An invoice will be given to you at the focus group to be processed later by the accounts department at WDGH). Trust employees may also apply but they will need to obtain prior approval from the Director of Nursing.

This study is a collaborative investigation between WDGH NHS Trust and Bournemouth University but only researchers at Bournemouth University will have access to information collected. This process will ensure that all data collected will remain anonymous. A report will be presented at the end of the study.



## Appendix 3

### Questionnaire

Employees of WDGH please complete all questions where applicable (and return to the researcher at Bournemouth University). Members of the public please complete questions 2, 3 and 4 (before the focus group starts).

#### What should nursing practice and care in West Dorset General Hospitals NHS Trust be?

If you are interested in taking part in a focus group to discuss issues around the practice and care provided by registered nurses at WDGH please provide the information below. All of this information will remain strictly confidential.

The information is for demographic profiling (all groups) and contact purposes and group selection (for employees of WDGH). It may also be used anonymously as part of the report. All the details will be held in a secure place by the researcher and destroyed when the study is completed.

#### Employees of WDGH NHS Trust please to complete question 1:

1. In order to contact you please provide:

Your name:

Telephone number with dial code

(please include the best times to reach you)

At work:

At home:

Email (if you have regular access to this service):

#### All groups please complete questions 2, 3 and 4:

2. Your age:

3. Are you male or female:

4. Your title/job/profession:

What makes a good nurse?

Employees of WDGH NHS Trust to complete questions 5, 6 and 7 please (where applicable):

5. Self-selection into groups:

This information will be used to identify which focus group you will be invited to attend. This question is about the role you feel you fulfil within your work area rather than your actual title or job description.

Please self-select into the group you most readily identify with (please choose one):

|                            |                            |
|----------------------------|----------------------------|
| Newly qualified nurse      | Experienced nurse          |
| Nursing support staff      | Directorate                |
| Speciality                 | Doctor                     |
| Consultant                 | Mental health professional |
| Leadership role            | Manager                    |
| Executive                  | Non-Executive              |
| Allied health professional | Administration/Secretarial |
| Pharmacy                   | Chaplain                   |
| Service support staff      | Other (please specify):    |

6. Number of years qualified – please answer this question only if you have a registered clinical health professional qualification.

7. For nurses only:

Have you always worked in the NHS in Dorset as a registered nurse? Yes/No

For employees of WDGH NHS Trust only:

When completed, please return this form to the researcher at Bournemouth University using the pre-paid sticker provided. This return will imply your consent to be contacted by the researcher for the purpose of organising focus groups.

# Appendix 4

## Consent Form

**Consent form to be signed by all participants before the focus group starts.**

Title of the Project:

What should nursing practice and care in WDGH NHS Trust be?

This is a collaborative study between West Dorset General Hospital NHS Trust and Bournemouth University.

Name of the Researcher(s):

Professor Iain Graham, Christine Partlow, Teresa Keane, Farnaz Heidari

Please initial each point 1-8:

- 1. I confirm that I have read and understood the information sheet dated June 2002 for the above project.
- 2. I understand that my participation is voluntary and that I am free to withdraw at any time without my care or legal rights being affected.
- 3. I am willing that my words as part of the (anonymous) focus group be tape-recorded and transcribed later for analysis.
- 4. I am willing for the researcher to make (anonymous) field notes.
- 5. I expect that all data collected will be stored in a secure place and made anonymous for the final report.
- 6. I agree that all discussions within this room remain confidential and will not be referred to or discussed again elsewhere.
- 7. I am over 18 years of age.
- 8. I agree to take part in the study.

|                         |      |           |
|-------------------------|------|-----------|
| Name of the participant | Date | Signature |
|-------------------------|------|-----------|

|   |      |           |
|---|------|-----------|
| Name of the person taking consent<br>(if different from the researcher) | Date | Signature |
|---|------|-----------|

|                        |      |           |
|------------------------|------|-----------|
| Name of the researcher | Date | Signature |
|------------------------|------|-----------|

One copy to be kept by the participant and one copy to be kept by the researcher.

## Appendix 5

### Focus group information sheet

This research project is a collaboration between WDGH NHS Trust and Bournemouth University.

#### What should nursing practice and care in WDGH NHS Trust be?

##### **What is a focus group?**

A focus group is a research method used to explore a particular topic from a range of perspectives. The facilitator of the group has a number of prepared trigger questions that are designed to encourage discussion between the members of the focus group about their views and ideas on the subject. What individuals say during the sessions is considered to be confidential by the other members. The sessions are usually tape-recorded to assist the research staff but the tapes are kept securely and only used by the researchers. Members should not be concerned about their views being attributed to them as any data from the focus groups which is given in the research findings will be reported anonymously.

##### **Who will be there?**

The focus group should be made up of no more than 10 individuals. The membership will be people who are considered peers, for example all experienced nurses, or all doctors (wherever possible depending upon peoples availability). Two members of the research team will facilitate the focus group, one taking a lead role.

##### **How long will it take?**

After consent and introductions the focus group should take about 90 minutes depending upon the fullness of the discussion during the session.

##### **What do I need to do as a member of the focus group?**

Come prepared to share your views on what you believe to be the most valuable aspects of the role performed by registered nurses. This could include things nurses are already actively engaged in or it could also be areas of work you would like to see developed. Think a little about your role and how your role relates to the/other registered nurses. How do you feel about current issues and what do you see as important for the future.

Light refreshments will be provided.

Taken from the format developed by Professor Kate Galvin and Holly Crossen-White, Institute of Health and Community Studies, Bournemouth University.

## Appendix 6

### Focus group – order of events

#### 1. Welcome, thanks and introductions

You have been invited here to assist with research commissioned by the Director of Nursing for WDGH NHS Trust to share your views about what you consider to be most valuable about the role of the registered nurse both currently and in the future. This information will help the Trust Board to develop nurses' education and skills in the most appropriate ways.

We will be discussing your thoughts and opinions, the things you most value and want to keep as nursing activities as well as things that perhaps they don't do that you feel they should be doing as registered nurses. We also want you to consider who are the nurses and where extended roles may fit both now and in the future.

There are no right or wrong answers just different points of view. Please feel comfortable to share your view even if it differs from what others have said. We are interested in a range of opinions and we are just as interested in negative things as positive things. In this type of research all your views are helpful.

#### 2. Ground rules

Before we begin we would like to suggest things that make discussions more productive.

- Only one person to speak at a time – we are tape-recording and this will help us to capture all of your comments. Tapes will be held securely and destroyed when the study is completed.
- We will use first names only for the discussion – but there will be no names used in the report. Confidentiality will be protected.
- My role is to ask questions and listen. We want you to feel free to talk with one another. We will ask questions and move the discussion through the questions. There is a tendency in these discussions for some people to talk a lot and for some to not say very much but it is important to hear from all of you. If this happens, my colleague or I may invite your opinion if you are not saying very much and equally if some are sharing a lot we may ask you to let others share their thoughts.

#### 3. Beginning

Consent forms to be signed, claim forms (and pre-paid labels) to be distributed, turn off mobile phones if possible, name badges (first name only), start tapes. Let's go round and find out a little bit about each other. Please tell us your first name (and your role where mixed group).

#### 4. Questions

#### 5. Ending/Close

- Is there anything that you feel has been missed out in our discussions?
- Is there anything you would like to add?
- To conclude the focus group can you please give one sentence which describes what it was like to be part of this focus group?

## Appendix 7

### Focus group questions

1. What is nursing (the activity)?
2. What is it that nurses do (the function)?
3. What should nurses be doing (that they are not doing at the moment)?
4. What stops them (from doing those things)?
5. What do patients most remember about nursing?
6. Who are the nurses?
7. Where do expanded roles fit in?
8. Sisters/charge nurses - are they nurses or something different?
9. What would you say are the three most important things nurses do?
10. What would you say are the least important things nurses do?

Questions 11 and 12 for people who may have a view about these issues – in particular doctors whose own roles have changed and are continuing to change, also managers and others – to be offered but not pursued – at the researcher's discretion.

11. In view of the modernisation agenda and inevitable changes what impact do you think that will have on nursing?
12. How do you think that agenda will affect the things nurses do?

**For nurses only:**

13. What do you enjoy about nursing?
14. What keeps you in your job?
15. Why do you stay working at WDGH?
16. Why would you leave WDGH?