

The Elements of Nursing ... all but unknown

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Introduction

Nursing at the Royal Victoria Hospital has consistently been in the vanguard of professional excellence and innovation. From within its ranks came the first nurse practitioner in Northern Ireland, the first tissue viability nurse, the first nutrition and specialist nutrition nurses and the first Macmillan paediatric nurse. There are an increasing number of specialist nurses working in areas such as stoma care, epilepsy, fractures, diabetes, glaucoma and pain management. The commitment to enhancing roles and improving clinical outcomes has been supported through a thriving commitment to nursing research.

I am particularly delighted to see how you have embraced the liberating principles of the UKCC's document *The scope of professional practice* and have accepted the challenge of expanding your roles to enhance further the quality of the care you provide to your patients and clients. This has given rise to nurse-led clinics for people with asthma, bone fractures and skin complaints which have been recognised through a host of national awards. The Royal Hospital Trust is the first acute trust in Northern Ireland to gain full King's Fund accreditation.

Florence Elliott

This address is given in honour of Florence Elliott, one of the most outstanding nurses that Northern Ireland has produced. After a distinguished career as a staff nurse and midwife, she was appointed to the post of Matron at the Royal Victoria Hospital in 1946. Florence was the first Royal-trained nurse and the first Ulster woman to hold this prestigious position.

She was a great believer in innovation in nurse training and practice, provided that it was of benefit to patients and clients. She never wavered from her firm belief that the prime and over-riding concern of the nurse is the welfare of the patient. Florence also contributed actively within the wider world of nursing. She was a Vice-President of the Royal College of Nursing from 1964 to 1965 and a member of the Joint

Nursing and Midwives Council for Northern Ireland from 1946 to 1966. She served as Chairman of the Council for the three years before her retirement in 1966. Her considerable achievements were recognised through the award of the OBE in 1951 and, latterly, by being made a Life Governor of the Royal Victoria Hospital.

On her retirement, Peggy Nuttall, the then editor of *Nursing Times*, described Florence as:

"the greatest nursing leader Northern Ireland has ever known and one whose contribution to the nursing affairs of the United Kingdom was as valued 'over the water' as at home."

Role, Characteristics and Elements of Nursing

The Bicentenary provides an opportunity not only to celebrate past and current achievements but also to look towards the future. Today, as in Florence Nightingale's time, the role of the nurse is to provide skilled nursing care to those who require it and in accordance with the needs and circumstances of those who require it. In exploring some notions on the elements of nursing I would like to use the theme of *partnership* - nursing's partnership with the public and nursing's partnership with others who contribute to that broad canvass that we call health care.

Nursing, perhaps above and beyond all other health care professional groups, is closest to the people it serves. This closeness and sustained contact demands a set of unique personal characteristics on the part of the nurse - sympathy, understanding, tolerance and compassion. These qualities are required not only at the individual patient-practitioner level but also, through collective responsibility, at the community and societal level. The aim of nursing remains the same as in 1859. What has changed beyond recognition is the means by which nursing can achieve that aim.

But, what is nursing care? What are the elements that

differentiate it from medical care or the care given by therapists, support workers, technicians and many others? Several definitions have been attempted not least by the four Chief Nursing Officers of the United Kingdom in their report 'The Challenges for Nursing and Midwifery in the 21st Century', better known as the Heathrow Debate. Their definition, drawn from a tradition of caring based on skills and values, was immediately recognisable in its description of what nurses and midwives do and the concerns and special responsibilities they should have. However, debates on the elements of nursing, medicine or any other group involved in health care are, to my mind, incomplete unless they start with what the patient and the public needs from their perspective, rather than what it is that those in health care currently do. The difficulties of genuinely involving the public in such debates cannot be underestimated. Nevertheless, it cannot be denied that the health professions' partnership with the public is, in general, an unequal one and we should strive to redress that.

A particular problem with defining nursing is that it has been and is very flexible in responding to different needs over the decades. For example, shortages of domestic staff in the two World Wars led to nurses taking on such work in hospitals - much against Miss Nightingales' principles. More recently, changes in the hours worked by junior doctors and difficulties in recruiting and retaining general practitioners have provided opportunities for nurses to develop their roles in closer support of their medical colleagues. This flexibility is both a strength and potential weakness - the latter because in today's climate, if you cannot define it and justify it how do you calculate its added value and therefore financial worth?

Nursing and the Public

The elements of nursing with which I am concerned are those which serve patients and clients and which the patient or client helps to determine. Nursing as a profession should, in my view, be a little less concerned with debates about its status as an art or science and rather more with its role within a partnership, not only with patients and clients but also with the wider public.

We are all familiar with the terminology and buzz phrases - user participation, patient empowerment, client-focused care. But how does nursing, as a body, engage directly with patients and clients in a genuine and meaningful partnership, as well as indirectly through health care consumer organisations? One of

the UKCC's key objectives is to increase direct public access to, and involvement in, all our public protection work.

First and foremost, the UKCC's *Code of professional conduct* sets out the standards of education, practice and conduct required of all registered nurses, midwives and health visitors at all times. The code is, therefore, an instrument of public protection and a contract with the public, defining the expectations that the public can have of our practitioners. It also defines that which distinguishes registered nurses, midwives and health visitors from unregulated health care assistants.

Secondly, some of our Council members and many of our committee members represent the voice of the health care consumer. All of our professional conduct committees, which consider allegations of professional misconduct by registered nurses, midwives and health visitors, now include at least one consumer representative. We hold an annual conference with representatives of consumer organisations so that we can listen to their views and explain our public protection work to them. Our Council meetings and all of our Professional Conduct Committee meetings are open to the public.

And thirdly, we have recently published an information leaflet, *Protecting the public*, which is the first ever UKCC publication to be written specifically for the information of patients and clients, rather than registered nurses, midwives and health visitors. The leaflet explains the public protection work of the UKCC, how the public is involved in our work and sets out contact details.

Sadly, what gets into the media and therefore what the public hears most about, is when that partnership is violated in some way. Abuse of any kind is indefensible and at the UKCC we are working on how we can help registrants and employers recognise, deal with and most importantly, prevent abuse happening at all. At both an individual and organisational level, we need to strive to ensure that every person's health care experience is a good one and that, at the very least, people's vulnerability is not exploited.

Nursing, Teams and Multi-disciplinary Working

Providing quality nursing care is undoubtedly a team exercise - not only with the patient but with all those involved, be they a qualified professional or

unqualified carer, relative or friend. Good nurses are good co-ordinators not just in the administrative sense but also in the 'whole person' sense. Professor Celia Davies of the Open University has termed this "... the skills of 'creating community', drawing out and enhancing the contribution of others whatever their formal roles and titles." I would venture to suggest that this is a fundamental element of nursing. Nevertheless, the 'team exercise' that is mentioned the most is multi-disciplinary working. This term has many interpretations and manifestations but whichever one is used, multi-disciplinary working has increased markedly over the last few years and most commentators expect that this trend will continue and deepen. Rarely can it be said that within a health care team one practitioner possesses all the requisite experience, attributes and skills to deal alone with the individual needs of a patient. However, there are genuine difficulties in achieving *effective* multi-disciplinary working - not least the different levels of initial preparation for practice between disciplines not to mention defence of dearly held 'territories' and the expectations of patients and employers. These difficulties will have to be tackled openly and honestly if the perceived benefits of disciplines working more closely together are to materialise.

At the Royal Victoria Hospital, Nursing Development Units have recently become Care Development Units to promote and support a multi-disciplinary initiative. Care Pathways also embody the multidisciplinary approach, reinforced by the commitment from senior management within the trust to drive forward multi-disciplinary working. I am sure the energetic research programme will, if it has not already, start to evidence the benefits to patients.

Education - Preparing for Future Practice

But, how will professional education and training provide the appropriate preparation for a more flexible and multi-disciplinary workforce? 'The Future Health care Workforce' report published last year from the University of Manchester's Health Service Management Unit threw some fairly large pebbles into the pond of professional education and training. For example, common core training including medical students and management trainees; preparation of 'generic carers' - admittedly, a term the report disliked - and those 'generic carers' forming the pool from which therapists, or specialists would be drawn; more flexible entry levels to training through Accreditation

of Prior Learning or Achievement; an occupational standards base to education and training and a greater influence by employers in the education of the current and future health care workforce. The resulting ripples from these 'pebbles' have varied in size and intensity. But - whatever the reaction - the report has made people think. It cannot be denied that patients should be able to expect a consistent level of competency from all health care professionals and therefore some commonality in how that competence is expressed in education would make sense; neither can it be denied that there are inflexibilities - for organisations and trainees - in the current single discipline approach to professional education. However, any moves towards greater commonality of education and increased flexibility of working need to be firmly driven by the needs of patients and clients - not economic or administrative imperatives although, these will play their part.

Increasingly, reflective practice is replacing the more traditional interpretation of professional knowledge as something to be acquired or possessed. This, of course, is nothing new. As Florence Nightingale observed as long ago as 1859,

"The everyday management of a large ward, let alone of a hospital, - the knowing what are the laws of life and death for men, and what are the laws of health for wards ... - are not these matters of sufficient importance and difficulty to require learning by experience and careful inquiry ...?"

Reflective practice works towards an alternative concept of knowledge - seeing knowledge as not something to be obtained once and for all but as something which, in Celia Davies' terms, "... grows and develops from the fusion of expertise and experience and of the formal and the intuitive." Increasingly that fusion will come from and need to support multi-disciplinary and multi-agency health care.

The UKCC has presaged this development both through what in 1991 was a relatively new preparation for nursing and midwifery practice - Project 2000, and more recently through the introduction of its standards for maintaining registration and continuing professional development, more widely known as PREP. The current Project 2000 model of pre-registration education encourages nurses and midwives to think widely, to study alongside other professional and non-professional health care groups and to develop a firm base of skill and competence. However, as the report of the four UK Chief Nursing

Officers' Heathrow Debate makes clear, it is important that the Project 2000 model and its successors do not limit opportunities for nurses to cross frontiers - a point that was picked up in the 'The Future Health Care Workforce' report I mentioned previously.

The UKCC's Post Registration Education Project requirements will, from April 1998, affect every single registered nurse, midwife and health visitor - all 650,000 of them. By linking evidence of continuing professional education and development with continuing registration, the UKCC has taken a significant step towards ensuring that practice more closely meets the needs of patients and clients.

The initiative is about linking professional development with quality practice. The process, particularly through the use of the personal professional profile, demands a lifelong commitment to personal development but, more importantly, the ability to reflect upon and to analyse the beneficial impact upon professional practice of study activity undertaken by registered nurses, midwives and health visitors. It is this impact which the UKCC will be most concerned with monitoring when its audit system for PREP is in place from 2001. Continuing professional development should lead to better patient and client care otherwise it is a waste of time. However, proving the exclusivity of its influence in challenging to say the least.

Patterns of Health Care and Professional Boundaries

Looking more widely, it is clear that existing patterns of health and social care are being remoulded as pressures for health care increase, not just in the United Kingdom but across the world.

Public resources are increasingly being focused on providing services that address the basic questions of:

- what do people need?
- how can those needs be met? and
- will it lead to an improved outcome for the patient or client?

Inevitably this raises questions about how skills and expertise are used to best effect.

Developing broader-based and more flexible roles is at the centre of the patient-focused care initiative, still in its infancy in the United Kingdom but already providing examples of effective and innovative health

care. The challenge for us all - the UKCC included - is to embrace flexibility without diluting the value to the public of employing registered nurses, midwives and health visitors. The blurring and crossing of traditional role boundaries is already happening. In the past, relationships between different groups of health care professionals has led to a tacit acceptance of each other's responsibility and authority. Sometimes the law, but more often custom and practice, have defined who does what and how. Some of these accepted demarcations are coming under pressure and dissipating. This is challenging enough for the professions to deal with but probably even more of a challenge for the public to comprehend. It is incumbent upon us all to ensure that the public know what to expect of those who are caring for them and that they are competent.

Nurses' roles have changed and often the person who a patient believes to be a registered nurse may be an unregulated health care assistant. This raises the question of whether the public's perceptions of nurses are clear and realistic. Expectations are driven not just by changing needs but also by what people want and what they believe they are entitled to. Nursing, however it is defined, exists to serve the public and the public have generally had confidence in them. They have been accessible to and active on behalf of those who depend on the care they provide. Although, the public's view of nurses and nursing has probably always been a compound of myth and reality, what has not changed is the public's recognition of nurses' duty of care for patients and clients.

Summary

In summing up, I have explored briefly some notions on the elements of nursing through the theme of partnership with the public and with others involved in health care. These notions, which are by no means exclusive, have centred around five main areas;

Firstly, the unique personal characteristics demanded by the closeness of sustained contact with patients and clients;

Secondly, the primacy of the patient's and the public's needs in defining nursing or any other health care profession;

Thirdly, the need for nursing both individually and organisationally to look outwards and engage with the wider public and their changing attitudes towards the professions;

Fourthly, the unique skill of 'creating community', *working with, co-ordinating* and *leading* teams across disciplines in the interests of the patient and the challenge that true effectiveness of multi-disciplinary working presents for both education and practice; and

Fifthly, the importance of reflective practice throughout the working life of nurses as a means of better meeting patients' needs.

How nursing retains this focus whilst adapting to a constantly and rapidly shifting health and social care environment, will largely determine how nursing endures as a profession. If the example set by Florence Elliott and the many innovations and developments at the Royal Victoria Hospital are anything to go by, the people of Northern Ireland, nurses in Northern Ireland and health care generally in Northern Ireland, can look forward to another 200 years of healthy partnership.

FURTHER READING:

Celia Davies

The Cloak of Professionalism: - A case of Yesterday's Fashion? Unpublished speech to UKCC Council members, June 1996.

Department of Health

The Heathrow Debate: The Challenges for Nursing and Midwifery in the 21st Century London, HMSO, 1993.

Health Services Management Unit

The Future Healthcare Workforce University of Manchester, 1996.

Florence Nightingale

Notes on Nursing Churchill Livingstone, London, 1980.

Muriel Skeet

Notes on Nursing: The Science and the Art Churchill Livingstone, London, 1980.