Nursing in crisis. Project 2000

How many grades ?

An answer to Sue Pembrey

THE LEVEL OF NURSING DEBATE.

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The irony about the bewildering variety of much of British Nursing personnel in terms of innumerable grades, specialities and types is not lost on the business acumen of Reeds' Nursing Agency. Their promotion poster depicts a huge and colourful chessboard where different types of nurses are poised and moved along offered for hire according (probably) to competetive price ranges, and may be also to required skills which are said to be differently distributed throughout the nursing labour force. Are we talking about a rhetoric of essential differences in the standard of provision of nursing care? The issues the poster raises concern themselves with the thorny and persistently recurring debate about how many levels of nurses are needed.

Not all that long ago, in the active days of Briggs considerable thinking about this moot point culminated in recommendations of sorts: For general nursing this suggested, that as far as levels are concerned, there should be two; that the two should be interlinked; that the two should represent different levels of skills and different levels of complexity and that the nature of the linking process should include provisions whereby having acquired a certificate of nursing practice (first phase), a subsequent period of further (more advanced) training would complete the second phase, an educational process towards becoming a fully fledged registered general trained nurse. This occurred a bare sixteen years ago. Since then the Brigg's report like its predecessors, other nursing reports, has joined them on the shelves in the archives where it gathers yet another layer of dust. It should have acted instead as an important momentum that it was then and still is. But this is the fate of much cataclysmic behaviour and archives after all do provide an enormous source for PhD studies about the whys and the wherefores of well considered recommendations never seeing the light of day at the time of their publication, 'and so it goes' says Vonnegut.

We have moved on and now look back on the intervening sixteen years of nursing

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activity when the nature of the current crisis in nursing determines yet another process of re-thinking.

When in Britain some of nursing education moved into academia during the late 1960's and early 70's and was therefore compelled to think about nursing's theoretical nature, the until then almost commonsense understanding that there is something known as basic nursing and something known as technical nursing seemed abhorrent, an almost immoral proposition. As the notion of basic as opposed to technical embodies a hierarchy of values, irrespective of intended motives, and nursing was now in the business of actively forging for itself a highly respectable i.e. professional image, the division of technical versus basic had to be blurred, publicly in the supposed interest of nursing's clientelle, the patients, and privately one suspects in the interest of the professionalisation of the occupation of nursing. That a social activity such as nursing which operates at the absolute intersection between a patient and the medical system where a patient's vulnerability is at its most wounding, should be divided into two levels of care to which hierarchial values become attached as in a priory process was no longer acceptable to many of those who then thought, taught and practised nursing. The Nursing Process, a transcended idea probably arising out of the 1960s American Civil Rights Movement, first developed by American nurses, and its tentacles later spreading incredibly fast certainly over much of the 'developed' western world, compounded our confusion about a supposed mechanistic model of care which it was argued divides the body for the purposes of healing into separate components, elements, organs etc. directing the specific gaze at the culpable organ or tissue at the expense of the total human being.[1] Before the Nursing Process made its dramatic entrance into Britain in the middle of the 1970s, the division of nursing activities into separate and isolated skills seemed no problem. And indeed for the devoted nurse whose competence included an ad hoc acquisition of acceptable social skills (an amount of charm, conversation and empathy) as opposed to professional skills (the art of bedding, the taking of pulse and respiration, the passing of a Rhyle's tube,) an attenuated

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mechanistic division of the sick human being for the purpose of applying medically prescribed orders did not appear to be totally out of place for it was the pattern of the dominant mode of delivery of care.

The arrival of the Nursing Process changed all that - not immediately - but it became the trigger upon which nursing re-thought its mission. A mechanistic division of the sick human being into separate bits was supplanted by an holistic notion of the human being. Though attempts have been made to clarify the notion of holism[2] it remains a vague and unprecise concept and can offer little guidance for practice. A holistic notion of man spells out figuratively a universal concept of man as standing outside the social and political forces of his period. Is this a reality? At a period of rapid social change of the nature we face momentarily, the political development of an holistic view of man (and woman?) is a great comforter. The notion of whole has a magic quality. By implication it must be good for it embodies an organic conception of being as opposed to the previously mentioned mechanistic view of the world. This must surely be preferable to the atomised state of an individual whose alienation is responsible for a fragmentary state of existence. So holism perpetuates a romantic image of that which perhaps was and that which surely should be! In part its attraction is properly related to its obscurity when its formlessness lends itself to shades and different levels of interpretations. Even if we could define precisely what an holistic view of nursing constitutes, does this lead necessarily and sufficiently to a production of an holistic nursing practice? Do we mean by this to overshadow the problems and conflicts of interest in any division of labour? Is there an idea that having got hold of the notion of holism, such conflicts as there are in any division of labour need no longer be confronted, because it is pushed out of an idea even if not out of practice?

Nursing's almost moral crusade to end ~~the~~ 'task' ~~of~~ conceptualisation, resulted in the idea that all tasks to be applied (and nursing is also about tasks!) should either be delivered by one nurse, or if that proves impossible that

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one nurse must accept the entire responsibility for the administration of the tasks. Therefore a division of labour cannot be circumventable, it exists, and in turn it is subject to the prevailing norm of the currently existing social structure and ~~sense of~~ social order where power and authority patterns willy-nilly cut right across any wishful notions of holism. This is not to argue that the extreme task orientation which was so prevalent in British Hospitals (has it disappeared completely?) is disruptive to any interpersonal relationship between nurse and patient and its pernicious system should be ameliorated. Similar developments are not unique to nursing. It takes place elsewhere particularly amongst a radical section of medical, natural and social scientists who registered their disillusionment with the medical enterprise as a progressive activity.[3] It is still part of an on-going debate[4] also in Nursing as Sue Pembrey has demonstrated so skilfully in her article.[5]

By the time we reach its last sentence we will have become convinced if we were not before that a patient - any patient? - is entitled to the services of a trained nurse; that applied nursing knowledge is indivisive in the sense that its particular components and elements are integrated in its ultimate aims to provide a comprehensive nursing cover for a specific patient. We are learning from nursing research that optimally arrived-at nursing practice standards can be developed and set as nursing prescription if an understanding of nursing competence has any meaning within that context. However, there is no reason to assume that a nurse's competency (a minimum standard of knowledge and skill) legitimated through the admission to the professional register (page 48, column 1, para 1,) ensures subsequent competent practice. There is a world of difference between being considered a competent practitioner by decree and being able to practice competently from thereon under any circumstances. Though in order to practice competently a prerequisite of knowledge, skill and understanding is essential, its acquisition alone cannot ensure such practice. When the (competent) practioner, a single individual is put into the situation of practising together with other such individuals a whole new set of circumstances prevails and these are related to the social, professional and ideological dimensions at the place of work. The single individual is no longer in total control of his/her own work; other forces intervene and the resultant process of negotiation determine an individual's activity. No matter how well our nurse is

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prepared to nurse, no matter how much, how little he/she knows about the subject of nursing and or the subject to be nursed, her/his nursing activities will be constrained according to the composite constellation of the institution, of the work place, at ward level as well as at more senior management levels. An ability to nurse competently depends on, apart from knowledge, also on resources and an organisation which places the entire responsibility for good nursing practice onto the individual nurse without ensuring at the same time the provision of adequate resources makes a mockery of professional accountability where duties are compromised because they are not accompanied by rights, a somewhat lopsided understanding of natural justice.

To ~~make~~ ME it is not good enough that our statutory bodies should only be responsible for training policies and their implementation without ensuring at the same time that such well defined policies (if that is what they are!) have a chance of being put into practice. In this instance the nurse is given the duty to carry out her professional responsibility while the means with which to apply them, the authority, has no other istitutional backing except through a register which says no more than that nurse X has passed his/her examination. From thereon she/he is completely left alone to sink or to swim. What is required and seems to me to be the right of any (competent) nurse to expect which goes with her responsibility to deliver, is a statutory nursing practice policy, a standard, imposed by the UKCC so that its training directives have a chance of being implemented. As a statutory body merely to formulate policies and to make the individual nurse entirely responsible for carrying our her/his professional expertise without statutorily to ensure backing-up provisions, abnegates its duty to the public. Such policy, would spell out the parameters of institutionally acceptable good, bad or indifferent practice and the negligent hospital or other institution subject to this policy's requirement can then be called to answer its case. Such a policy can be supervised and evaluated similar to current UKCCinspectorate patterns about an institution's delivery of training directives.

The point S. Pembrey makes about there ~~being~~ "ARE NOT" two standards should be unequivocal if by that is meant that there is only one standard of competency in terms of what constitutes a trained nurse. A licensed practical nurse as in the USA or an enrolled nurse in Britain has a standard of competent

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practice to defend much as the trained general nurse has and the requirements for institutional backing applies to her or his case as well. Though there can be only one uncompromising standard, levels of care however must differ according to a clientelle's requirement and not everyone needs the services of a fully trained general nurse.

In her thinking about different models of care S. Pembrey brings in a care assistant, an assistant to the patient, not the nurse who will work, it seems under the jurisdiction of the trained nurse and who will be trained patient specific. With this model are we getting rid of the enrolled nurse, intending therefore to cut out existing ambiguities about who is responsible for nursing and who will be involved in its practice, by returning through the backdoor a demoted kind of enrolled nurse, poorly trained, poorly paid and put-upon, where only the trained nurse can reign supreme? The acceptance of the need to bring in assistants is an admittance as Sue Pembrey is quite ready to concede that 'nursing is not the sole province of registered nurses'. If this is the case, rather than dismantling the role of the enrolled nurse, another look at the Brigg's model is suggested which should clearly circumscribe the two levels of care with one standard so that nursing does not fall into a vacuum as Pembrey suggests it might.

It is quite feasible that within a nursing budget different team mixes can be utilised to provide changed qualities of care. But I am concerned about a team with only registered nurses and care assistants. Care assistants will be attractive to the authorities because of their relative cheapness. They will have received nominal training only and will therefore find themselves in a state of acute dependency at the mercy of double exploitation; a) through low wages from the employing authorities and b) at the hand of the registered nurse of the team who is in the position to control the carer and delegate work, withholding knowledge and or sharing it, all according to the individual arrangements between nurse and carer. The care assistant will have little opportunity to participate fully within such a fraught power relationship where the registered nurse can do all the control and delegation. Such a system facilitates manipulation simply because of its sheer plausibility! Only one person has the knowledge, skill and competence and he or she will act as the arbiter. The carer is defenceless. The advantage to any nursing team of having a variety of trained personnel (general trained and enrolled

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nurses) is to recognise a varied richness of experience (partially embedded in type and nature of training) in relation to a clientelle's different health needs which collaborates for the benefit of the would-be patient. Each group's different expertise will bring to the nursing situation a type of knowledge somewhere close to a patient's nursing needs. It is in the different approaches of such groups that the advantage lies. Also and equally importantly within the whole spectrum of potential nursing needs within any given population not everyone requires all the services a fully trained nurse has to offer, but equally no one should be subject to services by untrained or poorly trained personnel. Services of this kind, comprising various levels of care can only exist providing both types of nursing practices are clearly circumscribed and have the benefit of institutional backing through a legal UKCC nursing practice policy. This is true work sharing of collaboration where a mix of recognised professional competencies which are not interchangeable would provide full support for the complex, difficult and often exhausting activity of nursing in which all participate. Nursing or any other decision should never be left in the hands of <u>one</u> person however competent the nurse might be. Competent decisions are those carried out by a mix of trained personnel, each working comfortably from within her/his parameter of training and responsibility.

So far, public and private institutions delivering health and illness care have been able to get away not only with substituting enrolled nurses for registered nurses when convenient, but also with employing vast numbers of non-trained and partially trained personnel.[6] This is possible because the institutions as institutions are not answerable to anyone for the care they provide; only the individuals are the ones who are potentially culpable and particularly in periods of recession when private and public fiscal funds are manipulated in order to uphold a specific ideology, nursing budgets because of their size, receive most of the fiscal scrutiny.

To open the doors for assistant carers whether for nurses or for patients gives license to employing authorities to employ and to people it with mainly untrained staff. The realities of any political situation, expressed through the current political and economic climate, is never the time for the spinning of utopian dreams and wishful thinking about ideal types. It is to recognise that even if at the helm of any medical and nursing institution nurses and doctors officiate who are sympathetic to the nursing voice, their behaviour

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will be in tune with public doctrine. This is not because their personalities are nasty, nice or indifferent, but rather that the relationship of power exemplified by the process of the political economy in which we all participate dictates particular avenues to pursue leaving narrow options only. If we want to function as professionals we need to recognise these parameters which, however, experientially are never static! I think for those reasons it is positively dangerous to add to those already unqualified but yet nursing,[6] another group, the care assistants. What we should be doing is to recognise the immense contribution of the enrolled nurse, circumscribe her/his practice and demand of the authorities to develop an institutional code of nursing practice for support.

The work at Burford Community Hospital in Oxfordshire based as it is on the work of the Loeb Institute at New York has enormous merits. Both these institutes cater partially for post-acute hospital cases and partially for nursing cases which are GP and District Nurse referred. There is no reason why these institutions should not be run entirely satisfactorily by general trained nurses and eventually perhaps by nurse practitioners as developed by the McMaster programme in Canada. However it is one thing to develop and to carry out a number of different nursing models and another to upgrade one of those models as generalisable for an entire country.

In the first place what happens within a small institution of 16-50 beds let us say is not easily transferable to large scale institutions of 600-1000 beds. The different scales and scopes in different size institutions demand different managing patterns and the adaptation for practice of research results from one institution to another must be frought with problems. Secondly, whereas smaller institutions might be able to prove that a system of primary nurses, where a small nursing staff carries out high quality care is in fact a cheap option for the institution, IT MIGHT NOT APPLY FOR LARGER INSTITUTIONS. Once primary nurses will have realised fully the implications of their superb practice, they will demand as they should, a very much higher financial reward - and in terms of large public funding it will be no cheaper, though it might provide a better service, but this requires a major research project which includes answering the question whether everybody needs a fully trained nurse.

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I probably will be accused of limiting my sights about nursing to the constraints of the current political climate. It will be argued that therefore there is no vision because that vision is dictated by today and does not take into account long term planning. Planning can go forward at two levels. One is towards a utopian dream where wishful thinking is both the father of the thought and as ill-advised as it can only come from that source. Another is to develop a brick-building programme which takes current and resonable future predictions into account, proceeds step-wise but is poised for change when new and different opportunities both arise and are developed.

The future health needs of Britain coupled with acute demographic population changes require the development of vast varieties of nursing care programmes which take into consideration that not only clients' needs will drastically change but that also the source of the traditional labour power in nursing, young ladies, will dry up in the late 1990s when the number of eighteen year olds will have dropped dramatically. Instead of the cutting out of the enrolled nurse, he/she should be used to the fullest of her capacity in a vast variety of yet unexplored settings and the same should apply to the fully trained nurse. Their respective power position within the system should be guaranteed by a publicly acceptable and enforceable code of nursing practice.

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