

Over to you...

Cost-effective nursing

How can nurses care most effectively for their patients while keeping a check on ever increasing costs? Anthony Carr, ANO, Newcastle AHA(T), believes that the 'careful and proper' use of the skills and abilities of nurses at all levels would go a long way towards that aim

THE question that has to be asked is, 'Can we continue to increase resources for the needs of our health services to an unlimited amount?' Any nurse who has managed a nursing service for just five years has seen costs rise continually.

Ways must be found of providing an effective health service which is cost-conscious and cost-limiting. In the United Kingdom 70% of costs in the hospital service relate to staff; in the community it is 75%. Effective use of staff could therefore produce the greatest savings. We must also look at the duplication of services in hospitals near to each other and more effectively use our resources.

There are many things which could be done to increase nursing effectiveness. In hospitals in the United Kingdom it is a most difficult management problem to maintain a proper three-shift system. Staff are reluctant to start early in the morning or leave late at night. Also, staff who work four nights of 10 hours will not easily change to work five nights of eight hours. If that could be arranged, very much more effective use could be made of staff.

Rapidly in the United Kingdom the student is becoming supernumerary to the establishment. If a calculation is made of the amount of time spent in service to the patient, then the salaries per hour for my health authority are as follows: sister, £2.60 per hour; student, £2.13 per hour; staff nurse, £1.99 per hour; enrolled nurse, £1.82 per hour; nursing auxiliary, £1.54 per hour.

My problem is that the non-service of students has not been replaced with money to buy other staff, so I can demonstrate a falling of staff numbers and an increased caseload. This may or may not mean falling standards of patient care.

To me, standards of care relate more to people as individuals than to the physical presence of a certain number of nurses on a ward at a particular time. I want ward sisters again to be the guardians of standards of nursing

care, not to blame the selection of students or lack of resources but rather to be people who insist on every nurse holding to a personal high standard of care.

New programmes of training are more than likely to increase this complex problem. My concern is two-fold. First, the standards of patient care that can be maintained and, second, the danger of reducing the numbers of nurses in training to lessen the effect of reduced service commitment. The long-term effect of this latter action will be to put back future plans for expanding nursing services for many years.

The team

In this situation of rising costs and less service offered, it is essential to look at the structure of the nursing team at ward and community level so that precious skills are used to the full.

I would maintain very strongly that to nurse patients effectively and to get the best for our money, the nursing team has to contain staff prepared at different levels.

It must, of course, be headed by what the EEC nursing directives call a first-level nurse—our registered nurse. I believe there is a place for a second level of preparation for a nurse which in the United Kingdom we call an enrolled nurse. I also contend that the nursing team should be completed by an auxiliary nurse as long as she is suitably prepared in education and training terms.

In this country today more people are being treated and nursed by non-nurses than nurses. Less than 1% of the UK population is in hospital at any one time, while less than 7% of the community are visited in a year in Newcastle. There is much more illness than that about. Who then cares for the sick? Other people like mothers, aunts, next door neighbours. We called these people 'carers' in our district nursing working party report. Without them nurses could not nurse; they would be overwhelmed.

I contend that if we all applied the

Nursing Process to all our patients and produced individual care programmes for each patient, we would discover different levels of need. Staff of all abilities should thus be trained to meet these different levels of need. It is to my mind a waste of skill to train one level of nurse. Nursing is unique in that it can cater for persons of many abilities and qualities. The secret is the careful and proper use of these skills and abilities.

In the early 1900s, two-thirds of British nurses practised their profession outside hospital. Some were district nurses, many were private nurses or nurses belonging to religious orders. Only one-third were working in institutions. In my area health authority at present only 6% of nurses practise outside hospital.

I am sure that many more people could be kept out of hospital. Too few community nursing services offer nursing care through the day and night. In consequence, terminally ill patients have to be admitted to hospital just a few days before dying. I get a sense of failure every time I hear of that happening.

I was fortunate enough to be able to launch a night nursing service in the Newcastle community in 1976. With only about six nurses, acutely ill patients and terminally ill patients can receive between one and three visits a night. I believe that, at a total yearly cost of £35 000, this service is not only cost-effective but humane, and the work is very dear to those nurses undertaking it.

Over the next three years I want to expand the district nursing teams considerably throughout the 24 hours. Somehow we have to reverse the trend to send everybody to hospital. We must take a new look at offering a comprehensive community programme of care and health education. I believe that if we had properly developed community nursing teams of registered nurses, enrolled nurses, and nursing auxiliaries, patients could be treated at home for illnesses for which they are now admitted to hospital. Community

amount of experience we were able to discuss it at some length. He answered numerous other questions that had been on my mind and the following morning we did the drug round together and again I learnt a great deal about drugs in use on that ward.

You may ask why this student should have enough knowledge to teach a staff nurse and whether could I trust him. He was doing a two-plus-one course and was due to register in the next few months. In the eyes of the hospital he was in charge of the ward but was not allowed to do certain things such as checking drugs.

In charge

On my fourth span of duty I was in charge of the ward. This particular night was not too bad as it was a fairly quiet ward but the next night was awful. It was a very busy ward, which appeared to be badly run: whatever I tried to do I seemed to find something to obstruct me. For instance it took three attempts to assemble a working thermometer—a sheer waste of time and energy.

My mood was black. I felt it was impossible to care for the patients properly and it took even longer to orient myself to the ward and patients. The other staff were obviously affected in the same way and grumbled a great deal and it didn't help that the staff nurse I replaced had been removed for other duties.

At one point during the evening I was asked by the doctor to set up a cardiac monitor on a patient. In my book this was a non-nursing duty. Certainly neither in my training nor at any time since have I been instructed as to how to set one up and in any case my expertise in the medical field is limited. I explained this to the doctor. 'Ring up night sister and get her to do it then', I was told. This I felt was totally unreasonable as it was 10 o'clock and I knew she was busy.

I was also informed that nursing staff did set up monitors in the hospital but I wasn't giving in. There has been so much debate over the past few years about non-nursing duties and I felt justified in making a stand. Later in the evening this doctor came up to me and was very polite, introduced himself and said he hoped that he hadn't upset me! I have since mentioned the matter to a member of the tutorial staff in the school of nursing and discovered there has been quite a lot of trouble about this particular point and that I did the right thing.

I found it difficult to know how roles have changed. I often work with an auxiliary and it is very hard to know the limit of her permitted duties as opposed to those she would like to perform. It is a relief to see learners

taking less responsibility on night duty and to see so many trained staff around. There also seem to be proportionately more sisters who are able to support ward staff more and in many cases do so. They do try to help new members of staff but often do not realise which ones are returning to nursing after a break.

On the agenda for this year's Rcn representative body meeting is a resolution calling for all qualified nurses who have been absent from active nursing practice for a significant period to attend a mandatory period of retraining at a recognised centre before returning to nursing. The note attached to the resolution says that it is not intended that this retraining should supersede any present legislation affecting certain groups who are already subject to such training.

Current back-to-nursing courses are haphazard and certainly do not exist in all hospitals where staff are recruited who have been away from nursing. Obviously managers and tutorial staff would like to see them introduced where possible but money is short and other things are often seen as more important.

There is also much debate as to who should run such courses. The school is the obvious place but tutors are in short supply. So hospitals often look elsewhere for a suitable person to be responsible for the course, such as within personnel departments or in some cases the in-service training officer.

I certainly think that it is dangerous to let nurses onto the ward after a break without any form of induction, particularly if the break has been a long one. But how would 'a significant period' be defined, how long would these courses be, and should the course be held in the hospital in which the nurse is going to practise so that she can learn about the policies of that particular hospital?

Most nurses who have taken a break in service have done so because they have been bringing up a family. Many wish to return while the children are still quite young as it is then possible to work at night and at weekends when husbands can look after the family. To ask one of these women to attend a course during the day is unrealistic because they are unable to leave the children anywhere.

A few hospitals already recognise this difficulty and arrange suitable back-to-nursing courses but they are very few and far between. There is however little doubt that these courses are very heavily subscribed.

The course content varies greatly from place to place. Obviously if a mandatory period of retraining was required of nurses returning to the profession one would hope that the

content would also cover certain basic aspects, no doubt as laid down by the responsible body. However, different individuals would require slightly different courses depending on length of time out of the profession and the type of work (if any) undertaken during the break in service.


One course I looked at certainly seemed to fit the bill for the average nurse. It covered all aspects of clinical nursing both in the lecture room and on the wards, in particular covering drugs very thoroughly; it also covered lifting, resuscitation and use of pre-packed sterile equipment, as well as developments in the health service, including community services.

I did wonder if it would have been helpful to add a session on basic nursing care as, although in principle this does not change much, in practice there are many variations. Many nurses who trained in the days of sterilisers on the wards would also have been used to collecting unconscious patients from theatre, so perhaps an updating of pre and post-operative care would not be amiss: after all, if one is going to do a course the idea is to prepare one to return to the clinical situation as a useful member of the team and not to put too much strain on the existing team.

Time for questions

Clearly any course is going to seem too short for the average member. It would be impossible to cover all subjects as fully as during basic training but one of the chief criticisms of any course tends to be that it was too rushed and that not enough time was allowed for the sessions nor enough time for questions and discussion. However, as many say who have done the courses, a little is better than none and certainly it helped to regain one's confidence.

I do wonder how the average nurse administrator would feel if suddenly asked to return to a ward to work a shift. I am sure that many would feel very nervous despite their close proximity to the patients through their jobs. I have spoken to several administrators at different levels and all agreed they would rather not be put to the test.

In conclusion, I must say that I have found going back to nursing a rewarding and interesting experience. If I make further breaks to have more children the prospect of 'back to nursing' courses each time I return is rather daunting. Yet some kind of briefing is clearly required. Imagination and flexibility will be needed to work out better ways for management to meet that responsibility but in the meantime I hope that the Rcn's resolution receives the support it obviously deserves. 

nurses would again have the sense of real achievement as acutely ill patients recovered.

It is rather a joke with some patients that the last place to be ill in is a hospital. At home a patient has some control over his own destiny; in hospital he often has none.

I have tried as far as possible to deal separately with quality of care and cost effective nursing. The reason is that they are not always compatible. Quality often, but not always, needs extra

resources. As a profession we have to decide where we can combine the two and where we have to demonstrate that good safe nursing requires more funds. The case has to be clearly put; the days are gone when emotional stories about patients gained sympathy and funds; now it is cold facts that are required.

To sum up, we must re-dedicate ourselves to the task of caring for people. It is not enough to remember Florence Nightingale's words or even look back with longing to our training

days. If nursing means anything, it means a fresh dedication of ourselves today—a new commitment to find a quality of care that at present may be missing in our wards and in our staff.



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