NEWSLETTER

JOURNAL OF THE DISTRICT NURSING ASSOCIATION

Professional Association and Registered Trade Union for District Nurses

1981—2 **JUNE**

President: Anthony Carr, Esq., SRN, QN, FBIM, FHA

Vice-President: Mrs Martin Acland

Chairman of Committee: Miss A. Dalzell, MBE, RGN, SCM, HVCert, QN

Secretary and Treasurer:

Editor: Mr R. A. M. Mitchell, SSC

Main Office: 26 Castle Terrace, Edinburgh, EH1 0AU. Tel. 031-229 7717

The Fascinating Future of District Nursing

Anthony Carr, SRN, QN, FBIM, FHA,

President, District Nursing Association, ANO
Newcastle Area Health Authority (Teaching)

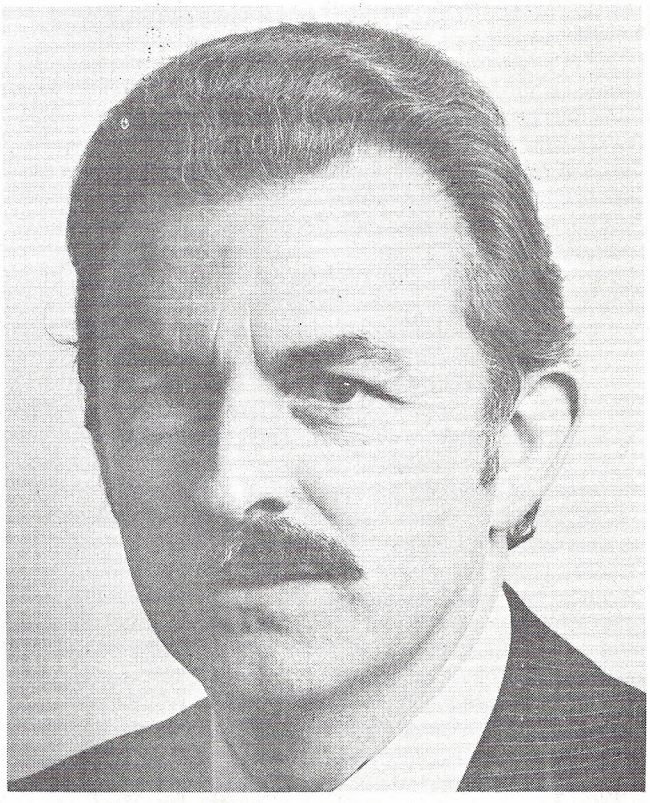
It is a privilege and honour to be addressing members of the District Nursing Association today. This is the first time as President of your Association that I have been able to be with you at an Annual General Meeting. Last year, personal family events prevented me from delivering an address to you. The Committee, however, suggested at one of their meetings that I should take on this responsibility this afternoon. I genuinely thought I had got away with it but, as you can see, I have conformed to the Committee's wishes.

I can think of no more exciting subject to talk about in nursing than the future of district nursing. It seems to me that various events over the last few years have assured that the major development in nursing that is to take place, and is already taking place, will be within the sphere of district nursing. I say that because of various developments that have taken place over the last few years. Let me deal with them in order.

A working party was set up by the old Panel of Assessors in 1974 to review urgently the training and education of the district nurse (SRN/RGN). This report was published in 1976 and there was great interest shown not only by the profession at large but also by the then Department of Health and its ministers. Mr Moyle in particular took very great personal interest in the development of district nursing and I think due to his influence as much as anybody else's the programme was pushed ahead with the encouragement of the Department and of course of the Panel.

Then the second working party to review the work of state enrolled nurses in the community was established in 1977, and that report eventually found its way to the profession in March 1980.

The third development was the reconstitution of the Panel of Assessors and the independence that was given to it. This is now taking place in practical form and shortly the Panel will be established within the building occupied by the Central Council for the training of Health Visitors. I would emphasise that it is important that both organisations I have mentioned work together but the emphasis I would place upon the separateness at this stage of the two organisations.



Anthony Carr

Another major development has been the appointment of the Chief Professional Officer to the Panel. This is Miss Barbara Robottom who will be taking up her appointment in early September. I think this is an important development because up till that point it was essentially a civil servant who was Secretary to the Panel and although they have been most committed to district nursing, and I would here pay tribute to Mr T. W. Matthews, the first Secretary to the Panel, who for many many years worked for the interest of district nurses, it is nevertheless true that it is time to have a professionally qualified Chief Officer to look after the interests of district nurses.

We can be assured that when the Central Council takes over formally from all the other statutory and other bodies then the interests of district nurses will be protected by a standing committee arrangement and it is important at that stage that the Chief Officer is able to make her maximum contribution to discussions on how that new organisation will work.

Some might be disappointed about the continuing use of the term "district nurse". I don't know if this reflects present status feelings of district nurses or not, but let me explain my own views on this matter and perhaps you would like to raise it in discussion later.

You will see that I have talked about the fascinating future of district nursing. I think first of all it would be very difficult for me to talk about the fascinating future of district sisters and charge nurses, because that is really what it is not about, it is not about people as much as a service. Now district nursing indicates a service offered to the community by specially trained nurses. I think the community understands the title "district nurse". It has a history going back nearly 100 years and in days before the National Health Service it was often the district nurse that carried out much of the health care in a person's home when they were ill. The term "community nursing sister or charge nurse", or some such title, denotes to me far more the status of the individual than the work that she does. I would therefore ask you to seriously consider the term "district nurse" and "district nursing" for the future. I do not think in any way this detracts from your status and I would just remind the audience here today that I have not yet met a health visitor who wants to be called a "health visiting sister", or sister of any description, but is quite content to use the title "health visitor".

In the same way, from September 1981, it is the term "district nurse" that will be protected by conditions of service and so in the immediate future we shall be in a position where the term "district nurse" is a protected title and this is as it should be and in that term we are talking about a hundred years of history.

I have no objection whatsoever locally to district nurses being called district nursing sisters or charge nurses. But that is more to do with the status of the person as I have said rather than the job that they do.

I mentioned elsewhere about two years ago that when you look into the future of district nursing a sub-title could be education or catastrophe. That is if we believe H. G. Wells when he said "Human history becomes more and more a race between education and catastrophe".

So in the future what do I see for district nursing. I believe this depends entirely on the place that the district nurse works. If she or he works in a urban area then I see a different type of structure emerging than if he or she worked in a rural area. Being as the mass of population do in fact live in large towns and cities perhaps I could speculate on that type of organisation and then the audience can make their own individual adjustments for working in the rural areas, particularly in Scotland and Wales, and Cumbria in England.

In the urban arrangement I see within the primary health care team another team. This is the nursing team, and I think there are potentially three levels of nursing in that team. The first level of nursing in the community is the highest level and that is the district nurse protected by conditions of service and working in accordance to a standing committee of the Central Council for the United Kingdom. The district nurse will have four major objectives and these are:

1. **To assess and meet the nursing needs of patients in the community.**

To achieve this objective the nurse will use her skills as a nurse by using what has been defined recently as the "nursing process". This is:

— a systematic gathering of information
— assessment of information
— planning of care
— giving of care
— evaluation of care.

This, indeed, is the unique function of the nurse. In this, she or he should excel.

The working party on district nursing held as an ideal Virginia Henderson's definition of the unique function of the nurse, which 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."*

She continues:

> *"This aspect of her work, this part of her function, she initiates and controls; of this she is master."*

We have to separate the two major aspects of the work of a nurse, although they are complementary to each other. But I would suggest that the cause taken up by Miss Florence Nightingale with the medical profession so long ago has to be resurrected with every new decade of nurses, especially at this present time when so much technology is applied by medical science to patients, with outstanding success in many cases.

The two separate components of nursing are the treatment and caring aspects. Of course, both intermingle in the total care plan for the patient, but if our medical colleagues ever emphasise the treatment aspect to the detriment of the whole care plan for the patient unnecessarily, then we have a duty to our patients, their relatives, other colleagues, and ourselves, to remind them that the social, emotional, physical, and spiritual needs of patients may need our support and certainly our understanding. This is not new. Two thousand years ago Jesus said in the words as recorded in the Gospel of Matthew:

> *"For I was hungry and you gave me meat, I was thirsty and you gave me drink, I was a stranger and you took me in, naked and you clothed me, I was sick and you visited me, I was in prison and you came unto me. Then shall the righteous answer him, saying, Lord, when saw we thee being hungry, and fed you, or thirsty and gave you to drink, when saw we you a stranger and took you in, or naked and clothed you, when saw we you sick or in prison and came unto you, and the King shall answer and say unto them, Truly, I say unto you, insomuch as you have done it unto one of the least of these my brethren, you have done it unto me."*

It should be so natural for a nurse to care, in the fullest sense, that our response to someone pointing this out to us should be like the disciples of old who could not see that they had done any of these things, nothing extraordinary, just a natural approach.

2. **Applies skill and knowledge acquired, and imparts effectively to patients, other carers, staff, and general public.**

The district nurse of the 1980's will be skilled at and

effective in teaching in relation to both the prevention and treatment aspects of health and disease. I hope that the district nurse with her primary health care team colleagues will develop caring plans for those people having some of the many modern social diseases of our present society. These diseases I suggest include smoking, excessive consumption of alcohol, over eating, and the anxiety complexes so prevalent in families and individuals today. Also what about family relationships. This will be in addition to her traditional role of teaching simple techniques, of caring, feeding and nursing patients. She will teach these techniques to relatives and other carers. As doctors and nurses, we may begin to learn that the patient himself is part of the caring team and should have a real and many times the major say in his treatment and total caring programme. Certainly, if he is able, he should give approval to what we are planning to do. The view that "doctor or nurse always knows best" sydrome may have to begin to die in the 1980's.

Other carers means anybody else who contributes to the caring programme such as home helps, neighbours, meals on wheels ladies, local youth and Church groups. The list is endless, or could be if we thought about it long enough.

3. **Skilled in communication, establishing and maintaining good and effective relationships, able to co-ordinate appropriate services for the patient, his family, and others involved with the delivery of care.**

The nurse will have a much greater understanding and appreciation of the dynamics of individuals and their group relationships. It should be thought an impossible nursing task to assess the nursing needs of patients and their families without an appreciation and understanding of the psychological, emotional, spiritual, and social needs of that particular family unit. I wish to see a skilled, articulate nurse taking her proper place in the primary health care team, together with her doctor, health visitor, and social work colleagues. To be seen as a talker and leader as well as a doer and obeyer of important instructions.

4. **Lastly, the 1980's higher level nurse will have an understanding of management and organisational principles, particularly as applied within a multi-disciplinary team, and will have developed an inquiring mind and a positive attitude to possible future developments in the community to meet with the health care needs of individuals and groups.**

The working party in 1974 found that, at present, teams tend to work alongside each other, not necessarily for each other. Before you protest ladies and gentlemen, may I say that today I believe I am talking to the converted. What about the mass of other nurse and doctor colleagues not here today who are attached but not integrated?

This high level nurse will be protected by mandatory status, that is, no Area Health Authority may be allowed to employ a district nurse without the nurse possessing an appropriate higher post-basic qualification in district nursing. I am pleased, as I said before, that it is the title "district nurse" which is to be protected by conditions of service. There is nothing to compare with that title, certainly not in my opinion "district nursing sister or charge nurse". "District nurse" has its own mystique and magic, please do not destroy that by new titles. There is change and progress, not always I suggest synonymous.

I assume methods of supervision will have been improved by the time the 1980's have arrived. It was anticipated that with the new nursing structures following the Mayston Report, that nursing officers would have time and authority to be able to supervise standards of care offered by nurse colleagues. Unfortunately, with some exceptions, this has not been possible. A recent survey of the daily work of 39 nursing officers which I undertook gave the following results over a normal five-day working week for community nursing officers:

Office routine	— 24% of total time available
Telephone calls	— 13%
Attendance at meetings	— 10%
Travel	— 5%
Interviews	— 5%

Giving a total of 57% of time not associated directly with patients. With those activities that could be associated with patients were:

Clinical involvement	— 11%
Consultations with other staff	— 12%

A total of 23%.

It is hoped that when the new cirriculum is commenced that the new student district nurse, when returning for her last three months supervison, will be able to look forward to working closely with her nursing officer.

This supervision and co-operation will, in my opinion, mean at least eight one-hour sessions with the student. To be able to do this, the nursing officer must have a complete understanding of the aims and objectives of district nurse training and know of the standards of care required in particular situations. This will mean a total review of the work of the nursing officer no less so that appropriate counselling, supervision, and instruction, can be given to the student. I do hope that this practice will then overspill to her other nurse colleagues that she supervises.

There will be much more freedom for education centres to offer a comprehensive system of education to new district nurse students. The new outlined curriculum allows for a larger measure of experimentation, both in the way the subject is taught and the content of the subject matter. By then, the district nursing standing committee of the Central Council will be mainly interested in the overall aims and objectives of the education centres and assessment of these objectives in the student at the end of the course. Approval of education centres, therefore, will be on a basis of what type of student will emerge after training and the type and qualification of staff supporting the student, both in the centre and in the Authority. There will, of course, be great interest shown in the overall aims and objectives detailed in the centre's submission to the statutory committee. The 1980's may even see these centres carrying out their final examinations.

Second level nursing in the community

Here there is much more controversy. There is a movement, a very genuine one, to suggest in large towns and cities that a staff nurse grade be used to work under the direction of a qualified district nurse. I think we do have to be careful in this area. The term "staff nurse" is a very significant term. This term means that they are on occasions expected to act-up for the ward sister in hospital terms, and that is quite correct and every encouragement should be given to the staff nurse to do so. There is support from both ward sisters on adjacent wards and if need be the nursing officer and senior nursing officer are available. In most general hospitals, if not all, medical staff are readily available in times of crisis or where the nurse is not sure advice can be readily available. This is totally different working in a patient's home. Therefore, any title which suggests either to the person holding that title, or to the persons receiving that care, that the person can act-up once the senior person is away is wrong. If statutory training means anything at all it means that the person recognised as qualified must be in charge at all times. I know this does bring difficulties, particularly in rural areas, and I don't pretend to have the full answer. But surely the approach should be that every patient is entitled to have as the senior nurse managing his case a qualified district nurse. If that is accepted as policy then I think it is not too difficult to work out arrangements that meet this criteria. It means, of course, that the senior nurse, the

district nurse, must have a written down individualised plan of care for each patient. She can then see much more clearly what levels of care need to be given and then who should do it. So at the second level I see no reason if with extreme care we use a registered nurse not qualified in district nursing to carry out some duties under the supervision of a qualified district nurse. These could be in a whole range of situations. I would have thought that a nurse possessing the qualifications SRN/RGN, could work (a) in a doctor's surgery, (b) in the surgery and the community, (c) in the community all of the time, and a special category of the nurse specialist from hospital, the stoma therapist, the renal dialysis nurse, all working under the management arrangements of the district nurse. Where they are SRN's then some title will have to be found for them, certainly not "staff nurse", but already our conditions of service allow us to use the title "SRN/RGN" in the community. I would prefer something like Assistant Home Nurse. I think there has to be preparation for these people to work in the new environment but the essential thing is that the person so employed works under the direction and instruction of the district nurse at all times. You see that person needs to understand that she works with and accepts the overall direction of the district nurse in matters relating to the total care programme for each individual patient. They certainly need to understand such things as (a) meeting the nursing needs of people, individual patient's having first been assessed by the district nurse, (b) understand changes in the physical, emotional and psychological aspect of people of all ages and knowing when to report these so that reassessment of the caring programme can be made, (c) able to carry out agreed rehabilitation programmes, (d) able to teach simple health education to all those who assist in the care of patients, (e) understand the communication processes within the appropriate caring team and other outside bodies, (f) have a real appreciation of those facts leading to the maintenance of health including recognition of the signs of alcoholism, drug addiction, and so on, (g) a realisation of the services available to the patients, and (h) ability to keep accurate records. Therefore, a community nursing service in the late 80's may have the assistance of registered nurses who are unqualified in district nursing terms. Used as "Assistant Home Nurses".

A third level of nursing in the community would be that of the state enrolled nurse. I don't know how many people have read the report of the working party on the education and training in district nursing for the state enrolled nurse but I would understand that some state enrolled nurses would feel somewhat disappointed. But it will all depend on how nurses, both registered and enrolled, interpret basic nursing in status terms. Allen Boylan put it superbly at a recent Nursing Focus conference for the Association of Health Careers Advisers when he said that the nursing profession saw work in status terms. The SRN's did high status things like giving drugs while the SEN's did low status things like giving bed pans and treating double incontinent patients.

The working party that looked at the state enrolled nurse saw basic nursing in the community as requiring high skill and motivation. Seemingly simple nursing tasks were in fact highly complex demanding a nurse possessing qualities not always present in every applicant. We saw of high quality a nurse possessing good practical general nursing experience adapted with real skill and understanding in the patient's home environment. If nurses see this as high status, as we did, then they will welcome many of the proposals put forward.

The role and function of a state enrolled nurse in the community is a very confused area. I would hope by the late 1980's we could accept as fact, and in practice, the following definition:

> *"The state enrolled nurse is a member of the district nursing team. She is accountable to the qualified district nurse for carrying out part or all of the nursing care programme for individual patients and their families, recording her findings and reporting back to the qualified district nurse."*

You will see from this statement that it is suggested that the state enrolled nurse's professional role is working with and to the qualified district nurse, while her function, the job she does, is carrying out either the whole individual patient care programme or parts of it as assessed and planned by the qualified district nurse after appropriate consultation. Again, you can see the importance of having a recorded individualised systems approach to patient care. It is much easier in that situation to determine the work of the state enrolled nurse than if there is no written assessment at all.

Basically, the training of state enrolled nurses in the 80's should be (a) to make them competent to undertake delegated nursing duties within the community under the direction of a qualified district nurse, and (b) be held personally accountable for the nursing standards of those delegated duties.

I would hope in the 80's that there is a new status for the state enrolled nurse. I would hope that the registered nurse would be called the "district nurse" and possess the qualification of National District Nursing Certificate. I would very much hope that the state enrolled nurse will be known as the "district enrolled nurse" and hold the qualification of National District Enrolled Nursing Certificate. This aim is twofold in that it separates more clearly the registered and enrolled nurse and secondly gives the enrolled nurse her own status and designation. I personally believe that both grades working in the community that are qualified should have their salary situation reviewed. I believe for instance that the qualified district nurse should on the date of the mandatory training requirements move to a Sister Grade I position on the salary scale. I also believe that state enrolled nurses while training should receive the state enrolled nurses scale of pay and that upon qualification they should move to a higher salary which at the moment is paid to senior enrolled nurses. I see no position in the community for some enrolled nurses being paid a higher salary than others. Surely, if a person has gone through a systematic period of training then she is entitled to that higher reward remembering that although always working under the direction and supervision of the district nurse the state enrolled nurse is alone with the patient and has to make many of the day to day decisions affecting the lives and wellbeing of both the family, relatives and other carers present in the patient's house.

The last level in the community is particularly applicable to those nurses working in inner city areas and large urban districts of cities. I believe that nursing auxiliaries can be employed safely within the district nursing services if they have first undertaken an appropriate course of training. The success of using auxiliaries is that they should be trained in limited skills and be allowed to undertake only limited duties and if they do this under supervision after training then they can eventually perform to a very high level of performance and receive great satisfaction undertaking this work. For instance, they should be able to bath, dress and undress elderly and disabled patients under supervision. They would be under the immediate control of a district nurse or to her through a district enrolled nurse. I believe that ratios should also be laid down for all staff working for a district nurse. I believe this is essential if the standards of patient care are to be developed and maintained at a high level. Perhaps for the nursing auxiliary it would be better to have a list of "do nots" rather than "do's". This is another biblical saying "Thou shalt not" and in the case of nursing auxiliaries I would suggest that we have three points:

1. Thou shalt not do the patient harm.
2. Thou shalt not carry out duties apart from an emergency not having first been taught those duties or procedures.

3. Thou shalt not keep to yourself information that would lead to a reassessment of the level of staffing needed to care for the patient in the present situation.

And so you have the various levels in nursing proposed. So in the late 80's early 90's I see the district nurse recognised as a leader of the enlarged nursing team. The team in an urban area to consist of up to say three including the district nurse herself with either an SRN (limited duties) as "Assistant Home Nurse", an SEN (qualified), or a nursing auxiliary, or a combination.

I believe there will be a continuing development of 24-hour nursing services. I would be surprised if in the early 1990's there is not a considerable increase in all numbers of staff engaged in caring for patients in the community. I believe the economic situation will be such that more and more patients will be treated at home by general practitioners, by consultants visiting patients in their homes, and by district nurses developing new skills in attempting to care for patients at home.

By the mid-1980's I trust Practical Work Teachers will not only be paid for their work but have a programme of education that properly fits them for their job. In addition, only have one student at a time and have a case load that enables them to teach the student properly.

One last thing, I do believe that the time is rapidly coming where senior nurses will have to change their attitudes to nurses working in general practices and I would see a time coming in the next ten years where Health Authorities either agree to provide a full community nursing team which would include the practice nurse, or the general practitioners themselves will continue to employ more and more of their own staff, take away a lot of the skilled work of district nurses and place them upon the practical nurse in his or her own surgery. I think this would be a retrograde step and I would like to see an Health Authority taking a positive lead in this situation and offer to the general practitioner a comprehensive nursing service, according to the needs of general practice were at that time. If that does not provoke you into comment then perhaps nothing will.

I see the future for district nursing very bright indeed and I am very very pleased and delighted to be part of that development. Can I say finally that Machiavelli was right when he said:

> *"There is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things."*