Is teamwork working?

TONY CARR questions the effectiveness of teamwork and says the real proof that it is working is when it is clearly demonstrated in the primary health care team.

Ted Wright

WHEN YOU look back at the history tory of British district nursing, see the progress made in the past decade and compare it with 100 years before, the change is remarkable. In the early 1900s about two-thirds of qualified nurses were practising in the community, with only one-third in hospitals. These figures have now reversed, with a minority now practising in the community, and the overwhelming majority in acute hospitals. One hundred years ago the district nurse worked mostly for local voluntary organisations and medical practitioners. Now the scene is much more complex.

First, district nurses are members of the primary health care team: along with the general practitioner, health visitor, midwife, social worker and community psychiatric nurse they form a comprehensive team. That team, if properly organised, can be a force for change in the standards of health care provision and positive health education. Unfortunately, in many situations, talk of professionalism, status, clinical freedom, who is to be leader of the team, all work against the thrust that could be made in the community. Tremendous strides *are* being made in some places but, in general, many of the so-called teams must be questioned. Different professionals may work with the same patient, but their aims and objectives can vary a great deal.

Symposiums

National symposiums have been conducted to try to reach some rationalisation of this process. Common core parts of curricula would certainly help, but perhaps students of various disciplines should meet and work together during the various stages of training, so that a common understanding may slowly emerge. The patient's position can sometimes be forgotten in the enthusiastic development of services and nursing is no exception to this.

I recently questioned why staff in hospitals start work at 7.30am. The answer to this raised many more questions. Gradually, it emerged that many of our health services are arranged around the needs of staff and far less around patients' needs. It would be

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interesting to ask in some districts when disabled patients should be put to bed. The staff might say that it must be by such and such a time because shortly after that they go off duty, rather than reorganise the service around the needs of a particular disabled person. So, where does the patient fit into the primary health care team? Is he merely a recipient of the ministrations of various disciplines involved? Does he really have a say in his treatment or rehabilitation programme?

I am sure many staff try to persuade the patient to take a certain course of action, but are the patient's needs really taken into account, and if they are how much decision-making is he encouraged to undertake for himself? How often does the patient have the opportunity to direct the primary health care team? It is an important question, but perhaps not many people would want to know the answer.

To make any progress in this direction, all those involved in primary health care should be able to criticise their own attitudes and behaviour before they criticise other disciplines and professions, and then try to offer some leadership on the way forward. It is so easy to identify problems but so difficult to bring change to what may seem an impossible situation.

Geographical

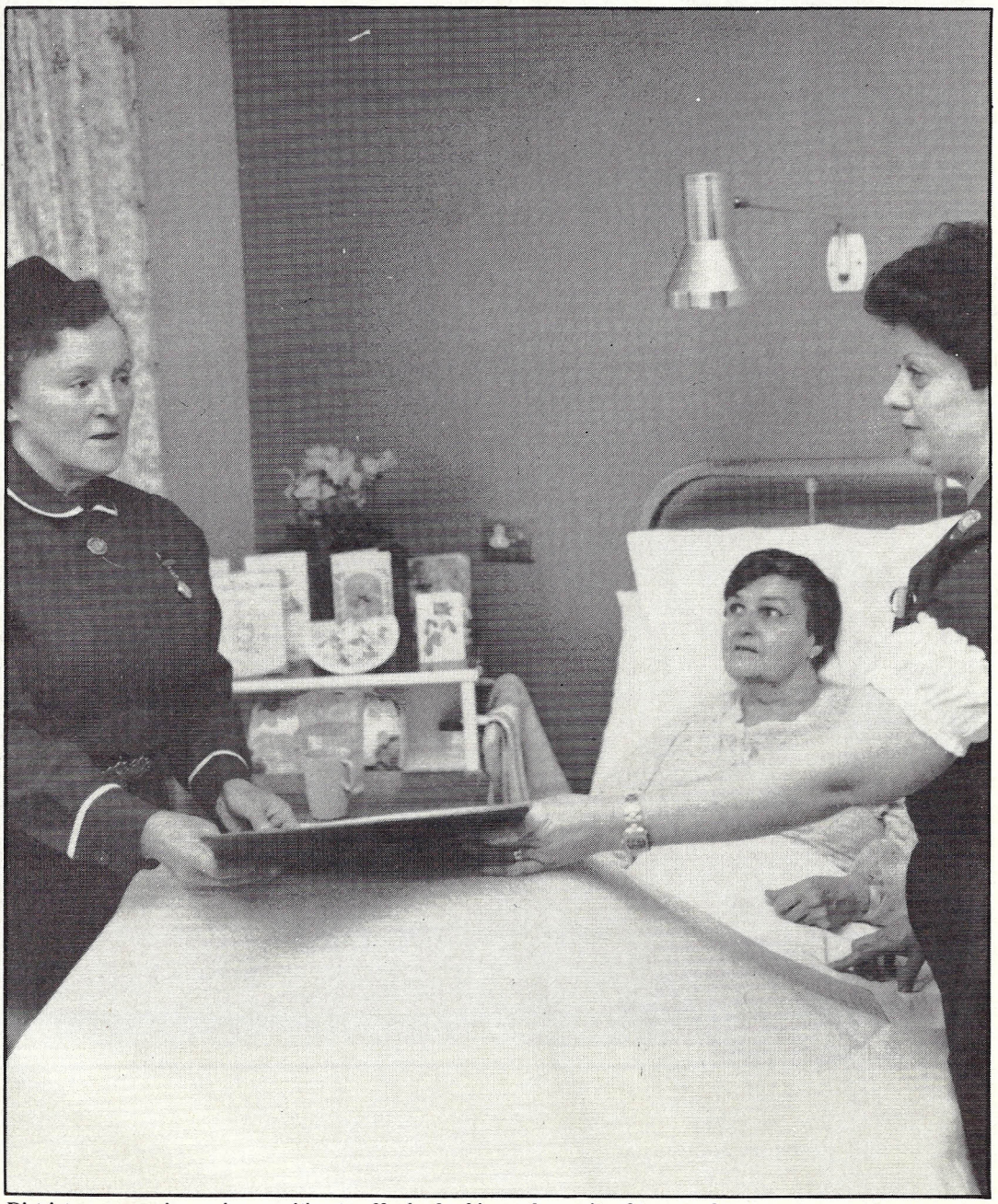
As health service expenditure gains more and more critical attention from central government, I am sure the argument for geographical management of community services, as opposed to group attachment, will be raised in many districts. The nursing profession will have to produce more evidence than it has done at present to justify continuing a more costly type of service. Are doctors, health visitors, district nurses and midwives really so integrated in the care of patients that to separate them would be a major step backwards? Philosophically, the argument would certainly suggest this, but in practice district nursing records and health visiting records are often kept separately from the GP's records, and the boast that each can look at the other's is really just not good enough.

If there is no overall record of progress which clearly indicates the input made into each of the professions and disciplines concerned and no consensus on the total approach to a particular patient or client, there could be a very good management argument for not continuing with group attachment schemes. I am not saying that they should not continue, but I am trying to highlight that there are many problems as yet unsolved in this major area of teamwork.

Who, out of all the professions concerned, is going to offer leadership in this direction? District nurses are in a unique position and they should call their professional organisations and nursing management to take active steps in this area. They must gain the co-operation of their GP colleagues to develop a totally integrated comprehensive care service for all clients and patients on a GP's list.

Perhaps the nursing service should also be looking critically at the service it offers to social services residential homes and develop a partnership with them that will, where necessary, raise the standards of care in all homes and residential establishments to a uniform level.

District nurses are becoming more and more involved with their nursing colleagues. I was criticised when I spoke at the annual meeting of The Queen's Nursing Institute in



District nurses are in a unique position to offer leadership on the merits of teamwork.

1977, of what I could see developing in the 1980s. This "team" is coming into existence despite many setbacks. The Association of Nurse Management recently voted against a reasonable demand from the Royal College of Nursing's Primary Health Care Society to properly recognise the trained district nurse.

Rates of pay

It does not help at all to develop a nursing team concept when nurse managers cannot see the necessity of paying qualified district nurses a considerably different rate of pay from registered nurses without district nurse qualification. The argument as put forward in the nursing press by nurse management was pathetic in the extreme and showed yet again an almost total ignorance among senior managers of the development of primary health care. Be that as it may, registered nurses unqualified in district nursing, will not only continue to be employed but will increase in number as the demands of community care grow.

So it is essential that each health authority immediately takes steps to develop its own particular form of individual care plans for patients. Every normal thinking nurse must see that, until an individual written assessment is made for each patient, there is no way in which that patient can be safely cared for by anybody but a qualified district nurse. If, however, a care plan is developed which clearly indicates levels of care necessary, then it is not only in order professionally, but it makes sound economic sense to employ staff with the district nurse to help to carry out some of the lower levels of care necessary.

I am referring to registered nurses, unqualified in district nursing, state enrolled nurses with district enrolled nurse training and even nursing auxiliaries. I am not saying that bed bathing a patient, or putting him into a bath is necessarily a nursing auxiliary's job – it depends on the individual needs of the patient – but patients' needs can be fulfilled in many ways, not only by a nursing team under the direction of a qualified district nurse but by marshalling other carers and relatives, which district nurses have done for more than 100 years.

The team, as stressed in the report on the education and training of the state enrolled nurse in district nursing, should be small, so the skills for a qualified district nurse are not mismanaged. That report suggested two people, either full- or part-time. I agree with that proposal. However, if there are more than two staff, the district nurse starts to become an administrator; less than two, then it may be that the district nurse's skills are being wasted on duties that could be undertaken quite adequately by somebody with less training and experience under proper supervision.

The team of nurses must be organised extraordinarily well if the patients are to receive the type of care to which they are entitled. The care must be carefully recorded and changes in the patient observed either by the visiting nurse or the patient's relatives or other carers, should be seriously taken into consideration. The qualified district nurse must visit all her patients regularly because she must be held accountable for the performance of her less experienced colleagues.

Responsibility

Human nature is the same the world over: many demand authority in jobs but there are far fewer people keen to take on the subsequent responsibility and accountability for that authority. If they wish to move into the high professional profile that many of their colleagues are urging them to undertake, all nurses must be seen to be totally accountable for the care they offer patients.

Maybe more research should be undertaken, but that is not my suggestion. I suggest that district nurses recognise their responsibility for offering some sort of leadership in this area and start behaving differently, taking responsibility, managing staff adequately and looking at the personal needs of patients in far greater detail than perhaps many of us have done in the past. Then they should write up their experiences to persuade other colleagues to take a much greater interest in the organisation of the patient's care and so influence one another towards greater endeavours in caring for the whole person.

Potential problems of home visiting by specialist hospital nurses also have to be considered. District nurses must see that a nurse specialist such as a diabetic nurse is sometimes a considerable asset to the team's work and to the care of the patient. This is not to suggest that the district nurse hands her patient over to the specialist, but sees this new input as enhancing the total care of the patient.

The question is often raised: "But how do we know when a specialist is visiting a GP's patient?"

The local community nurse management should see that effective policies are agreed with GPs and hospital consultants and the community nursing staff.

Teamwork may be a slogan, it may be a teaching objective, but the real proof that teamwork works is when it is clearly demonstrated in the primary health care team and in the district nursing team. Is it working well in *your* district? □