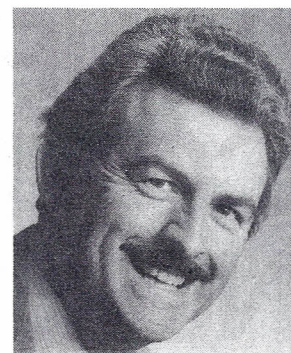


# District nurse training in the 1980s



*This is the text of the speech made by Anthony Carr, ANO at Newcastle AHA (T), who gave the address at the QIDN's 1977 AGM.*

This is a great year of significance for district nursing in general. It may be that this year the Department of Health may finally approve the outlined curriculum and programme proposed in 1976 in the Report of the Panel of Assessors on the Education and Training of the District Nurse (SRN/RGN).

It may be that this year, or perhaps next, mandatory status may be granted by the Secretary of State for Health to district nurses holding the National District Nursing Certificate or Queen's Nursing Certificate.

It may just be possible to hear the welcome news that district nursing has achieved statutory status under the revised Briggs proposals which may be placed before Parliament in their next session. It is certain that an outline curriculum for district nurse training for the State Enrolled Nurse will start to receive careful and considerable attention this year by the setting up of a second working party, which has already had its first meeting.

Yes, it is a very significant year for district nursing. In fact, we may well look back several years from now and see that the greatest changes that ever took place in the community nursing services occurred in 1977/78. I believe we may be standing in the midst of important nursing history today, and I feel very privileged to play a small part in this activity.

I am using for the first part of my address the work undertaken by my first working party on the Education and Training of the District Nurse, and I shall try and look forward five years or so into the 1980s and speculate — a hazardous occupation.

I see essentially three levels in nursing within the community, and I will deal with these three in turn.

## First-level nursing in the community

At the highest level the district nurse, now protected by law working

under a statutory body, will have four major objectives:

*(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.

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.*

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 our understanding.

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

The district nurse of the 1980s 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. 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 syndrome that 'doctor or nurse always knows best' may have to die in the 1980s.

'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 1980s higher level nurse will have an understanding of management and organisational principles, particularly as applied within a multidisciplinary 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 found that, at present, teams tend to work alongside each other, not necessarily for each other.

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 that nurse possessing an appropriate higher post-basic qualification in district nursing.

The profession must say what it wants when it asks for mandatory status. What happens to those nurses who do not possess an acceptable post-basic qualification in district nursing? We proposed that from the date of acceptance of the report by the Secretary of State all new vacancies or posts created should only be filled by qualified district nurses.

Within five years all existing nurses presently carrying out district nursing duties without post-basic qualifications be given the opportunity to qualify for the new training as a right without entry requirements being fulfilled. At the end of five years, a fully qualified district nursing service would have been achieved.

There will also be protection, I believe, by statutory training requirements at national or/and country level. I see a statutory committee comprised of district nurses in the majority (when district nursing is discussed) setting the standards of competence by entry requirements, an educational programme and examinations, ideally working closely with, or part of the statutory Council for Health Visitors.

In 1976 we, as a Working Party, found that the patient could be at some risk by being nursed by someone without a post-basic training, and I assume that this fact will have produced the result I have just mentioned. To my mind, it is unthinkable that statutory training status will not have been achieved by the late 1970s or very early 1980s.

The present reaction of the country's district nurses demanding statutory training is spontaneous and real. Of the many I have talked to, not one has mentioned status but all have mentioned two essential demands.

First, the proper education of all district nurses and, secondly, protection for the patient from unsafe practitioners. A good sound reaction by professionally minded people in these modern days and which contrasts sharply with the usual self-seeking, self-gratifying claims of other groups of workers. I am proud to be identified both with their claim and the way they intend achieving their objectives.

I believe the title District Nurse should be protected by law. There is nothing to compare with that title. District Nurse has its own mystique and magic, please do not destroy that by new titles.

I assume methods of supervision will have been improved by the time the 1980s have arrived. It was anticipated that with the new nursing structures following the Mayston Report, 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

Activity surveyed	% of total time available
Office routine	— 24%
Telephone calls	— 13%
Attendance at meetings	— 10%
Travel	— 5%
Interviews	— 5%
Giving a total of 57% of time not associated with patients. With those activities that could be associated with patients were:	
Clinical involvement	— 11%
Consultations with other staff	— 12%
A total of 23%.	

recent survey of the daily work of 39 nursing officers, which I undertook and which is as yet unpublished, gave the above results over a normal

five-day working week for community nursing officers. (See table.)

It is hoped that when the new curriculum is begun the new student district nurse, when returning for her last three months supervision, will be able to look forward to working closely with her nursing officer. This supervision 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 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 statutory committee 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 1980s may even see these centres carrying out their final examinations.

## Second-level community nursing

Here I am on new, untrodden, sacred ground. I will, however, propose a restructuring of the community nursing service. I take comfort in the fact that as a non-expert in these matters, I can suggest what to the experts may be heresy without being unduly perturbed. My suggestions may, however, make even the experts re-examine their present position.

I therefore propose for the 1980s one grade of nurse to carry out a



major nursing function, namely, to care for people under directions of a higher authority. I have called this new nurse a District Staff Nurse. The basic qualification would be either SRN/RGN or SEN(G).

She would work: (a) in a doctor's surgery; (b) in a surgery and the community; (c) in the community all of the time; (d) in the clinic; (e) in the school health service, or be (f) a nurse specialist from hospital, for instance a stoma therapist, or renal dialysis nurse.

All would require mandatory training. It is to my mind almost unbelievable how we put some patients at risk by not insisting on proper post-basic preparation for all nurses meeting with patients in the community. A basic requirement for all the new district staff nurses would be to have had three years' training and experience in the hospital nursing services.

This would include State-enrolled nurses. It would be a requirement before entry into the community nursing services. The reason, I suggest, is that this would better secure a nurse with a certain maturity towards nursing and to people in general.

Secondly, all would be required to undertake a core-module of education followed by shorter modules of experience, depending on the type of work chosen. The aim of the educational course would be to produce a district staff nurse who could work well in defined duties supervised by a higher level nurse.

It may be that if school nurse training was included, the school nurse working in the school health service without the traditional health visitor's supervision could be given a further module of training beyond that thought reasonable for the school nurse with health visiting involvement, before she worked without direct supervision.

The nurse specialist attending patients in the community from hospital still requires basic preparation before working in patients' homes. She 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.

The course curriculum is something I am not qualified to pronounce on and, no doubt, yet another working party would have to produce this material. The

curriculum, however, should include:

(a) meeting the nursing needs of people, individual patients having first been assessed by the district nurse,

(b) understanding changes in the physical, emotional, and psychological aspects of people of all age ranges and knowing when to report these, so that reassessment of the caring programme can be made,

(c) being able to carry out agreed rehabilitation programmes,

(d) being able to teach simple health education to all those who assist in the care of patients,

(e) understanding of the communication processes within the appropriate caring team and other outside bodies,

(f) real appreciation of those factors leading to the maintenance of health, including recognition of the signs of alcoholism, drug-taking, and so on.

(g) realisation of the services available to the patient.

(h) ability to keep accurate records.

A community nursing service in the 1980s, in a large urban area, could be structured as follows:

(i) a higher level district nurse holding a national district nursing diploma,

(ii) normally one, but up to two, district staff nurses working in the community and one district staff nurse working in a doctor's surgery, or a combination of these duties. The district staff nurses all holding an appropriate post-basic qualification perhaps entitled District Training Certificate (DTC).

Recognition by the DHSS of district staff nurse ratios to a qualified district nurse is essential if proper supervision is to be maintained and patient care programmes successfully carried out. This system would also allow for a major development to take place in staffing levels at reasonable costs without a consequent lowering of standards of patient care.

I have mentioned school nursing because it may be possible to offer core-training to all staff with a nursing function, followed by a special school nurse module. Of course, the school nurse would not be part of the district nurse team.

### Third-level nursing in the community

Lastly, the third-level nurse. There is a need, especially in many urban areas, for persons possessing certain

limited skills to assist the district staff nurse and district nurse in their daily work. District nursing auxiliaries having undertaken an appropriate course of training agreed nationally would be able to bath, dress and undress elderly and disabled patients under supervision.

They would be under the immediate control of a district staff nurse and part of the district nurse's district nursing team. Again, ratios laid down nationally for these staff is essential if standards of patient care are to be maintained at a high level. Of course, this training would be mandatory, and again, I would propose a curriculum, but time and expertise prevents this fully. It would, however, have emphasis on another biblical saying, the 'thou shalt not'; in this case, the 'thou shalt not's' in nursing:

(i) thou shalt not do the patient harm,

(ii) thou shalt not carry out duties, apart from an emergency, not having first been taught those duties or procedures,

(iii) 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.

To summarise: In the 1980s I see the district nurse recognised by statute as a leader of an enlarged nursing team. The team in an urban area to consist of up to three district staff nurses SRNs/SENs, and not more than three district nursing auxiliaries. A team within a team.

Let there be no mistake, the patients are there but, unlike a hospital ward where the patient can be seen, in the community they can be easily missed if the service is not there to care for them. The three levels of nursing should receive proper mandatory education and have well-understood policies regarding the performance of those duties.

I would suggest that the cost of developing this service over 10 years would not be much more than 6 per cent per annum as confirmed in the recent document by the Minister of State, *The Way Forward*.

I end with what I hope you will feel is an appropriate quotation:

*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. (Machiavelli)*