

# **What Has Happened to Named Nursing? Perceptions of the Named Nurse System**

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## **ABSTRACT**

**Ann Josephine Humphreys**

### **What Has Happened To Named Nursing? Perceptions of the Named Nurse System**

The purpose of this study was to explore the previously little researched area of the implementation of the Named Nurse Standard in hospital settings. The Standard formed part of the Government's programme of health service reforms that aimed to enhance the patient experience by having an identified nurse in charge of their care from admission to discharge.

Quantitative and qualitative methods were used to identify whether nursing work was organised to facilitate the named nurse concept and the patient's perception of who delivered their care. A case study approach in surgical wards in two NHS trusts enabled comparison of clinical settings with a high adherence to the Standard's criteria and wards with a low adherence. The areas selected for comparison were the methods of organising nursing work, nurses' perceptions of the Named Nurse Standard and the patient's experience of the named nurse role.

The results show that, although levels of patient satisfaction were high, this was not associated with care from a named nurse. There was no significant difference between the methods of organising nursing work on the wards in the two adherence categories. Furthermore, the Named Nurse Standard was not fully implemented on any of the wards sampled.

The main recommendation of this study is that innovations in nursing practice should be evaluated in a pilot study before being introduced nationally. Areas recommended for future research in the organisation of nursing work include day case units and discharge planning.

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## DECLARATION

At no time during the registration for the degree of Doctor of Philosophy has the author been registered for any other University award.

Signed: 

Date: 30-09-03

# CHAPTER ONE

## INTRODUCTION TO THE STUDY

### 1.0 Introduction

This study explores the impact of the implementation of the Government sponsored Named Nurse Standard on patients' perceptions of their hospital experience and the organisation of nursing care. Introduced at the beginning of the 1990s in the NHS in England, the tenet of the Standard was that an individual, qualified nurse should be accountable for a patient's care from admission to discharge. It was codified in the Patient's Charter (DOH 1991) and formed part of the Government's programme (DOH 1983, DOH 1989a, DOH 1990) to provide a modern, quality National Health Service (NHS). Health service managers were required to implement strategies to meet the Standard, together with a system to monitor the level of performance. The data collection for the study commenced in 1999, six years after implementation, when it could reasonably be expected that the Named Nurse Standard would be integrated into the health service provision.

### 1.1 Review of the previous literature

The origins of the Named Nurse Standard are considered in Chapter Two from a political and professional stance. The health service reforms (DOH 1983, DOH 1989a, DOH 1990), with their emphasis on consumerism and accountability devolved to local level, are shown to shape the Patient's Charter. Among a number of advances in nursing considered is the discourse on more individualised nursing care associated with the development of team nursing (Matthews 1975, Waters 1985, Reed 1988) and primary nursing (Manthey 1988, Pearson 1988, Binnie 1987, Bowers 1989, MacGuire 1989). It is demonstrated that this discourse was used to inform the development of the Named Nurse Standard.

There is little systematic research reported in the literature on the implementation of the Named Nurse Standard. There are some small-scale surveys on the perceptions and experiences of the Standard from nursing or patient perspectives, and these are discussed in Chapters Three and Four. However, the majority of these studies are questionnaire-based and there is an absence of rigorous work on implementing the Named Nurse Standard from the emic perspective.

## **1.2 Research design and methods**

Chapter Five illustrates how the design of the study was selected and developed. The literature review had established that the Named Nurse Standard (DOH 1991, DOH 1995) was associated with organising nursing care to enable an identified nurse to be responsible for a specific patient, for the duration of their stay. Thus, the implementation of such a Standard implies, at the very least, an adjustment to the configuration of nurses' work. It is shown how, from this conclusion, the aim of this study was developed as follows:

To explore the implications of the Named Nurse Standard, for the organisation of nursing work, through the world view of those identified in the literature as the key players. The key players being qualified nurses, patients and ward managers.

Therefore, an ethnographic design was selected, utilising a case study approach, to provide a rich picture of the informants' world view. From this focus on how clinical areas functioned within the Standard two research questions were developed for the study. They were:

1. Do areas where there is an identified Named Nurse system function any differently to those areas where there is no identified Named Nurse system?

2. What are the implications of the Named Nurse Standard for the organisation of nursing work?

It is shown how the design of the study enabled collection of reliable, valid data that would provide a comparison of the methods of organising nursing care, nurses' perception of the Named Nurse Standard, and patient's experience of the named nurse role. To permit this comparison of how clinical areas function the criteria associated with the Named Nurse Standard, which had emerged from the literature, were mapped against Thomas and Bond's work (1990) on organising nursing work. From this mapping organisational modalities, such as primary nursing, were categorised into 'high' adherence and 'low' adherence to criteria associated with the Named Nurse Standard.

Surgical wards in two NHS trusts with similar configurations were chosen for the fieldwork. This was because, in surgical wards, there was a rapid throughput of patients, which gave the opportunity to identify the pattern of allocation of patients to a nurse or team of nurses on admission. Two trusts were used so that comparison could be made between wards identified to have 'high' and 'low' adherence to criteria associated with the Named Nurse Standard. To maintain the balance of the study a high adherence category ward and a low adherence category ward was used from each trust.

There is discussion of the ethical issues that need to be considered when undertaking fieldwork in a clinical setting including the role of the researcher in a naturalistic enquiry. Data collection for the study commenced in September 1999 and was completed in August 2001.



### **1.3 Results and discussion**

In Chapter Six the results of the study are presented and discussed. Results from the high and low adherence category wards are compared in three key areas: the organisational structure of the wards, which nurses did what, and whether these decisions were made with reference to the Named Nurse Standard; the process of nursing and the extent to which the Named Nurse Standard was implemented; and finally the results of the patient perception questionnaire are discussed and the extent to which patient satisfaction may be attributable to one identifiable, qualified nurse accountable for their care during their stay.

Chapter Seven presents a critical review of the study and includes the author's reflections on the process. The relationship between patients' satisfaction and the nursing care they receive in hospital is explored. Conclusions are drawn from the results of the study on how the implementation of the Named Nurse Standard impacted on nurses' exercising their accountability. Furthermore recommendations for future practice and research on the principle of ensuring continuity of care for patients through an identified nurse are made.

## CHAPTER TWO

### THE ORIGINS OF THE NAMED NURSE

#### 2.0 Introduction

The introduction of the Named Nurse Standard (DOH 1991) was potentially one of the most significant changes to the nurses' role in contemporary times. It was sponsored by government and supported by nurse leaders; it was patient centred; it empowered nurses and it acknowledged the value of nursing. Finally, and most importantly, it focused on the nurse-patient relationship to improve patient outcome. However, within a decade of its launch the Named Nurse Standard, as such, was no longer part of the government's strategic intention (DOH 2001a). Furthermore, the evidence indicates that at service level the Standard had not been fully implemented (Dooley 1999, Steven 1999, Allen 2001),

The literature was selected for this review to provide the historical context of the Named Nurse Standard from a political and professional perspective. This was to illustrate that the Standard was grounded in change to social policy and nursing practice. There was a rise of consumerism and with that came an increased expectation of health service provision. Although the Named Nurse Standard centres on the relationship between nurse and patient the origins of the Standard are crucial to understanding why nurses, in particular, responded in the way that they did. The literature presented in Chapter Two focuses on the relevant government documents and examines the origins of the Standard within the health service reforms (DOH 1983, DOH 1989a, DOH 1990). Parallel to, and influenced by these reforms were the developments in nursing, in particular the individualised approach to patient care. Those changes are considered in the literature on the different methods of organising nursing work.

Having established the historical context to the implementation of the Named Nurse Standard consideration is given to the evidence of the impact on the two groups most effected by the change. These are patients and nurses. Literature was selected to illustrate the mixed response to the Standard which included apathy, antipathy and lack of awareness. In contrast, some nurse and patient groups saw the Named Nurse Standard as an opportunity to improve patient outcome. Finally this review demonstrates that, although mechanisms were in place to monitor the implementation of the Standard, there had been no systematic research on the impact of the change in nursing practice. Thus, it will illustrate that it is now timely to evaluate the effect on nursing work and patient experience.

Chapter Two is the first of three chapters that consider selected literature associated with the Named Nurse Standard. The focus is on exploring the origins of the Standard in government policy and the nursing literature. Chapter Three examines how the Named Nurse Standard has been implemented in the clinical setting. It also examines nurses' knowledge, perceptions and experience of the Standard. Chapter Four reviews those three areas from the patient's perspective.

This chapter considers three key aspects. The first aspect puts into context the Named Nurse Standard within the nursing discourse of the 1980s and 1990s, with particular reference to organisational methods. The second key aspect is the health service reforms and related policy documents. Using a chronological approach, it will consider the introduction of general management and how the foundations for the Patient's Charter were laid (DOH 1991). The final aspect concerns weaknesses associated with the introduction of the Patient's Charter and how this may have affected the patient experience.

## 2.1 Background

The Named Nurse Standard was codified in the Patient's Charter (DOH 1991) and formed part of the Conservative Government's health service reforms. The Standard was one of a number of statements concerning the level of service that a patient could expect from the National Health Service (NHS). The Named Nurse Standard promised that a patient would have an identified nurse responsible for their care from admission to discharge (See Table 1).

<p style="text-align: center;"><b>National Charter Standard 8</b></p> <p>A named qualified nurse, midwife or health visitor responsible for each patient.</p> <p>The Charter Standard is that you should have a named, qualified nurse, midwife or health visitor who will be responsible for your nursing or midwifery care</p> <p><b>The Patient's Charter 1991 page 15</b></p>
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**Table 1: Named Nurse Standard 1991**

When the Standard statement is considered at face value it seems unambiguous, reasonable and achievable. The language appears to be uncomplicated, as it states clearly that it is an identified qualified nurse who will be answerable for the care for each patient. Therefore, it meets the requirement of a standard statement as identified by Marr and Giebing (1994) in that it indicates a level of quality. It also seems to meet the professional aspirations of nursing to deliver more patient-centred care (Henderson 1966, Henderson 1978, Giovannetti 1980, Binnie 1987, Pearson 1988 Thomas and Bond 1990, Wright 1990). Nevertheless, however germane the Standard may be perceived to be to the improvement of the patient experience the political intention behind it cannot be ignored.

The Named Nurse Standard refers to how nursing work is organised within a framework of modernising the health service and the aim of these reforms was to make the NHS more efficient and cost-effective. Its introduction must therefore raise the question of whether the

Standard primarily led to the efficient use of nursing resources to meet patient need. If this interpretation is accepted, then the Standard could become a political artifice to measure the performance of the largest group of health workers in the NHS as Savage (1995), amongst several writers suggests. However, accepting political intent as the sole reason for the introduction of the Named Nurse Standard may be overly simplistic as it misses the relationship with patient-centred care. In an attempt to explore these questions, the following section will consider some of the changes in approaches to nursing work and the changes in the nurses' role that preceded the introduction of the Named Nurse Standard.

## **2.2 Developments in Organising Nursing Work**

The traditional method for the delivery of nursing care was task allocation or functional nursing. It was a hierarchical model in which patient care was sub-divided into tasks and allocated by the nurse in charge to nurses based on their seniority (Pembrey 1975). The positive aspects of task allocation were that it enabled the person in charge to monitor and control the activity of all the ward staff to ensure that the work was completed. It also meant that work was completed in a prompt manner by a nurse who had experience in that activity. However, the Report of the Committee on Nursing (DHSS 1972) noted concern that the efficiency of task allocation was only achieved at the expense of the patient experience. There is general agreement in the literature that this method of organising nursing work fragmented patient care. In addition it was not possible to implement individualised care because patients were not holistically assessed. Two of these early studies (Lelean 1973, Jones 1975) associated unmet patient needs with functional nursing. In a later work Miller (1985) reported on the effects on older patients who received care that was not based on an assessment of individual need. Older patients who had been in hospital more than a month receiving nursing care based on the traditional approach became more dependent than those receiving individualised care.

Two authors considered task allocation from a nursing perspective. The first, Menzies (1961), in her study of a large teaching hospital, reported that nurses exploited the fragmented approach of task allocation to maintain a 'professional distance' from patients. It was a strategy, Menzies concluded, which enabled nurses to avoid direct involvement with patients and thereby reduced the anxiety engendered by working so closely with them. Henderson (1978) supports Menzies' view that, nurses used what she describes as functional nursing, as a strategy. However, this was not to prevent anxiety but to avoid knowing that they had 'failed' to meet individual patients needs. It was possible because functional nursing enabled 'shared responsibility' for patients: each nurse was responsible for one or more aspect of care but no single nurse could be held accountable for the total patient experience.

It may be assumed that as nursing developed a patient-centred approach the incidence of functional nursing would decline. However, in the early 1990s this method of organising nursing work was continuing to be used in some areas (Thomas and Bond 1990, Audit Commission 1991). This could be attributed to the way that nursing staff had chosen to meet the increasing demands on healthcare provision. Functional nursing enables a safe level of nursing care to be delivered within the staff resources, but it means that individualised care may not be achieved. In addition it raises the issue of individual nurse's accountability for patient care when the organisation of nursing work results in the responsibility for care being shared.

Two other methods of organising nursing care, team nursing and primary nursing, will be examined in detail as they are accepted as the main methods in current use. Furthermore both methods are referred to in the literature concerning the Named Nurse Standard.

### **2.3 Team Nursing**

Team nursing is an organisational method in which nursing staff are divided into groups, with a nominated leader who is invariably a qualified nurse (Matthews 1975). The function of the team leader is to take responsibility for organising and allocating the nursing care to the other team members. The team leader is also accountable for the handover at the end of the shift. Therefore, they maintain contact with members of the team who are on other shifts, whilst handing on the care of the team's designated patients. There is no established skill-mix associated with team nursing. The configuration varies according to the clinical setting but would normally be a combination of qualified and unqualified staff. The benefit for the patient is that they have access to the combined skills of all the team. However, there is a risk that this approach could develop into fragmented care that is characteristic of task allocation.

Teams are usually assigned to care for a group of patients for a period of time. Although, this can vary from one to a number of shifts it is usually the latter (Waters 1985, Melville 1995). It can enable continuity of care for the patient but will depend on how the team functions. Teams may allocate identified nurses to individual patients or they may work on a day-to-day allocation of patients. It can be a benefit when a patient is in hospital for periods of time, as staff work shifts and cannot always be on duty when the patient needs care. The positive aspects of team nursing for the staff is that they can get to know a relatively small number of patients well but also have the benefit of the support of colleagues. As Reed (1988) indicates, this is a particularly important consideration for the support and supervision of junior staff. However, the writer notes that this could also create a similar problem of 'shared accountability' if the boundaries of individual responsibilities are not clearly delineated. The team leader has a key role in identifying the scope of the team's responsibilities in respect of individual patients.

In contrast to task allocation, team nursing can affect the role of the ward sister/charge nurse. The traditional hierarchical model of central control cannot work within the framework of team nursing. To be effective in their role the team leader has to assume some aspects of the ward sister role and take responsibility for co-ordinating patient care and allocating staff. However, this may mean displacing the sister/charge nurse from their position in the ward structure. As a consequence, the hierarchy becomes flatter and the ward sister/charge nurse may have to adopt other roles, such as co-ordinator of the ward or even a team leader.

#### **2.4 Primary Nursing**

The other method of organising nursing work pertinent to this study, primary nursing, has a more profound effect on the role of the sister/charge nurse. A primary nurse is the qualified nurse who has total responsibility for the care of a patient for the duration of their stay (Pearson 1988, Bowers 1989, MacGuire 1989). This responsibility can be delegated to a nursing colleague or 'associate nurse' when necessary, but the primary nurse remains accountable for 24 hours a day. Mantney (1988), the nurse accredited with originating the primary nurse concept, described it as a 'responsibility relationship', and a role that empowers the qualified nurse with the authority to take decisions as well as give hands on care. The underlying tenet of primary nursing is that the individual practitioner is autonomous, has authority and uses their professional judgement to determine patient care (Sellick et al 1983, Binnie 1987, Thomas and Bond 1990). In this organisational mode the hierarchy is flattened, and nursing staff are either primary or associate nurses. Therefore, the ward sister/charge nurse cannot adopt the traditional role of managing the ward and acting as conduit between ward staff and allied health professions.



The role of primary nurse appears to have the potential to place great pressure on the incumbent. However, several authors report a higher rating in job satisfaction in wards where primary nursing had been introduced (Blair et al 1982, Sellick et al 1983, Perala and Hentinen 1989). This could be attributed to closer interaction with individual patients or it could be that the qualified nurse appreciates the autonomy of the role. Alternatively, it may be that the primary nurse gains satisfaction working in an area using a philosophy of care that values the partnership of patient and nurse. The literature on the impact of primary nursing is generally positive. Pearson et al (1989) and Bond et al (1991) report increased patient satisfaction in settings where primary nursing has been introduced. In addition Wainwright and Burnip (1983a) and Reed (1988) report an improvement in the quality of care. However, there needs to be caution when interpreting these results as some are from small studies in specialised units, for example, Wainwright and Burnip (1983a) and Reed (1988). Giovannetti (1980) challenged the evidence that primary nursing could be equated with an improvement in patient outcome because of the lack of an operational definition and limited systematic research.

In a later review of the literature Pontin (1999) attempted to define primary nursing, concluding that it was an organisational method based on a patient-centred approach that should be used in institutions. This was a broad definition that did not give sufficient details to be used to discriminate primary nursing from other organisational modes. It has already been shown that the Named Nurse Standard is associated with the organisation of nursing care. Therefore, it is necessary to identify the existing organisational method used in any clinical setting before considering the impact of the Named Nurse Standard.

Two studies were considered as possible frameworks for the present study. The first was Bowman et al's (1993) 'classification system for nursing work methods', in which ratings of

'strong', 'moderate' or 'weak' were given to 13 features of ward organisation. The responses were then classified as indicative of primary nursing, team nursing or task allocation. Bowman et al's work was not used for this aspect of the study because it involved collecting data from patients as well as nurses.

The work chosen for the study was a questionnaire by Thomas and Bond (1990). It had been developed to identify which of three recognised organisational methods qualified nurses perceived were used on a ward. Respondents were asked to identify a statement that most strongly represented the practice on their ward in the following six categories of nursing work:

- grouping of nurses and length of allocation to specific patients
- allocation of nursing work
- organisation of the duty rota
- nursing accountability for patient care
- responsibility for writing the patient nursing notes
- liaison with medical/paramedical staff

The responses were classified as primary nursing, team nursing or task allocation, also known as functional nursing. There was a fourth category, 'no particular modality', where there was no recognised method of work identified. Thomas and Bond had recommended changes to the original version of the questionnaire. These modifications were made and the questionnaire used for this study (See Appendix 1). It was considered appropriate because it identified nurses' perceptions of the organisational mode, did not require patient participation and was designed to be used in any setting.

The nursing profession had seen the selection of the organisational method as part of their role. The accepted practice was that the method was decided at local, usually ward, level

based on hospital policy, ward philosophy, patient profile and available resources. As the professional role became more defined, this also became a way of exercising their accountability. The implementation of the Named Nurse Standard as a management imperative appeared to remove the element of choice from members of the profession.

## **2.5 Accountability**

The codifying of a practitioner's accountability for their practice (UKCC 1984) was developed to assist practitioners when confronted with issues such as 'shared accountability'. This was a code of professional conduct that gave guidance on professional practice to qualified nurses. It confirmed that each qualified nurse would be accountable or answerable for their own actions. In the example of so-called 'sharing of accountability' in task allocation (Reed 1988) it would be expected that the qualified nurse would take responsibility for clarifying their specific responsibilities in respect of an individual patient's care. The code can be seen as one of a number of indicators in the 1980s that nursing was moving to a more professional, autonomous role. It has already been shown that the established method of organising nursing care was being questioned (Henderson 1978). A more patient-centred approach to care was being considered (Henderson 1966, Giovannetti 1980, Pearson 1988, Thomas and Bond 1990, Wright 1990) which would give a practitioner the opportunity to exercise their accountability within whatever organisational method was being used.

In the 1980s there were other changes in nursing as it strove to become more autonomous and achieve its aim of professionalisation. These included developing a body of nursing knowledge that would underpin practice (Chinn and Jacobs 1987), and a move away from a biomedical model to a more holistic approach to care. Two examples of this are Roper et al (1980) and Orem (1980). There was also a change in the system of education in nursing

(UKCC 1986) involving a move away from the apprentice model of learning to a student-centred approach. This meant that students would undertake their learning in the practice setting but they had no commitment as part of the workforce. The curriculum was broader and included social sciences. Nursing was described by some writers as 'the new nursing' (Salvage 1992) to illustrate how it was reflecting social changes including the status of women and the evolving role of the patient as a 'consumer' of healthcare.

The next stage towards making nursing more autonomous would have been to challenge the hierarchical model within the health service. Traditionally nursing was dominated by the medical profession and the bureaucratic nature of the NHS meant that professional groups such as medicine were a powerful influence in the decision-making process. However, as nursing considered the developments in their professional role, the government introduced the health service reforms to modernise the service.

## **2.6 Health Service Reforms**

At the beginning of the 1980s the demands on the healthcare services were escalating without a matching increase in resources. The Conservative government were committed to providing more effective and efficient healthcare for patients. Their strategic intention was to restructure the health service and create an internal market. This would increase competition and encourage a more efficient use of resources. The aim was to develop a quality service within a 'value for money' framework with the implementation of the Griffiths Report in 1983 (DOH) as the first stage in this process.

The Griffiths Report introduced the principle of general management into the NHS replacing a management structure that had been based on consensus between different professional groups. Authority was centralised in a general manager to make decision-making more effective in this large and complex organisation. It aimed to remove the power

from the professional groups, in particular medicine. However, there are suggestions that the power and influence had been reduced but not removed. Owens and Glennerster (1990), argue in their analysis of the impact of general management, that the organisation had changed but the 'power relationships' within it remained. The writers assert that there were some areas where medical consultant contracts were with regional authorities and so the holders were accountable to managers outside the organisation. This, they suggest, meant in effect that there was little change from the pre-Griffiths' situation in terms of power.

Walby et al (1994), in their study of interprofessional groups in the NHS, report some resonance with views expressed by their respondents regarding professional autonomy in the post-Griffiths' era. The study, which included interviews with over 250 nurses and doctors from five hospitals, representatives of professional groups and hospital managers, was undertaken in 1990/91. It was, therefore, well placed to reflect on the first years of general management in the NHS. Walby et al (1994) question Owens and Glennersters' (1990) assertion and prefer to emphasise that the legacy of the Griffiths Report was in laying the foundations for the subsequent reforms in the health service. The internal market required the clear lines of accountability that the general management structure provided.

Centralising the lines of accountability impacted on the nurses' role in a fundamental way. Traditionally nurses were accountable, through a nursing hierarchy, to one nurse manager both as a professional and as an employee. The general management structure changed this. There were few instances of a nurse appointed as general manager in the early days of the new structure. However, this did not mean that the manager assumed a combined role of professional and manager. Those who were in post were appointed for their management abilities and not their nursing experience which meant, for the majority of nurses, they were accountable to a non-nurse. However, they also had a professional responsibility to the

nursing statutory body to uphold the 'primacy of the interests of patients or clients' (UKCC 1984). The potential for tension between these conflicting lines of authority was acknowledged in two studies (Owens and Glennerster 1990, Walby et al 1994). Nevertheless, although the health service reforms had changed the structure within the health service the aim was also to change public perception of the NHS.

## **2.7 Patients as Consumers of Healthcare**

Changing public perceptions of the NHS was an important part of the Conservative government's healthcare reforms. The intention was to develop a quality health service that was cost-effective and cost-efficient and based on clinical need. However, the public expected health services to be available to all and any restrictions would be profoundly unpopular with the electorate. An integral part of the strategy was to redefine the patient as a 'consumer' of healthcare. Emerging first in 'Patients First' (DOH 1979), a government consultative document that emphasised the importance of the patient when planning services. The commitment was to enabling patients to influence healthcare services and to have more choice. The organisational changes needed to move forward the reforms in the NHS were achieved through the implementation of the Griffiths Report (DOH 1983). Ten years later, the White Paper 'Working for Patients' (DOH 1989a) detailed how the creation of the internal market with increased competition would give consumers greater choice and a better standard of healthcare. The structure was in place to move forward with the next stage of the reforms. The aim was to give patients sufficient information to be able to make informed choices about healthcare.

Several authors were sceptical about this consumerist approach. Pollitt (1989), writing at the time the White Paper was published, questioned whether this was just rhetoric and suggested that patient involvement in healthcare choices would be limited. Allen (2001)

focused on the potential conflict between raised expectations of the health service and cost containment. Prior to the publication of the Patient's Charter in 1991 (DOH) there were public perceptions about healthcare entitlements but very little written information. It was not until the publication of the Patient's Charter (DOH 1991), that patients' rights to healthcare and the standards they could expect were codified.

## **2.8 The Patient's Charter**

The purpose of the Patient's Charter document (DOH 1991) was to ensure that consumers had all the relevant information concerning their healthcare rights. As part of the strategy to inform the public before the official launch in April 1992 a copy of the document was delivered to every household in England. It gave details about seven existing and three new rights to healthcare services and introduced nine Charter Standards. The existing rights included access to emergency care at any time and referral to a consultant with the option for a second opinion. The three new rights related to guaranteed waiting times for hospital waiting lists, access to information on local services and response to complaints about NHS services. The Charter Standards were described as the level of service that should be achieved by provider units. This included the Named Nurse Standard (See 2.1, Table 1).

There was a mixed reception to the introduction of the Patient's Charter. Launching the document with a general election imminent was labelled by many as politically cynical (Cole and Davidson 1992, Shuttleworth 1992, Hogg and Cowl 1994). However, two authors gave cautious welcome to the document. Benton (1993) acknowledged the limitations of the Charter and concluded that at least it gave patients some information about healthcare services. This notion was supported by Ryland (1996) who asked:

'who in their right mind could possibly argue against those kind of standards when previously there were none at all' (Ryland 1996: 1060)

Farrell et al (1998), however, argued against this approach. Their broad-based study of perceptions of the Patient's Charter was undertaken by the King's Fund in 1997. Written evidence, interviews and focus groups were used to gather data. The informants were patients, carers, professional groups, NHS managers and staff and representatives from voluntary organisations and homeless and minority ethnic groups. One of the conclusions of the study was that the Patient's Charter had given consumers information about their entitlements to healthcare that was not realistic. Cohen (1994) supported this view, and anticipated that patient complaints would rise as the health service did not have the resources to meet the demands of the Charter. Several authors attributed the lack of confidence in the Patient's Charter to the government's top-down approach to implementation of a policy without consultation with staff or users (Cohen 1994, McSweeney 1994, Savage 1995). There may be a lack of evidence for the implementation of a Patient's Charter but there are indications in the literature of the origins of the term 'named nurse'.

## **2.9 The Named Nurse**

All the earliest references to 'named nurse' seem to have been made in the context of organising nursing care in a more individualised way. The first public reference to the term 'named nurse' is attributed to Dame Ann Poole, the then Chief Nursing Officer of England, in a speech she gave in 1982 (Jackson 1994). She argued that nurses in hospital should adopt the community nursing system of informing patients of the name of the nurse caring for them. Pembrey (1984: 545) supported the principle in her reflection on the progress nursing had made in organising care to ensure 'allocating a named nurse to a named patient'. The first published reference to this nurse-patient relationship is accepted to be in the Department of Health document, a Strategy for Nursing (DOH 1989b), (See Table 2).



### **Targets for Practice**

One: The full accountability of nursing, midwifery and health visiting practitioners, with responsibility for individual patients or clients, should be recognised and applied in all healthcare settings.

Two: The development of primary nursing should be encouraged.

**A Strategy for Nursing 1989** page 32

**Table 2: A Strategy for Nursing 1989**

The term 'named nurse' is not specifically mentioned but is implicit in both targets for practice. The two contain attributes associated with the Named Nurse Standard, including individualised care and organising nursing care to enable an identified nurse to care for an individual patient. However, Snell (1989) questioned whether the three years the nurse leaders spent working on the Strategy for Nursing were worthwhile suggesting that it lacked the influence to ensure its implementation.

The document is of particular interest to this study because it introduced the concept of monitoring targets in the organisation of nursing care. This was also a requirement of the implementation of the Named Nurse Standard. Subsequently, the imperative became the one of the most contentious issues in the literature on the Named Nurse Standard (Cohen 1994, MacAlister 1994, Friend 1995, Farrell 1998, Allen 2001). However, this aspect of the Strategy for Nursing goes without comment in the literature which perhaps supports Snell's observation (1989) concerning the lack of commitment to the document. There certainly was a prompt review of the document. This was initiated by the newly appointed Chief Nursing Officer at the Department of Health, who wanted to refocus the strategy in light of the changes in the NHS. This is understandable as there were other, related documents being published at that time.

The new document, 'A Vision for the Future' (DOH 1993a), was launched at the same time the Patient's Charter came into effect, and identified the contribution that nurses, midwives and health visitors could make to healthcare. Congruent with the government's strategy to devolve the decision-making down to local level, the document went out for consultation to practitioners, professional organisations and other stakeholders. The outcome of the consultation provided a system of targets with a monitoring framework. Two of the targets converged with the Named Nurse Standard (DOH 1991) (See Table 3).

<b>Targets</b>	
One:	Each patient should have been assigned to a named nurse, midwife or health visitor throughout their period of care and local units will be expected to have developed the means of monitoring the initiative.
Six:	Each nurse, midwife and health visitor should be able to clearly identify the caseload or group of patients/clients for whom he/she is the named professional and has responsibility for care.
<b>Vision for the Future - The Nursing, Midwifery and Health Visiting Contribution to Health and Health Care 1993</b>	

**Table 3: Vision for the Future 1993. Targets One and Six**

A monitoring exercise was undertaken one year after the launch of the document (DOH 1994a), and it is possible to consider the findings as one indication of the progress of the Named Nurse Standard. All trust executive nurses and directors of nursing were surveyed by postal questionnaire, and over two thirds of the 669 responded. The findings indicated that 95% of the respondents had achieved Target One and established a monitoring system for the named nurse approach. These results seemed to indicate very good progress towards achieving this target. However, the authors of the report acknowledged that the findings were limited because there was no indication whether the responses represented a whole trust or one ward. Accepting this limitation, it would seem reasonable to assume that the implementation of the named nurse role had been discussed in those areas.

The final document considered in this section is the 'Scope of Professional Practice' (UKCC 1992a), which was one of a suite of documents produced by the nursing statutory body on principles to guide practice. It is pertinent because it provides a statement on the 'named nurse role' by the statutory body. The document was produced in recognition of the expanding boundaries in nursing, midwifery and health visiting. In one of the sections (See Table 4) guidance is given on providing care as a patient's 'identified' or 'named' practitioner. The aspects of the role are described, including 'co-ordinating' and 'supervising' the delivery of nursing care.

**Practice and the 'Identified' Nurse, Midwife and Health Visitor**

The Council recognises that, in a growing number of settings, patients and clients will be in the care of an 'identified' practitioner. The practitioner may be identified as the 'named' practitioner or as the primary, or associate or sole practitioner providing nursing, midwifery or health visiting care. In such roles, individuals assume key responsibility for co-ordinating and supervising the delivery of care, drawing on the general and special resources of colleagues where appropriate. Professional practice naturally involves recognising and accepting accountability for these matters...in this key role'

**The Scope of Professional Practice 1992 page 10**

**Table 4: The Scope of Professional Practice 1992**

It makes it clear that, if a nurse assumes the role of named nurse they are accountable for that patient's care. The professional principle being applied is that accountability cannot be delegated to others. The nurse may use professional judgement to devolve 'responsibility' for aspects of care to a colleague. However, the nurse is accountable for having devolved that responsibility. If this definition is used to interpret the Named Nurse Standard (UKCC 1992a) (See Table 1) a practitioner would be 'responsible' and not 'accountable' as a named nurse. It can be assumed that in the Patient's Charter (DOH 1991) the term 'responsible' was used because the language was more accessible to target readers. The Scope of Professional Practice gives the professional perspective on the named nurse role and nurses should use the guidance to inform their practice.

It has been shown above that the Named Nurse Standard was strongly grounded in nursing discourse. All the elements appeared to be in place for qualified nurses to take on a role that reflected the professional aspiration of individualised patient care. Professional guidance on the role of 'identified' nurse for a patient had been given by the statutory body and in the nursing literature there was information on organisational methods that could be used. However, when the Named Nurse Standard was introduced it was not part of a nursing strategy but a Patient's Charter (DOH 1991) that was one of the mainstays of the consumerist approach for the Conservatives. The stated aim of the Charter was to improve patient experience of healthcare through informing the public of their rights to healthcare and ensuring that the NHS could deliver that level of service. The intention deserves support but the language used of 'quality' and 'choice' is resonant with political rhetoric. However, it is difficult to measure the success of the Charter or any of its component parts because of the limited research into its effects.

The one early study (RCN 1994) that measured consumer overall awareness of the Patient's Charter and the Named Nurse Standard found that only 2% of respondents associated the Charter with improving standards of care. This was not the interpretation that the government would have wished. However, these perceptions are reflected in other literature on the Patient's Charter. The following section considers negative views of the Patient's Charter. The comments relating specifically to the Named Nurse Standard are considered in Chapters Three and Four. Those chapters explore in more depth the literature relating to nurses and the patients as the two key stakeholders in the Named Nurse Standard.

## **2.10 Weaknesses of the Charter**

On coming to power the Labour government promised a review of the Patient's Charter and this came relatively early in their first term. This was a broad based review undertaken by

Dyke (1998) which included consideration of the findings from Farrell et al's study (1998) and consultation with health service staff around England. As has already been shown, Farrell et al's work used a representative sample of users, carers, NHS staff and voluntary sector organisations to review the Patient's Charter, and they concluded:

'The overwhelming view of the [Patient's] Charter among those who had experience of it was that it had limited usefulness. Most people acknowledged positive aspects to it but these views were expressed much less enthusiastically than those concerned with its weakness'. (Farrell et al 1998: 7)

In his report Dyke (1998) accepts Farrell et al's conclusions but offers a more upbeat and perhaps politically expedient view of the success of the Patient's Charter:

'The results of the research are outlined in the King's Fund Report, which are pretty conclusive - on the face of it the Patient's Charter failed ... Despite these widespread criticisms I would suggest that the Charter was not an unremitting failure ... it began to legitimise a more consumerist culture.....'. (Dyke 1998: 10-11)

Presenting a picture of a Labour government retaining the policy of the outgoing government, setting in place a review and prepared to respond if changes were needed. However, despite the recommendations of the Dyke report (1998) that a new Patient's Charter be introduced, there was no change to policy until 2001, when a new document, 'Your Guide to the NHS', was published (DOH 2001a). In the intervening three years the Patient's Charter (DOH 1991, DOH 1995) remained in place. Although the new document reiterated some of the standards from the Patient's Charter, the Named Nurse Standard was not one of them. The data collection for this present study was nearly completed when 'Your Guide to the NHS' was published. Therefore no change to the design of the study was made. Furthermore, it was accepted that any changes in the sample hospitals captured during the latter stages of the data collection would form part of the rich picture of the participants' experience.

The main weaknesses of the Patient's Charter identified in the literature, and specifically in the reports from Farrell et al (1998) and Dyke (1998), will be considered in the final part of this chapter. Four main themes will be examined: clarity of the language, the relevance to the patient experience, monitoring the standard and top-down management.

### **2.11 Clarity of Language**

The main concern about the language of the Patient's Charter (DOH 1991) was what was meant by a 'patient right'. Several writers attempted to clarify what constituted a 'right' under the Patient's Charter (Hill and Ng 1992, Hogg and Cowl 1994, Farrell 1998). In Dyke's report (1998) he suggested that 'aspirations' would be a more appropriate description of the patient entitlements described in the Charter. Hogg (1994) and Wilder (1995) took a different view and explored the Patient's Charter in the light of the government's legal duty to provide healthcare. They both concluded that aspects of the Patient's Charter were existing statutory rights but there was no legal precedence for the Charter itself. Hill and Ng (1992) did an extensive study of local charters in 50 family health services and 140 health authorities. They reported that in many instances 'rights' and 'standards' were used interchangeably. What emerges from the literature on the Patient's Charter is that it is a publication that lacks the precise definitions of terms that would be required in a legally enforceable document. However, it is given a quasi-legal status by its attribution as a charter for patients that safeguards their health service rights.

The government did respond to some of the early comments about the Charter by introducing a second edition in 1995 (DOH). The main changes in the document were to the standards, with additions made, revision of some of the existing statements and the division of standards into two categories, namely 'rights' and 'expectations'. 'Rights' were those services that all patients would receive all the time and included the so-called 'defining

principles' of the NHS, for example, receiving treatment based on clinical need. 'Expectations' were defined as standards that the NHS was aiming to achieve but with the caveat of 'circumstances permitting'. There was no rationale given for this change but the majority of standards that became 'expectations' required resources and also had a time constraint on them. The Named Nurse Standard was one that became an 'expectation' in the second edition of the Patient's Charter (DOH 1995) (See Table 5).

<b>Hospital Services</b>
You can <b>expect</b> a qualified nurse, midwife or health visitor to be responsible for nursing or midwifery care. You will be told their name.
<b>The Patient's Charter and You 1995 page 14</b>

**Table 5: The Named Nurse Standard - Second Edition 1995**

An additional statement had been added to the original (DOH 1991) that assured patients that they would be told their 'named' nurse's name. There was no rationale for the change but it might be that it was perceived to be an example of good 'customer relations' in the new consumerist culture. It could also be an example of local accountability in action, as it would make it easier for a nurse to be identified if the patient had been given their name.

## **2.12 Relevance to Patient Experience**

The second weakness of the Patient's Charter was that it lacked patient involvement. Several authors comment on the lack of user and carer involvement in its development (Hogg 1994, McIver and Martin 1996, Farrell et al 1998) and suggest that it should be rectified in any future work. Pfeffer (1992) supports the suggestion but argues that the Charter only focuses on hospital services which threatens to disenfranchise those patients with long-term health problems who require community services.

From their small study of patients who had used the Accident and Emergency services at two London hospitals Britten and Shaw (1994) make specific recommendations about the type of service that patients want. They report that the standards in the Patient's Charter had resonance with the respondents but they wanted additional standards that were relevant to their experience, for example, pain relief and information giving and receiving. Lack of relevance to the patient experience is a recurring theme in the literature. Farrell et al (1998) cite a NOP Consumer Market Research survey (1994), that concluded that the respondents saw the Charter as a list of services they could expect from the NHS but not really as pertinent to their experience. This view is also supported by Farrell et al's own report (1998), in which none of the patients in the focus groups is reported as having seen a copy of the Patient's Charter. Some had heard of it but were not clear about its purpose. There are two further studies on this theme that will be reviewed more extensively, as they offer insight into perceptions of the Patient's Charter.

The first study was from the Royal College of Nursing, who commissioned research from Audience Selection Limited (RCN 1994) to examine public awareness of the Patient's Charter. Of the 2000 people polled on the telephone over two consecutive weekends two-thirds had heard of the Patient's Charter. However, less than half of these respondents could identify any aspects of the Charter, and only one per cent could identify the Named Nurse Standard. The other research report by Bruster et al (1994) is fundamental to the planning of this current study. This was a rigorous study of the perceptions of patients recently discharged from hospital. A stratified sample of 36 hospitals in England was used, and a random sample of approximately 150 patients from each hospital was interviewed at their discharge address two to four weeks after their hospital stay. A total of 5150 patients were interviewed. All the respondents had been on medical and surgical wards. Using a structured interview schedule data were collected on patients' opinions of their hospital.



The researchers mapped the findings against the standard statements in the Patient's Charter (DOH 1991). The results showed that five of the nine Patient's Charter Standards were not met. The Named Nurse Standard was one of these five, with only one third of the patients (n=1827) responding that they thought there was a particular nurse in charge of their care.

The question that arose from Bruster et al's work (1994) was why the Named Nurse Standard was not more widely used. It is acknowledged that the data collection for the study took place only one year after the launch, but this was a government imperative that had been publicised and was being closely monitored. However, the findings of Bruster et al indicate that respondents perceived that there was not a named nurse system in place. These findings, together with the evidence from the literature on nurses' experiences of the Named Nurse Standard, were used to inform the design of this present study.

### **2.13 Monitoring the Patient's Charter Standards**

There is little positive comment on the monitoring process for the Patient's Charter standards and the examples there are tend to be government documents (DOH 1994b). The majority of authors note concern regarding either the method or purpose of monitoring. Several link the imperative to monitor performance with the politically inspired contracting process in the NHS (Cohen 1994, MacAlister 1994, Savage 1995, Allen 2001). The type of audit system that was put in place (DOH 1992) seemed to confirm that central government wanted to retain control of 'organisational power'. Clarke and Newman (1997) suggest that devolution of accountability to local level means that those managers have to perform because they are being monitored against national performance targets. Publishing local league tables means that failure to achieve targets could be associated with poor local managers rather than failure of central government.

Savage (1995) suggests that the Named Nurse Standard could be used in this way to identify nurses who are not 'performing'. However, it is not clear who would be held 'accountable' for not achieving the Named Nurse Standard if, as the 1995 edition of the Patient's Charter (DOH) states, that it is an 'expectation'. How can an 'expectation' be satisfactorily monitored? A possible way could be to link it to patient satisfaction or clinical outcome. However, as Benton (1993) and Farrell (1998) point out, the Department of Health required quantitative data on output and did not have the facility to measure the quality of the patient experience. In addition, quantitative data are more readily presented in league tables and therefore more attractive for use in the contracting process.

The creation of the internal market in the health service (DOH 1989a) introduced the ideology of the free market into the NHS. The aim being a more cost-effective and cost-efficient health service through increased competition. The internal market comprised the 'purchasers' of health care, for example District Health Authorities and Family Health Services Authorities, and 'providers' of services, these included NHS trusts and the private sector. Through complex funding streams money was allocated to Health Authorities based on the projected health needs of their local population. The hospital league tables were one source of information that could be used by the purchasers to measure how local services performed against national targets. It was argued that creating competition would mean that the high performing providers would be rewarded with more contracts, and the lower achieving units would be encouraged to improve (DOH 1989a).

Several authors challenged the validity of drawing conclusions from possibly unreliable data. They argued that if the standards lack clarity (Friend 1995, Hart 1996, McIver and Martin 1996) then the accuracy of the data had to be in question, thus making it impossible to be confident in the findings. As has already been shown concern had been raised about poorly

defined 'rights' and 'standards' (Hill and Ng 1992, McIver and Martin 1996).

However, Friend (1995) and Allen (2001) considered the pressure on managers and staff to 'balance the books' and make sure audit returns were complete. Strategies for managing these processes included complying with the targets 'on paper' but, argues Allen (2001), this did not always accurately reflect what was happening in practice. Staff felt driven to achieve the quantity of the activity rather than the quality of performance (Hart 1996, Farrell et al 1998). Other staff became disillusioned when their efforts to meet the Charter standards were not recognised, as a quotation from Farrell et al (1998) illustrates:

'I once put extra time and effort into looking precisely where the problems [with trolley waits] were ... [but] nobody was interested anyway. So we've just resorted to the minimum data collection we can possibly attempt now'.  
(Farrell et al 1998: 9)

Dyke (1998), in his review of the Patient's Charter, accepts the evidence from Farrell et al (1998) and others that staff could develop a 'tick box mentality' of compliance to meet the management imperative rather than recording accurate data.

#### **2.14 Top Down Management**

It was also argued that staff felt disempowered because the Patient's Charter standards had been imposed from the 'top down' without consultation (Cohen 1994, McSweeney 1994, Savage 1995). Although, this was not entirely accurate, as has been shown, for nurse leaders were involved in the 'Strategy for Nursing' (DOH 1989b) and the 'Vision for the Future' (DOH 1993a), both of which informed the development of the Patient's Charter (DOH 1991, DOH 1995). However, Dyke (1998) acknowledged that the Patient's Charter was a Downing Street initiative that lacked widespread consultation with health professionals. The apparent dissonance between the nursing profession and their leaders was not because nurses were unfamiliar with or resistant to standard setting in healthcare. As several authors agree, if nurses were involved in developing standards they would have a

clear understanding and ownership of them (Barnett and Wainwright 1987, Dunne 1987, Kitson et al 1990). Nor was it because they did not accept the principle of individualised care that underpins the Named Nurse Standard (Henderson 1966, Henderson 1978, Giovannetti 1980, Binnie 1987, Pearson 1988, Thomas and Bond 1990, Wright 1990). The literature suggests that the dissonance was because the Named Nurse Standard was introduced through a top-down management initiative linked to the contracting process (Cohen 1994, McSweeney 1994, Savage 1995).

### **2.15 Summary**

There is little systematic research about the Patient's Charter but what is available suggests that it was not a policy that was readily accepted by patients or local NHS staff. The government could argue that it was a successful consumerist initiative because there was evidence, from their extensive monitoring of local activity, that rights and standards were being met. However, both anecdote and some small scale research suggest that in some cases there was outward compliance in meeting the required standards, but that staff were also 'managing' the figures so that minimum standards were recorded. There is no evidence of widespread inaccuracy in the data. However, there was acknowledged lack of clarity in the standards being measured and, taken with the evidence of outward compliance to record-keeping, must cast doubt on the validity of the data.

From a patient perspective, the reported perceptions were of a document that was at best incomplete, and at worst irrelevant to their needs. There did seem to be an over-emphasis on acute services in the Patient's Charter. In addition the standards did not appear to reflect patient priorities. It has to be accepted that it would not be possible for all patient clinical needs to be codified in a Charter. However, there are some aspects of clinical care noted by patients, for example pain relief, that would be appropriate across hospital services.

However, the data that were collected from the Patient's Charter were quantitative, with no opportunity for the qualitative elements of the patient experience.

The evidence indicates that there are few recorded differences between patient perceptions as in-patients and when they are discharged. In the only large-scale study of patient perceptions of the Patient's Charter one-third of the recently discharged patients thought that one nurse had been in charge of their care. Although, this suggests that patients were generally unaware of their entitlements to healthcare; however, it has to be treated with caution as this study was undertaken within a year of the Patient's Charter being launched. Almost ten years later consumers have many different sources of healthcare information and may be more aware of their entitlements to healthcare.

Healthcare workers, and nurses in particular, were concerned that the Patient's Charter was a top-down management initiative that was implemented without consultation with staff groups. There was concern that it was directly linked to the contracting process, and was a way of monitoring and controlling performance. Nursing staff had traditionally been involved in deciding which method of organising nursing they would use in the clinical setting. The implementation of the Named Nurse Standard was associated with management imperatives that appeared to remove that element of professional judgement.

There are a number of questions emerging from the literature about the nature of the patient and nurse perceptions of the implementation of the Named Nurse Standard. There is the issue of which organisational modes were chosen by nurses in the hospital setting to meet the Named Nurse Standard in hospital. The decision could have been driven by the need to achieve the Standard but there may have been other considerations, for example, the relevance of the patient group and the availability of resources. Finally, there is the question of which organisational mode was in place on wards where the patients did not perceive

that there was a named nurse system in place.

These questions began to provide a framework for the design of the present study. The participants were identified as the two groups associated with the implementation of the Named Nurse Standard. The first group are qualified nurses because they assume the role of a named nurse. This may require changes to the organisation of their nursing work and enhance their accountability. The second group are patients who will be recipients of care from a named nurse. The literature reviewed in this chapter has identified ambivalence in both these groups towards the notion of the Named Nurse Standard. However, the area where there has been limited work is on the application of the concept of the named nurse role into practice. Therefore it is reasonable to conclude that the focus of the study should be on the perceptions and experiences of nurses and patients in the clinical setting.

## **CHAPTER THREE**

### **NURSES AND THE NAMED NURSE**

#### **3.0 Introduction**

This chapter will consider the response of the nursing profession to the introduction of the Named Nurse Standard. The views of nursing leaders and the profession will be examined to identify how the initiative was received. Different approaches to the operational aspects of the Standard will be considered, and the influences on implementation. Finally the impact of the Named Nurse Standard on the professional role of nurses will be explored. There is a small body of nursing literature available on this topic, the majority of which is anecdote and comment from the popular nursing press. The other main source of literature that will be used is selected government publications.

#### **3.1 Ownership of the Standard**

Evidence in the literature suggests there was a dichotomy between the response of the nursing leaders and the nursing profession to the introduction of the Named Nurse Standard (DOH 1991). Comment on the Standard from the nurse leaders was generally positive. Authors including Davies and Davis (1992), Hancock (1992a), Royal College of Nursing (1992), Watkins (1992) and Wright (1993), described the Named Nurse Standard as public acknowledgement of the value of nursing. In contrast, the response from the nursing profession focused on concerns about the effects of the Standard on their nursing work. These included how the implementation was to be resourced (Shuttleworth 1992, Neal 1995), the effect on accountability (Tingle 1993), and the political motivation for the introduction of the Standard (Cole and Davidson 1992, Jolley and Brykczyńska 1993, Mackereth et al 1994, Savage 1995).

It could be argued, in the early days of the Named Nurse Standard, that these were not unexpected responses by the two groups. It was part of the nurse leaders' 'visioning' role to analyse and comment upon new initiatives that might move forward, or inhibit, the aspirations of nursing. As has been shown in Chapter Two (See 2.9) nurse leaders were directly involved in the precursors to the Standard, for example the Strategy for Nursing (DOH 1989b). This would have given them opportunity to appreciate the context, and significance of the Named Nurse Standard, whilst the nursing profession, perhaps understandably, were looking at the effect on their day-to-day professional practice. The health service reforms had already resulted in a number of changes to their working environment, for example the reconfiguring of the NHS into trusts. The difference with the introduction of the Patient's Charter was that the Named Nurse Standard impacted directly on how nurses organised their nursing work. Furthermore, the Standard had to be implemented very quickly. The date set by the Government for implementation of the Patient's Charter (DOH 1991), April 1<sup>st</sup> 1992 was within six months of its launch. This gave very little opportunity for the publication of relevant literature, and offered no time for reflection and debate, all of which might have contributed to the apparent dissonance of the nursing profession.

Cole and Davidson (1992) suggested that some nurse leaders were also concerned about how rapidly the Named Nurse Standard had to be implemented. Although this view was tempered slightly in the comments by the General Secretary of the RCN (Hancock 1992b), she reports that the profession were 'surprised' that the Standard was to form part of the Patient's Charter because of the short lead-in time. However, in a letter to all RCN members in March 1992 endorsing the concept of the named nurse, Hancock (1992c) acknowledged the possible negative effect on the profession of the rapid implementation of the Standard. It is worth noting that the purpose of the letter was to distribute a Department



of Health information leaflet, 'The Named Nurse Your Questions Answered' (DOH 1992). The government financed the mailing which could be seen to illustrate their awareness of the dearth of information about the Named Nurse Standard. However, as not all nurses were, or indeed are, members of the RCN the strategy could only have limited success as a vehicle for informing nurses about the Standard. An alternative interpretation of the action could be that central government was exercising 'organisational power' (Clarke and Newman 1997), by devolving accountability to the RCN. Therefore any failure to inform the nursing profession would be associated with that organisation rather than the Department of Health. However, the action could be viewed more positively as a calculated attempt to distribute information to a critical mass of nurses, with the anticipation of the 'cascade' effect. Nevertheless, it is reasonable to conclude from Hancock's comments (1992c) that nurse leaders had anticipated the introduction of the principle of the named nurse role, but the timing of the Patient's Charter was unexpected.

### **3.2 Valuing Nursing**

Hancock, on behalf of the RCN, and Wright were the main contributors to the early literature on the Named Nurse Standard, and therefore offer an interesting perspective. Both authors agreed that the Standard was public recognition of the significance and value of nursing in patient outcome (Hancock 1992b, RCN 1992, Wright 1992a, Wright 1992b, Wright 1993). However, Steven (1999) challenged the advocacy of the Named Nurse Standard by the RCN and other leaders, suggesting that the Standard might have been exploited to advance the professionalisation of nursing. The argument has resonance with Salvage's critique of 'New Nursing' (1992). Although the nurse leaders' supported the Named Nurse Standard it could be interpreted as promoting the profession as the phrase 'recognition of the value of nursing' (Hancock 1992b: 39) was used. However, the phrase was generally balanced with comment about the positive effect that care from a qualified

nurse had on patient experience (Hancock 1992b, Wright 1993).

Wright presented the 'named-nurse concept' as a method of organising nursing work to improve patient care (1992a, 1992b, 1993, 1995). He argued that, after years of struggle for professional recognition, the Named Nurse Standard endorsed the significance of the nursing profession, citing the inclusion of the Named Nurse Standard in the Patient's Charter (DOH 1991) as public affirmation of the government's support for nursing. Anticipating the argument that the Standard would raise public expectations that could not be achieved (Farrell et al 1998, Cohen 1994, Savage 1995, Allen 2001), Wright suggested that nurses could use the Named Nurse Standard to challenge the NHS managers to provide the necessary resources for individualised patient care. He advised nurses to take control of the Named Nurse Standard and use it as follows:

'It [the Named Nurse Standard] is a tool which can be used to further the quality of patient care. Whether it succeeds or not, will be largely in the hands of nurses themselves' (Wright 1993: 19)

It is interesting to note that Wright was associated with the 1993 Department of Health publication about the implementation of the Named Nurse Standard into a variety of clinical settings. Therefore he was aware of how nurses had managed to introduce the Standard into their organisation of nursing work. However, in a subsequent work Wright (1995), acknowledged that the positive momentum of implementation had not been maintained. He suggested that this could be attributed to the perceived political intention behind the Patient's Charter (DOH 1991). As has been shown in Chapter Two (See 2.10), this view was consistent with negative perceptions expressed by other authors (Hogg 1994, McIver and Martin 1996, Savage 1995, Farrell et al 1998).

Although Wright (1992a, 1992b, 1993, 1995) and Hancock (1992a, 1992b) did not debate the political imperative of the Patient's Charter (DOH 1991), they accepted there was

government policy associated with it. They advised the profession to see the Standard as an opportunity to develop their professional role. They argued that it embodied three key aspirations for the nursing profession: individualised patient care; the empowerment of qualified nurses; and acknowledgement of the value of nursing.

Hancock (1992a, 1992b), had supported the introduction of the named nurse as a logical and welcome development in nursing. However, she also argued that the Named Nurse Standard could be seen as an endorsement of the qualified nurse as 'value for money' in delivering quality, cost-effective patient care (Hancock 1992b). This argument illustrates the concerns of many in the health service in the post-Griffiths' era (DOH 1983) about the effect the government policy of efficiency would have on the skill-mix of the NHS workforce.

### **3.3 Skill-Mix**

Studies available in the early 1990s which informed the nursing skill-mix debate included work by Buchan and Bell (1991) and the Audit Commission (1991). Both reports highlighted the benefits of using nursing resources efficiently and effectively. Ten years later another Audit Commission report, 'Ward Staffing' (2001a), attempted to establish a correlation between staffing levels and quality. The findings were inconclusive because variations in ward staffing policies and quality monitoring procedures in NHS trusts limited comparison of the data. However, Hancock's argument (1992b) of the value of the qualified nurse in patient outcome was supported by Carr-Hill et al (1992). Using a modified version of Qualpac (Wandelt and Ager 1974), (See Appendix 2), Carr-Hill et al (1992) measured the quality of nursing care delivered by different grades of staff. The findings showed that the higher the grade of nurse the better quality of care the patient received. However, these results were challenged by findings in a later study (Warr 1998).

Warr's study (1998) had been developed from Carr-Hill et al's work, but focused on the role of the Health Care Assistant (HCA). The findings of Warr's study demonstrated that HCAs delivered a higher quality of patient care than nursing auxiliaries and some grades of qualified nurse. It was not unexpected that support workers, who had undergone training as HCAs, delivered a higher quality of care than nursing auxiliaries, who had limited preparation. However, in what appeared to be a rigorous study, it was less clear why some grades of qualified nurse performed less well than HCAs. Although it was a small study, it is interesting to consider the findings in the context of evidence about the cost-effectiveness of a qualified nurse delivering a high standard of care (Audit Commission 1991, Buchan and Ball 1991, Carr-Hill et al 1992).

Recruitment and retention of staff in the NHS were significant issues in the 1990s with the inevitable impact on skill-mix in the nursing workforce. The problems affecting the NHS could be attributed, in part, to social changes with more part-time working and family-friendly policies in the workplace. The latter being particularly significant for nursing, as it still was a predominantly female profession. There were also changes to the workplace regulations (DTI 1998) that necessitated changes to shift patterns in some areas. An outcome of the shortfall in permanent staff was an increased use of temporary, or 'bank' staff to fill vacancies. The temporary staff were generally employed on a single shift basis, and therefore not attached to any specific clinical setting for a significant length of time.

An Audit Commission report published in September 2001 showed that, nationally, there had been an increase in the use of temporary nursing staff in hospitals. The findings showed that on a 'typical day' in the NHS 20,000 temporary staff were working in trusts, which represented 10% of the shifts worked (Audit Commission 2001b). This instability in the workforce had an inevitable impact on the organisation of nursing work in NHS, but it also

presented obstacles to implementing the Named Nurse Standard (Melville 1995). The criteria for the Standard of a qualified nurse (DOH 1992, DOH 1994b), available for the admission and discharge of a patient (DOH 1991, DOH 1995), could not be achieved with temporary staff.

Two changes in NHS policy in the early 1990s were pertinent to the implementation of the Named Nurse Standard. The first was the imperative to make hospitals more efficient (DOH 1989a), by increasing the throughput of patients. This meant shorter in-patient stay, and an expansion of day-case services. Related to this was the increased demand for hospital beds (DOH 2002) with the change in the demographic profile of the population, and raised life expectancy for both men and women (DOH 2001b).

The second issue was the discourse on junior doctors' hours (NHS Management Executive 1991, SCOPME 1991). The proposed reduction in hours could only be achieved by increasing the number of junior doctors, or relocating certain tasks to other staff including nurses. However, before nurses could absorb these additional tasks into their role, there would need to be a review of work practices to identify which responsibilities could be delegated to colleagues. There is no evidence in the literature that this became part of the specific debate about the implementation of the Named Nurse Standard. Nevertheless, it is reasonable to assume it was part of the human resources planning as NHS managers considered the requirements of the Patient's Charter, as both these issues required changes to nurses' working practices. The response of the nursing profession to the debate about the Named Nurse Standard will be considered in the following section.

### **3.4 Response of the Profession**

There is no evidence in the literature that illustrates how the majority of nurses responded to the introduction of the Named Nurse Standard. However, there are some small surveys and

anecdotal evidence that give a 'snapshot' of the professional perspective. There was indication of indifference (Wright 1995) as well as antipathy to the introduction of the Standard (Cohen 1994, Steven 1999). Two reader opinion polls in nursing journals (Shuttleworth 1992, Nursing Standard Readers Panel 1995) reported mixed views about the Standard. In the early poll (Shuttleworth 1992) three quarters of the 200 respondents indicated that the Charter Standards would have no impact on their practice. This could be because there was a lack of knowledge about the recently introduced Patient's Charter (DOH 1991). Alternatively it could be evidence of the cynicism about another in a series of health service reforms (DOH 1983, DOH 1989a, DOH 1990). However, Shuttleworth suggests that this apathy was predicated on the view that this was just another change that would not be fully implemented because of chronic underfunding in the NHS.

The second poll had a much smaller sample of ten readers (Nursing Standard Readers Panel 1995). It should be noted that this poll had been undertaken just after the publication of the second edition of the Patient's Charter (DOH 1995). In that edition the Named Nurse Standard was categorised as an 'expectation', and not a 'right'. Therefore, this might have influenced the panel's response. However, the findings showed that the panel was divided on whether the Charter was a positive step for healthcare or political rhetoric. There were a number of limitations on these findings, including the sample size, and how participants were selected. Nevertheless, the results indicated a lack of enthusiasm and, perhaps more importantly, lack of ownership of the Named Nurse Standard.

Several authors attempted to explain the apparent apathy to the Named Nurse Standard as a reaction to a political policy that had been imposed without consultation (Jolley and Brykczynska 1993, Cohen 1994, McSweeney 1994, Farrell et al 1998, Allen 2001). However, Steven (1999) blamed management at local level, arguing that poor

administration of the change process meant nurses were not motivated to implement the Standard. In contrast, Allen (2001) in a study of changes in nurses' work presented a complex picture of how nurses 'complied' with the management agenda to meet the Named Nurse Standard. The findings showed that nurses organised their work to meet patient needs. Although recording a named nurse in the patient notes was perceived to be an adjunct to that activity rather than the driver.

There was some evidence of reaction to the perceived negativity of the profession. Several authors suggested that nurses should take control of the Standard to improve patient care (Wright 1993, Mackereth et al 1994, Jack 1995). Jolley and Brykczyńska (1993) suggested that nurses could achieve this by developing the political acumen to challenge management. However, delegates at the RCN Congress in 1996 debating the 'Application and Effectiveness of the Named Nurse Principle in the Patient's Charter' acknowledged that the profession had failed to grasp the opportunity that the Standard offered. The delegates concluded that, in the absence of a profession-led definition of the named nurse role, it had to be assumed that one would be imposed on nursing. The outcome of the debate illustrates a lack of direction, co-ordination, and ownership of the Named Nurse Standard by the profession. At local level there appeared to be some adherence to the Named Nurse Standard, although there were variations in the interpretation of the term 'named nurse'.

The study by Dooley (1999), illustrates how the term 'named nurse' was used by one researcher. Dooley surveyed qualified nurses in four community hospitals to identify their perceptions of the named nurse role. A self-administered questionnaire was used to collect qualitative and quantitative data. Despite employing follow-up strategies only one third of the sample responded (n=21) and this limits generalising from the results. Nevertheless, the results are pertinent as they offer insight into a poorly researched area. The findings showed

that all the respondents reported the named nurse concept was part of their organisation of nursing work. Furthermore, although there were some differences in the respondents' knowledge of the role, there was agreement that the named nurse role was positive for patient care.

One of the issues arising from this small study was the absence of a direct reference to the Named Nurse Standard. Dooley used the term 'named nurse concept' in the survey. This could have been because he wanted to explore nurses' perceptions of the role, rather than their knowledge of the Standard. Dooley would have been aware of the reported antipathy associated with the Named Nurse, and it could be argued that he chose to explore the 'named nurse concept' to separate it from the political associations of the Named Nurse Standard, thus minimising potential bias. In focusing in this way on the concept of the named nurse, rather than the Named Nurse Standard, Dooley (1999) was following the work of Hancock (1992a) and Wright (1993). Although Dooley's work is much later there is still a focus on exploring the values underpinning the Named Nurse role rather than providing an operational definition.

### **3.5 Defining the Named Nurse**

It is evident from the literature that many different terms were used in conjunction with 'named nurse'. The most frequently used term was 'Standard', which appeared mainly in Department of Health documents (DOH 1991, DOH 1993b, DOH 1994b, DOH 1995) and when authors referred to or quoted from the Patient's Charter. However, other terms were used by authors including: 'system' (Jack 1995); 'approach' (Hancock 1992b, RCN 1992); 'initiative' (Wright 1995) and 'concept' (Mackereth et al 1994, Melville 1995, Savage 1995, Dooley 1999, Steven 1999). In addition Boyington (1992) referred to 'named nursing' and several authors used the 'the named nurse' (NHSME 1992, Broomfield 1996,



Dargan 1997). Although some of the authors offered a definition of the term the majority did not. Nevertheless, it is reasonable to conclude that, in the literature from 1991 to 2001, all references to 'named nurse' are associated with the Named Nurse Standard (DOH 1991, DOH 1995).

Some of the terms used by authors suggested that the 'named nurse' was a method of organising nursing care, for example 'approach' and 'system'. However, there was general agreement that it was not an organisational mode, but that the Standard had to be implemented through a method of organising nursing work (DOH 1994b, Hancock 1992b, Wright 1993, Jack 1995). These modes could include primary nursing, team nursing and the key worker system (DOH 1994b, Wright 1993). However, there was some inconsistency in terminology in Wright's later work on the Named Nurse Standard (1995). In that work Wright described the named nurse concept as an 'organisational method' and team nursing and other methods of organising nursing work as 'organisational models'. However, despite the confusion with terminology, Wright's basic premise remained that an existing organisational method had to be used to implement the Named Nurse Standard.

Dargan (1997) in a guide to implementing the Named Nurse Standard in the hospital setting, challenged the dominant view. She offered a framework that had been developed from primary nursing specifically to implement the named nurse role, but was not one of the accepted methods of organising nursing work. It was entitled the 'Named Nursing Programme' and went beyond detailing the method of organising nursing care to include guidance on the professional development of staff. Dargan (1997) was one of the few authors who offered a comprehensive guide to her interpretation of the named nurse role.

### 3.6 Characteristics of a Named Nurse

Having examined the terminology associated with the Named Nurse Standard, some of the definitions of 'named nurse' from the literature will be considered to identify common characteristics. For the purposes of this study the two definitions of the Named Nurse Standard (See 2.1 and 2.11) given in the two editions of the Patient's Charter (DOH 1991, DOH 1995) are accepted as the basis for the research. The following considers how a number of authors have attempted to interpret those statements into operational definitions. The first definition is from Wright (1992a), one of the authors most closely associated with the implementation of the Standard, as follows:

'The essence of the named nurse concept is that one qualified nurse, midwife or health visitor is accountable for the care of particular patients. This nurse is the patient's 'special' nurse. The organisation of care under this system is designed to promote maximum continuity and co-ordination throughout the patient's stay. Whenever possible, the same nurse should care for the same patient'. (Wright 1992a: 28)

The characteristics Wright attributed to the named nurse role included continuity and co-ordination of patient care. Jackson (1994) developed this theme by suggesting that the named nurse role enabled 'supreme' continuity and co-ordination of a patient's care. Although Melville (1995) supported these views she argued that the only way to ensure continuity of care would be to organise nursing staff rotas to reflect the patient's stay. Here Melville was challenging NHS managers to provide the required stability in the workforce, whilst acknowledging the changing work patterns of staff and the fast throughput of patients.

Other characteristics Wright (1992a) referred to included accountability, and a particular or 'special' relationship between a clearly identified, qualified nurse and a specific patient. The RCN (1992), commenting on the Named Nurse Standard at a similar time, supported Wright's definition, but argued it should also include delivering care, as follows:

'The named nurse approach gives the opportunity, wherever possible, to retain responsibility for and assure continuity of care to designated patients. The named nurse is a direct care-giver'. (RCN 1992: 31).

This was an interesting emphasis because it seemed to argue against delegation, when appropriate, to other members of the ward team. Several authors (Watkins 1992, Wright 1995, Jackson 1994), acknowledged that exercising professional judgement in delegation was an essential part of the named nurse role. This was because a named nurse, unlike a primary nurse, was not accountable for 24-hour care of a patient (Wright 1993, DOH 1994b). Therefore, it is reasonable to assume that the RCN definition was arguing for a balance in the named nurse role, between organising and delivering patient care. However, Wright (1993) also emphasised delivery of care in his exposition of the named nurse concept. He argued that inappropriate to consider that only ward managers and senior nurses could be a 'named nurse'.

Dargan (1997) supported the view that the nurse-patient relationship was the foundation of the named nurse concept in her definition of the role as follows:

'The Named Nurse co-ordinates the patient's care and the patient gives his informed consent to that care'. (Dargan 1997: 15)

The introduction of the notion of 'informed consent' into the named nurse-patient relationship was powerful because of its association with the legal duty of care. However, in this context, Dargan was referring to the balance between the patient and the named nurse, in terms of information and decision-making. She argued that the named nurse framework enabled the patient to be a 'formal' rather than passive partner in the planning of care. Partnership in care, as a characteristic of the named nurse role, was supported by several other authors' work (Boyington 1992, Jackson 1994, Jack 1995). In addition, there was reference to the nurse-patient relationship in planning care, in the government's guidance on implementing the Patient's Charter (NHSE 1992).

A complex picture has emerged from this review of the nursing profession's perceptions of the Named Nurse Standard. There appeared to be a dissonance between the government's consumerist policy, and a role that seemed to reflect the nursing profession aspiration to deliver individualised patient care. As it was a new policy a variety of terms were used by authors to describe their interpretation of the Named Nurse Standard. However, there was consensus that the 'named nurse concept' could not stand alone as a method of organising nursing work, but had to be implemented through another organisational mode. The lack of rigorous, large-scale research on the implementation of the Named Nurse Standard meant an over-reliance on comment and anecdotal evidence. Nevertheless, it was possible to map characteristics associated with the Standard, which included continuity and co-ordination of patient care, accountability, partnership in patient care and delivery of care. The following sections will consider the organisational methods advocated in the literature to implement the named nurse concept.

### **3.7 Organisational Methods**

Part of the criticism of the Named Nurse Standard from the nursing profession was that it only reiterated the way that nurses had always worked (Shuttleworth 1992, Wright 1993, Nursing Standard Readers Panel 1995). However, there was also conjecture that it was another name for primary nursing (Cole and Davidson 1992, Wright 1993). It has to be acknowledged that the central tenet of the Named Nurse Standard is the nurse-patient relationship and this has resonance with the principles of primary nursing (Manthey 1988, Pearson 1988, Binnie 1987, Wright 1990). However, as has already been shown, the named nurse role did not have the 24-hour accountability for a patient associated with primary nursing. Furthermore, unlike primary nursing, there was no evidence that a single method of organising nurse work was advocated (DOH 1994b, Wright 1993, Childs 1995, Melville 1995).

There was however, some debate about primary nursing as a mode for implementing the Named Nurse Standard. Several authors argued that primary nursing best facilitated the intention of the Named Nurse Standard (Hancock 1992b, Tingle 1993, Wright 1993, RCN 1992). This assertion was challenged by Jack (1995) who urged that the named nurse concept should not be considered as primary nursing. Nevertheless, the nursing profession was offered guidance on the different organisational methods that could be used to implement the Standard (Hancock 1992b, DOH 1993b, DOH 1994b, Melville 1995). The challenge for nurses preparing to implement the Standard would seem to be whether it could be achieved through their existing organisational method.

Although there was general agreement regarding the different organisational methods that could be used to implement the Named Nurse Standard (DOH 1992, Hancock 1992b, Wright 1993, DOH 1994b, Melville 1995), there were two exceptions. The first was Dargan (1997) who advocated her 'Named Nurse Programme' as the method to implement the named nurse concept. The second was in the Department of Health information (DOH 1992, DOH 1994b), which appeared to suggest that task allocation could be used to implement the named nurse concept. Advocacy of task allocation was at variance with the general view, and with the principle of continuity of care. It could have been that task allocation had been interpreted to mean delegation of responsibility by the named nurse to other staff. However, the example given suggests that this was not the case. Nevertheless, it was generally agreed that the methods of organising care that could be used to implement the Named Nurse Standard included primary nursing, patient allocation and team nursing (DOH 1992, Hancock 1992b, Wright 1993, DOH 1994b, Melville 1995).

There were additional methods of organising care mentioned by several authors, for example, key worker systems that were principally used in integrated health and social

services (DOH 1992, Wright 1993, DOH 1994b). However, the universal principle that underpinned all the advocated methods was continuity of care through an identified practitioner responsible for the care of a specific patient or client. Despite the apparent apathy of the profession (Wright 1993, Savage 1995), there was some evidence in the literature that these organisational methods were being used to implement the Named Nurse Standard.

### **3.8 Implementation of the Named Nurse Standard**

The main source of early evidence on the implementation of the Standard was a Department of Health document published one year after the launch of the Standard (DOH 1993b). As could be expected in a document that was promoting government policy, it reported very positively on the success of the Named Nurse Standard. However, the political comment in the document was limited as it focused on case studies from practitioners. The purpose of the publication was to illustrate the different ways that the Standard could be met. However, it also demonstrated that, within a year, the contributors were not only aware of the Named Nurse Standard but had implemented it in their care setting. Although these case studies presented a very positive picture of the implementation there was no indication that the contributors were representative of the national picture. In addition, it must be noted, that the evidence was anecdotal as there had been no systematic evaluation of the change process. Nevertheless, the case studies are an interesting record of the implementation of the Standard in a variety of clinical areas. This evidence also challenges the picture of indifference in the profession to the Named Nurse Standard presented by some authors (Shuttleworth 1992, Wright 1993, Cohen 1994, Nursing Standard Readers Panel 1995).

There were nearly forty short case studies presented in the document (DOH 1993b), and each study attempted to present the main issues associated with implementing the Named

Nurse Standard. The clinical settings were diverse but the issues which emerged were common to many of the areas. These issues included preparation of ward staff, allied health professionals and patients, ownership of the initiative, management of the change process, and support from senior managers. These issues were consistent with those identified by the several authors (Hancock 1992b, Melville 1995, RCN 1992). As has already been shown, two organisational issues pertinent to managing the implementation of the Named Nurse Standard were the management policy on the efficient use of beds, and changes to nursing staff work patterns. A case study by Reid (1993) has been selected from those presented in the document (DOH 1993b) to review more extensively. This case study illustrates how one ward team addressed the challenge of implementing the Named Nurse Standard.

Reid (1993) described the clinical setting as a 'busy' 20-bedded surgical ward in a district general hospital admitting emergency and waiting list patients. The length of stay ranged between overnight and over one month. The bed occupancy was approximately 100%, and the weekly turnover was estimated to be between 30-50 patients. All staff were qualified, and on internal rotation to night duty. Staff on day duty worked five 7½-hour shifts per week, and pre-registration nursing students were supernumerary to the nursing establishment. The issue of equity of workload was addressed through assessment of patients on admission and allocation to a primary nurse according to the level of their dependency. To implement the Named Nurse Standard each primary nurse assumed the role of named nurse. The staff were divided into three teams, with a primary nurse in each. The aim of the apparent 'mixing' of team and primary nursing was to ensure continuity of care in the absence of the named nurse. Such strategies were supported by Melville (1995) who argued that managing staff work patterns, and parity of workload were two crucial aspects in achieving the Named Nurse Standard. Furthermore, several authors suggested that delegation of responsibility of care to colleagues was a recognised attribute of the named

nurse concept (DOH 1992, Watkins 1992, Wright 1993, Jackson 1994, Wright 1995).

One of the problems Reid (1993) identified was failure to allocate patients to a named nurse on admission because of the high patient throughput. Reid acknowledged that, in such situations, there was the potential that patient allocation to a named nurse could become a 'paper exercise'. This conclusion supported the findings of 'token compliance' demonstrated by Allen (2001). However, these findings were at variance with the government advice about the suitability of the named nurse concept in areas of high patient throughput (DOH 1994b).

Evidence from the other case studies (DOH 1993b) indicated that the complexity of change required to implement the Named Nurse Standard depended on the existing system of organising nursing work. Reid (1993) had reported on the organisational changes that were required in a ward that had primary nursing in place. It would seem, not unsurprisingly, that those areas where that method of organising nursing work was used appeared to require less specific organisational change to implement the Standard (Carney 1993, Corrigan 1993, Wills 1993). This conclusion was supported by several authors who believed that primary nursing best facilitated the named nurse concept (Hancock 1992b, Tingle 1993, Wright 1993, RCN 1994).

However, there was evidence (DOH 1993b) which indicated that community services would have to make minimal organisational changes to meet the requirements of the Named Nurse Standard (Forbes 1993, McKay 1993, Raper 1993). Two of the case studies involved NHS based services and described a team approach to managing patient care with the team leader as the named nurse (Forbes 1993, McKay 1993). The respective District Nurse or Midwife assessed, planned and if appropriate delegated the direct care, or part of it, to a member of the team. They had been able to assume the role of the named nurse without requiring



changes to their role. The remaining case study concerned a non-NHS occupational health setting where the implementation of the Named Nurse Standard was perceived as an opportunity to improve the existing service (Raper 1993). From the evidence it may be concluded that, with few exceptions, the Named Nurse Standard presented more challenges to organisational methods in hospital settings than in the community services. Melville (1995) supported this argument suggesting that community nurses' professional practice was synonymous with the principles of the Named Nurse Standard.

### **3.9 Staffing**

There was general agreement that implementation of the Named Nurse Standard required adequate and appropriate staffing levels (Dooley 1999, RCN 1992). This was supported by the findings of the RCN commissioned telephone poll of public awareness of the Patient's Charter (RCN 1994). Nurses and managers in six randomly sampled NHS Trusts were asked about their perceptions of the implementation of the Named Nurse Standard. Respondents reported that the main inhibitor to implementing, and maintaining the Standard was poor staffing levels. The results from Dooley's small study (1999) supported this finding. Although the issue of increasing staff resources was not specified in any of these studies reference was made in all to staff shortages. Therefore, it can be assumed that there were shortfalls in the establishment, due to staff vacancies, sickness or annual leave.

A study by Crinson (1995) suggested that the competing demands on nursing staff to meet NHS targets affected the named nurse-patient relationship. A postal survey of all senior nurses in Accident and Emergency Departments (A&E) in England explored the impact of the Patient's Charter on the quality of care. Responses to questions about the Named Nurse Standard indicated that over two thirds (n=109) of the respondents perceived there had been no change to the nurse-patient relationship with its introduction. However, comparison

of that finding with other results from the study, indicated that the nursing resources in the A&E Departments were focused on meeting the waiting time, or 'triage', standard (DOH 1995), rather than developing the named nurse role.

Broomfield's survey (1996) of the affect of the named nurse role on the nurse-patient relationship, was inconclusive. Although the study, of staff in four coronary care units was limited by a small sample size (n=48), it was one of the few surveys conducted in the first year of the launch of the Standard. Despite the inconclusive results on the nurse-patient relationship other findings in the study suggested that the respondents endorsed the concept of a named nurse. In contrast, Proctor (1995) considered the nurse-patient relationship by analysing nursing staff rotas over a two month period to identify levels of continuity. The findings demonstrated tensions between meeting the organisational demands to staff the ward, ensuring continuity of care for the patient and meeting the professional development needs of the nursing staff.

As the implementation of the Named Nurse Standard required changes to the organisation of nursing work it is perhaps surprising that there was no explicit reference to the need for increased staffing levels. This might be explained by the argument proposed by Binnie (1987) and Ersser and Tutton (1991) that the quality of the nurses, and not the number, should be considered when planning changes to organising nursing work. However, some authors argue that it was more likely to be acknowledgement that central government would not provide additional funding to support the implementation of any of the Patient's Charter Standards (Melville 1995, Wall 1995).

In contrast, there was debate regarding the grade of nurse who could be a named nurse. Although this was complicated by the lack of clarity in terminology used, with 'grade' relating to a job specification, and 'level' meaning the professional level of competence. The

Named Nurse Standard statement (DOH 1991, DOH 1995) was not specific and only makes reference to a qualified nurse. An E grade nurse was identified in the study by Dooley (1999) as the most appropriate to be a named nurse. In contrast Dargan (1997) was not specific about the grade of nurse, but argued that the named nurse should be on duty during the patient's stay. Melville (1995) supported that view in principle, but emphasised that the level of professional competence and confidence should also be taken into consideration (UKCC 1992a, UKCC 1992b).

Several authors related the level of competence to professional registration arguing that first or second level nurses could take on the named nurse role (DOH 1992, RCN 1992, Wright 1993, DOH 1994b, Broomfield 1996). However, a named nurse is expected to act autonomously in their practice and the pre registration education of the enrolled nurse does not prepare them to do this. (UKCC 1992a, UKCC 1992b). Thus, having an enrolled nurse as a named nurse could be interpreted as working outside their professional remit. Although this viewpoint reflects the competencies associated with the level of registration of an enrolled nurse it ignores the professional development and specialist knowledge of the individual. Tingle (1993) and Melville (1995) argue that individual nurses develop their knowledge and skill throughout their careers and they should be accountable for the roles and responsibilities they accept. Therefore, whatever the level of a registered nurse, if they have assumed the named nurse role they must accept the associated accountability (UKCC 1992a, UKCC 1992b).

In summary it has been demonstrated that no one method of organising nursing was advocated to implement the Named Nurse Standard. However, there was agreement that primary nursing was considered to be resonant with the principles of the Standard. From the limited body of literature it was possible to identify common themes associated with the

implementation of the Standard. These themes included preparation of ward staff, allied health professionals and patients, management of the change process and support from senior managers. There was agreement that successful implementation of the Standard required adequate and appropriately prepared staff. Furthermore, that nurses should recognise the professional accountability associated with the role of the named nurse. Two of the inhibitors to implementation were identified as the management policy of the efficient use of beds, and changing in working shift patterns. In the following sub-section consideration will be given to the criteria associated with the Named Nurse Standard, and how these might impact on the professional role of the nurse.

### **3.10 Professional Role**

Central to the professional role of the qualified nurse is accountability (UKCC 1992a, UKCC 1992b) and, as has been shown in Chapter Two (See 2.5), accountability cannot be delegated. Each nurse must take responsibility for accepting or declining the named nurse role. However, to exercise professional judgement in that situation it is first necessary to understand what the role entails. Evidence in the literature suggests that, at the launch of the Named Nurse Standard, nurses were not fully aware of the criteria associated with the named nurse role (Hancock 1992b, Tingle 1993). Although this might have been a reason for the initial apathy of the profession (Shuttleworth 1992, Wright 1993), within one year of the launch there was some information available on the Standard (DOH 1992, DOH 1993b). Despite the availability of such information there appeared to be no significant impact on nurses' perceptions (Cohen 1994, Nursing Standard Readers Panel 1995, Wright 1995, Steven 1999).

Analysis of the first edition of the Named Nurse Standard (DOH 1991) identified two basic attributes of the role (See 2.1, Table 1). The first was care planning including assessment,

implementation and evaluation of care for a specific patient. The second attribute was responsibility for co-ordinating care for the duration of the patient's stay (Wright 1993). The first attribute is the foundation of a nurse's professional practice (UKCC 1992b), and the latter can be seen as the logical development of the concept of individualised patient care. Therefore, it has to be concluded that the concept of the named nurse was grounded in the professional discourse.

Although the Named Nurse Standard was a politically driven initiative it is difficult, from a professional perspective, to appreciate the reluctance of experienced nurses to accept the role. Nevertheless, nurses were concerned about the impact of the Named Nurse Standard. To attempt to understand the basis of these concerns some of key criteria associated with the Standard will be considered further. As the main sources of information about the Standard were the Department of Health documents (DOH 1992, Wright 1993, DOH 1994b) these were examined and the criteria associated with the named nurse concept were summarised. These are presented in Table 6.

<b>Criteria Associated With The Named Nurse Standard</b>	
<b>Organisational</b>	<b>Professional</b>
Different Organisational Methods	Qualified nurse – first or second level
All Clinical settings	Delegation
Ward Manager Role	Direct Care Giving
Variable Caseload	Continuity of Care
Monitoring	Partnership in Care
	Co-ordination of Care
	Identified Nurse

**Table 6: Criteria associated with the Named Nurse Standard**

A number of these criteria have already been reviewed including organisational methods and giving direct care. The remaining criteria will be considered to identify the emerging issues for the profession.

### 3.11 An Identified Nurse

Wright (1993) referred to this criterion as the making the named nurse 'visible' to their designated patient. The requirement for this was made explicit in the statement 'You will be told their name' in the second edition of the Patient's Charter (DOH 1995). It meant that clinical areas were expected to have strategies in place to ensure that a patient was informed who their named nurse was (DOH 1994b). Examples of strategies that could be employed were given, including the use of notice boards, bed notices, business cards, name badges, and finally recording the named nurse's name on all patient documentation. There was particular emphasis placed on this criterion in the government literature (DOH 1992, DOH 1994b), as follows:

'In many respects, assuming the patient is able to understand, the ultimate test of the named nurse is that patients are able to say who their nurse is'.  
(Department of Health 1992: 2)

For those commentators concerned about the political association with the Named Nurse Standard (Jolley and Brykczyńska 1993, Savage 1995) this was a clear, measurable target that could easily be monitored. Mackereth et al (1994) acknowledged the concern about 'blame' but argued that the principle underpinning the Standard was professional accountability. However, the ambivalence of nurses about making nursing 'visible' appears not to question the principle, but to be sceptical, and concerned about the strategies. One example of this was the suggestion that patients be given a written copy of their named nurse's duty rota enabling them to know when the nurse would be available. Boyington (1992) reported resistance to this strategy from nurses concerned about the suitability of giving such 'personal' information. Dargan (1997), challenged this argument suggesting that if a named nurse had developed a plan of care with a patient it was only reasonable, and logical, to discuss their next meeting. Tingle (1993), commenting from a legal perspective, argued for more debate about the issue to ensure that it was for the benefit of the patient

but without compromising the nurse-patient relationship.

The suggestion that name badges should be used provoked similar debate but focused on the personal safety of nursing staff. Wright (1992b, 1995) acknowledged the concerns of nurses working in areas considered to be at 'high risk' of violence towards staff, that a name badge might make them feel more vulnerable. However, he argued that any interface between a nurse and patient was a potential 'risk' to the nurse and that professional judgement should be exercised in such situations. Tingle (1993) supported this and suggested that such difficulties should be anticipated, and the risks minimised. The findings of an RCN poll of nurses and managers about the Named Nurse Standard (1994) suggested that staff in Accident and Emergency Departments should only have their first name on their badge.

In contrast, two nurses working in Accident and Emergency Departments expressed their support for more openness through the use of name badges (Jackson 1994), and business cards (Fanning 1993), arguing that it would improve communication. Evidence about the effectiveness of recording the name of the nurse on the patient's bed headboard was less positive. Jack (1995) and the RCN (1994) suggested that, although there had been 'token compliance' in writing a nurse's name on the notice board, in some instances there was no interaction between the named nurse and patient. Ambivalence towards making the named nurse more visible could be attributed to the perceived association with consumerism and monitoring individual performance. However, in the government's monitoring advice to trusts (DOH 1994b), the claim that the Named Nurse Standard could be associated with blaming an individual nurse for poor performance was refuted. Furthermore, it was argued that all the strategies were aimed at enhancing the continuity of patient care, and not at identifying a scapegoat if things went wrong.

### **3.12 Continuity of Care**

Ensuring continuity of care was another of the criteria associated with the named nurse role. It involved co-ordination and delegation as the named nurse was responsible for a patient's care for the duration of their stay but was not 'on-call' 24 hours a day (DOH 1992, Wright 1993, DOH 1994b). There was general agreement that workload demands would require a named nurse to delegate some care of their patient during a span of duty (DOH 1992, Watkins 1992, Wright 1993, Jackson 1994, Wright 1995). Jack (1995), argued that the selected method of organising nursing work would provide a structure for this to occur, for example, team nursing. In contrast, Melville (1995) argued for an 'identified deputy' who would be responsible for the patient's care in the absence of named nurse. This would enhance the continuity of care by reducing the number of nurses caring for each patient.

The notion of an 'identified deputy' (Melville 1995) had resonance with the 'associate nurse' role in primary nursing (Goulding and Hunt 1991). In that role the associate nurse would have responsibility for delivery of the planned patient care in the absence of the primary nurse. Dargan (1997) rejected the associate nurse role arguing that, in the absence of the named nurse, the nurses on duty have to take responsibility for the patient's care. Her view was that a named nurse should be responsible for a patient's care when on duty, but it is reasonable to expect staff to be designated to continue that care in their absence.

Part of the named nurse role was to ensure that patient care was co-ordinated, therefore it was surprising that there was limited reference in the literature to inter-professional working. It was implied in the discourse on discharge planning and transferring care (DOH 1992, Wright 1993), but was made not explicit. Gelling (1992) argued that the introduction of the Named Nurse Standard provided an opportunity to enhance patient care through an equal partnership between a 'named nurse' and a 'named medical consultant'. However,



findings from Walby et al (1994) on inter-professional working suggested that medical consultants, in particular, were concerned about flattening the hierarchy in the nursing team. This was because there would be no one nurse in charge to whom they could refer. The authors also suggested that medical staff might feel the named nurse role challenged the boundaries of responsibility for patient care and 'contested the authority' of medical staff.

Nevertheless, as a recent Health Service Commissioner report demonstrated (HMSO 2000), discharge planning for patients required greater co-ordination. Boyington (1992) supported this arguing that nurses should be more proactive in planning patient discharge. A pilot study by Nixon et al (1998) of an audit of communication between primary and secondary care staff in discharge planning offered an interesting perspective on the named nurse role. Self-administered questionnaires were used to identify the perceptions of hospital and community staff. There was variation in response rates from the two groups of nurses. Less than half (n=12) of the 30 hospital nursing staff sampled, responded. In contrast, nearly three quarters of the community nurses returned completed questionnaires. However, there were conflicting findings in the community nurses' perceptions of the named nurse role, which the authors attributed to lack of clarity in the questions. Nevertheless, it can be concluded that there were concerns about the management of the discharge planning, between primary and secondary care, that could be addressed by a clearer appreciation of the named nurse role.

Although nurses have been shown to have a central role in discharge planning (Audit Commission 1991) accepting the named nurse role brings increased responsibility (Allan and Cornes 1998) for discharge planning and other co-ordinating activities. As traditionally these activities were associated with the ward sister/charge nurse role, it is reasonable to assume that, the named nurse concept would have some impact on those roles.

### **3.13 Ward Sister/Charge Nurse Role**

There was general agreement that the ward sister/charge nurse role would continue after the implementation of the Named Nurse Standard (Hancock 1992b, Wright 1993, Tingle 1993, Melville 1995, Dargan 1997). However, there was a dichotomy of opinion about whether the role of ward sister/charge nurse would change. Two authors (Hancock 1992b, Tingle 1993) suggested that there would be no change to the boundaries of the role. It is surprising that Hancock (1992b) suggested that the ward sister/charge nurse would continue as 'co-ordinators of care'. Given the requirements of the Named Nurse Standard it seems reasonable to assume there would have to be a change in the co-ordination of care as the named nurse role developed (Wright 1993, Melville 1995, Dargan 1997). This would remove some responsibilities from the ward sister/charge nurse while providing them with the opportunity to enhance other aspects of their role, for example, clinical leadership (Wright 1993). Several authors identified the ward sister/charge nurse as central to the preparation (RCN 1992, Reid 1993, Mackereth et al 1994, RCN 1994) and support of named nurses (Tingle 1993, Wright 1993, Melville 1995).

In her comments on the way forward it would appear that Hancock (1992b) was refuting the management assumption that the Named Nurse Standard would make the ward sister/charge nurse role redundant. The management discourse concerning the ward sister/charge nurse role would be understandable if primary nursing had been introduced with its absence of hierarchy. However, even in settings with primary nursing additional roles had to be developed as the high patient turnover increased the demands on practitioners. Ersser and Tutton (1991) described this role as a 'nurse co-ordinator'. The responsibility of the incumbent was to act as a 'go-between' for the primary nurse and the multidisciplinary team. The purpose of the role was to transmit information and, therefore, the co-ordinator did not need to know 'everything' about the patients.

In some settings the co-ordinator also took responsibility for administrative issues, for example, arranging transport for patients (Allsopp 1991). Although, as the role concerned effective communication between professionals, the co-ordinator did not need to be a senior nurse. Savage (1995) argued that, at the launch of the Patient's Charter (DOH 1991) senior politicians assumed that the Named Nurse Standard was introducing primary nursing, which did not require a ward sister/charge nurse role. However, subsequent government documents and management actions appear to endorse the ward sister/charge nurse role, for example, in the Charter Standard monitoring document (DOH 1994b).

### **3.14 Monitoring the Standard**

Although monitoring of the Named Nurse Standard was seen by some as political rhetoric (Jolley and Brykczyńska 1993, Savage 1995) several authors acknowledged that this was an integral part of a quality service (Boyington 1992, RCN 1992, Wright 1993, Jack 1995). The government's strategy document for monitoring the performance of NHS trusts in meeting the Named Nurse Standard (DOH 1994b) presents an interesting combination of information. One section of the document demonstrated an open approach to evaluation, with the inclusion of NHS staff workshops to review the implementation of the Standard. The second approach was highly directive with information on how to monitor the Standard giving examples of audit tools. The document was aimed at purchasers and providers of healthcare and makes clear their respective responsibilities in monitoring performance against the Named Nurse Standard.

The findings from the workshops were presented, but there were no details of sample size, or grade or role of the participants. Although the absence of information makes it difficult to evaluate the robustness of the findings, they are interesting to consider in terms of this current study. Some of the 'benefits' to patients that were attributed to the implementation

of the Standard, were reported to be more individualised care, and improvement in drug administration. In addition, the positive aspects for nursing staff were said to be autonomy and greater job satisfaction. However, the benefits to the organisation were reported to include an increase in nurse accountability and the devolution of budgeting to the named nurse. The reference to responsibility for budgeting could support Savage's concern (1995) that purchasers would use the Named Nurse Standard to identify levels of performance by individual nursing staff. However, there was no published evidence that this had occurred. Furthermore, and more surprisingly given the level of audit required, central government has not published performance figures on the Named Nurse Standard. Nevertheless, this document demonstrated that the government expected purchasers and providers to implement a structured audit of the Named Nurse Standard.

### **3.15 Summary**

The literature reviewed in this chapter demonstrated there was a dissonance in the response from the nursing profession to the implementation of the Named Nurse Standard. This was attributed to a number of reasons. The main reason was the association with the political intent of the health service reforms and, in particular, the concern that the introduction of the Named Nurse Standard was a way of monitoring individual performance. In addition there was concern expressed about the rapidity of implementation of the Standard only six months after the launch. Many in the profession felt that they had been given insufficient time to prepare, plan, and inform staff about the initiative.

The support for the Named Nurse Standard in the early 1990s came mainly from the nurse leaders who interpreted its introduction as a public endorsement of the value of the qualified nurse role. They argued it embodied three key aspirations for the nursing profession: individualised patient care; the empowerment of qualified nurses; and acknowledgement of

the value of nursing.

Although there was some debate in the early stages of the implementation of the Standard, there was limited clarification on the characteristics and criteria for the role. For many in the profession this reinforced the view that the Named Nurse Standard was just reinterpreting the existing role of the qualified nurse. The evidence to support the development of the Standard was limited and focused on awareness of the role, or on small-scale studies of nurses' perceptions of the implementation. However, much of the early literature was government documentation, guidelines and anecdotal evidence concerning methods to implement the Standard.

It was possible to identify some of the factors that hindered implementation. These included high throughput of patients, instability in the staffing levels and the changing boundaries to nursing work. Furthermore, it was suggested that to successfully implement the Standard required commitment, and support from all levels in the organisation.

Despite the absence of an operational definition of the Named Nurse Standard characteristics and criteria associated with the named nurse role were identified. The characteristics included continuity and co-ordination of care, partnership in care and advocacy. The criteria associated with the role were a qualified nurse, identifiable to a patient as their named nurse, and responsible for a patient's care from admission to discharge.

Finally, it was shown that the Named Nurse Standard had to be implemented through a method of organising nursing work. However, the selected mode should be based on the principle of an identified nurse caring for a specific patient. Therefore, task allocation was not considered to be appropriate as it fragmented care delivery and depersonalised the

patient experience. Primary nursing was seen to best facilitate the principles of the Standard, but it was accepted that all methods of organising nursing work, which supported the principle of individualised care could be used.

The emerging questions from the literature in this chapter focus on two key areas. These are the organisation of nursing work associated with the successful implementation of the Named Nurse Standard, and the impact of the Standard on the professional role of the nurse.

Issues relating to the organisation of nursing work include the decision-making process of nursing teams as they organise their nursing work to meet the Named Nurse Standard. In addition, the criteria that the teams use to decide whether the existing organisational mode has to be changed to meet the Named Nurse Standard. Finally, whether the criteria used by the nursing teams are consistent with the criteria associated with the Named Nurse Standard, which have emerged from the literature.

The impact of the Named Nurse Standard on role of the nurse focuses on professional accountability. This is because the named nurse role is associated with enhanced responsibility, and a more visible presence within the nursing team and to the patient.

## CHAPTER FOUR

### PATIENTS AND THE NAMED NURSE

#### 4.0 Introduction

Patient knowledge, perception and experience of the Named Nurse Standard will be considered in this chapter. It is noted that, as with other aspects of this topic, there is limited systematic research available. Selected criteria from those identified in Chapter Three as associated with the Named Nurse Standard will be used to explore this aspect of the literature. These criteria have been selected as representative of the patient experience and include, defining the named nurse, partnership in care, continuity of care, co-ordination of care, the direct care giver and an identified nurse.

#### 4.1 Knowledge of the Named Nurse

To explore patient knowledge of the Named Nurse Standard it was appropriate to first consider the sources of information available to the public as this may give insight into public expectation of the 'named nurse'. It was reasonable to assume that the public received information about the Named Nurse Standard from two main sources. The first was from the national distribution of copies of the Patient's Charter in 1991 to all households, and the inevitable related media comment to any government initiative. The second source would be through interaction with the health services, either as a consumer or a significant other. This could be through literature or face to face encounters with staff. The context of the launch of the Patient's Charter was also interesting to consider because of the potential effect on public perceptions.

As has already been shown, the Patient's Charter was launched immediately prior to a general election. Several authors argued that the timing meant the promises of improved health services would be associated with the political rhetoric of electioneering (Cole and

Davidson 1992, Shuttleworth 1992, Hogg and Cowl 1994). If this attribution was accepted it could be supposed that the public might not take note of any of the Charter Standards. Alternatively, consumers could have taken particular note of any, or all, of the Standards relevant to their personal experience. Evidence from an RCN study (1994) of consumer awareness of the Patient's Charter seemed to support the latter interpretation. When respondents were asked which Charter Standards they were aware of, ten per cent referred to outpatient waiting times. Comparison of these responses with the one per cent of respondents who identified the Named Nurse Standard, demonstrates a significant difference in consumer awareness.

It was reasonable to assume from these findings that public awareness of the Standards was probably related to personal experiences of healthcare rather than general appreciation of the Patient's Charter. However, it should be noted that the government stated in their literature that the public were aware and involved in developing the second edition of the Patient's Charter (DOH 1994b, DOH 1995). There was no evidence made available to support this so it was difficult to examine the validity of the claim. Nevertheless, there was evidence that interaction with health service workers had some impact on consumer awareness of the Named Nurse Standard (RCN 1994).

The findings of the RCN study (1994) are interesting because the sampling was nationally representative (n=2,000), based on the electoral register, and not associated with a recent, specific healthcare experience. However, the study did attempt to identify the impact of any recent interactions with hospital or community nurses on respondents' knowledge of the Named Nurse Standard. The findings indicated that less than a third of respondents remembered receiving information about the Named Nurse Standard from a nurse giving them care. The respondents' perception of receiving individualised care was slightly more



encouraging with under a half recalling that they had received care from a specific nurse. It seemed to indicate that many nurses were following the principles of the 'named nurse concept'. However, it would appear that the majority were not making patients aware of their entitlements to a named nurse (DOH 1991). Nevertheless, it was reasonable to conclude that written information had a limited impact on consumer knowledge of the Named Nurse Standard. Some contact with a nurse increased awareness slightly but significantly more respondents recalling direct interactions with an identified nurse.

#### **4.2 An Identified Nurse**

The principle underpinning the Named Nurse Standard (DOH 1991, DOH 1995) is that a patient is able to identify which specific nurse is responsible for their care. It was codified in the first edition of the Patient's Charter (DOH 1991) as the patient 'should have a named, qualified nurse' (See Table 1). However, in the second edition (DOH 1995) it was more explicit, and reads 'You will be told their name' (See Table 5). As has been shown in Chapter 2 (See 2.11), no specific reason was given for the change but the government reported that the Patient's Charter had been revised in response to consumer comment (DOH 1995). This assertion was challenged by several authors (Hogg 1994, McIver and Martin 1996, Farrell et al 1998) who argued that, in reality, patient and user involvement was limited.

In contrast, Savage (1995) suggested that the Named Nurse Standard was not just directed at improving patient experience but could also be used to identify, and monitor the performance of individual nurses. Savage argued that this type of data could be used to inform the contracting process. The link with the contracting process was reinforced by the government's monitoring document 'The Named Nurse, Midwife and Health Visitor-Checking That It Happens' (DOH 1994b), which was aimed at purchasers and providers of

healthcare services. In the document were examples of audit tools endorsed as best practice these included interviewing patients or carers about who was their named nurse. However, the dimension that the Named Nurse Standard failed to address was the quality of the experience for the patient.

The central tenet of the Patient's Charter assumed that achievement of the Standards was equated with positive patient outcome. However, Dyke (1998), in his review of the Patient's Charter, acknowledged that it was a shortcoming in all the Charter Standards. He accepted that all the criteria could be met but a patient could still be 'deeply dissatisfied' with their healthcare experience.

Evidence of patient knowledge of the name of their named nurse is limited but one small study did explore that issue (Fanning 1993). In the study patient opinions in an Accident and Emergency Department were surveyed using a self-administered questionnaire. The survey was undertaken six months after the introduction of the Named Nurse Standard nationally, but Fanning noted it had yet to be implemented into the department concerned. There were a number of limitations on the study including a response rate of less than half (n=21). In addition, Fanning acknowledged that the responses might have been influenced by the timing of distribution of the self-administered questionnaire. An inconsistency in the research process had arisen. This was because the two nurses distributing the questionnaires recruited participants at different times during the patient's journey through the department. However, the findings regarding the level of patient knowledge of the Patient's Charter were consistent with the RCN study (1994). Although, less than a quarter of respondents had read the Patient's Charter, the majority were positive about knowing the name of the nurse caring for them. Furthermore, the most frequently cited reason for supporting the introduction of the Named Nurse Standard was that it would improve public relations, and

give a personal service. Consistent with the findings of the RCN study (1994) the majority of the respondents did not associate knowing the name of the nurse with improving quality of care. Nevertheless, the findings suggested that patients were supportive of a more individualised level of care.

One of the factors which may influence patient perception of the named nurse concept is the healthcare setting in which patient-centred studies take place. Fanning's work (1993), for example, was undertaken in an area of rapid patient throughput where clients are usually seen by different nurses at different stages of their care. Therefore, in such an environment a patient might respond positively to the concept of continuity from one named, nurse. Commenting on patient experiences in an Accident and Emergency Department, Davies and Davis (1992) suggested that a named nurse would facilitate a patient's pathway by handing on care to another named nurse. It was acknowledged that it would mean that the patient had more than one named nurse delivering their care. However, Davies and Davis, considered it to be a way of ensuring that patients received individualised care in a busy healthcare setting. Although Burke et al (1995) supported the teamwork approach they argued that knowing the name of the named nurse was not sufficient if that nurse was not available. They concluded that a patient should be made aware of who acted on behalf of the named nurse, in their absence, thus ensuring continuity of care.

Hospital services offered different challenges to managing the implementation of the named nurse concept. One of the ways to manage the change was by a formal process of education, implementation and evaluation. Bryce (1996) illustrated how the approach was used in a management of change project to enhance the introduction of the named nurse concept in a district hospital. The change programme included preparing staff, and informing patients about the named nurse concept. Before the planned change less than

three-quarters of respondents (n=50) could identify their named nurse. After the change all respondents from a similar size sample could identify their named nurse. It could be argued that identifying a named nurse's name might not indicate that the patient has interacted with him/her. However, Bryce also measured this and reported that three quarters of respondents (75%) reported speaking 'regularly' to their named nurse.

In contrast, Green's study (1996a) of patients' recall of their stay in an Intensive Care Unit (ITU) found that, although patients could not identify their named nurse, they could remember information given to them by nurses. However, the findings suggested that a follow-up visit by a named nurse could enable the patient to manage better the memory of their stay in ITU. These examples supported the argument that the Named Nurse Standard could be used in any setting (DOH 1992, Wright 1993, DOH 1994b). However, there was limited indication about how patient perceptions of a named nurse were identified.

Three studies used measurement of patient recall of their hospital experience to identify whether respondents perceived they had an identified nurse responsible for their care (Bruster et al 1994, NHSE 1994, RCN 1994). Although two of the studies have already been reviewed (Bruster et al 1994, RCN 1994), it is interesting to consider the contrast in questions used in all the studies. In the RCN study (1994) two specific questions relating to the Named Nurse Standard were asked. The first question enquired whether the respondent was aware of the right to have a named nurse 'directly responsible' for their care. The second question asked whether the respondent recalled having a named nurse allocated during their stay. The wording is slightly different in the one question associated with the Named Nurse Standard in the work by Bruster et al (1994). They refer to a nurse 'in charge of care'. In both these studies the Named Nurse Standard was associated with nurses' accountability for a patient's care. In contrast, the NHSE study (1994) used a different

perspective to interpret the named nurse role.

In the NHSE's work patient perception of the named nurse formed a small part of a large study into ways of reducing delays in the patient pathway through hospital services (1994). It was a multi-method study undertaken on medical wards and surgical wards in one NHS hospital. Although a patient satisfaction survey was administered on the telephone two weeks after discharge there was no indication in the report of the sample, or response, size. However, of particular interest to this present study, were the questions in the research relating to the Named Nurse Standard. Respondents were asked to identify a nurse who had been 'particularly helpful' during their hospital and to give reasons for their choice. It is not possible to comment on the results of the questionnaire because these were not presented in the report. However, the conclusions drawn by the authors indicated that patients were highly satisfied with their care, although the majority could not identify their named nurse. However, these conclusions could be challenged on the issue of the face validity of the named nurse question. There was no attribution in the question to the criteria associated with the named nurse for example, responsibility for care, co-ordination, or continuity of care. In addition, helpfulness implies a social skill that could be attributed to any member of the healthcare team and not specific to a 'named nurse'. Nevertheless, the study suggests that management did associate the role of the named nurse with increased efficiency and patient satisfaction.

### **4.3 Patient Satisfaction**

There was debate in the literature concerning the use of patient satisfaction as an indicator of the quality of healthcare services. Several authors are critical that the concept of satisfaction had no clear definition (Locker and Dunt 1978, Bond and Thomas 1992, Williams 1994, Avis et al 1995). Williams (1994) takes this further, arguing that there was

limited understanding about how patients make judgements about care, with the consequence that conclusions drawn from satisfaction surveys might be unreliable. However, Avis et al (1995) suggested that many studies were based on the 'expectation-fulfilment model'. The premise was that a patient is satisfied if, and when, the level of service meets their expectations. The authors suggested that there were a number of difficulties associated with using this approach. These difficulties included discriminating between the different aspects of healthcare delivery to be measured, and identifying the reference points of satisfaction for the patient.

Moore and Thompson (1986) suggested that where there was not a clear association between expectation and satisfaction, patients would indicate without reference to their expectations. Williams (1994) supported this concluding that this effect could be seen in surveys that reported high levels of satisfaction. Furthermore, Williams argued that this could be attributed to patient reluctance to comment negatively on healthcare, particularly respondents in the older age group. Nevertheless, there was agreement that the lack of a clear definition of satisfaction brought into question the reliability and validity of the design of measurement tools (Locker and Dunt 1978, Bond and Thomas 1992, Carr-Hill 1992, Avis et al 1995, Walker et al 1998, Bruster et al 1994).

Several authors suggested that there was a lack of discrimination in the use of patient satisfaction surveys (Carr-Hill 1992, Thomas and Bond 1992, Avis et al 1995). Examples of this type of survey that have been used include an audit of health service provision (NHSE 1994), and an evaluation of patient experience (Moore and Thompson 1986). However, Bruster et al (1994), challenged the over-reliance on patient satisfaction as a measure. The authors argued that patients could be asked to comment on their hospital stay and these perceptions could be used to identify areas of concern. In contrast, Avis et al (1995), and

Walker et al (1998) proposed using qualitative methods to identify patient satisfaction to avoid the problems inherent in using mechanistic measurement tools. Taking a different stance Bond and Thomas (1992) acknowledged the methodological arguments associated with measuring patient satisfaction but suggested that a tool could be developed that would be 'fit for purpose'.

This work by Bond and Thomas (1992) was used later to inform the development of a tool to measure patient satisfaction with nursing care (Thomas et al 1996a). In a subsequent study it was used to measure patient satisfaction associated with the method of nursing work (Thomas et al 1996b). That work is pertinent to the current study as it included an item on the named nurse. The tool, the Newcastle Satisfaction with Nursing Scales (NSNS) was developed by Thomas et al (1996a), from patient opinions of nursing care obtained through interviews. The emerging themes from the data were analysed and developed into a questionnaire, which went through a staged process of testing, modification and validation (McCull et al 1996, Thomas et al 1996c). The final version of the instrument was a self-administered questionnaire designed to measure patient experience and satisfaction with nursing. The development of the instrument seems to have addressed some of the methodological issues relating to validity and reliability, associated with patient satisfaction surveys.

The NSNS (Thomas et al 1996a) were used by Thomas et al (1996b) to measure patient satisfaction associated with the method of organising nursing work. Part of the study considered whether the levels of patient satisfaction were associated with having a specified nurse responsible for a patient's care. It was a large-scale study of nearly 2000 patients, from 20 medical and surgical wards, in five hospitals. Questionnaires were distributed on the day of patient discharge, of which nearly three quarters were returned (n=1559). To

enable comparison of methods of organising nursing work ward sisters were asked to complete a criteria-based questionnaire (Thomas and Bond 1990). From the results, wards were categorised into one of four organisational modes, primary nursing, team nursing, functional and 'other'. Only 16 of the wards could be categorised into a mode, of which seven were identified as primary nursing, and nine as team nursing. The findings demonstrated that nearly half the respondents (n=700) identified one nurse responsible for their care, and this was associated with higher levels of satisfaction. For these patients their experience of nursing care was rated higher ( $P=0.001$ ) and they reported greater satisfaction ( $P<0.001$ ) than respondents who could not identify one nurse responsible for their care (Thomas et al 1996c).

Comparison of the two categories of ward indicated little difference in the levels of patient satisfaction. However, it was found that patients on the wards with team nursing were more likely to identify a 'named nurse' responsible for their care than patients on the primary nursing wards. These unexpected findings seem to be supported by Webb and Hope's study (1995) of just over 100 patients on wards with primary nursing. Less than a half of the respondents (n=47) identified that there was one nurse in charge of their care. Findings from both these studies (Webb and Hope 1995, Thomas et al 1996b), seemed to challenge the argument that primary nursing best facilitated the concept of the named nurse (Hancock 1992b, Tingle 1993, Wright 1993, RCN 1994). Nevertheless, the findings of Thomas et al's study (1996b) demonstrated that an identified nurse in charge of a patient's care was associated with high levels of patient satisfaction. Therefore, it would be reasonable to assume that this can be attributed to the relationship between the patient and the identified nurse.



#### **4.4 Partnership in Care**

The relationship between a patient and their named nurse was at the centre of the Named Nurse Standard (DOH 1991, DOH 1995). However, there was limited published evidence of the impact of the Named Nurse Standard on patient outcome. As has been shown, there has been some work associated with an identified nurse responsible for a patient's care (Bruster et al 1994, NHSE, 1994, RCN 1994, Webb and Hope 1995) and the link with levels of satisfaction (Thomas et al 1996b). Nevertheless, the main source of evidence associated with the partnership in care from the patient's perspective was the Department of Health's monitoring document (DOH 1994b). Although it formed part of the political strategy to monitor the Named Nurse Standard, it included qualitative findings on the 'benefits' to patients of the named nurse-patient partnership. These benefits included greater empowerment; a relationship based on trust, and increased patient and carer involvement in planning care. However, although these benefits were attributed to the patient experience, close inspection of the document show the comments were actually reported by NHS staff. However, even with these limitations the findings confirm the association of the Named Nurse Standard with the opportunity for patients to participate in their care.

Giving a patient the opportunity to work in partnership with a named nurse, however, also gives them the right to refuse. Wright (1993), suggested that this could be attributed to unfamiliarity with the named nurse role or related to the specific nurse. Professional accountability gives the nurse a framework for managing these sensitive situations (UKCC 1992b). However, there was contrasting evidence about whether patients preferred nurses to be informal in their approach to them (McGirr et al 1990, Hunt 1991, Webb 1992, Webb and Hope 1995, Walker et al 1998).

Two authors (Hunt 1991, Webb 1992) suggested that patients were not always comfortable with nurses sharing personal information with them. This was supported by McGirr et al (1990), who argued that patients preferred the more formal approach of using patient titles rather than first names, particularly for the older person. However, the later study by Webb and Hope (1995) illustrated a more mixed response from patients. Although the participants responded to nurses who were informal and approachable, they also indicated that titles should be used for the older patient. Nevertheless, the most recent evidence gives support to the informal approach. Walker et al (1998), categorised patient positive responses to an informal approach as 'feeling valued as an individual' and 'feeling at home' which suggests that patients respond to acknowledgement of their individuality. It is reasonable to assume, therefore, that these are the issues that the named nurse has to be aware of when working in partnership with a patient.

The evidence on the named nurse-patient partnership in care was mainly associated with managing the process of empowerment, and patient participation in care (Reed 1992, Wright 1993, Jackson 1994, Childs 1995, Jack 1995, Dargan 1997). This could be interpreted as the named nurse and the patient negotiating the plan of care throughout the duration of the patient's stay. Dargan (1997) described the approach as 'power transference' from the nurse to the patient. This enabled the patient to take control of their care. The concept is expressed by Benner (1984) as 'maximising the patient's control'. Skelton's argument (1994) was that empowerment was not about token acknowledgement of the patient as decision-maker, but involved supporting a patient in exercising choice. Although this view was supported by several authors they expressed concern that empowerment might be misinterpreted as coercion by a patient who would simply comply with a nurse's request (Avis 1992, Waterworth and Luker 1990).

Conversely, Dargan (1997) cautioned nurses to be aware as power transference could challenge a patient's perception of the traditional patient role, and they might not wish to accept the role of partner in care. Several authors acknowledged these reservations arguing that the process of enabling a patient to participate in their care should be managed within the patient's own boundaries (Pearson 1988, McMahon 1990). It is reasonable to assume that partnership between a named nurse and patient involves empowerment, negotiation, participation and decision-making.

#### **4.5 Patient Participation**

Patient participation has been interpreted in number of ways in the literature prompting Cahill (1996) to conclude that it was a very poorly defined concept. The Audit Commission (1993) emphasised the positive relationship between patient participation and decision-making. However, Saunders (1995) taking a broad view suggested it could encompass all aspects of care, including decision-making. Biley (1989) and Brearley (1990) concur arguing that patient participation was an accepted practice in many care settings.

In contrast, some authors focused on specific elements relating to patient care, including involvement in the decision-making process (Pearson 1988, Jewell 1994, Saunders 1995), self-medication (Webb et al 1990), and physical care (Clark and Latter 1990). Cahill (1996) considered all these interpretations of patient participation and attempted to identify the contributing elements. She argued these included an identifiable relationship between nurse and patient, free movement of information, movement of power from nurse to patient, and acknowledgement of the cyclical nature of illness. Cahill was arguing that a nurse should create a climate that enables a patient to make their own decisions concerning their care.

Part of enabling patients to choose how to participate in their care was acknowledgement of their right to decide the level of involvement. Biley (1992) argued that it was incumbent on

healthcare services to develop strategies to motivate and facilitate patients to participate in their care. However, the evidence suggests that nurses had to be aware of factors which might influence a patient's decision to participate in their care. These included lack of motivation (Biley 1989), unwillingness (Waterworth and Luker 1990), or inability (Jewell 1994, Saunders 1995). In contrast, the evidence from Brooking's study (1986) suggested that some patients saw participation in their care as a positive experience. The findings from over 100 patients indicated that younger patients demonstrated a higher level of participation in decision-making in their care. However, Brooking concluded that the group was probably more prepared to participate as they were well informed, more aware of their healthcare needs, and had more experience of hospitalisation. These findings illustrate one of Cahill's (1996) elements of patient participation as an affirming experience. Waterworth and Luker (1990) offered a different perspective to the active participants in care described by Brooking (1986). The findings from their small study of 12 patients showed respondents to be looking to the nurse for cues on what was acceptable to do, rather than taking an active part in the decision-making.

This has demonstrated some of the factors that may influence a patient's decision to participate in care. In the following sections consideration will be given to two elements of patient participation identified by Cahill (1996), which are associated with the Named Nurse Standard. These are information giving and the nurse-patient relationship

#### **4.6 Information Giving**

There was general agreement in the literature about the importance of information to patients (Ley 1988, Tschudin 1995, Childs 1995, Rigge 1997, Walker et al 1998), and this appeared to be codified in the first edition of the Patient's Charter (DOH 1991). The provision of information on treatment intentions became an established right in the Patient's

Charter. Although the second edition of the Patient's Charter (DOH 1995) extended the right to information it also introduced the consumerist policy of hospital league tables and local standards. Burke et al (1995) reporting consumer views as representatives of the Information Team at the Association of Community Health Councils (ACHC), challenged whether the intention of providing choice associated with league tables would improve patient experience. They argued there for improvement in the provision of 'accurate and informed answers' to questions relevant to patients healthcare needs.

Although Wall (1995), supported the Patient's Charter Standard which gave consumers the right to access performance and league tables, he suggested that the information could be open to misinterpretation. Wall acknowledged that he was arguing from a management perspective but suggested that league tables only provided part of the picture. He argued that using league tables meant that the consumer was being asked to make decisions based on incomplete information. By this Wall meant that league tables presented the statistics, but not the context of service provision, for example, ambulance response times in a rural area might be influenced by time of year. However, he did concur with general view that patients should be provided with information about treatment as well as NHS trust services in order to make informed decisions.

A study by Britten and Shaw (1994) of patient experience in an Accident and Emergency Department explored the provision of information in relation to the Patient's Charter Standards. The authors mapped the experience of 83 patients against the rights and standards in the Patient's Charter (DOH 1991, DOH 1995). It is worth noting that there were no references in the responses to the Named Nurse Standard. The findings indicated that respondents regarded the issues addressed in the Patient's Charter were appropriate but too broad, and they wanted more individualised information, for example, pain relief. These

findings are consistent with Otte's qualitative study (1996) of the perceptions of eight patients undergoing day-case surgery. Although this was a small study all respondents identified insufficient information at every stage of the experience as one of their main concerns. In contrast, to Britten and Shaw's study, (1994) the respondents in Otte's work were asked to identify their named nurse, but none of them could. Findings from both these studies are consistent with Farrell et al (1998) who reported that patients felt that specific information about their treatment would have given them more control of their healthcare experience.

There is a body of evidence that indicates that patients do not receive the information they want (Moores and Thompson 1986, Webb 1986, Audit Commission 1993, Coyne 1995, McColl et al 1996, Otte 1996). However, there was some contrasting evidence regarding patient satisfaction with the role of the nurse as provider of information (Cortis and Lacey 1996, McColl et al 1996). These two studies are interesting to compare because they used similar sample sizes (n=1500). It is worth noting that neither of these studies considered the Named Nurse Standard. The findings of the first study (Cortis and Lacey 1996) indicated that a minority of respondents (8%) were dissatisfied with the information they were given by nurses. In contrast, McColl et al (1996) found that there was an increase in the level of dissatisfaction with nearly a quarter of respondents (24%) expressing concern with the information from nurses. The areas of concerns highlighted by the respondents in McColl et al's work included information given at the wrong time, lack of detail, and no information about diagnosis. These findings supported the general view that patients were not receiving the level of information they wanted.

Consumers of healthcare can access an increasing number of sources of information about healthcare issues. These include electronic sources, the media's presentation of health

issues, and user group material. There is anecdotal evidence that shows patients use these sources to inform their interactions with healthcare workers. However, as Sitzia and Wood (1998) noted when patients were ill they wanted information about their diagnosis and treatment from healthcare workers.

Findings from Walker et al (1998) indicated patients used two sources to meet their need to 'feel adequately informed'. The majority of respondents in this study identified doctors as the main providers of information concerning diagnosis and treatment. Although respondents associated nurses with information-giving they were not specific about their responsibilities. In contrast, Webb and Hope (1995) demonstrated that patients identified teaching about healthcare needs as one of the key responsibilities for nurses. However, Tschudin (1993) arguing from an ethical perspective, challenged nurses with their unique knowledge of individual patients to be more proactive in their role as information-providers. Several authors supported Tschudin's argument that information for patients on healthcare issues should be individualised (Baddley 1995, Britten and Shaw 1994, Walker et al 1998).

It was acknowledged that patients were often reluctant to ask questions about their condition and treatment (Ley 1988, Meredith 1993, Walker et al 1998). The inhibitors to seeking information included not being given the opportunity to ask questions, staff appearing to be too busy and the patient's lack of confidence in their ability to ask appropriate questions. However, there was general agreement that the introduction of the named nurse concept offered a framework in which a patient could make informed decisions (Hancock 1992b, RCN 1992, Wright 1993, DOH 1994b, Dargan 1997). Although having a named nurse might not overcome the social inhibition felt by some patients about asking questions it might be easier to approach one identified nurse.

The purpose of having one identified nurse in charge of a patient care was to ensure continuity and co-ordination of care (DOH 1991, Hancock 1992b, Wright 1993, DOH 1995). The literature related to those two concepts will be considered in the following sections.

#### **4.7 Continuity of Care**

Continuity of care, in terms of the Named Nurse Standard, was associated with pre-planned, managed, seamless and connected delivery of care (DOH 1991, Hancock 1992b, Wright 1993, DOH 1994b, DOH 1995). For the majority of patients in hospital their care will be delivered by a number of nurses. Therefore, if the aim is to enable continuity of care there has to be a number of structures in place. These include an identified nurse responsible, written care plans, and a structured handover of care. Although it was argued that continuity of care was enhanced by the implementation of the named nurse concept there was limited evidence of this from the patient's perspective (DOH 1994b).

However, there are two examples of management of change projects, related to the implementation of the named nurse concept, that have been subjectively evaluated by patients and relatives (Neal 1995, Allan and Cornes 1998). The project by Neal (1995) was undertaken by a clinical nurse specialist in a palliative care unit and an associated outpatients clinic. Primary nursing was in place on the unit and the nursing staff rotated through the two areas. An associate nurse was responsible for patient care in the absence of the primary nurse. The identified problem with continuity of care was that patient attendance at the outpatients clinic was not associated with attendance by their primary nurse. With the introduction of the named nurse concept, attendance at, and staffing in, the clinic was changed to ensure that the majority of patients were seen by their primary nurse. The change was not formally evaluated, but Neal reported that subjective responses by the



patients were positive. This finding was consistent with the responses of relatives to the named nurse concept in a day hospital (Allan and Cornes 1998).

It could be argued that these projects were successful because the units were small and the patient group stable. However, as has been shown, management of change projects can have a positive impact in a larger hospital setting (Bryce 1996). Although, in Bryce's study, the success criterion was whether a patient could identify their named nurse, and was not associated with patient satisfaction. In contrast, the Department of Health attribution of benefits of the Named Nurse Standard associated continuity of care with 'fewer errors and complaints' (DOH 1994b). This does not seem to be an unreasonable conclusion given that continuity of care is associated with less fragmented care, and more effective lines of communication.

Lines of communication between nursing staff are formalised into the handover of care, either at the end of span of duty, or when a patient moves from one area to another (Davies and Davis 1992, Fanning 1993). For example, moving from a ward setting to community services (Nixon et al 1998). According to the Named Nurse Standard when on duty a named nurse is accountable for handing over care of their patient to another designated nurse (Wright 1993, DOH 1994b). However, the enhanced aspect of the named nurse role meant that the patient would be aware that their named nurse would take back responsibility on their return to duty (DOH 1991, DOH 1995). In this way, patient care was managed through the named nurse-patient partnership. The patient would have the choice to seek information from a designated deputy in the absence of their named nurse, or wait their return.

Otte (1996) argued the absence of a handover of care contributed to the dissatisfaction of patients in a day case surgery setting. However, Watkins (1993) commenting on

implementing the named nurse concept through primary nursing, reported that patients held mixed views about participating in the handover of their care. This indicates that, notwithstanding, the method of handover of care, the purpose should be to ensure continuity of care for the patient.

As has been shown in Chapter Three (See 3.3) nurses had to overcome a number of organisational challenges in the attempt to ensure continuity of care. These included the rapid throughput of patients and the increased use of day case surgery. One of the effects of the increasing demands for hospital beds was the process of boarding out patients from one speciality to another, perhaps unrelated speciality, to accommodate an emergency admission. Walby et al (1994) described these patients as 'outliers'. Although there is no evidence of the impact of the system on patient experience, it is reasonable to assume that patients found their care was fragmented between two ward teams. In such instances, management of continuity of care would be through the named nurse from the outgoing ward handing over care to a named nurse on the incoming ward.

Another way of managing the increasing demands on beds was to have mixed sex wards. Part of the management policy of cost efficiency was to maximise the use of beds and resources. In some areas this meant mixed sex wards, and in other areas there were single sex bays in a ward with shared facilities. The Patient's Charter (DOH 1995) recognised the right of a patient to choose whether they wanted to be admitted to a mixed sex ward. However, it was not a right to a bed on a single sex ward. The patient would be offered the opportunity to accept the bed or to defer admission to hospital. Several studies have noted patient concern about their loss of privacy and dignity on mixed sex wards (Britten and Shaw 1994, Burgess 1994, Burke et al 1995, Pontin and Webb 1996, Walker et al 1998). Although the issue does not directly affect how a named nurse manages the continuity of

care for a specific patient, it might impact on patient perceptions of the hospital experience.

#### **4.8 Co-ordination of Care**

The Audit Commission (1991) acknowledged the qualified nurse as central to the co-ordination of multidisciplinary team working. There was general agreement that the Named Nurse Standard made that role explicit (DOH 1991, Wright 1993, DOH 1995, Dargan 1997). Although there is limited evidence in the literature to support the assertion, consideration will be given to two aspects pertinent to patient perceptions. These are multidisciplinary team communication and discharge planning.

Evidence from two studies undertaken in community hospitals suggested that the introduction of the named nurse concept initiated the development of multidisciplinary standards and audit tools (Paton 1993, Allan and Cornes 1998). Furthermore, both studies reported positive feedback from patients or carers. The work by Allan and Cornes (1998), as has been shown, was a small management of change project. In contrast, Paton's study (1993) was led by a project officer and included interviews with 50 patients. The later project's findings indicated that patients had an increased awareness of all the multidisciplinary team relevant to their care, including the named nurse.

In a study of patients' significant others in an Intensive Care Unit Potinkara and Paunonen (1996) identified the role of the named in supporting and informing relatives and carers. In addition, they demonstrated the named nurse role as co-ordinator of multidisciplinary team working. Duffy (1995) also considered nurses' working practice in a small unit. This was the care of patients in a mental health unit under special observation. Using a grounded theory approach nursing staff were interviewed and two core categories emerged of 'controlling' and 'helping'. Although the study did not offer the patient perception of the named nurse role, it illustrated the importance for a patient of one identified nurse as

advocate and co-ordinator. In contrast, Green (1996b) presented a poignant anecdote of a patient's poorly co-ordinated care associated with a named nurse. Although acknowledged by Green as subjective, this case study illustrated the expectation of relatives that a named nurse would be a provider of information and co-ordinator of care.

The other aspect associated with co-ordination of care was discharge planning and the role of the named nurse. Evidence indicated that, prior to the implementation of the Named Nurse Standard in 1992 (DOH 1991), Waters (1987) was stressing the importance of discharge planning. Waters argued that discharge planning needed to be considered on admission, and that communication between hospital and community staff should be improved. It is reasonable to conclude that a named nurse could, and should fulfil both those functions. However, there was limited evidence that the named nurse role had made a significant impact on discharge planning. One example was a Social Services Inspectorate report (1995) into the newly implemented care management arrangements, it concluded that discharge planning was more appropriate to a patient's needs if a named/primary nurse was involved.

Findings from the NHSE study (1994) into improving patient experience would seem to support the argument that a specific nurse should co-ordinate discharge planning. The aim of the study was to evaluate how effectively and efficiently the patient pathway was managed in a large district hospital. It included analysis of 150 patient care plans for evidence of multidisciplinary collaboration in care and discharge planning. The findings showed there was limited collaboration between multidisciplinary team members, and little evidence of patient involvement care in discharge planning. The evidence illustrates the need for co-ordination in discharge planning, and suggests that this could be achieved if the Named Nurse Standard was fully implemented.

There was some contrasting evidence on patient perceptions of discharge planning related to the Patient's Charter Standards. As has been shown, the government's interpretation of the benefits to the patient of the Named Nurse Standard was illustrated in the monitoring document 'Checking That It Happens (DOH 1994b). The benefits attributed to discharge planning managed by the named nurse, were that it was faster, appropriately timed, more effective, and appropriately resourced. These conclusions are challenged by Burke et al (1995) from the ACHC, who argued that Community Health Councils were reporting significant patient dissatisfaction with discharge planning. This was supported by a Health Service Commissioner report (HMSO 2000) which concluded that co-ordination of discharge planning for patients was an ongoing issue in the health service. Although these reports were not considering the Named Nurse Standard discharge planning was a key aspect of the named nurse role.

#### **4.9 Summary**

There was little evidence in the literature of patients' perceptions or awareness of the Named Nurse Standard. The information that was available indicated that many patients did not associate the Patient's Charter in general, and the Named Nurse Standard in particular, with their own experience. It would seem that the patient view was consistent with many in the nursing profession who associated the Patient's Charter with government rhetoric.

In this chapter three studies on patient experience of the named nurse role were reviewed. In two of the studies the section on patient perception of the Named Nurse Standard formed only a small part of a much larger study. Nevertheless, there was consistency in the results of these studies which showed low levels of patient awareness of the named nurse role. It should be noted, however, that none of these studies referred to the term 'named nurse' as such. In each instance, variations on the phrase 'nurse responsible for care' was used to

identify the patient perception of the nurse managing their care.

There were a number of themes in the literature that could be associated with the characteristics of the named nurse role in relation to the patient experience. These characteristics included participation in care, partnership in care, continuity of care and information giving. The impact of the named nurse role on the continuity of patient care was one area that been considered in two management of change projects. Both reported positive outcomes in patient perception of their hospital experience.

Within the small body of research on patient experience of the Named Nurse Standard a few studies have used satisfaction surveys. One of these studies used a measurement tool that had been developed to include a question on the patient experience of the named nurse role (Thomas et al 1996b). Use of this tool as part of a study of the organisation of nursing work had shown an association between an identified nurse in charge of care, and higher levels of satisfaction.

All the evidence to date has focused on patients' perception of their experience and their satisfaction with the named nurse role. There has been no published work on how nursing care might be organised to facilitate the named nurse-patient relationship in the clinical setting. Therefore, the emerging questions for this present study are associated with patient perceptions of nursing care received in a setting with a named nurse role in place. In addition, in such a setting, could the named nurse-patient contact be measured and would a patient be able to identify whether there was a particular nurse in charge of their care?.

## **CHAPTER FIVE**

### **RESEARCH DESIGN AND METHODS**

#### **5.0 Introduction**

The literature review demonstrated that the Named Nurse Standard (DOH 1991, DOH 1995) was associated with organising nursing care to enable a named nurse to be responsible for a specific patient, for the duration of their stay. Furthermore, that the named nurse role was associated with enhanced responsibility and accountability. A number of characteristics were attributed to the enhanced professional role. These characteristics included continuity and co-ordination of care, and partnership in care. However, it was also demonstrated that the implementation of the Standard was part of the government's consumerist policies. It was suggested that the association with consumerism might have contributed to the apparent ambivalence of nurses to a role that reflected the profession's aspiration to deliver individualised patient care. Notwithstanding the significance of the Named Nurse Standard to the nursing profession, the evidence shows that there has been limited systematic research into its implementation. Therefore, it was concluded that this was an aspect of a nurse's role that should be explored further.

This chapter will examine the rationale for the selection of a qualitative study using an ethnographic approach to explore the implementation, and impact, of the Named Nurse Standard on the nurses role and patient perception. In addition, the appropriateness of the design will be considered in terms of rigour, data collection methods and ethical issues.

#### **5.1 Rationale for the Research Design**

There were three issues from the literature that prompted the design of this study. These were:

1. What organisational method(s) are used to implement the Named Nurse Standard?
2. What is the impact of the Named Nurse Standard on the role of the nurse?
3. What are the patients' perceptions of nursing care received?

To refine these broad issues into research questions consideration was given to the 'tests of researchability, significance, feasibility and researcher's interest' identified by Polit and Hungler (1991). Using these tests as guidance it was concluded that the significance of the Named Nurse Standard was how nurses interpreted the concept in their working practice, and the associated effect on patient experience. Furthermore, that these interesting issues could be researchable and feasible if refined into consideration of how clinical areas functioned within the Named Nurse Standard, and focused on the specific aspect of organising nursing work. From these conclusions two research questions were developed as follows:

1. Do areas where there is an identified Named Nurse system function any differently to those areas where there is no identified Named Nurse system?
2. What are the implications of the Named Nurse Standard for the organisation of nursing work?

Using a framework developed by Yin (1994) a number of different approaches to research design were explored for this study. He proposes that three aspects of the research questions should be mapped against different research approaches to identify the most appropriate strategy for a study. The first aspect is categorising the form of the research using the standard range of questions including, 'who', 'how' and 'why'. The second aspect is the extent to which behaviours will need to be manipulated. The final category indicates whether the study will be an examination of history or grounded in contemporary behaviours. Table 7 demonstrates the mapping of the research questions for this study



against four research strategies. These strategies were selected for consideration as they represent a range of most frequently used approaches in nursing research.

Strategy	Form of Research Question	Requires Control Over Behavioural Events?	Focuses on Contemporary Events?
Experiment	How, why	Yes	Yes
Survey	Who, what, where, how many, how much	No	Yes
Action Research	How, why	Yes	Yes
Case Study	How, why	No	Yes

**Table 7: Mapping of research questions against research strategies (After Yin R 1994 Case Study Research: 6)**

As a result of this mapping action research and an experimental strategy were rejected as possible approaches for this study because both required control and manipulation of behaviours. Action research was not considered feasible because the researcher, although a nurse, was not part of the NHS trust system which meant that opportunities for initiating change would be limited (Robson 1993). Furthermore, if action research is to be undertaken it requires the co-operation of participants in the design, implementation, and evaluation of the change in practice (Whyte 1984, Robson 1993). The author was aware from the literature that there was ambivalence to the Named Nurse Standard, and that this approach could be interpreted as a management tool.

Using an experimental design was explored but rejected because the strategy requires identification of a control group to enable the performance of the dependant variable to be measured (Politt & Hungler 1991), which would not have been feasible in this case. The government had directed that the Named Nurse Standard be implemented in all areas five years before the data collection was to take place. Therefore, it was reasonable to assume that the Named Nurse Standard would be embedded in the organisation of nursing work, and it would not be possible to identify the necessary control group.

Of the two remaining research strategies the survey design can be an efficient way of gathering information from a large number of people. However, this approach would not have enabled the in-depth examination of the real world experience of the participants required to address the research questions (Politt & Hungler 1991, Robson 1993). Yin (1994) argues that there may be occasions where a number of research strategies could be used but the case study approach is most appropriate when:

‘ a ‘how’ or ‘why’ question is being asked about a contemporary set of events over which the researcher has little control’. (Yin 1994: 6)

The purpose of this study is to examine ‘how’ wards function with the Named Nurse Standard fully implemented compared to wards that do not have a system completely in place. As has already been shown, the government had required all healthcare providers to implement the Named Nurse Standard. Therefore it was concluded that a case study design would be appropriate for this study as the Named Nurse Standard was a contemporary issue in nursing practice over which the researcher had no control.

A further consideration in the choice of appropriate design was what Field and Morse (1985) describe as the ‘maturity of the concept’. This means the level of knowledge that is known about a topic, or issue, under consideration. In a scientific approach that aims to measure ‘cause and effect’ the variables to be manipulated need to be clearly defined. It is not normally possible if the body of knowledge concerning a topic is limited. In these circumstances a qualitative approach that explores the phenomena to identify a picture of the real world would be appropriate. In respect of the Named Nurse Standard, it has been shown that there was no operational definition, and the body of evidence comprised of limited research, professional discourse, and anecdote. Although, it has to be acknowledged, the criteria associated with implementation of the Named Nurse Standard did emerge from the literature. However, as the purpose of the study was to get a rich

picture of how qualified nurses interpreted and implemented the Named Nurse Standard, a qualitative approach was chosen.

Using the principle that the methodology selected should be appropriate to collect the data, and to do it meaningfully, it needed to be from the emic perspective. Therefore, a naturalistic approach (Lincoln and Guba 1985), using a case study method (Yin 1994), was selected to provide a rich picture of the phenomena.

## **5.2 Case Study Method**

Bergen and While (2000: 926) describe case study research as 'familiar yet elusive'. They argue it is a research approach used by many disciplines including education (Hammersley 1986, Stake 1995), psychology (Robson 1993), and nursing (Vallis and Tierney 1999) but with limited explanation of the methodology. However, there is general agreement that case study research is an in-depth investigation of a single subject (Field and Morse 1985, Hammersley 1986, Yin 1994). The single subject being either an individual, a social unit or setting such as a village or hospital ward, or a set of documents (Field and Morse 1985, Stake 1995, Yin 1994). The single subject identified for this current study is a hospital ward to enable comparison of the methods of organising nursing care through multiple case sampling (Yin 1994).

A characteristic of case study design over which there is disagreement in the literature is whether it is an ethnographic approach. Several authors support the ethnographic definition (Field and Morse 1985, Lincoln and Guba 1985, Merriam 1988). In contrast Yin (1994), one of the main advocates of case study research, rejects those views arguing that they focused on data collection methods rather than on the research strategy. The definition of case study research proposed by Yin (1994) is as follows:

**'an empirical enquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident' (Yin 1994: 13)**

This notion of an empirical investigation is supported by Robson (1993). Both authors argue that the strength of case study research is that multiple sources of evidence (qualitative and quantitative) can be used to investigate complex issues. Although Yin (1994) acknowledges that managing large volumes of data could present problems he argues that this can be addressed by identifying a data analysis framework at the beginning of the study.

Yin (1994: 20) advises that five aspects be considered when designing a robust study. These are:

1. a study's question
2. its propositions, if any
3. its units of analysis
4. the logic linking the data to the propositions, and
5. the criteria for interpreting the findings.

As has already been shown in Table 7 the mapping of the research questions for this study, and the subsequent discussion, address the first two aspects. The third aspect is the identification of the 'case' to be studied. The single unit or subject in this current study will be a surgical ward in a hospital. To enable comparison of the ways that the Named Nurse Standard (DOH 1991, DOH 1995) has been implemented multiple cases will be sampled . Yin (1994) acknowledges that aspects four and five are not always clearly defined in case study research. In this current study the selection of the design was to enable collection of reliable, valid data that would provide a comparison of the methods of organising nursing care, nurses' perception of the Named Nurse Standard, patient experience of the named

nurse role, and the quality of care in four hospital wards (See 5.3).

Issues of validity and reliability in case study research have been raised by several authors including Gray (1998), Vallis and Tierney (1999), Pegram (1999), and Bergen and While (2000). Yin (1994) counters the criticism of the poor generalisability of case studies by arguing that a theoretical framework should be developed first. This enables the theory to be tested through replication of the findings from which the results can be generalised. This theory replication and testing should also enhance the internal validity of case studies. He asserts that construct validity is increased in three ways; by using multiple sources of evidence that can be compared and contrasted; establishing a clear trail or 'chain' of evidence that can be checked if required; and 'member checking' (Lincoln and Guba 1985) by the respondents of the findings to ensure they are representative of their world view. Finally, Yin advises that identifying a clear audit trail of the stages of the study will enhance reliability.

Having considered the different research strategies available for this study a case study approach using qualitative and quantitative methods (Robson 1993, Yin 1994) was designed (See Table 8 and Figure 1). The rigour of the study design will be considered in Chapter 5.5.

### **5.3 Research Design**

The study was designed in three stages (See Table 8), to capture the real world experience of those identified to be the key players in the Named Nurse Standard. That is the qualified nurses, patients and ward managers. The purpose of the design was to collect reliable, valid data that would provide a comparison of the methods of organising nursing care, nurses' perception of the Named Nurse Standard, patient experience of the named nurse role and the quality of care in four hospital wards. The surgical wards in two NHS trusts were

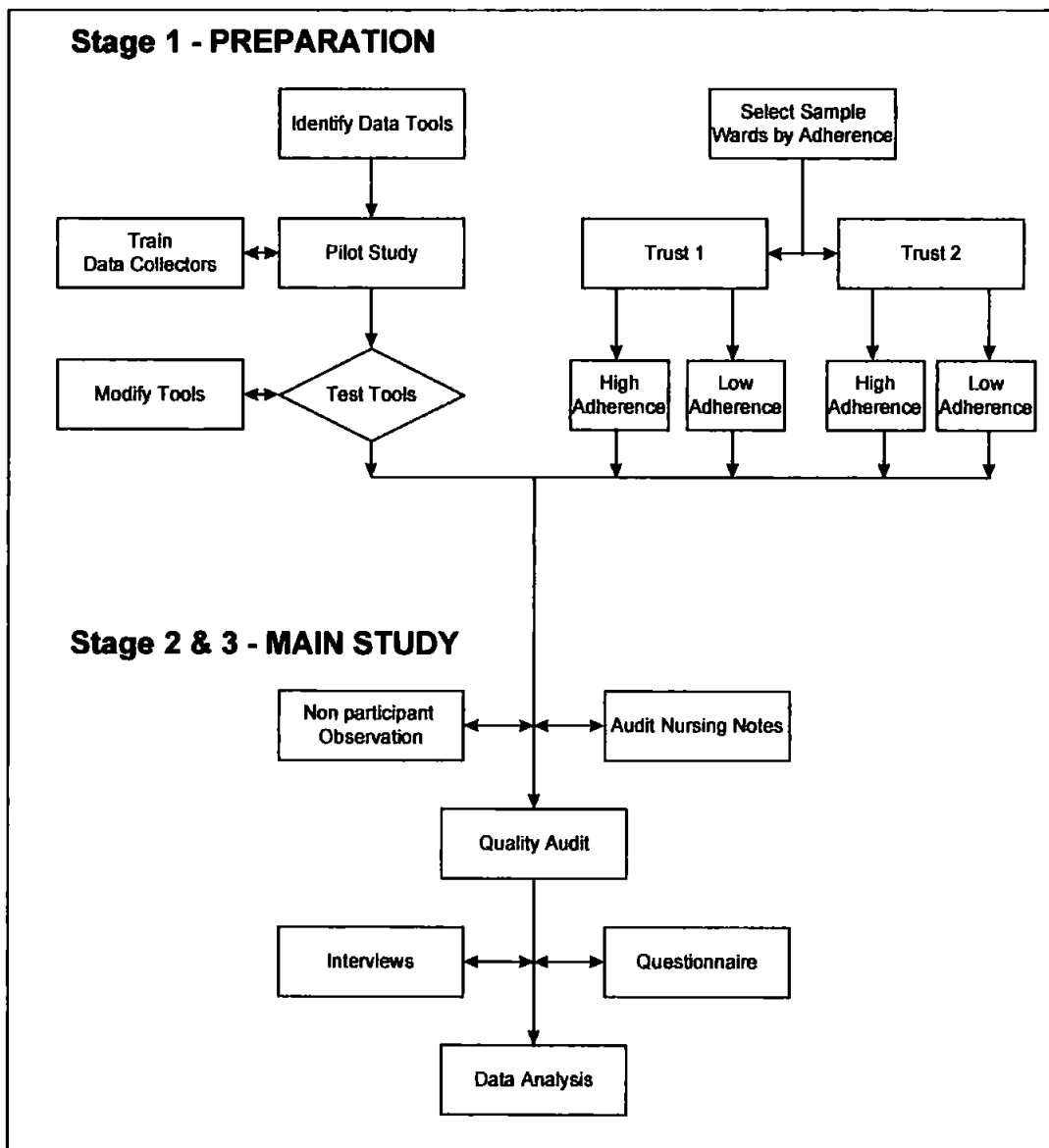
selected for the sample. Surgical wards were chosen because it was assumed that there was a shorter patient stay. Using surgical wards for the study would identify whether the principle of continuity of care (DOH 1992, DOH 1994b), associated with the Named Nurse Standard, could be demonstrated in an area with fast patient throughput. Furthermore, it would also illustrate whether the qualified nurse could develop the autonomous role, associated with the named nurse concept, in an area traditionally seen as having more 'technical' care (Smith 1976, Pearson et al 1992). Finally, from a methodological perspective selecting one clinical speciality enabled multiple case sampling, and subsequent comparing and contrasting of the findings.

<b>Stage One</b>	Selection of the Sample Pilot Study
<b>Stage Two</b>	Non-participant Observation of Nurse-Patient Interaction Audit of Nursing Records Quality Audit of Nursing Practice Semi-structured Interviews of Ward Managers and Qualified Nurses
<b>Stage Three</b>	Structured Interviews of Patients Concerning their Perceptions of the Nursing Care Received

**Table 8: Design of the Study**

When a case study approach is being used Miles and Huberman (1994) suggest that the centre or 'heart' of the study should be identified and then the 'bounded context'. In this study the heart of the case was identified as the Named Nurse Standard, and the bounded context as the ward setting. Using a qualitative methodology gives the sampling an iterative quality so, as new areas of information are identified, they can be examined and interpreted. It has been argued that the absence of clearly delineated parameters in this approach lacks rigour. However, the research questions in this study were such, that an experimental approach could not be used. Therefore, a qualitative approach was used but designed to ensure that the findings were as robust. Figure 1 presents a flow diagram showing the

preparatory stage of the study, including the selection of the sample and data collection tools, and the main study.



**Figure 1: Flow chart of study design**

Two strategies were used in the design to address to ensure the findings were robust. The first was the selection of the cases to sample. As all NHS trusts were required to implement the Named Nurse Standard at the same time, it was possible to sample wards from two hospitals. This allowed different cases to be compared and contrasted to enhance the validity of the findings. The sampling framework will be discussed later in the chapter. The second strategy was to use both quantitative and qualitative methods in the study, as this

strengthens the research findings (Field and Morse 1985, Miles and Huberman 1994) and is consistent with the case study approach (Robson 1993, Yin 1994).

#### **5.4 Selection of Data Collection Instruments**

Two validated data collection instruments were used to enhance the rigour of the study. Both of these instruments focused on the patient experience. The first was a modified version of the Quality Patient Care Scale (Qualpacs) (Wandelt and Ager 1974) developed by Carr-Hill et al (1992) and used by Warr (1998), which provided a measure of the quality of care received by patients on the sample wards received. The findings were to be used to compare, contrast, and identify convergence with the results of the non-participant observation of nurse-patient interactions and the audit of nursing notes. The second instrument was the Newcastle Satisfaction with Nursing Scales (NSNS) (Thomas et al 1996a) which was used to identify the patient experience (See 5.12.1). The purpose was to determine patient rating of, and satisfaction with their care, and their perceptions of which nurse was responsible for that care (See Appendix 8).

##### **5.4.1 Qualpacs**

Qualpacs (Wandelt and Ager 1974) is a 68 item scale which was developed in North America and used to measure the quality of care received by a patient. Data are collected by direct observation of nurse-patient interaction. The scale is divided into six subsections: physical, general psychosocial-individual, psychosocial-group, communication and professional implications. The standard of measurement is the care expected from a first-level nurse. Observers rate the care received by the patient using a five point scale from poorest care (1) to best care (5). Care is observed for two hours and then indirect evidence is collected from nursing notes (See 5.11.3). Two observers independently rate the observed care and mean scores are generated for each patient and then totalled to produce a ward



mean score. Wandelt and Ager (1974) acknowledged there could be criticism of the over-reliance on the professional judgement of the observer in the rating of the nurse-patient interactions. However, they argued that qualified nurses were exercising professional judgement in their day to day practice and only needed to be trained to use the scale. The importance of the training observers to use Qualpacs is supported by Carr-Hill et al (1992) and Redfern and Norman et al (1994). As has been shown, this was acknowledged in the current study, and a three-day training programme was provided for the data collectors.

The original testing of Qualpacs was undertaken in three hospitals (n=113 patients) with reported inter-rater reliability coefficients ranging from 0.64 to 0.91 (Wandelt and Ager 1974). Data were used from 20 patients in the largest study group (n=96 patients) to calculate item, subscale and total score variances and covariances to test internal consistency and a Kuder-Richardson reliability coefficient of 0.96 was obtained. A Pearson's correlation of 0.98 indicated stability in rating of five patients over two days. Testing for validity was through comparison of the scores of twenty one wards with the independent ranking of the quality of care obtaining a correlation coefficient of 0.52.

There was subsequent testing of the internal consistency of Qualpacs by Fox and Ventura (1984) using factor analysis on data from over two hundred and fifty patients (n=269). Although coefficient alphas ranging from 0.70 to 0.92 across the six subscales and 0.95 for the instrument were obtained, the authors were critical of the focus on psychosocial and communication aspects of the instrument. The findings in the study of skill-mix by Carr-Hill (1992) supports this criticism as the items in the psychosocial-individual and physical sections were rated in nearly 90% of cases. However, Wainwright and Burnip (1983b) found that it was the section on 'psychosocial-group' that was rarely rated. In their modifications to Qualpacs Carr-Hill et al (1992) removed the psychosocial section as they

did not consider it to be relevant in surgical and medical wards. The authors also anglicised some of the wording in the instrument for use in England. To test the validity of the modified instrument they compared the Qualpac scores from 15 wards with scores from eight patient outcomes measures, for example pain control. The correlation coefficients ranged 0.05 to 0.28 which the authors suggest indicates that the two instruments were measuring different aspects of quality.

The other large scale testing of the validity of Qualpacs was undertaken by Redfern and Norman et al (1994) in their assessment of three quality measurement instruments. These were Qualpacs, Monitor and Senior Monitor. Patients from medical, surgical and elderly care wards were divided into four dependency groups (n=123). Each group of patients were assessed using two of the measurement instruments. Pearson's  $r$  was used to test the convergent validity of the three instruments. The findings from the medical and surgical wards show no significant correlation between Monitor and Qualpacs. In contrast, on the elderly care wards in which Senior Monitor and Qualpacs are compared, the correlation coefficients were all positive.

Although from these findings and other results in the study Redfern and Norman et al (1994) concluded that, of the instruments tested, Qualpacs was the most valid, they also made a number of recommendations. These recommendations included minimising the potential influence of the data collectors on the research field, and modifying the instrument by reducing items. These proposals were consistent with Carr-Hill et al (1992) who recommended that the instrument should be modified and used only to measure directly observed care. These recommendations were accepted for this current study and the modified Qualpac instrument (Carr-Hill et al 1992, Warr 1998) was used to measure the quality of care the patients received.

#### ***5.4.2 The Newcastle Satisfaction with Nursing Scales (NSNS)***

In contrast to Qualpac (Wandelt and Ager 1974) there is limited published evidence on the use of NSNS in research studies. However, there is more detailed information about the original process of validation of the instrument (Priest et al 1995, Thomas et al 1995a, Thomas et al 1995b, McColl et al 1996, Thomas et al 1996a, Thomas et al 1996b, Thomas et al 1996c). The rationale for developing the instrument was an absence of British satisfaction scales that reflected patients' views of nursing care (Thomas et al 1995a). They acknowledged criticisms associated with the use of satisfaction measurement tools including the lack of a definition of satisfaction (Locker and Dunt 1978, Bond and Thomas 1994, Avis et al 1995); lack of clarity in variables affecting healthcare experiences (Williams 1994, Avis et al 1995); bias towards positive views of healthcare (Williams 1994) and issues of validity and reliability in the design of the tools (Carr-Hill et al 1992, Bruster et al 1994, Walker et al 1998). How far the authors were able to address these issues in the development of the NSNS was presented in a series of articles (Priest et al 1995, Thomas et al 1995b, McColl et al 1996, Thomas et al 1996a, Thomas et al 1996b, Thomas et al 1996c).

The first stage of development of the scales was qualitative, using focus groups and semi-structured interviews to obtain patient views on their experiences of nursing care and what constituted good and bad nursing care (Thomas et al 1995a, Thomas et al 1995b). Locker and Dunt (1978) and Bruster et al (1994) support the approach of eliciting general views before obtaining opinions on specific aspects of care. The sample was of 150 patients recently discharged from 17 medical and surgical wards in five hospitals and six general practices. Analysis and coding of the audio taped interviews by five researchers identified recurring themes which were categorised into eleven concepts. Issues of inter-rater reliability were addressed through comparisons of coding and generation of definitions of

the concepts. The concepts included 'information' and 'informality'. These findings are consistent with other studies which indicate that patients want information (Moore and Thompson 1986, Audit Commission 1993, Britten and Shaw 1994, Otte 1996, Walker et al 1998), and respond positively to nurses who are more informal in their approach (Webb and Hope 1995, Walker et al 1998).

The experience of nursing care scale was piloted with a sample of 566 patients (Priest et al 1995). Respondents were asked to rate their experience of nursing care on a five-point Likert scale with some statements using 'strongly disagree' to 'strongly agree' (SD-SA) categories and other items a 'never' to 'always' (N-A) range of responses. Statistical testing for content validity resulted in statements with a non response rate above five per cent being removed from the scales. Cronbach's alpha of less than 0.7 or item-total correlations of less than 0.4 suggested poor internal consistency and those items were also omitted. In addition, statements with a more than an 80 per cent response rate to one category were removed to ensure discriminatory power. The calculation of responses for each respondent using a 0 to 100 scale, with 100 equating to the 'best experience' showed scores had a positive skew (mean = 84.0, standard deviation = 11.4) and therefore refinements were made to the scale. This finding was consistent with the criticism that satisfaction surveys invariably elicit a positive response (Williams 1994).

A second pilot of two modified versions of the scale was used to compare response options. Both versions used an expanded Likert scale of seven points to increase the range of possible responses. However, version one retained the combination of SD-SA and N-A responses and the second had SD-SA for all statements. Results from statistical testing of the response layout using the F-test show the variance was significantly higher when the combined option of SD-SA and N-A was available ( $p=0.029$ ). Although increasing the

response scale from five to seven points resulted in no significant difference in the means ( $p=0.09$  using the Mann-Whitney) there was a significant increase in the variance ( $p<0.05$ ). Priest et al (1995) report that the format of testing and modifications were used to produce the final version of the scale (Thomas et al 1996). This has 26 statements on experiences with nursing care rated on a seven point Likert scale, and 19 items on satisfaction with nursing care rated on a five point Likert scale. A third section in the final version of the instrument concerns demographic information and includes a question on care from a specified nurse.

The testing of the validity and reliability of the NSNS as a measure of patient experience of, and satisfaction with, nursing care is reported by McColl et al (1996) and Thomas et al (1996c). The aims of that study included testing whether the scale could identify differences between wards and hospitals, and the influence the place of completion would have on response. The sample was taken from patients on the day of discharge from medical and surgical wards in five hospitals in England. The researchers had calculated that a sample of 80 patients per ward was required to detect differences in nursing care experiences. This would enable identification of a 5% difference with 80% power. The overall response rate of patients agreeing to participate was 81% ( $n=1559$ ) with response rates for wards ranging from nearly 70% to over 90%.

Cronbach's alpha was used to test for internal consistency for the experience of nursing care scale (0.91) and the satisfaction scale (0.96). This shows that items could be reduced without impacting on the scales. Using analysis of covariance both the experience scale and the satisfaction scale were shown to identify differences between the wards and hospitals ( $P<0.001$ ). Tests for construct validity examined variation in a number of areas. Two are considered here as they are of particular interest to this study. The findings show that older

patients rated nursing care more positively ( $P < 0.001$ ) although there was no association between age and satisfaction ( $P = 0.22$ ). This result does, in part, support Williams (1994) assertion that older patients are less likely to be critical of the nursing care they receive. Just under a half of the sample ( $n = 700$ ) identified a specific nurse responsible for their care. Rating of experiences of nursing care for those respondents were more positive ( $P = 0.001$ ), and satisfaction was higher ( $P < 0.001$ ). Finally, a paired  $t$  test found no significant difference in the scores of those questionnaires completed in hospital and those completed at home. ( $P = > 0.05$ ).

There is only one published study on the use of the NSNS (Walsh and Walsh 1999) and the findings show a positive skew for both the experience scale and the satisfaction scale. However, the conclusions that can be drawn are limited because organisational and methodological issues affected the study. Although there is limited published evidence on the use of the NSNS they were selected for this current study as a validated tool that would measure patient perception of care from a specific nurse.

### **5.5 Rigour of the Study**

Assessing the credibility of the research process in the scientific paradigm is based on the concepts of internal validity, generalisability reliability and objectivity. Lincoln and Guba (1985) suggest that these terms are not appropriate in a naturalistic enquiry, and propose four alternative criteria; credibility, transferability, dependability and confirmability. The rigour of using the case study approach in this study has been assessed against these criteria.

Credibility corresponds with internal validity and refers to whether the findings are an appropriate, authentic picture of the real world of the participants. The credibility in this study was enhanced in a number of ways. As has already been shown, a variety of qualitative and quantitative methods were used to strengthen the design. This enabled data

to be interpreted and compared to strengthen credibility of the findings. In addition, in one aspect of the study, two data collectors trained in the application of the validated audit tool were used to evaluate the process of nursing in each ward. Qualpacs (Wandelt and Ager 1974), the chosen audit tool, have been shown to have a high construct validity (Redfern et al 1994). Although the researcher could have been identified as one of data collectors this may have contaminated the research field for subsequent stages of the study, and therefore the team of data collectors was used.

The author undertook all other aspects of the data collection, and a number of strategies were undertaken to minimise subjectivity and bias. These included using a semi-structured interview approach that enabled the researcher to clarify information with the informants, as it was given. In addition, informants were invited to 'member check' (Lincoln and Guba 1985) the transcripts of the interviews to authenticate the data. Furthermore, all the data collection methods that were specifically developed for this study were tested in the pilot study, and modified as required. Finally, the non-participant observation was undertaken on different day shifts, and on a weekday, and a weekend. This gave a rich picture of the setting, but also allowed cross-checking of the emerging patterns to be made.

Transferability or 'fittingness' is the corresponding criteria to external validity or generalisability. Using small numbers in the study means that generalisability is limited. However, using a case study approach gives a rich picture of the real world experience. Furthermore, the purpose of the detailed explanation was to give a description of the case studies to enable the reader to decide whether this approach would be appropriate to use in their own setting,

Polit and Hungler (1991) argue that to answer some research questions a balance has to be made between selecting data collection methods that enable transferability or

generalizability of the findings, and the iterative quality of a naturalistic enquiry. The balance in this study was to get a rich picture of the participants' real world and, by the use of multiple case sampling, enable comparisons between settings (Yin 1994).

The alternative criterion to reliability is dependability or auditability, and relates to the consistency of the process of the study. Lincoln and Guba (1985) propose that the reader should be able to follow the 'audit trail' of the researcher's reasoning, Yin (1994: 98) describes this as a 'chain of evidence'. To do this the research methods and process, including the relevant raw data, need to be presented in a clear way. In the scientific paradigm reliability concerns the consistency of the data collection instruments to measure what it was intended to measure. This means that the instrument should collect data on the specific attributes being considered. However, as has already been shown, the approach requires clearly defined attributes and a level of control to manipulate the variables.

In contrast, with a naturalistic approach, the data collection methods enable the phenomena to emerge from the setting. However, the rigour of the design depends on whether the reader can, through the presented material, identify how the researcher drew conclusions from the study. Furthermore, it can enable a purposeful look for disconfirming data in relation to the conclusion. This study aimed to collect data on how nursing care was organised in four hospital wards, in relation to the Named Nurse Standard. Gathering information on each from ward managers, nurses and patients' perspective of the way the ward operated, gave the rich picture needed to construct the four case studies (Yin 1994). It was anticipated that there would be sufficient, dependable, information to compare the functioning of the four wards in terms of the process of nursing, and patient experience.

The final criterion of rigour is confirmability or objectivity that can be considered alongside auditability, as it concerns the 'neutrality' of the evidence. That is, are the findings grounded



in the data, or are they effected by subjectivity and bias? Objectivity is one of the underlying principles of the scientific paradigm, or the convergence in the conclusions of two researchers to the same data set. However, in a qualitative methodology the researcher aims to examine and interpret the data and draw conclusions from the emerging trends. The potential for subjectivity and bias is inherent in this approach. To attempt to minimise this, in the current study validated audit tools were used for part of the data collection, and data from the interviews were authenticated by participants. Nevertheless, one of the key considerations in this, as in all qualitative studies, was the role of researcher as instrument, and the potential influence that might have on the research process.

## **5.6 Researcher's Role**

The author was sensitive to role of the researcher as data collecting instrument in a naturalistic enquiry. However, as a nurse undertaking a study in her area of expertise there were advantages and disadvantages (Field and Morse 1985, Field 1989, Carr-Hill et al 1992). One of the main issues to be considered in planning this study was what the research might be seen to represent, and how this would influence the data collection. As has already been shown in Chapter Three (See 3.4), nationally there was ambivalence about the Named Nurse Standard, and the associated management intent of measuring nursing performance (Wright 1993, Jolley and Brykczyńska 1993, Mackereth et al 1994, Savage 1995). Raising the question whether the researcher would be seen by the nurse participants as a 'tool of management' to evaluate their performance. Alternatively, the researcher and the two data collectors were lecturers in nursing, and this research could have been attributed to the audit of the educational environment.

To address these potential concerns written information about the research was prepared by the author at the beginning of the study, and made available to all the ward settings. It

explained that it was an independent study and detailed the purpose of the research, the role of the researcher, and the anonymity and confidentiality of the findings. In addition, it was noted that the information gathered would not be shared with ward staff or the hospital managers, but that the final report would be made available to all (See Appendix 3). This written information was used, together with verbal preparation, at every stage because of the length of the study, and the inevitable staff changes on the sample wards.

The influence of the researcher's presence in the research field was also considered as part of the design of the study. In a qualitative methodology the researcher has to enter the field to collect the perceptions of the participants in their real world setting, but in doing so the field maybe distorted (Field and Morse 1985, Field 1989, Polit and Hungler 1991). This could mean that participants change their behaviour, or modify their responses to questions, because of the presence of the researcher in the setting. The chosen method to attempt to minimise the effect in this study, was to 'acclimatise' staff to the presence of the researcher on the sample wards. This was achieved by agreeing a schedule of how the staff would be prepared for each stage of the research, with each ward manager. This varied from meeting with individual nurses to attending ward meetings. In addition, the position chosen for the author to sit to undertake the non-participant observation of the nurse-patient interaction was discussed, and agreed with the ward manager. The acclimatisation took place over a period of time, and staff became accustomed to the researcher visiting the ward at different times and staying for varying lengths of time.

A similar lengthy period of preparation was not possible with the two data collectors who undertook the assessment of the quality of care. However, there was concern raised in one setting about the effect of their presence during the fieldwork. The preparation of the research field for the quality audit had followed the same pattern as other aspects of the

study. That is the author agreed access with the ward managers, written information was made available, and the ward managers discussed the study with their ward staff. Following the initial preparation, the data collectors discussed the process of the quality audit with the ward staff on the sample wards. However, during the final observation session on one of the wards, the nurse in charge of the ward for that shift approached the data collectors to discuss the audit process. Concern was voiced that the observers were intrusive and influencing the delivery of nursing care. Following discussion, between the data collectors and the nurse in charge of the ward for that shift, it was agreed that the two-hour observation session would be discontinued one hour early. The author was not involved in these discussions but was subsequently briefed by the data collectors.

Following discussion between the author and the ward manager it was agreed that the observation session should not be rescheduled immediately. This was because the relationship of trust between the nursing staff on the ward during that observation session and the data collectors, appeared to have broken down. Furthermore, the observation session could not be undertaken at the end of the study as it would have effected the congruence of the design. Nevertheless, it is worth noting that the episode did not appear to adversely effect the nurses' willingness to participate in subsequent stages of the research. This can probably be attributed to their familiarity with the author, as researcher, and the commitment of the ward manager to the study.

The final issue that was considered in relation to the researcher in the fieldwork was the parameters of the observer role. One advantage of the author as a nurse was that the professional discourse, and the norms of the participants, were recognisable. In addition, the familiarity with the professional role facilitated the coding of the nurse-patient interactions. However, noting Field and Morse (1985) advice the author was aware that knowledge of

professional behaviour was open to subjectivity, and that attributions could be made of what was intended instead of recording the event. To minimise the subjectivity the activity codes for the observation were developed from the work of Roper et al (1980), and the nursing activities in the Criteria for Care (Ball et al 1984), and tested in a pilot study and modified. It means that a non-nurse could have used the tool, but it would have taken them longer to become familiar with the coding categories.

It was also considered important to clarify that the role of the author in the clinical setting was as a non-participant observer of particular aspects of the ward activity, and not as a nurse. For any nurse researcher, particularly a novice, there is a tension between remaining objective as a researcher, and professional accountability as a nurse. To manage this it was explained during the information sessions for staff that, the researcher would observe the patients but not intervene in their care. However, it was made clear that if, in the professional judgement of the researcher, it was an emergency situation she would intervene. In addition, the author confirmed that a similar principle would apply to any situations that were, in the professional judgement of the researcher, unethical or unacceptable (Field and Morse 1985). Each of the NHS trusts in which the fieldwork took place had clear lines for reporting that could be used in such situations. Although clarifying these issues may reinforce the participants' association of the research as a management tool, it makes explicit the researcher's responsibilities as a professional.

## **5.7 Ethical Issues**

The ethical issues associated with the role of the researcher as an observer of practice has already been considered (See 5.6). Other ethical issues pertinent to this study include gaining informed consent from patients and nurses to participate in the study, ensuring anonymity and confidentiality for the participants, and obtaining access to the research field.

As has already been shown, written information concerning the study was made available to nurses at all stages of the study, which gave assurances regarding anonymity and confidentiality. A similar information sheet was developed for patients (See Appendix 4). In addition, the nurse in charge of the ward at the time of fieldwork identified which patients could be approached to participate in the study. The criteria for inclusion in the study were that patients were able to consent for themselves and were not under the age of 16.

Having identified which patients could be approached the researcher discussed the study with each one, including the right to refuse to participate, before asking for consent. Written consent to be observed was sought from the in-patients (See Appendix 5). For patients who were asked to complete a questionnaire implied consent (Field and Morse 1985) was assumed if it was completed and returned. Patients were asked for permission to send a questionnaire to them for their completion and no follow-up mailing was made. This same approach was used to obtain informed and implied consent from the nursing staff to participate in completion of a questionnaire concerning the organisational method used in the ward, in the interviews, and the non-participant observation. (See Appendix 6).

Obtaining access to the research field was through the permission and support of a number of 'gatekeepers'. Several authors argue that these gatekeepers can be at any level of an organisation and may facilitate or impede access (Field and Morse 1985, Robson 1993). In this current study the gatekeepers at organisational level were the Local Research Ethics Committees, and the Directors of Nursing at trust level. Two Local Ethics Committees granted ethical approval for the study in 1997. At the same time the Directors of Nursing of two NHS trusts were approached about the study. They both gave their permission for the fieldwork to be undertaken in the acute surgical wards of their respective hospitals. In addition, due to limitations on the timing of the study, the research design was modified. In

an ideal world the patients would have been interviewed following discharge. However, a postal questionnaire, the Newcastle Satisfaction with Nursing Scales (Thomas et al 1996a), was used to assess patient perception of their nursing experience (See Appendix 8). This did not affect the rigour of the findings as it was a validated tool for measuring patient satisfaction and experience of nursing care (McColl et al 1996, Thomas et al 1996a), (See 5.4.2).

Both Directors of Nursing enabled access to the relevant senior nurse in each hospital. These senior nurses prepared the way for the author to enter the field at a ward managers meeting. The response from all ward managers involved was positive and remained so throughout the study. They became the 'insider' in the research field, a role identified by Field and Morse (1985) as important in any qualitative study to facilitate acceptance of the researcher. Having gained access to the ward settings the first stage of the study was to identify the wards for the fieldwork (See Table 9).

## 5.8 Stage One of the Study

	Method	Purpose
<b>Stage One</b> September - December 1999	Self-administered questionnaire to ward managers and nurses on the organisational method used	To identify the sample of highest and lowest adherence to criteria associated with the Named Nurse Standard
<b>Pilot Study</b> March - October 2000	Non-participant observation of nurse-patient interactions  Audit of nursing notes  Interviews with nursing staff	To test and if necessary modify data collection tools
<b>Stage Two</b> <b>Main Study</b> February 2001	Non participant observation	Codify nurse-patient interaction To identify the extent to which the Named Nurse Standard is operational
February 2001	Audit of nursing notes	Review of nursing records To identify if Named Nurse is recorded
March -April 2001	Quality of care audit using Qualpacs (Wandell and Ager 1974)	Quality audit of nursing practice
June - July 2001	Semi-structured interviews - Nurses' perception of the Named Nurse Standard	Semi-structured interviews of wards managers and qualified nurses. To identify which nurses did what and how it was done
<b>Stage Three</b> May - August 2001	Self-administered questionnaire to patients using Newcastle Satisfaction with Nursing Scales (Thomas et al 1996)	To obtain patient perceptions of the nursing care received and identification of the Named Nurse

**Table 9: Timetable for the Study**

The modified research design for the study is presented in Table 9 and includes the timetable for, and the purpose of, the data collection. Demonstrating that the process through which valid, reliable data were to be collected would provide a comparison between the sample wards. The two NHS trusts in the study had similar configurations as both served rural and urban communities, and provided emergency care, acute care, and care of the older person services. In each hospital four wards were designated 'acute surgery'. The first stage of the study concerned identifying the organisational mode of each of the eight surgical wards so that a sample of four wards, two from each trust, could be selected.

## 5.9 Selection of Sample

To select a sample for the fieldwork a self-administered questionnaire, developed from the work of Thomas and Bond (1990), was distributed to all permanent, qualified nurses on day duty in the eight surgical wards. The purpose was to identify the organisational method that qualified nurses perceived was used on each ward. This would then be used to indicate which wards had a high adherence to criteria associated with the Named Nurse Standard, and which wards had a low adherence. Bank nurses were excluded because of their limited experience of the ward organisation. In addition, qualified nurses on night duty were excluded because the ward managers reported that, because of staffing levels, the organisational method was not maintained for 24 hours. Furthermore, the resource constraints of the study meant that the observation periods could only occur during day shifts.

Thomas and Bonds' work (1990) was used because it enabled discrimination among the three recognised methods of nursing work, these being primary nursing, team nursing and task or functional nursing. There was a fourth category 'no particular modality' where there was no recognised method of work identified. Bowman et al's classification system (1993) for nursing work methods was also considered for this stage of the study, but as it involved gathering data from patients it was not used. This was to avoid contamination of the research field and exploitation of the patient sample.

Permission to use the questionnaire in this study was sought from the authors (Thomas and Bond 1990), who advised further work to develop the tool. This was undertaken, modifications were made to three of the original questions, and two questions added (See Appendix 1). The modified questionnaire identified eight features of organising nursing work as follows:



1. Grouping of patients and length of allocation to specific patients
2. Allocation of nursing work
3. Organisation of the duty rota
4. Nursing accountability for patient care
5. Initial nursing assessment of patient care
6. Responsibility for writing patients' nursing notes
7. Verbal handover reports
8. Liaison with medical/paramedical staff.

Each feature has a number of explanatory statements and participants were asked to indicate which one statement described their current practice. Each statement was coded according to one of the three methods of organising nursing work, or no particular modality. For the purposes of this study the statements were mapped against the criteria identified in the literature as associated with the Named Nurse Standard (See 3.10, Table 6).. Consistent with the literature (DOH 1992, Hancock et al 1992b, Wright et al 1993, DOH 1994b, Thomas et al 1996b) primary nursing and team nursing had the highest adherence to criteria associated with the Named Nurse Standard, and task allocation or functional nursing and no particular modality had the lowest adherence. This can be illustrated by a statement for feature one, coded as primary nursing, that reads:

'Individual qualified nurses are given responsibility for individual patients for the duration of the patients' stay in hospital' (Thomas and Bond 1990: 1111)

The results of the mapping of the criteria associated with the Named Nurse Standard with the features of the organisational methods identified in Thomas and Bond's work (1990) are presented in Table 10.

High Adherence Category	Low Adherence Category
<b>Grouping of patients/Length of allocation to specific patients</b>	
<ul style="list-style-type: none"> <li>• staff are divided into teams with a designated leader and allocated to a group of patients for one shift or part of a shift</li> <li>• staff are divided into teams with a designated leader and allocated to a group of patients for periods longer than one shift</li> <li>• individual qualified nurses are given responsibility for individual patients for the duration of the patients' stay in hospital</li> </ul>	<ul style="list-style-type: none"> <li>• staff are organised as one group</li> <li>• allocated singly or in pairs or in threes to patient areas for part of a shift</li> <li>• work across ward for whole of a shift</li> <li>• individual qualified nurses are given responsibility for individual patients for part of a shift or for the duration of a shift</li> </ul>
<b>Allocation of nursing work</b>	
<ul style="list-style-type: none"> <li>• team leaders allocate work for their team</li> <li>• the most senior nurse in the team allocates work</li> <li>• individual nurses decide what care to give to their individual patients</li> </ul>	<ul style="list-style-type: none"> <li>• ward sister/charge nurse or nurse in charge allocates work</li> </ul>
<b>Organisation of the duty rota</b>	
<ul style="list-style-type: none"> <li>• within two or more teams</li> <li>• to enable individual nurses to be responsible for individual patients</li> </ul>	<ul style="list-style-type: none"> <li>• entirely invested in the ward sister/charge nurse</li> <li>• for the ward as a whole</li> </ul>
<b>Nursing accountability for patient care</b>	
<ul style="list-style-type: none"> <li>• entirely invested in the team leader</li> <li>• entirely invested in the individual nurse responsible for individual patients</li> </ul>	<ul style="list-style-type: none"> <li>• it is shared</li> </ul>
<b>Initial assessment of patient care</b>	
<ul style="list-style-type: none"> <li>• team leader when it involves their patients</li> <li>• patient's individual nurse</li> </ul>	<ul style="list-style-type: none"> <li>• ward sister/charge nurse or nurse in charge</li> <li>• any qualified nurse available</li> <li>• any nurse available</li> </ul>
<b>Responsibility for writing nursing notes</b>	
<ul style="list-style-type: none"> <li>• each team leader writes the notes for the patients in his/her team</li> <li>• individual nurse responsible for the patient's care throughout their stay</li> </ul>	<ul style="list-style-type: none"> <li>• ward sister/charge nurse or nurse in charge</li> <li>• nurse/nursing auxiliary/learner who provided care for the patient that shift</li> </ul>
<b>Verbal handover reports</b>	
<ul style="list-style-type: none"> <li>• team leader when it involves their patients</li> <li>• patient's individual nurse</li> </ul>	<ul style="list-style-type: none"> <li>• ward sister/charge nurse or nurse in charge</li> <li>• any qualified nurse available</li> <li>• any nurse available</li> </ul>
<b>Liaison with medical/paramedical staff</b>	
<ul style="list-style-type: none"> <li>• team leader when it involves their patients</li> <li>• patient's individual nurse</li> </ul>	<ul style="list-style-type: none"> <li>• ward sister/charge nurse or nurse in charge</li> <li>• any qualified nurse available</li> <li>• any nurse available</li> </ul>

**Table 10: Categories of high and low adherence to criteria associated with the Named Nurse Standard (After Thomas and Bond 1990)**

Table 10 shows that the features categorised as 'high adherence' are associated with providing continuity of care for the patient. Nursing staff are allocated to care for individual groups of patients, for one or more periods of work, with the lines of accountability clearly through individual qualified nurses. These features are consistent with the criteria of continuity of care associated with the Named Nurse Standard. In contrast, the features of the organisational modes in the 'low adherence' category reflect a hierarchical model. The emphasis is on completing the nursing work, albeit safely, rather than on the continuity of the individual patient's experience. The clear differences between the features in the two categories is consistent with the aim of collecting valid, reliable data that would provide a comparison between, the wards that have a high adherence to criteria associated with the Named Nurse Standard, and wards that have a low adherence.

The overall response rate to the first mailing of the questionnaire was 45% and varied for each ward between 35% and 56%. Each ward was visited to check with the ward manager that the details of the staff numbers were correct, and a second mailing was sent. Respondents were asked to complete and return the questionnaire, or complete and return a slip indicating that they had responded to the first mailing. The overall response to the second mailing rose to 71%, and varied for each ward between 67% and 89%. The responses were analysed, first into one of the three methods of organising nursing work, or no particular modality. Where a respondent indicated more than one response it was categorised as 'no particular modality'. The questionnaire had eight questions and of the 66 responses only one question was not answered on one questionnaire. This was added to the 'no particular modality' category. One questionnaire was returned incomplete and with a covering letter. This was not included in the analysis. The responses to criteria associated with primary nursing and team nursing were then grouped in the high adherence category, and task or functional nursing and no particular modality in the low adherence category.

These two groups were expressed as a percentage of the total number of responses for each ward (See Appendix 7)

Selection of the wards was based on the results of the high and low adherence categories. It is interesting to note that, for the majority of the wards, there are similarities in the results for the two categories. The exception was Ward 24 in Trust One. The findings demonstrate that, in terms of nurses' perceptions of how they organise their work, there was a low adherence to the criteria associated with the Named Nurse Standard. From the results four wards were selected for the case studies, two wards from the highest level of adherence category, and two from the lowest level of adherence category. To maintain the continuity of the research a highest adherence and lowest adherence ward from each trust was selected. The wards in each category were recoded to reflect the trust to which they belonged, and their classification. Therefore, the coding for the high adherence wards was Trust One Highest (T1H) and Trust Two Highest (T2H), and for the low adherence wards it was Trust One Lowest (T1L) and Trust Two Lowest (T2L).

As part of the preparation for the study the nursing staff had been told that some wards would be selected for fieldwork, but were not informed of the specific criteria associated with that decision. The ward managers on the four wards that were not to be used in the main study were informed and thanked for their participation. The ward managers on the sample wards were informed of the outcome and prepared for the second stage of the research. Nursing staff in the sample were not informed of the results of the categorisation of the wards to prevent contamination of the research field.

In the mailing of the questionnaire participants were asked if they would be willing to be interviewed in the second part of the study. A number did agree and a list was compiled of those who responded positively, and retained for reference. The next stage of the study was

to pilot the tools for the non-participant observation, the audit of the nursing notes and the interview schedules.

## **5.10 Pilot Study**

The purpose of the pilot study was to test the feasibility of using the tools developed for the non-participant observation, the audit of the nursing notes, and the interview schedules. It also included organising the training for the data collectors who were to undertake the audit of the process of nursing using Qualpacs (Wandelt and Ager 1974, Carr-Hill et al 1992, Redfern and Norman et al 1994).

### ***5.10.1 Non-Participant Observation***

The aim of the non-participant observation of nurse-patient contacts was to identify which members of the nursing staff interacted with the patients, and the content of that interaction. The purpose of this was to identify whether the patient's named nurse was delivering care and, in the absence of the named nurse, who was giving the patient care. The definition of nurse-patient interaction used in this study was:

‘any contact between a member of the nursing team, qualified or unqualified and the patient being observed, during the period of observation’

It was the patient experience that was being observed and any and all contacts were recorded. The nature of the contact was noted using nursing activity codes, the length of interaction and the member of nursing staff making the contact recorded.

The nursing activity codes for the observation were developed from two sources. The first was the activities of living described by Roper et al (1980), as this was the approach to planning patient care cited by most of the ward managers. The second source was the nursing activities in Criteria for Care (Ball et al 1984), in particular the Direct Care and Indirect Care categories. A list of 21 codes was generated (See Table 11).

<b>Nursing Activity Codes</b>	
1 Communicating with patient - social	11 Patient escort
2 Assisting with eating and drinking	12 Admitting a patient
3 Assisting with hygiene	13 Discharging a patient
4 Assisting with elimination	14 Giving information - therapeutic
5 Administering medication	15 Assisting members of the multidisciplinary team
6 Administering analgesia	16 Charting and recording
7 Assisting with patient movement - non-therapeutic	17 Handing over care
8 Assisting positioning - therapeutic	18 Communicating with multidisciplinary team
9 Recording vital signs	19 Communication with relatives
10 Nursing procedures	20 Teaching learners
	21 Other

**Table 11: Nursing Activity Codes**

The pilot study took place in a surgical ward that had not been used in the original group of eight wards. Its clinical speciality was surgical but as it was not designated as part of the general surgical unit, it had not been considered for the fieldwork. The ward shared several of the attributes of the sample wards, including short length of patient stay, and layout of small bays and side rooms, and so was considered appropriate for the pilot study. Access to the ward was obtained through the senior nurse for the unit and the ward manager. The staff were briefed a week before the observation session and information sheets concerning the study were left on the ward for reference for all staff (See Appendix 3). The researcher followed the protocol for the study for obtaining written consent to participate from the nurses, and the two patients who were to be observed.

One of the objectives in piloting the observation tool was to identify the appropriate position for the researcher to undertake the observation. It was important for the researcher to be near enough to observe the nurse-patient contacts, but not so close that it would influence their interactions. The options concerning where the researcher would sit were discussed with the ward manager. These included at the nurses station and in the corridor. However, neither were considered feasible as the researcher would not have been able to observe the patients without being obtrusive. Therefore, it was agreed that to observe the

two patients the author would sit by an empty bed in the ward bay. However, there were a number of difficulties associated with being positioned by a bed. The main difficulty was that hospital beds do not stay unoccupied for long, and when a patient was admitted the researcher had to move to another position in the bay. In addition, the layout of the bays precludes unobtrusive observation of patients in certain locations. Therefore, it was concluded that the observation for the main study should be undertaken from outside a ward bay, so the researcher could move positions unobtrusively.

It had been intended to use time sampling for the coding. This meant that nurse-patient interactions with two patients would be observed every ten minutes during the span of duty. This was seven and a half hours on that ward. Difficulty was encountered getting a representative picture of the interactions using this approach as there were 'bursts of activity', and then no nurse-patient contact. Adjusting the time frame was considered, but a review of the coding sheets and field notes, indicated that this would not have captured all the nurse-patient interactions. Therefore, it was decided to use event sampling to capture all the nurse-patient contacts during the observation period.

It is worth noting that this approach might not have been appropriate if the span of duty was longer than eight hours. At the time of the pilot study, and the non-participant observation in the main study, all the wards sampled worked a shift weekly shift pattern of 37.5 hours over five days. The normal span of duty was seven and a half hours. However, over the duration of the study shift patterns were being reviewed because of the workload demands on the wards. As a consequence all the wards in the study were considering introducing 12 hour shifts for nursing staff.

The other associated staffing issue that had to be considered in the design of this study was the vacancy rate on the sample wards. There was a stable vacancy rate on all the wards

sampled of less than 10%. However, if the vacancy rate had been 50% or above it would have been too difficult to organise the continuity associated with the Named Nurse Standard.

Two other issues arose during the pilot study. The first concerned the differentiation between the activity codes 'administering medication' and 'administering analgesia'. Although the latter had been included to differentiate between medication administered as part of a 'medicine round' and analgesia given when required by the patient, it was not clear through observation without checking. However, as the aim of the study was to differentiate the contact between staff and patient, rather than discriminate completely between types of activity 'administering analgesia' was removed from the coding.

The second issue was ensuring sufficient time to approach patients who met the criteria for inclusion in the study before the fieldwork. One of the criterion was a patient should be designated as a 'surgical' patient and not they were in a surgical ward. However, on all the wards in the sample there were a number of "outliers" (Walby et al 1994), who had been moved from another speciality because of the demand for beds. This limited the potential patients for inclusion in the study. Therefore, it was agreed with the ward managers that patients in the 'higher dependency bay' would be approached to participate if they met the other criteria for inclusion in the study. These patients would be surgical patients and less likely to be moved either within, or out of the ward. It was agreed they would be approached on the day of the study and asked if they would participate. To identify the level of continuity of care there were to be two observation sessions on consecutive days. The first day would be on a late or afternoon shift, followed by an early or morning shift. This pattern would enable the author sufficient time to approach potential participants before the fieldwork commenced.



Patient awareness of the named nurse responsible for their care was also part of this aspect of the study. However, as the recording of patient responses was included in the audit of nursing notes, it will be considered with that element of the pilot study.

### **5.10.2 Audit of the Nursing Notes**

The checklist (See Table 12) developed for the audit of nursing notes was informed by the criteria identified for the named nurse (See 3.10, Table 6). The checklist was used to audit the documentation for all the observed patients. Information from the notes was used to answer questions 1-8, and the author asked the participants question 9 at the end of the non-participant observation session.

<b>Analysis of Documents</b>	
<b>Nursing Notes</b>	
1.	Is the Named Nurse Recorded?
2.	Is the date of the first meeting recorded?
3.	Was this within the first 24 hours of the patient's admission?
4.	Is the meeting recorded in the care plan?
5.	Are daily meetings with the Named Nurse recorded?
6.	Did the Named Nurse write the care plan?
7.	Is today's care recorded by the Named Nurse?
8.	Is there an 'associate' nurse identified on the care plan?
<b>Information from Patient</b>	
9.	Does the patient know the name of their Named Nurse?

**Table 12: Form for the analysis of nursing documentation of all patients**

At the end of the observation period the two patients who had been observed were asked whether they knew the name of their named nurse. Neither of the patients replied 'yes'. However, one of the patients mentioned the nurse who had been caring for them that day. Although, this was not specifically related to the named nurse concept it did suggest that the wording of the question to patients should be reviewed. The author was interested in

whether patients associated the term 'named nurse' with their hospital experience. Therefore, the question regarding the named nurse was retained and the question 'Is the patient aware of a specific nurse responsible for their care?' was included. The wording of the question being consistent with the approach of Bruster et al (1994) and the RCN (1994). The other change made to the checklist after the pilot study was to omit Question 8 concerning an associate nurse. It had been included because of the association with continuity of care in the absence of the named nurse. However, as it did not form part of the standard documentation for recording patient care, it was not considered appropriate to include it in the final version of the checklist (See Appendix 9).

### ***5.10.3 Semi-structured Interviews of Nurses and Ward Managers***

The schedule for the interviews of ward managers and nurses was developed from the literature and the criteria for the Named Nurse Standard (See 3.10, Table 6). A semi-structured approach or 'guided interview' (Field and Morse 1985) was selected as the researcher wanted to obtain a rich picture of nurses' perceptions of the Named Nurse Standard. A structured approach was considered to be too constraining because it does not allow for probing and clarification by the interviewer. Field and Morse (1985) suggest that a guided interview technique can be used when the key aspects of an issue have been identified, and these can be used to elicit the informants' views. It was considered appropriate to use the approach in this study because there has been limited previous research on nurses' perception of the Named Nurse Standard.

The schedule was piloted with a ward manager from a specialist surgical ward not involved in the study to avoid contaminating the research field. A number of issues arose concerned with managing the interview process. The first was that the informant did not want to be audio-taped. The researcher respected that request and contemporaneous notes were taken

throughout the interview. However, reflection on the notes of the interview suggested that the author did not have the 'full record' that Robson (1993) argues is required of any interview. Field and Morse (1985) offer a number of ways of managing informants' concerns regarding audio-taping. These include making the tape recorder as unobtrusive as possible though not covert, and using telephone interviewing. To avoid what might have been perceived as coercing informants to be audio-taped, the researcher anticipated taking notes if any expressed concern.

Another constraint on interviewing which was identified in the pilot study was the location in which it took place. To strengthen compliance all the interviews took place in a quiet room, in the vicinity of the informant's workplace. Therefore, there was minimal disruption to the informants' working day. In addition, it recognised that informants can be inhibited by the process of being interviewed, even if they are familiar with the researcher (Field and Morse 1985). However, in the pilot study because of the proximity of the interview room to the ward setting, the interview was interrupted by another member of staff seeking information from the ward manager. In the main study 'Please Do Not Disturb' signs were placed on the door to the room requesting that staff did not enter during the interview.

Two changes were made to the order of the interview schedule as a result of the pilot study. The first was the biographical details were obtained at the beginning of the interview rather than at the end. This was to encourage informants to respond by answering short, focused questions before moving onto the less structured part of the interview. Robson (1993) advocates this approach suggesting that there is one structured section in the schedule of a semi-structured interview. The second change was the question concerning length of time on the ward. This was adjusted when interviewing ward managers to read 'length of time managing the ward', to identify levels of responsibility associated with implementing

changes, such as the Named Nurse Standard. See Appendix 10 for the revised interview schedule.

During this part of the study the planning commenced for the identification and training of data collectors to use Qualpacs (Wandelt and Ager 1974). All changes arising from the pilot study were incorporated into the protocol for the main study.

### **5.11 Stage Two - Main Study**

Stage Two of the study was designed to identify the organisation of nursing work on the sample wards. This was obtained through non-participant observation of nurse-patient interactions, and a review of the nursing notes. In addition, an audit of the process of nursing was undertaken. Finally, the perceptions of nurses and ward managers of the impact of the Named Nurse Standard on the organisation of nursing work, were elicited in semi-structured interviews.

#### ***5.11.1 Non-Participant Observation of Nurse-Patient Interaction***

The non-participant observation took place on two consecutive days on each ward, making a total of eight observed shifts. Each period of observation was one span of nursing duty or 'shift'. The total observation time for the high adherence wards was 32 hours, and for the low adherence wards 30.5 hours. Two patients were observed in each period of observation to identify which nursing staff interacted with them. The type of activity engaged in was recorded and the length of the interaction. The schedule was designed to include one week day and one weekend day to identify if there was any change in nurses' responsibility when staffing levels in other departments were reduced (See Appendix 11). Observing a late shift, followed by an early shift, would indicate the level of continuity of patient care. Therefore, where possible the same patients were observed on both days, making a total of eight patients. Using the same pattern for each ward also enhanced the continuity of the research.

The nurse in charge of the ward for the shift was approached at the beginning of the observation period and asked to identify which patients could be approached to participate in the study. Patients who were not able to consent for themselves were excluded from the study, and anyone under 16. In addition, any patient not designated as a 'surgical patient' was not invited to participate in the study. The observation took place in the higher dependency bay in each ward as this was one of the areas designated for surgical patients. In addition, it enabled the researcher to be positioned to observe two patients at the same time.

Written consent to participate in the study was obtained from patients who were to be observed, and the nurses on the shift. All the participants were told that the author would be observing the nurses who interacted with the patients, but they were not told the activity codes. At the end of the first shift the nurse in charge of the ward was approached to see which patients could be observed on the following day. If it was not possible to observe the same patients, then alternative patients were identified and approached to discuss their possible participation in the study. Thus avoiding the necessity to approach patients early in the morning,

During each eight-hour shift the researcher sat quietly in a position close enough to the higher dependency bay to observe both patients. As a non-participant observer the researcher could unobtrusively watch the interactions, without directly influencing the activity. Event sampling was used so that all the nurse-patient contacts during the span of duty were recorded. The grade of nurse, and the length of each intervention were recorded using the nursing activity codes. The researcher did move if a patient changed position within the bay and could no longer be observed. However, if the curtains were pulled around a patient's bed the researcher did not move to observe the interaction. The

researcher used her experience as a nurse, and nurse lecturer, to code these nursing activities. For example, if the curtains were around the patient's bed and the nurse caring for them took in a bowl with water and towels, then this activity would be coded as 'assisting with hygiene'.

Field notes were used to note the occasions when the patient could not be observed, and to record information about the environment on the ward, and the layout of observation area. At the end of each observed shift the patients were asked if they knew who their named nurse was, and also whether they were aware of a specific nurse responsible for their care. The patient responses were recorded on the audit of nursing notes checklist.

The data were analysed for each patient to demonstrate the number of nursing staff who interacted with them during the shift. The grade of each nurse who delivered care was examined to establish whether the patient was receiving care from qualified or unqualified nurses. The frequency of interaction, and total length of time that each nurse spent with each patient was analysed separately to determine continuity of care. It was then compared with the results of the audit of the patient's notes to establish whether the patient received care from their named nurse. The results for each patient were then grouped into the highest adherence wards and lowest adherence wards categories, and compared to identify whether there was a difference in patient interaction with their named nurse. In addition, the findings from each data set were cross tabulated to establish whether wards in the 'highest adherence to the named nurse criteria' had different patterns of working compared to those in the lowest adherence category.

### ***5.11.2 Audit of the Nursing Notes***

At the end of each observation period the nursing records for each of the observed patients were audited using the checklist for analysis of patient documentation (See Appendix 9).

This was to identify whether a named nurse was recorded on the documentation, and if so whether they had planned, implemented and evaluated care for that patient.

The data were analysed to determine whether each patient had been allocated a named nurse on admission. This was then compared with the patient's knowledge of their named nurse to establish whether this was part of individualised patient care, or a paper exercise. Questions 2 - 7 were analysed to establish whether there was continuity in the planning, delivery and evaluation of care.

The nursing documentation for all the surgical patients on each ward was examined to determine whether the named nurse had been recorded. This was then cross-tabulated to establish whether there was a difference between the wards in the highest and lowest adherence categories.

### ***5.11.3 Quality Audit of Nursing Practice***

An audit of the process of nursing was undertaken to contribute to the rich picture of the organisation of nursing work on the sample wards. The nurse-patient relationship is one of the characteristics associated with the Named Nurse Standard. Qualpacs (Wandelt and Ager 1974) identify the quality of patient care by measuring nurse-patient interactions (See 5.4.1). The results from this part of the study were to be used to compare, contrast and identify convergence with the results from the non-participant observation, and the audit of the nursing notes. Qualpacs (Wandelt and Ager 1974) were selected as they have been shown to have a high construct validity compared to other similar tools (Redfern et al 1994, Norman and Redfern 1995). As has been shown, the work by Carr-Hill et al (1992) suggested that modifications to the tool would enhance its effectiveness in the measurement of quality of care. In a subsequent study Warr (1998), used the modified Qualpacs assessment tool to evaluate the effectiveness of different grades of nurses. The author of

that study (Warr 1998), was approached for permission to use modified Qualpacs forms in this current work, and to provide training for a team of data collectors. The author gave agreement and a three-day training programme for four observers, that included a fieldwork exercise to ensure inter-observer reliability, was provided.

Two data collectors were sufficient for the study as the observation periods followed the pattern of the non-participant observation to maintain the coherence of the research. Although it was not possible to follow the week day and weekend pattern each ward was observed on two consecutive days, each of which was a different shift, giving a total of eight observed shifts. Two patients were observed on each shift. This was a total of 16 patients. Each of the observation periods was two hours, with a further hour to read the nursing documentation on the patients. The data collectors worked as a pair but rated and recorded the interactions separately.

Measuring the quality of care using Qualpacs (Wandelt and Ager 1974), is by direct observation of nurse-patient interactions which are divided into six sections as follows:

1. Psychosocial (individual)
2. Psychosocial (group)
3. Physical
4. General
5. Communication
6. Professional Implications

The observer rates the nurse-patient interaction under items in each section using a five point score (See Table 13). If an item is 'not applicable' or 'not observed' this is recorded and those items are excluded from the scoring.



<b>Category</b>	<b>Score</b>
Best Care	5
Between	4
Average Care	3
Between	2
Poorest care	1
Not Applicable	Excluded From Scoring
Not Observed	Excluded From Scoring

**Table 13: Qualpacs Scoring Scale**

As has already been shown (See 5.6), there was an issue with the data collection on one of the wards and this will be considered further in the analysis of the results in Chapter Six. The data were analysed by totalling the scores for each item, and dividing by the number of items scored to produce a mean score for each patient. Wandelt and Ager (1974) advise that a ward mean score can be generated from a data set of five patient mean scores or 15% of the ward; which ever is the greater. In this study, to maintain the coherence of the research four patients were observed on each ward. It was accepted that this was not a sufficient data set to produce a ward mean score. However, the aim was not to consider ward level. It was to identify a mean score for those wards with the highest adherence to criteria associated with the Named Nurse Standard, to compare with the mean score for the wards with the lowest adherence. Therefore, it meant that the mean score for each of the two adherence categories was generated from a data set of mean scores for eight patients, thus meeting Wandelt and Ager's criteria.

#### ***5.11.4 Semi-structured Interviews of Nurses and Ward Managers***

Three qualified nurses from each of the sample wards were interviewed to explore their perceptions of the Named Nurse Standard in relation to the organisation of nursing care in the ward, and professional accountability. A purposeful sample (Miles and Huberman 1994)

of a ward manager and two nurses from each of the four wards (n=12) was identified to be interviewed. On one of the wards there was a change in ward manager during the study. Therefore, to maintain the congruence of the study the senior staff nurses, who had been acting ward managers, were approached and they agreed to be interviewed. In addition, the author had retained a list of names of nurses who had completed a questionnaire in stage one of the study, and had expressed interest in participating further. A number of these nurses had moved to other wards and so were excluded from the study. However, the remainder of the nurses listed, which included two of the ward managers, were approached to participate. This could have been a problem because these informants were self-selecting. However, the researcher was pragmatic about identifying informants willing to participate as many of the nurses on the sample wards had also completed a questionnaire for the study.

The interview process and purpose were explained to all informants and agreement to participate was obtained. The interviews took place in the ward office or a quiet room close to the ward. The audio-tapes of the interviews were transcribed and returned to the participants for 'member checking' (Lincoln and Guba 1985). One of the 12 informants asked for minor grammatical changes to be made and the transcript was amended accordingly.

The transcripts were analysed by 'unitizing' and 'categorizing' the data (Lincoln and Guba 1985), so that common themes could be identified. The four themes that were identified are presented in Table 14.

<b>Themes from the Interview Data</b>	
1.	Trying to meet the Named Nurse Standard
2.	In an ideal world  The Named Nurse role  Who can be a Named Nurse?
3.	Organising nursing work  Division of nursing work  Patient allocation  Managing the ward
4.	Accountability for nursing care  Planning nursing care  Keeping the records straight  Professional accountability

**Table 14: Themes identified from interview data**

Following the naturalistic design of the study the results are presented as highest adherence wards and lowest adherence wards within the four themes, with associated quotations from the data. This gives the emic perspective of the informants as they describe their world. In addition, it enables comparison of nurses' perceptions of the Named Nurse Standard in the highest adherence and lowest adherence categories.

## **5.12 Stage Three of the Study**

In the final stage of the study patient perceptions of their hospital stay were sought to assess their experience of nursing care. This was to provide the patient perspective in the rich picture of the sampled wards.

### ***5.12.1 Patient Perceptions of Nursing Care***

The Newcastle Satisfaction with Nursing Scales (NSNS) (Thomas et al 1996a), was used to determine patient satisfaction with their care and their perceptions of which nurse was responsible for that care. The NSNS was selected because, as was shown in Chapter Four

(See 4.3) and in 5.4.2, it was a validated tool. In addition, it had been used by Thomas et al (1996b) to measure patient satisfaction associated with the method of organising nursing work and perception of a specific nurse in charge of their care.

The scale is presented in three sections. In the first section there are 26 statements on aspects of nursing. Respondents are asked to indicate on a seven-point Likert scale how true each statement was to their experience. The second section is a 19-item 'Satisfaction with Nursing Care Scale'. Respondents rate their satisfaction on a five point Likert scale. In the final section participants are asked to record biographical details, information on the duration of the hospital stay, and answer a question associated with the criteria for the Named Nurse Standard. In the question respondents are asked to identify whether there was one particular nurse in charge of their care.

Thomas et al (1996a) advise that the NSNS are administered before the patient is discharged. However, the test of the scales for validity and reliability identified no statistically significant difference in scores between questionnaires administered at home and in hospital ( $P \geq 0.05$ ) (Thomas et al 1996c). The target population for this current study were surgical patients on the day of discharge therefore, distribution by post was selected to facilitate administration of the questionnaire.

The nurse in charge of the ward was asked for advice about which patients could be approached to participate in the study. A convenience sample of 20 patients from each of the four wards was approached on their anticipated date of discharge. If they agreed to participate in the study a postal questionnaire was sent to their discharge address seven days after they left hospital. An explanatory letter and a reply paid envelope was enclosed. The criteria for inclusion in the study were as follows:

1. Surgical patient
2. Minimum of one night stay in the ward
3. Day before or day of discharge
4. Discharging to home or another address but not transferring for further treatment
5. Aged 16 years or over

Thomas et al (1996b) advise that patients should be in a minimum of two nights before NSNS are used. This was amended to one night in this study to reflect the changing configuration of patients' stay. In addition, applying a two-day criterion would have excluded a significant number of patients on one of the wards, from being approached to participate in the study. Implied consent was assumed if the participants completed and returned the questionnaire.

There was a very positive response rate as shown in Appendix 12. There was a 100% response rate from two of the wards, and 75% response rates from the remaining two wards. The total response rate for both the highest adherence and lowest adherence wards was 88%. A high response rate is unusual with postal questionnaires. A number of factors could have prompted the majority of the respondents to complete and return the questionnaires. The first was the personal interaction the author made with each patient rather than an initial contact by post. Additionally, the questionnaires were sent one week after the patient's discharge when the hospital experience was likely to be fresh in their mind.

### **5.13 Summary**

Review of the literature identified limited evidence of large-scale, systematic research into the impact of the Named Nurse Standard, on the organisation of nursing work and patient perception. Thus two research questions were developed to explore the functioning of ward settings in relation to the Named Nurse Standard, and the implications for nursing work.

The aim of the research design was to collect valid, reliable data that would provide a comparison between the wards that have a high adherence to criteria associated with the Named Nurse Standard, and wards that have a low adherence. The areas selected for comparison were methods of organising nursing work, nurses' perception of the Named Nurse Standard, patient experience of the named nurse role, and the quality of care.

A naturalistic approach (Lincoln and Guba 1985), using a case study method (Yin 1994), was selected to capture a rich picture of the real world experience of the three key players in the Named Nurse Standard. That is the qualified nurses, ward managers, and patients. One clinical speciality, surgical wards, was chosen to enable multiple case sampling and subsequent comparing and contrasting of the findings. Ethical issues and the role of the researcher in a qualitative methodology informed the study.

Quantitative and qualitative methods were used to collect data to strengthen the validity of the findings. Non-participant observation identified nurse-patient interactions and the organisation of nursing work. Comparison of those results with an audit of nursing notes illustrated the documentation of the named nurse role. A quality audit of the process of nursing was undertaken, and the results compared and contrasted with the audit of nursing notes and the non-participant observation, to identify convergence. The final stage of the study was a survey of recently discharged patients on their satisfaction with nursing care, and their perception of a specific nurse in charge of their care.

## **CHAPTER SIX**

### **RESULTS**

#### **6.0 Introduction**

This chapter presents the results from the qualitative and quantitative data collection. The purpose is to explore whether the nursing care on the sample wards was organised to facilitate the named nurse concept, and to identify if this was associated with adherence to the Named Nurse Standard. Patient perception of the named nurse concept during and after the hospital experience is examined. The results of the observation of nurse-patient interactions are explored to identify whether the organisation of nursing work on the sample wards, enabled continuity of care for patients. Furthermore, these results are compared with the audit of the nursing notes to determine whether patients received their nursing care from a named nurse. Finally, nursing staff perceptions of the Named Nurse Standard, and how it has impacted on their professional role and practice, is presented as a narrative within the themes that emerged from the data.

#### **6.1 Non-Participant Observation of Nurse-Patient Interactions**

The results presented in this section will demonstrate the level of continuity of care the observed patients received over two consecutive days. On one of the high adherence wards (T2H) it was not possible to observe one patient on both days of the fieldwork. Although the patient (Patient 6) was observed on Day One they were moved to another bay in the ward overnight. Therefore, it was not possible to continue the observation of that patient. Another patient (Patient 4) was approached and agreed to participate. However, to avoid skewing the results for T2H both these patients have been excluded from the data set. Therefore, results for three patients in the high adherence wards will be considered, and four patients in the low adherence wards. It is worth noting that the patient on T2H was

moved overnight within the ward to meet the demands on hospital beds.

Ward ID	Patient ID	Staff ID	Category	Days	Interactions			
					Number	%	Time	%
T1H	11	670	Q	2	4	33	07:52	19
		672	U	1	2	17	14:56	36
		673	U	1	4	33	16:16	39
		677	U	1	2	17	02:34	6
	<b>Total</b>				<b>12</b>		<b>41:38</b>	
T1H	13	669	Q	1	1	6	03:22	6
		670	Q	2	8	50	30:48	55
		672	U	1	1	6	00:57	2
		673	U	1	4	25	06:23	11
		676	Q	1	1	6	08:42	15
		677	U	1	1	6	05:58	11
<b>Total</b>				<b>16</b>		<b>56:10</b>		
T2H	5	621	U	2	10	59	11:45	39
		623	Q	1	2	12	05:53	20
		624	Q	1	3	18	08:01	27
		626	Q	1	1	6	01:04	4
		627	U	1	1	6	03:02	10
<b>Total</b>				<b>17</b>		<b>29:45</b>		

Q = Qualified Nurse and U = Unqualified Nurse

**Table 15: Nurse-patient interactions over two days on high adherence wards**

The results presented in Table 15 and Table 16 show that every patient experienced a level of continuity in nursing staff delivering their care. As was expected all patients received care from more than one nurse over the two days. However, from a team of nurses working on each ward, every patient interacted with at least one nurse on day one and day two. There is some difference between the number of nurses providing continuity of care between the high adherence wards and the low adherence wards. On the high adherence wards the continuity of care for the three patients was provided by one nurse. For example, on T1H Patient 11 received care from Nurse 670 on day one and day two (See Table 15). In contrast, on the low adherence wards a team of nurses provided continuity of care for three of the four patients. For example, on T1L Patient 9 received care from three nurses on both days (See Table 16). These results suggest that, in this aspect of the organisation of care, the patients on the low adherence wards are experiencing a team approach to nursing care.



In contrast, on the high adherence wards care is associated with named nurse criteria of one identified nurse.

Ward ID	Patient ID	Staff ID	Category	Days	Interactions			
					Number	%	Time	%
T1L	9	645	Q	2	7	28	35:12	54
		646	Q	2	9	36	23:15	38
		647	U	2	3	12	05:04	8
		648	Q	1	1	4	01:20	2
		649	Q	1	2	8	03:35	3
		650	Q	1	1	4	02:45	2
		652	Q	1	2	8	02:33	2
	<b>Total</b>				<b>25</b>		<b>01:13:44</b>	
T1L	10	645	Q	2	6	33	12:53	33
		646	Q	2	8	44	16:25	41
		649	Q	1	4	22	09:44	26
	<b>Total</b>				<b>18</b>		<b>00:39:02</b>	
T2L	1*	600	Q	2	5	71	07:08	87
		602	Q	1	2	29	01:04	13
	<b>Total</b>				<b>7</b>		<b>00:08:12</b>	
	2	600	Q	2	17	45	31:13	42
		602	Q	1	2	5	03:26	5
603		U	2	2	5	03:25	5	
<b>Total</b>				<b>38</b>		<b>01:14:51</b>		

\*Discharged home on day two after 4 of the 8 hour observation session

Q = Qualified Nurse and U = Unqualified Nurse

**Table 16: Nurse-patient interactions over two days on low adherence wards**

One of the main criteria of the Named Nurse Standard is that the role is taken by a qualified nurse. Comparison of the results presented in Table 15 and Table 16 show that there is some difference between the two adherence categories concerning the grade of the nurse providing continuity of care. On the low adherence wards there was continuity of care from at least one qualified nurse for all patients. In contrast on T2H, one of the high adherence wards, the continuity of care provided for Patient 5 is from Nurse 621, an unqualified nurse. Although this could be associated with delegation of responsibility to a designated other, in the absence of the named nurse, there is no evidence to support this. This was because there was no mechanism in the patients notes, on any of the wards, to record delegation to other nursing staff.

Another characteristic of the named nurse is that they are a direct caregiver. Meaning that the contact between named nurse and patient includes nursing intervention, and is not exclusively about planning and co-ordinating care. Table 15 and Table 16 present the total number of interactions, and the total duration of those interactions, by grade of nurse for each adherence category. The results for the low adherence wards (See Table 16) show that two patients received all their care from qualified nurses. These were Patient 10 T1L and Patient 1 T2L. Of the remaining two patients one, Patient 9 T1L, had over three-quarters of their interactions with qualified nurses, which represents over 90% of the nurse-patient contact time. However, it must be acknowledged that the pattern of this patient's care appears more fragmented. The patient interacted with a total of seven nurses, of which four were on two or fewer occasions. In contrast, the pattern of interaction on the high adherence wards (See Table 15) indicates a higher frequency of unqualified nurse-patient interaction, for more of the total contact time. The total qualified nurse-patient interaction time ranges between 50% and 100% on the low adherence wards, compared to a range of 20% to 70% on the high adherence wards.

The difference between the two adherence categories is also shown in the range of frequency of contacts. On the high adherence wards the frequency of qualified nurse-patient contact ranges between 33% and 62%, and between 50% and 100% on the low adherence wards. These results are interesting as it would be expected that those wards with the highest adherence to criteria associated with the Named Nurse Standard, would have greater contact between qualified nurse and patient.

These results suggest that there were different methods of organising nursing work being used on each of the wards. However, it also needs to be noted that there were variations in the nursing staff profile on the sample wards. This can be seen most clearly on T2H, which

was the ward that provided continuity of care through an unqualified nurse. The ward was using bank staff to cover vacancies. Three of the five nurses observed during the data collection were temporary, which perhaps explains why an unqualified nurse on T2H provided the continuity for Patient 5 from day one to day two.

## **6.2 Audit of the Nursing Notes**

Having identified that there was some evidence of continuity of care the results in Table 15 and Table 16 were compared with the findings from the audit of nursing notes (See Appendix 13). This was to identify whether a named nurse had delivered care to their designated patient. However, there was no named nurse, as such, recorded on the nursing notes for any of the patients observed for the two-day observation period, although all the patients had been on the wards for a minimum of four days. Thus, in this aspect of patient documentation there was no difference between wards in the two adherence categories. Nevertheless, it is noted that all other sections of the documentation were completed.

However, a difference between wards in the two adherence categories emerges if data from the two patients on T2H, (Patient 4 and Patient 6), who were excluded from the data set, are considered. There was a named nurse recorded on the nursing documentation for both of these patients on this high adherence ward. The findings for these patients had been excluded from the data set because they had only been observed for one day. However, although there was a named nurse identified on the documentation for both patients, neither of them had received care from that specific practitioner since the day of admission. This was because one of the patients had been admitted to one ward in the hospital and then transferred to T2H. The named nurse was on the original ward. In the second instance, the named nurse was based on T2H but had gone onto days off before commencing night duty.

There was no difference between the two adherence categories in the results of the audit of the named nurse in the documentation, and patient awareness of their named nurse (See Appendix 13). None of the patients in the sample recognised the term 'named nurse'. In addition, none of the patients were aware of a specific nurse responsible for their care. However, two patients, one from a high adherence ward and one from a low adherence ward, did ask the researcher to clarify the term 'specific nurse' in the research question. Both patients asked whether 'specific nurse' referred to the nurse who had been caring for them that day, or since they were admitted. When it was clarified that it referred to a nurse since admission both patients responded that they were not aware of a specific nurse responsible for their care.

The nursing notes of the observed patients were audited at the end of day one to identify whether a named nurse was recorded. The nursing notes were audited again at the end of the second day of observation to see if any additional information about a named nurse, had been included. It was noted at the end of day two that there was no additional information about a named nurse in any of the nursing records.

The nursing documentation for all the surgical patients on each ward was examined at the end of the first day of the observation to establish whether the named nurse had been recorded. Table 17 presents the results of this part of the audit. There was no named nurse, as such, recorded on any of the nursing notes on the low adherence wards. However, on T2H one of the high adherence wards, over three-quarters of the patient records (n=15) had a named nurse recorded. As the allocation of a named nurse to a patient is associated with continuity from admission to discharge it is interesting that T2H had such a high level of compliance in the records. This was the ward with a high level of bank staff and provided continuity of care through an unqualified nurse.

Adherence Category	Ward Code	Patient Records	Named Nurse Recorded	% of Total Records
High	T1H	29	0	0
	T2H	18	15	83
Low	T1L	23	0	0
	T2L	14	0	0

**Table 17: Audit of nursing notes by ward**

Although the audit of the nursing notes showed that the majority of the wards did not record a named nurse, all the patient records audited from Trust One had the 'admitting nurse' section completed. Examination of the nursing records for T1H and T1L indicated that the 'admitting nurse' was the practitioner who completed the initial assessment of the patient. As this function is associated with the named nurse the records were examined to identify whether these terms were being used interchangeably. However, there was a section entitled 'Team Leader/Named Nurse' that was blank on every record that confirmed that was not the case.

The results from these two aspects of the data collection have shown that, on the low adherence wards there was a greater time and frequency of qualified nurse-patient contact, than on the higher adherence wards. However, no association with the Named Nurse Standard can be made as there was no evidence of the role in the patient records. In addition, there was no patient awareness of the role. In contrast, on the high adherence wards on average the qualified-nurse patient contact was lower, but there was some evidence of the recording of a named nurse in the nursing notes. However, consistent with the low adherence wards there was no patient awareness of the role. The next stage of the study also considered nurse-patient interaction but from a quality of care perspective.

### 6.3 Audit of the Process of Nursing Using Qualpacs

Qualpacs (Wandelt & Ager 1974) were designed so that the results from a small sample of patients will represent the level of quality of care being received by patients in that population. To maintain the congruence of the study, the results of the Qualpacs audit on each ward are presented in the low and high adherence to criteria associated with the Named Nurse Standard categories. These are presented in Table 18 and demonstrate that there is convergence between the scores for the two categories. Both adherence categories have a mean score within the range of three. This corresponds to 'average care' and represents the level of quality being received by patients in each adherence category. If these results are compared to the findings of the non-participant observation (See Table 15 and Table 16), it suggests that patients can receive an acceptable level of care, through a number of different organisational modes.

	High Adherence				Low Adherence			
	T1H		T2H		T1L		T2L	
Patient ID	A	B	C	D	E	F	G	H
Day One	3.30	3.71	2.52	2.98	4.45	4.47	2.40	2.72
Day Two	No contact	2.47	4.52	4.07	*No contact	*4.0	No contact	2.41
Total Mean Score	3.17		3.53		4.31		2.51	
Category Mean Score	3.35 (Average Care = 3)				3.41 (Average Care = 3)			

\* Audit discontinued after one hour of observation

**Table 18: Mean scores for the Quality of Nursing Care Audit for wards with high and low adherence to criteria associated with the Named Nurse Standard**

Comparison of the mean scores of individual patients that contribute to each category mean score show a similar range. On the high adherence wards the range is 2.47 to 4.52 and on the low adherence wards it is 2.40 to 4.47. This corresponds to 'between poorest care and average care' to 'between average care and best care'. However, the distribution of scores

is different. In the low adherence wards the scores are clustered in scores of 2 or 4. These clusters also reflect the wards in which the sampling took place. On T1L the scores are all in the '4' banding. In contrast on T2L all the scores are in the 2 range. However, in the high adherence wards there is a wider distribution of scores between the 2, 3, and 4 bandings. Although there are limitations on the interpretation of these findings, the results for T2H appear to suggest there was a difference in the level of nursing care received by patients over two days.

It is interesting to compare these scores with the results of the non-participant observation. The findings shows that T2H was using a number of bank staff to supplement the staffing levels because of vacancies and staff sickness. In addition, it was the only ward in which an unqualified nurse provided the continuity of care for the observed patient. It might be assumed that the quality of patient care delivered might be affected if staff are unfamiliar with the environment. Nevertheless, the findings show that the category scores are similar, as is the range of scores. However, the distribution of scores particularly in the low adherence category are related to individual wards

There are two other factors that should be considered in relation to the validity of these results. The first is that T2H was the only ward in which a complete data set of four patients was collected. This was because for two patients, one on T1L and one on T2L, there was no nurse-patient contact in the observed period. The pattern of nurse-patient interaction, then periods of no contact, was also noted in the pilot for this study and it was accepted that this might occur when observing patients. However, on T1L the data set was incomplete because the observation session was discontinued after one hour, at the request of the nurse in charge of the ward for that shift. As a consequence on T1L there were incomplete data associated with one patient, and no data for the other patient. However, the data gathered

for Patient F on Day Two were scored and this score was used, with the score for day one, to generate the low adherence category mean score. If the score is excluded from the data the low adherence category mean score remains in the average care range of 3 but changes from 3.41 to 3.29. However, excluding four patients still gives a large enough sample to generate a category mean score for both high and low adherence categories.

Inter-rater reliability is the other factor that has to be considered when interpreting the results in this aspect of the study. As has been noted in Chapter 5 (See 5.4.1 and 5.11.3) Qualpacs was chosen for this study because it has been shown to have high construct validity compared to other similar tools (Redfern et al 1994, Norman and Redfern 1995). However, the face validity of the raw data (See Appendix 14) suggests there may not have been inter-rater agreement on what constituted an interaction. This can be illustrated by Patient Two on T2L (See Appendix 14) who was rated on eight occasions by data collector one (See 1.2.1) and on 32 occasions by data collector two (See 1.2.2). Another possible explanation for this variation is the assiduousness of the data collectors.

Several authors have noted the importance of ensuring data collectors are trained to use Qualpacs (Wandelt and Ager 1974, Carr-Hill et al 1992, Redfern et al 1994). As part of the preparation for the present study the data collectors were prepared, and undertook supervised fieldwork to ensure they were familiar with using the tool (See 5.11.3). However, comparison of the findings from Trust Two, where the first data were collected, with the results from the audit in Trust One suggests that inter-rater agreement increased as the study progressed. This makes conclusions from these results tentative and this has been considered when interpreting the findings. Indeed the validity of these results could be questioned if undertaking a quality process alone. However, these findings have been used to compare and contrast with the results of the non-participant observation, and the audit of



nursing notes to contribute to the whole study.

The results presented here have focused on observing nurse-patient activity to identify whether the organisation of nursing care on the sample wards, was consistent with criteria associated with the Named Nurse Standard. The results have been generated from data gathered by audit of documents and observation of patients. The next two sections will present the perceptions of the key players associated with the Named Nurse Standard. That is the nurses, ward managers and patients.

#### **6.4 Semi-Structured Interviews of Ward Managers and Qualified Nurses**

This section considers the results of the interviews with qualified nurses on the four sample wards. The purpose of the semi-structured interviews was to get a rich picture of the organisation of nursing work on each ward, from the perspective of qualified nurses. Following the naturalistic design of the study quotations from informants are presented to illustrate the themes that emerged from the data, which gives the emic perspective of the participants as they describe their world. The quotations are presented with the 'ers' and 'ums' deleted from the text. In each of the themes the quotations are presented within the two categories of high adherence and low adherence to criteria associated with the Named Nurse Standard.

##### ***6.4.1 Trying to Meet the Named Nurse Standard***

The first theme reflects the attempt to change the organisational method on each ward to meet the Named Nurse Standard. At the time of this fieldwork the Patient's Charter (DOH 1991, DOH 1995) had been in place for eight years. The document had been reviewed once and was being reviewed again. As has been shown the notion of Charter Standards was well established as part of the management policy (DOH 1994b). However, although the informants acknowledged the requirement that the Standard should be implemented, they

describe how the ward staff tried to change work practices but were constrained by a lack of resources.

### ***High Adherence Wards***

'...I don't actually do named nurse... with the shifts and the acute patients the named nurse was just not working... we tried to do it but there wasn't continuity so we did team nursing ...the girls that have done it, couldn't see, neither could tell me how they saw that we could get it to work on here...when it had worked, they tended to be on the smaller wards with different types of patients'. T1H Ward Manager

'...we did try...but sometimes the priority is to get things done...all the patients are coming in... we are doing everything we do for patient safety. It might be good to do the named nurse but it is just meeting the patient's needs because that is what they want...'. T1H Staff Nurse

'...with the named nurse... maybe you wouldn't be able to take it all on and that's maybe where the team work comes a bit better because you're working between... maybe two, three qualified nurses plus a nurse in charge of the whole ward...you can spread the stuff around, where if you are a named nurse ...you've got to try and get it done.' T1H Staff Nurse

'... when the named nurse first came out it would get silly because we used to write on the headboard, you used to have the patient's name and their consultant and their named nurse and you'd come back to work after a fortnight's holiday to find you are a named nurse for Mr. Jones, who you have never set eyes on before...to be honest we haven't really paid much attention to it' T2H Staff Nurse

'... we did try...we put a named nurse on the patient's headboard when they were first admitted, as the nurse that admitted them and into the admission paperwork, but we found that, maybe, that nurse would go off duty for a couple of days... or the patient would be moved and so their named nurse wasn't with them. So we stopped doing it' T2H Junior Sister

These informants on the high adherence wards give a number of reasons for the failure to fully implement the Named Nurse Standard. They describe how recording the admitting nurse as the named nurse in the patient records, and on the patient's bed headboard, was initially successful. However, the pattern of shifts worked by nursing staff and the short length of patient stay meant that allocation of a named nurse to a patient became more ad hoc. As a consequence nurses were allocated as the named nurse to patients in their

absence, and thereby undermining the principle of continuity of care associated with the Charter Standard. In addition the informants could not identify a clear link between organising nursing work to meet the Named Nurse Standard and patient safety. They perceived that the demands on the named nurse were too high, and that a team approach would enable a fairer distribution of the workload.

### ***Low Adherence Wards***

‘... we have not strictly kept to the rules of it... I am not saying that it is not a helpful concept, but I feel that in the current climate of vacancies, sickness, we have adapted our way of managing the ward to, to the current staffing and, perhaps the ward is run more as a complete team than as a named nurse’. T1L Ward Manager

‘... [the patients] came to us because we were the only empty beds at the time and now they are moving to a whole different ward and....I don’t think is particularly brilliant for the patients, they don’t know where they are, especially if they are a bit elderly, and sometimes it seems to me they get shifted a bit unnecessarily but there you go’. T1L Staff Nurse

‘we should be aiming for continuity...it sounds good in theory but I don’t think in practice it works, due to staffing constraints and staffing levels and the fact that we are trying to get people into the job so we give people a life outside work, taking part-timers in, so we can’t do everything can we? T2L Junior Sister

‘...every patient who comes in has a named nurse allocated to them but it is very difficult especially on a surgical ward with a fast turnover to keep that named nurse with that patient...quite often the patient comes in on the morning of the operation and then goes home the following day, so it is quite difficult to follow that patient through with the same nurse... ’. T2L Ward Manager

On the low adherence wards the informants report a similar picture of high throughput of patients and the configuration of staff working patterns, impeding adherence to the Named Nurse Standard. They suggest that trying to accommodate part-time working and managing vacancies meant having to adapt the way that the nursing work was organised. On T1L this was managed by organising the ward as one team. In contrast, on T2L the ward manager reported that each patient was allocated a named nurse, but the short patient stay made it

difficult to maintain the desired level of continuity of care. One of the informants on T1L considered the negative impact on the patient experience of being moved within, and between wards, to accommodate emergency admissions. There is a sense of powerlessness in this response. Although the informant acknowledged that moving patients could have a detrimental effect on patients, particularly the older person, it was viewed as a necessary practice to manage the demand on beds.

These comments show the consistent view held by all informants was that the Named Nurse Standard was not being met in the ward in which they work. There was acknowledgement that they had attempted to implement the Charter Standard, but that it was not successful. This was attributed to three main organisational factors. These were the fast throughput of patients, the increasing demand on in-patient beds, and the shortage of nursing staff. The two managers in the high adherence category, which might be expected to be achieving many of the named nurse criteria, are explicit that it was no longer done. However, it is the ward manager of T2L, a low adherence ward, who indicates that every patient admitted to the ward is allocated a named nurse. Nevertheless, this perception is at variance with the findings from other aspects of the study. These are the audit of the nursing notes, and the non-participant observation, both of which showed that there was no named nurse recorded on any of the nursing notes on T2L. In addition, the patient perception was that there was no specific nurse responsible for their care.

However, an area of agreement across the adherence categories was the effect of the organisational constraints in preventing achievement of the continuity of care, associated with the named nurse role. The staffing levels are perceived by the majority of the informants to be a particular problem because of the changes in shift patterns and part-time working. The solution identified by staff in both adherence categories was to organise the

staff into teams to serve a number of purposes. For a staff nurse on T1H, a high adherence ward, the purpose is to 'spread the load'. This supports the perception that the workload, particularly documentation, had increased. However, a colleague on the same ward is more specific, describing the aim to be to 'get the work done', and this aim is driven by the need for patient safety. Suggesting that the decision to have team nursing as an organisational mode was pragmatic to complete the nursing work, and not attributed to an ideology. This is consistent with the decision-making process on the low adherence wards. Staff on both wards acknowledge that the continuity of care associated with the named nurse concept is better for the patient. However, it was perceived by the junior sister on T2L as a theoretical concept that did not work in practice.

The issue of moving patients within the ward is referred to by staff, in both adherence categories, as one of the reasons why the named nurse concept was not successfully implemented. The team nursing approach used on all the wards is associated with geographical locations. Therefore, if the patient is moved from that location they automatically become the responsibility of the other team. This perception is interesting because it suggests that there was no provision for staff to care for patients outside of the boundaries of the team. Furthermore, it would appear there was no system of delegation of care beyond managing patient care within the skill-mix. Delegation is one of the cornerstones of the Named Nurse Standard that enables continuity of care to be maintained.

This theme focused on the organisational issues associated with implementing the Named Nurse Standard and the following conclusions can be drawn. The Named Nurse Standard was not being fully met in any of the wards in the two adherence categories. In addition, organisational constraints, such as staffing levels and rapid patient throughout, were perceived to have impeded the continuity of care associated with the Named Nurse

Standard. Finally, the chosen method of organising nursing work on each ward was team nursing, which is a mode compatible with implementing the Charter Standard. It is worth noting that the majority of the informants did not express an opinion on the named nurse role. However, the next theme explores the informants' perceptions of the underlying principles of the Named Nurse Standard.

#### ***6.4.2 In An Ideal World***

Emerging from this second theme is the nursing perspective on one of the research questions for this study. That is 'What are the implications of the Named Nurse Standard for the organisation of nursing work?' The first theme demonstrated that the initial attempts at implementing the Charter Standard were impeded by organisational constraints. However, in this theme the informants considered how the named nurse role might be implemented if the organisational constraints were removed. Two sub-categories emerged from this theme. These were 'The Named Nurse Role' and 'Who Can Be A Named Nurse?'.  
  
**The Named Nurse Role**

In this sub-category the informants demonstrate their awareness of the characteristics associated with the named nurse role. In addition, there is reference to the attributes that a post holder should have.

#### ***High Adherence Wards***

'They are the link for the patient, they can be an advocate, someone a patient knows and are responsible for the whole of their stay, they take things on for the patient and do them. They do the assessment and the care plan and see them during their stay'. T1H Staff Nurse

They would individually plan the care and... if you were looking after that patient for your named nurse you would liaise before changes were made to the care that they had planned'. T1H Ward Manager

'To me they would take them from admission through discharge and through the journey they are with us ...Taking care of them'. T2H Junior Sister

'They are somebody for the patient to be familiar to... who they can ask for advice and who they should know that they can speak to and who should be up to date with the care, and the general sort of well-being, of either the relative or the patient themselves'. T2H Staff Nurse

The first informant from the high adherence wards considers the overall role of a named nurse as acting with, and acting for, a patient during their hospital stay. In addition, the named nurse is described as a co-ordinator of care, and a point of contact for patient and relatives. This is described by another informant in terms of assisting a patient along the pathway or journey through the hospital experience. Finally, there is recognition that other team members have to refer to the named nurse if they wish to change a particular patient's plan of care.

### ***Low Adherence Wards***

'I think a named nurse should be somebody who is approachable... because patients see so many different nurses...but if they can focus on somebody ...people have a name that they can remember...if there is something they want to discuss or talk about'. T1L Staff Nurse

'In an ideal world it would be lovely if the named nurse admitted the patient and was around on the day of the operation and was around to discharge the patient...'. T2L Ward Manager

'... the named nurse is a person that the patient and relatives can locate to ask any questions from, it just gives them a focus... to speak up on behalf of the patient with the doctors and help them with the empowerment of their own care, guide their care along and liaise with the other members of the team that are looking after them'. T2L Staff Nurse

'... the patient should be allocated a named nurse who they can refer to through out their hospital stay...they will know the name of that nurse and, then an associate nurse also when that nurse is not on duty, ... the named nurse would admit the patient, explain things to them and be an advocate for them, and would be responsible for their smooth running of their hospital stay and their discharge plans as well. T2L Junior Sister

The informants' perceptions of the named nurse role are similar on the low adherence wards. The nurses identify the named nurse as an advocate, and co-ordinator of care liaising with the multidisciplinary team on behalf of the patient. One of the informants, a staff nurse on T1L, recognised the value to the patient of having one nurse amongst the nursing staff that could be approached for information. Furthermore, there is reference to the named nurse being available at the key points in the patient journey. That is admission and discharge.

These responses indicate that all the informants had an awareness of the named nurse role and many of the associated responsibilities. These responsibilities included planning a patient's care from admission to discharge, being an advocate, and co-ordinating care with the multidisciplinary team. In addition, delegation of responsibility in the absence of the named nurse was acknowledged. Although this is expressed as 'liaising' by a staff nurse on T1H, the junior sister on T2L argues that there should be an 'associate nurse' clearly identified to the patient. However, it is interesting that none of the nurses use the term 'accountability' or 'professional role'. It could be that the informants were focusing on the operational aspects of the role, or it might be related to the wording of the Named Nurse Standard in the Patient's Charter (DOH 1991, DOH 1995), which refers to 'responsibility'.

Several nurses refer to attributes associated with the role. A staff nurse on T2H suggests that patients and carers needed someone on the ward with whom they were 'familiar' to act as link and information-giver. Similarly, a staff nurse on T1L suggests the named nurse should be 'approachable' so the patient knows one nurse from whom they can seek advice. This comment acknowledges that a patient will come into contact with a number of nurses during their stay. This is an interesting comment because the results of the non-participant observation indicate that T1L had the highest number of nurses in contact with one patient.



It has been shown that the informants in both adherence categories had a similar level of knowledge of the requirements of the named nurse role. These requirements included accountability for care, and providing continuity of care for a patient. However, as will be considered in the following sub-category, there were some difference in opinion concerning who could be a named nurse.

### **Who Can Be A Named Nurse?**

Although there is some debate about whether a first and second level nurse could be a named nurse, the Named Nurse Standard specifies that it should be a qualified nurse (DOH 1991). The following two examples, one from each adherence category, reflect the majority view that a named nurse should be a registered nurse:

#### ***High Adherence Wards***

'...the named nurse... would have been somebody that was trained and that would admit the patients ... they need to be able to plan and evaluate their care so they need to be a registered nurse... I don't think you could possibly put one of the HCAs [Health Care Assistant] as a named nurse because she couldn't make any nursing care decisions for the patients'. T2H Junior Sister

#### ***Low Adherence Wards***

'I think it would have to be a staff nurse, who would be the named nurse in the first instance and I think the Health Care [Assistant] would be the associate nurse as, as I understand it, but I might be wrong'. T1L Staff Nurse

The informants' rationale for a named nurse being qualified is that they are the decision-makers regarding a patient's plan of care, and that this responsibility could not be undertaken by an unqualified nurse. However, in the second example reference is made to a Health Care Assistant (HCA) adopting the role of associate nurse. This is perceived to be a member of the team to whom the named nurse can delegate responsibility in their absence. This perception is commensurate with the principles of the Named Nurse Standard statutory professional requirements because the named nurse would retain accountability for the

patient's care. In contrast two informants suggest that HCAs could take on the role of named nurse.

### ***Low Adherence Wards***

'...anybody can be a named nurse on a shift... I rate our Health Care [Assistants] very highly, if anything they probably have the most to do with the patients on a day to day basis and.... are more skilled at actually chatting to patients... I don't see anything wrong with them becoming named nurses because if anything they are more skilled and adept at getting little bits of information and I think the patients would confide in them more...'. T1L Staff Nurse

'... the most important thing from the patient's point of view is probably consistency not level of nurse... so I don't see why a Health Care Assistant couldn't be a named nurse...obviously that person wouldn't be able to do everything for that patient... patients get to know the Health Care Assistants probably better than anybody else which is why I wonder whether it might not be an idea, ....it's probably an unusual one but I think it may work'. T2L Ward Manager

These views challenge the principle of the Named Nurse Standard that is; a qualified nurse exercises their accountability through managing a patient's care from admission to discharge. This enables the patient to work in partnership in care with the named nurse because they have the professional knowledge, skill and attributes to facilitate decision-making. Both respondents suggest that a HCA might have more inter-personal contact with patients, and therefore be the one in whom the patient most readily confides. However, the findings from the non-participant observation on both of the wards challenge this assertion (See Tables 15 and 16). The results for T1L show that Patient 10 had no contact with an unqualified nurse, and for Patient 9 it was less than 10% of the total time. The evidence from T2L differs slightly. Although it demonstrates that for Patient 1 all contact was with qualified nurses, for Patient 2 over half the nurse-patient contact time was with an unqualified nurse. However, Nurse 604 is a student nurse and therefore the actual patient-HCA contact is 5% of the total time.

It is noted that both these informants were from wards with a low adherence to criteria associated with the Named Nurse Standard, and these perceptions would be commensurate with the characteristics of that category. However, these views contrast with the majority of informants in the low adherence category. The ward manager on T2L seems to be 'thinking aloud' ideas about how the demands of the Named Nurse Standard might be met, if a HCA was given the role of a named nurse to a specific patient.

The comments presented in this theme indicate that all the informants perceived the named nurse role as somehow different to the role they undertake at present. Therefore, it is reasonable to conclude that the impact of implementing the role would be that some, or all, aspects of the organisation of nursing work would have to change. However, there is dissonance in this perception because the Named Nurse Standard has been implemented, as part of government policy, in all NHS trusts since 1992. It is apparent from the informants' comments that either the Standard is not being implemented, or if it is then not all the criteria are being adhered to. Nevertheless, many of the roles attributed to the named nurse role by the informants reflect much of their current nursing work, for example, planning individualised care. This suggests there might be impediments to implementing the named nurse role into the sample wards. These could include organisational constraints, such as staffing levels, but another impediment may be the willingness or desire of qualified nurses to take on the role. None of the respondents suggested they did not want to be a named nurse, but neither did they express a willingness to take on the role. The informants may not have been explicit about wishing to assume the role because they perceived it was axiomatic. This perspective will be explored again in the theme of 'Accountability for Care'. In the following theme consideration will be given to how the informants perceive their current organisational mode.

### **6.4.3 Organising Nursing Work**

One of the criteria associated with the Named Nurse Standard was the organisational method required to implement it. This theme presents the informants' perceptions of their current organisational method in three sub-categories. These are 'Division of Nursing Work', 'Patient Allocation', and 'Managing the Ward'.

#### **Division of Nursing Work**

Each of wards had a permanent establishment of qualified and unqualified staff. Bank nurses were used to supplement the team and pre-registration students of nursing, supernumerary to the ward establishment, were allocated to the wards for between six and 12 weeks. All the wards were divided into a number of single side-rooms and small bays of upwards of four patients. The wards were all mixed-sex and admitted emergency and elective patients.

The following quotations present the informants' perceptions of the organisational methods of wards in the high and low adherence to criteria associated with the Named Nurse Standard categories.

#### **High Adherence Wards**

'The off-duty is split... So there is a trained, a minimum of one trained on for each end for roughly 16 patients each end...with the staffing we have got I think it is the safest option that we have got at the moment...because we are relatively short...I don't think you can be more innovative because if there is just not enough of us here... I think sometimes the status quo is safe'. T1H Ward Manager

'At the end of the four weeks... more often than not you're rotated... so if you were the female end, next month you'll work down the male end...you more or less stay in the same team... sometimes due to sickness and things like that you may work different ends in the same month to cover...'. T1H Staff Nurse

'We have a workboard and the nurses are divided into those teams... we do try and keep to those teams but obviously that doesn't always work out if people have been off sick, ... we try and have continuity of care so if you have been there one day you are more likely to get the same team the next

day. Before we did the long shifts if you were on the late shifts you were virtually guaranteed to have the same team the next day... it helped in the continuity of care'. T2H Staff Nurse

'... if somebody has been at an end, like last night or yesterday then they will work with the same patients again, if it is feasible... it's continuity really and, trying to split the grades so there is two Ds and two Es in each team. It doesn't always work we haven't got the staff or the hours...'. T2H Junior Sister

On the high adherence wards the informants describe how the complement of ward staff is divided into two teams, and each team always includes at least one qualified nurse. These teams correspond with the division of the ward into two 'ends'. Although the aim is for the nurses to work within those designated teams, it is accepted that changes might be made to accommodate staff sickness. On T1H the teams rotate between the two ends on a monthly basis to balance the workload. On the other high adherence ward (T2H) a workboard is used to record which nurses are in the teams for each shift. The aim of the approach was to provide continuity of care but, as the staff nurse on T2H acknowledged, it had proved more difficult because the work pattern of many nurses had changed. This meant that many staff were working three 12-hour shifts per week instead of five, seven and a half hour days. However, there was general agreement that, irrespective of the number of shifts worked, the usual practice was for nurses to work in the same team, and therefore with the same patients on a shift-to-shift basis.

### ***Low Adherence Wards***

'I decided... to see how we could best fulfil the criteria of the named nurse and we found that due to the way we run the ward with the off-duty... we decided that we would introduce it in such a way that the nurses would look after the set of patients, from one set of days off through to the next...so it was done on the shift basis to keep the same patients, cared for by the same nurses, for as many spans of duties as we could' T1L Ward Manager

'You get allocated an end and [the nurse in charge] will try to keep you there several days running so that you have got continuity so I think that does work out quite well up there...so you have seen those same patients and they have seen you'. T1L Staff Nurse

'We work in teams, we have three teams, when we have got enough staff and those teams tend to look after the same patients all the time and depending on sickness and annual leave and things sometimes it is a bit more difficult but generally it works OK'. T2L Ward Manager

'... we tend to stay in the same team for three months and then we all move around....so everybody has a turn with the high dependency patients and everybody gets a break at the other end of the ward.... that may change depending on the dependency of patients...[with] an experienced E grade nurse leading each team and then basically share out [the staff] I have got ...'. T2L Junior Sister

These examples illustrate how the nurses on the low adherence wards decided how they would organise nursing work to meet the criteria of the Named Nurse Standard. The ward manager on T1L reports that the team approach was based on maintaining the same group of nurses, caring for the same patients, for as many days as possible. In contrast, on T2L the three teams of nurses work together for three months before being reassigned. This informant also gives details of how each team is led by an experienced 'E' grade nurse.

The high adherence wards function in similar ways with two teams of nurses relating to specific and set geographical areas of the ward. These areas are referred to by the informants as 'ends', which usually correspond to the division of male and female patients. The duty rota for nursing staff is planned to reflect these 'ends'. Therefore the staff are informed in advance which end of the ward they will be working. However, on T1H there was a set system of rotation of staff from one end of the ward to the other, on a monthly basis.

The principle underpinning the identification of these teams was achieving a skill-mix of qualified and unqualified staff that would provide continuity of care for patients. Nevertheless, the day-to-day allocation of staff was perceived to be driven by patient safety. Therefore if there was staff sickness some team members might have to be moved to enable a reasonable skill-mix for each group of patients. However, because some staff worked

three 12 hour shifts per week on T2H the skill-mix was maintained, but it was perceived to disrupt the continuity of care. The results of the non-participant observation in this study are consistent with these comments (See Table 15). The findings show that T2H was the only ward in the sample that had to supplement the ward team with bank staff. Interpretation of team nursing used on the high adherence wards is consistent with organising staff to enable continuity of care. However, this has to be compatible with how patients are allocated to the care of the team. This will be considered in the sub-category 'Patient Allocation'.

Organisation of nursing staff on the low adherence wards into geographically based teams was consistent with the methods used on the high adherence wards. Nevertheless, there were some differences, for example, T2L was the only ward where staff were divided into three teams. However, T2L and T1H had a similar system of rotating staff periodically between the two ends of the ward. In other aspects of organising staff there was agreement between the wards in the two categories including, for example, the aim for stability in the team of nurses caring for a specific group of patients. It is reasonable to conclude from these findings that all the wards had a method of organising nursing work that, in principle, would enable the criteria associated with the Named Nurse Standard to be met. The next factor to be considered is the allocation of patients to the teams of nurses.

### **Patient Allocation**

Patients are normally admitted to the sample wards either as an elective patient, which would mean that they are admitted directly from home into a ward, or as an emergency. If a patient was admitted as an emergency they might receive care in another department and then be admitted to a ward. Therefore it might be a number of hours or longer, before a patient is admitted to the designated surgical ward. In the following quotations staff describe how they manage the admission of both groups of patients.

### ***High Adherence Wards***

'...[they are admitted] where the bed is because the ends are male and female so therefore the team is either male or female... we move the poorly patients but it is all within the ends...'. T1H Ward Manager

'...on the day of surgery they would be prepared, go off to theatre in their bed and ... if they were going to come back and they're quite a poorly person, we would move them to an appropriate bay and move whoever wasn't as poorly in the bay down to their space and we would just do the bed moving....' T1H Staff Nurse

'At the moment we tend to look at the surgery that they are having, depending on the type of surgery depicts really where they go on the ward, if they are having surgery that requires bowel prep.... we tend to give them a cubicle with a toilet'. T2H Junior Sister

On the high adherence wards the decision concerning where a patient was to be located was based on the gender and dependency of the patient. Both of these wards were divided into male patient and female patient areas. On admission a vacant bed is identified for the patient in the appropriate area of the ward. However, if a patient requires immediate care they are assigned to a bed near to the nurses station so they can be closely observed. As a consequence, patients are frequently moved from bed station to bed station within the ward. The staff nurse on T1H acknowledges that this is a frequent occurrence for patients returning from the operating theatre. Maintaining the privacy and dignity of patients are considered relevant by the junior sister on T2H because of the type of surgery some have to undergo.

### ***Low Adherence Wards***

'Well it is mostly allocated because one end of the ward is male and the other is female... however we have got six side-rooms [we] allocate patients who were having bowel resections so that they have the facility to toilet for their bowel preparation or in a sidearm with a commode if we could not provide them with one with a toilet'. T1L Ward Manager

'... so when the patients have all gone to theatre we look in centre bay to see which one of them is the least ill of all and swap them over... so there is a great movement of beds so they are closer to the nurses station to keep a closer eye on them... then as they improve you can gradually move them



back up the ward a bit and move down the sicker ones again...' T1L Staff Nurse

'...whichever bed that's available unless it is somebody who is highly dependent, in which case they'll be placed in beds that are nearer the nurses station, which is easier for observation, we have two rooms where we keep the more highly dependent patients, but it will be where there is a bed available for them or unless we need to nurse in a cubicle for whatever reason' T2L Junior Sister

On the low adherence wards the same criteria were used to decide where patients would be located. These were gender specific areas of the ward, privacy for patients being prepared for bowel surgery, and moving the acutely ill patients to beds which could be directly observed.

There was agreement by all informants that the main criteria used to decide where a patient would be physically located in the ward were dependency and gender. For example, those patients who were assessed as needing high levels of nursing care immediately on admission were situated as near as possible to the nurses station. On one of the high adherence wards, T1H, a staff nurse acknowledged that as a consequence other patients in the ward might have to be moved. There is an effort to meet the individual needs of patients, as illustrated by the allocation of patients having bowel surgery to a sideroom with a toilet. However, there is a pragmatic acceptance by all informants that patients have to be moved to different locations in the ward, to meet the demands for beds.

Gender is the other main criteria used by all informants to decide the location of the patient bed. On all the wards the bays are designated single-sex and there was agreement across the categories that these should be maintained as such. This issue generated some comment from the informants as illustrated by the following quotations:

### ***High Adherence Wards***

'Sister doesn't like mixing centre bay but, recently, we haven't had a lot of

choice, we've had poorly patients that really need to be in centre bay ... but you can't always justify it, what with having to meet all the standards for privacy and dignity... 'T1H Staff Nurse

### *Low Adherence Wards*

'No, we don't mix the bays...the odd time it's happened when the bed managers have asked us to put a patient in a, say a female patient in a male bed who is going to theatre, to come back to a female bed when the patient's gone home, but no I wouldn't do it personally'. T2L Junior Sister

'...we have... a ward policy where we try not to mix bays, it's a bit of a contention really because in the past you have been, not bullied so much, but it's 'Oh is there any chance you can do anything?', we do try not to' T1L Staff Nurse

Only three informants mentioned the issue of mixing the sexes in a bay within the ward. The first informant was a staff nurse on T1H, a high adherence ward, who acknowledged that the ward manager did not like mixing the sexes in the higher dependency bay. However, the staff nurse described incidents where this approach had been set aside. On those occasions if patients of different sexes needed the type of high dependency care then that bay would be designated mixed sex. In contrast, on the low adherence wards the informants report how decisions to mix the sexes in a bay in a ward were influenced by managers external to the ward. The junior sister on T2L described this as a short-term solution to a bed shortage. However, the second example from the low adherence wards shows a staff nurse feeling pressured by managers to mix the sexes in the bay.

There is a Patient's Charter Standard (DOH 1991, DOH 1995), that is noted by the staff nurse on T1H, concerning single sex wards. However, it seems generally accepted that nurses may judge that a patient requires nursing in a certain location, and then mixing the sexes in a ward might have to occur. However, as is illustrated by the last two quotations, there is the perception that a management imperative to use resources more effectively might be used to override these professional decisions.

These comments indicate that the decision about where to locate a patient in a ward is not associated with ensuring their care is delivered by a named nurse, or their deputy. The criteria that are used do respect the privacy and dignity of the patient, and ensure they are nursed in an appropriate location. However, there is no mention of 'matching' a nurse to a patient to enable continuity of care. Although the patients are allocated to a team led by a qualified nurse, there is no suggestion that the team leader was associated with the named nurse role. These findings are significant for this study because the principle of the Named Nurse Standard is that the named nurse is responsible from admission to discharge. This cannot be possible with the described system of allocation unless the named nurse is identified with the team. Although it was not referred to by any of the informants this may be considered in the theme associated with accountability. However, these findings show that criteria associated with the Named Nurse Standard were not used, by any of the informants within the two adherence categories, to decide where to allocate patients in the ward setting.

### **Managing the Ward**

The final sub-category in the theme 'Organising Nursing Work' is 'Managing the Ward'. Each of the four wards has a ward manager or senior sister/charge nurse who has 24 hour accountability for the ward. Their lines of accountability in the organisation are to a senior nurse in the surgical unit. Although wards in both adherence categories used a team approach to organising nursing care there was a different management approach in each ward. This is illustrated by the following quotations.

#### ***High Adherence Wards***

'The ward is divided into two teams... there is a team leader for each of the ends of the ward, then there is a nurse in charge' T1H Staff Nurse

'We have one nurse in charge and they usually go round and do, like, the ward rounds with doctors and deal with the 'adminny-type' bits, like the discharges and all the different people that need practice nurses, district nurses and all that. They usually deal with all that and then pass any changes from the ward round to the nurses at either end'. T1H Staff Nurse

'... [the co-ordinator will] do the rounds and... normally, the leaders of each team will do the drugs... the co-ordinator role should be like overseeing and seeing if there is people are not coping... not doing discharges properly. It's my job to oversee them and if I am in a team I can't do that and that's the reason for our co-ordinator role'. T2H Junior Sister

'Yes we do have a co-ordinator. It is usually the most senior nurse on for that shift'. T2H Staff Nurse

The informants on the high adherence wards describe hierarchical management structures with clearly defined roles and responsibilities. On T1H it is reported that the nursing staff are divided into two teams, with a leader for each team, and a nurse in overall charge of the ward. The nurse in charge is responsible for liaising with the multidisciplinary team and related administration. The informants from T2H describe a similar management structure and set of responsibilities. However, although the nurse in charge of the ward on T2H is the most senior nurse on duty, they are referred to as the co-ordinator.

### *Low Adherence Wards*

'[I used to] be in charge of the whole ward but soon found it was better to actually have a concept of what was going on in the whole ward but work as a team leader for one area...because one criticism that we have from other departments is, when they phone the ward and try to speak to the person who is looking after a patient, if that ...nurse is off the ward then nobody knew what was going on and so ...in the morning everybody has [a report] about all thirty patients...'. T1L Ward Manager

'I was helping the girls on the male end, as well as dealing with the management issues that came up... we wanted beds and we had to transfer patients to another ward that didn't belong to us... by the time you liaised with various others it's a bit impossible to do that and be working on your end at the same time'. T1L Staff Nurse

'We don't have an overall co-ordinator... however if I am in charge I tend to have a fairly good idea about what is going on in the ward really so that they can generally ask me and I'll know'. T2L Ward Manager

'...whichever nurse is looking after whichever team looks after the discharges, the drugs, the admissions, everything for that team. There's an overall person who is in charge as it were, it's like it's me today if there were to be a major incident, or, or anything untoward were to happen ...'. T2L Junior Sister

'...during the shift, it's just the three teams and there is nobody above the three teams'. T2L Staff Nurse

On the low adherence wards two differing systems of managing the ward emerge. On T1L the ward manager describes how the combined role of nurse in charge and team leader evolved from an original plan for two teams, and no nurse in charge. It was changed because other departments in the hospital complained about communication. The concern was that some queries about patients had to be deferred until the nurse caring for that patient was available to supply the information. Therefore, on T1L the nurses on each shift receive a progress report on all patients, and not just those in their care. However, as the staff nurse on T1L notes, it is difficult to balance the demands of being in charge of the ward with working in a team. In contrast, on T2L the informants indicate that the ward staff are divided into three teams and there is no nurse in charge. Each team works as a semi-autonomous unit managing their workload within the staffing resources available. However, although there is a nominal nurse in charge in the event of a major incident, the ward manager still retains an overview of all the patients on the ward.

On the high adherence wards informants describe a hierarchical structure to manage the ward. The clearest expression of this is the description from the two staff nurses on T1H of two team leaders, and a nurse in charge doing the ward rounds and administration. The structure on T2H is also hierarchical, but the most senior nurse on duty takes on a role as a co-ordinator of the ward whose function is to oversee and support staff. Neither of these roles are combined with being a team leader.

In contrast, on T1L one of the low adherence wards, the nurse in charge role was combined with working in the team. Both the staff nurses describe how difficult they found it to balance the competing demands of the two roles. On T2L there is no hierarchical role structure, as the staff nurse comments 'there are three teams and nobody above'. However, there is still a senior nurse designated to be in charge in the event of a major incident. Although the approach exemplifies the flattened hierarchy associated with team nursing, the ward manager retains the traditional role of the ward sister knowing everything occurring on the ward.

In the flattened hierarchy of T2L the team leader assumes an enhanced level of organisational responsibility for managing the care of patients allocated to the team. However, there is one aspect of the team leader role, on this and all the other wards, where the boundary between the team leader and the nurse in charge or co-ordinator is not clear. This is participating in the ward round with the medical staff as illustrated in the following comments:

### ***High Adherence Wards***

'...if and when we have got enough staff then the team leaders try to [go on the ward round] but it is the nurse in charge... who then reports back to the team after a ward round and gives a quick update of what the changes are'  
.T1H Ward Manager

'The nurse in charge, they go around with the doctors and the physiotherapists, it is the nurse in charge who does the round'. T1H Staff Nurse

'That's normally goes down to the co-ordinator's role because they generally do the ward rounds... and normally one of their roles after they have done the ward round is they give any new information to the entire team that morning, but generally they will then go off and arrange things that need to happen with other members of the team....'. T2H Staff Nurse

Both informants on T1H agree that the nurse in charge of the ward for a shift participates in the ward round, and then reports back to the team. However, it is accepted practice that the

team leaders also accompany the nurse in charge, if staffing levels permit. On the other high adherence ward the informants perceive that liaison with the medical staff is the responsibility of the co-ordinator of the ward.

### *Low Adherence Wards*

‘The person who is head of the team tends to speak directly to the doctors about their patients, that might be in the form of a ward round, going round with that consultant or registrar’. T1L Ward Manager

‘...The doctors still like to see Sister on the ward round... the trained nurse in each team would go on the ward round when it comes to her patients unless they’re tied up. Often I will go [as most senior nurse on duty] around the whole ward whatever with the consultant’. T2L Junior Sister

On the low adherence wards the team leaders are expected to participate in the ward round to discuss the care of the patients for whom they are responsible. However, the junior sister on T2L acknowledges that the medical staff prefer to have the ward sister and the team leaders participating in the ward round.

On the high adherence wards the nurse in charge assumes a traditional role of participating in the ward round and reporting back to the team leader. There is an expectation on T1H that the team leaders will participate in the ward rounds if sufficient staff are available. However, on T2H the ward rounds are perceived to be part of the co-ordinator role. This role includes responsibility for reporting back to the teams and initiating action arising from the decisions made on the ward round. In contrast, on the low adherence wards the team leaders are expected to participate in the ward round. However, the junior sister on T2L acknowledges that medical staff hold the traditional view that the ward sister participates in the ward round. Nevertheless, in terms of the criteria associated with the Named Nurse Standard, it is the organisational method on low adherence wards that appears to be more fully supporting the concept of co-ordination of care.

In this theme a rich picture of the methods of organising nursing work on the wards in the low adherence and high adherence categories has been presented. It has been shown that wards in both adherence categories had organisational methods in place that would facilitate achievement of the Named Nurse Standard. In contrast, the allocation of newly admitted patients to locations on all wards appeared not to be informed by the criteria associated with the Charter Standard. Finally, there was a difference between the two adherence categories in the development of the team leader role. It has been shown, the team leader role on the low adherence wards more readily support the Named Nurse Standard criteria of co-ordination of care.

The final theme emerging from the data is 'Accountability for Care'. As a professional nurse all practitioners are accountable for their practice. However, this theme accountability will be considered in relation to the criteria associated with the Named Nurse Standard.

#### ***6.4.4 Accountability for Nursing Care***

Accountability for the care of a patient, from admission to discharge, is at the centre of the Named Nurse Standard. This theme will be considered in three sub-categories. These are 'Planning Nursing Care', 'Keeping the Records Straight' and 'Professional Accountability'.

#### **Planning Nursing Care**

The patient documentation for each NHS trust varies slightly but all record biographical details, admission and discharge information, and a plan of care. Both trusts used pre-printed care plans that describe standardised nursing care for relevant conditions, for example, pre-operative care of a patient undergoing abdominal surgery. A pre-printed care plan is used by the nurse responsible for admitting the patient as a basis for planning care, and it is individualised to reflect patient need. This is the 'initial assessment' of patient need and forms the basis for care planning throughout the patient stay, and for discharge. In



addition in Trust Two there was a system of pre-operative assessment of patients undergoing elective surgery in an outpatient clinic. These clinics were a response to the increasing demand for inpatient beds. The patient stay was shortened by completion of necessary preoperative tests as an outpatient approximately a week before admission. These included some preliminary nursing notes, relevant blood tests, X-rays, and a set of vital sign recordings. The following quotations describe admission of a patient to the sample wards:

### ***High Adherence Wards***

'Whatever qualified nurse is free down that end...if both nurses are tied up down that end... then the nurse in charge of the ward overall would admit for them...'. T1H Staff Nurse

'... any of the trained nurses that were within that team, whoever is available at the time. If there are two trained nurses in the team and one is busy doing something the other one will go off and do the admission. I mean even sometimes the co-ordinator will do an admission, if they are both tied up ,and she or he will go and do it'. T2H Staff Nurse

The staff nurse from T1H indicates that the initial assessment of a patient's needs is undertaken by any of the nurses in the relevant team who are available to do so. However, if all the qualified nurses are fully occupied then the nurse in charge assumes responsibility for the assessment. There is a similar process described by the informant from T2H with the co-ordinator completing the patient's assessment in the absence of the team members.

### ***Low Adherence Wards***

'...It will be the nurse who is in charge of that end of the ward, the team leader [will complete the initial assessment] '. T1L Ward Manager

'.... the staff nurse who is running the end will admit the patient and therefore do the initial assessment and write all that in their care plan'. T1L Staff Nurse

'...it can vary from a staff nurse to a student nurse.... unfortunately there is nobody in particular who is allocated [to admit patients] ...our students are very competent... and provided it is OK with the patient, they'll complete

the admission with them... we go through the admission after and check to countersign it and see if it needs be'. T1L Staff Nurse

'The trained nurse in charge of that team on that shift [would do the initial assessment]'. T2L Staff Nurse

'...when anybody comes to us regardless of whether they have come to us from pre-assessment or whatever we always go through the paperwork, put our own care plans in and ...making a plan of care for the patient...it would be a qualified nurse or possibly a student nurse if they are working with a qualified nurse under supervision and, it would be whichever nurse is looking after that team, whichever patient that team is allocated in to'. T2L Junior Sister

There is some disagreement between the informants on T1L regarding which nurse is responsible for the assessment of a newly admitted patient, and completion of a plan of care. Although two of the staff agree that it is the team leader, the third informant indicates that no specific nurse is identified as responsible. This informant suggests that it can be any of the qualified staff, or even a student of nursing under supervision. However, it is acknowledged that the permission of the patient would be sought if a student nurse was going to be involved with the assessment.

These comments indicate that, in the high adherence category, the admission and completion of the nursing documentation is the responsibility of a qualified nurse within the relevant team. However, the perception is that no designated nurse is identified to undertake the role. Informants refer to 'anyone who is free' (T1H staff nurse) and 'any of the trained nurses' (T2H staff nurse). In contrast, on the low adherence wards the majority of respondents considered the nurse in charge of the team, for that day, as responsible for the initial assessment of a patient. However, there are differing views within T1L, as one of the staff nurses perceived that there were no qualified nurses designated as responsible for the initial assessment of patients.

The approach described by informants on the high adherence wards is a pragmatic, team

approach. The team functions by members supporting each other and 'spreading the load' of responsibilities. However, on the low adherence wards the role is focused on the team leader and reflects one of the attributes of planning care associated the Named Nurse Standard. Nevertheless, there is no suggestion that the team leader is then specifically responsible for that patient's care. On the contrary, it appears that subsequent care will be based on the care plan but responsibility for the patient will be shared between the team, based on the initial care plan. The findings show the initial assessment of the patient on the low adherence wards is perceived to rest with an individual nurse, but this is not associated with continuing responsibility.

### **Keeping the Records Straight**

As an outcome of the launch of the Patient's Charter all NHS trusts were required to provide information on the implementation of the Charter Standards. To comply with this requirement each of the trusts studied had a Director of Nursing who had agreed a process for data collection on the implementation of the Named Nurse Standard. However, as this qualitative feedback indicates, there were a variety of perceptions of the requirements for record-keeping.

### ***High Adherence Wards***

'On the [patient] profile it has got 'admitting nurse' on the front but nowhere that I have noticed is there anywhere I need to put myself on [as named nurse] the only place that I've put mine is as admitting nurse'. T1H Staff Nurse

'... it has got who the admitting nurse is [on the patient care plan] it does not say 'named nurse', ...it also has space for the Team Leader/Named Nurse on patient profile'. T1H Ward Manager

'We don't here [record the named nurse] there is space for the team that they are in but not for the named nurse'. T2H Staff Nurse

'... [the named nurse] is not filled in now it used to be...but sometimes the nurse who admits them puts it in, not the pre assessment clinic nurses, the

nurses on the ward'. T2H Junior Sister

The first two examples in this group are the perceptions of record-keeping from informants on T1H. They describe the requirement to record their name on the patient's notes as the nurse who admitted them to the ward. In addition, the informants note that although there is not a specific section entitled 'named nurse', there is space to record 'team leader/named nurse'. There is some disagreement between the informants on the other high adherence ward concerning the various sections on the patient documentation. The staff nurse indicates there is no section to record the named nurse. However, the junior sister suggests there is a named nurse section on the patient notes. She continues that although it is usually not completed, occasionally the nurse who admits the patients records their name in the named nurse section.

### *Low Adherence Wards*

'...on the front of the Trust document there is a place to say, 'admitting nurse' and that could be called the named nurse'. T1L Ward Manager

'...on the front of the profile there is a thing on the bottom that says 'named nurse' now I always fill it in, only because the way that I fill it in is as the nurse-in-charge of that shift at the time of admission ...but otherwise nine times out of ten it will be a blank space so you don't know who the named nurse is...'. T1L Staff Nurse

'...what I do if I am admitting a person is I'll put myself down because I am the first person that has seen them [the patient], but a lot of people forget to do that so that it just gets missed from what I noticed... I would say that more often it's not done'. T2L Ward Manager

' It is written down on the headboard of the patient just under the patient's name along with the name of the consultant... any one writes that down. If they come from another ward whoever is in charge of that team on that shift will get put as the named nurse or they'll just think, sometimes it is the auxiliaries, who will just pick a name'. T2L Staff Nurse.

'On the admission form it does say named nurse and I have to say that I don't always fill it in as I don't feel it is fair to fill it on somebody else's behalf, because sometimes you can come along and find someone has put your name as named nurse when you didn't even know that you were or you

may only be there for one shift and then maybe on holiday for two weeks...if I'm looking after a patient and I'm on for a stretch of duty I just put my name on their name board on the bed and I will go and introduce myself to the patient...' .T2L Junior Sister

On the low adherence there are also a variety of perceptions regarding record-keeping. The first informant is from the same NHS trust as the informants on T1H, and is referring to generic documentation. This informant is suggesting that the section in the patient notes for recording the admitting nurse could be synonymous with the named nurse. However, the second informant from T1L perceives there is a section to record the named nurse, and has set informal rules on when it should be completed. These are the named nurse is the nurse in charge of the ward at the time the patient is admitted, as distinct from the nurse who admits the patient. However, as this informant acknowledges these are personal rules and other nurses do not complete the named nurse section on the patient documentation.

The quotations from the second low adherence ward, T2L, illustrate the variety of perceptions about recording the named nurse. The first example is from the ward manager and confirms that, although the nurse admitting a patient should be recorded as the named nurse, the section is seldom completed. In contrast, the staff nurse from T2L suggests that the named nurse is recorded on the patient's bed headboard, together with the name of the relevant medical consultant. In addition, this informant perceives there was no one person designated to allocate a named nurse to a patient. Therefore, it is sometimes the team leader's name that is recorded, or it may be a random selection of a qualified nurse's name. The final viewpoint on record-keeping on T2L is from the junior sister and this shows a mixed picture of compliance. The informant confirms that the named nurse section is not usually completed, but suggests that the role is still allocated to staff sometimes, even in their absence. The preferred approach for this informant is to record the name of the nurse caring for the patient on their bed headboard, and ensure that the patient is aware of who

that nurse is.

Examination of the responses demonstrates there is difference in perceptions of record-keeping across and within the adherence categories. This can be illustrated across the categories by the apparent differing terms associated with the patient record. All the informants on T1H, and the ward manager on T1L, refer to a section entitled 'admitting nurse', which is always signed by the nurse who completes the initial assessment of the patient. In addition, both ward managers note the different terminology used. The ward manager of T1L suggests that 'admitting nurse' could be interpreted as 'named nurse', and the ward manager of T1L notes there is a section on the patient record entitled 'team leader/named nurse'. From this complex picture it can be assumed that in Trust One the 'admitting nurse' section on the patient record is always completed. Furthermore, there is a section entitled team leader/named nurse that is not normally completed. Comparison of these findings with the audit of the nursing notes show consistency in the recording of the 'admitting nurse' section, and non-completion of the named nurse section (See 6.2). At variance with this is the staff nurse on T1L who had developed 'informal rules' concerning completion of the 'team leader/named nurse section'. These rules were based on recording who was in charge of the ward at the time a patient was admitted. However, this appears to be an anomaly relating to one nurse rather than the normal practice of record-keeping.

There is a contrasting picture from Trust Two. On the high adherence ward, T2H, the commonly held perception is that the named nurse section used to be filled in, but now is no longer completed. However, the junior sister notes that there are occasions when staff do record a named nurse on the patient notes. Unfortunately, there are no details of specific criteria for doing this. The perception is supported by the evidence of the audit of nursing notes, which found that over three-quarters of the patient records on T2H had a named

nurse recorded. Another mixed picture is illustrated by the perceptions of informants on T2L. Although the ward manager and junior sister perceive that the nurse who admits the patient will be recorded as the named nurse, they also acknowledge that it is not always done. They acknowledge that staff other than the admitting nurse may be identified as the named nurse, but be unaware of this until they read patient notes or see their name on a patient headboard.

Although it can be concluded that the recording of a named nurse, as such, was not common practice in any of the wards sampled all the other requirements for record-keeping were complied with. Furthermore, on the occasions when a named nurse was recorded it was associated with individual decision-making rather than adhering to a particular process. When these perceptions are compared with the informants' views identified in the preceding themes, it is reasonable to assume that the named nurse role as such, was not fully implemented in any of the wards sampled.

### **Professional Accountability**

Accountability underpins the role of the qualified nurse and assuming the role of named nurse enhances the responsibility of this professional role. This is because the named nurse is identified, by name, as the practitioner responsible for a patient's care from admission to discharge. In this final sub-category of the theme the informants' perceptions of how the introduction of the Named Nurse Standard affected their accountability, as a registered practitioner, are presented. The quotations from the informants have been grouped into three perspectives, within the two adherence categories, to reflect the different interpretations of accountability emerging from the data. The three perspectives are identified by an introductory sentence and considered together at the end of the section. The first perspective is that the introduction of the Named Nurse Standard made some

informants more aware of their accountability as registered nurses.

### ***High Adherence Wards***

'I think it made you more aware of your accountability when you were admitting a patient, when you are documenting things and your name was there on everything. I also feel that it was putting pressure on you because if you were the named nurse and somebody else wrote something in after, I always felt.... I didn't order that ...I think you were a little bit wary'. T2H Junior Sister

The informant indicates that the Named Nurse Standard raised their awareness of the professional requirement for record-keeping. However, there is also acknowledgement that there was apprehension regarding the level of responsibility involved in the role. This was related to other team members amending the plan of care prescribed by the named nurse.

### ***Low Adherence Wards***

'I think to an extent nurses are already being made more aware of our accountability...I think especially now with the Patient's Charter, because people are more aware of their rights, what their entitlements are, and want answers to questions...I think that it's made us more aware and it keeps us a bit on our toes, it keeps us more updated and I don't think it is a bad thing at all'. T1L Staff Nurse

'... I think it makes people more aware and with the documentation and things, reporting of incidents and or of anything untoward or conversations with patients... I think it has improved our awareness of accountability certainly'. T2L Junior Sister

The first informant is acknowledging that the impact of the Patient's Charter has meant that patients have an increased awareness of their entitlements, and expect answers to queries regarding treatment and care. The staff nurse perceives this has required nurses to keep up to date with their practice. The second informant from the low adherence wards supports the view, but suggests that increased awareness of accountability has been manifested through more attention to documentation and record-keeping.



The second perspective shows the concern about the purpose behind the introduction of the named nurse role. In particular these informants express concern about the lack of choice about whether or not to be a named nurse.

### *High Adherence Wards*

'... it makes it easier on paper to tell [that] this person was the named nurse... it puts more emphasis on you to get the job done, because if you don't you are easier to pick out for what you are doing. Although if you are the named nurse and the off-duty is not checked first, then you have to document why you haven't got it done, that way at least you are covering yourself ...if mistakes are made and your name is down as the named nurse you could end up finding yourself accountable for something you weren't even there for'. T1H Staff Nurse

This informant expresses concern that an audit of patient records would identify a particular nurse as responsible for an individual patient's care. Therefore, it was perceived as increasing pressure on individual practitioners to identify which care had been planned by the named nurse, and what was the responsibility of other nurses.

### *Low Adherence Wards*

'I think it makes that one person more accountable for what goes on with the care of the person that they are named nurse for and in a way I think that's quite a lot for that one person, because I have found I've been on days off and I'll come back and I'll be someone's named nurse and not met them and I've got to be accountable for the care that they have had, yet I have not given them any of that care'. T2L Staff Nurse

'I think people were a little bit frightened of it initially but people have accepted it more now and I have seen people change and become more, be more aware of their accountability and much more likely to document things... in decision-making and information-giving, so in that respect I think it has got to be a good thing'. T2L Junior Sister

The staff nurse from T2L reports on the occasions when the named nurse role has been allocated when they were off-duty for a number of days. On returning to duty the practitioner becomes accountable for patient care that other nurses have prescribed and delivered. The informant perceives this to be an almost unacceptable level of responsibility

for a qualified nurse. In contrast the second informant, a junior sister, acknowledges that initially the Named Nurse Standard increased the anxiety of nurses concerning the impact on their accountability. However, this informant suggests there has been a positive effect as nurses have enhanced their decision-making and record-keeping skills.

In contrast, the perspective of some informants was that their professional accountability was unaffected by the introduction of the Named Nurse Standard.

### ***High Adherence Wards***

‘...if I’ve discharged somebody and I’ve not done it properly then on my head be it... so whether it is the named nurse or not, whoever has taken responsibility to discharge that patient it’s their accountability for that, for what they have done or what they haven’t done’. T2H Junior Sister

‘...we are accountable for the care and the practice that we give, regardless of whether we are the named nurse for that patient or not, you are just accountable for your own practice. T1H Ward Manager

Both these informants perceive themselves accountable for their own practice irrespective of the enhanced responsibility associated with the named nurse role. The junior sister from T2H uses the example of discharging a patient to illustrate the point concerning accountability. This is, if an error were made in the discharge plan then the nurse who was given responsibility for that aspect of care would be accountable. The view is endorsed by the ward manager from T1H.

### ***Low Adherence***

‘...whether you are the named nurse or not, you are accountable for any care you give to any patient. You might feel more accountable if you kept strictly to... the actual concept of the named nurse. I personally feel accountable to all my patients and the care that is given to them... on my ward ... and I think the most senior nurse in charge of the ward on any shift feels likewise’. T1L Ward Manager

The ward manager from one of the low adherence wards (T1L) offers a slightly different

perspective which demonstrates an understanding of the enhanced responsibility associated with the named nurse role. This informant indicates awareness of their own professional accountability for practice, and for all the junior staff on the ward. However, there is also acknowledgement that adherence to the criteria associated with the Named Nurse Standard would increase responsibility for individual nurses taking on the role.

The two issues for the informants who were 'more aware' and 'concerned' appear to be related to two criteria associated with the named nurse role. These were that practitioners could be identified as the named nurse who has continuing responsibility for a patient from admission to discharge. The staff nurse perceived this would make it easier to blame an individual named nurse for poor performance. The junior sisters on T2H and T2L have a slightly different perspective on the same theme of individual responsibility. They focus on the need for clear documentation to enable discrimination between the named nurse's plan of care, and any subsequent updating by other nurses. However, the staff nurse on T2L was concerned at becoming accountable, in their absence, for care planned by another nurse. In contrast, the staff nurse on T1L felt a heightened awareness of accountability because patients were more cognisant of their rights.

Although there are a number of negative outcomes attributed to the implementation of the Named Nurse Standard, some of the informants are more positive about the resulting heightened awareness of accountability. This can be illustrated by the perception of the junior sister on T2L that it had raised awareness in documentation, decision-making and information giving. However, one group of informants perceived there had been no change to their professional accountability following the implementation. This was because these informants accepted that each nurse was accountable for their own practice as a qualified nurse. It is not unsurprising to note that the informants who made these comments are all

senior nurses in their respective wards. Two are ward managers on T1H and T1L and the other is a junior sister on T2H.

Comparison of the informants' different perceptions regarding the impact of the Named Nurse Standard on accountability, across and within the two adherence categories, has been considered. These included concerns regarding the motive behind 'naming' a nurse, heightened awareness regarding responsibility for documentation, and the possible impact on accountability. Although there is no emerging trend that can be directly attributed to a ward or adherence category, it is apparent that senior ward nurses perceive the Charter Standard will have no impact on their accountability.

This section has presented the results of the semi-structured interviews in a narrative of quotations from informants to give a rich picture of their perceptions. Four themes emerged from the data and these were 'Trying to Meet the Named Nurse Standard', 'In an Ideal World', 'Organising Nursing Work' and 'Accountability for Care'. Each theme was explored across and within the high adherence to criteria associated with the Named Nurse Standard wards, and low adherence wards identified for this study. The results have been compared and contrasted with other findings in the study, and the following conclusions have been drawn.

There was agreement on practices and views between the adherence categories in a number of areas. These included the system of organising nursing work, allocation of newly admitted patients, awareness of the requirements of the named nurse role, and the perception that the criteria associated with the Named Nurse Standard were not being fully met. However, there were differences in the management structure of the wards, planning care and the boundaries of the team leader role. In addition there was diversity within and across the adherence categories in perceptions of record-keeping, the impact of the Named

## Nurse Standard on accountability, and the awareness of who could be a named nurse

The first area of agreement was the perception that the Named Nurse Standard was not being fully met because of organisational constraints. These constraints included the rapid throughput of patients, the increasing demand for hospital beds, and staffing issues related to working patterns. All these issues were perceived to impede organising the ward to enable continuity of care for patient through the named nurse concept.

The method of organising work in all the wards was team nursing. This finding was consistent with the literature that identified team nursing as one of the organisational methods that would facilitate the achievement of the Named Nurse Standard. In addition, there was agreement across the adherence categories on the criteria for the allocation of newly admitted patients. However, this was not compatible with Charter Standard as the patients were allocated to care of a team of nurses, and not to an identified named nurse.

Although there were similar systems being used on all the wards to identify staff to care for newly admitted patients, this method was not compatible with criteria associated with the Named Nurse Standard. The system of allocation by gender and dependency meant patients were allocated to a team of nurses rather than to an individual nurse. This approach would not be compatible with the criteria associated with the Named Nurse Standard.

There was also consistency across the adherence categories in the informants' knowledge of the requirements of the named nurse role. These include accountability for care and the emphasis on providing continuity of care for a patient.

One of the areas of difference between the categories was the management structure of the ward. On the high adherence wards a hierarchical structure was in place with a nurse in charge who organised and managed the ward on a day-to-day basis. However, within the

low adherence category there was further diversity. On one of the wards there was a hierarchical structure with a nurse in charge who also assumed a team role. In contrast, on the other low adherence ward there was a flattened hierarchy with team leaders on a day-to-day basis, and a nominal nurse in charge to manage major incidents.

The impact of the management structure on the boundaries of the team leader role also illustrates the differences between the adherence categories. The participation of nursing staff in ward rounds with medical staff exemplifies the diversity of approaches. On the high adherence wards the nurse in charge assumed a traditional role of participating in the ward round and reporting back. In contrast, on the low adherence wards the team leaders are expected to participate in the ward round. In terms of the criteria associated with the Named Nurse Standard, it is the organisational method on low adherence wards that appears to be more fully supporting the concept of co-ordination of care.

The final area of difference between the categories is also associated with the team leader role. This is the initial planning and assessment of patient care. On the low adherence wards there was general agreement that the team leader was responsible for the initial assessment and planning of patient care. In contrast, on the high adherence wards the admission and completion of the nursing documentation were perceived to be the responsibility of any qualified nurse in the team. The approach to planning care on the low adherence wards reflects one of the attributes of planning care associated the Named Nurse Standard. However, there is no evidence that this approach meets the Charter Standard requirement for continuing and specific responsibility for that patient's care for the duration of their stay

Although there was some difference in perceptions concerning record-keeping, across and within the adherence categories, there was agreement that it was not common practice to record a named nurse, as such, on the patient record. This appeared to be associated with

the different terms used in each trust to identify nursing roles and responsibilities. However, it was concluded that the named nurse role, as such, was not fully implemented in wards in both adherence categories.

Another issue about which there were contrasting views not associated with the wards or adherence categories, was the perception of who could be a named nurse. There was general agreement that it must be a qualified nurse. However, two informants suggested that Health Care Assistants could adopt the role because of the level of contact they had with the patients. However, this approach would not meet the criteria required by the Named Nurse Standard that the named nurse is a qualified practitioner.

Finally there was diversity in perceptions associated with the impact of Named Nurse Standard on accountability. These included concerns regarding the motive behind 'naming' a nurse, heightened awareness regarding responsibility for documentation, and the perception that it would have no impact on accountability. There is no apparent attribution of these perceptions to a ward setting or adherence category. However, the senior ward nurses are the group who perceive the lack of impact on accountability.

The results presented in this chapter have considered the organisation of nursing work and the quality of nursing care. The following section will present the findings from the patient perspective. This will include patient knowledge of the nurse responsible for their care and satisfaction with that care.

## 6.5 Patient Perceptions of the Named Nurse

The final stage of this study was to explore the patient perception of their hospital stay in relation to the nurse responsible for their care. The results of a survey of patient perception using the NSNS (Thomas et al 1996a) will be presented to identify whether the identification of the named nurse was associated with the length of the patient stay, age of patient, or satisfaction with nursing care. Quantitative and qualitative data will be presented to provide a rich picture of the patient experience. The results will be compared, and contrasted to determine whether there was any difference between the perceptions of patients who were cared for in wards with high adherence to criteria associated with the Named Nurse Standard, and those in wards with low adherence.

### 6.5.1 Demographic Details

There was a nearly 90% response rate to the postal questionnaire and this gave a sample size of 35 patients in each adherence category. Demographic data on gender and age were collected and Table 19 shows the distribution of the sexes across the high and low adherence categories.

Gender	Adherence		Total
	High	Low	
Female	16 (46%)	24 (69%)	40 (57%)
Male	19 (54%)	11 (31%)	30 (43%)
Total	35	35	70

**Table 19: Gender of respondents by wards with high and low adherence to criteria associated with the Named Nurse Standard**

All the wards in the sample were mixed-sex so it is to be expected that there would be a distribution of male and female patients. However, it is interesting that only a third of respondents ( $n=11$ ) in the low adherence category were male compared to over a half in the



high adherence category (n=19). Although it could be assumed that this was related to the type of surgery in each ward, the sample wards were selected because the surgery performed was not gender specific. However, these wards were organised as mixed sex wards, and having a higher level of one gender might influence the patient experience and their perceptions of care.

There is a contrast in the patient age distribution between the two adherence categories. The mean age of patients in the high adherence category was 64 years, with a range of 38 to 90 years. However, the mean age was lower on the low adherence wards at 53 years, with a range of 21 to 86 years. In Table 20 patient ages are presented in three categories, and demonstrates more clearly the differences between the two adherence categories.

Age	Adherence		Total
	High	Low	
18 – 39	1 (3%)	8 (23%)	9 (13%)
40 – 64	13 (37%)	9 (26%)	22 (31%)
65 – 99	21 (60%)	18 (51%)	39 (56%)
<b>Total</b>	<b>35 (50%)</b>	<b>35 (50%)</b>	<b>70</b>

Chi square = 6.40 Degrees of Freedom = 2 p value = 04071156

**Table 20: Age categories of respondents by wards with high and low adherence to criteria associated with the Named Nurse Standard**

On the low adherence wards over half the patients (n=18) are over 65 years, but there is a more consistent distribution between the two lower age bands. In contrast, on the high adherence wards the distribution is skewed to the older age band with nearly two thirds of patients (n=21) aged 65 years or over. The age range that is poorly represented in the high adherence category is the younger age group of 18 to 39 years, with less than 5% (n=1) of the sample. However, the over representation in the older age group in the total sample is

consistent with the national picture of an ageing population, and the age range of patients in hospital care. It is the high adherence wards that more clearly reflect this picture of the older patient in hospital.

The third aspect of the demographic data that is relevant to consider is the length of patient stay, as it is associated with the continuity of patient care. The mean length of stay on the low adherence wards is seven days with a range of 1 to 35 days. The high adherence category has a higher mean of 13 days and a range of 1 to 42 days. To demonstrate the rate of patient throughput in the wards the results are categorised into four categories of length of stay as presented in Table 21.

Length of stay (nights)	Adherence		Total
	High	Low	
1 – 4	17 (49%)	11 (31%)	28 (40%)
5 – 7	11 (31%)	10 (29%)	21 (30%)
8 – 14	5 (14%)	12 (34%)	17 (24%)
> 15	2 (6%)	2 (6%)	4 (6%)
<b>Total</b>	<b>35 (50%)</b>	<b>35 (50%)</b>	<b>70</b>

Chi square = 4.22    Degrees of freedom = 3    p value = 0.2390961

**Table 21: Length of stay of respondents by wards with high and low adherence to criteria associated with the Named Nurse Standard**

These results demonstrate that on the high adherence wards there is a patient stay of 1 to 4 days for nearly a half of respondents (n=17). In contrast, on the low adherence wards one third of patients (n=11) were in the shorter stay category. The other interesting result in the lower adherence category is that one third of patients (n=12) are in the 8 to 14 day category. This result differs from the high adherence category, but also is at variance with the perception that surgical wards have shorter patient stay than other hospital specialities.

In addition, it contrasts with the results of the semi-structured interviews in this study. Those results showed the perception of the nurses in wards in both adherence categories was that rapid patient throughput had, in part, constrained the full implementation of the Named Nurse Standard. However, the results of this aspect of the study show that, for over two-thirds of the patients in the low adherence category (n=24), and half of the patients in the high adherence category (n=18), their hospital stay was 5 days or longer. This would suggest that there was sufficient time to facilitate continuity of care, and for a patient to identify if there was a specific nurse responsible for their care.

The results relating to the length of patient stay, were cross-tabulated with the findings of the over 65-age group to identify whether there was an association between age, and experiences of hospital stay. The older age group was selected because they represented the largest age group in this study, and because of the association with longer patient stay.

Length of stay (nights)	Adherence		Total
	High	Low	
1 – 4	10 (48%)	5 (28%)	15 (39%)
5 – 7	7 (33%)	4 (22%)	11 (28%)
8 – 14	3 (14%)	8 (44%)	11 (28%)
> 15	1 (5%)	1 (5%)	2 (5%)
<b>Total</b>	<b>21 (54%)</b>	<b>18 (46%)</b>	<b>39</b>

**Table 22: Length of stay of respondents for the age category 65 – 99 years by wards with high and low adherence to criteria associated with the Named Nurse Standard**

As the results in Table 22 demonstrate, on the high adherence wards nearly half the patients (n=10), in the 65 and over age group had a short patient stay of 1 to 4 days. In contrast, on the low adherence ward only a quarter of the patients (n=5), are in the shorter stay category and nearly a half (n=9), are staying for 8 days or more. It can be concluded from these

results that, although the high adherence wards have more patients from the older patients, that nearly half of these are short stay patients. This contrasts with the older patient group on the low adherence ward who tend to stay longer.

These demographic data present a contrasting picture between the two adherence categories in all aspects. The high adherence wards have a nearly equal mix of male and female patients, an older patient profile but a shorter patient stay. In contrast, in the low adherence wards nearly three-quarters of the patients are female, there is a wider age range of patients, and the patients tend to stay longer. Having illustrated the patient profile of the low adherence and high adherence wards in this study, the next section will consider the results of the patients' experience of the named nurse role.

#### **6.5.2 Patient Experience of the Named Nurse**

This section will present the results of the patients' perceptions of whether a named nurse was responsible for their care during their stay. The results presented in Table 23 are patient responses to the question of whether they perceived a specific nurse was responsible for their care, during their recent hospital stay. The responses are categorised into 'yes', 'not sure', and 'no'.

Named Nurse	Adherence		Total
	High	Low	
No	17 (49%)	19 (54%)	36 (52%)
Not sure	15 (43%)	11 (32%)	26 (37%)
Yes	3 (8%)	5 (14%)	8 (11%)
Total	35	35	70

Degrees of freedom = 2

p value 0.54158900

**Table 23: Patient perception of named nurse in charge of care by wards with high and low adherence to criteria associated with the Named Nurse Standard**

The results demonstrate that just over 10% (n=8) of the total respondents perceived that there was a specific nurse in charge of their care. However, the majority of respondents could not identify a named nurse in charge of their care. Of these over half (n=36) were positive that there was no named nurse managing their care, and one-third (n=26) who were not sure. Although these results appear to demonstrate that there was no named nurse system in place, there are a significant number of patients who are undecided. There could be a number of reasons for respondents selecting 'not sure'. These include the time lapse since the hospital stay and difficulty in understanding the question. However, comparison of these results with the audit of nursing notes, and nurses' perceptions of nursing work, show agreement that the Named Nurse Standard was not fully implemented in the sample wards.

This is an interesting finding for this study as the sampling has shown that two of the wards have a higher adherence to criteria associated with the Named Nurse Standard, than the other two wards. Therefore, congruent with the study, the results from the two adherence categories will be compared to identify whether there is difference or agreement. Comparison of the two adherence categories shows, that 5% (n=2) more patients identified a specific nurse in charge of their care in the low adherence category, than in the high adherence. The difference between the two categories is the same in the 'no' category (n=2). However, in the 'not sure' category there are 11% more patients (n=4) in the high adherence category than in the low adherence category. This ambivalence of respondents could be attributed to the association of a 'specific' nurse in charge of care with the nurse who completed their initial assessment of care. If there were this association it might have been expected that respondents in the low adherence category would be 'unsure'. However, the results of the semi-structured interviews show that the team leader is perceived to have responsibility for planning patient care on admission. Nevertheless, these results show that only a small percentage of patients associate the care they received with a named nurse. The

following section will consider whether patients were satisfied with the care they received.

### 6.5.3 Patient Satisfaction

As part of the measurement of patient satisfaction in this study respondents were asked to rate the nursing care that they received, and the results are presented in Table 24. The first thing to note is that the distribution is skewed to the positive. This is because none of the respondents used the first three points, on the seven-point Likert rating scale, to rate their nursing care. These points were 'dreadful', 'very poor' and 'poor'. In addition, over three-quarters of the patients selected 'very good' and 'excellent' as their responses to the questions. These findings are consistent with the view that patients are reluctant to be critical regarding the nursing care that they receive.

Rating	Adherence		Total
	High	Low	
Fair	3 (9%)	3 (9%)	6 (9%)
Good	7 (20%)	2 (6%)	9 (13%)
Very good	9 (26%)	20 (57%)	29 (41%)
Excellent	16 (46%)	10 (29%)	26 (37%)
<b>Total</b>	<b>35</b>	<b>35</b>	<b>70</b>
<b>Mean score</b>	84.8	84.3	
<b>Std v.</b>	16.8	14.0	

**Table 24: Patient rating of nursing care by wards with high and low adherence to criteria associated with the Named Nurse Standard**

Accepting the limitation associated with measuring patient satisfaction there are some areas of agreement and contrast between the two adherence categories. The standard deviation indicates there is no significant difference between the mean scores for the two categories. In addition, there is consistency in the frequency count at the lower end of the scale, with



less than 10% of respondents (n=3) in each adherence category rating their care 'fair'.

It is the top-end of the scale that demonstrates a differing frequency of response. This can be seen in the distribution between categories of 'very good' and 'excellent'. The overall total for these two categories demonstrates that it is on the low adherence wards that the majority of respondents rated the nursing care they received very highly, compared to the high adherence wards. This is shown in the results of nearly 90% of the patients (n=30) in the low adherence category rating the nursing care 'very good' to excellent', compared to three-quarters (n= 25) in the high adherence category. However, a comparison of the results in each banding of the scale demonstrates a contrasting picture. It shows nearly half of the patients (n=16) on the high adherence wards rate the nursing care they received as 'excellent', compared to less than a third of respondents (n=10) on the low adherence wards.

To attempt to identify whether there was a consistency, between the high rating of nursing care and the overall experience of care, the results of the satisfaction with care were considered. Table 25 presents the results by all respondents, and by those patients who had responded that a named nurse was in charge of their care.

	All respondents		Named Nurse (Yes)	
	High Adherence	Low Adherence	High Adherence	Low Adherence
<b>Number of respondents</b>	35	35	3	5
<b>Mean score</b>	77.0	76.4	72.8	70.5
<b>St. Dev.</b>	19.1	17.0	12.4	27.9

**Table 25: Patient satisfaction by all respondents and by yes to a Named Nurse in charge of care for wards with high and low adherence to criteria associated with the Named Nurse Standard**

The rating of satisfaction is identified through a frequency count of responses. The responses are scored 0 to 100 and a high score is indicative of a high level of satisfaction. The mean score for each adherence category for all respondents is in the high level of satisfaction range. However, the standard deviation (19.1 and 17.0) demonstrates there is no significant difference between the mean scores for the two categories. This means that there is no significant difference in the levels of satisfaction of respondents in the two adherence categories. From these results it is reasonable to conclude that patients were generally positive about their hospital experience. To attempt to identify whether this positive rating was linked to care from a specific nurse the mean satisfaction score for 'yes' to named nurse in charge of care (See Table 25), and rating of nursing care (See Table 24) were generated.

Nurse Rating	Adherence		Total
	High	Low	
Fair	0 (0%)	2 (40%)	2 (20%)
Good	1 (33.3%)	0 (0%)	1 (12%)
Very good	1 (33.3%)	1 (10%)	2 (20%)
Excellent	1 (33.3%)	2 (40%)	3 (38%)
Total	3 (37%)	5 (63%)	8
Mean Score	83.3	76.7	
Std. Dev.	16.7	21.3	

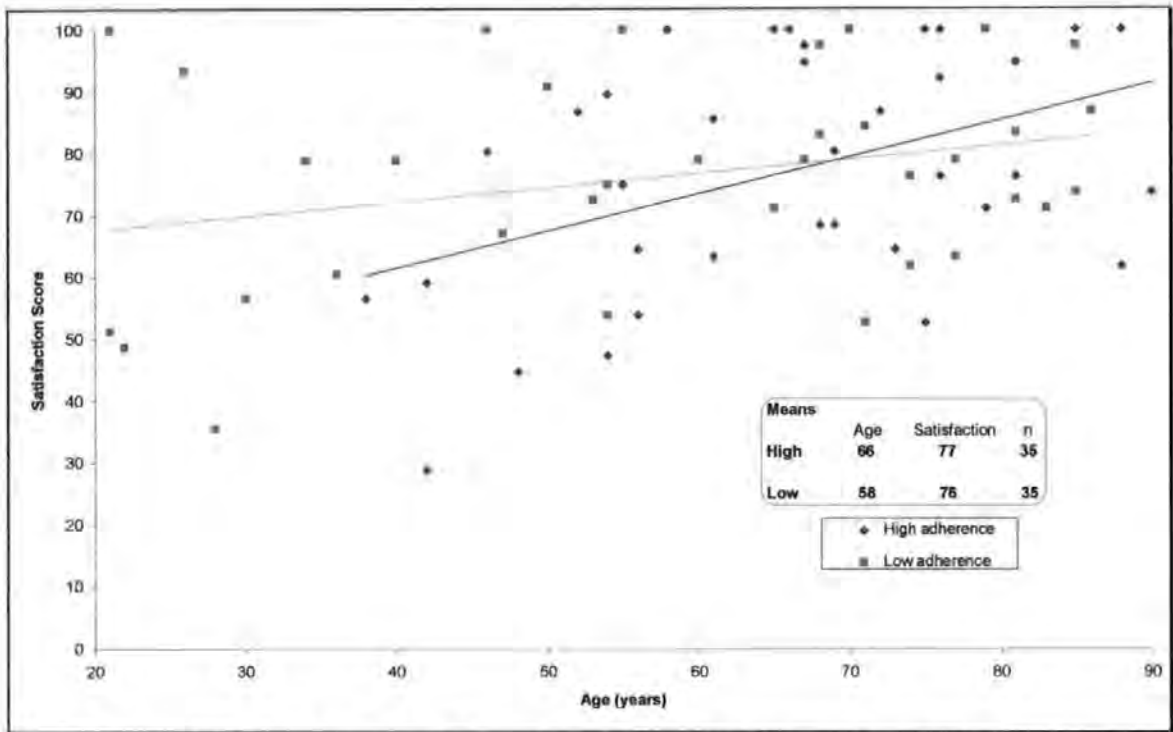
**Table 26: Rating of nursing care for patients responding yes to Named Nurse in charge of care by wards with high and low adherence to criteria associated with the Named Nurse Standard**



Mean scores were generated for the two adherence categories because the small sample limited meaningful comparison of the two adherence categories. The results are presented in Table 26 and show that there is a difference in the mean score of the high adherence wards (83.3), and the low adherence ward (76.7). However, the standard deviation of the scores indicate that this difference is not significant. Both the scores indicate that patients rated their nursing care highly. However, when compared to the results of all respondents (See Table 25), the mean scores are not higher when an identified nurse is in charge of care.

Although the sample size was small the distribution of responses between the two adherence categories shown in Table 26 was considered to be interesting. The results in the low adherence category show two clusters of responses, one in the 'fair' rating, and the other in 'excellent'. Each cluster represents nearly a half of responses (n=2). The distribution of responses in the high adherence category is more even, with no responses in the 'fair' rating, and a third (n=1) in each of the other three categories. Although this distribution pattern is interesting, mean scores have been used to conclude there is no significant difference in the rating of nursing care between the two adherence categories. In addition, the mean scores for the patients with an identified nurse are lower than for all respondents, suggesting that having a named nurse has not increased the rating of nursing care.

There is a similar pattern of a lower mean score for respondents who identified a specific nurse in charge of their care, in terms of patient satisfaction (See Table 25). As has been shown, there is no significant difference in the mean scores for satisfaction between the two adherence categories. However, consistent with the rating of nursing care, the satisfaction mean score is lower in both adherence categories when a specified nurse is in charge of their care. It would seem reasonable to conclude that having an identified nurse in charge of a patient's care does not increase the levels of satisfaction.



**Figure 2: Satisfaction scores with age for wards with high and low adherence to criteria associated with the Named Nurse Standard**

Age was considered as an alternative attribution for the high rating of satisfaction with care. As shown in Table 20, over half the patients in the total sample were 65 years and above, and on the high adherence wards nearly two-thirds of the respondents were in the older age group. Therefore, the results of the satisfaction nursing care scores were cross-tabulated with the results from the age profile. From this cross-tabulation a scatter plot was generated (See Figure 2) to identify any trends between age and satisfaction scores, in the two adherence categories.

The results demonstrate a cluster of older patients on the high adherence wards in the satisfaction score range of 'excellent'. The plotted trend line indicates a greater degree of satisfaction with the nursing care received by older patients on the high adherence wards. In contrast, on the low adherence wards there is a wider distribution but the trend is also that the older patient expresses greater satisfaction.

It seems reasonable to conclude from these results, within the limitations of a small sample size, that no association has been demonstrated between care from a named nurse and higher levels of satisfaction. However, there is a trend for greater levels of satisfaction to be expressed by older patients. It is also noted that there is no significant difference between the adherence categories in the levels of satisfaction and rating of nursing care. Nevertheless, the general trend of patient opinion in the quantitative data in this study was to a high level of satisfaction associated with their nursing care. However, the qualitative data presents more divergent perceptions.

#### ***6.5.4 Patient Comments on Hospital Stay***

There were a number of qualitative comments made by respondents (n=47) of which the majority were positive (n=44). The following comment, from a patient on a high adherence ward, illustrates the majority view:

‘All the nurses are kind and work very hard to put all patients in their care at ease’. T2H Pt.003

This informant’s perception was that the nurses on T2H made every effort to ensure that patients felt comfortable in the hospital environment. However, some respondents made both positive remarks and suggestions about areas for improvement.

Three trends emerge from the patients’ comments. These are ‘the impact of staffing levels’, ‘information-giving’ and ‘the organisation of the ward’. The comments are presented in the two adherence categories. However, comparison is limited because not every patient made comments as part of their response to the questionnaire.

#### **The Impact of Staffing Levels**

The first comments relate to the patient perception of staffing levels. These are seen to be generally inadequate for the level of dependency of patients, and level of throughput of

patients, as follows:

### ***High Adherence Wards***

'Nurses who have had the experience of looking after older patients should be in attendance more often when there are elderly people on the ward. I did get the impression that some of the nurses didn't seem to have much time and care for old people that needed extra care...'. T1H Pt.050

'Sometimes night staff made me wait before emptying my catheter bag which kept me awake but seemed very efficient when there was a real emergency'  
T2H Pt.014

The first respondent refers specifically to the care of the older person suggesting that staff, with experience in that aspect of nursing, should be part of the nursing team. This is because this patient perceives that the nurses did not give the time, or care appropriate to the older patient. Patient 014 suggests that nurses did not always respond promptly to requests for care, citing the occasions when sleep was disturbed waiting for the staff to empty a urinary catheter bag. However, this is balanced by praise for the nurses in their management of emergency situations.

### ***Low Adherence Wards***

'The nurses were excellent and did everything they could to help you to the best of their ability, but they are understaffed and need more help'. T1L Pt 034

'Nurses needed. If nurses had more time the nursing care would be that much better. If there had been a few more nurses there it would have made their and my life better. It was the small things they did not have time to do'.  
T2L Pt.020

'The nursing staff were having to deal with a wide range of patients, including confused elderly patients, which meant they did not always have the time to spend with individuals. In my case my condition was not one that needed constant nursing so I was more than happy with the level of nursing care... On one occasion there was only one fully trained nurse on the ward. Senior nurses had to operate 'crisis management' all the time prioritising patient's needs. More staff would obviously help... especially more experienced staff so that the burden of carrying out more advanced nursing duties could be shared'. T1L Pt.011

These respondents from the low adherence wards expressed concern about the shortage of nurses on the ward. Patient 034 is very positive about the care that nurses give, but notes that extra staffing is needed. This view is supported by Patient 020 who indicates that the shortage of staff required the nurses to prioritise the care they delivered. This meant that small, but significant, aspects of personal care could not be given. The third patient (Patient 011) also refers to the priorities of care, and the particular needs of the confused older patient. This patient is not referring to the care they have received personally, but to what they have observed in the care of other patients. However, this patient also identifies the need for an increase in the number and experience of nurses to meet the complex needs of patients.

The comments regarding staffing levels are consistent with the perceptions of the informants in the interviews of nursing staff (See 6.4.1). These comments related specifically to the implementation of the Named Nurse Standard but can be considered as part of the general picture of the wards. However, respondents are usually 'on the side' of the nursing staff and attempt to justify any deficiency in care received. The perception is that the nurses are doing their best but the staffing levels restrict what they can do. In addition, there is acceptance that the restriction on time and resources mean nurses prioritise care, with the consequence that some patients might have to wait for attention.

Prioritising care generates some criticism from two respondents (Patient 050 and Patient 011) because of the perceived approach to the care of the older patient. It should be noted that two patients represent less than 1% of the total sample (n=70). However, the perception held by Patient 050, that nurses appear not to 'care' about older patients, is a powerful comment. This is because nursing is associated with caring and therefore, not to care for the needs of a particular group of patients challenges the underlying principle of the

profession. In contrast, Patient 020 suggests that increasing staff levels would improve the hospital experience by ensuring that nurses have time to do the 'small things', instead of having to prioritise care.

### **Information Giving**

An aspect of care about which patients expressed more negative comments was information-giving as follows:

#### ***High Adherence Wards***

On the whole, nursing standards were good, but nurses are only allowed to divulge so much information regarding patients. When diagnosis is found and treatment is needed, where elderly patients are concerned, next of kin should be informed either **before** or with the patient, especially in cases where further treatment is needed i.e. chemotherapy...'. T2H Pt.016

'Being able to take a little more time to explain things and be sympathetic to the patient's needs. Patients should not feel bad if they need to ring for a nurse, particularly at night. They should not 'tell patients off' as I was... all because a relative had left a chair by my bed. They need to inform patients more'. T1H Pt.094

Patient 016 indicates that the majority of the care delivered was positive. However, the limitations on the amount of information that a nurse could give were perceived to be inappropriate. In addition, this respondent suggests that more consideration should be given to how, and to whom, information about diagnosis and treatment is given, particularly when dealing with older patients. The second informant is critical about the attitude shown by nurses towards patients when it appears that the rules of the ward have been breached. This patient suggests that nurses should not make patients feel uncomfortable when they request assistance, but be prepared to give more information.

#### ***Low Adherence Wards***

'I found the nursing staff to be pleasant and competent within the limits imposed upon them. For instance a Sister was not permitted to divulge the nature of my operation so that my husband was forced to find a doctor to

discover this. When eventually he found one the information was quite meaningless. I have nothing but praise and admiration for the nursing staff'. T1L 092

'It was also apparent that it often took quite a long time for doctors to come to the ward when nursing staff requested his presence. It does not help the nurse/ patient relationship when she/he has to tell her/his patient waiting for medication that the doctor has not signed off the change and despite being called three hours ago has not yet appeared on the ward'. T1L Pt.011

Respondents expressed the need to be adequately informed and turned to the nurses as the main providers of information. However, they felt frustrated that the nursing role appeared to be limited in that aspect of patient care. This frustration is illustrated by comments from two patients on T1L. These are Patient 011 and Patient 092 who had to wait for a member of the medical staff before they could get the information they wanted. However, the respondents appear to recognise the system and seem to appreciate the extent, and limitations, of the nursing roles.

From a different perspective one of the respondents (Patient 094) looked to nurses for cues on how to behave within the ward setting. This was associated with information-giving regarding the ward etiquette for moving furniture. However, there was also comment about the effect of the nurse's response to a patient's request for assistance. There is a notion of powerlessness about having to ask for assistance that was amplified by the perceived negative response from the nurse. These are interesting comments, albeit from only one respondent, because they are at variance with the principle of the individualised approach to care. However, respondents do also make comment on how changes to organisation of the ward could improved communication and other aspects of care.

### **Organisation of the Ward**

Two respondents offered suggestions about how wards could be organised so that the lines of communication would be clear and more efficient. Both were from low adherence wards

and the first advocates a hierarchical model as follows:

### ***Low Adherence Wards***

'Care should be co-ordinated by one superior person, then all staff nurses take their patient concerns to that one superior person...Care would automatically increase! And then be organised'. T1L Pt.052

This respondent is suggesting that one nurse is designated in overall charge of the ward to whom all queries could be directed. This could be seen as a plea to bring back the traditional role of ward sister but could equally be seen to have resonance with primary nursing, or indeed the named nurse. However, one patient (Patient 020) has their own, forthright views about what should happen to the Named Nurse Standard:

### ***Low Adherence Wards***

'Do away with the named nurse system. I never knew who my 'nurse' was in actual person. Improve name tags, name sewn on uniforms are not easily read. From a patient's point of view it is important to know the names of all nurses dealing with them'. T2L Pt.02

This respondent expresses the view that patients should know all the nurses delivering care, and that this could be achieved by making name badges more legible. However, they also suggest that the named nurse role should be withdrawn because they never knew who their allocated nurse was. The perceptions of these two respondents appear to be that there needed to be a structure to the ward, that was visible with the authority vested in one individual. The comment about T1L from Patient 052 is interesting because, although the ward is organised with a nurse in charge, they also work as a team leader (See 6.4.3). This could explain the patient's perception that no one nurse was in overall charge of the ward.

The response from Patient 042 was the only one in the data set relating to the named nurse role and demonstrates the perception that the named nurse role is a virtual, or token role. Nevertheless, this respondent's comment is consistent with the perceptions of the qualified



nurse respondents in the sub-category 'Keeping the Record Straight (See 6.4.4). In addition, the ward manager of T2L, the ward the respondent is commenting on, acknowledged that the named nurse role was not fully adhered to (See 6.4.1). This was attributed to the fast throughput of patients and variations in staffing levels.

Emerging from the patient responses is the perception that patients want to be able to identify who is responsible, and accountable for the organisation of care. It is reasonable to assume this is because they wish to be adequately informed concerning their care by a nurse who they perceive to have authority. However, this authority is associated with a hierarchical figure in charge of the ward and not necessarily the nurse in charge of care. When these perceptions are considered in terms of the Named Nurse Standard, this small number of respondents appears to want a nurse in charge of the ward and not necessarily a named nurse in charge of care.

Although not directly related to the organisation of care the following response from a patient reflects the priority of someone waiting for admission to a high adherence ward:

'There is a lot of tension caused when you ring up on the morning of your admission to be told to ring later as there isn't a bed at the moment. In my case it happened on three separate occasions, and as it was imperative that I got in each time, I and my wife had to plead my case that I have cancer, and to delay admittance meant that I would not be able to start radiotherapy treatment. Each time we had to phone three or four times and we phoned the consultant's secretary as well. It's bad enough having cancer without having to go through the extra stress of being told there may not be a bed' T2H Pt.014

This patient describes the stress on himself and his wife when admission to hospital was delayed because no appropriate bed was available. This happened on three occasions. As the hospital admission was part of ongoing treatment for cancer the patient felt compelled to make a strong case for a bed to be made available for him. This response illustrates the human face of the statistics regarding the increasing demand on hospital beds. However, it

would appear that it is accepted practice to ask patients to telephone the ward on the morning of admission, to confirm that a bed is available. Field notes for this study recorded this only once, and that was on ward T2H. However, this individual experience might indicate a reason for patients rating their hospital stay positively. It could be that patients are 'grateful' to be admitted for treatment because of the delays that might have occurred previously, and this inhibits them from making negative comments.

As has been noted, the number of responses limits comparison of the perceptions of respondents in the two adherence categories. However, the perception of the majority of respondents was that the nursing staff did not have the time, or resources, to give care to all the patients. Although respondents acknowledged that nurses had to prioritise care delivery, they perceived that this meant that some aspects of patient need were not always fully met. This was noted in particular in the care of the older patient. Other negative comments included the lack of an identified nurse in charge of the ward, and the level of information giving. Although there was one response regarding the named nurse role, it was not positive. This was because the role was not associated with the reality of the patient experience. Nevertheless, the general trend of responses was balancing the negative comments about their hospital experience, with an appreciation of the limitations imposed by organisational constraints. These qualitative comments represent the final aspect of the data collection and a summary of the main points of the study will be considered next.

## **6.6 Summary**

The results from the qualitative and quantitative data collection have been presented in this chapter to provide a rich picture of the participants' world. The aim of the study was to explore the organisational methods on surgical wards in relation to the named nurse role. The wards were categorised into low and high adherence to criteria associated with the

Named Nurse Standard. Using these two categories the results have been compared and contrasted to identify convergent and divergent trends. This was to identify the implications of the Standard for the organisation of nursing work. There were limitations on the interpretation of the results because of the small sample sizes and these have been acknowledged where appropriate. The main findings can be summarised as follows:

There was a greater time and frequency of qualified nurse-patient contact on the low adherence wards than on the high adherence wards.

Continuity of care tended to be provided by one nurse on the high adherence wards, and on the low adherence wards this was by a team of nurses. On the high adherence wards an unqualified nurse was used to provide the continuity of care, contrasting with the low adherence wards where it was by qualified nurses. However, in neither adherence category was the provision of continuity of care associated with the named nurse role.

It was not common practice in the wards, in either of the adherence categories, to record a named nurse as such on patient records, although all other documentation was completed.

There was consistency in the perceptions of staff across the two adherence categories that the Named Nurse Standard was not fully implemented in the ward setting. This finding is in agreement with the majority of patients sampled that there was no specific or named nurse in charge of their care.

The difficulty in fully implementing the Named Nurse Standard was attributed by staff in both adherence categories to organisational constraints. These included the rapid throughput of patients, the increasing demand for hospital beds, and the number and work patterns of nursing staff.

Team nursing was used to organise nursing work on the wards in both adherence categories. Although the team leader role was more developed on the low adherence wards, it was not directly associated with the identification of a specific nurse to care for an identified patient. In addition, the patient allocation on admission to the wards in both categories was to a team and not to an individual nurse.

There were contrasting management structures between the wards in the two adherence categories. A hierarchical model was used on the high adherence wards with a designated nurse in charge. In contrast, in the low adherence category there was diversity between the two wards. Although one ward had a combined role of team leader and nurse in charge, the other ward had a flattened hierarchy using three teams and a nominal nurse in charge in case of major incident.

There was agreement between the two adherence categories on the quality audit of nursing care, with each being rated within the range of 'average care'. In contrast, in wards in both adherence categories patients rated nursing care they received positively and reported high levels of satisfaction. No association was demonstrated between care from a named nurse and higher levels of satisfaction. However, there was a trend for greater levels of satisfaction to be expressed by older patients.

The patient profile on the high adherence wards was a nearly equal mix of male and female, more patients in the older patient range but a shorter average patient stay. In contrast, on the low adherence wards nearly three-quarters of the patients were female, there was a wider age range of patients and a longer average patient stay.

Finally, there was consistency across the adherence categories in the informants' knowledge of the requirements of the named nurse role. These requirements included accountability for

care and the emphasis on providing continuity of care for a patient. However, there were diverging opinions on the impact of the Named Nurse Standard on accountability. These ranged from negativity to no change in accountability.

Consideration of these results indicates that none of the wards sampled had a fully functioning system of organising nursing work within a named nurse framework. Nursing staff perceived this to be associated with organisational constraints including shortage of staff. However, the method of organising nursing work adopted on all the wards was shown to have the potential to implement the Named Nurse Standard. Nevertheless, the patient perception of the nursing care received on all wards and satisfaction with that care was rated highly.

## **CHAPTER SEVEN**

### **DISCUSSION AND CONCLUSION**

#### **7.0 Introduction**

The purpose of this study was to explore the previously little researched area of the implementation of the Named Nurse Standard in the hospital setting from the nurse and patient perspective. This was achieved through observing how nursing care was organised on surgical wards and by gathering data on nurse and patient perspectives of the Standard. There were a number of emerging themes in the literature that informed the study. These included perceptions of the Named Nurse Standard, the changes in organisational mode associated with the implementation of the Standard, the possible impact on the nurses' role and the improvement in the patient experience.

The study aimed to explore the implications of the Named Nurse Standard for the organisation of nursing work. Therefore a naturalistic design was selected to capture the perspectives of the key players, that is the nurses and patients. The data collected in the study have enabled a comparison between wards that had a high adherence to criteria associated with the Named Nurse Standard and wards that had a low adherence. This chapter will discuss the findings presented in Chapter Six using the following themes: perceptions of the Named Nurse Standard, the organisation of nursing work and the patient perspective.

#### **7.1 Perceptions of the Named Nurse Standard**

As has been shown in Chapters Two and Three the introduction of the 'Named Nurse Standard' (DOH 1991) was a political imperative, part of the government's quality agenda (DOH 1983, DOH 1989a). The Standard statement was that a qualified nurse should be accountable for an individual patient's care for the duration of their stay (See Table 1).

Although the government provided guidance on how the Standard was to be monitored (DOH 1994b), individual trusts were empowered to decide how it was to be implemented in their organisations. This meant organising a structure and process for the introduction of the Named Nurse Standard into each clinical area in the trust and a system for monitoring the outcome.

The leaders of the nursing professions were supportive of the political initiative as it was seen to endorse the role of the qualified nurse and the commitment to individualised patient care (Hancock 1992b, RCN 1992, Watkins 1992, Wright 1993). However, as Shuttleworth (1992) and Savage (1995) show, there was ambivalence within the profession about the Named Nurse Standard. The factors contributing to this appear to be a combination of mistrust of a politically driven initiative, lack of clarity concerning the role and the conviction that there would not be sufficient resources for it to be successfully implemented.

### ***7.1.1 Implementing the Principles***

The findings of this study are consistent with the ambivalence of the nursing profession to the implementation of the Named Nurse Standard (Shuttleworth 1992, Nursing Standard Readers Panel 1995, Savage 1995). However, in contrast to the evidence in the literature (Cole and Davidson 1992, Jolley and Brykczyńska 1993, Mackereth et al 1994, Savage 1995) the informants in this study did not focus specifically on the political imperative for implementing the Named Nurse Standard. Their main concern, not unsurprisingly, was how the Charter Standard was interpreted and implemented at local level and the resulting impact on them as individuals. Some informants did associate the named nurse system with a management intent to monitor the performance of individual nurses. This view is in agreement with the argument of Savage (1995) that the Named Nurse Standard could be perceived as part of the blame culture in the NHS. Monitoring the performance of trusts in

achieving the Patient's Charter Standard was an integral part of the health service reforms (DOH 1992). Therefore it is not an unreasonable assumption to make that, in a Charter Standard that sets a level of individual performance, there could be audit of a specific practitioner. Although the government saw it as necessary to refute the claim in their guide to monitoring the implementation of the Charter Standard (DOH 1994b), the informants in this current study were not aware of any checking of adherence to the Named Nurse Standard at trust level. Nevertheless there were some nurses who perceived that they were more 'identifiable' as a named nurse.

In the literature being an 'identified' or named nurse was associated with enhanced responsibility (UKCC 1992a, Wright 1993). This positive acknowledgement of the introduction of the Charter Standard was a recurring theme in the early work of nurse leaders (Davies and Davis 1992, Hancock 1992a, Hancock 1992b, RCN 1992, Watkins 1992). In contrast, some of the informants in this current study linked 'visibility' to increasing pressure and demands on their professional role. These particular concerns were associated with the 'naming' of the named nurse in the patient record.

The concern that the Named Nurse Standard makes an individual nurse more 'visible' or identifiable is interesting, and seems to deny the fundamental principle that a qualified nurse is accountable for their professional practice (UKCC 1992b). As part of their ongoing responsibilities, a nurse signs nursing records when admitting, planning care for and discharging patients and thus, by implication and fact, is identifiable. Therefore there is, and will always be, the opportunity for the nursing record to be audited and an individual nurse identified and asked to account for the care given. However, in this study the problem that the informants found difficult to reconcile with their accountability was when they were made a named nurse to a patient in their absence.



In these instances the informants were not available at the time of the patient's admission to assess and plan care. Therefore the responsibility was undertaken by another member of the nursing team. However, because a specific practitioner had been designated as the patient's named nurse they became accountable for that plan of care. It would appear such decisions were associated with ensuring that the records showed that every patient had an identified named nurse, rather than adhering to the principle that a specific nurse be available for the patient's admission. These findings are consistent with the 'token compliance' in record-keeping identified by the RCN (1994) and Allen (2001) in which named nurses were allocated 'on paper' but had minimal or no contact with the relevant patient. However, the comments in this current study have to be put into context as these informants were illustrating some of the problems associated with the initial implementation of the Named Nurse Standard.

### ***7.1.2 Implementing the Named Nurse Standard***

The perceptions of the informants in this study indicate that the initial introduction of the Named Nurse Standard into the ward setting was not completely successful. The picture that emerges from the findings indicates a very mixed picture of the implementation and subsequent compliance with the Named Nurse Standard. In addition there was an interesting diversity in views between the staff perceptions in the adherence categories regarding this. On one of the low adherence wards the ward manager perceived that the team had 'not strictly kept to the rules' of the Named Nurse Standard. However, it is somewhat surprising that it was the managers on the high adherence wards, which might have been expected to be achieving the criteria, who were explicit that the named nurse system, as such, was not being implemented. Although such comments suggest that the informants had some knowledge of the requirements of the Named Nurse Standard, problems arose in attempting to adhere to the criteria in practice.

Having sufficient and appropriate information about a new initiative is one of the keys to successful implementation. Although there was limited information in the nursing press on the Named Nurse Standard (Hancock 1992a, Hancock 1992b, Watkins 1992, Wright 1992a, Wright 1992b) there were government documents available (DOH 1991, DOH 1992). The publication 'The Named Nurse Your Questions Answered' (DOH 1992) was particularly useful as it addressed 'frequently asked questions' about the Standard. Additional information did become available in 1993, with the Department of Health's publication of the case studies on the implementation of the Named Nurse Standard (DOH 1993b). Although each case study varied in its approach to detail and so might not have proved very useful to a reader seeking specific guidance, it did contain an exposition by Wright (1993) on the principles of the Named Nurse Standard. However, it was a large publication and therefore may not have been readily available for reference by nursing staff at ward level.

It is reasonable to assume from this that the informants seeking guidance on implementing the Named Nurse Standard would need to 'interpret' the available literature in the absence of an operational definition, or a set of process standards provided by the relevant trust. However, the findings in this study suggest that ward staff may not have accessed even those limited sources. A variety of strategies were used by the informants to gather information about how to implement the Named Nurse Standard. These included mapping the criteria of the Named Nurse Standard against the existing method of organising work and drawing on the professional experiences of other qualified nurses.

Utilising the success of others can be a useful strategy in situations where there is limited time for due consideration of all other options, as was the case with the implementation of the Named Nurse Standard. However, the approach may not prove helpful if there are insufficient resources and time to support the necessary changes. The findings of this study

demonstrate that, despite attempting to use pragmatic approaches to implementing the Named Nurse Standard, the informants acknowledged that they were not achieving all the required criteria.

Emerging from this picture of the early attempts to implement the Named Nurse Standard is not the indifference of nursing staff reported by Wright (1995) or the apathy noted by, amongst several authors, Cohen (1994) and Steven (1999). It appears that the informants in both adherence categories made a pragmatic attempt to implement a management initiative that required prompt action, and with apparently limited guidance about how to manage the change within their particular setting. Although there is evidence that there was the support from senior nurses in the trust that is consistent with the advice of Wright (1993) and the RCN (1992), there were no process standards for the named nurse role available in either trust. However, the findings indicate that all the informants did attempt to implement the Named Nurse Standard with varying degrees of success, although these efforts appeared to have been constrained by organisational issues.

### ***7.1.3 Constraints on Change***

In this study there were three commonly cited organisational constraints to the full implementation of the Named Nurse Standard. These were the staffing levels, the increasing demand on hospital beds and the rapid throughput of patients. Of these, staffing levels was most frequently cited. On all the wards sampled the nurse in charge made reference to the tension between organising staff to meet the demands of the ward and ensuring continuity of a named nurse during a patient's stay. These ward managers were attempting to balance the 24-hour needs of patients with the skill-mix of nursing staff. In the absence of the named nurse a patient would be cared for by other members of the nursing team. On the low adherence wards there was broader reference to how vacancies and absence of staff due to

sickness affected staffing levels, and the subsequent negative influence on the continuity of patient care. These findings are consistent with the work of Dooley (1999) and the RCN (1994) in concluding that the main inhibitor to implementing and maintaining the named nurse role was poor staffing levels.

However, staffing issues identified in this study were not just related to a shortage of nurses but also to the configuration of the work patterns. The findings show that each ward sampled had some nursing staff working part-time hours. To meet shortfalls in staffing levels, all the wards in the study used temporary staff. The requirement to use bank nurses to meet staffing needs is consistent with the Audit Commission report (2001b) on the increasing use of temporary staff in the NHS. Although several authors had anticipated that the introduction of the Named Nurse Standard could require reconfiguration of staff (Jack 1995, Melville 1995, Neal 1995), consideration had not been given to the impact of the increasing need to use temporary staff. The findings of this study indicate that the ward managers had to supplement the permanent nursing establishment with temporary staff to meet the demands of the service. Although it meant that there was a reasonable number of staff available to care for patients, there were insufficient permanent staff to enable continuity of care by an individual nurse to be provided. It is interesting to note that none of informants in the study followed Wright's advice (1993) to use the requirements of the Named Nurse Standard to challenge the trust management to increase the staffing resources.

The findings of this study also indicate that, somewhat ironically, the management imperative to make the NHS more efficient and give the consumer a better service (DOH 1989) impacted on the successful implementation of the Named Nurse Standard. As a consequence there was a rapid throughput of patients and increasing demands on hospital

beds. In consequence patients admitted to a ward, albeit for a short period of time, were moved within the ward or to another ward in the hospital to accommodate emergency admissions. The effect on patients of the emphasis on efficiency included delays in hospital admission because of the shortage of available beds.

The findings in this study are consistent with those of Reid (1993) who identified that the fast throughput of patients on a surgical ward impeded the identification of a named nurse. However, they are at variance with the advice from the Department of Health (1994) that it is particularly important for patients in areas of high throughput that there should be continuity of care by one nurse. The principle underpinning this argument is sound and supports the professional aspiration for individualised care. However, it needs the resources advocated by the RCN (1992) and Melville (1995), and the findings of this study indicate that the nursing staff did not perceive that these were available.

It can be concluded from the results considered in this first section that the initial implementation of the Named Nurse Standard was impeded by limited local and national information on the topic. However, it was implemented in all the wards, although organisational constraints including staffing levels and the rapid throughput of patients in surgical wards, meant that the requirement for continuity of care for a patient could not always be met. This conclusion suggests that the implementation of the Named Nurse Standard might have been more successful in a clinical setting with a lower patient throughput. However, the findings of this study indicate that, irrespective of the speciality, successful implementation of the Named Nurse Standard would require adequate and appropriate staff resources.

There was no significant difference between the wards in the two adherence categories in the ways staff attempted to change the organisation of nursing work to implement the

Named Nurse Standard. In the following section consideration will be given to the method of organising nursing work adopted by the nursing staff in the wards sampled, and how this impacted on the roles within the nursing team.

## **7.2 Organising Nursing Work**

The priority for the ward managers on each ward was to ensure that the nursing work was completed within the bounds of 'patient safety'. Therefore patient's needs would be met by all members of the nursing staff, for example if a patient asked for assistance any one of the staff would respond. Using this approach is similar to task allocation which ensures that patients' needs are met, but it depersonalises care (Lelean 1973, Pembrey 1975, Miller 1985). To adapt the approach to meet the Named Nurse Standard, each ward manager would have to ensure that a qualified nurse was available to admit, assess the needs and plan the care of an individual patient and also be available at the time of discharge (Wright 1993). Although the evidence in the literature suggests that any organisational method, with the exception of task allocation, can be used to implement the Named Nurse Standard (DOH 1992, Hancock 1992b, Wright 1993, DOH 1994b, Melville 1995), the ward managers had to utilise the existing workforce. Therefore any proposed organisational method had to be achievable within the existing skill-mix.

Binnie (1987) and Ersser and Tutton (1991) suggested that when considering changing the organisational method on a ward it is the quality not the number of nurses that is important. This approach was supported by the findings of Carr-Hill et al (1992) that the higher the grade of nurse, the better the quality of care. Although Warr (1998) found that HCAs delivered a higher quality of patient care than some grades of nurse, they would not be appropriate to be named nurses as they are not registered practitioners (DOH 1991, Wright 1993, DOH 1994b). However, as has already been shown in this study, the working

patterns of the qualified staff also had to be considered in the identification of an appropriate organisational method to implement the Named Nurse Standard.

The weekly shift pattern of all the full-time, qualified nursing staff at the beginning of the study was five days of 7.5 hours per day. A total of 37.5 hours per week. Thus, it is reasonable to expect that any nurse will only be on duty for a proportion of a patient's stay. The only exception to this might be if a nurse was on a 12 hours a day shift pattern and caring for a patient who has a one-day stay. This configuration could be very efficient, as a named nurse would then be available to co-ordinate the entire patient stay (Otte 1996). Although none of the wards sampled was a day case unit, one had changed to three 12-hour shifts per nurse, per week by end of the study. The change had been at the request of the staff as a way of managing the workload demands. In addition the hospital was located in a rural area and, with the limited public transport available, staff found it easier to make three journeys to work a week rather than five.

Nevertheless, using the five shift per week pattern and taking the average length of a patient's stay on the low adherence wards of seven days as an example, a named nurse would be on duty for less than a quarter of the patient's stay (22%). In addition they would only be on duty for five of the seven days of the patient's stay. Although the provision for the delegation of responsibility to others in the absence of the named nurse is a feature of the Standard (DOH 1992, Watkins 1992, Wright 1993, Jack 1995, Melville 1995), the intention is that the named nurse is on duty for two key points. That is the day of admission and of discharge. However, if the pattern were adhered to, consideration would have to be given to the duty rota of the named nurse. This is because ensuring that the named nurse was present on admission and at discharge could fragment their days off duty. In addition, it was anticipated that every named nurse would carry a caseload of patients (Wright 1993,

DOH 1994b, Melville 1995), and it would not be possible for a named nurse to be available at the admission and discharge of every one of their patients. Therefore it can be assumed that, with whichever method of organising nursing work, there would have to be periods of time during a patient's stay when care was delivered by different members of nursing staff. For all the ward managers in this study, team nursing was selected as the method of organising nursing work to meet the demands of the service.

### **7.2.1 Team Nursing**

Nursing staff on all four wards described working in 'teams' of nurses, with the groupings relating to specific areas of the ward. Although the configuration and numbers of the teams varied on each ward, all were based on a geographical division of the ward, and usually corresponded with the location of the male and female patients. The selection of team nursing by the informants is consistent with the RCN study (1994), which found that it was the most frequently chosen organisational method for implementing the Named Nurse Standard. However, the findings in this current study show that the main drivers for selecting team nursing were to use the nursing resources efficiently and effectively (Audit Commission 1991, Buchan and Bell 1991) whilst ensuring safe levels of patient care. Therefore, meeting the criteria of the Named Nurse Standard became a subsidiary driver rather than the main reason for selecting team nursing.

The systems adopted by the staff in the four sample wards had many of the characteristics attributed to 'team nursing' as an organisational mode (Matthews 1975, Waters 1985, Reed 1988, Thomas and Bond 1990, Melville 1995) that are also resonant with the Named Nurse Standard. These include allocation of a group of nurses to care for specific patients over a span of days to enable continuity of care (Jackson 1994, Melville 1995, Dargan 1997). In addition the organisation of the duty rota needed to ensure that members of the team were



on each daytime shift to facilitate the delegation of care of a patient in the absence of a named nurse (DOH 1992, Watkins 1992, Wright 1993, Jackson 1994). Finally, a nominated leader was needed for each team who could be a named nurse, as well as identifying other members in the team to take on that role (DOH 1991, DOH 1995). However, despite having these structures in place the wards in both adherence categories were not achieving the criteria associated with the Named Nurse Standard.

The lack of adherence to the criteria associated with the Named Nurse Standard at the time of this study cannot be attributed to insufficient knowledge of the requirements. As is shown in the theme 'In an Ideal World', the perceptions of the nursing staff demonstrate a level of knowledge and awareness of the Charter Standard and associated responsibilities that is commensurate with the literature. In addition some of the informants show a broader interpretation of the Standard, for example, the need for information for carers (Paton 1993, Allan and Cornes 1998).

Although the nursing staff did have a level of knowledge of the named nurse role, it would appear that it led them to perceive that it was only achievable in an ideal world. The main components of an appropriate environment to meet the Named Nurse Standard were perceived to be a nursing establishment sufficient for the speciality, and a stable throughput of patients. Stability meaning any change of ward location was for clinical and not organisational reasons. Although these would provide the structure and resources for the named nurse concept they do not take into account that changing work patterns of staff are insensitive to patient flow. As has been shown, there was an increase in the use of 12-hour shifts and more part-time and temporary staff (Audit Commission 2001a, Audit Commission 2001b). These changes undoubtedly had an impact on the provision of continuity of a named nurse on duty at the admission and discharge of a patient.

### **7.2.2 *Continuity of Care***

Continuity of care and accountability are the central tenets of the Named Nurse Standard (Hancock 1992b, Wright 1993, Jackson 1994, Melville 1995, Dargan 1997). These principles were supported by the nurses in this study. However, there was a dissonance between the idealised world and the reality of the organisation of work in practice. As the results of the observation of nurse-patient interaction demonstrated, the continuity of care for patients in wards in both adherence categories was from a team of nurses and not one named nurse (See 6.1 Tables 15 and 16). Nevertheless, the perceptions of the informants indicate that they did recognise and accept the dissonance between the criteria of continuity of care in Named Nurse Standard, and the method of team nursing they were using. These perceptions demonstrate again the balancing of the available resources with the provision of continuity of care for the patients.

Although the aim of the staff on each ward was the stability of nursing teams caring for groups of patients, there was always the caveat of numbers and skill-mix of staff permitting. The staff would revert to working with a whole team approach and task allocation if there were a shortage of nurses. Although it demonstrates the priority of getting the nursing work completed for 'patient safety' rather than individualised care reasons, it is consistent with the findings of the RCN study (1994). Thus, the team approach to organising nursing work was superseded by the priority to meet the physical needs of patients and personalised care became of secondary importance.

When all the findings of this study are compared, the majority of the results indicate that continuity of patient care was not associated with criteria of the Named Nurse Standard (DOH 1991, DOH 1995). These were the perceptions of the nurses and ward managers (See 6.4.1), in-patients (See 6.2, Table 17), and recently discharged patients (See 6.5.2,

Table 23). However, the audit of the nursing notes on one of the high adherence wards was at variance with these findings (See 6.2 Table 17). The results presented in this table show that over three-quarters of the audited patient notes on one of the high adherence wards had a named nurse recorded. This could be attributed to the practice of 'sometimes' recording a named nurse on the patient notes that was acknowledged by the junior sister, although it is in contrast to the perceptions of the other informants that a named nurse is not recorded. However, another possible explanation for the result could be the influence of this study and the presence of the author on the ward (Field and Morse 1985). A 'named nurse' may have been recorded on the majority of the patients' notes to be seen to 'comply' with the study. Influencing the research field was one of the issues that the author, as an ethnographic researcher, was sensitive to when planning the fieldwork and took steps to try to minimise its effect. These included visiting the ward before the study commenced, becoming familiar with the staff and providing information about the study.

There is another example when the presence of the researcher may have influenced the response of an informant. This was the perception of one of the ward managers that a named nurse was allocated to 'every patient who comes in'. However, this assertion was not supported by the findings of the audit of the nursing notes and was at variance with patient perceptions of their hospital experience (See Appendix 13 and 6.5.2, Table 23). Nevertheless, it was the ward manager's perception and it is accepted that they assumed that the system to ensure continuity of patient care that was initially introduced was still ongoing.

As has been shown, the criteria associated with continuity of care in the named nurse role is associated with the admission, planning and discharge of a specific patient (DOH 1991, Wright 1993, DOH 1994b, Dargan 1997). Although the findings in this study indicate

contrasting approaches to the admission of patients on the high and low adherence wards, neither process met the named nurse criteria. However, the approach taken on the low adherence wards had some attributes associated with the named nurse role. On these two wards the nurse in charge of the team to which a patient was allocated was responsible for the initial assessment of need and care planning. This is consistent with the named nurse criteria that a qualified nurse is identified on admission, to assess and plan the care of a patient (Wright 1993, Dargan 1997). However, in contrast on the high adherence wards there was a more pragmatic approach that meant that 'whatever qualified nurse is free' in the relevant team undertook the initial assessment of the newly admitted patient. Although it is surprising that it should be the wards in the low adherence category that were consistent in this aspect of the named nurse role, there was no recognition of this 'specific' nurse by patients. Furthermore, there did not seem to be planning on any of the wards to associate availability of a qualified nurse to admit a patient, with that same practitioner being there to discharge them.

The availability of the named nurse at patient discharge is one of the criteria of the Named Nurse Standard emphasised by Wright (1993) and Boyington (1992). However, as has been shown (See 4.8), discharge planning is one area of patient care that is acknowledged to require more attention (Waters 1987, SSI 1995, HMSO 2000). The evidence in the literature is that, despite the advice to commence discharge planning at the time the patient is admitted, it continues to be uncoordinated and prone to delays (NHSE 1994). The need to provide appropriate and co-ordinated discharge planning, particularly for the older person, has been highlighted by the introduction of the National Service Frameworks (DOH 2001b). Discharge planning would seem to be an aspect of patient care in which a named nurse could make a significant difference (DOH 1994b). The enhanced responsibility of the named nurse role provides incumbents with the knowledge of the patient's needs and the

authority and opportunity to plan and co-ordinate care, all of which could be used to make the transition from hospital to the community setting smoother for the patient. However, as Nixon et al (1998) indicate, there may need to be clarification of the boundaries of the named nurse role, for both hospital and community nurses, to enable the approach to be effective.

Within each clinical setting there will be particular problems associated with discharge planning. For example, in this current study there were patients who were admitted as emergencies and it was initially difficult to predict a date of discharge. Although, as Waters (1987) and Boyington (1992) argue, discharge planning is concerned with being proactive and using professional judgement in relation to discharge dates. In addition, the age profile of the patient respondents in this study indicates that more than a half were aged 65 years or over (n=39). This means that it can be anticipated that a proportion would have multiple health and social care needs that would have to be considered in the planning of discharge from hospital. Thus, this finding is consistent with the national demographic picture (DOH 2002) which recognises that discharge planning for older people needs a co-ordinated and multidisciplinary approach (SSI 1995, DOH 2001b).

However, the findings in this study indicate that none of the wards had a co-ordinated approach to discharge planning through one specific, qualified nurse. Although on one high adherence ward the nurse in charge was identified as responsible for discharge planning, the informants from the other wards were not specific about this aspect of patient care. It would appear from these findings that there are a variety of approaches to discharge planning on the wards sampled. Furthermore, that discharge planning does not appear to have been factored into the allocation of a nurse responsible for a patient's care, because the emphasis was on which staff were available at the time of admission.

The following sub-section in this exploration of the organisation of nursing work will consider who was responsible for managing the nursing teams on each ward.

### **7.2.3 Management Roles**

Each of the wards in this study had a Ward Manager who carried a level of financial and personnel as well as clinical responsibility. The term ward manager has been used because it is not gender-specific but the role is synonymous with the ward sister/charge nurse. The ward manager has continuing responsibility for the ward even when they are off-duty. However, the responsibility is discharged through delegation to appropriate members of the nursing team on a shift-to-shift basis. This study considers the day-to-day management of the ward. The findings indicate that there were contrasting management structures between the wards in the two adherence categories. A hierarchical model was used on the high adherence wards, with a designated nurse in charge. However, in the low adherence category there were different management structures. On one ward the nurse in charge combined the role with team leader. In contrast, on the other ward there was a flattened hierarchy with three teams of nurses and a nominal nurse in charge in case of major incidents.

The findings in this study are in agreement with the general view that the ward manager role would continue after the implementation of the Named Nurse Standard (Hancock 1992b, Wright 1993, Tingle 1993, Melville 1995, Dargan 1997). However, because the named nurse role was not evident on the sample wards, it is not possible to show whether it had a direct impact on ward manager responsibilities (Wright 1993, Allan and Cornes 1998). Nevertheless, it is possible to identify how the informants perceived that the change to team nursing, associated with the implementation of the Named Nurse Standard, affected the ward manager role. The clearest expression of these changes could be seen on the two low

adherence wards. One ward manager perceived that the flattened hierarchy of team nursing, with no designated nurse in charge, led to a breakdown in communication with other departments. In a similar way, even on the ward with a flattened hierarchy, the ward manager demonstrated an aspect of the traditional role of nurse in charge of knowing everything that was happening on the ward. It is clear that the ward manager is enabling the team leaders to have an enhanced level of responsibility, but is not completely relinquishing the management of the ward. In contrast the ward managers on the two high adherence wards managed through a hierarchical structure of nurse in charge and co-ordinator. Although the co-ordinator role was related to organising and managing the ward, there was also the element of overseeing and supporting staff.

There are some similarities between the responsibilities of the co-ordinator, as described in this study, and the role of 'nurse co-ordinator' (Ersser and Tutton 1991, Allsopp 1991) which was developed to manage lines of communication in primary nursing settings with a high patient throughput. In contrast to the role adopted on the high adherence ward in this study the nurse co-ordinator described by Allsopp (1991) and Ersser and Tutton (1991) was not hierarchical. It was a system whereby primary nurses delegated responsibility for liaising with members of the multidisciplinary team to a nurse co-ordinator. When the primary nurses felt they were too busy to participate in ward rounds the nurse co-ordinator became a conduit to transmit information between the nurse responsible for a patient's care, and the multidisciplinary team. The rationale was that using a nurse co-ordinator would enable the primary nurse to be free to deliver direct patient care, whilst ensuring that information about their patient was appropriately passed on. As the nurse co-ordinator was acting as a 'go-between' (Ersser and Tutton 1991) for the primary nurse, they did not need to know everything about the patients. However, the co-ordinator in this present study had greater resonance with the nurse co-ordinator role identified by Allsopp (1991). This is because the

Ersser and Tutton role concerned effective communication between professionals, whilst the Allsopp role and the co-ordinator on the high adherence ward were identified as responsible for communication and initiating action, for example, arranging transport for patients. However, these aspects of the role can also be seen to be overlapping with the team leader role.

The informants in this study used the term 'team leader' in two ways. The first was used on wards in both adherence categories to describe the most senior nurse in a team on a shift. They organised and supervised the team of nurses in delivering care to the designated group of patients on a shift-to-shift basis. The team leader could change every shift according to the duty rota. The second interpretation of 'team leader' was consistent with the team leader role described by Matthews (1975) as the most senior nurse in a team according to the divisions of the off-duty. Thus the junior sister on a low adherence ward planned for an experienced E grade nurse to lead each team and, as such, would supervise and support junior colleagues in the team (Reed 1988).

There were variations in the boundaries of the team leader role between the wards in the two adherence categories. These differences were most marked in the interface with the inter-professional team. On the low adherence wards the team leader was expected to participate in the wards rounds with the medical staff. In contrast, on the high adherence wards the hierarchical structure was reinforced, with nurse in charge or co-ordinator participating in the ward rounds and reporting back to the nursing teams. However, the latter approach, as has been shown, has resonance with the need to manage effective communication, as described by Ersser and Tutton (1991) and Allsopp (1991).

The other aspect to note concerning these findings is that this was one of the few references made by the nurses in this study to inter-professional working. This is somewhat surprising



in an organisation in which team working underpins patient care (Walby et al 1994). However, there is also limited reference to inter-professional working in the literature on the Named Nurse Standard. It is implied in the discourse on discharge planning and transferring care (DOH 1992, Wright 1993), but it is made not explicit. Nevertheless, it is interesting to compare how medical teams work with the way nursing functions within the Named Nurse Standard. A medical consultant is ultimately accountable for a patient's care but discharges responsibility through the junior members of the team. In the same way community nurses have always managed their accountability for patients within a team setting, which has meant that minimal changes were required to implement the Named Nurse Standard (Forbes 1993, McKay 1993). It is reasonable to conclude from the findings in this study that there are difficulties with managing the accountability associated with the Named Nurse Standard within a surgical ward setting.

#### ***7.2.4 Impact on Accountability***

All the nurses in this study accepted that they were accountable for their own practice (UKCC 1992a, UKCC 1992b). However, as has been shown in 7.1.1, their perception of the initial implementation of the Named Nurse Standard was that the role was inappropriately allocated. At the time of this study the informants' perceptions of the impact of the named nurse role on accountability were varied. Although a proportion of the nurses acknowledged that it heightened their awareness of accountability, two of the more junior staff remained concerned about taking on the responsibility of the named nurse role. However, the more senior of the nursing staff indicated that they were confident that, if required, they could discharge their accountability as a named nurse.. These varieties of views indicated that the named nurse role was associated with a perceived increased responsibility for individualised care. However, it has to be noted that the requirement did already exist in the UKCC's Scope of Professional Practice (UKCC 1992a).

It is reasonable to conclude that the informants were exercising their accountability when they did not fill in the 'named nurse' section in the patient record (See 6.2 Table 17), because they were acknowledging the reality of the situation. This is because the organisation of nursing work, and the off duty rota, did not facilitate individual staff to care for individual patients at the two crucial points in their stay, that is, admission and discharge. Therefore a named nurse, within the criteria of the Named Nurse Standard, could not be recorded in the patient records. Which offers a rationale for why over three-quarters (n=69) of nursing notes audited for this study did not have a named nurse recorded. The possible reason for the completed records has already been considered in this chapter (See 7.2.2). Although one of the staff nurses on a low adherence ward had developed informal rules on completion of the named nurse section on the patient record, this was not evident in any of the nursing notes audited. Despite the absence of a named nurse on the majority of the patients' records, the findings of this study indicate that nurses had discharged their responsibility for record-keeping because all other aspects of the nursing notes were completed (UKCC 1992a, UKCC 1992b).

### **7.2.5 Leadership**

Although leadership was not central to this study an analysis of it's relevance in the clinical setting may contribute to an explanation for some of the findings. The ward sister/charge nurse was the operational manager responsible for introducing the Named Nurse Standard at ward level. Leadership is fundamental in managing change (Lorentzon 1992), and the evidence from this study indicates that the process was not facilitated in a way that would enable staff to fully implement criteria associated with the Named Nurse Standard (DOH 1991, DOH 1995). These findings support the view of Steven (1999) that poor administration of the management process at local level meant that nurses were not motivated to implement the Standard. Perhaps the most striking example of this is the

apparent limited preparation for the implementation of the Standard in the wards sampled. Planning for the change was crucial because, as several authors argue (DOH 1993b, Forbes 1993, McKay 1993, Raper 1993, Melville 1995), with few exceptions the Named Nurse Standard presented more challenges to organisational methods in hospital settings than in community services. However, there was a limited lead-in time to the change (Cole and Davidson 1992), and the findings suggest that the implementation was managed through a pragmatic rather than proactive approach to planning.

It would seem to be straightforward to argue that the ward managers should have exercised stronger leadership in the implementation of the Named Nurse Standard (DOH 1991, DOH 1995). However, that would have ignored the effect that organisational and professional changes were having on the role of the ward sister/charge nurse. The health service reforms (DOH 1983, DOH 1989a, DOH 1990) had replaced the consensus model of management with a general management structure, and had introduced the notion of consumerism into healthcare. At the same time there were developments in nursing including professionalisation (Salvage 1992); a more patient centred approach to care (Pearson 1988, Thomas and Bond 1990, Wright 1990); and a change to the system of nurse education (UKCC 1986). In addition, there was ambivalence towards the 'top down' introduction of the Named Nurse Standard that needed to be addressed (Cohen 1994, McSweeney 1994, Savage 1995, Dyke 1998). The findings of this study show that all the ward staff found it difficult to sustain the required changes in such a challenging environment.

As has already been shown (See 7.2.3), there was general agreement that the ward manager role would continue after the introduction of the Named Nurse Standard (Wright 1993, Dargan 1997). However, both these authors refer to 'leadership' rather than 'management' emphasising clinical support and professional expertise in preference to managing resources.

Wright (1993) argues that clinically credible nurse leaders can establish a framework for the practitioner to exercise the enhanced accountability required of the named nurse role (UKCC 1992a). Notwithstanding, the findings of this study demonstrate the tension between conflicting demands of meeting patient safety (See 7.2) and the requirements of the named nurse role. On all the wards patient safety was a priority and the named nurse role was allowed to lapse because there was no supportive infrastructure in place. Thus, it is reasonable to conclude that if there was a clinical leader in place with power and authority to act the principles underpinning the Named Nurse Standard could be implemented (DOH 1991, DOH 1995, Wright 1993).

Since the commencement of this study there has been a national drive to strengthen nursing leadership through the introduction of nurse consultants (NHSE 2000) and modern matrons (NHSE 2001). The matron role, in particular, is seen as addressing the gap in clinical leadership at ward level. The purpose of the modern matrons is to improve the quality of patient care working at ward level to ensure that clinical problems are resolved quickly and appropriately. It seems not unreasonable to argue that the modern matron role has the power and authority to support the principles of the Named Nurse Standard (DOH 1991, DOH 1995). Therefore, it might have been more appropriate to have implemented the Standard after the introduction of the modern matron as the infrastructure would have been in place to facilitate the required organisational changes.

It can be concluded from the results presented on organising nursing work that ensuring a safe level of patient care was the primary consideration for the nurses in this study. Team nursing was selected as the most appropriate method because it utilised the limited staffing resources as effectively and efficiently as possible. In addition it offered a framework for continuity of individualised patient care that did not rely on an individual practitioner. It

meant that if staffing levels were reduced nurses could be moved between teams to maintain an acceptable skill-mix.

The management structures put in place on each ward endeavoured to identify clear lines of communication and responsibility. Although there was some blurring of boundaries between the ward manager and the team leader role these were seen to be part of the 'team' approach to delivering patient care. The resistance to the full implementation of the Named Nurse Standard was not overt or confrontational. However, the nursing staff could not identify how the named nurse role could function with the available staffing levels and with the short patient stay in the surgical setting. Adherence to the Named Nurse Standard was left to lapse in all the wards sampled, with the majority of the nurses exercising their accountability by not making token records in the patients' notes.

### **7.3. Patient Perspective**

The Patient's Charter offered the consumer the expectation that a named nurse would improve their healthcare experience (DOH 1991, DOH 1995). The findings of this study indicate that the respondents (n=70), recently discharged from wards in the high and low adherence categories, had high levels of satisfaction with their care, with mean scores of 77 and 76.4 respectively out of a possible 100 (See 6.5.3 Table 25). In addition, they rated the nursing care they received very highly, with mean scores of 84 for each adherence category (See 6.5.3 Table 24). From these findings it is reasonable to conclude that the patients' perceptions of their hospital stay were positive. It is noted that there are limitations with patient satisfaction surveys (Carr-Hill et al 1992, Avis et al 1995, Walker et al 1998) and there was an attempt in this study to minimise the effect by using NSNS, a validated tool for measuring satisfaction with nursing work (Thomas et al 1996a). In addition, the findings of this aspect of the current study have been compared with the results of a survey of patients

using the NSNS by Thomas et al (1996b). However, unlike the findings of Thomas et al, the high levels of patient satisfaction in this study were not associated with awareness of a specific nurse in charge of their care.

### *7.3.1 Awareness of a Named Nurse*

The findings of this study are consistent with the studies by Bruster et al (1994), the NHSE (1994) and the RCN (1994), all of which demonstrate low levels of awareness of a specific nurse in charge of their care in patients recently discharged from hospital. In this current study nearly 90% of respondents (n=72) did not perceive that there was an identified nurse in charge of their care. Although these findings are at variance with the expectations raised by the Named Nurse Standard (DOH 1991, DOH 1995), they are supported by data from the other aspects of this study. These are the audit of the nursing notes (See Table 17) which showed that the majority of the patient notes (n=69) reviewed did not have a named nurse recorded. Furthermore, the continuity of care identified in the nurse-patient contact (See Table 15 and Table 16) was not from a specific, identified nurse. Finally, these findings are supported by the perceptions of the nurses and ward managers interviewed that the Named Nurse Standard was not fully implemented in any of the wards sampled.

It can be concluded from these findings that, because there was no named nurse identified, patients could not recognise a specific nurse responsible for their care. The team approach to organising nursing work adopted by all the wards meant that patients would probably interact with a small number of nurses during their stay. However, there was no provision for the one-to-one relationship associated with the Named Nurse Standard (Hancock 1992b, Wright 1993). Nevertheless, the majority of patients demonstrated high levels of satisfaction with the nursing care received. If, as these results show patient satisfaction was not associated with one nurse in charge of an individual patient's care, then other possible

influencing factors have to be considered.

Williams (1994) suggests that older patients indicate higher levels of satisfaction with care because they are reluctant to comment negatively on the care they receive. Higher levels of older people responded in this survey, with over half (n=39) who were 65 years or over. These proportions reflect the national picture of an ageing population and associated age range of patients in hospital (DOH 2001b, DOH 2002). However, although there is a difference in the mean age of respondents in the wards in the two adherence categories of 58 years in the low and 64 years in the high, there was no significant difference in the levels of satisfaction. Nevertheless, a scatter plot of age and satisfaction scores (See Figure 2) indicates a trend in patient perception in both adherence categories. This indicates that older patients report a higher level of satisfaction. Williams (1994) suggests that these high levels of satisfaction might indicate an unwillingness to be critical.

However, these findings can be compared with the results of the Qualpacs quality audit (Wandelt and Ager 1974) to identify the level of nursing care received by patients in the two adherence category wards. The Qualpacs mean scores for both adherence categories were within the banding of 'average' care, with the low adherence category score of 3.41 and a high adherence category score of 3.35 (See Table 18). This means that all the respondents were in wards that delivered a satisfactory level of nursing care to patients. Therefore, it can be assumed that there was no difference between the levels of nursing care received by patients that might influence the perceptions of respondents' satisfaction with their hospital stay. Emerging from these findings is the conclusion that there was a general trend in both adherence categories for the older patient to express greater satisfaction with the nursing care received, but this was not associated with care from a specific or named nurse.

### **7.3.2 Experience of Nursing Care**

Respondents were also generally positive in the written comments they made in the NSNS survey about their experience of the nursing care they received. Nearly two-thirds (n=44) included positive comments. These perceptions are pleasing as they give acknowledgement to the commitment that nursing staff had to patient care. However, it is not always helpful to have this 'rose-tinted' image of nursing portrayed. As has already been shown in this study, nurses acknowledged that they were not always able to give the care that they would like and were doing everything 'for patient safety'. Nurses are skilled professionals who need objective feedback to be able to improve their performance, to celebrate what is positive and improve performance where there are gaps. They also need robust evidence to support their case for change, for example, to skill-mix.

Comment is useful to inform the skill-mix debate and perhaps support a challenge for increased nursing resources, as advocated by Wright (1993). However, some of the patient respondents did make comment about the need for nurses with particular skills in care of the older person. The perception of the respondents was that there were insufficient nursing staff with the skills in a surgical ward, with a fast throughput of patients, to give appropriate care to this client group. This finding is consistent with the intent of the National Service Framework for Older People (DOH 2001b) that health, and indeed social services, should be considering a level of provision appropriate to the older person.

Although the majority of respondents were not directly critical about the personal care they received, a number commented on the need for information-giving to be improved. These findings are consistent with many studies that indicate dissatisfaction with information giving in healthcare situations (Audit Commission 1993, Coyne 1995, Otte 1996, Britten and Shaw 1994, Moores and Thompson 1986, McColl et al 1996, Walker et al 1998). A



small number of respondents made suggestions about communication being channelled through one nurse to ensure that patient care was co-ordinated, however only one patient made direct reference to a named nurse (See 6.5.3). Nevertheless, the perception of that patient is consistent with the findings of this study, which is there were no identifiable named nurse systems in place in the wards sampled.

It is interesting to note that this patient wanted to be able to identify the name of all the nurses who were delivering their care. This is consistent with the evidence that patients wish to be treated as individuals (Walker et al 1998). Alternately, this view may reflect the changing perception of patients as passive recipients of nursing care into consumers of healthcare. Thus supporting Dyke's argument (1998: 11) that, although the Patient's Charter may have been a flawed concept, its value was that it '... began to legitimise a more consumerist culture'. In this way, participation in care (Jewell 1994, Saunders 1995, Pearson 1998) can be seen to equate to the partnership in care envisaged in the Named Nurse Standard (Boyington 1992, Jack 1995, Dargan 1997).

It can be concluded from these findings that the positive patient perceptions about their hospital stay were not associated with the Named Nurse Standard. Furthermore the high rating of nursing care received could not be attributed to a specific nurse responsible for the care of an individual patient for the duration of their stay. This suggests that the team approach to organising patient care was perceived by the majority of the patients to meet their needs. However, those aspects of care identified by patients as requiring improvement can be attributed to a more consumerist approach to healthcare. This can be shown by the request for more information about their treatment, and the wish to be made aware of the names of all the nurses caring for them. However, it is only a reflection of the changing culture in all service industries and in business as a whole. Part of customer care is to

individualise the approach and the most overt way is to be identified by name. It may be surprising that it has taken so long for nursing to acknowledge the changing culture in society. Therefore, it could be seen as somewhat ironic that nurses have not fully embraced the Named Nurse Standard as a vehicle for achieving the professional aspiration of an individualised approach to patient care.

#### **7.4 Reflections on the Research**

Two key aspects arise concerning the methodology for this study. The first is the appropriateness of the methodology. The study was designed to be able to enter the world of the nurses and patients in a clinical setting. Although there were a number of inhibiting factors, including the changing dynamics of both the NHS trusts during the lifetime of the study, there was a form of stability within each ward setting. This was despite the fact that some of the wards had to change physical location, although this was always associated with improvement in facilities. The stability was within the nursing team, and although again there were staffing changes, there was sufficient opportunity for the researcher to become familiarised with and familiar to the nursing staff in each setting. Acceptance into the research field is recognised as important in qualitative methodology (Field and Morse 1985).

It was appropriate for the author to be the one data collector for the non-participant observation. If there had been more than one researcher it may have influenced the behaviour of the participants. As it was, the author was able to be unobtrusive in recording nurse-patient interactions. In addition she was able to move if necessary to view a nurse-contact more clearly. On reflection, it may have been more appropriate for the author to be one of the data collectors in the quality audit. This was because of the perceived influence on the research field of the two data collectors, who were not as familiar to the participants

as the author was. Alternatively, a longer period of acclimatisation of the data collectors might have minimised the influence of their presence.

The combination of interviewing of nurses and the questionnaire completed by patients did provide a rich picture of the experiences of those two groups. Although interviewing patients as well as the nurses might have yielded a greater depth of information, it would have meant that the breadth of patient experience in the four wards sampled would not have been available. This was balanced by using different data collection methods, which enabled comparison and contrast of the wards in the two adherence categories and thereby increased the robustness of the findings.

For the author as a nurse the second aspect related to the methodology is the reflection on professional practice. Using a non-participant approach to observing practice enabled the proximity to the nurse-patient interaction that was required for recording, but without the possible subjective involvement that participating in care might have produced. This gave the professional detachment but enabled the gathering of rich data to inform the study findings. It is therefore reasonable to conclude that the study design did enable the collection of valid, reliable data that allows confidence in the findings.

## **7.5 Conclusion**

The intention of the study was to address two research questions relating to the implementation of the Named Nurse Standard. The first question considered a comparison of wards that had a high adherence to criteria associated with the Named Nurse Standard with wards that had a low adherence. The second question was to examine the implications of Named Nurse Standard for the organisation of nursing work. The findings of this study show that there was no significant difference in the organisation of nursing work between wards that appeared to have high and low adherence to criteria associated with the Named

Nurse Standard. In addition, the Named Nurse Standard was not fully implemented on any of the surgical wards sampled. As the Charter Standard was a government imperative, it is interesting to consider the findings of this study in that context.

The study results illustrate that the Named Nurse Standard was an initiative that was implemented rapidly and with limited information. Nursing staff within the wards studied had to interpret the requirements but without clear operational guidance. The management of change process was not structured in a way that would facilitate staff to fully implement all the criteria associated with the Named Nurse Standard. Some nurses believed that it was an imposed system with a hidden intent to enable managers to measure individual nurses' performance. As a result there was ambivalence towards the principle underpinning the Named Nurse Standard.

Nurses in acute environments were challenged to consider whether the existing systems for managing nursing work were appropriate. Some nurses involved in this study perceived that implementation of the Named Nurse Standard involved changes to work practices and boundaries of roles. This was because the Named Nurse role was associated with perceived increased responsibility for individualised care. However, it has to be noted that the requirement already existed in the UKCC's Scope of Professional Practice (UKCC 1992a). The study illustrates that organisational issues constrained the introduction and impeded the full implementation of the Named Nurse Standard. The results show that the Standard is not being adhered to in the wards sampled. Furthermore, this lack of adherence has developed in a covert manner without a formal management process.

Although this study has shown that the Named Nurse Standard was not fully implemented in the acute hospital setting, this can be contrasted with the success of the principle in the organisation of nursing work in the community setting. Prior to the introduction of the

Named Nurse Standard the nursing work in the community environment was successfully managed through a qualified nurse accountable for the care of a caseload of patients. This system required minimal changes to meet the requirements of the Named Nurse Standard. The significant difference between the two settings is that the community nurse visits each patient by appointment at specified time. The exception to this, that has to be acknowledged, is the 'hospital at home', but this was not considered in this study. However, in the acute hospital setting patients require observation and care over a 24-hour period.

If the ethos of the community approach is to be transported into the acute setting it must take the intensity of 24-hour observation and other influences on the organisation of nursing work in hospital into consideration. These include the changing boundaries of the qualified nurse role with the reduction in junior hospital doctor hours. This means that qualified nurses are taking on additional tasks that involve numbers of patients and it therefore restricts the opportunities for continuity of care for specific patients. Thus the contrast in cultures between the two settings is that the community nurse can normally exercise direct caseload management and predict the needs of clients over a period of time. Whilst in the hospital setting the qualified nurse has to respond to organisational demands, including emergency admissions and rapid changes in patient healthcare needs.

It is ten years since the launch of the Named Nurse Standard and, after the initial momentum of the government launch, it has faltered in its application in the acute clinical setting. In addition, the document that the Charter Standard was codified in, the Patient's Charter, has been superseded by a patient's guide to the NHS (DOH 2001a) following a review by the government. The Named Nurse Standard does not feature in that document. Therefore, from the government perspective the Named Nurse Standard has moved from

the national picture to local initiatives and standards if the relevant trusts consider it appropriate to their service provision.

For patients, the Patient's Charter, and with it the Named Nurse Standard, has brought the consumerist culture into healthcare. It has offered the opportunity to facilitate dialogue about patient entitlements but also an expectation that care will be delivered by named individuals. This approach is consistent with an individualised approach to patient care that underpins the professional approach to nursing care. However, and perhaps more challenging, it gives the patient the expectation of professional responsibility associated with being identified by name.

This challenge for nursing may also be the opportunity to consider professional accountability. The nursing leaders who strongly supported the introduction of the Named Nurse Standard saw it as providing endorsement to the professional role of the nurse. However, it means that the named nurse is just that, a professional who can be identified in discharging their accountability for care. Therefore it is reasonable to conclude that the implication of the Named Nurse Standard for nursing work is a framework in which to consider enhanced responsibility, continuity and co-ordination of patient care.

## **7.6 Recommendations**

The main recommendation from this study is that innovations in nursing practice, such as the Named Nurse Standard, should be evaluated in a pilot study before being introduced nationally. This would mean that adaptive measures could be put in place to ensure that, where appropriate, the initiative was successfully implemented. Although the Patient's Charter has been superseded the results of this study and the evidence in the literature show that the principle of the Named Nurse role is grounded in the nursing discourse. Therefore

the two other recommendations arising from this study are for further research using the principles underpinning the Named Nurse role.

The first recommendation for further research is that the principle of the Named Nurse Standard should be used to reconfigure and evaluate the organisation of nursing work in day case units. This could be evaluated through an experimental research design using parallel day-case units in two NHS trusts. This would enable the introduction of a system whereby a qualified nurse would be accountable for a patients' care from admission into one of the day-case units to discharge. The second day case unit would be the control group. An alternative methodology, that of action research, could be used to manage and evaluate the introduction of the Named Nurse Standard within a single or multiple day-case units.

This study identified a deficit in the quality of discharge planning for patients. This would seem to be an aspect of patient care in which a named nurse could make a significant difference to the patient experience. The enhanced responsibility of the named nurse role would provide the opportunity and authority to plan and co-ordinate care to make the transition from hospital to community setting smoother for the patient. Therefore a second recommendation for further research could focus on the principle of the Named Nurse as a co-ordinator of care within a multidisciplinary team with a particular emphasis on preparation and implementation of personalised discharge plans.

Although the discharge planning process may be a central component of some nurse education programmes it seems from these findings that there needs to be a greater emphasis in both pre and post registration curriculum.. This should include clarification of roles and responsibilities of hospital nurses, community nurses and other health and social services where they interface in discharge planning for a patient. Sharing learning between different healthcare groups would increase awareness and is consistent with the

interprofessional agenda. An action research approach could be used to identify and evaluate change in nursing practice and patient perception.

Nurse education programmes should also provide opportunity to debate the contribution of the Named Nurse Standard in the context of developing patient-centred care. This should include consideration of the principles of enhanced accountability, continuity and co-ordination of care, partnership in care and the organisation of nursing work. Further research could be undertaken to evaluate the impact of the introduction of modern matrons on the organisation of nursing work using a case study approach.



## APPENDICES

### Appendix 1 Modified Questionnaire (Thomas and Bond 1990)

#### Named Nurse Research Project Nursing Staff Questionnaire

#### University of Plymouth Institute of Health Studies

The following questions refer to the way in which nursing care is organised in your ward.

**1. Please read through the following list and tick which *one* most accurately describes the way you organise staff on your ward.**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| A. The ward staff are organised as one group, and are allocated singly, in pairs or in threes to patient or ward areas for part of their shift and work across the whole ward for the remainder. | <input type="checkbox"/> |                          |
| B. The ward staff are organised as one group and are allocated singly, in pairs or in threes to patients or ward areas for their entire shift.   | <input type="checkbox"/> |                          |
| C. The ward staff are divided into teams with a designated leader, and allocated to a group of patients for one shift or part of a shift.  | <input type="checkbox"/> |                          |
| D. The ward staff are divided into teams with a designated leader, and allocated to a group of patients for periods longer than one shift.   | <input type="checkbox"/> |                          |
| E. Individual qualified nurses are given responsibility for individual patients for the duration of a shift or part of a shift.  | <input type="checkbox"/> |                          |
| F. Individual qualified nurses are given responsibility for individual patients for periods longer than one shift, but less than the total duration of the patients' stay in hospital.           | <input type="checkbox"/> |                          |
| G. Individual qualified nurses are given responsibility for individual patients for the duration of the patients' stay in hospital.  | <input type="checkbox"/> | <input type="checkbox"/> |

**For  
official  
use**

*If none of the above apply, please describe below your method of organising work.*

**2. Under usual staffing conditions who normally allocates work when nurses come on duty? (Please tick *one* box)**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| A. Sister or nurse in charge allocates work.                             | <input type="checkbox"/> |                          |
| B. Team leaders allocate work for their team.                            | <input type="checkbox"/> |                          |
| C. The most senior nurse in the team allocates work.                     | <input type="checkbox"/> |                          |
| D. Individual nurses decide what care to give their individual patients. | <input type="checkbox"/> | <input type="checkbox"/> |

**3. How is the Off-Duty (or Duty-Rota) organised?: (Please tick appropriate box.)**

- A. For the ward as a whole?
- B. Within two or more groups or teams?
- C. To enable individual nurses to be responsible for individual patients?

**4. Who has nursing accountability for patient care? (Please tick appropriate box.)**

- A. It is entirely vested in the ward sister
- B. It is entirely vested in the team leader
- C. It is entirely vested in the individual nurse responsible for individual patients.
- D. It is shared.

*If D applies, please describe below how accountability is shared.*

**5. Who usually completes a patient's initial assessment? (Please tick one box.)**

- A. The ward sister or nurse in charge.
- B. The team leader, when it involves her patients.
- C. The patient's individual nurse.
- D. Any qualified nurse available
- E. Any nurse available

**6. Who is usually responsible for writing the nursing 'kardex' or nursing notes? (Please tick one box.)**

- A. The ward sister or nurse in charge writes the notes for most of the patients.
- B. Each team leader writes the notes for the patients in his/her team.
- C. The patient's individual nurse responsible for his/her care throughout his/her stay in hospital writes his/her notes.
- D. The nurse/nursing auxiliary/learner who has provided care for that patient during the shift does so.

**7. Who usually conducts verbal handover or change of shift reports ? (Please tick one box.)**

A. The ward sister or nurse in charge.

B. The team leader, when it involves her patients.

C. The patient's individual nurse.

D. Any qualified nurse available

E. Any nurse available

**8. Who usually liaises with the medical staff about patient care? (Please tick one box.)**

A. The ward sister or nurse in charge.

B. The team leader, when it involves her patients.

C. The patient's individual nurse.

D. Any qualified nurse available

E. Any nurse available

Thank you for completing this questionnaire.

As part of this study I will be interviewing a small number of nurses about their work. If you are prepared to be interviewed please provide the following information.

---

**I would be willing to take part in an informal interview.**

Name:.....

Place of work: .....

Contact telephone number: .....

### **Categories for analysis**

**F** = task allocation or functional nursing

**T** = team nursing

**P** = primary nursing

**O** = no particular modality

### **Questions**

1. Nurse grouping
2. Work allocation
3. Duty rota
4. Accountability
5. Initial assessment
6. Writing nursing notes
7. Information hand-over
8. Liaison with other disciplines

Questionnaire reproduced with the permission of Ms Lois Thomas.

Reference: Thomas L & Bond S 1990. Towards defining the organization of nursing care in hospital wards: an empirical study. **Journal of Advanced Nursing**, 15, 1106 - 1112.

**Appendix 2 Qualpac Patient Care Scale (Wandelt and Ager 1974)**

**Modified by Carr-Hill et al (1992)**

**Qualpac Patient Care Scale**      Date \_\_\_\_\_ Rater \_\_\_\_\_

Interactions Record: AM/PM

No: 

--	--	--	--	--	--	--	--	--	--	--

Time: 

--	--	--	--	--	--	--	--	--	--	--

# QUALPACS

## Schedule of Elements of Care

### **Psychosocial (individual)**

Actions directed towards meeting psychosocial needs  
of individual patients  
(15 items)

### **Psychosocial (group)**

Actions directed towards meeting psychosocial needs  
of patients as members of groups  
(8 items)

### **Physical**

Actions directed towards meeting the physical needs  
of individual patients  
(15 items)

### **General**

Actions that may be directed toward meeting either  
psychosocial or physical needs  
of the patient or both at the same time (15 items)

### **Communication**

Communications on behalf of the patient  
(8 items)

### **Professional Implications**

Care given to patients reflects initiative and responsibility  
indicative of professional expectations  
(7 items)

(Wandelt and Ager 1974)

## **QUALPACS SCORING**

**Best Care = 5**

**Between = 4**

**Average Care = 3**

**Between = 2**

**Poorest Care = 1**

**Other categories**

**Not applicable**

**Not observed**

# Psychosocial

Actions directed towards meeting psychosocial needs of individual patients

		1	2	3	4	5	6	7	8	9	10	11
1. Patient receives nurse's full attention #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
2. Patient is given opportunity to explain his feelings #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
3. Patient is approached in a kind, gentle, and friendly manner #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
4. Patient's inappropriate behaviour is responded to in a therapeutic manner #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
5. Appropriate action is taken in response to anticipated or manifest patient anxiety or distress # D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											



		1	2	3	4	5	6	7	8	9	10	11
6. Patient receives explanation and verbal reassurance when needed #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
7 Patient receives attention from nurse with neither becoming involved in a nontherapeutic way #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
8. Patient is given consideration as a member of a family and society #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
9. Patient receives attention for his spiritual needs #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
10. The rejecting or demanding patient continues to receive acceptance #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											

		1	2	3	4	5	6	7	8	9	10	11
11. Patient receives care that communicates worth and dignity of man #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
12. The healthy aspects of the patient's personality are utilised #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
13. An atmosphere of trust, acceptance and respect is created rather than one of power, prestige and authority #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
14. Appropriate topics for conversation are chosen #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
15. The unconscious or nonoriented patient is cared for with the same respectful manner as the conscious patient # D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											

# Physical

Actions directed towards meeting physical needs of patients

		1	2	3	4	5	6	7	8	9	10	11
16. Nursing procedures are adapted to meet needs of individual patient for treatment #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
17. Patient's daily hygiene needs for cleanliness and acceptable appearance are met #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
18. Nursing procedures are utilised as media for communication and interaction with patient #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
19. Physical symptoms and physical changes are identified and appropriate action taken #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
20. Physical distress evidenced by the patient is responded to quickly and appropriately # D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											

		1	2	3	4	5	6	7	8	9	10	11
21. Patient is encouraged to observe appropriate rest and exercise #D/*I	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
22. Patient is encouraged to take adequate diet #D/*I	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
23. Action is taken to meet the patient's needs for adequate hydration and elimination #D/*I	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
24. Behavioural and physiological changes due to medications are observed and appropriate action taken #D/*I	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
25. Expectations of patient's behaviour are adjusted and acted upon according to the effect the medication has on the patient # D/*I	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											

		1	2	3	4	5	6	7	8	9	10	11
26. Medical asepsis is carried out in relation to patients personal hygiene and immediate environment #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
27. Medical and surgical asepsis is carried out during treatments and special procedures #D/*I	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
28 Environment is maintained that gives the patient a feeling of being safe and secure #D/*I	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
29. Safety measures are carried out to prevent patient from harming himself or others #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
30 Established techniques for safe administration of medications and parenteral fluids are carried out # D/*I	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											

# General

Actions that may be directed towards meeting either psychosocial or physical needs of the patient or both at the same time

		1	2	3	4	5	6	7	8	9	10	11
31. Patient receives instruction as necessary #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
32. Patient and family are involved in planning for care and treatment #D/'I	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
33. Patient's sensitivities and right to privacy are protected #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
34. Patient is helped to accept dependence/ independence as appropriate to his condition #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
35. Resources within the milieu are utilised to provide the patient with opportunities for problem solving #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											



		1	2	3	4	5	6	7	8	9	10	11
36. Patient is given freedom of choice in activities of daily living whenever possible and within patients ability to make the choice #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
37 Patient is encouraged to take part in activities of daily living that will stimulate his potential for positive psychosocial growth and movement toward physical independence	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
38 Activities are adapted to physical and mental capabilities of patient #D/*I	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
39 Nursing care is adapted to patient's level and pace of development #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
40. Diversional and/or treatment activities are made available to the patient according to his capabilities and needs #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											

		1	2	3	4	5	6	7	8	9	10	11
41. Patient with slow or unskilled performance is accepted and encouraged #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
42. Nursing care goals are established and activities performed which recognise and support the therapist's plan #D/*I	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
43. Interaction with the patient is within framework of the therapeutic plan #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
44. Close observation of the patient is carried out with minimal disturbance #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
45. Response to the patient is appropriate in emergency situations #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											



# Communication

Communication on behalf of the patient

		1	2	3	4	5	6	7	8	9	10	11
46. Ideas, facts, feelings and concepts about the patient are communicated clearly in speech to medical and paramedical personnel #D	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
47. Family is provided with the opportunity for reciprocal communication with the nursing staff #D/*I	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
48. Ideas, facts and concepts about the patient are clearly communicated in charting #I	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
49. Well-developed nursing care plans are established and incorporated into nursing assignments #1	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											
50. Pertinent incidents of the patient's behaviour during interaction with staff are accurately reported #D/*I	Best care											
	Between											
	Average Care											
	Between											
	Poorest Care											
	Not applicable											
	Not observed											

		1	2	3	4	5	6	7	8	9	10	11
51. Staff participate in conferences concerning patient care #D	Best care											
	Between											
	Average are											
	Between											
	Poorest care											
	Not applicable											
	Not observed											
52. Effective communication and good relationships with other disciplines within the hospital are established for the patient's benefit #D/*I	Best care											
	Between											
	Average are											
	Between											
	Poorest care											
	Not applicable											
	Not observed											
53. Patient's needs are met through the use of referrals, both to departments in the hospital and to other community agencies #D/*I	Best care											
	Between											
	Average care											
	Between											
	Poorest care											
	Not applicable											
	Not observed											

## Professional

Care given to patient reflects initiative and responsibility of professional expectations

		1	2	3	4	5	6	7	8	9	10	11
54. Decisions that are made by staff reflect knowledge of facts and good judgement #D*/I	Best care											
	Between											
	Average care											
	Between											
	Poorest care											
	Not applicable											
	Not observed											
55. Evidence (spoken, behavioural, recorded) is given by staff of insight into deeper problems and needs of the patient #D*I	Best care											
	Between											
	Average care											
	Between											
	Poorest care											
	Not applicable											
	Not observed											
56. Changes in care and care plans reflect continuous evaluation of results of nursing care #D*I	Best care											
	Between											
	Average care											
	Between											
	Poorest care											
	Not applicable											
	Not observed											
57. Staff are reliable: follow through with responsibilities for the patient's care #D*I	Best care											
	Between											
	Average care											
	Between											
	Poorest care											
	Not applicable											
	Not observed											
58. Assigned staff keep others informed of the patient's condition and whereabouts #D	Best care											
	Between											
	Average care											
	Between											
	Poorest care											
	Not applicable											
	Not observed											

		1	2	3	4	5	6	7	8	9	10	11
59. Care given to the patient reflects flexibility in rules and regulations as indicated by individual patient needs #D/*I	Best care											
	Between											
	Average care											
	Between											
	Poorest care											
	Not applicable											
	Not observed											
60. Organisation and management of nursing activities reflect due consideration for patient needs #D/*I	Best care											
	Between											
	Average care											
	Between											
	Poorest care											
	Not applicable											
	Not observed											

## Qualpacs Patient Care Scale

Patient ID

--	--	--

Male = 1

Female = 2

--

Age

= 1

= 2

--	--	--

--

Ward

= 1

= 2

--

Rater ID

--	--

Date

--	--	--	--	--	--

Start Time (24 hours)

--	--	--	--

Comments

Best Care = 5, Between = 4, Average Care = 3, Between = 2, Poorest Care = 1, Not Applicable = 7, Not Observed = 8

Staff Grade	A,B,C,D,E,F,O													
<b>Psychosocial Care</b>		<b>Intervention No.</b>												
1.	Patient receives nurses' full attention													
2.	Patient is given opportunity to explain his feelings													
3.	Patient is approached in a kind, gentle and friendly manner													
4.	Patient's inappropriate behaviour is responded to in a therapeutic manner													
5.	Appropriate action is taken in response to anticipated or manifest patient anxiety or distress													
6.	Patient receives explanation and verbal reassurance when needed													
7.	Patient receives attention from nurse with neither becoming involved in a nontherapeutic way													
8.	Patient is given consideration as a member of a family and society													
9.	Patient receives attention for his spiritual needs													
10.	The rejecting or demanding patient continues to receive acceptance													
11.	Patient receives care that communicates worth and dignity of man													
12.	The healthy aspects of the patient's personality are utilised													
13.	An atmosphere of trust, acceptance and respect is created rather than one of power, prestige and authority													
14.	Appropriate topics for conversation are chosen													
15.	The unconscious or nonorientated patient is cared for with the same respectful manner as the conscious patient													

Best Care = 5, Between = 4, Average Care = 3, Between = 2, Poorest Care = 1, Not Applicable = 7, Not Observed = 8

	Staff Grade A,B,C,D,E,F,O													
	<b>Physical</b>	<b>Intervention No.</b>												
16.	Nursing procedures are adapted to meet needs of individual patient for treatment													
17.	Patient's daily hygiene needs for cleanliness and acceptable appearance are met													
18.	Nursing procedures are utilised as media for communication and interaction with patient													
19.	Physical symptoms and physical changes are identified and appropriate action taken													
20.	Physical distress evidenced by the patient is responded to quickly and appropriately													
21.	Patient is encouraged to observe appropriate rest and exercise													
22.	Patient is encouraged to take adequate diet													
23.	Action is taken to meet the patient's needs for adequate hydration and elimination													
24.	Behavioural and physiological changes due to medications are observed and appropriate action taken													
25.	Expectations of patient's behaviour are adjusted and acted upon according to the effect the medication has on the patient													
26.	Medical and surgical asepsis is carried out in relation to patient's personal hygiene and immediate environment													
27.	Medical asepsis is carried out during treatments and special procedures													
28.	Environment is maintained that gives the patient a feeling of being safe and secure													
29.	Safety measures are carried out to prevent patient from harming himself or others													
30.	Established techniques for safe administration of medications and parenteral fluids are carried out													



Best Care = 5, Between = 4, Average Care = 3, Between = 2, Poorest Care, = 1, Not Applicable = 7, Not Observed = 8

	Staff Grade A,B,C,D,E,F,O													
	<b>General</b>	<b>Intervention No.</b>												
31.	Patient receives instruction as necessary													
32.	Patient and family are involved in planning for care and treatment													
33.	Patient's sensitivities and right to privacy are protected													
34.	Patient is helped to accept dependence/independence as appropriate to his condition													
35.	Resources within the milieu are utilised to provide the patient with opportunities for problem solving													
36.	Patient is given freedom of choice in activities of daily living whenever possible and within patient's ability to make the choice													
37.	Patient is encouraged to take part in activities of daily living that will stimulate his potential for positive psychosocial growth & movement towards physical independence													
38.	Activities are adapted to physical and mental capabilities of patient													
39.	Nursing care is adapted to patient's level and pace of development													
40.	Diversional and/or treatment activities are made available to the patient according to his capabilities and needs													
41.	Patient with slow or unskilled performance is accepted and encouraged													
42.	Nursing care goals are established and activities performed which recognise and support the therapist's plan of care													
43.	Interaction with the patient is within framework of the therapeutic plan													
44.	Close observation of the patient is carried out with minimal disturbance													
45.	Response to the patient is appropriate in emergency situations													



Best Care = 5, Between = 4, Average Care = 3, Between = 2, Poorest Care = 1, Not Applicable = 7, Not Observed = 8

	Staff Grade A,B,C,D,E,F,O													
	<b>General</b>	<b>Intervention No.</b>												
46.	Ideas, facts, feelings and concepts about the patient are communicated clearly in speech to medical and paramedical personnel													
47.	Family is provided with the opportunity for reciprocal communication with the nursing staff													
48.	Ideas, facts, and concepts about the patient are clearly communicated in charting													
49.	Well developed nursing care plans are established and incorporated into nursing communication													
50.	Pertinent incidents of the patient's behaviour during interaction with staff are accurately reported													
51.	Staff participate in conferences concerning patient care													
52.	Effective communication and good relationships with other disciplines within the hospital are established for the patient's benefit													
53.	Patient's needs are met through the use of referrals, both to departments in the hospital and to other community agencies													

Best Care = 5, Between = 4, Average Care = 3, Between = 2, Poorest Care, = 1, Not Applicable = 7, Not Observed = 8

	Staff Grade A,B,C,D,E,F,O													
	<b>Professional Implications</b>	<b>Intervention No.</b>												
54.	Decisions that are made by staff reflect knowledge of facts and good judgement													
55.	Evidence (spoken, behavioural, recorded) is given by staff of insight into deeper problems and needs of the patient													
56.	Changes in care and care plans reflect continuous evaluation of results of nursing care													
57.	Staff are reliable: follow through with responsibilities for the patient's care													
58.	Assigned staff keep others informed of the patient's condition and whereabouts													
59.	Care given to the patient reflects flexibility in rules and regulations as indicated by individual patient needs													
60.	Organisation and management of nursing activities reflect due consideration for patient needs													

## **NURSE INFORMATION SHEET**

### **A Study into the Perceptions of the Named Nurse System**

I am the Pre Registration Nursing Programmes Co-ordinator at the Institute of Health Studies and am currently studying for a PhD at the University of Plymouth. For my research study I have chosen to investigate how nursing care is organised in hospital wards. The Patients Charter, issued by the Government, states that every patient should have a named qualified nurse responsible for their nursing care (Dept of Health, 1991&5). I will be studying a number of wards to identify how the Named Nurse System is organised.

Thank you if have already participated in the first stages of the study.

For the next part of the study I will be observing the work patterns of nurses as they care for patients on your ward. I will be positioned to be able to see the nurses as they work but will not participate in patient care. Within a few weeks of my observation session two colleagues will undertake an observation session using Qualpac, which measures the quality of the nursing process.

I will be interviewing nursing staff about the organisation of the ward and a number of nurses have already indicated that they would be willing to participate in this.

Patients on the ward will be invited to complete a questionnaire which will be sent to them after they have been discharged.

The information I gather will not be shared with ward staff or the hospital managers but the final report will be available to all at the end of the study. The results from this study could be used to make changes to the organisation of nursing care in hospital.

All the information you give will remain confidential and no reports of the study will identify you.

You are not required to participate in the study and may decline to do so without needing to give a reason. If you do agree to participate and subsequently change your mind you may withdraw from the study without needing to give a reason.

If you want further information about the study I can be contacted at:

**Ann Humphreys**

The Institute of Health Studies,  
University of Plymouth,  
Drake Circus  
Plymouth  
PL4 8AA

**Tel 01752 233854**

## **Appendix 4 Information to Patients Concerning the Study**

### **PATIENT INFORMATION SHEET**

#### **A Study into the Perceptions of the Named Nurse System**

My name is Ann Humphreys and I am a Nurse working as a Lecturer in Nursing at the University of Plymouth. I am studying for a PhD and for my research study I have chosen to investigate how nursing care is organised in hospital wards. This study has been in progress for 2 years.

The Patients Charter, issued by the Government, says that every patient should have a named qualified nurse responsible for their nursing care (Dept of Health, 1991 & 1995). I am interested in how different wards organise the Named Nurse System

During the study myself and two other researchers will be observing the work patterns of the nurses as they care for patients. We shall be positioned to be able to see the nurses as they work but will not participate in patient care.

The information from this study will not be shared with ward staff or the hospital managers but the final report will be available to all at the end of the study. The results from this study could be used to make changes to the organisation of nursing care in hospital.

All the information you give will remain confidential and no reports of the study will identify you.

You are not required to participate in the study and may decline to do so without needing to give a reason.

If you do agree to participate and subsequently change your mind you may withdraw from the study at any time without needing to give a reason.

If you want further information about the study I can be contacted at:

Ann Humphreys  
Programme Co-ordinator, Pre Registration Nursing Programmes  
The Institute of Health Studies,  
University of Plymouth,  
Drake Circus,  
Plymouth PL4 8AA

Telephone 01752 233854

**PATIENT CONSENT FORM**

**Study Title: Perceptions of the Named Nurse System**

Please complete the following:

*Please delete  
as necessary*

- Have you read the Patient Information Sheet? Yes / No
- Have you had an opportunity to ask questions and discuss this study? Yes / No
- Have you received satisfactory answers to all your questions? Yes / No
- Have you received enough information about the study? Yes / No

To whom have you spoken.....

Do you understand that you are free to withdraw from the study:

- At any time? Yes / No
- Without having to give a reason for withdrawing? Yes / No

Do you understand that all information you give will remain confidential? Yes / No

Do you agree to take part in this study? Yes / No

Signed..... Date.....

(Name in block letters).....

Signed (Researcher):..... Date.....

(Name in block letters).....

**NURSING STAFF CONSENT FORM**

**Study Title: Perceptions of the Named Nurse System**

Please complete the following:

*Please delete  
as necessary*

Have you received enough information about the study?

Yes / No

To whom have you spoken?.....

Do you understand that you are free to withdraw from the study:

- At any time? Yes / No
- Without having to give a reason for withdrawing? Yes / No

Do you understand that all information you give will remain confidential? Yes / No

Do you agree to take part in this study? Yes / No

Signed..... Date.....

(Name in block letters).....

Signed (Researcher):..... Date.....

(Name in block letters).....

**Appendix 7 Results of Highest and Lowest Adherence to Criteria Associated with the Named Nurse Standard by Trust and by Ward**

<b>Location</b>	<b>Ward</b>	<b>Coding for Study</b>	<b>High Adherence (%)</b>	<b>Low Adherence (%)</b>
<b>Trust 1</b>	21		56	44
	22	Trust One Highest (T1H)	57	43
	23		52	48
	24	Trust One Lowest (T1L)	27	73
<b>Trust 2</b>	81		58	42
	82	Trust Two Lowest (T2L)	53	47
	83		56	44
	84	Trust Two Highest (T2H)	59	41

**Appendix 8 The Newcastle Satisfaction with Nursing Scales (Thomas et al 1996a)**

- 1   ward  
3  hospital  
4    patient  
7  time

CONFIDENTIAL

**YOUR VIEWS OF NURSING CARE**

The following questions are about the nursing care you received during your stay in hospital. They ask about the care given to you by nurses and about your views of that care. Finally, they ask some questions about yourself.

These questions are part of a study I am doing looking at the way nursing care is organised in hospital wards.

I would like you to think carefully about each question and to answer it as honestly as you can. Don't spend too long on any question. Your first reaction will probably be better than a long thought-out answer. If you are unsure about how to reply to any question, please give the best answer you can and write your comments beside the question.

Your name and address does not appear anywhere on this booklet. The information that you give will not be used in any way that could identify you personally.

**Ann Humphreys Principal Lecturer in Nursing University of Plymouth**



## SECTION 1: YOUR EXPERIENCES OF NURSING CARE (EXAMPLE)

The first set of questions, starting on the next page, ask about your experiences of nursing based on your stay in the ward. The questions consist of a statement followed by seven possible responses. To answer the questions, please circle the number which best describes your experience. On the rest of this page we give two examples of how to answer the questions.

### Example 1

If the nurses were always very quiet during the night, you would answer the question by circling number 7 - that means 'Agree completely'. Your answer would look like this.

**Nurses were very quiet during the night**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

### Example 2

If nurses were not smartly dressed, you could answer the question by circling number 6 - that means 'Agree a lot'. Your answer would look like this.

**Nurses were not smartly dressed**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

If nurses were always smartly dressed, you could answer the question by circling number 1 - that means 'Disagree completely'. Your answer would look like this.

**Nurses were not smartly dressed**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

If you are unsure about how to reply to any question, please give the best answer you can and write your comments beside the question.

PLEASE TURN TO QUESTION 1

## SECTION 1: YOUR EXPERIENCES OF NURSING CARE

Please circle <b>one</b> response for <b>each</b> question
--

## 1. It was easy to have a laugh with the nurses.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

## 2. Nurses favoured some patients over others.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

## 3. Nurses did not tell me enough about my treatment.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

## 4. Nurses were too easy going and laid back.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

## 5. Nurses took a long time to come when they were called.

Agree completely	Agree a lot	Agree a little	Neither agree nor disagree	Disagree a little	Disagree a lot	Disagree completely
1	2	3	4	5	6	7

## 6. Nurses gave me information just when I needed it.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

PLEASE TURN TO QUESTION 7
---------------------------

**Nurses did not seem to know what I was going through.**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

**Nurses turned the lights off too late at night.**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

**Nurses made me do things before I was ready.**

Agree completely	Agree a lot	Agree a little	Neither agree nor disagree	Disagree a little	Disagree a lot	Disagree completely
1	2	3	4	5	6	7

**No matter how busy nurses were, they made time for me.**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

**I saw the nurses as friends.**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

**Nurses spent time comforting patients who were upset.**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

**Nurses checked regularly to make sure I was okay.**

Agree completely	Agree a lot	Agree a little	Neither agree nor disagree	Disagree a little	Disagree a lot	Disagree completely
1	2	3	4	5	6	7

**4. Nurses let things get on top of them.**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

**5. Nurses took no interest in me as a person.**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

**6. Nurses explained what was wrong with me.**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

**7. Nurses explained what they were going to do to me before they did it.**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

**8. Nurses told the next shift what was happening with my care.**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

**9. Nurses knew what to do without relying on doctors.**

Agree completely	Agree a lot	Agree a little	Neither agree nor disagree	Disagree a little	Disagree a lot	Disagree completely
1	2	3	4	5	6	7

0. **Nurses used to go away and forget what patients had asked for.**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

1. **Nurses made sure that patients had privacy when they needed it.**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

2. **Nurses had time to sit and talk to me.**

Agree completely	Agree a lot	Agree a little	Neither agree nor disagree	Disagree a little	Disagree a lot	Disagree completely
1	2	3	4	5	6	7

3. **Doctors and nurses worked well together as a team.**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

4. **Nurses did not seem to know what each other was doing.**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

5. **Nurses knew what to do for the best.**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

6. **There was a happy atmosphere in the ward, thanks to the nurses.**

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

## SECTION 2: YOUR OPINIONS OF NURSING CARE

## HOW TO ANSWER THESE QUESTIONS

In this section, we ask your opinions of the nursing care you received during your stay on the ward. For each question, please circle one number which best describes your view.

Thinking about your stay on the ward, how did you feel about:

	Not at all satisfied	Barely satisfied	Quite satisfied	Very satisfied	Completely satisfied
The amount of time nurses spent with you	1	2	3	4	5
How capable nurses were at their job	1	2	3	4	5
There always being a nurse around if you needed one	1	2	3	4	5
The amount nurses knew about your care	1	2	3	4	5
How quickly nurses came when you called for them	1	2	3	4	5
The way the nurses made you feel at home	1	2	3	4	5
The amount of information nurses gave to you about your condition and treatment	1	2	3	4	5
How often nurses checked to see if you were okay	1	2	3	4	5
Nurses' helpfulness	1	2	3	4	5
The way nurses explained things to you	1	2	3	4	5
How nurses helped put your relatives' or friends' minds at rest	1	2	3	4	5
Nurses' manner in going about their work	1	2	3	4	5
The type of information nurses gave to you about your condition and treatment	1	2	3	4	5
Nurses' treatment of you as an individual	1	2	3	4	5
How nurses listened to your worries and concerns	1	2	3	4	5
The amount of freedom you were given on the ward	1	2	3	4	5
How willing nurses were to respond to your requests	1	2	3	4	5
The amount of privacy nurses gave you	1	2	3	4	5
Nurses' awareness of your needs	1	2	3	4	5

PLEASE TURN TO SECTION 3 QUESTION 1



## SECTION 3: QUESTIONS ABOUT YOURSELF

These questions are about you. To help us understand your answers to the other sets of questions, we need some information about the kind of person you are. If you are unsure about how to reply to any question, please give the best answer you can and write your comments beside the question.

Please indicate whether you are:

Please circle **one** number

Male	1
Female	2

How old are you?

Please **write your age in years** at your last birthday **on the dashes below**.

Age in years     — —

We would like to know a little about your education.

Please circle **one** number

Are you still in full time education?	Yes	1
	No	2

At what age did you leave full-time education?

Please **write age on the dashes below**

Age on leaving full time education   — —

Including last night, how many nights did you spend in **the ward on this occasion?**

Please **write the number of nights on the dashes below**

Number of nights   — —

Was there one particular nurse in charge of your care in the ward?

Please circle **one** number only

Yes	1
No	2
Not sure	3

How would you rate the **nursing care** you received in the ward?

Dreadful	Very poor	Poor	Fair	Good	Very good	Excellent
1	2	3	4	5	6	7

**Overall** how would you rate **your recent stay** in the ward?

Dreadful	Very poor	Poor	Fair	Good	Very good	Excellent
1	2	3	4	5	6	7

Are there any ways in which the **nursing care** could have been improved during your stay in hospital?

Are there any other comments you would like to make?

**PLEASE TURN TO NEXT PAGE**



Today's date

day	month	year
<input type="text"/>	<input type="text"/>	<input type="text"/>

**THANK YOU FOR YOUR KIND ASSISTANCE**

**Please return the completed questionnaire in the stamped addressed envelope. All information will be treated with the strictest of confidence.**

**Appendix 9 Form for the Analysis of Nursing Documentation**

<b>Analysis of Nursing Notes</b>	
	<b>Nursing Notes</b>
1	Is the Named Nurse Recorded?
2	Is the date of the first meeting recorded?
3	Was this within first 24 hours of the patient's admission?
4	Is the meeting recorded in the care plan?
5	Are daily meetings with the Named Nurse recorded?
6	Did the Named Nurse write the care plan?
7	Is today's care recorded by the Named Nurse?
	<b>Information from Patient</b>
8	Does the patient know the name of their Named Nurse?
9	Does the patient know if there is one specific nurse responsible for their care?

## Appendix 10 Semi-Structured Interview Schedule

	<b>Interview Schedule</b>
1	Biographical details: Qualified Nurse - Length of time qualified & Length of time on the ward Ward Manager - Length of time qualified & Length of time managing the ward
2	Meeting the Named Nurse Standard on the ward
3	Method of organising nursing care on the ward
4	Named Nurse responsibilities
5	Named Nurse and accountability
6	Named Nurse Standard and the impact on patient care

**Appendix 11 Schedule for Non-Participant Observation of Nurse-Patient Interaction**

Location	Ward	Session One		Session Two	
		Shift Time	Day	Shift Time	Day
Trust One	T1H	Late	Friday	Early	Saturday
	T1L	Late	Sunday	Early	Monday
Trust Two	T2L	Late	Friday	Early	Saturday
	T2H	Late	Sunday	Early	Monday

**Appendix 12 Response Rate To Patient Satisfaction Questionnaire (NSNS)**

<b>High Adherence</b>		<b>Low Adherence</b>	
<b>Ward T1H</b>	<b>Ward T2H</b>	<b>Ward T1L</b>	<b>Ward T2L</b>
75%	100%	100%	75%
n=15	n=20	n=20	n=15

**Patient Response Rates to The Newcastle Satisfaction with Nursing Scales (NSNS)**

**Appendix 13 Audit of the Nursing Notes Data**

	Ward Code	Patient ID	Day(s)	Duration of Stay (Days)	Named Nurse Recorded	Patient Aware of Named Nurse
<b>High Adherence</b>	T1H	11	1 & 2	10	No	No
		13	1 & 2	5	No	No
	T2H	5	1 & 2	16	No	No
		6	1	5	Yes	No
		4	2	7	Yes	No
	<b>Total</b>					2 40%
<b>Low Adherence</b>	T1L	9	1 & 2	6	No	No
		10	1 & 2	6	No	No
	T2L	1	1 & 2	7	No	No
		2	1 & 2	5	No	No
	<b>Total</b>					0
<b>Total All Patients</b>					2 22.2%	0

**Awareness of Named Nurse by Individual Patient and in the Nursing Documentation**

## Appendix 14 Summary of Qualpac Data

HIGH ADHERENCE				LOW ADHERENCE			
Ward	Patient ID	Mean	Observations	Ward	Patient ID	Mean	Observations
T1H	1.1.1	3.50	29	T1L	1.1.1	3.90	38
	1.1.2	3.11	31		1.1.2	5.00	37
	1.2.1	3.14	25		1.2.1	3.94	33
	1.2.2	4.29	36		1.2.2	5.00	39
	2.1.1	No activity			2.1.1	Discontinued	
	2.1.2	No activity			2.1.2	Discontinued	
	2.2.1	2.21	28		2.2.1	4.00	25
	2.2.2	2.74	33		2.2.2	4.00	28
<b>Mean score</b>		<b>3.17</b>	<b>30</b>	<b>Mean score</b>		<b>4.31</b>	<b>33</b>
T2H	1.1.1	2.84	25	T2L	1.1.1	2.29	14
	1.1.2	2.21	21		1.1.2	2.51	22
	1.2.1	3.00	23		1.2.1	2.25	8
	1.2.2	2.97	17		1.2.2	3.20	32
	2.1.1	4.05	29		2.1.1	No activity	
	2.1.2	5.00	21		2.1.2	No activity	
	2.2.1	3.57	30		2.2.1	2.16	33
	2.2.2	4.57	21		2.2.2	2.67	29
<b>Mean score</b>		<b>3.53</b>	<b>23</b>	<b>Mean score</b>		<b>2.51</b>	<b>23</b>
<b>Overall Mean score</b>		<b>3.35</b>		<b>Overall Mean score</b>		<b>3.41</b>	

Third digit of patient ID denotes data collector: 1 = data collector one and 2 = data collector two

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