Ongoing Educational Needs of Trained Nurses

Mary F. Stapleton

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ABSTRACT

The research was undertaken to ascertain the views of trained nurses on the need for ongoing professional education and the availability of such education as perceived by nurses in one Health Region.

The main tool used was a questionnaire developed for the research, for which two ordinal scales were devised. Some questions were dichotomous, some open-ended and two questions contained four-point scales.

The sample of 284 nurses contained respondents of two grades, Charge Nurses and Nursing Officers; and from two divisions, general nurses and midwives. These nurses were from forty-five hospitals which were situated in urban and rural areas. The hospital size varied from less than fifty beds to more than two hundred beds.

The results indicated that Charge Nurses in the general divisions exhibited low levels of satisfaction with the facilities for ongoing education provided for them. Midwives, who have statutory 'refresher' courses were more satisfied than general nurses. Nursing Officers in the general divisions were more satisfied than Charge Nurses. Respondents were aware of facilities for post-basic specialist training and realistic in their perceptions of other facilities.

These findings are discussed, their limitations identified and areas requiring further research identified.

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"For sociology whether 'professional'
or 'lay' is our way of making sense
of the social world about us."

David Robinson.

Introduction

The Charge Nurse is the nurse in charge of a ward or department. It can be established from the literature that such a nurse equates with the Head Nurse in North America, with the Unit Head in Israel and with the Ward Sister in Australasia.

In National Health Service Hospitals the Charge Nurse is seen as the archetypal nurse. She/he is, for patients, relatives of patients and doctors the person who makes nursing care operational. The literature provides evidence of her/his capacity to provide a ward environment which patients recognise as supportive and it is contended that such an environment can influence the time span of patients' recovery from an illness.

The objectives of the present research were:

1. To establish if Charge Nurses recognised a need for continuing professional education to enable her/him to fulfill her/his own and others expectation of the role.
2. To investigate the educational facilities available.
3. To establish how much knowledge Charge Nurses have of these facilities.

In seeking these objectives two approaches were made:-

1. A literature search examined nursing through the perspectives of role, professionalism and historical development so that understanding of nursing as an occupation could be established.

Chapter 1 examined the literature on the early development of nursing as we recognise it and Chapter 2 followed this through from the period immediately after the opening of the Register for Nurses to the present. Relevant reports on nursing are discussed in this chapter. In Chapter 3, in order to understand something of the effect of the development of new roles within a social grouping, some literature on role theory was examined and Chapters 4, 5, and 6 look at the role of the trained

nurse as it is identified in the literature, in general and specific terms. Chapter 7 discusses some of the literature available on the theory of professionalism and the status associated with this so that some of the forces which may be influencing nursing could be considered. Chapter 8 considers the literature in relation to the ongoing educational needs of trained nurses to see if there is any justification for considering nursing needs in these terms.

Through the examination of the literature it was possible to identify an area of expertise which was nursing and was related to the Charge Nurse role. From this was posited a need to update nursing knowledge so that such expertise could be maintained over time.

2. A survey to elicit the views of registered nurses.

Chapter 9 discusses the methods used in the survey and Chapter 10 presents the findings related to the data collected by questionnaire. Chapter 11 presents the findings relating to the data collected by means of interviews. Chapter 12 examines the findings and draws some conclusions.

Specific groups of trained nurses were differentiated:

(a) by specialty - nurses in general divisions and nurses in midwifery divisions formed the sample, since midwives have a statutory requirement to attend a five day refresher course every five years and general nurses have no such requirement. Differences in satisfaction levels in these groups, if they existed, could be of value when conclusions were drawn from the data.

(b) by grade - nurses of Charge Nurse and of Nursing Officer grade were included since in the present structure of nursing the grade of Nursing Officer is recently introduced and is above Charge Nurse

in the hierarchy of nursing administration. When the Report of the Committee on Senior Nursing Staff Structure (1966) recommended the introduction of this post it also recommended the introduction of management training for registered nurses which included nurses of Charge Nurse and Nursing Officer grade. The existence of management education inputs postulates a need for continuing education for nurses since if one deficit can be identified others may exist.

This research attempted to identify differences in the perception of such need and the levels of satisfaction with the way perceived needs were met. In addition to grade and specialty, other variables considered to be influential were:

Shift (night or day)	Span of duty (part or full-time)
Social status	Home commitments
Sex of respondent	Length of time qualified
Availability of journals	Use of Libraries
Type of nursing	Size of hospital

Participation in post-basic educational programmes.

In undertaking this descriptive study it was intended that nurses, who were the potential receivers of educational updating programmes should be enabled to indicate:

1. If they recognised a need for such updating programmes.
2. If they knew of the existence of such programmes.
3. If programmes which existed met their perceived needs.
4. If there were unmet needs how best these deficits could be made good, and that any information collected should be considered in relation to that collected from other sources, e.g from the Joint Board of Clinical Studies and from Centres of Higher Education offering post-basic education for nurses.

The researcher is aware that the sources used are somewhat eclectic but justifies this in terms of triangulation where different theories are

investigated in relation to the situation being examined. This also applies to the analysis, where content analysis is applied to the unstructured final comments, in addition to the use of the computer in analysing other data.

Because no similar research has been identified in this country references have been made to literature from North America and Israel when comparisons with other research findings have been made.

Nursing in this study has been perceived as a subsystem of a larger Health Care System and it is within the framework of a systems approach that this research has been set.

CHAPTER 1

As it was in the beginning.

" ... and there met Elizabeth Garrett, who was inspired by her example to become the first woman doctor to take her training in this country. She had a cool and practical view of her aims in life and when asked, 'why not be a nurse?' she replied, 'I prefer to earn a thousand rather than twenty pounds a year!'

Winifred Hector

This chapter endeavours, within limitations, to indicate the historical frame within which nursing is set.

The nursing service, as we accept it today, derives from the vision of Florence Nightingale. Funds subscribed by the nation after Scutari, enabled her to finance a training school at St. Thomas's in 1860, which influenced nurse training throughout the country. However, Abel-Smith (1977) reminds us that King's College Hospital operated a training school for nurses by 1856, and Cartwright (1977) notes the influence on Miss Nightingale of the reforms to nursing practice instituted by Sister Mary Jones, of the Sisterhood of St. John the Evangelist in 1848. Cartwright also notes the difficulties that the Nightingale system engendered during its initial stages when what he calls 'a cadre of educated women' were being encouraged to spread the gospel of high standards of care of the sick to be undertaken by nurses who were trained in these skills. He describes the movement as being in the control of women ' ... who all too often condescended to their work, regarded themselves as 'gifted' to clear up the mess made by the ignorant male and treated their colleagues, administrators and medical staff alike, as underlings whose sole duty lay in obeying their commands.' There is documented evidence of friction between the new nurses and the hospital establishments of the time. Abel-Smith (1977) cites Miss Burt's problems at Guy's Hospital. South's (1857) pamphlet in defence of the existing nursing service at St. Thomas's Hospital also indicates difficulties. Mr. South differentiated between the nurses and the sisters and his reference to the treatment of older sisters by medical staff as being similar to the way they treated 'old superior family servants' would be recognised by Katz (1969). He considered that the attitude of present day medical staff (in America) to nurses is reminiscent of the old caste system operating in the southern states of

America, where whites despised negroes in general but could hold individual negroes in fond regard and treat them kindly. Mr. South described the duties of a ward sister of the period thus:

> "She received directions from the surgeon orphysician for the administration of medicines, diets, et cetera, reported anything untoward to the Apothecary or Matron, and made a report on the patients to the physician or surgeon at each of his visits. She supervised the work of the nurses and regulated the patients."

However, Mr. South did not view 'nurses' as a general term for an occupation which could produce people with increased expertise in certain skills - e.g administrative skills, as evidenced by the existence of ward sisters and matrons. White (1975) contends that Mr South is 'patronising and condescending' towards nurses which indicates agreement with Katz. White also notes that the present confusion that surrounds the functions of the trained nurse in the ward is an old problem since ward sisters (the present day Charge Nurses) have always been more concerned with the organisation of care than the giving of such care themselves. Pembrey (1978) suggests that Charge Nurses are now abdicating their responsibility for the organisation of care and that this lack of role differential results in a reduction in the standard of nursing which reaches patients since the ability to observe and supervise is lost, if the Charge Nurse role does not incorporate them in practice.

Miss Nightingale's "Missionaries" spread to voluntary hospitals in England (and further afield). This new organisation of nursing had matrons who were trained nurses and who were responsible for all aspects of the nursing service offered. (Seymer L R, 1956). Trained nurses of 'Sister' grade were in charge of wards in which nursing care was

undertaken by nursing probationers whose duties included much which was of a housekeeping nature, a practice continued almost to the present day. Such activities enabled sisters to control the cleanliness of the ward and thus to develop a satisfactory environment in which patients recovery could take place. The effect of lack of control over domestic cleanliness has been noted by Graham (1980) when he states in the nursing press that nurses should have restored to them full authority over ancillary staff working in their area, because the result of lack of control has been " ... a great decline in standards of hygiene" and he goes on to say that " ... any casual inspection of hospital corridors and even ward areas will bear this out." Research evidence to support this is however, not offered.

In developing the new nursing, Miss Nightingale's ladies frequently needed the backing of their powerful mentor. It is evident that some of the leaders of the medical world also supported the new nursing development since without this approval the process of nurse training would never have had access to hospitals in which to operate. Since the new scientific approach to medical care developed (Foucault, 1973), medical staff needed a reliable, obedient, intelligent helper to enable them to enact this new role. It was also true that doctors had very little idea of the functions of the nursing role. South (1857) was obviously confusing nurses with ward maids and only his description of ward sisters' duties conformed to what is now and what then was Miss Nightingale's concept of nursing (Nightingale, 1970). That there was a need for what can now be designated as nursing, can be identified by the rapidity with which the principle of nurse training swept the country. Between 1860 when the Nightingale School opened and 1892, voluntary hospitals had accepted the role of the trained nurse and had Matrons who were themselves nurses and in charge of nurses. (Abel-Smith, 1977). 1881 saw the appointment of Miss Manson to St. Bartholomew's Hospital. In 1887, Miss Manson became Mrs Bedford Fenwick

and was thereafter active in nursing politics, (Hector, 1973), and we can identify some of the changes in nursing which were occurring by examining Miss Manson's career. Miss Hector enumerated Miss Manson's achievements at St. Bartholomew's thus:

1. The School of Nursing which had such modest beginnings in 1877, had national renown by the time she left. The Prince of Wales, speaking in 1891 at a presentation to the Treasurer of Bart's, said that the female staff, which had been 116 in 1873, then numbered 250 and a " ... Training School had been establised whose certificate is one of the most valuable nursing diplomas."

   Applicants for training were plentiful. When giving evidence before a Select Committee of the House of Lords on the management of Metropolitan Hospitals, Mrs Bedford Fenwick stated, "The last year I was at St. Bartholomew's I had one thousand five hundred letters of enquiry. I do not call them applications; they were not absolutely applications but letters of enquiry for, say, fifty vacancies."
2. The training period had been increased to three years, and increasing numbers of students stayed to become staff nurses and sisters, thus raising the quality of the trained staff.
3. She regularly asked for rises of salary for lay and nursing staff after long service, and for improvements in the catering and ward equipment.
4. The worst anomalies in the arrangement of the nurses' hours of work were removed, and more generous off-duty given.
5. She founded the Trained Nurses' Institute from which nurses possessing the Bart's certificate were available for private nursing.

6. She constantly put before the Board of Governors the sickness rates at a time when the nature of infections was most imperfectly understood.

Thus indicating the state of nursing in St. Bartholomew's at the time.

Mrs Bedford Fenwick left active nursing when she married but gave a lifetime of effort towards the development of nursing as a profession. Miss Hector also illustrates the conditions of patients recovering from surgery by quoting a sister of that period describing her own training. She mentioned three methods of healing; first intention, granulation and suppuration of which she saw only suppuration, which indicates the activities which occupied nurses of the period.

It is interesting that the methods chosen to spread the gospel of nursing across the country is questioned by both White (1975) and Cartwright (1977) who suggest that the youth and inexperience of the ladies involved may have resulted in lack of subtlety in the approach they used and that this may have generated unnecessary opposition. However, White also notes that in the Municipal Hospitals, nurses used less confrontation because their organisation was such that they had no authority except that which the Medical Officer allowed them and they became skilled at introducing new practices by stealth, which enabled withdrawal to take place if the time for such change seemed inopportune. It is, however, doubtful if such methods really proved their worth since nursing in most United Kingdom non-teaching hospitals, was not involved in decision making or planning, until the implementation of the new management structure for nurses following the Salmon Report (1966). (Baly 1973).

CHAPTER 2

Pathways to today

" ... No one man is capable, without the aid of society, of supplying his own wants; and those wants acting upon every individual, impel the whole of them into society, as naturally as gravitation acts to a centre."

Thomas Paine.

This century has generated a steady stream of investigations into nursing. The years up to 1919 were punctuated by the battles associated with the pros and cons of registration. Mrs Bedford Fenwick led the pro registration faction and after Florence Nightingale's death in 1910 the battle against registration was spearheaded by Miss Luckes, the Matron of the London Hospital. Hector (1973) tells us of Miss Luckes view of nurses in relation to the ability of an ordinary woman to work a fourteen hour day every day of the week. "I do not think a nurse is an ordinary woman or she would not have chosen work which taxes her feelings and energies, mental and physical, so much." Hector also describes Miss Luckes as not wishing to degrade the high art of nursing to the status of a mere profession.

Bills were brought before Parliament year after year between 1904 and 1914 and were rejected. The war however changed attitudes. With the possibility of the enfranchisement of women the matter became of more importance to politicians and in 1919 Dr Addison the first Minister for Health introduced a Bill which was passed in December. Doctors, of course, had been heavily involved in the controversy, both supporting and deploring registration (Bendall and Raybould, 1969). The Nurses Act, then, enabled the formation of the General Nursing Council. This body was responsible for the registration of nurses and for the development of a training syllabus. The period of turbulence for nurses was by no means over, since battles over the registration of existing nurses and the acceptance of hospitals as training schools became central issues. However, by 1923 the General Nursing Council produced a format for examinations. Preliminary examination papers were comprised of:

a. 2 of 1½ hours each to include:

anatomy, physiology, hygiene, nursing

b. 20 minute oral, and

c. 30 minute practical examination

Final examination papers included:

a. medicine, surgery, gynaecology
medical, surgical and general nursing

b. 20 minutes oral, and

c. 35 minutes practical examination

This study, concentrating as it does upon the educational needs of Charge Nurses in the field of general nursing has not pursued the difficulties associated with registration for the supplementary registers. The area is a fascinating one and is worthy of further study but it is peripheral to the present research. Midwives also, having achieved recognition by the opening of the midwives register in 1902, are worthy of more investigation than is offered in this research and further information on the development of the midwifery service is to be found in Donnison's recently published history. All of the midwives in this study were registered general nurses with the added qualification of State Certification in midwifery. In this research midwives are of interest as a specialist group of nurses, of similar grades to general nurses, who already have a statutory obligation to attend updating programmes of five days duration every five years. These programmes, approved by the Central Midwives Board, are available at several centres throughout England and Wales. Midwives may not practise if this obligation is not fulfilled.

In 1932, the Lancet Commission on Nursing published a report. The terms of reference of this commission required them to offer suggestions for making nursing more attractive to women suited to the work and 'suited' seemed to mean well educated.

The existence of the Commission indicated that, with the continued expansion of health services and the sophistication of medicine, the demand for nurses outstripped the supply. Baly (1973) notes that the paucity of other career opportunities influenced many of the educated women who actually entered nursing, rather than the standards required of recruits. The Lancet Commission's recommendations included:

> A reduction in the hours worked - not more than ten hours daily, excluding time off.
>
> Advance notice of duty patterns - to enable the planning of social activities.
>
> Less rigid regulations regarding the Nurses Homes.
>
> Improvements in sisters salaries with a £10 annual payment to recognise ward teaching.

In addition, the Commission commented upon the lack of assertiveness of Ward Sisters regarding living conditions. The Commission found that these women resented, not the infringement of their freedom, but the lack of differentiation in these infringements between themselves and nurses in training.

This commission contained only two nurse members out of a complement of twelve. This perhaps illustrates the views of the society of the time and indicates the paternalistic attitude of the medical profession towards nursing. White (1975) views on this are discussed on page 9 and Bagley (1974) also argues that nursing as an occupation suffers both from society's view of women as subservient to men and nurses as subservient to doctors. Another recommendation of the Commission, that the preliminary examination be so structured that part could be undertaken before leaving school was a matter of considerable controversy for several years. In 1939 the interim report of the Interdepartmental Committee on Nursing Services (Athlone Report) was

still exercised by the lack of opportunity available to nurses to plan their social lives and recommended higher rates of pay, longer holidays and no more than a ninety six hour fortnight. It was the Athone Report which recommended the acknowledgement of a lower grade of nurse than the state registered nurse, to take account of the many women of varying amounts of experience and little or no training who were already working in hospitals and that a roll should be kept of these nurses.

In the years before the 1919 Nurses Act a Nurses Association had been organised, one of several associations founded by Mrs Beford Fenwick and in 1916 the College of Nursing Ltd came into existence. It is this college which later became the Royal College of Nursing. From its inception the college was concerned with the better training of nurses and the advancement of nursing as a profession. By 1918 its Department of Education was involved in the development of tutor courses and later in courses for nurses involved in other work. Health Visitors were also offered training. This department, later to be the Division of Nursing Education (and in 1970 the Institute of Advanced Nursing Education), also was concerned in the development of the Diploma in Nursing Studies offered by the University of London. The Education Department of the College in Birmingham produces programmes, approved by the Joint Board of Clinical Studies, of specialist interest. There are also short programmes on the application of research to nursing activities.

It was the Royal College of Nursing which commissioned the Nursing Reconstruction Committee (Horder 1942) to consider the implementation of the Athlone Committee's Interim Report and the 1943 Nurses Act enabled the General Nursing Council to enrol those nurses recommended by the Athlone Committee and later to develop training for this grade of nurse, first recognised as the Enrolled Assistant Nurse and later as the State Enrolled Nurse.

These developments preceded the National Health Service Act of 1946 but in the years that followed the paradox that existed in nursing, that it was both monolithic and in a constant state of ferment, continued. Report followed report.

The Recruitment and Training of Nurses (Wood 1947)

The Work of Nurses in Hospital Wards (Goddard 1953)

The Reform of Nursing Education (Platt 1964)

The Committee on Senior Nursing Staff Structure (Salmon 1966)

The Report of the Committee on Nursing (Briggs 1972)

The Report of the Royal Commission on the Health Services (1979) (also had a chapter on nurses and midwives)

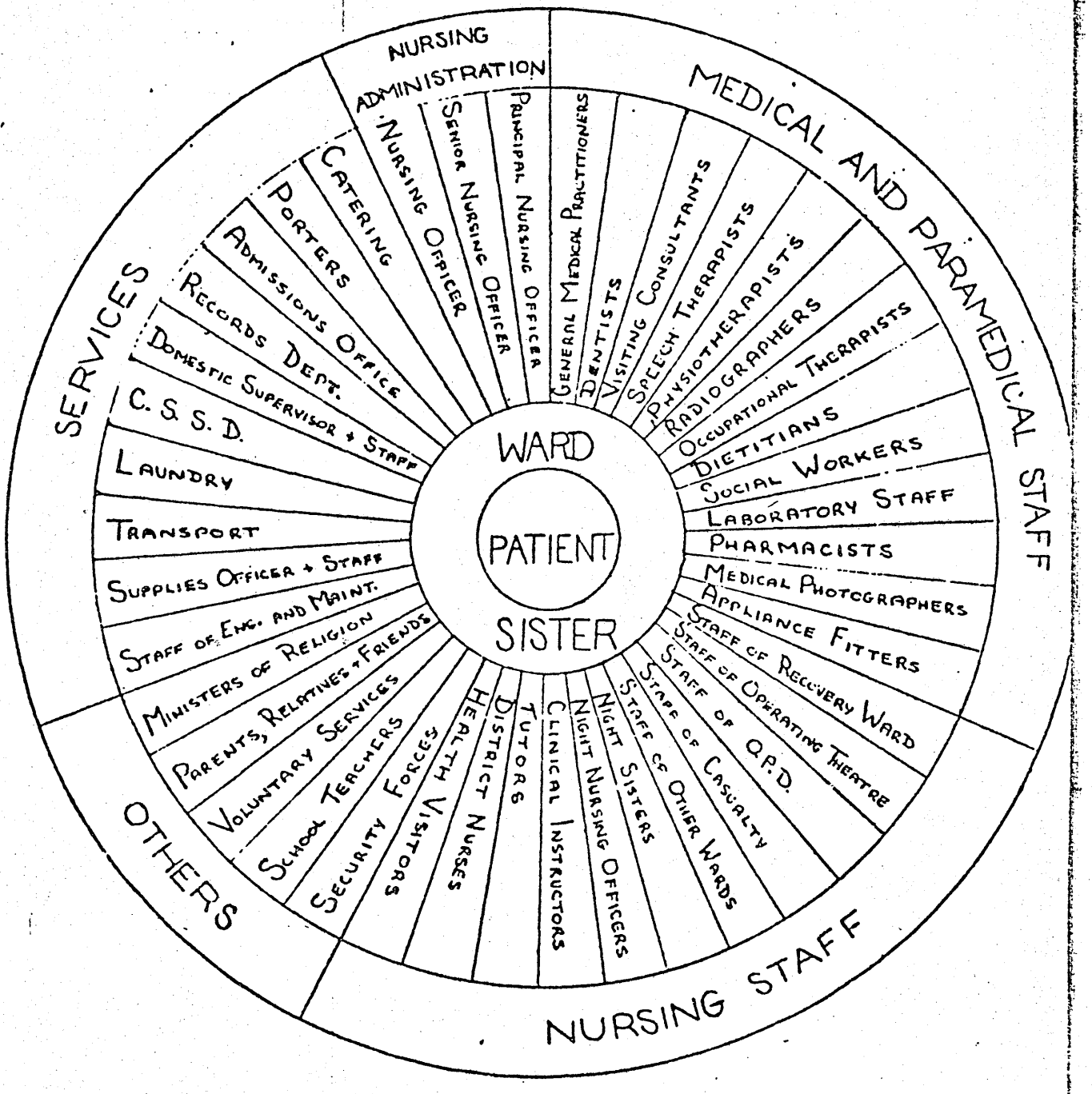
In examining the above list, one is interested in those reports which generated new thinking and whether this thinking resulted in action. The Athlone Report saw many of its recommendations implemented. The Wood Report which recommended far reaching changes in the status of nurse learners, precipated little action and much controversy. The Goddard Report resulted in the introduction of new terminology which, taken out of its context resulted, in McFarlane's (1976) view, in the debasement of actions directly related to patient care - 'technical' equalled highly skilled and 'basic' equalled low skilled and the effects of this interpretation are still influencing nursing attitudes. The Platt Report, despite the efforts of the Royal College of Nursing resulted in little action. The Salmon Report, on the other hand, was implemented in its entirety over a period of very few years, whilst the Briggs Report's major recommendation of a change in the structure of the organisation of nurse training has taken seven years to reach the statute books. The prospect of yet another reorganisation of the Health Services has already followed the Report of the Royal Commission on the Health Services. It is too early to say what other changes will follow.

Mackenzie (1979) considering the differing speeds in relation to action following the Salmon and Briggs' Reports has this to say about the Salmon Report " ... it is much more plausible to see this as a scheme attractive to lay administrators at each level, from the Treasury, through the Ministries, down through the hierarchy of lay administrators and finance officers. It purported to clarify a very confused situation." Mackenzie also suggests that there was a vested interest among technicians of work study and organisation and methods, who had already done much work and recognised the need for a great deal more if the report were implemented. Baly (1973) however, regards the report of the Prices and Incomes Board (1968) as the critical factor operating. Mackenzie (1979) considered that nurses had nothing to lose from the new structure and that nurse administrators had much to gain and that these factors combined with the others to make implementation something to be encouraged. What Mackenzie saw as available to nurses through the Salmon pattern of organization was an improved career structure and improved financial conditions. The question of an improved career structure for nurses is discussed later in this report (Chapter 11, page 139) when data collected at interviews with Charge Nurses and Nursing Officers is presented.

The effect of the Salmon structure upon nursing is also discussed later in the chapter relating to Nursing Officers (Chapter 6, page 45) but it is useful to discuss the report itself since the results of its implementation were so far reaching. Davies (1977) commenting on the changes recommended by the Salmon Report (1966) argues that these changes were well suited to what she identifies as a latent occupational strategy related to nursing. As in Miss Nightingale's day, Davies posits, nurses moved by improving their position in the power structure by means of management control and it was the loss of status at this level, which had been operating since the inception of the National Health Service

which eroded the power and status of nurses. The attempts of the Royal College of Nursing to interest the government in the care/ prevention aspect of nursing had foundered on the power struggles going on elsewhere. Cartwright (1979) also suggests such manipulations although he does not view these behaviours as part of an overall strategy, latent or otherwise.

In the next chapter an attempt is made to examine some theories on role which are relevant to an examination of nursing since as nurses are part of the general social structure, changes in society have implications for nurses. The role of the nurse is recognised as being primarily concerned with helping, nurturing aspects of patient care. The need to offer succour to the sick being the principal component of the role. The nurse, however, is also an employee, and is part of a hierarchical structure. She/he must not only deliver care to patients but may be concerned with the organisation of such care, and with the mobilisation of resources to make care possible. In a hierarchical structure this may require considerable skills in the art of assessment and negotiation. In addition to the nursing hierarchy other structures exist within the organisation of a hospital. Other disciplines with aims similar to those of nurses but with different priorities compete for resources of time, material and manpower. Different statuses exert differing degrees of power and the nurse directly involved in the delivery of patient care must enable the patient to have access to the services offered by, for example, catering departments, medical practitioners, investigative facilities and treatment personnel, in addition to the delivery of nursing services. Figure 1 shows the roles which interact with the Charge Nurse and give some indication of the multiplicity of demands made upon the holder of such a role.



WARD SISTER
SERVICE CO-ORDINATION CHART

.H & S.S.
Ireland
With permission)

From the Report on the Feasibility of Achieving Nursing Economies and Increased Efficiency in Hospital and Community Nursing Services.

CHAPTER 3

Role Development

"As soon as we become involved in particular conflicts with other groups in society, as soon as we are brought face to face with particular social problems; we are at once made aware of how little we really know about social reality and at once realise that a more painstaking study of the facts is necessary."

Ronald Fletcher

It is necessary, before discussing the educational needs of nurses, to define nursing and the nurse. Melia (1979) suggests that, for a sociological perpective, an examination of 'role' is crucial to the understanding of function. To this end an attempt has been made to discuss some theories associated with role in general terms, before considering the difficulties associated with changes in long established roles or the introduction of new roles in a hospital environment, which as Georgopoulas and Mann (1972) indicate, is complex, since, as an organisation it demands rules but these cannot cover all the eventualities generated by patients who are not necessarily passive and make their own demands upon staff.

Gross, Mason and MacEachern (1958) define 'role' as a set of expectations - a set of evaluative standards applied to an incumbant of a particular position. Smith (1976) conceptualises role in terms of activity and defines it as a patterned sequence of learned actions performed by an individual in society. He reminds us that roles can be reciprocal for example, parent - child, husband - wife, nurse - patient. Southall (1959) also notes the reciprocity of roles. Other definitions of role include that of Chinoy (1968) who describes role as a cluster of norms around a status, and Banton (1965) who classifies role in terms of differentiation. Thus, he says, sex may affect the way people respond to an individual, as may occupation, with its implication of class difference but leisure roles, for example, may have little effect outside the area in which they are enacted. Smith (1976) describes roles which articulate with each other as a role set. In hospital an example of the role set of the Charge Nurse could contain patient, relative, doctor, student nurse, housekeeper, porter, Nursing Officer (see Figure 1 on page 21) Banton (1965) further discusses signs in terms of uniforms, badges et cetera and this is important in hospitals where many of the role differentiations are indicated by uniform change.

Johnson and Martin (1958) analyse the nurse role in relation to that of the doctor in terms of the degree of instrumental and expressive elements they both contain.

Table 1

Comparison of Doctor Nurse Functions

Functions	Doctor	Nurse
Instrumental	Primary	Secondary
Expressive	Secondary	Primary

Identifying the instrumental aspects of the social systems devised by the doctor - patient - nurse triad, they see the medical function as striving, by means of investigation, diagnosis and the prescription of treatment, directly towards the goal of patient recovery. The nurse, they describe as being more involved in the tension reducing aspects; presenting the medical view to the patient and presenting the patient view to all significant others. This presentation of role implicitly accepts Parson's (1972) view of the patient's voluntarily relinquishing certain responsibilities by the very act of becoming a patient, therefore, accepting temporarily the dependent role in the triadical relationship, which is legitimised by the "ill" label. It is true that Illich (1976) and Kennedy (1980) dispute this legitimacy, making a plea for the demystification of medicine which would allow the patient to participate in decision making; but society gives at least tacit acceptance of it and the present interaction between nurse, patient and doctor acknowledges this acceptance. Thus nursing is seen, even when technical procedures are involved, as directed by the nurse to show caring comforting attitudes and in producing this environment the nurse is contributing the nursing element of the patient's recovery.

Maclean (1974) reinforces this viewpoint when she identifies the traditional designations of nurse - sister - matron and relates them to the nurturing aspects of the nursing role. Banton (1965) in discussing roles, notes also their competitive aspects and states that occupants of roles can develop protective perceptions of other roles with which they interact. For example, an achieving role may be seen by non-achievers as conceited and the non-achievers may be seen by achievers as jealous. Such a situation may complicate the development of new roles and in nursing, the Nursing Officer/ Charge Nurse interaction may be affected in this way.

Biddle (1961) defines role in terms of norms and defines norms as the expectations of a group regarding the enactment of a role and goes on to describe role consensus as the expectations of many groups towards the attributes of a role. Brown (1965) on the other hand, identifies roles in terms of ascribed roles (those into which a person is born) and achieved roles (which are mainly occupational) and suggests that in Western culture, "professional" values can be identified by the ability to set the demands of achieved role above the demands of the ascribed role. He goes on to indicate areas of conflict and in nursing for example, this could occur within the role when being a mother prevents the enactment of Charge Nurse role to the satisfaction of the role occupant, or conflicts which can exist if, for example, the Charge Nurse's (subordinate) view of the Nursing Officer role is different from the view held by Senior Nursing Officers (superordinates). Such lack of congruence could give rise to role tensions for the Nursing Officer. Gross, Mason and MacEachern (1958) identify just such possible conflict in relation to the School Superintendent role interacting with teachers and school governors and discuss various strategies developed to deal with the conflict, potential or actual. Such lack of role congruence, however, does not necessarily lead to conflict. Parsons (1957) considers that new thinking may occur as a result and stimulate the development of roles. Out of conflict also, strategies may occur which

allows the role to change. However, in the absence of coping mechanisms, such conflict may be the source of high levels of anxiety. In hospitals this anxiety has been noted by Revans (1964), Menzies (1960) and Cartwright (1969).

The impact that specialisation has upon key roles has been described by Southall (1959) who indicates that a proliferation of such specialist roles must diminish the content of the original role. Thus, in hospitals, the advent of the specialist roles of dietitians, physiotherapists, radiographers and housekeepers has reduced the breadth of the nurse role. This reduction in breadth should allow the development in depth of the "caring", "expressive" aspects of the role. However, as Senior (1978) suggests, the nurse role is still implicitly, if not explicitly, involved with most of the other aspects. Dietary advice may not always be available but the patient must be fed. Housekeepers and therapists, in the main, keep office hours but routine needs make demands upon the nurse throughout the twenty-four hours. The expressive aspects of the role cannot be switched on and off since, if the patient perceives that caring, comforting interactions are denied in one situation they may no longer respond in another more "appropriate" interaction. This may prevent the nurse role being fully operational at any level. The response of the nurse to patient needs may be on an expressive affective level but demonstrated at an operational level, e.g., the giving of food or drink and so efforts to constrain nursing to certain limited aspects of patient care are thwarted by the nurturing aspects of nursing which cannot function on an intermittent basis. It is therefore arguable that the reduction in the breadth of the nurse role is more apparent than real. In depth, the role is continuing to develop, since the rapid increase in knowledge in the biological sciences, together with the expansion of the behavioural sciences, (Chapman, 1977 and Staunton, 1979) has created an environment which has contributed to societal change. This makes it necessary to examine the professional educational

inputs available to trained nurses and to determine what they themselves recognise as educational needs in this dynamic situation.

To nurse implies the existence of patients and people become patients by means of their relationship with doctors. These roles, those of patient, doctor, nurse interact with one another within the hospital setting. However, differences exist. Patient is differentiated by means of the acceptance of a state of dependency (Smith 1976) and Parsons (1972) states that the sick person is allowed exemption from the performance of normal social-role obligations and exemption from responsibility for his own state. The doctor copes with the patient's need by means of investigation, diagnosis and the prescription of treatment. The nurse undertakes delivery of the prescribed treatment and generates nursing care to meet the levels of dependence exhibited by the patient. This includes observation and recording of various signs and symptons. The interaction between the roles of nurse and doctor makes role differentiation more difficult.

Gilbertson, (1977) writing of the confused role of the ward sister in New Zealand, states that role ambiguity and misunderstanding are often functions of unclear training objectives and varying expectations of those who interact with such particular roles. He argues that text book definitions of the role are not tested by research and posits a need for such research within a framework of applied role theory as a basis for understanding the complexities of the role as it is undertaken, since, he states, it is clearly understood that "... the crucial source of initiation to achieve patient care in a total sense must come from the ward sister." Research in this country relating to the Charge Nurse role is concerned with certain limited although important aspects of the role, for example, Pembrey (1978) examines the management component of the role and Fretwell (1980) and Ogier (1979) the teaching component. How these components are integrated into the whole has not yet been adequately examined.

In the ensuing search of the literature, the role of nurse is examined first in general terms and subsequently in relation to specific types of nurse. It is intended by this to identify the intellectual and emotional demands made upon nurses undertaking these roles thus indicating if such demands require ongoing updating of knowledge upon which to base performance.

CHAPTER 4

The State Registered Nurse

"A hospital accepts and cares for ill people who cannot be cared for in their own homes. This is the task the hospital is created to perform, its 'primary task'. The major responsibility for the performance of that primary task lies with the nursing service, which must provide continuous care for patients, day and night, all the year round. The nursing service therefore, bears the full, immediate and concentrated impact of stresses arising from patient care."

Isobel Menzies.

Roper (1976) defines nursing in these terms:

"Within the context of a health care system and in a variety of combinations, nursing is helping a person towards his personal independent pole of the continuum of each Activity of Daily Living: helping him to remain there; helping him to cope with any movement towards the dependent pole or poles; in some instances encouraging him to move towards the dependent pole or poles; and because man is finite, helping him to die with dignity."

The nurses' interpretation of the role they are intending to enact allows them to identify the skills they will need to undertake the role. It also enables the Charge Nurse to be seen within this framework as a co-ordinator, deliverer and teacher of nursing care. The definition encompasses the nurse's complementary relationship with the doctor's activities of diagnosis of disease and prescription of treatment and enables the nurse to identify the nursing component of care. Roper considers that nursing does not benefit from the current disease labels used to identify the patient's health since nursing is concerned with the patient's condition and not his disease label - a point also made by the Scottish National Nursing and Midwifery Consultative Committee (1976).

Henderson (1978) asks, "Is there a universal concept of nursing?" She goes on to state that before answering the question she must reconstruct it to enable her to identify for whom the concept is required; if it is for the public at large, for other health workers, or for nurses themselves. Miss Henderson posits that the elements common to all these groups might be identified as a universal concept of nursing. However, in 1968, Miss Henderson defined nursing for the International Council of Nurses in these terms. "The unique function of the nurse is to assist the individual sick or well in the performance of those activities contributing to health or its recovery which he would perform unaided if he had the necessary will

or knowledge, and to do this in such a way as to help him to independence as rapidly as possible." This concept of nursing can be related to Roper's identification of the nurse as helper in the activities of daily living.

McFarlane (1976) refers to the nurse as a "continuity man" both as a giver of care and as a co-ordinator of care, acting as a surrogate for doctor, patient or relative in turn and having a major professional contribution to make, marked by the nature of the acts she performs. She stresses the helping, assisting, serving nature of the nursing role and suggests that this dimension, which Henderson (1978) also stressed, is in danger of playing a subsidiary part and being relegated to the "unskilled" to undertake, these tasks being considered unworthy of the technicians role that nurses are in danger of assuming. Austen (1976) also makes this point when she discusses the reduction in status of the work undertaken in the home, relating it to the advance of technology debasing tasks and thus reducing the status of those undertaking these tasks. Austen was describing the work of women in the home. In nursing, increasing technology surrounding the patient is causing the essential care tasks to lose status and with the reduction in the status of the tasks, reduction in the status of those undertaking these tasks - nurses. The extension of the role to enable nurses to undertake high status procedures e.g. those which have become routine for doctors, has always been part of the pattern of development in nursing but it is only now that the quantity of such tasks is challenging nursing in its essentials, since only recently has technology developed its present multiplicity of demands. For example, the present tendency for nurses to undertake the administration of drugs into intravenous lines has resulted in an increase in prescriptions for the delivery of medication in this way. Constraints previously operating, that doctors themselves administered drugs by this route presumably acted as a control on this type of prescription. The removal of this constraint has

resulted in considerable increase in this type of nursing activity. Since the nurse involved must be a trained nurse and the only trained nurse available is often the Charge Nurse, the additional time consumed by drug administration has a concomitant effect upon the Charge Nurse's ability to supervise and co-ordinate care or to teach.

The proposal made by McFarlane (1976) for the development of the role of the nurse rather than for its extension, stems from her definition of "development", which she relates to the helping, assisting, aspects of nursing and "extension", which she defines as moving away from the patient towards medically derived tasks Both Roper (1976) and Hunter (1971) touch on the process of role development, when they comment on the inadequacy of the medical model as a basis for professional development in nursing. Hunter considers that nursing could and should encompass both the technical tasks abdicated by the doctor and the increasing theory now becoming available to nursing to enable nurses to develop social and relational skills. MacGuire (1964) and Dodd (1974), however, found that nurses were reluctant to acknowledge the possibility of acquiring such skills, which they considered to be part of the personality and therefore there or not there; not skills which could be learned: That nurses of learner status were in the process of socialising into nursing and thus learning to relate to patients and other workers, was not identified by nurses in Dodd's study as being indicative of an ability to acquire skills of this kind. Quenzer (1974) also notes that nurses seem unaware that such interpersonal skills contributed to a therapeutic environment for the patient. Pepper (1977) and Ogier (1979) indicate that Charge Nurses would benefit from further training in interpersonal skills, suggesting that Charge Nurses recognised that they lacked such training.

Saunders (1955) discussing the ambiguous status of the nurse, notes that she is expected to have extensive knowledge, master complicated skills and carry heavy responsibilities, but that society offers relatively low

rewards for this. Chapman (1977) makes something of the same point, when she comments on the medical view of the nursing role and considers that, although doctors want an intelligent observer and a nurse capable of carrying out complicated technical procedures, they do not want a "colleague". They see the emergence of nurses from degree courses as a threat to the medical monopoly of knowledge. She also considers that doctors see intelligence and the desire and ability to deliver nursing care to patients as mutually exclusive and thinks that this view exacerbates the situation. Devine (1978) also identifies this lack of role definition, noting that as subordinates, nurses are expected to render obedience to superiors and to conform to rules and regulations. At the same time as professionals they are being encouraged to consider themselves autonomous. Devine's study took place in Nova Scotia but Charge Nurses in this country might well identify with the findings. It is useful to compare Devine's view of the situation with the somewhat more rarified definition of nursing offered by Schlotfeldt (1965). Here the nursing role is seen in terms of "meeting the patient's needs" by means of assessment of the interpersonal and environmental climate so that it can be made therapeutic. The nurse is seen as working with the doctor as a true professional and negotiating with the doctor on the basis of patient need, as to who should assume responsibility for a particular aspect of the therapeutic regimen at any point in time. In Devine's study there is little evidence that doctors pay any more than lip service to the concept of the nurse as a professional nor was there any evidence that doctors saw nurses as partners in a decision making process, despite the episodic nature of medical care which Hyderbrand (1973) comments upon. Bendall (1973) sees the lack of role definition in nursing as leading to a process of status reduction and cites three measures used by nurses to offset this:-

1. The tendency to increase the academic qualifications required of entrants, is one method, used as a general attempt to lever up the "floor" upon which nursing is based. There is no research evidence, Bendall states upon which to consider an appropriate level of educational qualifications for entrants to nursing but professionalisation suggests academic standards.

2. Tutors have made their own bid for status enhancement by supporting the development of teachers, lecturers and professors of nursing.

3. The Salmon structure brought status enhancement to nursing managers.

However, both teachers and managers suffer professional status deprivation in that they have moved away from the direct delivery of patient care and in this situation Miss Bendall sees a particular threat to status security. Grosvenor (1978) however, considers that this is a feature amongst practice disciplines generally not only nurses and that practitioners, secure in the knowledge that they are providing a service for other people which would be missed immediately were it withdrawn, have a clear justification for their existence. Managers, Grosvenor agrees, lack this clear definition of usefulness and consequently lean more heavily on other status supports. MacKenzie (1979) suggests that this explains the pressure of nurses in management roles for the development of a rational management structure.

The state of organising nursing care, instead of directly delivering patient care, has been noted by Corwin (1961) as being associated with role ambiguity in nursing, in the United States. Corwin found that well defined role conception is positively associated with personal self assurance and that staff, who when deprived of a clear conception of their role, could distance themselves from such a threat to self, by moving away from the ambiguous role. Dodd (1974) identifies the problem at another level.

She recognises that tutors teaching an "ideal" type of nursing which is not operational in the real world, place an intolerable burden upon the nurse practitioner who has to adopt strategies of avoidance to cope with the situation and in doing so suffers further status threat. If technology has debased the nurturing aspects of nursing as Austen (1977) and Schulman (1972) suggest and if such debasement has resulted in loss of status and status reduction has created a loss of power, it can be deduced that lack of power at Charge Nurse level can affect the delivery of patient care. It is interesting that Merton (1960) acknowledges the need for nurses to seek professional status. He accepts their legitimising of this need within a framework of the possession of expertise which is exercised. Professional status carries with it the social accolade of autonomy and as Merton states, autonomy is related to self-respect.

> "In our society, as in many other societies, people find this measure of autonomy rewarding. They take satisfaction in knowing that it is they, not others who decide what they are to do in a particular field of operation, how it is to be done and by whom it is to be done. Autonomy and its correlate, self-respect are just as real rewards for human beings as money income, with all that that income makes possible. Were it not, many members of many professions would drift, in even larger numbers than they do now, into occupations where they receive more income but less respect. It is this fact, of course, that periodically leads to the economic exploitation of certain professions."

Austen (1977) also recognises that nurses seek their status rewards within the concept of professional development rather than hierarchical progress. It is in the field of nursing knowledge and its availability to practitioners that problems exist. The movement of nurses towards professional autonomy by means of managerialism noted by Davies (1976)

is also considered by Johnstone (1978) who posits that this movement can lead to division between "enablers" and "carers", since the ritualistic deference behaviours which co-exist in nursing with the aspirations of professional striving may disguise these differences. Thus the nurse practitioner (in this research, the Charge Nurse) in her/his need to update knowledge relevant to nursing and to maintain status in nursing vis-a-vis patients, learners, colleagues and doctors may be forced to look towards the medical profession rather than to senior nurses if such nurses are not seen as a source of nursing knowledge of value to the nurse practitioner.

To clarify further the nursing roles under scrutiny, literature relating to the nurse in charge of wards was examined. In this country in the general field of nursing, the nurse in charge of a ward in a hospital traditionally was female and the designation "Sister" was used. Since the Second World War an increasing number of men were accepted for training for the general register and this meant that a greater number of wards had male nurses in charge. The designation Charge Nurse can be used for nurses of either sex and this is the term used in this report.

CHAPTER 5

The Charge Nurse

"But again, to look after all these things yourself does not mean to do them yourself. 'I always open the windows' the nurse in charge often says. If you do it, it is by so much the better, certainly, than if it were not done at all. But can you not ensure that it is done when not done by yourself? Can you ensure that it is not undone when your back is turned? This is what being 'in charge' means. And a very important meaning it is too. The former only implies that what you can do with your own hands is done. The latter that what ought to be done is always done."

Florence Nightingale

Caseldine (1977) postulates that the Charge Nurse role demands so much of the nurse in terms of clinical knowledge and teaching ability, in addition to managerial skills, that it is no longer a realistic expectation. The growth of knowledge in today's world, allied to the loss of status which he associates with the introduction of the Nursing Officer role, leads to increasing difficulties for a Charge Nurse operating in the traditional manner. Caseldine maintains that it is now time to develop the role of the nurse in terms of the nursing consultant. Such a consultant nurse should be available to nursing practitioners in the ward situation who are heading teams of nursing staff giving direct care to patients. The administrative management, he considers, should be under the control of Nursing Officers with clerks working in the wards, relieving nurse of administrative detail and thus truly enabling such nurses personally to operate as deliverers of care.

This development moves far from the Goddard (1953) definition of the Ward Sister's (the present day Charge Nurse) functions. Goddard saw the Charge Nurse role as an amalgamation of three main components:-

1. The supervision of nursing care and treatment.
2. The training of student nurses.
3. The co-ordination of services to the patient.

Subsumed under (1) is the interpretation of medical instruction and the delivery of medically prescribed treatment. Lalean (1977) noted that such interpretation can lead to difficulties when there is no written version of the medical order available. Whilst drug prescriptions are always written, other medical instructions may not be and could therefore be interpreted by the Charge Nurse rather as a cue than a command. If the doctor views the instruction as a command rather than a cue the resultant action or lack of action may lead to variability in the understanding of treatment given. Wilson (1975) identifies a difference in the doctor's perception of staff nurses' knowledge of the biological sciences and the

amount of knowledge that such nurses actually possessed. Wilson was investigating the state of knowledge of Staff Nurses. However, no more knowledge is identified for the Charge Nurses since "appropriate" experience at Staff Nurse level is the principal criterion upon which Charge Nurse appointments are made. Thus the same degree of incongruence may exist between the doctor's perception of knowledge possessed and the actual knowledge possessed by the Charge Nurse. This may well influence the Charge Nurse's interpretation of the doctor's instruction and underlines the need for systematic updating to be available to Charge Nurses, more than 25% of whom, in the present research, trained 25 or more years ago.

Kerrane (1977), discussing the American nursing situation, as an indicator of the development of the nursing role in this country, noted the problems associated with the demands of highly technical nursing. These areas draw heavily on available nursing resources and give nursing care of a satisfactory standard. However, patients not requiring such technical services are nursed where they may have to be cared for by nursing aides who have practically no nursing skills at all. Kerrane posits that the adoption by nurses of tasks which doctors find less interesting than diagnosis and prescription, may well reduce the nurses' ability to maintain standards of nursing care, since time needed to care for patients will have been consumed by tasks delegated by doctors. Davies (1971) notes that nurses of Charge Nurse grade saw the delivery of treatment, ordered by medical staff, as the most important function of their role; an observation also made by Dodd (1973). Davies (1971) interprets this finding within the framework of Etzioni's (1969) definition of a semi-profession. However, the lack of control of work volume, which underpinned Davies' (1971) identification of this state, may well be based upon inadequate information. Pressures operating affect doctors and nurses alike and are societal rather than professional. The admission of patients

in need of treatment is an uncontrollable variable in a national health service. This creates many problems in situations of inadequate resources whether the resources in short supply are human or financial. The nurse is primarily conscious of the needs of sick people who are labelled as patients when these patients are within the environs of the ward. Consultants, and by implication, their Registrars, become responsible for patients when they hear of them, whether they are in the ward or not, so long as the patients are in the catchment area. The doctor is required to "treat" any who are in need of treatment if this need has been legitimised by referral from a general practitioner. That such patients may require only half-an-hour of the physician's time in treatment means that the doctor recognises his capacity to treat, but such half-an-hour of medical time may generate a demand for nursing care which spans all of the twenty-four hours. It is perhaps the separation rather than the affinity of goals which generates an area of conflict here.

The importance of involvement of 'nurse', whether charge or other grade in clinical interaction with patient, was noted by Williams (1969) and Dodd (1973) and Pepper (1977). Williams indicates that for the Charge Nurse, the patient centred aspects of the role were the aspects which were stressed. Administrators, ignoring the demands of such clinical elements, identified the Charge Nurse only as a manager of services within the ward, thus intensifying the Charge Nurses difficulties in influencing nursing outcomes. Anderson (1973) states that doctors' expectations of the Charge Nurse were primarily that his instructions should be carried out and Dodd (1973) also found this. Dodd found too that Charge Nurses identified their authority in the ward as stemming from their ability to satisfy Medical Consultants rather than the nursing hierarchy. Bendall (1975) found that Charge Nurses could be doctor centred rather than patient centred and that this produced a particular type of

ward environment which could be identified by the patient. This was also described by McGhee (1961), Revans (1962) and Cartwright (1964) who acknowledge the ward environment which is a direct effect of the variable "Charge Nurse" and Walker (1967) also mentions this. Exchaquet (1967) notes another aspect of Charge Nurse control. She considers that Charge Nurses have moved from serving patients to serving all other departments within a hospital. She postulates that today's hospital nurses deliver upon demand, people, patients, material and time, so that such departments will not be inconvenienced. She contends that such developments produce efficiency at all levels except that of patient care. This again may relate to Austen's (1977) belief that increasing technology debases personal service.

Gilbertson (1977) poses two questions in relation to the role of the Charge Nurse:

" 1. What are the determinants of the Ward Sister role and what are resultant conflicts and ambiguities and their effects in terms of stress or other dysfunctions?

2. What are the factors resisting and facilitating the growth and development of a more professional health care team in various organisations?"

The organisation of the nursing service which followed the publication, in 1966, of the Report of the Committee on Senior Nursing Staff Structure, (The Salmon Report - see pages 19 and 45) was not research based. However, without adequate research, the rationalisation of nursing management resulted in the emergence of a new grade of nurse, the Unit Nursing Officer, administratively responsible for groups of wards and this role impinges to some degree upon the functions of the Charge Nurse. The development of this role may well introduce further areas of difficulty for the nurse of Charge Nurse grade. The present research

examines only one area of possible contribution to dysfunction in both the Charge Nurse role and the Unit Nursing Officer role. This contribution is the availability or lack of educational inputs which may enable nurses of these grades to update nursing knowledge, and with this in view the next chapter looks at the literature in order to establish understanding of the Nursing Officer role and to examine health service workers, both nurses and others perception of the role.

CHAPTER 6

The Nursing Officer

" ... if you have your ear to the ground you cannot have your head in the clouds. Admittedly you cannot see over the next hill, either, so you have to lift your head occasionally, and the value of a good staff to plan and think and look ahead is considerable. But the results of their thoughts and plans must be served up to the barons as a tempting refreshment which they can partake of if they choose, not as a medicine which they have to swallow whether they like it or not."

Antony Jay.

The rational system of management now existing in nursing derives from the implementation of the Report on Senior Nursing Staff (1966). This, the Salmon Report has been previously discussed on page 19 . In the report it is stated that nurses' views were found to have less status than the views of medical staff and hospital administrators when at meetings of governing bodies within the National Health Service. Subsequently, great emphasis was placed on the development of staff training in management skills and money was made available to fund such training. As a result of the Salmon Report (1966), a classical structure of management was imposed and nurses were graded from 5 to 10, dependent upon an increasing span of management responsibility. Salary was dependent upon grade.

Grade 5 STAFF NURSE	A state registered nurse who acts as assistant and deputy to a Charge Nurse.
Grade 6 WARD SISTER	Nurse in charge of a ward or department (e.g. Out-patient dept.) This designation is confusing when the person in charge is a man and the designation Charge Nurse is increasingly being used. It is the designation Charge Nurse which is used throughout this report.
Grade 7 UNIT NURSING OFFICER	A nurse in charge of a group of wards. (This could be a small hospital.) Or it could be a nurse in charge of a specialised unit, e.g. a dialysis unit.
Grade 8 SENIOR NURSING OFFICER	A nurse in charge of a group of units, frequently a whole hospital.
Grade 9 PRINCIPAL NURSING OFFICER	A nurse in charge of a main specialty, e.g. General, midwifery, psychiatry. A single specialty could span several hospitals.

Grade 10 CHIEF NURSING OFFICER	A nurse in charge of all nursing services in a group of hospitals.

The reorganisation of the Health Services in Britain in 1974 resulted in Community Nursing Services which had previously been the responsibility of Local Authorities, coming under the control of the newly formed Health Districts. These Health Districts were to be monitored by Area Health Authorities, who allocated the funds distributed by Regional Health Authorities. Each of these authorities had their own teams of officers. District Management Teams now had a District Nursing Officer who was responsible for all nursing services within the district, both hospital and community based. Nursing Divisions were developed. These were usually based on the main nursing specialties, which now included Community Divisions. The Salmon Structure grades 9 and 10 became defunct and District Nursing Officers and Divisional Nursing Officers were appointed. One other change in management for nurses which the implementation of the Salmon Report's recommendations brought about was the development of Staff posts in nursing management for nurses with special expertise in certain key areas. These posts were often of Senior Nursing Officer grade and, in the main, nurses offered skills in personnel, planning and infection control.

The totally new development which was introduced into the system was the role of the Nursing Officer.

The components of the Nursing Officer role identified by the Salmon Report (1966) were those of:

1. Nursing consultant
2. Work programmer
3. Staff controller

Wilson-Barnett (1973) and Rowland (1977) examining the instrumental aspects of the Nursing Officer role found that 49% and 56% respectively of

the Nursing Officer's working time was spent on administrative work and that a large part of the 37% of time which was spent in "patient directed activities" was taken up with "ward rounds". Both these researchers question the value of such "ward rounds" and suggest that other nursing activities might be undertaken to enable nurses of this grade to maintain their nursing competence. Neither of these reports offer alternative activities, but in an occupation based on the giving of care to the sick there must be many patient care activities which can be undertaken by any grade of trained nurse, when there are opportunities made for this to happen. Ongley (1976) also writing of the way that Nursing Officers use their time, notes that 46% is spent on administration and all of these studies mentioned that little time was observed to be spent on "teaching" activities. Ongley also noted that the mean time spent on individual tasks was 8 minutes and Rowland observed a mean time of 4 minutes. Ongley and Rowland both record that large amounts of Nursing Officer activities were unplanned. Clarke (1978) describes the lack of identification of "planning" as a nursing activity and Lalean (1973) as discussed elsewhere in this report (page116) notes the frequency of interruptions to which Charge Nurses were subjected. It may be that the ability to respond to needs as they arise is an essential attribute of the Nursing Officer function. Or, it may be an inheritance from the Charge Nurse role, where planning of activities was not recognised as a necessary skill. Smith (1977) examining the role of the Nursing Officer notes that participative observation produced a different emphasis on priority of activities from the replies elicited from the same group using questionnaires as a research tool. During observation Nursing Officers demonstrated their role as being mainly administrative, whilst written response indicated that the clinical aspects predominated. Smith speculates that observation produced "real world" information whilst the questionnaires indicated a psychological rationalisation

and such answers could be considered to indicate an ideal and desirable state, a point also made by Hagburg (1970). In another study of the role of the Nursing Officer, however, Carr (1978) found that Nursing Officers' activities break down into:-

> 20% of time spent on "teaching" with administrative and patient care activities using equal amounts of time.

indicating that the role was well integrated into the service. Wall and Hespe (1972) suggest that dissatisfactions exist and Rowland (1977) and Wilson-Barnett (1973) note that "communications could be a problem" and that "the hierarchy is too great". This could indicate a lack of delegation of responsibility which might be related to the lack of confidence in subordinates which Menzies' (1960) describes as part of the social defence system developed by nurses. Bagley (1977) delineates nurses of Nursing Officer grade as being in a state of anomic confusion. He identified them as being confronted with a confusing range of tasks coupled with a diversity of authority roles, where, he states, who is accountable to whom has not emerged with any clarity nor are the occasions when they may act in the clinical capacity assigned to them very clear. Such a state of normlessness he contends, results in great amounts of personal distress and unhappiness for the grades of staff affected.

The evidence, therefore, suggests that the varying facets of the Nursing Officer role do not articulate smoothly and that there is a concomitant degree of both intra and inter role conflict. Without the opportunity to develop greater expertise in nursing it is unrealistic to expect a Nursing Officer to operate in a clinical consultant role to a Charge Nurse who, even if she/he is in no better position regarding systematic inputs of knowledge, does have easier access to empirical knowledge relating to patient care. In addition, the demands of nurse managers senior to the Nursing Officer, may require performance which, in relation to available resources, could conflict with the Nursing

Officers perception of what is needed to provide adequate standards of patient care.

It is now necessary to identify how the present nursing structure evolved. Nursing was traditionally organised, since the development of the Nightingale School of Nursing at St Thomas's Hospital, by means of a centralised control. The Matron, with a varying number of assistants, organised the nursing service and was herself within the control of the senior administrative officer of the hospital, who might have been either a lay Administrator or a Medical Superintendent. She might or might not meet with the governing body, (Hospital Management Committee and Board of Governors). The Matron was very unlikely to have a part in decision making (Salmon 1966); being there by invitation and not of right.

The Matron's assistants undertook such tasks as were delegated to them by her. This could vary from day to day. There was not continuity of relationships. In the main, such communication systems as operated between assistant Matrons and ward staff and Matron's office were erratic. The dissemination of information was liable to disruption, since such information could flow from Matron to assistants and remain there; could flow from Matron to ward staff, by-passing assistants; could move from ward staff to Matron without informing assistants. One assistant Matron could receive information without informing others, (Baly, 1973). Lines of authority were similarly muddled. Charismatic Matrons existed and operated with flair and efficiency and systematic Matrons introduced order and organisation but the service as a whole carried the legacy of its housekeeping antecedents and did not utilise any theory of management.

The development of a rational management structure for nurses had effects both within and surrounding the service. Bagley (1974) says of post Salmon management in nursing that it brought to nursing an increase of power and it this, he suggests, that irked medical consultants and others involved in traditional methods of hospital organisation. He

notes how unbalanced the power statuses in hosptial were formerly and indentifies the opportunity for nurses to take part in major decision making as being upsetting to all who had previously accepted the rightness of male dominance. Dewar (1966) reflects medical dissatisfactions with the structure when he cites the plight of the Charge Nurse, under the control of the Nursing Officer " ... who will neither take doctors' instructions directly nor have the patients' confidence," indicating something of South's (1857) dissatisfaction with change in the structure of nursing management of an earlier age. Davies (1971) and Dodd (1973) note that Charge Nurses themselves saw their authority as stemming directly from their relationship with medical staff and not from their relationship with senior nurses. Dewar (1978) makes further comment on the Nursing Officer role indicating that he did not see this post as one which had an "enabling" function which would enhance the efficiency of the Charge Nurse. There is a tendency for medical staff to see all problems with nurses as stemming from the post Salmon structure. Thus Dewar also notes that patients prefer to ask junior nurses to perform small tasks for them rather than ask a Charge Nurse to do so. McGhee (1961) in her Scottish study also records this phenomenon, and Tagliacozzi and Mauksch (1972) describe such patients as being reluctant to play the "consumer role" openly, considering that requests made of junior nursing staff allowed them to maintain a feeling that they remain in "credit" with the Charge Nurse. Tagliacozzi and Mauksch describe this interaction in terms of "principles of social exchange" and suggest that patients act if the amount of service available were finite and this management of interaction helps them to feel an element of control over their own affairs. Roger (1978) also views the change brought about by the development of the Nursing Officer role in much the same terms as did Mr South in 1857. Roger regrets the passing of " ... the dowdy old ward sister" and the Matron, both perhaps mother surrogate figures. Unlike Schulman (1972) who

discussed this image of nursing, Roger does not see the disappearance of such people as a response to generalised social pressures but as a result of organisational change. It is worth speculating that the use of the designation of Unit Matron rather than Unit Nursing Officer might have generated less anxieties amongst medical staff if it were not for evidence that in 1966 Matrons were viewed rather less favourably by doctors than they have been recalled subsequently. Indeed Rudd (1973) indicates such other attitudes when he suggests that something like a Salmon structure was needed to wrench power from the old type Matrons who were, he states, often autocrats. Rudd however views the Nursing Officer role as a means to enabling Charge Nurses to work more efficiently.

The Salmon Report (1966) recommended that there should be professional preparation and management training to enable staff to exhibit the appropriate degree of expertise to equip them to respond to the particular demands of the Nursing Officer role. Salmon's recommendations regarding a management preparation were to be undertaken, in the first place during periods of 12 weeks study. In practice this has been reduced to 2 weeks with varying numbers of days later allocated to modular inputs in a few topics. Bagley (1974) suggests that training in management for senior nurses should be the same as that which is necessary for membership of the Institute of Health Service Administrators, which is the equivalent of 2 years full time study. In nursing, clinical expertise is recognised as being needed in highly specialised areas and evidence of attendance at Joint Board of Clinical Studies courses is becomming obligatory for those in charge of units such as operating theatres, dialysing units etc. In less specialised areas such as medical or surgical units, appropriate experience is the requirement. As Argyris (1957) notes, however, it is not the experience but how people internalise aspects of the experience that is important. It is difficult to justify the nursing consultant component of the Nursing Officer role (attributed by the Salmon Report 1966)

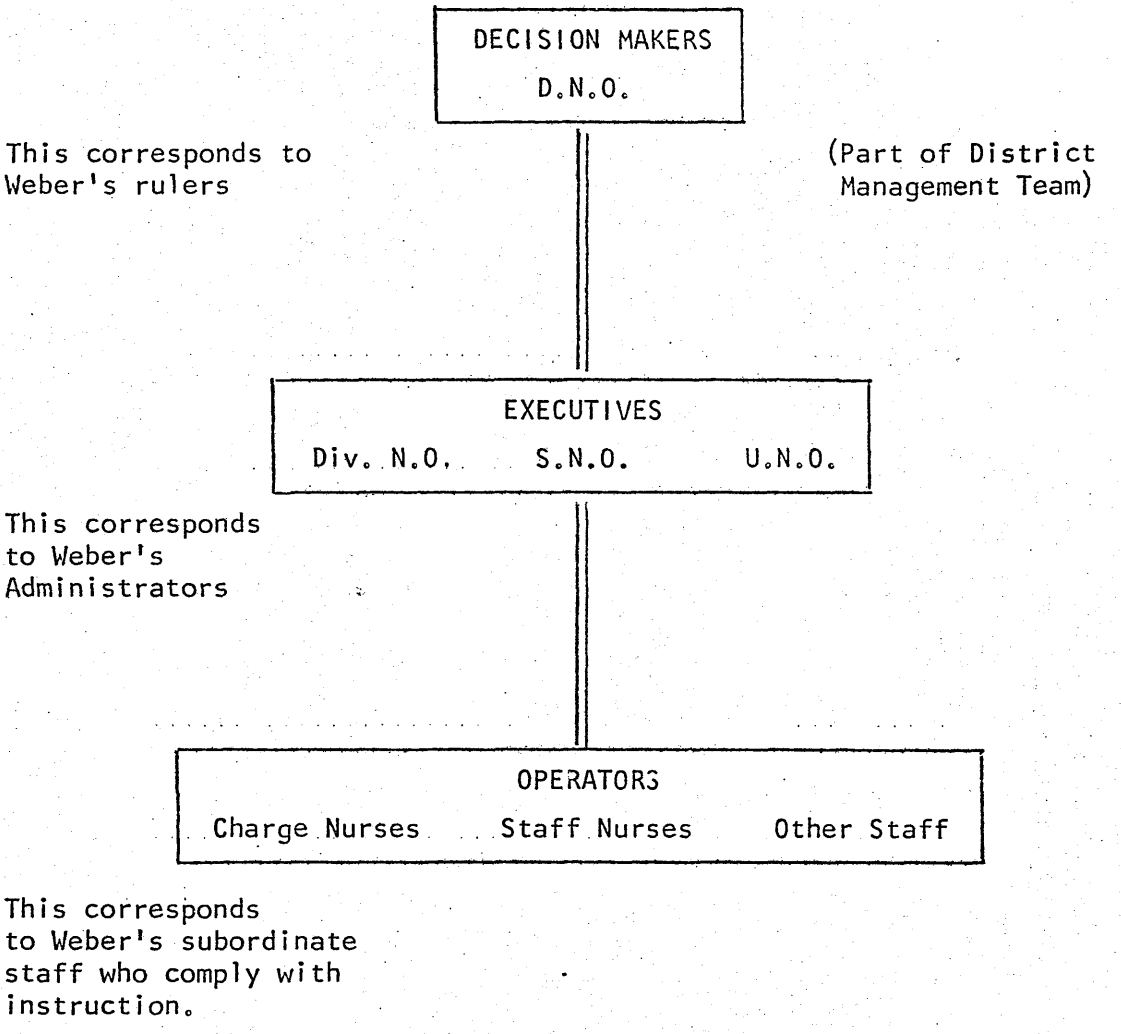
if no evidence of an ongoing acquisition of knowledge relevant to nursing, and/or advance nursing education is required.

In this country as has already been stated (see page 44), the nursing contribution to the hospital as an organisation is by means of a staffing structure graded in Weberian terms (Chapman 1976) from District Nursing Officers, in control of all nursing staff within a Health District by means of Divisional Nursing Officers, in control of divisions of nursing, to Senior Nursing Officers, in charge of a group of units, through to Nursing Officers who are in charge of groups of wards and then to Charge Nurses who are in charge of single wards. Thus the Charge Nurse as exemplified by Salmon is in a line relationship to the Nursing Officer for aspects of organisational policy and to the Medical Consultant for the delivery of medically prescribed treatment for patients. She/he also has autonomy in prescribing nursing care for individual patients. It is in this area of direct control of patient care that the current management organisation in nursing seems less than appropriate.

Georgopoulas and Mann (1972) describe the hospital as an organisation which operates a human rather than a mechanical system needing day to day adjustments since the work cannot be standardised and variability makes assembly-line techniques inappropriate. Formalised rules cannot be devised to cover all eventualities. In addition to this, they state that patients are not necessarily passive and may make their own demands so that staff need flexibility to meet the human needs that illness generates. They go on to note the paradox which exists, as the hospital is also a highly formalised, quasi bureaucratic organisation. Like all task oriented organisations it relies a great deal on formal policies and formal authority for controlling much of the behaviour and work relationships of its members. They observe distinct status differences among staff with sharp patterns of superordinate and subordinate grades.

The model below of the organisation of nursing is based on Weber's model of hierarchy and relates the concept of bureaucracy to the nurse management structure.

Figure 2



The model, however, ignores the complexities and paradoxes described by Georgopoulas and Mann and this over-simplifcation does not acknowledge the turbulence existing at ward level (Pembrey 1978). This is demonstrated in a later model, page 55 which reflects the unacknowledged dimensions which operate.

Within the human system described by Georgopoulas and Mann as controlled by formal policies, hospitals are expected to provide care to patients at all times with the precision of a machine and with minimum error. This environment can promote problems for those who operate within it. Davies (1971) also states this when she describes the complexities of hospital organisation, noting that such organisations depend on people internalising the value system and being able to translate these values into behaviour. The high level of anxiety in which actions take place, generates, she says, the rules and procedures which are adopted and which provide prescribed responses to emergency decisions. These prescribed behaviours says Davies, not only protect hosptials employees from the effect of the high levels of anxiety, noted by other researchers (Menzies, 1960 and Revans 1964) but also patients from the effect of decisions made under stress. Thus the model on page 52 demonstrates the concept of management applied to nursing following the implementation of the Salmon Report and it can be seen that little allowance has been made in organisational terms for the need for the flexibility recognised by Georgopoulas and Mann (1972). Woodward (1965) and Stewart (1970) note that the type of activity undertaken within an organisation or the type of technology generating the activity in which an organisation is involved, determines the most appropriate type of management pattern for that organisation and this continues Burns and Stalker's (1961) work in identifying properties of organisations which were designated as "organistic" to describe dynamic, changeful, unstructered situations and "mechanistic" to describe the static, easily anticipated conditions existing in other situations. They designate the formal hierarchical management structure as appropriate to the "mechanistic" type of organisational system and suggest that a less rigid pattern is needed in fluid, dynamic situations. Pembrey (1978) and Melia (1979) identify the ward in a hospital in the same terms as Georgopoulas and Mann (1972)

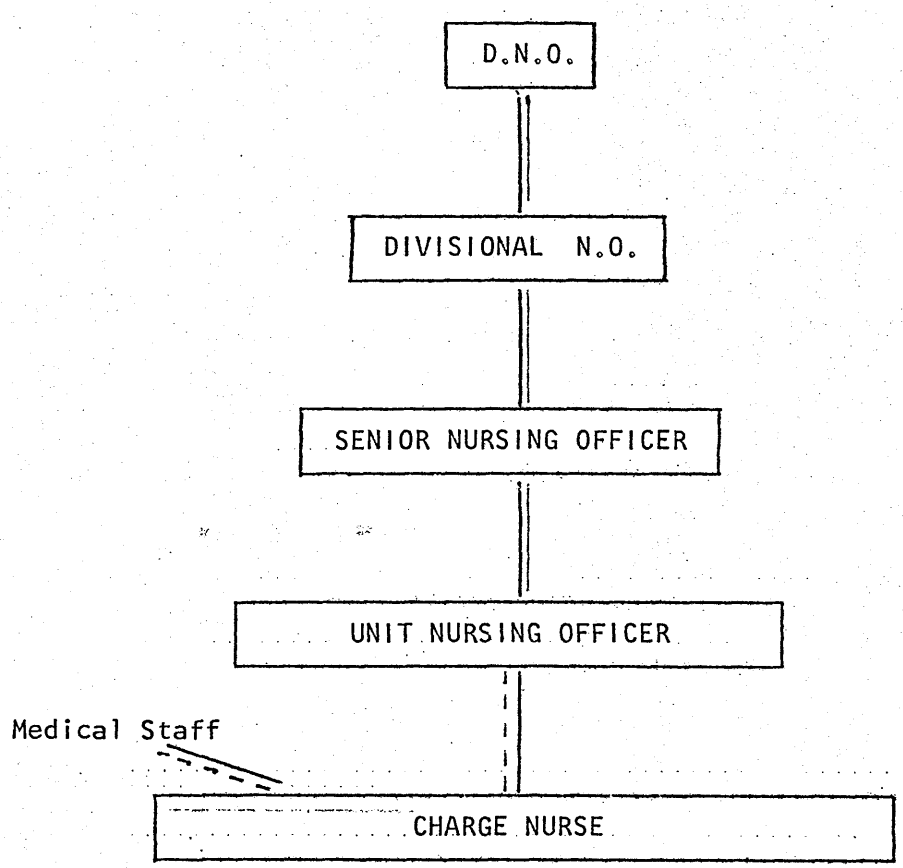
and see these areas as conforming to Burns and Stalker's (1961) "organistic" category and thus incapable of responding appropriately to the rigidity of the tightly structured line management visualised by the Salmon Report.

The model presented on page 55 indicates the increased organisational complexity existing at ward level. It can now be seen that the bureaucratic form is appropriate to the level of Nursing Officer. It thus reflects Weber's emphasis on the administrative function and attempts to illustrate the differences which exist at operational level.

The Charge Nurse is both directly responsible to the medical staff for the delivery of prescribed treatment and investigations (unbroken line) but not for how such care is delivered (broken line). Katz (1969) and Kelly (1966) note this when they identify the fact that doctors give orders on certain aspects of patient care; but in the immediate delivery of services to the patient the Charge Nurse is in control. The Charge Nurse looks to the Nursing Officer for resources to undertake the delivery of nursing care to patients but is not responsible to the Nursing Officer for the delivery of such care to individual patients (broken and unbroken lines indicate these states).

Figure 3

Model Showing Complicated Lines of Authority
Existing at Ward Level



The emphasis laid by the Salmon Report on the Nursing Officer as a clinical expert has a potential for complicating this situation with the risk of eroding the autonomy of the Charge Nurse within the boundaries of the ward, hitherto the nursing area which was undisputedly the area of clinical control of the Charge Nurse. In addition Charge Nurses cannot compel extra resources and are therefore dependent upon the Nursing Officer interpreting her/his needs. However, informal controls operate as well as formal ones. Goffman (1961) says of total institutions, that by their very rigidity they generate counter policies amongst inmates which, whilst the constraints remain unchallenged, enables inmates to find their own ways around these constraints. Although todays hospitals do not reflect Goffman's total institution concept absolutely, it is possible to examine some of the potential areas of dysfunction in the light of this theory. Thus it may be postulated that the Charge Nurse, who, for the patient, is the nurse operating as a "professional" nurse, has available two methods of control (Doctor - Charge Nurse and Nursing Officer - Charge Nurse). These may be manipulated to act in opposition to each other, thus leaving the Charge Nurse slightly more room to manoever in developing mechanisms to avoid constraints she/he may consider to be dysfunctional.

Austen (1978) writing of the present organisation of nursing services concludes that the rational system of management for nurses is designed to offer the rewards of career development and higher salary to nurses who are professionally orientated towards a value system different from nursing and this may well identify the nurse as reaching the apex of "professional" achievement at Charge Nurse level. If the intrinsic rewards of autonomy and expertise operate at this level, nurses may not regard hierarchical advancement as necessarily part of professional development. Thus, whilst nursing organisation benefits from a rational management system, the professional nurse regards the organisation as functioning to enable her/

him to deliver nursing care to the patient with the minimum of disruption. The compulsion of senior nurses to feel responsible for all the actions undertaken by nurse practioners of a less senior grade and to view such nurses as imbued with a lack of responsibility, discussed by Menzies (1960) and MacGuire (1964) complicates the situation at operational level, which is to say, in the wards or departments where the Charge Nurse is in control. Bendall (1977) considered that professionalism was affecting nurses. She noted that this striving for professional status was not motivating all groups of nurses at the same pace - thus she states that teachers and managers of nurses were exhibiting these aspirations to a greater degree than clinical nurses. Fretwell (1980) writing of Charge Nurses and professional status considers that nursing is in a transitional state and is moving towards professional status as along a continuum. The next chapter examines some of the literature relating to professionalism so that further insight can be gained in considering this influence on nursing.

CHAPTER 7

To Profess to Nurse

"To some extent the definition of a profession rests upon the degree to which its members can convince the public that it is one."

Robert Pinker

Felgate (1977) tells us there is semantic confusion surrounding the word profession and even in its technical sense, the definition of a professional occupation is fraught with misunderstanding. Carr-Saunders and Wilson (1933) note that, historically, the acquisition of a liberal education, undertaken in the renowned universities equipped men to enter "the professions". At this time, when army commissions needed to be purchased and means were required to maintain the lifestyle appropriate to rank, army officers were considered, with members of the judiciary and ordained members of the established church, to have professional status. The present necessity for qualification, control and ethical standards came later and indeed, heralded the present struggle for "professional" status aspired to by many of todays occupations. As has been noted on page 10 in medicine, the vicissitudes affecting the variety of practioners eventually resolved itself when social pressures demanded a more effective and therefore a more organised service. The Medical Act of 1858 provided the basis needed and the appropriate certification entitled the doctor to practise as a general practitioner. Further improvements in training developed from the efforts of the members of the profession themselves, when they recognised the need for expert specialist skills to be grounded in a broad based general education at university level. The lead given to medical practitioners by this development has enabled them to remain the leading professional amongst health workers.

A tendency has developed, in recent years, to provide recipes for professional status, and to examine occupations in the light of such recipes, indicating that a little more of the ingredient service, or status or control of entrants or less hierarchical control or use of motor skills would make the mixture right. Thus Hall (1973) asserts of nursing that:

1. It provides a service to society involving specialised knowledge and skills.

2. It possesses a unique body of knowledge which it constantly seeks to extend, in order to improve its service.

3. It educates its own practitioners.

4. It sets its own standards.

5. It adapts its service to meet changing needs.

6. It accepts responsibility for safeguarding the public it serves.

7. It strives to make economical use of its practitioners.

8. It promotes the welfare and wellbeing of its practitioners and safeguards their interests.

9. It is motivated more by its commitment to the service it renders than by considerations of economic gain.

10. It adheres to a code of conduct based on ethical principles.

11. It unites for strength in achieving its larger purpose.

12. It is self governing.

and concludes that nursing does not yet contain all the ingredients for full professional status but is moving towards such a goal. Pepper (1977) however, discussing the inadequacy of such trait definitions, contends that not only nursing is deficient but other high status occupations such as medicine are deficient by these measures. She posits other conditions which more efficiently define professional occupations and referring to medicine states that:-

1. The majority of practitioners have families of high social status.

2. A predominance of male practitioners.

and that this combination forms the criteria for professionalism. There is an impression here that the desire for enhanced status by nurses is in itself suspect and is perhaps being identified by Pepper as a rejection of "vocational" nursing which Williams (1978) associates

with Victorian society's acceptance of a service which required a total submission and eradication of self. Dingwell and McIntoch (1978) relate this to the religiosity of Victorian England which legitimised the emergence of nursing as a respectable occupation for women. The structure of nursing then, was the product of the social situation within which it emerged. It is useful, however, to recall that Merton (1960) (see page 35) sees the seeking of professional status with its social accolade of autonomy as a legitimate human development. This development may be more in keeping with todays social mores and more acceptable to nurses who have experienced nursing only in its post Salmon structure.

Wilensky (1964) analysing professionalism, notes that "scientists" are judged by other scientists and "professionals" are judged by their clients. He also implies that professionalism is a developmental state which occupations can strive towards; citing autonomy, status, control of standards, control of training as factors which may operate in degree only, at certain stages of development, which indicates agreement with Hall (see previous page). Wilensky also states that professionls operating in a bureaucratic organisation are at risk to certain strains, since there is a tendency for autonomy to decrease and the service ideal to be eroded within a bureaucratic structure. Blau and Scott (1963) discuss professionalism in terms of opportunity for decision making based on objective criteria, specific expertise in a strictly limited area and affective neutrality. Present trends in nursing, however, view the lack of emotional involvement suggested by the attribute "affective neutrality" as antipathic to the adequate functioning of the nurse. Blau and Scott (1963) also recognise professional status as being achieved rather than ascribed and being associated with the client's benefit rather than the practitioners, thus reinforcing Wilensky's findings. Carr-Sanders and Wilson (1933) also recognise a profession, not as a "sociological abstraction" but as an occupation with essential interest and importance

to the public and it is because of the status attached to these groupings that occupations attempt to join such ranks and create pressure for professional acknowledgement. Such views differ somewhat from Etzioni's (1969) who sees some occupations as permanently deficient in the necessary attributes of professionalism by reason of their preponderance of women, hierarchical structure or by the lack of time devoted to training (which implies deficiency in the body of knowledge available). He includes nursing among these occupations. There is, however, a degree of absolutism in such categorisation which creates difficulties in acceptance since all the factors mentioned are subject to change and in nursing have certainly changed over the years. The men/women ratio is changing. The hierarchical structure in nursing is very much an administrative convenience and has been changed before. The effect of the hierarchy on bedside nursing , which is where professional nursing is undertaken is probably no more than the constraints operating upon any group of workers who work with constraints set by the District Management Teams (Rowbottom 1971). However, Pepper (1977) who studied learner nurses in some depth in two wards in one hospital, concluded that they lack autonomy over their practice. Interestingly from this she deduces that trained nurses also lack autonomy, but the conclusion is difficult to support from the evidence offered.

Specialist knowledge seems to be a quality to which all professionals must have access. Katz (1969) writing of knowledge, its hoarding and its use, says of nursing in the United States that, "Hospitals are in short, under pressure to implement existing knowledge but at the same time involved in controlling knowledge. Physicians are chiefly responsible for deciding which items of knowledge are safe to use - safe for the patients and safe for their own reputations and the reputation of the hospital." Katz goes on to state that hospital administrators are responsible for deciding which bits of knowledge are too expensive to use

and therefore sees both the physician and the administrator in hospital as possessing knowledge and power (at least power over the application of knowledge) and that nurses accept the legitimacy of the doctors' control over knowledge. Ferguson (1976) makes something of the same point when she notes, " ... society has always invested the nature of learning with high status for those who are seen to have knowledge invariably also hold the power." Katz (1969) in relation to nurses, further notes that some nurses are aware of the element of control existing in the deprivation of knowledge and suggests that doctors are wary of nurses who are interested in acquiring more knowledge, since, he contends, doctors see nurses in the role of buffer or sponge which protects doctors from the consequences of inappropriate action or inaction. It is not possible to state if such a degree of passivity also exists amongst nurses in this country, although Dodd (1973) describes Charge Nurses acting in this way. However, Katz (1969) and Kelly (1966) also note that nurses consciously recognise an area of patient care which is exclusively in their control. Nurses assess the patients nursing needs, identify priorities in the delivery of care to meet these needs and organise the delivery of this care. Priorities in medically prescribed treatments are also identified and treatment carried out accordingly. Other services to the patient are also coordinated by the nurse in charge of wards and departments. Nurses make decisions in these matters which are referred neither to doctors nor to the nursing hierarchy. In this country Schools of Nursing may and do specify particular procedures which learner nurses must follow and this may create anxieties for Charge Nurses whose expertise may advocate other approaches. These are unresolved dilemmas but such conflict relates to the teaching of others not to the practice undertaken by the Charge Nurse and other permanent staff.

The belief expressed by Pinker (1978) with which this chapter is introduced tells us that the public confers professional status but not why the public confers such status. For nursing the demands made upon

Charge Nurses at ward level are considerable. These demands require not only an adequate knowledge base but an awareness that medical, biological and social sciences are in a dynamic developing state and all of these affect the nurse (Chapman 1974). Henderson (1980) says of these developments that technical skills increase in number and complexity and include physical and pychosocial evaluations and diagnostic tests, assisting with pre and post surgical care that involves the operation of sensitive and dangerous machines; also the administration of drugs whose numbers proliferate hourly and whose possible threats to human welfare should haunt those who give and those who take them. This state of change and conflict, expansion of knowledge, extension of role within which a Charge Nurse must operate demands that consideration be given to the need for the practitioner to have adequate opportunity for systematic updating if competence in nursing is to be maintained. The next chapter pursues this point by examining the literature dealing specifically with this particular need of trained nurses.

CHAPTER 8

Why Education?

"Obsolescence is a fact of life. It is invidious and pervasive so that the signs may be missed. Practice may become outdated by the practitioner who is unaware. The rut becomes increasingly comfortable so that she continues to practise in the same way, day after day, year after year, until one day she discovers the world has passed her by and she wonders why."

Maura Carroll

Drucker (1965) says of educational development that it becomes a priority of national policy because education controls a country's military, technological and economic potential. Even more is there a likelihood of the good health of the populace to influence a country's military, technological and economic potention, for example, the poor health status of recruits for military service during the Boer War gave cause for concern when it became necessary to build a larger army, (Gilbert, 1966). The conjunction of health and education occurs when the training of staff for the health services is considered. The Todd Commission's Report (1968) tells us that " ... all doctors in whatever branch of medicine, must have the opportunity and the time for continuing education in order to keep up to date in their own field and to remain reasonably well acquainted with development in others." An earlier report, the Sub-Committee of the Standing Nursing Advisory Committee (1966) suggested that the concept of systematic and progressive education for the registered nurse had received little recognition, and considered that any educational facilities made available should recognise that home commitments and part time work imposes constraints upon staff which influences their ability to take advantage of updating courses. A factor which can be identified in the findings of the present research. More recently, the International Council of Nursing stated in 1976, "The nurse carries personal responsibility for nursing practice and for maintaining competence by continual learning." It is to identify what opportunity is available to nurses to undertake this responsibility that the present research has been undertaken.

Cooper (1970) argues that nurses as well as doctors continue professional education in many ways, citing:

1. Shared experience
2. Use of journals
3. Seminars
4. University programmes.

She notes that medical advances have forced doctors to continue learning if they wish to keep up to date and that such current medical developments demand different types of nursing skills, so that the nurse also must be a continuing learner. Darmastaater (1977) says that skills needed by professions change rapidly and that there is every indication that they will continue to do so. She considers another aspect of post-basic education for nurses; the quality of the programmes offered. In questioning the quality of such training in the United States she reminds us that the patient is potentially the real sufferer since the patient is at the mercy of a practioner's skills and abilities. Lysault (1970) and Burgess (1978) also advise nurses in the United States to be sceptical regarding the quality of educational programmes available.

In this country the Joint Board of Clinical Studies was set up in 1970 to offer a national system of post-basic clinical education for nurses. The terms of reference were:-

> "To consider the advise on the clinical needs of nurses and midwives for post-basic clinical training in specialist aspects of the hospital and community nursing services in England and Wales; to co-ordinate and supervise the courses provided as a result of such advice; and to discharge such other functions as we may assign to them. The Joint Board has the power to co-opt additional members for specific purposes and to appoint sub-committees as necessary."

The Board offers a wide range of specialist courses of varying timespan and some of the courses offer certificates of competence in the specialty, others offer certificates of attendance only. The educational programmes available are very flexible. Some extend over periods of 6 - 12 months; other courses are a mixture of day release combined with an introductory period of study; again, others occupy only a few days. Courses are offered with Joint Board approval in many centres, for example,

Schools of Nursing and Colleges of Technology throughtout England and Wales. In 1975 more than 800 certificates of competence were awarded to nurses from these specialty courses. The terms of reference of the Board confine their activity to education in nursing specialist areas and has not been able to offer any updating in these specialties, since resources are concentrated on meeting an initial need. The Board is not designed to provide general updating for nursing staff in the non-specialist fields of nursing. However, the third report of the Board states, " ... this would include opportunities for further education and training in the practice of nursing for all qualified."

Green (1978) confirms that there is little formal education open to nurses beyond registration and cites one Regional Health Authority's expenditure as:

Table 2 Post-Basic Educational Expenditure

Category	Numbers	Expenditure
Medical	2,391	£25,000
Nursing	28,665	£50,000

Smart (1974) writing of doctors, noted the rapid increase in attendance when seniority payments were tied to continuing education. This relates in some ways to Berg's (1973) finding that continuing education for nurses also needs "reward". She considers that there is a need to associate continuing learning with promotion possibilities and/or acknowledgement by seniors. Berg also identified a desire for professional knowledge as a motivating factor and Goldiak (1977) writing of continuing education for nurses in Israel, is adamant that this is a must for professional competence. In Israel, she reports that attendance at up-dating courses is acknowledged by credits which are recognised for salary benefits. In the United States there is a movement towards a systematic,

continuing education process related to relicensing, (Roem, 1974).

In an increasing number of States the introduction of Continuing Education Units represents hours of post-basic education. Usually, 10 contact hours equal 1 Continuing Education Unit and varying numbers of units, acquired over periods of 2-3 years, are demanded by these states before relicensing can take place.

There is no indication that, in this country, interest is being taken in a systematic record of individual nurses updating of nursing knowledge on a cumulative basis. Indeed, Auld (1979) speaking to nurses attending the Royal College of Nursing Research Society's annual conference says of nursing that " ... it continues to educate itself largely by a process of osmosis." In effect, also, the recommendations of the Salmon Committee (1966) moved the emphasis from clinical updating to management education for charge nurses.

It is perhaps worth considering at this point what Bilodeau (1969) says of retraining needs in industry. He states that it is possible to estimate the cost of retraining (and this can also be said to apply to updating) but it is not possible to evaluate the price paid for not retraining. Merton (1957) also touches on this when he refers to trained incapacity as a state of affairs when abilities function as inadequacies or blindspots. This occurs when actions based on training and skills which have been successfully applied in the past may result in inappropriate behaviour in changed conditions. Chapman (1976) indicates that the increasing body of knowledge from the behavioural sciences has made it possible for health service staff, such as Charge Nurses, to develop more understanding of patients as people. This knowledge also permeates society and may result in patients developing new expectations of Charge Nurses. Unmet expectations may generate anxieties, which have been noted by others, (see page 26) and these affect nursing behaviours. Such behaviours may in turn affect the speed of patients' recovery and therefore

have implications for the consumption of resources, both human and financial, which takes us back to Bilodeau's observation noted earlier in this chapter.

Page 15 shows the topics set for examination by the General Nursing Council in 1923. Roper (1976) investigating the training of nurses for the Register, states that there has been little change in the 3 year syllabus of training although there has been change in the terminology used. The move from the designation of learner nurses as probationers to students and the term education has superceded training as a description of the process by which nurses learn their skills. Roper also notes that the percentage of time spent in formal learning increased from 10% to 17% but that the total hours available reduced due to the shorter working week. She also recognises that even if the syllabus has not drastically changed it has expanded and the increase in material to be covered is being squeezed into a restricted time package. She also discusses the impact of secondment to specialist areas for training, e.g. pyschiatry and obstetric areas and posits that this places additional strains upon learners whose training is still an apprentice type training, when most of them will practice in the general field. Appendix G shows the difference between the 1923 syllabus and the syllabuses produced for 1970 and 1977 and it is apparent from the crammed programme for training in the 1977 version that more skills are being identified as being needed for nurses to make nursing operational but there is difficulty in making sufficient time available to develop the skills which are needed. In France, Colliere (1980) wonders if nursing is based on a body of knowledge which provides information about the life of people, their habits, their beliefs and their relationships or if it relies on a single unique source of explanation for illness. In Ireland, Staunton (1979) suggests that emphasis in nursing has moved from preoccupation with bodily ministrations to responding to the patients reactions, physical and psychological. In this country Chapman, McFarlane,

Pembrey, Ogier among others have, as already noted, emphasised this need for interpersonal skills in nurses but the commitments of the training programmes make adequate training in these skills difficult to accomplish during the three years available for basic training.

The preceding review of the literature suggests that not only is basic training in nursing inadequate to equip nurses to operate at the level of Charge Nurse but also suggests that the changes which are taking place in society and in medical science have implications for nursing which are of particular importance for the nurses who are responsible for the organisation of patient care. In addition to these recognisable needs it is worth speculating on what benefits might accrue from the encouragement of pleasurable, intellectual curiosity amongst practitioners since Whitehead (1932) writing of science suggests that advancement here is almost wholly the outgrowth of such curiosity.

Summary of Literature Search

The preceding chapters have used the literature to draw a framework within which the service of nursing can be identified. Sources taken from the history of nursing and from role theory have attempted to define the nurse in the social setting of the hospital and to clarify the confusion that surrounds the organisational structure of nursing. Literature relating to professionalism generally has been used to help understanding of the incipient professionalism which can be recognised within the occupation as it now exists. Literature relating to nursing and to the grades of nurse examined in the present study have been consulted to establish present state of nursing and to indicate that the pressures of stress and change which affect society generally are also reflected in the state of nursing. The key position of the Charge Nurse in the control of the delivery of care to the patient has been recognised.

No attempt has been made to provide a history of nursing and current controversies regarding the rightness or otherwise of the claims of those seeking professional status, in a sociological sense, have been but lightly touched upon. The researcher has assumed that social groupings such as nurses reflect society generally and may seek social rewards for services by the means offered by society and that the seeking of professional status may be part of the developmental process of nursing.

The literature cited indicates the clarity and the ambiguities which exist in nursing and identify the complexities which are to be found in the hospital setting. The development of new roles and the realignment of older roles has been noted and the need for a recognised method of enabling nursing knowledge to be increased and updated has been identified. The next section of this thesis investigates the views of nurses of two grades and two specialties in relation to the updating of nursing knowledge and uses a survey approach.

CHAPTER 9

Methodology

"..Our position may, therefore, be summed up as one which regards the social research procedure as a scientific enterprise. By this we mean a striving after objectively derived facts about the real world and the systematic organization of these facts into general explanations (theories) of social behaviour."

K. Krausz

S. H. Miller.

Methodology

The object of this research was to identify the views of trained nurses regarding their ability to keep up to date with nursing knowledge. It is therefore consumer orientated research and the design of the project and the identification of relevant variables emerged from the literature and from the experience of the researcher.

A social survey approach was considered appropriate since the data required were needed to describe a social reality. Moser and Kalton (1971) identify social surveys as concerned with the demographic characteristics, the social environment, the activities or opinions and attitudes of some groups of people. The present research was concerned with a particular group - trained nurses. The trained nurse category was reduced further and subgroups identified. These were;

Speciality - only those in general nursing divisions and midwifery divisions were involved.

Grade - only two grades were examined,

(a) Charge Nurse, the nurse in charge of a ward or its equivalent.

(b) Nursing Officer, the nurse in charge of a group of wards forming one Unit.

The population from which the sample was drawn was the staff of these grades employed in one Regional Health Authority. The sample size of 400 represented 10% of the nurses of relevant grades in post. The numbers of staff available were obtained from statistics collated at Region and the 400 sample was stratified to include the correct proportion of nurses from the districts included in the sample.

The original intention of the researcher to use three Health Districts to represent all Health Districts was modified in the light of experience. The sample was required to include hospitals, large, small, rural and urban, whose nurses were in the control of nurse managers of general and midwifery divisions. The inability of the Teaching District (that Health District containing the Medical Training School) to participate in the research necessitated a different approach since the absence of the wide range of hospitals existing in the Teaching District made the proposed sample unrepresentative of the Health Region generally. Details of the sampling procedure decided are given later in this chapter (page 77).

All District Nursing Officers of the districts selected (6 in number) subsequently agreed to participate in the research and all of these nurses made the research known to subordinate staff which enabled the researcher to make specific arrangements with the hospitals involved.

There were three main methods available to the researcher to inform staff who made up the sample of the aims of the research and what it required of respondents. The nurse managers in the different Health Districts decided which method they endorsed and the researcher took advantage of whatever opportunities were available.

The three approaches were:

1. A meeting was arranged by the District Nursing Officer which enabled the researcher to approach key people and to make arrangements to visit the hospitals where other meetings were arranged at which questionnaires could be distributed.
2. A Nursing Officer introduced the researcher to the staff who were part of the sample and thus facilitated the deliver y of the questionnaires.

3. The researcher was invited to visit the hospitals and deliver the questionnaires. Various techniques were used to identify the people in the sample and this varied from asking the nurse in charge of each Unit visited, where the staff in the sample were located, to asking a helpful Charge Nurse to locate the appropriate wards. Secretaries in Nursing Offices were also helpful in this way.

Although the methods of access differed between Health Districts and also between hospitals, in all cases the researchers visits had been legitimised and appointments to meet staff both for the delivery of questionnaires and for interviews were made, if not without difficulty, at least without any hitches. The sampling frame in all cases was the "Nominal Roll" a computer printout available to finance departments to identify nurses so that salaries could be paid.

Sussman (1971) notes that there is client revolt against all research (in the United States of America) stating that all target populations want some sort of pay-off for being researched. In the present study the author noted some indications of this from the nurses involved since it was clearly demonstrated that these nurses wanted some acknowledgement of their cooperation in the form of a report to the Health District of the findings of the study and it was agreed to make this available.

As has been stated, one Regional Health Authority was interested in the research and a Regional Nursing Officer introduced the subject at a meeting with District Nursing Officers so that the Health Districts included in the sample were thus notified that the research project was being considered.

The Population

Nurses of Nursing Officer and Charge Nurse grade in the midwifery and general divisions in one Regional Health Authority.

The Sample

Mann (1971) says of sampling that it is necessary because, in real life, it is often not possible to collect information about every case and that sampling saves time and labour but replaces certainty with probability. The object of sampling is to produce from a smaller number, information which represents the views of the population from which the sample was taken.

In the present research a "cluster sampling" approach was made. Brown (1958) says of cluster sampling that it contains units which are aggregates of natural units. She suggests that a school is an example of such an aggregate and in the present research Health Districts from different geographic environments throughout the Health Region were used in the way that Brown recommends schools be used.

The Health Districts contained hospitals of various sizes and these were located from the metropolis to the coast and were from eastern and western boundaries. The hospitals were from both urban and rural areas.

The method used to select the sample was systematic sampling. Here each name of the appropriate grade and speciality on the Nominal Roll was given a number from tables of random numbers (Dixon and Massey, 1969) and appropriate sized samples were selected from each Health District.

The selection of the sub-sample for interviewing took place on the first day the researcher arrived in each Health District. The names of all appropriate staff available during the time the researcher was in the district were put in a box and random selection by the lottery method was used to select the proportion allocated from each district. Nursing Officers and Charge Nurses were selected separately. Randomisation was relied upon to maintain the representativeness of other variables.

It is necessary to note that as a sampling frame the Nominal Roll had limitations, since staff who have left the organisation remain on the roll for varying periods of time in case salary adjustments

are required following pay awards. This was unknown to the researcher at the time and resulted in 21 questionnaires being returned as "not employed in this district". This reduced the sample to 379.

Stratification of the sample.

In order to take account of the variations in the size of districts, numbers of staff in the different grades, the distribution of staff between large hospitals and small hospitals and the numbers employed in the two specialties involved, the sample was stratified in each district to select the appropriate proportions from each group. Size of hospital was considered by deciding arbitrarily that large hospitals contained 200 or more beds and small hospitals fewer than 200 beds. Mann (1971) says of stratification that it safeguards the representativeness of the sample by ensuring that the known groups in the population are represented fairly in the sample.

Data Collection

Two methods were used:

1. Questionnaires.

These were delivered in envelopes which contained stamped envelopes addressed to the researcher. There was also an introductory letter to reinforce the information given when the questionnaires were delivered. (See Appendices D and E). Whenever possible the questionnaires were delivered personally by the researcher. Oppenheim (1966) says of this method of delivery that it ensures a high response rate by giving the benefit of personal contact. When, because of absence due to holidays or sickness, this personal distribution was not possible, arrangements were made with Unit Nursing Officers to have the questionnaires delivered. In some cases secretaries offered to ensure delivery.

Response rate: The 284 questionnaires which were returned represented a 75% rate of response.

Grebnik (1970) tells us that mailed questionnaires enables large numbers of respondents to be reached quickly but draws attention to the acute problem of non response and Oppenheim (1966) reminds us that non response is not a random process. In the present research non response was first tackled by personal delivery (as has already been stated) but the limitations on time operating prevented any attempt to reduce non response further except by posting reminder cards. These cards increased the response from 71% to 75%.

2. Interviews.

The main tool of the present research was the questionnaire developed for the research but, in order to increase understanding of the data collected, another approach, that of interviewing, was undertaken. 10% of the sample randomly selected (see page 77) were interviewed. The interviews were constructed around a checklist based on the questionnaire with some additional related subjects. The checklist was used as a guideline and respondents were asked to review the questionnaire before the interview took place. A spare questionnaire was available during interviews for those who did not bring the questionnaire with them. If the topics from the checklist were not mentioned spontaneously by the interviewees they were introduced by the researcher.

During the pilot stage it was verified that it took 45 minutes to cover adequately all that needed to be discussed. In practice most interviews took longer, many lasting more than 2 hours. Appointments were made with the staff involved and interviews were arranged to suit the interviewee. The venue proved difficult in some cases, but since all that was needed was reasonable privacy and a period without

interruption, the use of ward offices, coffee rooms and gardens proved suitable. Staff changing rooms were used on two occasions. When ward duty rooms were used during the pilot stage it was found that the interview was subjected to frequent interruption.
Notes were taken during interviews, with the respondents permission.
All those selected for interview agreed to participate.

Other interviews.

In approaching hospitals throughout the Region to make appointments to visit staff to distribute questionnaires a number of interviews, in addition to those required to introduce the research to the district, took place. The senior nurses in many hospitals sought interviews. Some of these were mainly of a social nature, others were directed to obtaining more information about the research or the researcher. These interviews were not recorded but gave the researcher considerable insight into the degree of anxiety felt by those nurses who were in charge of (mainly small) hospitals whose functions were changing or whose administrative allegiance had changed in the recent past. The anxieties these nurses expressed were remarkably consistent throughout the Region and no doubt reflected the threat of change and loss of status that then confronted health service staff in all Health Regions. This threat is at present increasing rather than reducing.

The scales used.

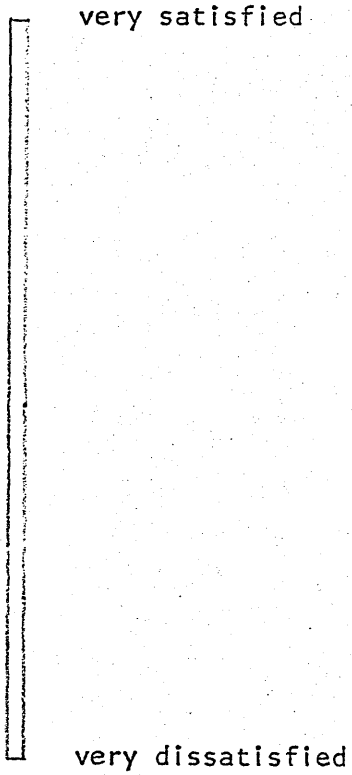
From the literature no appropriate scale of measurement of nurses' satisfaction with updating facilities available to enable them to maintain competence was identified and a simple self-rating scale called a "satisfaction thermometer" was devised for the research. The scale was 100 m.m. long marked at the lower end "very dissatisfied" and at the upper end "very satisfied". There were two scales used:-

Scale 1 measured satisfaction with journal/library availability.

Scale 2 measured satisfaction with post basic educational updating facilities available.

These scales are illustrated below.

Fig. 4



Respondents were asked to mark at the level they felt appropriate between the two points. The researcher later applied a score to these scales. The measure ranged from 0 to 100. Scores of 25 or below were categorised as dissatisfied and those of above 75 were categorised as satisfied. It is appreciated that the ordinal nature of such scales is a limitation on their power to discriminate between closely related scores and it is for this reason that scores from the extremes of the scales only were used to describe respondents views. Moser and Kalton

(1972) say of such scales that they are more sensitive than straight "Yes" "No" responses. They also stress the danger of "central tendency response" in such scales but consider that they are useful because they are easy to operate. The decision to use only the extremes of the scales is based on Moser and Kalton's comments modified by the results obtained during pretesting of the questionnaires. There was no evidence that the error of central tendency did, in fact, operate when the scales were used.

Reliability

Moser and Kalton (1972) say of reliability that it is the measure of the ability of a scale to give the same results when used under constant conditions. In this research the test and retest method of examining the reliability of the scales was used. Abdellah and Levine (1965) consider that the test and retest method can adequately be used to measure the effectiveness of the measurement tool used in social research.

In the present research a group of State Registered Nurses attending a course at a technical college outside the catchment area agreed to participate in the testing of the questionnaire. The group were asked only to cooperate in the research and the ten nurses who agreed were given the questionnaire to complete. The objectives of the research were explained and permission was requested to return to undertake some further work at a later date. When the completed questionnaires were collected arrangements were made to return in ten days time to continue the work.

The same questionnaires were distributed during the second visit. The colour of the paper was changed but otherwise no differences existed.

The correlation coefficient was 0.92 on Scale 1 and 0.90 on Scale 2. These represent what Brown (1958) describes as coefficients of stability. Krautz and Miller (1977) remind us that the second application of the test may have been influenced by the original use of the scale. It is accepted that in the present research it is unlikely that such contamination was completely reduced but in discussion with the group after the completion of the second questionnaires it was apparent that at a conscious level the nurses were unaware that the two questionnaires were identical.

Validity

Of validity, Abdellah and Levine (1966) state that data are valid if they actually measure what they are supposed to measure and advise that in some cases of research into nursing it may be necessary to use a panel of experts as a means of examining the validity of the instruments. In the present research this approach was used, therefore face validity only was tested. The limitations on this approach were accepted.

Two experienced nurse researchers were consulted during the development of the questionnaires and their views ascertained as to the ability of the questions to generate the required data. The completed questionnaires were presented to a second panel of nurses during the first visit to the technical college. The questionnaires were distributed to be read by 10 nurses and the objectives of the research were stated. The panel met the researcher after an hour and the usefulness of the questions in eliciting the type of data required was discussed. There was at least 75% agreement on all questions and this was accepted by the researcher in the absence of other criteria for validation as a satisfactory basis on which to proceed.

The Questionnaires

There were 23 questions asked of respondents and these were a mixture of dichotomous questions with space left for elaboration of replies and open ended questions. Question 19 used two four point scales to elicit information. The "satisfaction thermometers" have been discussed on page 81. The unstructured questions produced data which were categorised by the researcher and this is detailed on page 93.

Stacey (1969) suggests that the use of a variety of methods to elicit data from respondents enriches the findings of research and a further attempt at this enrichment was made by asking for the respondents' views on the need for the updating of nursing knowledge. Content analysis was used to order the additional data collected from these replies.

It is appreciated that the data collected in the present research is only applicable to the Regional Health Authority in which it was collected but it is considered that the findings may be of interest to nurses from other Regional Health Authorities.

CHAPTER 10

Analysis of Questionnaires

" The analysis of data involves the translation of information collected during the course of the research project into an interpretable and manageable form."

Denise Polit

Bernadette Hungler.

Analysis

A coding frame was developed and open-ended questions were categorised by the researcher before coding. Two subsamples of questionnaires (30 in each sub sample) were examined by two independent observers who checked the categorisations. Agreement was reached on these categories and the data were coded on to Cope Chat Hand Sort Cards for analysis. Because of the number of cards generated for each respondent relationships between variables could not be easily identified using this method and the data were subsequently coded for computer analysis. The Statistical Programme for the Social Sciences was used, frequencies and crosstab subprogrammes being utilised to generate descriptive data. Differences between groups were tested using chi square significance tests. The data were subsequently examined using the stepwise multiple regression subprogramme.

Chi square test of significance.

The chi square statistic (X^2) can be used to test the significance of different proportions in contingency tables. It is computed by comparing two sets of frequencies, the observed frequencies and the frequencies which could be expected if no difference existed between the groups. The formula for this calculation is:-

$$X^2 = \frac{\xi(O - E)^2}{E}$$

When O = observed frequency

and E = expected frequency if no difference exists.

Small differences are likely to be related to chance.

The degrees of freedom influence. These are equal to:-

(R-1) (C - 1) when

R = row and C = column. The level of probability acceptable is set at $p<0.05$.

The Chi square test of significance is non-parametric in nature (makes no assumptions about the nature of the distribution of the target population.) It is appropriate for use with ordinal scales. When the numbers in the cells is small Yates' correction is applied to the result before assuming significance. This formula is $X^2_c = \frac{(O-E-\frac{1}{2})^2}{E}$

Another test applied to test the reality of difference in proportion encountered is the Standard Error in the difference in proportion. The formula is $\sqrt{pq(\frac{1}{n_1} + \frac{1}{n_2})}$ when p = the proportion of the sample which contains the attribute and q = the proportion which does not. A difference of three times the standard error was accepted as significant.

The use of such significance testing indicates the existence of difference and estimates the probability that such difference could be due to chance alone.

Step-wise multiple regression analysis.

This test enables it to be determined how much of the variance in a dependent variable can be accounted for by variance in a number of independent variables. In this research the dependent variables were Scales 1 and 2 and the independent variables used were those which showed significant differences in significance tests. Stepwise multiple regression enters predictor variables sequentially into the regression equation. The variable with the greatest influence is entered first and subsequent variables entered show the amount of influence exerted by the remaining variables on the dependent variable, when the effects of the preceding variables have been removed.

Characteristics of the sample

It was establised empirically and from the literature, (Berg (1973) and Cooper (1966), that certain characteristics are influential

in shaping respondents' views on professional updating. These variables have been designated as *independent* variables and are described below.

It is recorded (page 78) that stratification was responsible for some of the patterns of distribution and the following frequencies emerged:-

Table 3. Frequencies by Grade, specialty and Hospital size

General nurses numbered.....	241	(85%)
Midwives.....	43	(15%)
	284	
Nursing Officers numbered.....	35	(12%)
Charge Nurses.....	249	(88%)
	284	
Staff from 'large' hospitals	136	(48%)
Staff from 'small' hospitals	148	(52%)
	284	

The above numbers relate to the patterns produced by stratification of the sample. (See page 79 for justification of the stratification used). Random selection produced the following:-

Table 4. Frequency by sex

Males numbered	42	(15%)
Females.....	242	(85%)
	284	

This 15% of the sample who are male nurses is close to the national proportion of male registered nurses of 16% (C.N.O. Report, Nursing

1974-1976). The proportion of senior staff is interesting. 21% of Nursing Officers are males. This distribution of males among senior nurses has also been noted by Jones (1979). Austen (1977) suggests that the present managerial structure in nursing encourages advancement amongst males more than females, since, she states, "... masculine knowledge input is widely regarded as valuable, not least by the leaders of the profession."

Re-examining the category "general nurses" into "Type of nursing" we find that:-

Table 5 Frequency by Type of Nursing

Medical/Surgical number.....	117 (41%)
Geriatric area number.....	47 (16%)
* Specialty area number.....	77 (27%)
** Midwifery area number.....	43 (15%)
	284

* Includes areas such as operating theatres, outpatient departments, Intensive therapy units, Opthalmic units, Radio Therapy.

** All staff recorded as working in Maternity areas are trained practising midwives.

Length of time qualified showed the following distribution:-

Table 6 Frequency by Length of Time qualified

Less than 5 years	35 (12%)
5 but less than 15 years.....	92 (32%)
15 but less than 25 years	87 (31%)
25 or more years.....	70 (25%)
	284

71% of those qualified less than 5 years were married.

61% of all others were married.

Hospital size in relation to 'small' hospitals showed the following distribution:-

Table 7 Frequency by Small Hospitals

100 but less than 200.....	64 (22% of sample)
50 but less than 100	28 (10% of sample)
less than 50 beds.....	56 (20% of sample)

The distribution of married and unmarried staff was:-

Table 8 Frequency by Marital Status

Married.....	151 (53%)
Unmarried.....	102 (36%)
Other (widowed, separated or divorced).....	31 (11%)

Since responses from the "other" category did not differ from the married group the two groups were amalgamated for the purposes of analysis.

Shift patterns showed:-

Table 9

Night duty staff numbered.....	59 (21%)
Day duty staff numbered	225 (79%)
	284

88% of night duty staff were married.

58% of day duty staff were married.

The number of respondents having dependents was of interest since having dependents could be a possible constraint on the mobility of staff and their ability to make use of educational programmes away from their own home districts.

In the present study it is apparent that some respondents have categorised spouses as "dependents" and this interpretation has been accepted as the reality for the respondents concerned since decisions on mobility are likely to be made in the light of this "dependence". The group "dependents" also includes other adults e.g. elderly relatives.

100 (55%) of married staff recorded dependents.

27 (26%) of unmarried staff recorded this.

63% of those on night duty had dependents.

40% of those on day duty had dependents.

Cooper (1970) discusses the means used by nurses to keep up to date with nursing and identifies periodicals, books and experience, in addition to formal and informal educational programmes. However, MacGuire postulates that anti-intellectualism is incorporated into nurse training. It may be, of course, that "intellectual" is regarded in the same way as Smart(1972) tells us that the adjective "academic" is regarded, when she states that it is frequently used to mean "no good to man nor beast". In the National Health Service this view is suggested by other than nurses, since a research report on the care of the elderly (Cornell and Coles, 1979) recommends itself to an Area Health Authority on the grounds that it is non-academic and therefore would be of use to decision makers. Anderson (1973) notes that nurses place great emphasis on experience as a means of increasing nursing knowledge, and it is, perhaps, useful to

remember that Rosen (1975) considers that, "...we are so utterly indoctrinated to believe that no true learning has taken place unless it has been written up or written out, that no one has seriously examined what kinds of important learning in any field might take place without a word having been written." Accepting that this may appropriately be applied to nursing, it is interesting to examine, in the present study, the means indicated by respondents by which they keep up to date with nursing knowledge. Appendix A, Table A10 shows this in detail. Table 10 below gives an overall view.

Table 10

Methods recorded by respondents as available to them to update nursing knowledge	N = 284
	%
Nursing Journals	95
Formal Training Programmes	58
Consultants Rounds	52
Own Resources	38
District Study Episodes	24
Informal Discussion with Medical Staff	19
Lectures from Medical Staff	8
Information from Professional Associations	8
Nursing Staff Meetings	6
Contact with School of Nursing	4
Use of Post Graduate Medical Centre	2

Accepting that means other than reading are available to nurses to enable them to keep up to date with nursing knowledge it is worth recording that respondents also indicated an awareness of the value of

reading material as a means of intellectual stimulus and as a source of professional knowledge and both written comments and the data from interviews suggest that respondents were aware of the paucity of easily available literature and viewed this as increasing the difficulty in keeping nursing knowledge up to date.

Information on journal reading.

The use of nursing journals as a means of keeping up to date with nursing presupposes that the information available is of use to nurses for this purpose and that all nursing journals are equally useful. This research asked only if nurses read nursing journals and in Appendix A Table 2 shows that 88% of respondents recorded reading a nursing journal in the month before the survey. The literature suggests that nurses are subjected to an information explosion related to the expansion of hospital and other care services and the complexity of procedures for treatment which are being developed (Conley 1972, Scott Wright 1971 and Orr 1979). Burns (1972) identified the American Journal of Nursing as a cheap method which offered help to nurses in their efforts to keep up to date. There is no similar study in this country relating to British nursing journals but it was assumed by the researcher that the reading of journals would be helpful rather than unhelpful to the nurse seeking information.

Availability of Nursing Journals.

Appendix A Table A1 shows that whilst 55% of respondents had nursing journals available in the hospital in which they worked, only 21% of respondents had journals conveniently available with the ward or department.

There were statistically significant differences between:-

Those working in hospitals of 50 beds or less..... 73%

and

Others..... 50%

Amongst those who had journals available within their working area statistical differences were noted in the responses from:-

Male nurses..... 9%

Female nurses..... 23%

also

Midwives (Charge Nurse grade)..... 50%

Others..... 16%

In general divisions:-

Nursing Officers..... 39%

Charge Nurses..... 13%

Who reads nursing journals?

Oppenheim (1966) reminds us of the difficulty of eliciting meaningful replies to questions of this kind since inaccuracies may creep in because of faulty recollection or because prestige bias may constrain people from answering accurately. Thus, whilst 95% of respondents recorded that they had read a nursing journal in the three months preceding the survey only 88% recorded reading a journal in the month before and this may be a more accurate record of reading habits. In an earlier study of the reading habits of trained nurses, Fisher and Strank (1971) recorded 86% of respondents as reading nursing journals. However, in that particular study the response rate of 23% could suggest an element of bias since those who responded might represent nurses who were interested in reading rather than all nurses.

In the present study there were statistically significant differences between:-

Male nurses.....43% of whom recorded reading journals in the week before the study and

Female nurses.....64%.

In Appendix C Table 19 the journals actually available to nurses are listed. The Nursing Mirror and the Nursing Times are by far the most frequently mentioned, 71% and 69% respectively. 18% recorded the British Medical Journal. Only 3 respondents identified a non-British journal being available.

In Appendix C also, Table 18, lists the number of journals respondents recorded as available to them.

14% of Nursing Officers recorded at least 5 journals

4% of Charge Nurses recorded this.

Who buys nursing journals?

Overall 51% of respondents.

Again recalling Oppenheim (1966) who considers respondents may be reluctant to record negatively on a topic such as reading, it appeared reasonable to test the reliability of the response on reading journals by the response to the question "Who buys journals". In Appendix A in Table A2 it can be seen that there is a negative correlation between the availability of nursing journals and the buying of them. Thus, those groups who have high proportions of journals available at work have low proportions buying nursing journals.

Statistically significant differences exist between:-

Those qualified less than 15 years .....62% and

Those qualified 15 or more years 43%

also

Those working in hospitals of 100 or more beds..55% and

Those working in hospitals of less than 100 beds....42%

The social situation existing in smaller hospitals may explain some of this difference. In smaller hospitals staff tend to have a sitting room or other communal meeting place and the presence of journals in these rooms tends to make reading material more readily available to interested staff. In the larger hospitals journals tend to be available in:-

(a) nursing libraries

(b) central nursing offices.

Such areas may be much less accessible to ward staff. Communal meeting places for nursing staff seem to be less available or less used in larger hospitals.

Libraries for nurses

The General Nursing Council in a paper dated April 1980 states that library services with the National Health Service should be regarded as essential for the provision of information in order to achieve high standards of patient care. Carmel (1975) suggests that there is widespread disquiet about library services (in the Health Services) and dissatisfaction with existing standards and postulates a need for a library service which would be a clearing house for information and a resource centre distributing information/books/journals at appropriate points. He suggests a need for the rationalisation of all such services within a district, which seems in agreement with the General Nursing Council's (1980) expressed view that the library should offer a knowledge base for the practitioners of clinical services. Tabor (1979) considering library facilities for nurses, does not indicate that there has been much change in the thinking related to library provision for nurses which he sees as essentially linked to the provision of library facilities for medical staff since nurses, he deduces, need some insight into the developments of knowledge in medical and allied fields; as development

in these fields also have implications for nursing care and such knowledge is necessary for the nurse if the best possible care is to be available to patients. Thus he makes a plea for the development of multidisciplinary health libraries in each Health District. Tabor (1979) also identifies libraries, in the field of health care, as a support service for both clinical and management purposes which he recognises as being particularly important when the continuing educational needs of trained staff are being considered. Most of what he discusses was given some emphasis by respondents in the present research, either implicitly or explicitly.

Berg (1973) noted that participants in education programmes made more use of journals and libraries than did non-participants and this was examined in the present study. Table 11 shows us that there is some support for this in the findings of the present research. Bergman (1979) in a study relating to nurses of similar grade to Charge Nurses in Israel, noted that nurses who participated in post basic educational programmes exhibited greater satisfaction with available facilities than did non-participants. In Appendix B Table 2a shows that amongst respondents who scored over 75 on the satisfaction Scale 1, 70% of these were participants in post-basic courses.

Table 11 Post basic programme participants by Use of Facilities

Use of facilities	Participants	Non Participants	N	Sig.
Use of professional library:				
previous week	63%	37%	19	N.S.
previous month	67%	33%	30	diff 3>S.E.
Use of other library (for profess.needs)				
previous year	56%	44%	100	N.S.
Read nursing journal previous week	59%	41%	174	diff 3?S.E.
previous month	58%	42%	76	N.S.
Buy nursing journal	59%	41%	146	diff 3 S.E.
Read medical journal (in previous 3 months)	59%	41%	101	diff 3?S.E.

Who uses libraries?

Overall 54% of respondents.

However, this was in the year previous to the survey and related to the use of a professional library within the employing Health District.

When this was related to the period just before the survey:

In the month previous.....11%

In the week previous..... 7%

There is little evidence in the present research that trained nurses are frequent users of libraries. Some explanation for this may be found in Carmel's (1975) paper referred to on page 97 where he suggests that

libraries in the health service are not necessarily suited to potential users. Some comments from respondents in the present survey indicate that this may be so and the following examples were recorded:

"It is six miles to the School of Nursing where the library is".

"The library is always closed when I can use it."

"I don't think they like sisters using the library."

"When I have finished work the last thing I think of trying to find is a library."

Appendix A Table A4 shows that 12% of respondents found that the libraries available met all their needs (48% of these [16] had not used a library in the year previous to the survey).

19% of respondents found that the libraries available met none of their needs.

Statistically significant differences amongst users were found between:

Respondents from hospitals of 200 beds or more.....65%

Respondents from hospitals of less than this.....44%

This may to some extent be explained by the fact the nursing libraries are usually associated with Schools of Nursing and are most likely to be attached to larger hospitals, indicating that when facilities are available within easy reach of ward staff they are more likely to be used.

Other differences existing:

Gen. Div. Nursing Officers....71% had used a library and

Charge Nurses.....51%

This refers to the year previous to the survey.

35% of respondents had used a general public library for health service purposes in the year previous to the survey. There were no statistically significant differences between the groups.

Because nursing practice is influenced by changes in medical thinking and new knowledge in medicine has implications for nursing (Chapman, 1977; McFarlane, 1976; Castledine, 1977) the extent to which nurses avail themselves of information from medical journals was sought. Appendix A Table A5 shows that 82% of respondents considered that nurses should read medical journals but only 36% of respondents had read such a journal in the 3 months before the survey. Of those who had read a medical journal in the month before the survey (15%), significant differences exist between:-

Those working in speciality areas.....24% and
(This group includes midwives)

Those working in other areas.....10%

There were comments from some staff in specialist units indicating that access to medical journals occurred because doctors brought journals to the unit. Specialist units (including midwifery) also frequently have libraries. These are small but accessible to staff.

Among those who did not consider that nurses should read medical journals there were three comments recorded:

"These journals are too high powered for nurses."

"You can only understand bits of them."

"I can barely find time to read nursing journals."

Who is satisfied with journal and library facilities?

A scale was devised to measure respondents' level of satisfaction with the facilities available. (See page 81 for information on this) and scores indicating satisfaction or dissatisfaction are recorded in Appendix B, Table B1.

Overall 40% of respondents scored 25 or less and those who scored in this part of the scale were categorised as dissatisfied.

Statistically significant differences existed between:-

Nursing Officers.....20% and
Charge Nurses.....43%

also,

Male nurses.....57% and
Female nurses.....38%

Other variables influence, Table B2 in Appendix B shows that

Those who have journals in hospital....33% register dissatisfaction and

Those who have not.....46% are dissatisfied.

and Those who have journals in ward/dep....20% score as dissatisfied.

Those who have not.....50% score here.

in addition,

Those who have read medical journals...33% are dissatisfied.

Those who have not.....45% score as dissatisfied.

Those who found professional libraries useful...26% score as dissatisfied.

Those who did not.....69% scored here

Participants in post-basic programmes..38% were dissatisfied.

Non participants.....44% scored here.

Table 2a, Appendix B shows us that of those who scored in the satisfied area of the scale (above 75) 70% were participants in post-basic educational programmes.

It is apparent that nurses' needs for professional updating by means of libraries and journals are not being met by the facilities available. It is also implied by comments made by some respondents that libraries in the health services were viewed as repositories of text books only and not as an information resource facility. Respondents were

also aware that libraries in Schools of Nursing were, not unnaturally, designed for the use of learner nurses and not those of trained staff. Few respondents were aware of other professional library facilities. Indeed, at the time of the survey, other facilities were limited, * post-graduate medical centre libraries being used in the main exclusively by medical staff. Other libraries available to nurses in the Region are London based, for example, Kings Fund Centre Library and the Royal College of Midwives Library. Such libraries are not easily accessible to nurses working full-time and running homes for families. There is, therefore, a need for easier access if libraries are to fulfill the aim expressed by the General Nursing Council (1980) that the library service offers a "knowledge base" to ensure that management decisions are made in the light of relevant knowledge and is the natural focus of research based practice.

Gillespie (1978) in a letter to the Nursing Times suggests that in Scotland, where library provision is adequate, there is evidence that nurses make good use of the facility.

*This has now changed; the South West Thames post graduate medical centre libraries are now available to all trained Health Service staff and some are being stocked accordingly.

Who needs updating and who has opportunity?

Davis (1980) considers that there are signs that nurses are becoming aware of information needs at clinical, educational and management level and this was of interest in the present research. In Appendix A, Table A6 it can be seen that:-

20% of respondents felt themselves to be in great need of updating.

Statistically significant differences existed between:

Those qualified for less than 5 years.....37% and

Those qualified 25 or more years.....14%

94% overall, felt in need of some updating whilst only 14% recorded that adequate opportunity was available to them.

Bendall (1975) discussing the educational needs of trained nurses at a conference at Nottingham University, regretted the divisions which had developed between nurses who concentrated upon education and those who were involved in patient care, since one result of this could be, she considered, a lack of awareness by practising nurses of a need for continuing education, as they lacked close contact educationalists within the profession. The responses recorded in Appendix A Table A6, whilst not dispelling these fears entirely, suggest that many nurses are aware of a need to update and seem to be in agreement with O'Connor who cites The National Commission for the study of Nursing and Nurse Education (1970) when she states "...technological advances altered aspects of practice and care delivery and social changes in the health professions and the larger culture would combine to make lifelong learning a practical necessity." O'Connor was writing of the United States of America but such a statement has relevance for this country also since social change and technological advance apply in both societies.

What post-basic education?

It was of interest to identify what proportions of the sample had recorded attendance at any post-basic educational programme. Appendix A Table A18 shows that:-

75% of respondents had attended management programmes.

58% of respondents had attended clinical programmes.

Taking the information on clinical programmes first:-

Among the 42% of respondents who had not attended any post basic programmes in the clinical field there were statistically significant differences between the following groups:-

Married staff - 51% had not attended formal postbasic clinical programmes.

Unmarried staff - 26% recorded this.

Those working in the specialty "Geriatrics" - 68% of whom had not attended a formal programme.

Those working in other areas - 36% of whom had not attended a formal programme.

Table A12 in Appendix A shows that staff from maternity divisions do not only record 100% attendance at Category 1 courses, without which they would not be trained midwives but also recorded high levels of attendance at Category 2 and Category 3 courses also. This is in addition to the mandatory requirement to attend a 5 day approved refresher course every 5 years.

Type of nursing shows other interesting differences also. Table A12 in Appendix A shows us that:

Respondents working in Geriatric areas show a lower proportion of respondents attending formal courses (Categories 1 and 2) but higher proportion attending informal (Category 3) courses.

Respondents working in smaller hospitals also record this.

Some explanation for this may lie in the fact that informal programmes can often be arranged by the participants themselves and do not need the cooperation of the employing authority since they can be arranged during off-duty periods and this factor may also influence the response of married staff. Comments from respondents suggested that this certainly occurred.

By what means do nurses update nursing knowledge?

Page 93 has a list of these. Statistically significant differences exist between:

1. Consultants rounds - 66% of those qualified for less than 15 years mentioned this.
   - 51% of those qualified for 15 years or more years did.
2. Own resources - 71% of Nursing Officers (General) mentioned this.
   - 32% of Charge Nurses (General) did.
3. District Study Episodes - 26% of female respondents recorded this and
   - 10% of male respondents.
4. * RCN/RCM/Assoc. - 33% of midwives recorded this and
   - 4% of other groups.

* Royal College of Nursing, Royal College of Midwives, Association of Theatre Nurses and like bodies.

It may be useful, at this point, to indicate the pedagogic nature of "Consultants Rounds". Consultants in hospital tend to walk round the wards according to a set programme. The number in attendance can vary from the Charge Nurse only, to a group consisting of doctors of House Officer and Registrar grade (and in teaching hospitals, medical students) physiotherapists, sometimes other nursing staff. A secretary may also attend. During this round patients are examined, diagnosed,

treatment prescribed evaluated and changed. The condition of the patient is thus regularly monitored and decisions made based on information collected during these visits. The consultant concerned may discuss the aetiology of the disease, research findings regarding the treatment, the effect of drugs and the applicability of investigations. The discussion may be joined by the Charge Nurse or it may be that she/he gives information only when asked. All other members of the group may also contribute. The discussion varies with the inclination and expertise of particular consultants from an in depth investigation of the condition of every patient to a rapid walk round to decide the next day's theatre list. No information was requested on the type of consultants' rounds in which respondents participated, only if they found it helpful in updating knowledge.

It is interesting that midwives record the Royal College of Midwives as a means by which more than one third of respondents keep professional knowledge up to date, since a very small proportion of general nurses regarded the Royal College of Nursing as such a source. Midwives recorded lectures and conferences attended both locally and further afield. No general nurse recorded local activity by the RCN as a source of nursing updating.

One other category of programme not recorded with the above consists of 3 - 5 day inservice training described variously as Art of Examining, Art of Teaching or Art of Teaching and Examining. 30 respondents, all of whom who had attended other post basic programmes, recorded attendance at one of these courses. Since many nurses of Nursing Officer grade and even more of Charge Nurse grade act as examiners for the General Nursing Council's Assessments of nursing skills and acceptance as an examiner is dependent upon some such training, the small number of respondents recording this was

surprising. A small exercise was undertaken with a sample of Charge Nurses, all of whom who were known to be examiners for the G.N.C. These nurses were outside the present research. It was found that of 20 nurses approached only 1 recalled the training programme related to examining when recording post-basic programmes attended. It may be that this situation operated with the sample of nurses approached for the purpose of this research. One Charge Nurse from the group approached outside the research stated when asked for some explanation:

"You can hardly call 3 days a training programme."

What type of post-basic programme?

Three main sources were identified:

1. Clinical programmes not in district.
2. Local Study Episodes (1 working day or 1/2 working day.)
3. Management Training.

Clinical Programmes.

These could be divided into 3 categories.

Category 1.....This included nationally registered clinical training mainly for sub divisions of the Nurses Register, but not exclusively this. Appendix C Table C3 gives details of these.

Category 2.....This was almost entirely Joint Board of Clinical Studies Courses.* (Appendix C Table C4)

Category 3.....Conferences, Specialist lectures other than those in home district produced by employing authority. (Appendix C Table C5)

Local Study Episodes

These were programmes produced by the employing authority, were ad hoc in nature and occasionally consisted of a full day's study covering several topics or ½ a working day devoted to one topic. No respondents recorded any modular programmes or any related topics. Appendix A Table gives details.

Management Training

All respondents who had attended these courses had attended programmes provided by the Regional Health Authority and no respondent recorded attendance at University, Polytechnic or Royal College of Nursing courses.

The Salmon Report (1966) (see pages 19 and 44 for further information on this) resulted in a considerable change in emphasis by hospital employing authorities in expectations of nurses regarding management education and Regional Health Boards, now Regional Health Authorities provided, either by arrangement with Colleges of Further Education and Polytechnics or by means of their own staff colleges, some training in management skills.

* Information on the Joint Board of Clinical Studies is to be found in Chapter 8 pages 67 to 68.

The Salmon Report (1966) recommended management training for nurses in three stages:

1. First line management, consisting of two periods of two weeks designed to meet the needs of Charge Nurses.
2. Second line management, to meet the needs of Nursing Officers consisting of 12 weeks tuition, again in two parts.
3. Top management courses, to meet the needs of more senior nurses, consisting of a further 12 weeks study.

In the South West Thames Region, where the present research was undertaken, management courses of two weeks duration introduce staff to management concepts. Further modules of training of 3 to 5 days duration

concentrate on:

The training aspects of the manager's role.

Effective Presentation of Information.

Staff development.

Interviewing

Committee work.

The two week management course is designed to allow the students to study:

Programming and planning of work

Personnel and employee relations

Interpersonal skills and self-awareness

Verbal communication, one to one and one to group

Written communication, reports and letters

Objectives setting, performance appraisal

Current issues in the National Health Service

Allocation and control of managerial resources

Who has attended management courses?

Overall 75% of respondents.

Statistically significant differences existed between:

Those on night duty - 61% attended and

Those on day duty - 75% of whom attended.

Those working full time - 79% and

Those working part time - 62% of whom attended.

Management training and participants expectations.

In Appendix A, Table A17 shows that, overall, 52% of respondents who attended management courses (213) recorded that the courses met their needs.

There were statistically significant differences between:

Nursing Officers (General) - 91% and

Others - 47% whose needs were met.

Nursing Officers (maternity) also exhibited lower levels of satisfaction with these courses but the numbers were small and the differences did not reach significance.

The courses related to work?

Overall, 51% of respondents considered that the courses attended related to work.

There were statistically significant differences between the responses of:

Nursing Officers (General) - 91% and

Others - 45% recorded this.

Again Nursing Officers (maternity) record differently. No Nursing Officer in the maternity area considered that the course related to work. The numbers are small and not statistically significant but in view of the high participation of midwives in post-basic education this response may reflect high expectations which are not being met or it may indicate a lack of involvement by midwives in courses which do not enhance their knowledge of their own specialist field.

Further information was elicited from respondents regarding the course contents to establish what expectations if any were not being met and these were limited to information on:

1. Theory content of the course (defining theory as the exposition of the principles of a subject)

60% overall considered that they required more theoretical content.

It is possible that in the two weeks or so available to tutors it is not seen by them as practicable to place the management concepts

being presented within a comprehensive framework of management theory but without an understanding of the various schools of thought which have contributed to this body of knowledge from scientific management through human relationships to the behavioural sciences, the information received may lack a reliable base and the enquiring nurse may well reject information which is not supported.

2. Practical applications.

57% of respondents considered that the presentation of information on such courses needed more practical application. There were no significant differences between groups.

Pembrey (1978) writing of Charge Nurses acquisition of management skills reports that the development of these skills was not enhanced by attendance at management courses but developed among those who exhibited such skills through experience at staff nurse level and that these Charge Nurses had all identified a 'role model' from whom they had learned their management skills.

The present study does not fully support this finding. Indeed many respondents commented, both at interview and in the questionnaires that (in addition to being an interesting experience) their attendance at management training courses had been valuable in stimulating them to develop new thinking and the most frequent comment was that the approach to teaching, which respondents identified as being informal, was suited to adults in a learning environment and was stated to be "encouraging". What seemed to occur was that the various parts of the curriculum, hung together without the bonding of theory, proved too difficult to assimilate during the short period of the course and, lacking reinforcement later, became difficult to build upon. Some respondents identifying a need to develop further their interpersonal skills cited management courses as the catalyst which enabled them to identify this need.

There were other comments from respondents:

3 recorded that their lectures were presenting "red" political theories.

4 that their lecturers discussed everything in terms of factory floor practices and did not relate anything to hospitals.

1 recorded that no-one mentioned patients needs throughout the course.

The high level of attendance at management educational courses suggests that:

(a) When the educational concept becomes fashionable

and

(b) Regional Health Authorities fund the programmes,

local employing authorities will take advantage of the provision offered. It may be that if the same emphasis was given to other forms of educational programmes for nurses, the same high levels of attendance could be anticipated.

In what areas do nurses identify a need for updating?

In Appendix A Table A5 shows us that respondents most frequently identified a need for:

1. General clinical updating.

Overall 25% of respondents recorded this.

Statistically significant differences existed between the responses of:

Midwives - 12% and

Others - 27%

This difference may indicate the effectiveness of the obligation upon midwives to attend updating courses every 5 years.

No other statistically significant differences were observed.

2. Interpersonal skills.

Table A7 in Appendix A shows us that 22% of respondents recorded a need for training in interpersonal skills.

Quenzer (1974) noted in her study that nurses were unaware that interpersonal skills could be used therapeutically for patients and Dodd (1974) found that nursing staff, in the main, did not consider that such skills could be inculcated during educational programmes. Bergman (1979) examining the educational needs of Unit Head Nurses (a group she equates with Charge Nurses in this country) in Israel, found that such nurses identified human relations skills as first in order of importance in training needs.

In the present research the question asked was:

> "Could you list any subjects which you consider could usefully be studied by nurses in charge of wards or departments to help them develop and maintain the skills required of them."

The replies categorised as "interpersonal skills" were identified by the researcher from the following seven groups of responses:

(a) Need to understand patients' anxieties.

(b) Need to help staff understand patients' needs. (This included reference to social and psychological aspects).

(c) Need to know how to support relatives in periods of great stress e.g. bereavement.

(d) Need to know how to relate to relatives generally.

(e) Need to know how to integrate staff into the ward team.

(f) Need to know how to make the ward team cohere.

(g) Need to know how to help other groups understand ward needs.

As in Bergman's (1979) study it can be seen that in this research nurses did give high priority to these factors without labelling them precisely. It may be that changes in society generally are the

precipitating elements here since nurse training, historically, whilst acknowledging the importance of an empathetic approach to patient care has been able to devote little time, in a crowded curriculum to developing these skills. (See pages 15 and Appendix G for information on the content of nurse training programmes). Statistically significant differences were observed between the following groups:

Those with dependents - 16% recorded a need for interpersonal skills.

Those with no dependents - 27% recorded this.

Males - 14% and

Females - 27% of whom recorded this.

Time qualified also influenced:-

Of those qualified less than 15 years - 30% identified

and Of those qualified 15 or more years - 15% identified.

It is possible that people with dependents and also those who have a number of years experience may feel that they have acquired such skills by means of their life's experience. There is, perhaps a danger here in assuming that all lives yield sufficient experience to enable people to develop such skills and that others will be capable of internalising the experience to enable them to develop these necessary skills. Another area of need identified by respondents, albeit to a lesser degree, was that of teaching skills.

Appendix C Table C3 tells us that 8 respondents had training as nurse teachers, either having clinical teachers certificates or were Registered Nurse Tutors. Another 30 respondents had attended 3-5 day programmes described either as Art of Teaching, Examining or Teaching and Examining. This represents 13% of the sample. Marson (1979) writes of nurse training in the United Kingdom that it assumes that nurses learn as they work and from this she makes a further assumption,

that trained nurses teach. Fretwell (1980) tested this in her study of the ward as a learning environment and concludes that the Charge Nurse both creates and controls this aspect of ward experience for nurses in training. Goddard (1963) noted that Charge Nurses spent little measurable time in interaction with learners. Lalean (1973) also comments on the small proportion of the ward sister's time which was spent in informal communications with learner nurses. 2% was the proportion observed. A further 14 - 22 minutes per day on average were spent on formal communications (giving of reports etcetera) in each ward. Lalean also noted that 20 communications an hour were liable to fragment the Charge Nurses time and suggests that this pattern leaves little time for teaching. Revans (1962) also noted the multivariate demands on the ward sister and the paucity of time actually available to be spent with learner nurses. These studies suggest that where there is little interaction there can be little teaching and Lamond (1974) says of learner nurses that they recorded the Charge Nurse as potential teacher in only one third of possible choices. Also, Catnach and Houghton (1961) in their study of methods of teaching in nurse training schools did not observe any incident which they categorised as "teaching" by Charge Nurses during the month in which their data were collected. However, Schurr (1968) reflects the Charge Nurses' views on this with the quoted comment, "Whatever we do we are always teaching." Pembrey (1978) (see page 151) seems to support this. Fretwell (1980) also, in her exhaustive study of the ward as a learning environment recorded that the time spent by Charge Nurses in the teaching of learners was observed to vary from 1% - 13% of the time available.

Respondents in the present research record relatively low priority to the acquisition of teaching skills and in response to the question, "Are there any programmes available to you to enable

you to develop the teaching skills required of you in your ward or department?" Some mentioned role models; doctors, sisters, other nurses. Others stated that to train as a nurse enabled the nurse to develop teaching skills for use in the ward situation.

Overall 12% of respondents recorded a need for training in teaching skills. (Appendix A, Table A7). There were statistically significant differences between:

Those qualified for less than 5 years - 20% of whom recorded this need.

Those qualified for 25 or more years - 6% of whom recorded this.

There are indications from this and from other studies, Goddard (1963) Lalean (1973) Lamond (1974) Fretwell (1980) that no clear understanding exists of the role of the Charge Nurse in the teaching of learners. Indeed Marson (1979) states that a frequently heard comment from Charge Nurses interviewed in her study was "....if I had wanted to teach I would have taken a nurse tutor course." Marson posits that if the emphasis was moved from "teaching" as a didactic activity and placed on "learning" as a personal development, some of these difficulties would be overcome; a plea for a facilitator of learning rather than a teacher. Ogier (1979) draws somewhat similar conclusions from her research stating that emphasis should be placed on training in interpersonal skills to enable Charge Nurses to meet the learning needs of nurses in training. The lack of consensus between the expectations of the educationalists and the perceptions of Charge Nurses is in need of further exploration since during a period when research indicates the increasing multiplicity of demands upon the available time of the Charge Nurse,

increasing emphasis has also been placed upon the teaching aspects of the role. Lalean (1973) suggests that the implications in terms of time of the teaching component of the Charge Nurse role should be acknowledged and catered for or the lack of available time should be duly accepted and adequate alternative arrangements made.

Other skills needed - less frequently recorded.

1. Specialist skills - 10% recorded.

   This category described needs associated with specialist areas of work and included reference to updating in theatre work, intensive therapy, neurological, renal and coronary care knowledge.

2. Technical Skills - 5% recorded.

   This category described knowledge needed to manage equipment and included reference to monitoring equipment used in assessment diagnosis and therapy.

3. Academic Skills - 4% recorded.

   This category included reference to the Diploma of Nursing, studies in sociology, psychology and biochemistry.

It was a surprising finding in this research that few respondents mentioned the Diploma in Nursing as a part of continuing education in nursing. Four respondents recorded reference to the Diploma in Nursing. One had been awarded the Diploma and one the Advanced Diploma in Midwifery. Two others mentioned this as a possible avenue for further study. This is discussed further on page 150.

Post-basic and Inservice Tutors

Question 12 in the questionnaire used in the survey asked:

"Is there a nurse specifically in charge of education for qualified nurses in your district?"

During the period of the survey there were three districts in the sample who had a nurse designated as a Senior Tutor, post-basic training or Senior Tutor, in-service training. Only 44% (124) answered this question. 90 respondents said that there was such a tutor. 30 came from districts which did not have such a post. 30 said that there was not a tutor for post-basic education. 10 came from districts that had a tutor in post.

This data suggests that respondents either did not interpret the question correctly or that the presence of a tutor specifically responsible for this aspect of nurse education had, at the time of the survey, made little impact upon the districts generally. An increase in the number of such appointments within the Region may well have given greater publicity within the districts to the existence of the post and brought about greater awareness. The lack of consistency in the responses means that the information must be treated with caution and these responses have not been included in the data entered for computer analysis.

Basic Nursing Training - was this sufficient to equip respondents for their present role?

This question produced replies which were surprising in view of the other information offered.

54% answered "Yes".

Statistically significant differences exist between:

Those qualified less than 15 years	- 43% of whom recorded this and
Those qualified 15 or more years	- 62% recorded "Yes".
Respondents from hospitals of less than 100 beds	- 75% recorded "Yes"
Respondents from hospitals of 100 or more beds	- 45% recorded this.

Most respondents who considered that their basic training was sufficient to enable them to undertake their present post commented either:

(a) that they had trained at a time when basic training was considerably better than the training being presently offered.

(b) that they had trained at a training school which offered very much better training than was available in most hospitals.

Only some respondents recorded training at teaching hospitals. It is possible that in replying to this question respondents were conscious of loyalties to an Alma Mater and considered that negative replies implied unjustified criticism of the training school. McGuire (1964) discusses this and suggests that this loyalty to hospital inculcated during the training period, includes a denial of the right to criticise. The design of the survey did not allow this subject to be pursued and it is an interesting area for further exploration. It would be useful to know, for example, why Nursing Officers considered that basic training equipped them sufficiently since no respondent in the survey in Nursing Officer posts could have trained at a time when such posts existed. Also it could be asked, What difference does hospital size make? Are changes in practice less evident in hospitals of less than 100 beds?

It was asked of respondents if they saw a need of short updating courses from which they could choose a programme to meet their own individual needs.

In Appendix A, Table A18 shows us that 97% of respondents saw a need for this. There was some divergence of view as to whether such updating should be voluntary or compulsory. Amongst the 97% who

recorded a need 71% considered that such updating should be voluntary.

28% felt that this should be compulsory.

Statistically significant differences exist only between:

Those working in general areas - 77% of whom prefer voluntary attendance.

Those working in specialised areas (this includes midwifery) - 63% of whom prefer voluntary attendance.

Appendix A Table A19 also demonstrates the view of respondents regarding systematic updating such as that which is mandatory for midwives. (See page 4 for the rules applying to mandatory updating for midwives)

Overall 3% of respondents considered that this was unnecessary.

Statistically significant differences exist between the views of respondents regarding whether or not such updating should be compulsory.

84% of midwives recorded that it should.

53% of others recorded that it should.

58% of all respondents considered that there should be systematic updating on a compulsory basis.

Proportion of respondents who recorded satisfaction with opportunities available to them to update nursing knowledge.

Scale 2 (described in the methodology chapter, page 81 was designed to measure respondents levels of satisfaction with the facilities perceived by them to be available to enable competence in nursing to be maintained. As with Scale I the limitations on such measurement was recognised and only scores of 25 and less were used to identify dissatisfaction, whilst scores of above 75 were accepted as indicating satisfaction with facilities.

In Appendix B Table B3 shows that:

Overall 46% of respondents registered dissatisfaction.

8% registered satisfaction.

Statistically significant differences were identified between the following groups:

Respondents on night duty - 59% of whom scored 25 or less.

Respondents on day duty - 42% of whom scored as dissatisfied.

Married nurses - 59% scored 25 or less

Unmarried nurses - 37% scored 25 or less.

Home commitements also influenced:

Those with dependents - 50% scored 25 or less.

Without dependents - 41% scored as dissatisfied

Specialty also had an effect:

Midwives recorded 16% as dissatisfied.

Others recorded 51%.

Grade influenced in the general division:

21% of Nursing Officers scored 25 or less

54% of Charge Nurses scored as dissatisfied.

Table B4 in Appendix B shows us that participants in post-basic educational programmes do not exhibit different responses overall but those who have participated in 3 or more programmes show statistically significant differences from those who have not participated.

Other factors which may be of importance to nurses when they are considering the need for updating nursing knowledge include :

1. Potential mobility
2. Preferred time span
3. Preference for full time or part time study.

Who is free to travel?

Appendix A, Table A13 shows that only 19% of respondents recorded

an ability to travel away from the home district.

Statistically significant differences exist between:

Married respondents - 13% of whom could travel

and Unmarried respondents - 29% of whom could.

Those who work full time - 23% who could travel and

Those who work part time - 5% of whom who could.

This may be demonstrating that career orientated respondents (those who work full time and are unmarried) can devote more time to the updating of nursing knowledge than can other staff. It must be remembered, however, that all of the respondents in this study are in charge of wards and departments for some part of the working day or night and will need to be as well informed as any other nurse who is in charge.

How long should a programme last?

Appendix A, Table A9 shows that more than half (79%) prefer study programmes lasting no more than 1 week and only 10% of respondents consider attendances at courses of longer than 1 month.

35% of respondents record a willingness to use their own time to keep up to date with nursing.

There are no statistically significant differences between groups.

Part time study rather than full time study?

In this research part time study is defined as study undertaken whilst still responsible for the ward or department. This means day release or some similar arrangement or study undertaken outside working hours.

Appendix A, Table A13 shows that:

41% of all respondents prefer this.

Statistically significant differences exist between:

Those working on night duty - 54%

and Those working on day duty - 38% of whom prefer part time study.

Those qualified 25 of more years - 57%

and Others - 36%

Those working in specialty areas - 57%

and Others - 39%

Who could extend the working day to include study/travel

Appendix A, Table A.13 shows us that:

Overall 50% of respondents could extend.

Statistically significant differences exist between:

Nursing Officers - 72% of whom could extend

and Charge Nurses - 49% of whom could

One other group who show statistically significant differences are those:

Working at nights - 61% of whom who could not extend

and Those working on days - 45% of whom who could not.

The subprogramme Multiple Regression was used to identify variables which predicted levels of satisfaction with facilities recorded on Scales 1 and 2. The variables included were those which showed significant differences in the scores of certain categories of respondents.

Scale 1

Variables:

Sex of respondents
Shifts worked
Grade of nurse

Availability of journals:

- in hospital
- in work place

Attendance at post-basic educational programme (including all three categories)

Social status

Presence of dependents

Type of nursing (general/maternity)

The results of this analysis were disappointing in that only 17% of the variance could be accounted for by the variables entered. The variables influencing were:

Availability of journals

Grade of nurse

Sex of respondent

Reading of medical journals

Attendance at post-basic educational programmes.

In Appendix B, Table B 5 it can be seen that 7% of the variance can be accounted for by the presence of journals in the workplace. The other variables accounted for the remaining 10% of variance. This suggests that a variety of journals circulating through wards and departments, perhaps on a Unit basis, would enable nurses to achieve higher levels of satisfaction with facilities available.

Scale 2

Variables:

Sex of respondents

Shift worked

Grade of nurse

Availability of journals:

- in work place
- in hospital

Reading of medical journals

Attendance at post-basic programmes (including all three categories)

Social status

Dependents

Type of nursing.

Table B 6 in Appendix B shows that 21% of the variance can be accounted for by the variables entered and that 17% of the variance can be influenced by one variable only. Thus:

Table 12

Presence of dependents -		17%
Type of nursing -		1%
Grade of nurse -		1%
Sex of respondents -		1%
Shift worked -	)	
Availability of journals -	)	
Social status -	)	
Reading of medical journals -	)	1%
Attendance at post-basic education programmes (all three categories).	)	

This suggests that the presence of dependents amongst nursing staff has a strong influence on the acceptability of educational courses available to them and since 45% of respondents (see page 91) in the sample recorded that they had dependents, the planning of such programmes must take cognisance of this.

In order to make the utmost use of the data available, the final comments supplied by respondents were investigated using the process of content analysis. Lindzey and Aronson (1954) state that when using this process, categories may be identified by means of a preliminary impressionistic analysis and Galtung (1967) that these categories must be treated in the same way as other units of analysis. In this research the categories were identified from the unstructured final comments of respondents and the analysis yielded 10 classes of response; 9 specific and 1 generalised category containing miscellaneous entries.

98 (35%) respondents made 185 comments. 6 comments related to the respondents' interest in the questionnaire and have been abstracted from

the rest of the analysis, leaving 177 comments.

Category 1

A need for new knowledge to enable trained nurses to keep up to date with nursing.

51 respondents referred to this - 29% of comments.

This is 18% of all respondents

Category 2

An expressed awareness of discouragement from the organisation for whom they worked, in their efforts to keep up to date with new knowledge.

31 respondents referred to this - 18% of comments.

This is 11% of all respondents

Category 3

A need for a new flexible approach to continuing nursing education. Here the use of films, cassettes and postal courses were mentioned.

28 respondents referred to this - 16% of comments.

This is 10% of all respondents

Category 4

A need for publicity regarding locally available programmes.

12 respondents referred to this - 7% of comments.

This is 4% of all respondents.

Category 5

A need for library facilities at times when the library can be used.

12 respondents referred to this - 7% of comments.

This is 4% of all respondents.

Category 6

A need for compulsory updating programmes.

12 respondents referred to this - 7% of comments.

This is 4% of all respondents.

Category 7

A need for more appropriate management training.

10 respondents referred to this - 6% of comments.

This is 3% of all respondents

Category 8

A need for effective programmes to give some skill in teaching nurses on the ward.

8 respondents referred to this - 4% of comments.

This is 3% of all respondents

Category 9

An identification of post basic up-dating programmes being used as a "reward" rather than as a necessary part of staff development.

6 respondents referred to this - 3% of comments.

This is 2% of all respondents

Percentages are rounded, where appropriate. Such percentages become less valid as numbers diminish.

Category 10

This group contained responses from:

3 Charge Nurses who kept up to date with nursing by reading nursing journals.

2 Charge Nurses who kept up to date with nurses by talking to doctors.

2 Charge Nurses who stated that trained nurses should keep up to date with nursing by nursing patients and not by going on courses.

The opportunity to utilise a different technique for data gathering, within the framework of an otherwise rather tightly structured questionnaire is useful and this self-generated data enriches the research and content analysis enables such data to be disciplined into identifiable categories.

Table 13

Categories of Comments
Related to Percentage
of Comments and of Respondents

Category	% of Comments		% of Respondents
1	30%	(51)	18%
2	18%	(31)	11%
3	16%	(28)	10%
4	7%	(12)	4%
5	7%	(12)	4%
6	7%	(12)	4%
7	6%	(10)	3%
8	5%	(8)	3%
9	4%	(6)	2%

(Figures in brackets represent numbers of comments)

CHAPTER 11

Analysis of Interviews

"The ward sister is:

A paragon of virtue

A fount of all knowledge

A Jack of all trades and master of all."

Opinions collected by P Young for a study sponsored by the King's Fund. She continues " ... but as yet there is no training for this arduous role."

Webb (1977) suggests that different data gathering techniques applied to the same problem help to clarify response. In the present research, triangulation was attempted by means of the following approaches:

1. The use of questionnaires.
2. The content analysis of final comments in the questionnaires.
3. The use of data from interviews.

Benney and Hughes (1956) consider that by its very nature the interview is a transitory experience and note that it is essential to establish a reciprocatory relationship in the short time available, therefore an interview, which is a meeting with a purpose, is dependent upon interaction between the people involved. Benney, Reisman and Starr (1956) remind us that the interviewer takes certain attributes to the interview and comment on the influence that factors such as age, sex or ethnic group may have upon the data collected. Williams (1970) also concludes that interviewer role performance is a factor influencing response. These views were useful reminders of the difficulty of developing absolute neutrality when conducting interviews. Page 79 describes the attempts made by the researcher to reduce any potential tensions associated with the interview. The experience of Davies (1971) in initiating interviews with Charge Nurses also influenced. Charge Nurses to whom questionnaires were being distributed (those who were selected for interview) were asked to participate in an interview and the time was set as soon as was convenient for the Charge Nurse. Most appointments were made for the afternoon of that day and all appointments were kept, the researcher stating that if the ward situation altered and the work pressures were too great at the time arranged a new appointment would be made. In fact, although some interviews were delayed no interviews were cancelled.

As already described (page80) the interview setting varied according to the local situation and the researcher concentrated on achieving a period free from interruption, in an environment which enabled a relaxed discussion to take place. The weather was dry and warm and the gardens were often used when there were secluded areas with seats available.

Appendix F shows the check list used to guide the interview. The questionnaires already distributed was also utilised in the initial stages of each interview to identify the priority given to the items included.

Table 14

Priority Given to Items in Section 1

Priority	Item
1.	Need for adequate nursing library
2.	Need for journals in an accessible place
3.	Need for small specialist ward library
4.	Adequate selection of journals
5.	Journals available in workplace
6.	Library opening hours to suit users

The responses here reflected the respondents perception of what was available. Some respondents referred to the inaccessibility of libraries and some to the libraries being designed for learner nurses and therefore that trained nurses were not appropriate users. The following statement demonstrates:

> "I have the feeling that I should not borrow anything although they don't mind my reading in the library."

Hospitals in some districts were very scattered and this was indicated by some respondents as a reason for difficulty in taking advantage of district library facilities which were known to be available. Financial difficulties facing the National Health Service was regarded by

many respondents as a limitation on any funds which could be legitimately be made available for the dispersion of books/journals throughout hospitals.

Comments regarding journals included these aspects:

> Journals were available in some hospitals and in small hospitals were readily available in sitting rooms or dining areas.
>
> Journals were available in School of Nursing libraries.
>
> Journals were available but in situations such as the waiting areas around nursing administrative offices.

The researcher was able to observe that this was indeed the case. Many hosptials had, freely available, in waiting areas attached to nursing administrative offices collections of one or more nursing journals. However, as Davies (1971) notes the complexities of the status hierarchies in nursing may militate against the utilization of journals in these circumstances and it was evident from discussion with Charge Nurses that journals, available as described, were not considered to be easily accessible as reference material. There were subtleties here which were not explored fully. Charge Nurses interviewed considered that nursing journals were a means of keeping up to date with nursing but several respondents suggested that leaving the ward to look up information in journals would not be considered appropriate behaviour.

Nursing Officers, on the other hand, expressed the views that journals were available to all trained staff and none of those interviewed considered that the siting of these journals in administrative office suites would inhibit their use by ward staff.

The need for appropriate text books to be available in the wards was mentioned by several Charge Nurses, some of whom used their own books in this way. Many of these described their text books as out of date. One Charge Nurse stated that she tried to add one such book regularly and estimated that she contributed books every couple of years.

Appendix C Table 18 contains information on the variety of journals available to nurses and it can be seen that there are few nurses who record a wide selection of journals being available. 79% of respondents record 1 - 5 journals available. Some respondents used the Post-Graduate Medical Centre Library, stating that it was easy to get permission and that the selection of journals was wide. Again, only those working in hospitals designated as District General Hospitals mentioned this. The percentage of Nursing Officers who perceived a wider selection of journals being available to them was 14% and Charge Nurses 8%. This difference may reflect the difference in role which exists, since Charge Nurses, as Davies (1971) described are ward-centred and therefore may perceive availability strictly in ward terms, whereas Nursing Officers by definition are Unit based and a unit may be dispersed geographically, allowing the Nursing Officer access to facilities over a wider area and therefore increasing awareness.

At interview some Charge Nurses also mentioned making their own journals available to staff within their wards. Others (3) mentioned medical journals being left by doctors. However, these were not available on a systematic basis.

That the nurses interviewed saw a need for updating information to be available to aid professional development was well supported by the interview findings. Respondents were also well aware of the financial implications of such facilities. There was some conflict as to the justification for spending more funds and the lack of reality associated with such expectations was mentioned by several Charge Nurses, who indicated that when budgets were tight, as they perceived them to be, it was unrealistic to think that such expenditure would be made. Several Charge Nurses indicated that their Local Authority Libraries were helpful in obtaining professional material.

The next area which was discussed was clinical updating relating

to educational programmes.

Table 15

Priority Given to Items in Section 2

Priority	Type of Programme
1 & 2	District based clinical programmes
3.	Need for specialist updating
4.	Need for more formal training programmes
5.	Better organised local lecture programmes
6.	Series of local study days covering one topic

It is appreciated that it is unrealistic to expect nurses, who are not educationalists to identify specific training/educational methods and what was hoped here was that those interviewed would be able to indicate deficits. It was evident from responses that nurses were thinking in very traditional terms when they considered any updating methods.

MacGuire (1964) has indicated the narrow professional basis of nurse training and it is a weakness in the present study that no particular effort was made to probe the views of respondents regarding the effect of this on their performance as Charge Nurses. Certainly, from the information offered it was apparent that nurses were well aware of the essential nature of interpersonal skills related to the Charge Nurse role but only 2 Charge Nurses stated specifically that they felt a lack of such training in their nursing education.

There was a consensus view amongst those interviewed that updating programmes for trained nurses should be available locally. Most nurses considered that the additional burden of having to leave their home district would reduce interest in such programmes if they were available.

Subsequent data relates to the information detailed in the Check list (see Appendix F).

The attitude of the employing authorities towards the needs of respondents to update nursing knowledge was sought. If this was not mentioned spontaneously it was asked if those being interviewed considered:

a. They were encouraged to take advantage of updating opportunities?

b. Their ability to do this was taken for granted?

c. There was indifference to their ability to do this.

d. They perceived themselves as being discouraged from doing this.

It was interesting that almost all respondents considered the financial implications of updating programmes and this constraint was offered by some as an explanation for lack of encouragement. In addition, many Charge Nurses stated that it was relatively easy to get funds if further education was needed to train as a teacher of nurses but that further education in clinical matters (if it lasted longer than one day) was regarded as a luxury in relation to clinical nurses.

Table 16

Attitudes to Updating

Responses	Numbers
Positively discouraged	8
Not discouraged but little available	7
Not discouraged but no money available	7
Updating taken for granted	5
Encouraged	4
Total	31

In addition to these comments, some Charge Nurses in the general divisions also commented that attendance at any kind of educational programme was presented by way of reward, rather than as a necessary commitment to

competence. Two Nursing Officers interviewed, on the other hand considered that Charge Nurse "expected everything to be handed to them on a plate."

Several nurses discussed this topic in terms of "professional" updating. This clearly meant that they were seeking knowledge relating to nursing and did not necessarily imply a sociological definition of professionalism. However, this awareness of a body of knowledge necessary to nursing may be an indication that nurses are, as Fretwell (1980) states, in a developmental state regarding professionalism.

It is perhaps useful here to remember that because of the interviewing format used, it was not possible to maintain a set method of questioning nor to use pre-determined probes to elicit information. The interviewer did however, endeavour to maintain a neutral attitude and most probing took the form of "Could you explain that a little" or "Am I interpreting you correctly?" At the end of each interview the interviewer read to the respondent what she had recorded and amended any mis-interpretations.

Pursuing the question of updating needs and its potential for reducing the time spent with patients:

Charge Nurses in the general division expressed these views:

a. Keeping up to date with nursing did not reduce the time spent with patients because it had to take place in the periods out of working hours.

b. Time spent in improving knowledge is of benefit to patients because it results in better care.

Midwifery staff stated that the time spent in updating and increasing knowledge was a necessary part of a midwife's career. Patients were more likely to be well looked after if the midwife was confident and knowledgeable midwives were more likely to be confident.

Nursing Officers all stated that they felt that the investment of time was not to the detriment of patient care. This was referring to their own

needs and one Nursing Officer considered that more training was needed in management techniques but that this was actively encouraged where she worked. Four of the Nursing Officers interviewed did not consider that they had opportunity for systematic updating. One considered that the present management training available within the National Health was systematic and adequate.

All midwifery staff regarded their opportunities for systematic updating to be adequate.

Charge Nurses in the general divisions responded differently. There was general agreement that there was no opportunity for systematic updating. One Charge Nurse who had attended a Joint Board of Clinical Studies course just before her appointment to her post a few months before the survey said that she felt that was happy about her own opportunities but she did not know what others did. Two main points were made:-

1. Those who took time and trouble were unacknowledged.
2. Those who made no effort were regarded as being just as competent as those who did try to keep up to date.

This evidence of a need for effort to be rewarded, either by being recognised by seniors or in terms of promotion, was also noted by Berg (1973) in an American study. No Charge Nurse interviewed regarded local study episodes as offering opportunity of systematic updating. However, in one Health District the Post-basic department of the School of Nursing considered that they provided the opportunity for Charge Nurses to devise ways of meeting their own updating needs in a systematic manner by offering them the possibility of taking part in any programme available whether for learners or trained nurses. No nurse interviewed in that district indicated any awareness of such opportunities.

When the data for this research was collected the effects of the 1974 reorganisation of the National Health Service were still being felt and respondents expressed the following views on this:-

a. Management changes of this kind had little impact on nurses working in the wards.

More than two thirds of respondents indicated this. A few nurses stated that decision making took very much longer. Another small group considered that the reorganisation had brought great benefits to the hospital.

Varying views were expressed regarding the nursing management structure operating. Most nurses considered that the management pattern developed after the publication of the Salmon Report (1966) had resulted (see page 44) in benefits for the Charge Nurse which enabled her/him to concentrate on the delivery of care to the patient within the wards. However, some Charge Nurses recognised their relationship with Nursing Officers as being part of a social exchange (Chapman 1977). These Charge Nurses viewed themselves as risking a loss of autonomy in clinical decision making in exchange for a reduction in administrative work. One Charge Nurse explained, "It takes away some of the irritating interruptions but you pay a price in interference at ward level."

Career Prospects

This was considered by most of those interviewed to have improved considerably but about half of the Charge Nurses qualified this by saying that opportunities for higher salaries had improved but not for nurses who wanted to remain looking after patients. All Nursing Officers felt that career opportunities were improved.

One other area of information was investigated. Nursing literature since 1970 has contained many references to the role of the Clinical Nurse Consultant. The Royal College of Nursing Paper (1974) describes the training for such a role and gives some descriptive definitions of its operation. In describing the post to the nurses interviewed, care was taken to differentiate this from the role of Clinical Specialist, usually a Nursing Officer, operating in a specialty field, for example, the nurse

in charge of a Renal Dialysis Unit. The role was defined as a nurse with clinical expertise who would be available to the Charge Nurse for consultation on clinical nursing problems. It was suggested that this expertise would be based on experience enhanced by advanced aducation. The education needed was not specified. Two Charge Nurses considered that this might be an interesting development allowing patient orientated nurses to remain in touch with patient care. However, both these nurses were sceptical of the ability of such nurses to maintain clinical expertise and both considered that the role would be in conflict with medical consultants, who would resent the development and create difficulties for an incumbent. They considered, also, that nurses in senior management posts would also see the role as threatening. All other Charge Nurses considered that this development could only be harmful to nurses in charge of wards. It was clearly stated by these nurses that clinical expertise should be available at ward level and that nurses of Charge Nurse grade were the people who needed this and should be encouraged to acquire and maintain this.

No midwife saw the role as a reality, citing the need for practitioners to be experts in the practice of midwifery.

Nursing Officers responded differently. All but one of the Nursing Officers considered that the role described was the one that they enacted. Some of these nurses had available their job descriptions which described the Nursing Officer as a clinical expert (these job descriptions were based on those examples given in the Salmon Report, 1966). (see page45). The responses suggested that this potential development was seen as a threat to status and described as likely to create difficulties for the nurse in the ward and for Nursing Officers.

All the Charge Nurses interviewed described the Nursing Officer as an "enabler" who was needed to clear the way for the Charge Nurse so that she/he could concentrate on the organisation of patient care. No Charge Nurse reported that the Nursing Officer operated as a clinical expert.

In Chapter 3 the literature was examined to clarify understanding of the concept of role and the development of conflict both within and between roles. It was apparent from the interviews undertaken that although sociological terminology was not used, the nurses interviewed had considerable understanding of the concept and also had awareness of potential areas of conflict. Charge Nurses saw the difficulties experienced by Nursing Officers whose awareness of the needs, for example, for adequate staffing levels, was difficult to reconcile with management policies operating. Role boundaries were clearly recognised - Charge Nurses differentiating between the Nursing Officer's control of resources and the Charge Nurses control over the organisation of the services within the ward. One Nursing Officer also discussed role stress which she recognised at Senior Officer level and commented that, "She (the Senior Nursing Officer) cannot go on fighting for resources for us as she does; it makes her job impossible. No-one seems to be able to understand the need of nurses for educational opportunities." Professional development was also acknowledged as a requirement, one Charge Nurse stating that nurses in charge of wards stagnate if they do not have the opportunity to acquire information on developments in nursing. Pembrey (1980) in discussion with Charge Nurses stated that not only did Charge Nurses need access to new knowledge in nursing but needed to have the means of assuring themselves that their knowledge was current. This seemed also to be identified by the nurses who were interviewed for this research.

Other Interviews

In order to establish the degree to which updating, post-basic education was available to nurses, interviews were sought with those who provided educational programmes for nurses and in addition to personnel in Schools of Nursing, representatives from other institutions responsible for the education of trained nurses were arranged. These included the Royal College of Nursing, Joint Board of Clinical Studies, two universities

and a polytechnic. In Schools of Nursing in the districts included in the sample, three schools had a tutor responsible for post-basic/in-service education in post for several years previous to the survey. One school made such an appointment during the survey and the other two districts made such an appointment later. Respondents from hospitals in these districts who worked in hospitals peripheral to the District General Hospital were not always aware that there was such a person in post in the district, suggesting that existing communication systems were not always successful, although one district reported that all educational sessions were advertised on prominent notice hoards and were identified by brightly coloured notices. This however makes the assumption that the target population looks at the notice board. The type of programme available in the districts which had a tutor in post, varied considerably. The main thrust in one district was through courses approved by the Joint Board of Clinical Studies, whilst at the same time offering study days to Charge Nurses and other trained nurses covering a variety of topics. In this district also the department was prepared to offer study facilities to any Charge Nurse who identified a particular need, utilising any programme being provided by the School of Nursing. This flexible approach was recognised by some nurses in the District General Hospital but staff in other hospitals in the District were not so well informed. Another District offered a variety of study days for trained staff and provided these on a hierarchical basis which meant that similar programmes were repeated for several grades of trained nurses, resulting in nurses being eligible to attend programmes every few months. Topics included lectures on fire prevention in a programme which also had a lecture on the behavioural sciences.. Another programme was devoted to alcoholism. In this School most sessions were part of a working day, the other sessions taking all of a working day. A Third District in the year before the survey offered thirteen sessions to trained nurses, for example, surgical dressing

techniques, care of the dying, and legal aspects of nursing. This district also provided Art of Examining programmes and had an affiliation with a College of Education which provided training in teaching techniques on a half-day release basis for ten weeks. In the year previous to the survey twelve people had attended. In these districts the programmes provided were based on needs identified by the providers from information acquired from staff within the Health Districts. No particular pattern was identified in the provision nor was there any evidence of follow-up or reinforcement of the information presented. Nurses who were responsible for educational programmes for trained nurses were also responsible for the provision of inservice training for nursing auxiliaries, which may have encroached upon the time available for the planning and development of programmes for trained nurses. It must also be noted that management education was the responsibility of another educational system organised by the Training Division of the Regional Health Authority.

Health Districts without tutors specialising in post-basic educational programmes, at the time of the survey, offered the same ad hoc approach to the updating of nursing knowledge but even less systematically and fewer study days were available. Interestingly, in all Health Districts, all staff reported a study session devoted to the change to an international system of measurement within the National Health Service. This change had been occurring at different rates in different sections of the Service over several years and the period of the survey marked the end of the changeover. In an interview with personnel at the Hendon Police College, staff concerned with the ongoing training of experienced police officers, stated that whilst it was difficult to plan programmes for police officers which would generally update personnel, all areas responded immediately to the production of programmes devoted to riot control techniques. Perhaps the Système International represents for nurses the concrete area of change that riot control represents for the police. This of course stresses the importance

of noting what changes are occurring and sharing this perception with nurses themselves, in order to plan programmes which meet expectations. Certainly the responses of Charge Nurses indicate that what is offered locally, whilst it may be interesting, is unsatisfactory in enabling nurses to feel confident that they are maintaining their competence and increasing knowledge. It is worth remembering that Luck et al (1971) writing of patients, hospitals and operational research, say of the Charge Nurse that she/he has a large amount of discretion in the organisation of patient care which thus affects the treatment and care that patients receive. It is this importance of the Charge Nurse role which creates the need for emphasis on the ability of Charge Nurses to maintain competence by means of educational updating, in addition to empirical extension of knowledge.

On page 136 respondents indicated awareness of certain biases existing in the support given to nurses pursuing advanced nursing education. Interviews with staff from the two universities offering advanced nursing education with a clinical option confirmed this to some degree. Personnel from both Edinburgh and Manchester noted that nurses who chose the clinical programmes (leading to a taught master of science degree) were mostly self financing or from overseas. In Leeds where an extension programme leads to a first degree for trained nurses it was also reported that applicants were having difficulty in raising financial support. At the time of the survey these three institutions were the only courses available to nurses at an advanced academic level and the Leeds programme was in the planning stage at the time of the survey. It is thus apparent that there is little choice available to nurses when seeking such education and the leaning towards locally produced programmes may well be influenced by the distance from home of the courses available.

It is necessary now to discuss the London University Diploma in Nursing course which is available in many centres throughout the country. Only 4% of respondents recorded this programme as a means of updating nursing

knowledge or increasing nursing knowledge. Interviews could not be arranged with staff from the university but a letter published in a nursing journal, Burtt-Jones (1980) states that this course registered 4,027 students for 1976-77. There has been no opportunity to identify why this discrepancy exists and interviews with Charge Nurses indicated that whilst respondents were aware of the existence of the courses they seemed to view them as largely irrelevant. The absence of information from the university makes it difficult to draw any conclusions from this information.

It has been stated that respondents were knowledgeable about the provision of specialist education in nursing (page104) and recognised the value of these courses in developing skills in these specialties. Information from the Joint Board of Clinical Studies discussed the remit of the Board (see page67). The programmes provided were not designed to update knowledge in the specialties in which training is provided and although the gap which exists in the provision of updating programmes for general nurses was acknowledged (see also the Third Report of the Joint Board of Clinical Nursing Studies, page68), the present terms of reference of the Board do not encompass this aspect of nursing education.

An interview with a representative of the Royal College of Nursing, at the London headquarters, indicated that their advanced nursing educational programmes concentrated mainly on teacher training courses and on education in management and administration. Certain specialty areas, such as Occupational Health are also catered for. In addition to these, Diploma in Nursing programmes are available. Nurses in clinical practice are helped by assistance in the development of associations for those with certain special needs, for example, those working in renal dialysis units and assist in the organising of conferences et cetera, for these self-help groups, whilst acting as facilitators in the development of the associations.

In examining the facilities available to trained nurses for educational development, the respondents lack of awareness of much opportunity

reflects the reality. There is a lack of co-ordination in what is made available and little new thinking in what needs to be provided. The useful libraries available in London are not helpful to nurses in other areas and the library facilities available in the Health Districts through the Post Graduate Medical Centres are designed to meet medical rather than nursing needs. The two streams of education available, management and clinical, are organised independently of each other and no common core identified and built upon. However the social science basis of management courses could be useful in extending knowledge in other areas of nursing and could be used to meet criteria which still need to be developed, so that educational programmes can be evaluated as part of an ongoing system of nursing education.

CHAPTER 12

Discussion and Conclusions

Discussion

In recording the way nurses use libraries, it is apparent from this study that the libraries available to trained nurses are neither conveniently available to them nor do they contain material which is necessarily useful. Indeed, for many respondents their right to adequate library facilities was a somewhat unexpected concept. There is a need for nurses to be made aware of the valuable nursing writings now being published and where these are available. Research on topics of interest to nurses working in wards need to be brought to the attention of such nurses in a systematic way. Seminars/discussions would enable this to occur. There is no evidence from respondents in the study that such opportunities are available. Such seminars could form part of an educational pattern which would allow discussion to develop around the topics being highlighted in journals et cetera, since without such opportunities Charge Nurses are somewhat isolated within their own departments and have little outlet for exchanging views with their peers. From the information supplied on journal reading, it can be seen that the range of journals within reach of these nurses was very limited. Most respondents referred only to the Nursing Mirror and the Nursing Times. Medical journals, such as the British Medical Journal, The Lancet and Modern Geriatrics, were recorded as being available by about 20% of respondents. A further 2% mentioned other journals. Little reference was made to material published overseas. The recognition of the similarities of nursing problems existing in other countries, despite the differences in the organisation of nursing services and training could be of value to nurses. Other perspectives, which contribute to new thinking, could lead to new solutions to old problems. The existing provision of reading material for trained nurses is of minimal usefulness in reaching the nurses in charge of wards and there is little incentive, at present, for nurses to make the considerable effort needed to overcome this. The number of nurses using public libraries for professional purposes indicates that the

inconvenience/inadequacy of hospital libraries at District level does act as a constraint upon their use.

Without knowledge shared amongst nurses by means of journals and other published material and opportunities to discuss and evaluate such new knowledge, it is difficult for this to be disseminated and assimilated. This research shows that, at present, there is little evidence that opportunities of this kind exist. The scores on Scale 1 which record satisfaction with such facilities suggests that there is an awareness among respondents that a more systematic approach to the problem is needed.

Moving on to other processes by which trained nurses keep up to date with new knowledge, 58% had attended some formal post-basic training programme, and on the whole were well informed regarding Joint Board of Clinical Studies courses available. There was however a clear understanding of the financial implications associated with other types of educational programmes and Charge Nurses stated, at interview, that unless nurses were interested in acquiring a teaching qualification, it was virtually impossible to be considered for any advanced nursing educational programme. This was borne out by comments made by educationalists in Edinburgh, Manchester and Leeds, where it was stated that students taking clinical or research options in the programmes offered, were, in the main, self-financed, whilst those attending teaching options were seconded. It is appreciated that, only a small proportion of Charge Nurses will be interested in the educational programmes offered by the universities. However, the newer developments of extension programmes offered by polytechnics, which enable nurses to build on their basic nursing education and undertake studies leading to a first degree, will offer greater opportunities in the future. If, however the official indifference recognised in relation to programmes already available persists, the effort needed by nurses to overcome this resistance, in addition to the efforts needed to undertake additional studies may prove too difficult. The Diploma of Nursing programmes also could be used as means

of offering educational development to nurses seeking promotion to Charge Nurse grade, presuming that it could be organised to meet this need.

When the data were collected for the present research only the universities of Manchester and Edinburgh were offering advanced nursing education with a clinical option. In addition to this, management studies at advanced level are available at several universities and polytechnics and there is a course in Social Research with a Health Service option in the University of Surrey. It can be identified, therefore, that lack of awareness of opportunities of advanced professional education which is clinically based can be associated with the paucity of such facilities.

At District level only 24% of respondents found local post-basic educational programmes useful. Indeed, despite some very flexible attitudes in some Schools of Nursing, little of this seems to permeate the staff of these districts. There is clearly a need for all educational opportunity to be given greater publicity. This is really suggesting that the methods presently used, however adequate they seem, do not reach many potential recipients and that some revolutionary thinking is needed to overcome this. This perhaps also applies to Diploma courses. It was also noted that most programmes offered were of an ad hoc nature and followed no particular pattern. There was no evidence of systematic updating programmes being offered locally. In some districts there was little evidence of updating post-basic programmes of any kind. Some Charge Nurses stated at interview that they found it difficult to manage attendance at the few programmes available because of the vagaries of ward staffing. (This was in reference to the difficulty experienced by Charge Nurses in planning staff duty rosters to meet such requirements because the necessity for making up deficits of staff in other wards frequently required the redistribution of staff at short notice).

In investigating the literature relating to nursing, the researcher

attempted to indicate the essential attributes of nursing and the philosophies which guide practice. The identification of the role of the Charge Nurse was also sought from the literature and the importance of this role in the delivery of care to patients was confirmed. Some of the stresses which exist at ward level were also demonstrated. What has not been made clear, perhaps, is the contribution of the learner nurse to the situation. A considerable proportion of the staff in any ward are untrained, many of these being nurses undergoing training. For the Charge Nurse this means that, not only do these nurses need to be trained and supervised but the progression of nurses through their training means that there are frequent changes of personnel and the nurse in charge is constantly managing the delivery of patient care through the services of nurses who are learning their skills and whose knowledge and abilities she/he has little time to assess and who, moreover, move on to other aspects of their training to make room for a further allocation of learner nurses. In this situation of frequent change of staff the Charge Nurse must ensure that the delivery of patient care is safe for patients and must also enable learner nurses to develop nursing skills both of a technical and social nature. It has been indicated in this research that little emphasis has been placed on the acquisition of interpersonal skills during training and the present overcrowded curriculum leaves little time for their development. The opportunities for teaching within the ward environment are, as Fretwell suggests, likely to be limited by the pressures to "get on with the work". There is an anomaly here, in that Charge Nurses, who have not been trained in teaching methods seem to be expected to "teach" in the most difficult situation of all; the stress filled and frequently work over-loaded wards of hospitals. How they teach and what they teach is never clearly defined. Pembrey suggests that nurses learn some of their skills by modelling their behaviour on that of Charge Nurses who exhibit such skills, and some work is at present being undertaken to enable Charge Nurses to acquire the skills

they need by means of role based training. This experimental programme is, at present, at an early stage of development and is available only in two hospitals, and in only one ward in each hospital. The existence of this one experimental training scheme for Charge Nurses highlights another paradox in nursing; that this role which is conceded to be a key role in the nursing care of patients has no established training to equip nurses to undertake the role. In view of this it is not surprising that opportunity to maintain knowledge or to acquire new knowledge in any systematic way is very limited.

Nurses in this study were knowledgeable of the variety of specialist training offered by the Joint Board of Clinical Studies and the necessity for such training for nurses working in specialist units was also recognised. Nurses were also well informed about training leading to registration on the supplementary registers, indicating that where opportunities for improving nursing knowledge exist, Charge Nurses know of them. There is also evidence from the scores on Scale 2, which records satisfaction with updating facilities, that greater proportions of Charge Nurses in General divisions record scores in the "dissatisfied" area of the scale. (45% of respondents of this grade scored 25 or below). The smaller percentage of Nursing Officers in this division who scored in the dissatisfied part of the scale is interesting, since there are no more opportunities for updating clinical knowledge available to Nursing Officers and there were no statistically significant differences in the attendance between the two groups. There were however statistically significant differences in the proportions of Nursing Officers recording local study epidodes as a means of keeping up to date with nursing and a greater proportion of Nursing Officers found that the management training programmes met their needs. It is worth noting that Nursing Officers attended the same programmes available to Charge Nurses, suggesting that management training is geared more to the needs of Nursing Officers than Charge Nurses. This may be some support for the view expressed

by Smith that the Administrative aspect of the Nursing Officer role is the predominent aspect in the real rather than in an ideal world. However, these findings may only mean that Nursing Officers as a group are more satisfied generally than are Charge Nurses. In the case of midwives, again, a much smaller proportion record scores in the dissatisfied area of Scale 2. These respondents, in addition to their attendance at statutory refresher courses, recorded higher proportions attending Joint Board of Clinical Studies courses. Midwives also recorded a lower proportion of respondents who found that the management training met their needs. It may be that the very specialist nature of midwifery practice results in midwives having little interest in programmes not couched in midwifery terms. Or, that the greater opportunities for professional updating available to midwives makes them more discriminating in their judgements.

Midwives also show statistically significant differences in the proportions who consider that refresher courses should be compulsory. Amongst those who were not in favour of compulsory courses there were comments showing that these midwives were considering the difficulties involved in making arrangements to live away from home for the necessary five days, not that the course were of no value. This view was reflected by other respondents who show a strong bias in favour of updating educational programmes being available in the home district. It was also recorded that many respondents would be prepared to contribute some of their own time to post-basic education. The usual qualification made was that such a contribution should be "reasonable".

In the responses from those who were interviewed there was little evidence that the concept of a Clinical Nurse Consultant role was fully understood and most respondents discussed the organisational difficulties of a Nurse Consultant role without conceptualising the benefits which may be available to the Charge Nurse from this development. It is possible that such a role would evolve more easily when the development of updating

and ongoing post basic educational programmes have become a reality.

The nurses who comprise the sample in this research provide evidence that for Charge Nurses in the General division of nursing in this Regional Health Authority, keeping up to date with nursing knowledge is largely a matter of individual effort unsupported by any educationally organised programmes. Not only is there evidence of little professional education orientated towards Charge Nurses to equip them to undertake the role, but there is also little in the way of systematic educational inputs available to such nurses after appointment. Charge Nurses in this study identified a need for clinical updating and for increased knowledge of interpersonal skills (which Argyle and others posit can be taught, using a variety of methods). These have also been identified by nurses of this grade in research undertaken in other countries and suggest growing consciousness among nurses of the demands made upon those who are directly involved in the organisation of care to patients. It is manifest that despite the many opportunities available to nurses to enable them to acquire training in specialist fields (the programmes provided by the Joint Board of Clinical Studies) there is little opportunity available to Charge Nurses to maintain competence by means of the systematic updating of nursing knowledge and the acquisition of new knowledge and that Charge Nurses are aware of these deficiencies. The educational system at present available to nurses does not encompass systematic updating for trained nurses and whilst it is not within the objectives of this research to consider the development of such programmes there is evidence from respondents that there is need for considerable innovation in the provision of such education if nurses are to make use of opportunities in a way which will not only meet their own needs but will offer evidence of competence to employing authorities.

It is contended by the author that the era is passed when nurses can rely on knowledge being acquired by, as has been stated by Auld "a process

of osmosis". The public has the right to expect the trained nurse, who accepts responsibility for their well-being when they become patients, to be able to meet these expectations with confidence.

The further reorganisation of the National Health Service which is now being contemplated opens up new possibilities for the structure of nursing. The literature abounds with references to a need of development of a clinical career structure for nurses and attention is drawn to the ambivalence which exists, where nurses of Charge Nurse grade are:-

1. The most important nurse in the delivery of nursing care to patients.
2. The nurse lowest in the management hierarchy.

In this research Charge Nurses clearly state that Nursing Officers are not recognised by them as experts in clinical care and view Nursing Officers as truly managerial in that they (Nursing Officers) are "enablers", giving access to resources both of materials and personnel and it is a role of major importance in allowing the Charge Nurse to concentrate on the care of patients in the ward areas. In a new structure the two clear elements of nursing responsibility could be recognised. Directors of Nursing Services, a new role envisaged could have support from two areas:-

1. Support from administrative staff recognised as being responsible for the provision of goods, services and staff to specific wards, and help from nurses with certain specialist skills in management, e.g. personnel skills. Educational programmes of academic credibility are needed for these nurses which could be built upon to enable those who wish to progress to more senior management posts to acquire further qualifications which would have equal status with other managers in the Health Service.
2. Clinical support from nurses with acknowledged clinical expertise. These nurses would be primarily available to help Charge Nurses and would act as consultants to ward nurses and would be responsible for increasing the body

of nursing knowledge by research and for disseminating knowledge gained from local and other research programmes to nurses working with patients. A tutor could form part of this team and would offer a direct link with nursing staff who train nurse learners in addition to facilitating learning by trained nurses.

It is suggested that the structure outlined is potentially available now but that access to education to support such development is haphazard and uncoordinated, although there are already in existence programmes of training in research skills. Some of the nurses undertaking this work would be in a position to register appropriate research with the universities which would lead to the award of higher degrees.

The researcher is aware that the proposed structure would result in a reduction of hierarchy since nurses outside the ward areas would be operating primarily as "enablers" in one form or another. The present pay structure for trained nurses is so wide and so varied that rationalisation to encompass this change is already both necessary and desirable.

To make such developments possible there is a need for a Learning Resource Unit at Regional level to service and coordinate programmes. Educational packages containing elements of learning from social and biological sciences are needed from trained nurses which would relate more realistically to nursing needs than the present educational programmes where some of the social skill learning available to Charge Nurses comes from management education and is therefore unrelated to the needs of patient care. It is also posited by the present researcher that there is a need for such educational programmes to be available locally in a form which could be built into recognisable educational units which could be linked to a reward system, as medical continuing education is linked. In such a development clinical experts, as postulated, could operate without threat to the autonomy of the Charge Nurse who would thus have the opportunity to

maintain and expand nursing knowledge and to view career development by means of clinical expertise, in addition to teaching and management.

It is essential that nurses should not lose the opportunity, presently available to them, to produce a structure which allows career development and professional satisfaction.

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APPENDIX A

APPENDIX A Table 1 Information on Journal Availability

STAFF	Journals Convenient %	Sig.	Journals Circulate %	Sig.	TOTAL
Overall	55		21		
Nursing Officers (Gen)	64	NS	39*	*x^2 1df	28
Charge Nurses (Gen)	52		13*	= 12.4	213
Nursing Officers (Mat)	43		29	$p<0.001$	7
Charge Nurses (Mat)	72		50		36
					284
Grade					
Nursing Officer	60	NS	37		35
Charge Nurse	55		18		249
					284
Social Status					
Married	52	NS	15	NS	182
Not Married	62		30		102
					284
Home Commitments					
Dependants	61	NS	19	NS	127
No dependents	51		22		157
					284
Sex					
Male	45	NS	9	x^2 1df	42
Female	57		23	=3.94	242
				$p<0.05$	**284**
Type of Nursing					
General	55		13	NS	117
Geriatric	68*	x^2 1df	19		47
Specialty	42	= 4.14	20		77
Maternity	64	$p<0.05$	46		43
					284
Time Qualified					
Less than 5 years	57	NS	17	NS	35
5 but less than 15 years	51		18		92
15 but less than 25 years	52		24		87
25 and more years	64		20		70
					284
Size of Hospital					
Less than 50 beds	73*	*x^2 1df	21	NS	56
50 but less than 100 beds	61	= 9.35	14		28
100 but less than 200 beds	56	$p<0.01$	28		64
200 and more beds	46		18		136
					284
Shift					
Night Duty	66	NS	15	NS	59
Day Duty	52		22		225
					284
Duty Span					
Full Time	56	NS	22	NS	220
Part Time	55		17		64
					284

* variable which is significantly different

APPENDIX A Table 2 Information on Journal Reading

STAFF	Read Nursing Journals: This Week %	Sig.	This Month %	Sig.	Last 3mth. %	Sig.	Buy Nrs. Jnls. %	Sig.	TOTAL
Overall	61		27		7		51		
Grade - Specialty									
Nursing Officers (Gen)	86	NS	11	NS	-	NS	36	NS	28
Charge Nurses (Gen)	59		27		10		54		213
Nursing Officers (Mat)	86		14		-		57		7
Charge Nurses (Mat)	53		39		-		44		36
									284
Grade									
Nursing Officer	86	NS	11	NS	-	NS	40	NS	35
Charge Nurse	58		29		8		53		249
									284
Social Status									
Married	59	NS	27	NS	10	NS	53	NS	182
Not Married	66		26		3		49		102
									284
Home Commitments									
Dependents	61	NS	30	NS	3	NS	54	NS	127
No dependents	60		24		10		50		157
									284
Sex									
Male	43	(1)	26	NS	21	NS	55	NS	42
Female	64		27		5		45		242
									284
Type of Nursing									
General	67	NS	20	NS	9	NS	46	NS	117
Geriatric	53		38		4		55		47
Specialty	60		25		10		60		77
Maternity	58		35		-		46		43
									284
Time Qualified									
Less than 5 years	49		37	NS	9	NS	51	(2)	35
5 but less than 15 years	72*	(3)	18		8		66		92
15 but less than 25 years	59		30		9		44		87
25 and more years	57		29		4		41		70
									284
Size of Hospital									
Less than 50 beds	59	NS	27	NS	5	NS	39	(4)	56
50 but less than 100 beds	61		25		11		46		28
100 but less than 200 beds	64		28		5		61		64
200 and more beds	61		26		9		53		136
									284
Shift									
Night Duty	71	NS	20	NS	3	NS	46	NS	59
Day Duty	59		28		8		53		225
									284
Duty Span									
Full Time	61	NS	27	NS	7	NS	52	NS	220
Part Time	62		25		8		50		64
									284

(1) $\times^2$ 1df = 6.74 $p<0.01$
(3) $\times^2$ 1df = 6.28 $p<0.02$

(2) $\times^2$ 1df = 10.60 $p<0.005$
(4) $\times^2$ 1df = 4.52 $p<0.05$

APPENDIX A Table 3 Information on the Use of Libraries

STAFF	Used Professional Library in Year Preceeding Survey %	Sig.	Used Other Library for Professional Purposes Year Preceeding Survey %	Sig.	TOTAL
Overall	54		35		
Grade - Specialty		x^2 1df =			
Nursing Officers (Gen)	71*	3.86	39	NS	28
Charge Nurses (Gen)	51	$p<0.05$	36		213
Nursing Officers (Mat)	57		14		7
Charge Nurses (Mat)	55		33		36
					284
Grade					
Nursing Officer	68	NS	34	NS	35
Charge Nurse	52		35		249
					284
Social Status					
Married	59	NS	41	NS	182
Not Married	45		26		102
					284
Home Commitments					
Dependents	56	NS	37	NS	127
No dependents	51		34		157
					284
Sex					
Male	36	NS	21	NS	42
Female	57		38		242
					284
Type of Nursing					
General	52	NS	32	NS	117
Geriatric	53		40		47
Specialty	56		39		77
Maternity	56		30		43
					284
Time Qualified					
Less than 5 years	57	NS	46	NS	35
5 but less than 15 years	64		32		92
15 but less than 25 years	55		39		87
25 and more years	37		30		70
					284
Size of Hospital		x^2 1df =			
Less than 50 beds	38	12.24	36	NS	56
50 but less than 100 beds	43	p 0.001	29		28
100 but less than 200 beds	50		36		64
200 and more beds	65*		36		136
					284
Shift					
Night Duty	58	NS	42	NS	59
Day Duty	53		43		225
					284
Duty Span					
Full Time	55	NS	34	NS	220
Part Time	48		37		64
					284

* variable which is significantly different

APPENDIX A Table 4 Usefulness of Health Service Library perceived as available

STAFF	Met needs All	Some	None	TOTAL
Overall	12%	61%	19%	
Grade - Specialty				
Nursing Officers (Gen)	29	54	39	28
Charge Nurses (Gen)	10	61	36	213
Nursing Officers (Mat)	29	57	14	7
Charge Nurses (Mat)	8	75	33	36
				284
Grade				
Nursing Officer	28	54	34	35
Charge Nurse	10	63	35	249
				284
Social Status				
Married	10	59	41	182
Not married	17	66	26	102
				284
Home Commitments				
Dependents	12	64	37	127
No dependents	13	59	34	157
				284
Sex				
Male	17	48	21	42
Female	12	64	38	242
				284
Type of Nursing				
General	14	58	32	117
Geriatric	21	40	40	47
Specialty	5	74	39	77
Maternity	12	72	30	43
				284
Time Qualified				
Less than 5 years	11	66	46	35
5 but less than 15 years	12	63	32	92
15 but less than 15 years	12	64	39	87
25 and more years	14	54	30	70
				284
Size of Hospital				
Less than 50 beds	12	45	36	56
50 but less than 100 beds	18	43	29	28
100 but less than 200 beds	12	61	36	64
220 and more beds	11	73	36	136
				284
Shift				
Night Duty	14	56	42	59
Day Duty	12	63	33	225
				284
Duty Span				
Full Time	64	64	34	220
Part Time	55	55	37	64
				284

APPENDIX A Table 5 Information on the Reading of Medical Journals.

STAFF TOTAL	Have Read: Should Read %	Last Week %	Last Month %	Sig. %	In prev. 3 Months	
Overall	82	5	10		21	
Grade - Specialty						
Nursing Officers (Gen)	75	4	11		29	28
Charge Nurses (Gen)	82	5	8		20	213
Nursing Officers (Mat)	86	-	14		43	7
Charge Nurses (Mat)	86	3	17		19	36
						284
Grade						
Nursing Officer	77	3	11		31	35
Charge Nurse	82	5	10		20	249
						284
Social Status						
Married	81	6	9		19	182
Not Married	83	2	11		24	102
						284
Home Commitments						
Dependents	80	6	9		18	127
No dependents	83	4	10		24	157
						284
Sex						
Male	71	2	14		12	42
Female	84	5	9		23	242
						284
Type of Nursing						
General	82	2	8	χ^2	15	117
Geriatric	77	4	4	1df	15	47
Specialty	82	10	13	=7.33	32	77
Maternity	86	2	16	p<0.01	23	43
						284
Time Qualified						
Less than 5 years	80	3	23		31	35
5 but less than 15 years	84	5	9		23	92
15 but less than 25 years	87	6	11		19	87
25 and more years	73	3	3		16	70
						284
Size of Hospital						
Less than 50 beds	71	4	9		18	56
50 but less than 100 beds	64	7	4		14	28
100 but less than 200 beds	91	2	9		20	64
200 and more beds	85	6	12		24	136
						284
Shift						
Night Duty	81	3	17		19	59
Day Duty	82	5	8		22	225
						284
Duty Span						
Full Time	81	4	10		23	220
Part Time	83	6	8		14	64
						284

APPENDIX A Table 6 Respondents Views on Professional Updating

STAFF	Need of				Opportunity for				TOTAL
	Great	Some	Little	None	Too Much	Adequate	Some	None	
	%	%	%	%	%	%	%	%	
Overall	20	74	3	2	(1)	14	69	16	
Nursing Officers (Gen)	11	86	-	-	-	14	82	-	28
Charge Nurses (Gen)	22	73	3	3	(1)	11	67	21	213
Nursing Officers (Mat)	-	86	(1)	-	-	71	29	-	7
Charge Nurses (Mat)	25	69	(1)	(1)	-	22	72	6	36
									284
Grade									
Nursing Officer	8	86	(1)	-	-	26	71	-	35
Charge Nurse	22	72	3	2	(1)	13	68	18	249
									284
Social Status									
Married	20	75	2	2	(1)	13	68	18	182
Not Married	21	72	5	3	-	18	69	13	102
									284
Home Commitments									
Dependants	21	71	4	2	(1)	15	66	16	127
No dependents	20	74	2	2	-	12	70	17	157
									284
Sex									
Male	19	69	7	5	-	7	62	31	42
Female	21	75	2	2	(1)	16	69	14	242
									284
Type of Nursing									
General	15	79	2	3	-	14	69	15	117
Geriatric	30	62	6	2	-	11	68	21	47
Specialty	22	74	3	(1)	(1)	9	69	21	77
Maternity	21	72	5	(1)	-	30	65	5	43
									284
Time Qualified									
Less than 5 years	37*	60	-	(1)	-	9	71	20	35
5 but less than 15 years	17	79	2	-	-	13	68	17	92
15 but less than 25 years	22	73	3	(1)	(1)	10	72	15	87
25 and more years	14*	74	6	6	-	24	61	14	70
									284
Size of Hospital									
Less than 50 beds	20	73	4	4	-	12	64	23	56
50 but less than 100 beds	29	68	-	4	-	4	79	14	28
100 but more than 200 beds	16	77	6	2	-	22	59	19	64
200 and more beds	21	74	2	2	(1)	14	72	12	136
									284
Shift									
Night Duty	22	73	3	(1)	-	15	61	24	59
Day Duty	20	74	3	2	(1)	14	70	14	225
									284
Duty Span									
Full Time	21	72	4	3	(1)	13	69	16	220
Part Time	17	81	2	-	-	20	64	16	64
									284

* x^2 1df = 7.1 $p < 0.01$

APPENDIX A Table 7 — Area Educational Need Identified Most Frequently

STAFF	General Clinical Updating %	Sig.	Inter-person Skills	Sig.	Teaching Skills	Sig.	TOTAL
Overall	25		22		12		
Grade - Specialty							
Nursing Officers (Gen)	21		14		21		28
Charge Nurses (Gen)	29		24		11		213
Nursing Officers (Mat)	-		-		14		7
Charge Nurses (Mat)	14		19		8		36
							284
Grade							
Nursing Officer	17		11		20		35
Charge Nurse	26		23		10		249
							284
Social Status							
Married	31		22		15		182
Not Married	16		21		6		102
							284
Home Commitments				χ^2 1df			
Dependents	28		16	= 4.98	11		127
No dependents	24		27	$p<0.05$	12		157
							284
Sex							
Male	29		14		14		42
Female	25		23		11		242
							284
Type of Nursing		χ^2 1df					
General	21	= 4.81	23		11		117
Geriatric	31	$p<0.05$	23		13		47
Specialty	34		22		13		77
Maternity	12*		16		9		43
							284
Time Qualified				χ^2 1df		χ^2 1df	
Less than 5 years	37		37	= 8.79	20*	= 5.05	35
5 but less than 15 years	20		27	$p<0.01$	9	$p<0.05$	92
15 but less than 25 years	28		15*		16		87
25 and more years	24		16*		6*		70
							284
Size of Hospital							
Less than 50 beds	27		14		7		56
50 but less than 100 beds	32		21		7		28
100 but less than 200 beds	22		23		11		64
200 and more beds	25		24		15		136
							284
Shift							
Night Duty	27		19		15		59
Day Duty	25		23		11		225
							284
Duty Span							
Full Time	27		22		12		220
Part Time	20		20		9		64
							284

* variable which is significantly different

APPENDIX A Table 8 Areas of Educational Need Identified Less Frequently

STAFF	Specialist Skills %	Technical Skills %	Academic Skills %	TOTAL
Overall	10	5	4	
Grade - Specialty				
Nursing Officers (Gen)	-	4	29	28
Charge Nurses (Gen)	12	5	2	213
Nursing Officers (Mat)	(1)	-	-	7
Charge Nurses (Mat)	6	6	-	36
				284
Grade				
Nursing Officer	(1)	(1)	23*	35
Charge Nurse	11	5	2	249
				284
Social Status				
Married	12	5	4	182
Not Married	8	4	4	102
				284
Home Commitments				
Dependents	11	6	6	127
No dependents	10	4	3	157
				284
Sex				
Male	5	7	5	42
Female	11	4	4	242
				284
Type of Nursing				
General	9	7	3	117
Geriatric	15	6	11	47
Specialty	10	1	5	77
Maternity	7	5	-	43
				284
Time Qualified				
Less than 5 years	9	3	3	35
5 but less than 15 years	8	7	3	92
15 but less than 25 years	11	3	8	87
25 and more years	13	6	1	70
				284
Size of Hospital				
Less than 50 beds	12	4	-	56
50 but less than 100 beds	7	4	11	28
100 but less than 200 beds	11	5	2	64
200 and more beds	10	6	6	136
				284
Shift				
Night Duty	15	7	2	59
Day Duty	9	4	5	225
				284
Duty Span				
Full Time	11	6	4	220
Part Time	8	2	3	64
				284

* x^2 1df = 30 $p<0.000$

APPENDIX A Table 9 Respondents Views on Time Span of Educational Programmes Preferred

STAFF	A Day %	A Week %	A Month %	Longer %	Use Own Time %	TOTAL
Overall	32	47	8	10	35	
Nursing Officers (Gen)	29	54	(1)	14	43	28
Charge Nurses (Gen)	30	48	10	9	34	213
Nursing Officers (Mat)	57	43	-	-	43	7
Charge Nurses (Mat)	44	39	-	14	33	36
						284
Grade						
Nursing Officer	34	51	(1)	11	43	35
Charge Nurse	32	46	8	10	34	249
						284
Social Status						
Married	34	42	9	13	32	182
Not Married	30	56	5	4	40	102
						284
Home Commitments						
Dependents	35	46	7	9	39	127
No dependents	30	48	8	10	32	157
						284
Sex						
Male	29	38	12	12	38	42
Female	33	49	7	9	35	242
						284
Type of Nursing						
General	32	44	10	8	27	117
Geriatric	23	57	6	11	45	47
Specialty	30	49	9	12	42	77
Maternity	46	39	-	12	35	43
						284
Time Qualified						
Less than 5 years	26	46	9	17	31	35
5 but less than 15 years	32	50	8	9	36	92
15 but less than 25 years	28	52	7	11	38	87
25 and more years	43	39	9	6	23	70
						284
Size of Hospital						
Less than 50 beds	38	41	11	4	30	56
50 but less than 100 beds	25	68*	-	-	32	28
100 but less than 200 beds	38	44	8	11	33	64
200 and more beds	29	47	8	14	39	136
						284
Shift						
Night Duty	42	39	8	7	41	59
Day Duty	30	49	8	11	34	225
						284
Duty Span						
Full Time	29	48	10	10	36	220
Part Time	44	44	2	11	34	64
						284

* x^2 1df = 5.3 $p<0.05$

APPENDIX A Table 10

More Frequently Mentioned Methods Available to Nurses Enabling Them to Update Nursing Knowledge

STAFF	Nursing Jnls.	Consultants Rounds	Sig.	Own Resources	Sig.	District Study Episodes (last 12/12)	Sig.	TOTAL
	%	%		%		%		
Overall	95	52		38		24		
Grade - Specialty								
Nursing Officers (Gen)	96	46		71	(1)	39*	(2)	28
Charge Nurses (Gen)	96	53		32		22*		213
Nursing Officers (Mat)	100	57		29		14		7
Charge Nurses (Mat)	92	47		44		25		36
								284
Grade								
Nursing Officer	97	48		63		34		35
Charge Nurse	95	52		34		22		249
								284
Social Status								
Married	96	51		39		21		182
Not Married	95	53		35		26		102
								284
Home Commitments								
Dependents	94	54		39		22		127
No dependents	95	52		36		25		157
								284
Sex								
Male	90	43		33		10	(3)	42
Female	96	53		38		26		242
								284
Type of Nursing								
General	96	58		32		25		117
Geriatric	96	42		40		21		47
Specialty	95	49		43		23		77
Maternity	93	49		42		23		43
								284
Time Qualified								
Less than 5 years	94	63	(4)	34		20		35
5 but less than 15 years	98	67		39		30		92
15 but less than 25 years	98	55		40		23		87
25 and more years	90	44		34		17		70
								284
Size of Hospital								
Less than 50 beds	91	41		27		14		56
50 but less than 100 beds	96	50		46		21		28
100 but less than 200 beds	97	61		30		25		64
200 and more beds	96	52		44		27		136
								284
Shift								
Night Duty	95	25	(5)	36		20		59
Day Duty	95	59		38		24		225
								284
Duty Span								
Full Time	95	55		39		24		220
Part Time	95	39		34		20		64
								284

(1) $\times^2$ 1df = 15.95 $p<0.001$
(2) $\times^2$ 1df = 4.00 $p<0.05$
(3) $\times^2$ 1df = 5.36 $p<0.02$
(4) $\times^2$ 1df = 7.18 $p<0.01$
(5) $\times^2$ 1df = 21.26 $p<0.001$

Table 11 — Number of Post Basic Educational Programmes Attended - Categories 1 and 2 only

STAFF	Nil %	1 %	2 %	3 %	4 %	TOTAL
Overall	42	36	17	4	(1)	
Nursing Officers (Gen)	35	39	21	4	-	28
Charge Nurses (Gen)	51	35	11	3	-	213
Nursing Officers (Mat)	-	14	43	43	-	7
Charge Nurses (Mat)	-	44	47	6	(1)	36
						284
Grade						
Nursing Officer	28	34	26	11	-	35
Charge Nurse	44	36	16	3	(1)	249
						284
Social Status						
Married	51	33	11	4	(1)	182
Not Married	26	42	27	5	-	102
						284
Home Commitments						
Dependents	42	37	15	5	(1)	127
No dependents	41	36	19	4	-	157
						284
Sex						
Male	50	24	17	9	-	42
Female	41	38	17	3	(1)	242
						284
Type of Nursing						
General	44	44	11	1	-	117
Geriatric	68	25	6	-	-	47
Specialty	47	29	17	8	-	77
Maternity	-	39	46	12	(1)	43
						284
Time Qualified						
Less than 5 years	54	31	11	3	-	35
5 but less than 15 years	35	36	23	6	-	92
15 but less than 25 years	49	32	13	5	(1)	87
25 and more years	36	44	19	1	-	70
						284
Size of Hospital						
Less than 50 beds	50	34	14	2	-	56
50 but less than 100 beds	54	18	25	4	-	28
100 but less than 200 beds	28	42	22	8	-	64
200 and more beds	43	38	15	4	(1)	136
						284
Shift						
Night Duty	52	34	10	3	(1)	59
Day Duty	39	37	19	4	-	225
						284
Duty Span						
Full Time	39	37	20	4	-	220
Part Time	52	34	8	5	(1)	64
						284

APPENDIX A Table 12 STAFF	Programmes - Formal Category 1 Clinical (Registers)	 Category 2 Other Clinical mostly J.B.C.S.	Informal Category 3 Short courses Conferences Lectures etc.	TOTAL
Grade - speciality				
Nursing Officers (Gen)				28
Charge Nurses (Gen)				213
Nursing Officers (Mat)				7
Charge Nurses (Mat)				36
				284
Grade				
Nursing Officer	63	8	9	35
Charge Nurse	47	10	8	249
				284
Social Status				
Married	46	3	12	182
Not married	67	7	3	102
				284
Home Commitments				
Dependents	48	9	11	127
No dependents	50	8	9	157
				284
Sex				
Male	42	10	9	42
Female	50	10	8	242
				284
Type of Nursing				
General	44	12	11	117
Geriatric	23	9	16	47
Specialty	44	9	7	77
Maternity	100	37	9	43
				284
Time Qualified				
Less than 5 years	54	6	11	35
5 but less than 15 years				92
15 but less than 25 years				87
25 and more years	46	8	4	70
				284
Size of Hospital				
Less than 50 beds	36	14	14	56
50 but less than 100 beds	46	-	15	28
100 but less than 200 beds	62	10	4	64
200 and more beds	49	8	8	136
				284
Shift				
Night Duty	39	6	12	59
Day Duty	52	9	7	225
				284
Duty Span				
Full Time	52	9	8	220
Part Time	39	9	11	64
				284

Table 13 Respondents Views on Educational Programmes Venue, Time Span etc.

STAFF	Could Travel From Home District %	Sig.	Part Time Study %	Sig.	Hours Available (Could Extend)	Sig.	TOTAL
Overall	19		41		50		
Nursing Officers (Gen)	25		39		71		28
Charge Nurses (Gen)	17		43		51		213
Nursing Officers (Mat)	29		57		72		7
Charge Nurses (Mat)	25		33		41		36
							284
Grade						x^2 1df	
Nursing Officer	26		43		72	= 6.17	35
Charge Nurse	18		41		49	p<0.02	249
							284
Social Status		x^2 1df					
Married	13	=11.0	42		50		182
Not Married	29	p<0.001	41		56		102
							284
Home Commitments							
Dependants	16		42		47		127
No dependents	22		40		55		157
							284
Sex							
Male	24		43		52		42
Female	18		41		52		242
							284
Type of Nursing				x^2 1df			
General	26		39	= 7.77	47		117
Geriatric	13		43	p<0.01	55		47
Specialty	16		57*		60		77
Maternity	26		33		47		43
							284
Time Qualified				x^2 1df			
Less than 5 years	26		31	= 9.34	58		35
5 but less than 15 years	13		37	p<0.005	57		92
15 but less than 25 years	18		38		51		87
25 and more years	24		57*		41		70
							284
Size of Hospital							
Less than 50 beds	25		46		41		56
	11		43		43		28
	16		39		57		64
200 and more beds	20		40		56		136
							284
Shift				x^2 1df		x^2 1df	
Night Duty	12		54	=5.92	39	= 4.9	59
Day Duty	21		38	p<0.02	55	p<0.05	225
							284
Duty Span		x^2 1df					
Full Time	23	= 11.01	39		57		220
Part Time	5	p<0.001	50		44		64
							284

* variable which is significantly different

APPENDIX A Table 14 Types of Teaching Preferred

STAFF	Lecture %	Seminar %	Both %	TOTAL
Overall	25	18	52	
Grade - Specialty				
Nursing Officers (Gen)	14	36	46	28
Charge Nurses (Gen)	24	17	53	213
Nursing Officers (Mat)	14	29	57	7
Charge Nurses (Mat)	36	11	50	36
				284
Grade				
Nursing Officer	14	34	48	35
Charge Nurse	26	16	52	249
				284
Social Status				
Married	24	15	55	182
Not Married	26	24	45	102
				284
Home Commitments				
Dependents	20	16	61	127
No dependents	28	17	45	157
				284
Sex				
Male	21	19	52	42
Female	25	18	52	242
				284
Type of Nursing				
General	21	19	52	117
Geriatric	23	15	57	47
Specialty	26	22	48	77
Maternity	33	14	51	43
				284
Time Qualified				
Less than 5 years	29	9	57	35
5 but less than 15 years	24	27	48	92
15 but less than 25 years	22	14	55	87
25 and more years	27	17	50	70
				284
Size of Hospital				
Less than 50 beds	27	9	59	56
50 but less than 100 beds	18	14	61	28
100 but less than 200 beds	27	19	48	64
200 and more beds	24	23	49	136
				284
Shift				
Night Duty	30	15	48	59
Day Duty	23	19	53	225
				284
Duty Span				
Full Time	25	20	50	220
Part Time	23	11	59	64
				284

APPENDIX A Table 15 Respondents Views on Sufficiency of Basic Training to Equip them for Present Post

STAFF	Basic Training Enough %	Sig.	TOTAL
Overall	54		
Grade - Specialty			
Nursing Officers (Gen)	36		28
Charge Nurses (Gen)	54		213
Nursing Officers (Mat)	57		7
Charge Nurses (Mat)	64		36
			284
Grade			
Nursing Officer	40		35
Charge Nurse	56		249
			284
Social Status			
Married	55		182
Not Married	52		102
			284
Home Commitments			
Dependents	59		127
No dependents	50		157
			284
Sex			
Male	57		42
Female	53		242
			284
Type of Nursing			
General	54	x^2 1df = 3.93 $p<0.05$	117
Geriatric	64		47
Specialty	43		77
Maternity	63		43
			284
Time Qualified			
Less than 5 years	49	x^2 1df = 10.3 $p<0.001$	35
5 but less than 15 years	41		92
15 but less than 25 years	61		87
25 and more years	64		70
			284
Size of Hospital			
Less than 50 beds	79	x^2 1df = 21.4 $p<0.000$	56
50 but less than 100 beds	68		28
100 but less than 200 beds	50		64
200 and more beds	43		136
			284
Shift			
Night Duty	58		59
Day Duty	53		225
			284
Duty Span			
Full Time	50		220
Part Time	67		64
			284

APPENDIX A Table 16 Respondents Views on Management Training

STAFF	Course Met Needs	Related to Work	Needed More Theory	Needed More Practical Application	Total Who Attended	TOTAL
	%	%	%	%	% based on these	
Overall	52	51	60	57		
Grade - Specialty						
Officers (Gen)	91	91	78	78	23	
Charge Nurses (Gen)	53	46	59	58	151	
Nursing Officers (Mat)	(1)	-	33	33	6	
Charge Nurses (Mat)	27	52	54	42	33	
Grade						
Nursing Officer	76	72	69	69	29	
Charge Nurse	48	47	58	55	184	
Social Status						
Married	58	57	62	63	126	
Not Married	44	41	56	49	87	
Home Commitments						
Dependents	53	55	65	62	86	
No dependents	51	48	56	54	127	
Sex						
Male	45	45	72	76	29	
Female	53	52	58	54	184	
Type of Nursing						
General	55	56	59	56	85	
Geriatric	70	63	67	63	30	
Specialty	56	41	63	66	59	
Maternity	26	44	51	41	39	
Time Qualified						
Less than 5 years	52	48	56	56	23	
5 but less than 15 years	46	58	71	64	70	
15 but less than 25 years	51	42	56	60	66	
25 and more years	61	52	50	44	54	
Size of Hospital						
Less than 50 beds	60	52	60	60	40	
50 but less than 100 beds	62	69	44	56	16	
100 but less than 200 beds	51	47	61	55	51	
200 and more beds	48	49	61	58	106	
Shift						
Night Duty	50	53	37	32	36	
Day Duty	52	40	47	46	177	
Duty Span						
Full Time	50	49	60	58	173	
Part Time	60	58	57	55	40	

% who attended of 213

APPENDIX A Table 17 Post-basic Educational Programmes Attended

STAFF	Clinical (Categories 1 and 2) %	Management %	Sig.	District Study Episodes in previous 12 months %	TOTAL
Overall	58	75		24	
Grade - Specialty					
Nursing Officers (Gen)	64	82		39	28
Charge Nurses (Gen)	49	71		22	213
Nursing Officers (Mat)	100	86		14	7
Charge Nurses (Mat)	100	92		25	36
					284
Grade					
Nursing Officer	71	83		34	35
Charge Nurse	56	74		22	249
					284
Social Status					
Married	49	69		21	182
Not Married	74	85		26	102
					284
Home Commitments					
Dependents	58	68	x^2 1df =	22	127
No dependents	59	81	6.49 $p<0.02$	25	157
					284
Sex					
Male	50	69		10	42
Female	60	76		26	242
					284
Type of Nursing					
General	56	73		25	117
Geriatric	32	64		21	47
Specialty	53	77		23	77
Maternity	100	91		23	43
					284
Time Qualified					
Less than 5 years	46	66		20	35
5 but less than 15 years	65	76		30	92
15 but less than 25 years	50	76		23	87
25 and more years	64	77		17	70
					284
Size of Hospital					
Less than 50 beds	50	71		14	56
50 but less than 100 beds	46	57		21	28
100 but less than 200 beds	39	80		25	64
200 and more beds	57	78		27	136
					284
Shift					
Night Duty	47	61	x^2 1df =	20	59
Day Duty	61	79	8.2 $p<0.01$	24	225
					284
Duty Span					
Full Time	61	79		24	220
Part Time	48	62		20	64
					284

APPENDIX A Table 18 — Respondents Views on Type of Updating Programme Needed

STAFF	Choice by Consumer from a Selection of Programmes: No Need	Sig.	Voluntary %	Compulsory %	Sig.	TOTAL
Overall	Nil		71	26		
Grade - Specialty						
Nursing Officers (Gen)			68	21		28
Charge Nurses (Gen)			75	25		213
Nursing Officers (Mat)			71	29		7
Charge Nurses (Mat)			56	39		36
						284
Grade						
Nursing Officer			68	23		35
Charge Nurse			72	27		249
						284
Social Status						
Married			74	25		182
Not Married			68	29		102
						284
Home Commitments						
Dependents			70	27		127
No dependents			71	25		157
						284
Sex						
Male			74	26		42
Female			71	26		242
						284
Type of Nursing		χ^2 1df				
General		= 6.68	78	21		117
Geriatric		p<0.01	77	23		47
Specialty			66	30		77
Maternity			58	37		43
						284
Time Qualified						
Less than 5 years			66	34		35
5 but less than 15 years			71	27		92
15 but less than 25 years			69	29		87
25 and more years			79	19		70
						284
Size of Hospital						
Less than 50 beds			70	25		56
50 but less than 100 beds			68	32		28
100 but less than 200 beds			66	33		64
200 and more beds			76	23		136
						284
Shift						
Night Duty			71	29		59
Day Duty			72	26		225
						284
Duty Span						
Full Time			71	26		220
Part Time			72	27		64
						284

APPENDIX A Table 19 Respondents Views on Type of Programme Needed

STAFF	Set 'Refresher' Courses (Midwives already have these) No Need %	Voluntary %	Compulsory %	Sig.	TOTAL
Overall	3	38	58		
Grade - Specialty					
Nursing Officers (Gen)	14	36	50		28
Charge Nurses (Gen)	1	44	54		213
Nursing Officers (Mat)	-	29	71		7
Charge Nurses (Mat)	8	6	86		36
					284
Grade					
Nursing Officer	11	34	54		35
Charge Nurse	2	38	58		249
					284
Social Status					
Married	3	39	55		182
Not Married	4	34	62		102
					284
Home Commitments					
Dependents	2	40	57		127
No dependents	5	33	59		157
					284
Sex					
Male	(1)	50	48		42
Female	4	36	60		242
					284
Type of Nursing				x^2 1df	
General	3	46	50	= 14.36	117
Geriatric	-	45	55	p<0.001	47
Specialty	5	36	56		77
Maternity	7	9	84*		43
					284
Time Qualified					
Less than 5 years	6	29	66		35
5 but less than 15 years	3	24	73		92
15 but less than 25 years	5	39	54		87
25 and more years	(1)	59	39		70
					284
Size of Hospital					
Less than 50 beds	-	45	55		56
50 but less than 100 beds	7	46	46		28
100 but less than 200 beds	-	36	62		64
200 and more beds	6	34	59		136
					284
Shift					
Night Duty	5	30	49		59
Day Duty	3	36	60		225
					284
Duty Span					
Full Time	4	34	60		220
Part Time	2	48	48		64
					284

APPENDIX B

APPENDIX B Table B1 Scale 1

STAFF	Sig.	Scores of 25 or less %	Scores of more than 75 %	Sig.	TOTAL
Overall		40	14		
Grade - Specialty	x^2 1df =			x^2 1df =	
Nursing Officers (Gen)	4.07 $p<0.05$	25 *	29 *	8.18	28
Charge Nurses (Gen)		45 *	10 *	$p<0.01$	213
Nursing Officers (Mat)	NS	-	14	NS	7
Charge Nurses (Mat)		33	25		36
					284
Grade					
Nursing Officer	x^2 1df =	20	26	NS	35
Charge Nurse	6.74 $p<0.01$	43	12		249
					284
Social Status					
Married	NS	43	10	NS	182
Not Married		35	21		102
					284
Home Commitments					
Dependents	NS	37	10	NS	127
No dependents		43	17		157
					284
Sex					
Male	x^2 1df =	57	5	NS	42
Female	5.98 $p<0.05$	38	16		242
					284
Type of Nursing					
General	x^2 1df =	46*	11	NS	117
Geriatric	4.32 $p<0.05$	36	15		47
Specialty		42	13		77
Maternity		28*	23		43
					284
Time Qualified					
Less than 5 years	NS	40	14	NS	35
5 but less than 15 years		42	13		92
15 but less than 25 years		41	15		87
25 and more years		37	14		70
					284
Size of Hospital					
Less than 50 beds	NS	46	11	NS	56
50 but less than 100 beds		50	14		28
100 but less than 200 beds		47	8		64
200 and more beds		33	19		136
					284
Shift					
Night Duty	NS	41	17	NS	59
Day Duty		40	13		225
					284
Duty Span					
Full Time	NS	39	15	NS	220
Part Time		44	11		64
					284

Scores Relating to Other Variables

APPENDIX B - TABLE B2 Scale 1

Influences	Sig.	Scores of 25 or less	Sig.	Scores of more than 75	TOTAL
Availability of Journals					
In hospital	x^2 1df=	33%	x 1df=	22%	157
Not in hospital	4.63 P<0.05	46%	6.61 P<0.02	10%	127
In department	x^2 1df=	20%	x 1df=	30%	59
Not in department	16.45 P<0.001	50%	33.4 P<0.000	5%	225
Buying Journals					
Respondents who buy	N.S.	44%	N.S.	11%	146
Respondents who do not buy		37%		17%	138
Reading Journals (Nursing)					
Read in previous three months	N.S.	39%	N.S.	13%	271
Not read		50%		17%	12
(Medical)					
Read in previous three months	X^2 1df=	33%	x 1df=	23%	101
Not read	3.96 P<0.05	45%	10.69 P<0.01	9%	183
Use of Libraries (Professional)					
Used in past year	N.S.	32%	N.S.	20%	153
Not used in past year		43%		13%	68
(Other for Prof. Purpose)					
Used in past year	N.S.	35%	N.S.	15%	100
Not used in past year		44%		12%	176
Usefulness of Prof. Libraries - Useful	X^2 1df= 42.46	26%	N.S.	19%	174
Not useful	P<0.000	69%		4%	78
Post Basic Education (Cat. 1, 2)					
Participants	x^2 1df= 9.3	38%	N.S.	17%	165
Non-participants	P<0.01	44%		10%	119

Table 2 a ref. Scale 1

	Scores	Participants	Sig.	Non-Participants	N
Post basic programmes excluding Cat. 3.	25 or less	55%	N.S.	45%	115
	Above 75	70%		30%	40

APPENDIX B Table B3 Scale 2

STAFF	Sig.	% who scored 25 or less	Sig.	% who scored more than 75	TOTAL
Overall		46		8	
Grade - Specialty					
Nursing Officers (Gen)	x^2 1df = 10.5	21*		14	28
Charge Nurses (Gen)	$p<0.005$	54*		7	213
Nursing Officers (Mat)		-		-	7
Charge Nurses (Mat)		19		11	36
					284
Grade					
Nursing Officer	x^2 1df = 12.62	17		11	35
Charge Nurse	$p<0.001$	49		7	249
					284
Social Status					
Married	x 2 1df = 4.29	59		7	182
Not Married	$p< 0.05$	37		9	102
					284
Home Commitments					
Dependents		50		8	127
No dependents		41		8	157
					284
Sex					
Male		55		2	42
Female		44		9	242
					284
Type of Nursing					
Maternity	x^2 1df = 17.75	16		9	43
Others	$p<0.001$	51		7	241
					284
Time Qualified					
Less than 5 years		40		6	35
5 but less than 15 years		46		4	92
15 but less than 25 years		51		9	87
25 and more years		41		11	70
					284
Size of Hospital					
Less than 50 beds		48		11	56
50 but less than 100 beds		43		11	28
100 but less than 200 beds		45		8	64
200 and more beds		45		6	136
					284
Shift					
Night Duty	x^2 1df = 5.61	59		10	59
Day Duty	$p<0.02$	42		7	225
					284
Duty Span					
Full Time		43		7	220
Part Time		55		9	64
					284

APPENDIX B - TABLE B4

Description of
Scores Related to Other Variables

Scale No. 2

Influences	Score 25 or below	Score above 75	N
	%	%	
Educational Needs Identified			
General Clinical Knowledge	43	7	72
Knowledge of Interpersonal skills	45	6	62
Knowledge of Teaching skills	61	9	33
Special Clinical Knowledge	52	7	29
Knowledge of Technical skills	71	-	14
Updating Methods used (Other than Educational Prog.)			
Own resources	49	6	100
Local study days	34	5	64
Informal discussion medical staff	43	11	53
Lectures by medical staff	33	12	24
Professional Associations	30	13	23
Nursing staff meetings	44	-	16
Contact with School of Nursing	17	17	12
Post Graduate Medical Centre Library	33	33	6
Participation in post - basic Educational Programmes (including Cat. 3)			
None	54	10	93
1 Programme	44	5	110
2 Programmes	39	10	59
3 or more	*23	4	22

* X^2 1 df = 4.99
$p<0.05$

Appendix B - Table B 5

Regression Analysis

Summary Table Relating to

Scale 1

Nursing Journals (available in work place)	7%
(available in hospital)	2%
Grade of Nurse	3%
Sex of Respondents	3%
Reading of Medical Journals	1%
Attendance at Post-basic Education Programmes (3 cats.)	1%
Total Variance accounted for	17%

Table B 6

Regression Analysis

Summary Table Relating to

Scale 2

Dependents	17%
Type of Nursing (general/midwifery)	1%
Grade of Nurse	1%
Sex of Respondents	1%
Nursing Journals Social Status Reading of Medical Journals Attendance at Post-basic Education Programmes (3 cats.)	1%
Total Variance accounted for	21%

APPENDIX C

Respondents who trained overseas N = 11	
Country	Numbers
Australia	4
Sri Lanka	2
Ghana	1
Jamaica	1
South Africa	1
India	1
Eire	1

TABLE 2

Distribution of Respondents throughout Hospital areas	
Medical/surgical	117
Geriatric	47
Midwifery	43
Theatre	26
Intensive Therapy Units	14
* Other	37
Total	284

* Includes Ophthalmics; Accident & Emergency; Urology; Outpatients; Orthopaedics; Paediatrics; Radiotherapy

TABLE 3

Category 1 Courses. N = 172	
Training	Number
Midwifery	116
Psychiatry	26
* Teaching	8
Orthopaedic	6
Tuberculosis	6
Sick Childrens'	6
Fever	3
Health Visitor	1

* Includes Clinical Teacher and Registered Nurse Tutor training

APPENDIX C

TABLE 4

Category 2 Courses	N = 70
Subject	Number
Family Planning	10
Theatre work	9
Intensive Therapy work	9
Community training	9
Opthalmic training	8
Accident & Emergency work	5
Psychiatric training	4
Parentcraft training	3
Special baby care	3
Anaesthetics	2
Tropical diseases	2
Neurological nursing	2
* Other	4

* Other included Diagnostic radio therapy, Urology, Care of the Mentally handicapped, Behaviour modification training

TABLE 5

Category 3 Programmes	N = 53
Topics	
Treatment of Cancer	
Midwifery Theory	
Care of Terminally ill	
Care of the Elderly	
Care of a Tracheostomy	
Care of patients with Renal Failure	
Care of Mentally Handicapped Patients	

No. of Programmes attended (including all programme categories)	
Number	% respondents
1 Episodes	39%
2 Episodes	21%
3 or more Episodes	7%

APPENDIX C

TABLE 7

Characteristics of those who have not attended any post basic training
C.N. (Gen)
married
Work in Geriatric Unit
Qualified less than 5 years
Work in hospitals of less than 100 beds
Work on Night Duty
Work Part-time

TABLE 8

Characteristics of those who prefer updating education on a part-time basis
Work on Night-duty
In Specialty areas
Are qualified 25 years or more

TABLE 9

Characteristics of those who could travel from home district
Not married
Work full time

APPENDIX C

TABLE 10

Characteristics of those who are dissatisfied with reading opportunities
Male
Charge Nurse

TABLE 11

Characteristics of those who are most satisfied with reading opportunities
Nursing Officer
General Division

TABLE 12

le 2

Characteristics of those least satisfied with facilities
Works on night-duty
Is married
Has dependents
Works in general division
Is of Charge nurse grade

APPENDIX C

TABLE 13

Characteristics of those who have adequate opportunity for updating
Unmarried
Qualified 25 years or more
Work in hospitals of more than 100 beds but less than 200 beds
Are midwives

TABLE 14

Characteristics of those who have no opportunity to update
Male
Works on night duty
In hospitals of less than 50 beds
Is of Charge Nurse grade

TABLE 15

Characteristics of those who identify a need for interpersonal skills
Have no dependants
Are female
Qualified less than 15 years
Work in the General Division

TABLE 16

Characteristics of those who found basic Nursing Training enough to equip for present post
Qualified more than 15 years
Work in a Non-specialist area
Work in hospitals of less than 100 beds

APPENDIX C.

TABLE 17

Additional Programmes not recorded elsewhere N = 30	
Course	Time
Art of Examining	3 days
Art of Teaching	3 days
Art of Examining and Teaching	3 - 5 days

APPENDIX C

TABLE 18

Numbers of Journals Staff considered available/Grade of Staff					
Journals	Grade of Staff				Total
	N.O.	%	C.N.	%	
0	3	(87)	33	(13)	36
1	0	(0)	19	(8)	19
2	8	(23)	77	(31)	85
3	8	(23)	58	(23)	66
4	6	(17)	32	(13)	38
5	5	(14)	10	(4)	15
6	3	(8)	7	(3)	10
7	0	(0)	4	(2)	4
8	1	(3)	2	(1)	3
9	1	(3)	1	(0.5)	2
10 and over	0	(0)	6	(2)	6
Total	35	100	249		284

% rounded

APPENDIX C

TABLE 19

Journals ranked by number of mentions	
Nursing Mirror	201
Nursing Times	197
* Nursing Week	73
British Medical Journal	52
Midwives Chronicle	42
Health and Social Services Journal	35
Midwives, Health Visitors & Community Nurse	35
The Lancet	33
* Queens Nursing Journal	33
Modern Geriatrics	30
Journal of Obstetrics and Gynaecologists of Britain	7
Pharmaceutical Journal	7
New Society	7
New Scientist	6
American Journal of Nursing	3

* These journals are no longer published

APPENDIX D

Dear

How Can Trained Nurses 'Keep Up'?

This questionnaire is part of a survey intended to discover if trained nurses, those of charge nurses and nursing officer grades, feel a need to update their knowledge and what facilities they consider they need to enable them to do this.

I know how busy you are (I myself work full time as a nurse) but feel justified in asking for your help since there is little information available on the subject and qualified nurses themselves are most likely to be aware if a need exists.

The information on the introductory page is very important since it will allow me to assess any local or special circumstances which may influence individual views. All information obtained will be confidential and individuals will not be identified. A code number will enable me to send a reminder to anyone who has forgotten to return the questionnaire.

The research takes place in the South West Thames Region and is registered with the University of Surrey.

I am very grateful for your help in this matter and enclose a stamped addressed envelope for the questionnaire which I hope you will return before

Yours sincerely,

(Mrs. Mary Stapleton)

APPENDIX E

Q U E S T I O N N A I R E

'ONGOING EDUCATIONAL NEEDS OF TRAINED NURSES'

Please tick relevant box.

Grade: 6 | 7 Part time ☐ Full time ☐ Night duty ☐ Day duty ☐ Male ☐ Female ☐ Unmarried ☐ Married ☐ Widowed / Divorced / Separated ☐

Home Commitments:

Responsible for someone 16 years and under. Yes ☐ No ☐

Responsible for someone over 16 years. Yes ☐ No ☐

Nurse training:

Did you train in this country? Yes ☐ No ☐

If 'No', please state which country.....

Are you a state certified midwife? Yes ☐ No ☐

Do you practise as a midwife? Yes ☐ No ☐

Length of time qualified:

Less than 5 years. ☐
5 years but less than 15 years ☐
15 years but less than 25 years ☐
25 or more years ☐

Type of Nursing:

Geriatric ☐
Medical ☐
Surgical ☐

OR Specialty: I.T.U. ☐ C.C.U. ☐ Renal ☐ Theatre ☐ A & E ☐ E.N.T. ☐ Ophthalmic ☐ Orthopoedic ☐ Neurological ☐

Other.....

Size of Hospital:

Less than 50 beds ☐
50 beds or more but less than 100 beds ☐
100 beds or more but less than 200 beds ☐
200 or more beds ☐

Travelling:

Is your travelling time to work:
(a) Less than ½ hour? ☐
(b) ½ hour or more but less than 1 hour? ☐
(c) 1 hour or more but less than 2 hours? ☐
(d) 2 or more hours? ☐

/Cont....

Please tick relevant box.

This section of the questionnaire relates to the opportunities available to you to use books and journals as a means of keeping up to date with nursing.

1. (a) Which journals are available, in your h spital, for you to read?

A. Nursing Times ☐
B. Queen's Nursing Journal ☐
C. Midwives Chronicle ☐
D. Health & Social Service Journal ☐
E. American Journal of Nursing ☐
F. Nursing Weekly ☐
G. Nursing Mirror ☐
H. British Medical Journal ☐
I. New Society ☐
J. The Lancet ☐
K. Nursing Chronicle ☐
L. New Scientist ☐
M. Journal of Obstetrics & Gynaecology of the British Commonwealth ☐
N. Pharmaceutical Journal ☐
O. Midwife, H.V. & Community Nurse ☐
P. Any others.....

.....

(b) Are there journals conveniently placed for you to browse through?

Yes ☐ No ☐

If 'Yes',

(c) Where are they available? (Please identify the journal, using the appropriate letter).

Journal	Place
.....	.....
.....	.....
.....	.....

2. (a) Do professional journals circulate through your working area?

Yes ☐ No ☐

If 'Yes',

(b) Could you identify these, using the appropriate letter?

.....

.....

3. (a) Do you have the opportunity to read a nursing journal? Yes ☐ No ☐
(b) Have you read one:
(i) this week ☐

/Cont.....

Please tick relevant box.

3. (b)....Continued...

(ii) this month ☐

(iii) in the last three months ☐

(c) Did you:

(i) buy these? ☐
(ii) have them supplied? ☐
(iii) get them from any other source? ☐

.....

4. (a) Do you have the opportunity to read a medical journal? Yes ☐ No ☐

(b) Have you read one:

(i) this week? ☐
(ii) this month? ☐
(iii) in the last 3 months ☐

.....

5. Do you think there is any need for trained nurses to read:

(a) nursing journals? Yes ☐ No ☐
(b) medical journals) Yes ☐ No ☐

.....

.....

Different types of library facilities are available for nurses. From the statements below could you identify the kind of libraries which are available to you for reference and loan purposes. (Please tick the relevant box).

6. (a) Library for learners only. ☐

(b) Library for learners which trained nurses may use for reference purposes. ☐

(c) Library designed to meet the needs of trained nurses. ☐

(d) Library whose facilities are designed to meet the needs of all nurses. ☐

(e) Library designed to be used by all trained staff. ☐

7. (a) Do the libraries available in your district contain books and journals which you consider useful? Yes ☐ No ☐

.....

.....

(b) Do the facilities meet:

(i) all your needs? ☐
(ii) some of your needs? ☐
(iii) none of your needs? ☐

/Cont.....

Please tick relevant box.

8. (a) Have you used a professional library in your district:

(i) in the last week? ☐

(ii) in the last month? ☐

(iii) in the last year? ☐

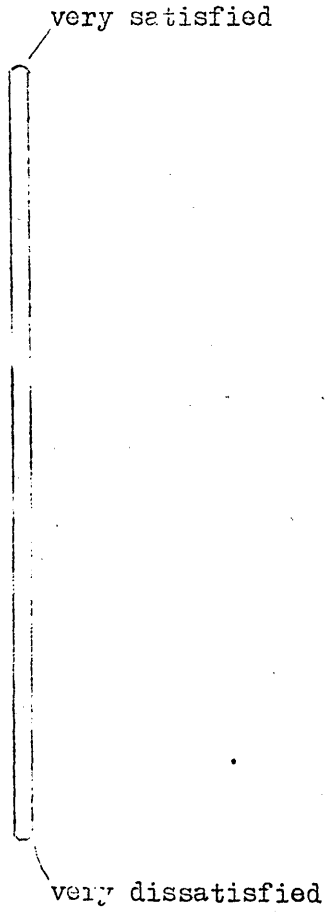
(b) Have you used any other library for professional purposes, during the last year? Yes ☐ No ☐

.....

.....

.....

9. I have drawn a thermometer which ranges from 'very satisfied' to 'very dissatisfied'.



Could you mark on this, with a line, how satisfied you feel with the journal/library facilities which are available to you, to enable you to keep up-to-date with nursing?

/Cont.....

Please tick relevant ...

The next section of the questionnaire is concerned with other ways in which you keep up-to-date with nursing knowledge.

10. (a) Do consultants' rounds help you keep your professional knowledge up-to-date? Yes ☐ No ☐

.....

.....

(b) Apart from consultants rounds, what facilities are available to keep your professional knowledge up-to-date?

.....

.....

11. (a) Do you know of any post-basic courses for nurses which you could attend?

Please list any that you can remember .....

.....

.....

.....

(b) Have you attended any of these courses?
(Include any training you have had since state registration).

Course	Year
.....	.....
.....	.....
.....	.....
.....	.....

(c) Did these courses meet your needs? Yes ☐ No ☐

.....

.....

12. Is there a nurse specifically in charge of education for qualified nurses in your district? Yes ☐ No ☐

13. (a) Are there ongoing educational programmes planned for trained nurses? (Sisters study days might be used for this). Yes ☐ No ☐
Can you list those available in the last 12 months:-

.....

.....

(b) Are there study periods based on one main topic around which a series of lectures/seminars are arranged? Yes ☐ No ☐
Approximately how many topics in the last 12 months:-

.....

.....

/Cont.....

14. Are there any programmes available to you to enable you to develop the teaching skills required of you in your ward or department?

Yes ☐ No ☐

.....

.....

15. Could you list any subjects which you consider could usefully be studied by nurses in charge of wards and departments to help them develop and maintain the skills required of them?

.....

.....

.....

16. Have you attended a management training course? Yes ☐ No ☐

If 'Yes',

17. (a) Did the course meet your needs? Yes ☐ No ☐

(b) Did it relate to your work? Yes ☐ No ☐

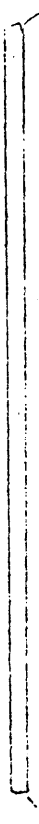
Any comments.....

.....

(c) Were there aspects of management theory about which you wished to know more? Yes ☐ No ☐

(d) Were there aspects of management practice about which you wished to know more? Yes ☐ No ☐

18. I have drawn a thermometer again so that you can indicate, with a line, how satisfied you feel with the training/educational facilities available to you to enable you to keep up-to-date with nursing.



/Cont.....

The next section is concerned with your views on the way to meet any needs that trained nurses may have for updating nursing knowledge.

19. (a) Do you feel any need to update your nursing knowledge?

Great Need	Some Need	Little Need	No Need

(b) Do you have the opportunity to update nursing knowledge?

Too much	Adequate	Some	No opportunity

Different types of educational programmes are available for adults. Please tick the type you prefer.

20. (a) Some one to talk to you - the lecture type of programme. Yes ☐ No ☐

(b) The opportunity to talk around a subject - the group discussion/seminar type of programme. Yes ☐ No ☐

(c) You may like both of these or neither, if there is some other approach which seems to you to be appropriate, could you list some details of this?

.....

.....

.....

21. (i) Which of the following study arrangements would you be able to attend? (Please tick all of those you would find possible)

(a) Full time, away from your own district. ☐
(b) Part time, away from your own district ☐
(c) Full time, in your own district? ☐
(d) Part time, in your own district? ☐
(e) A course you could attend in your own time? ☐

.....

.....

(ii) Is the time span of such courses important to you? (Please tick whichever one of the following applies to you).

(a) One day at a time only. ☐
(b) One week (Mon - Fri) at a time only. ☐
(c) One month at a time only. ☐
(d) Longer than any of these. (Please state limits) ☐

.....

(iii) Are the number of hours you are away from home per day a consideration? (From the following statements, please tick the one which applies to you).

(a) Hours must come within normal working and travelling time. ☐

(b) Hours could be extended (Please state limits). ☐

.....

(c) Time would not be a problem. ☐

(d) Any further comments.....

.....

/Cont....

22. (a) Do you consider it useful to have short courses of study available to trained nurses as an on-going programme from which they could choose?

Yes ☐ No ☐

.....

If 'Yes',

(b) Should attendance be voluntary? Yes ☐ No ☐

(c) Should attendance be compulsory? Yes ☐ No ☐

.....

(d) Do you consider it useful to have refresher courses every few years? (Midwives already have these).

Yes ☐ No ☐

If 'Yes',

(e) Should attendance be voluntary? Yes ☐ No ☐

(f) Should attendance be compulsory? Yes ☐ No ☐

.....

.....

23. Have you found that basic training in nursing has been enough to enable you to undertake the work required of you in your ward or department?

Yes ☐ No ☐

.....

.....

Thank you very much for completing this questionnaire.

/Cont...

Are there any comments you would like to make on this subject, either to expand an area which I have touched on or to introduce an aspect which I have missed? I shall be very grateful for any information you care to offer.

APPENDIX F

INTERVIEW CHECK LIST

1. Questionnaire, sections 1, 2 and 3

2. Recent changes: Re-organization
   Salmon structure

   Have they affected you in your work?

3. What about career prospects - are they better?
   worse?
   no different?

4. Would efforts to keep up to date with nursing affect the time spent with patients?

   Would any time spent have an effect on patient care?

5. Is updating or nursing knowledge:-

   (a) encouraged?
   (b) taken for granted?
   (c) treated with indifference?
   (d) discouraged?

6. Does systematic updating take place now?
   (explain systematic)

7. Define Clinical Nurse Consultant:-

   Is it known?
   Is it a possible development?
   Would you consider it?

APPENDIX G

The General Nursing Council for England and Wales

Syllabus of Subjects for Examination for the Certificate of General Nursing

I. Principles and Practice of Nursing Including First Aid

(i) Introduction

Outlines of the history and background of nursing.

Outline of the Health Service.

The Hospital, the various departments and functions, including its relationship with the Local Health Services.

Personal qualities and attitudes required of the nurse.

Standards of ethical conduct.

Relationship between the nurse, the patient and the relatives.

The place of the nurse in the hospital team, relationship with medical staff and other hospital workers.

(ii) Ward Management

The plan of the ward routine and the patients' day.

Elimination of noise.

Ventilation, heating and lighting.

Cleanliness of the ward as it affects the safety and comfort of the patients.

Care of linen; disposal of soiled and infected linen.

Care and use of equipment.

Care, storage and handling of food.

(iii) General care of the patient

Reception and admission of patients.

Transfer and discharge of patients.

Recording necessary particulars.

Care of the patient's clothing and other belongings, including valuables.

Observing and reporting on the patient's general condition and behaviour.

1962-1969

The nurse's responsibility for the patient's general cleanliness and hygiene.

Prevention and treatment of infestation.

Bedmaking, moving and lifting patients, helping patients to get in and out of bed.

Care of patients confined to bed.

Care of ambulant patients.

Serving meals.

Feeding patients. Measuring and recording fluid intake and output.

Recording weight.

Taking and charting the temperature, pulse, respiration and blood pressure.

Observing and reporting on urine, faeces, vomit and sputum.

Giving and receiving reports.

(iv) Human behaviour in relation to illness

Effects on people of coming to hospital as in-patients or out-patients and effects on their relatives and visitors.

The nurse-patient relationship.

Patients' reaction to illness.

The effects of emotional states on physical states.

Convalescence and rehabilitation.

(v) Nursing procedures

1. *Associated with general care of the patient*

Special positions used in nursing care.

Bed and cot making with modification of method required in special conditions.

Methods of warming the bed.

Methods of relieving pressure.

Prevention and treatment of pressure sores.

Disposal and/or disinfection of urine, faeces, sputum and vomit.

Care of incontinent patients.

Care of the unconscious patient.

Last offices.

Bathing of infants and children.

Feeding of infants and children.

2. *Prevention of spread of infection (or surgical technique)*

Prevention of spread of infection in a ward.
Principles of asepsis.
Aseptic technique.
Methods of cleansing, sterilisation and disinfection.
Preparation of lotions.
Conduct of surgical dressings and other sterile procedures.
Methods of securing dressings.
Methods of disposal of soiled dressings.

3. *Administration and storage of drugs*

Weights and measures (Imperial and Metric System).
Rules for the storage of drugs and poisons.
Rules for and method of the administration of drugs.

4. *Associated with specialised conditions*

Care of patient before and after anaesthesia.
General pre- and post-operative nursing care.
Inhalations.
Administration of oxygen; and oxygen and carbondioxide.
Nursing of patients requiring artificial respirators.
Intravenous and subcutaneous infusions.
Artificial feeding.
Gastric aspiration and washout.
Preparation and administration of enemas of various types.
Passing a flatus tube.
Colonic and rectal washouts.
Vaginal irrigations; perineal care; insertion of pessaries.
Catheterisation and irrigation of urinary bladder.
Treatment of the eye; bathing, irrigation, instillation of drops, application of ointments and dressings.
Treatment of the ear, swabbing, instillation of drops, insufflation, syringing, application of ointments and dressings.
Treatment of mouth and throat by gargling, irrigation and painting.
Uses and applications of heat, cold, medicated preparations.
Principles and methods of treatment by baths and sponging.

5. *Clinical procedures*

Collection of specimen of urine, faeces, vomit, sputum and discharge.

Urine testing.

Preparation and care of patient and preparation of apparatus for:—

(*a*) examination of ear, nose, mouth, throat; of respiratory, alimentary, urinary and genital tracts; neurological examination.

(*b*) Procedures including the examination of body fluids, gastric analysis, renal and liver efficiency test, estimation of basal metabolic rate, X-ray examinations; lumbar puncture, cisternal puncture; bone marrow puncture; venepuncture and venesection; aspirating the pleural cavity.

(*c*) drainage of peritoneal cavity and subcutaneous tissues.

6. *Operating theatre technique*

Preparation and use of theatre annexes.

Preparation, sterilisation, use and care of instruments and other equipment.

Position of patient for operation.

Observation and care of patient during anaesthesia and operation.

(vi) First aid and treatment in emergencies

Aims of first aid treatment.

General principles and rules to be observed.

Improvisation of equipment.

Methods of moving and carrying injured persons.

Use of triangular and roller bandages and splints.

Haemorrhage.

Shock.

Asphyxia.

Fractures.

Burns and scalds.

Poisoning.

Fits.

Emergencies, e.g., fire and accidents in the ward.

II. The Study of the Human Individual

Introduction to the development of the human individual; physical and mental.

General structure of the body with its relationship to function; how the body works.

The skeleton and its functions. How joints and muscles function.

Need for and supply of oxygen to the tissues.

Principles of nutrition and basic dietetic requirements.

The use of food and fluid.

The circulation of the blood and the functions of the lymph and tissue fluid.

Elimination of waste products.

Control of activity by the nervous system and hormones.

The appreciation of environment; the senses of sight, hearing, smell, taste and touch.

How mind and personality develop

The basis of mental health; constitution as a determinant of human behaviour.

Family relationships and security.

Social development at school, during puberty and adolescence, at work, in courtship, marriage and parenthood.

Maturity. Readjustments needed in middle age and old age.

Maintenance of Health

Housing and the home

Types of buildings.

The problem of noise.

Provision of adequate ventilation, heat and light.

Provision of an adequate supply of safe water.

Storage and care of food.

Disposal of refuse.

Cleanliness.

The Individual

Clothing, nutrition, exercise and recreation; fatigue, rest and sleep.

III. Concepts of Nature and Cause of Disease and Principles of Prevention and Treatment

Nature and causes of disease

Congenital abnormalities.

Nutritional disorders—deficiencies or excesses in the diet—failure in absorption.

Endocrine disorders.

Emotional stresses.

Trauma—types of injury and processes of healing.

Inflammation, symptoms and signs—local and general, effects and results.

Infection—types of organisms and methods of spread of infection; reactions; immunity.

New growths; types and characteristics.

Degeneration.

Poisons.

Undetermined origin.

These general headings setting out in the broadest possible lines the nature and cause of disease should be applied in the study of all types of conditions which will include general and specialised medical and surgical conditions affecting all age groups and all systems and organs in the body.

The study of any condition from which a patient may be suffering either of a general or specialised character should include:—

Applied anatomy and physiology.

Cause.

Symptoms and the well-known signs.

Reasons for investigation.

Treatment.

Nursing care to include observations and records.

Normal course of the disease. Complications.

Social aspects and rehabilitation.

Maintenance of health and prevention of disease

Factors contributing to the maintenance of health including health education (*see* Section II).

Personnel contributing to the maintenance of health and co-operation with the staff in wards and departments of hospital, the family doctor and the Local Health Authority.

The personnel concerned with physical and mental care outside hospital.

Factors contributing to the breakdown in health.

The influence of the patient's home and economic background in the prevention of disease and as an associated cause of disease.

The Social Services.

Treatment of disease

Relevant items from Section I, Principles and Practice of Nursing, and the application of physiological processes included in Section II, the study of the human individual, should be studied in relation to the nursing care required in the treatment of any condition from which patients may be suffering.

Other aspects of treatment

1. Rest

General rest of mind and body.

Importance of environment and planning the patient's programme to include adequate rest.

Physiological rest of affected organ or area.

Complications associated with prolonged local or general immobilisation.

2. Dietetics

Normal diet.

Ward meals.

Modification of the normal diet in the treatment of various conditions.

3. Pharmacology

Dangerous Drugs Act.

Regulations under the Pharmacy and Poisons Act.

The use, dosage, action and side effects of drugs commonly ordered in diseases of:—

- Cardio-vascular system
- Alimentary system
- Endocrine system
- Nervous system
- Genito-urinary system
- Respiratory system
- Locomotor system
- Preparations of vitamins and hormones
- Anti-histamines
- Chemotherapeutic agents.

4. Radiotherapy

Principles of treatment by X-ray and radioactive substances.

5. Physiotherapy

Principles of treatment.

6. Psychiatric treatment

Principles of psychological treatment and therapeutic climate.

Special treatments and drugs used in mental disorders.

7. Occupational and industrial therapy

Principles and use of occupational and industrial therapy as a means of return to health and working capacity.

General Principles of Medicine and Surgery

Medical and Surgical Nursing

Cardio-vascular system	Abnormalities of pulse, cardiac action and blood pressure. Diseases affecting the heart, blood, blood vessels and blood forming organs, lymphatic vessels and nodes.
Respiratory system	Abnormalities of respiration. Types of cough and sputum. Diseases of the respiratory tract, lungs and pleura.
Alimentary system	Abnormalities and disorders of appetite, swallowing, digestion, absorption, metabolism, and defaecation. Types of vomiting, diarrhoea and constipation. Diseases of the alimentary tract and its associated organs.
Urinary system	Abnormality of urine. Disorders of micturition. Diseases of the urinary tract.
Locomotor system	Abnormalities and diseases of bones, joints and muscles. Trauma.
Endocrine system	Effects of disordered function of endocrine glands.
Nervous system	Disorders and diseases of the brain, spinal cord, and peripheral nerves. Assessment of level of consciousness, sensory changes and types of paralysis.
Special senses	Abnormalities and disorders of sight, hearing, smell, taste and touch. Diseases of the eye, ear, nose, tongue and skin.
Communicable diseases	Immunity. Use of Sera and Vaccines. Mode of Spread of infection. Specific fevers. Venereal diseases. Respiratory tuberculosis.
Mental disorders	Inter-relation of mental and physical processes; psychosomatic disorders; psychotic and neurotic states.
Female reproductive system	Pregnancy; principles of ante-natal care. The stages of normal labour. Post-natal care of mother and child. Disorders of menstruation, pregnancy, the puerperium and the menopause. Displacements and diseases of the genital tract.
Male reproductive system	Disorders associated with these organs.

PREFACE

The Syllabus sets out in broad terms the subjects to be studied during training for Registration in the general part of the Register maintained by the General Nursing Council for England and Wales.

The concept underlying this syllabus is that of total patient care but for convenience the syllabus is divided into three main sections; nursing, the study of the individual and the nature and cause of disease together with the prevention and treatment. These three aspects of patient care should be learned concurrently throughout training. In this way the various needs of patients will be closely linked together; their needs as individuals and as patients requiring nursing and specialised care and rehabilitation in preparation for return home.

The patient in hospital cannot be considered in isolation from the community and the nurse must be aware of the services provided by local health authorities and voluntary organisations to help and safeguard individuals in their home and work. The nurse also has an important part to play as a health teacher and must have a knowledge of the factors in the environment which give rise to ill health since she will be called upon to advise patients and their relatives on how to care for themselves and their family in a way which will promote a state of physical and mental well being.

The syllabus includes a section on the elementary principles of management which will form the basis for further post-registration courses.

Learning will take place both in the teaching department and in the wards and departments of the hospital with some experience in the community services. Teaching will be by means of lectures, tutorials, group discussions and project work.

Since nursing is essentially a practical art the majority of the training period will be spent in the wards and departments of the hospital learning and practising nursing skills under the guidance of Registered Nurses. These skills and techniques are to be recorded in section 1 of the Record and the main types of conditions from which the patients are suffering, are to be shown in section 2. These two sections are to be a guide to the student in planning private study and writing patient care studies. Each student nurse must be responsible for her Record which should be completed regularly in consultation with the Registered Nurses supervising and teaching in the wards and departments and will thus provide a detailed record of training.

The period of training is normally 3 years exclusive of excess sick and special leave and student nurses will be required to pass written and practical examinations prior to Registration.

1969-1977

SYLLABUS OF SUBJECTS FOR EXAMINATION FOR THE CERTIFICATE OF GENERAL NURSING

1. PRINCIPLES AND PRACTICE OF NURSING

Including First Aid

Introduction

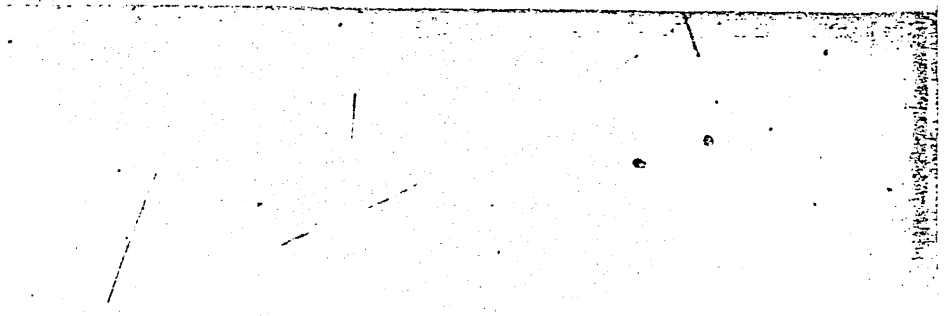
Outline of the history of nursing as a background to the present day.
Outline of the Health Service.
The hospital, the various departments and functions including relationship with the Local Health Services.
Personal qualities and attitudes of the nurse.
Standards of ethical conduct.
Relationship between the nurse, patients and relatives.
The place of the nurse in the hospital team, relationship with medical staff and other hospital workers.

Ward Organisation

Plan of patients' day.
Organisation of ward routine.
Ventilation, heating and lighting.
Reduction of noise.
Cleanliness of the ward as it affects the safety and comfort of patients.
Prevention of spread of infection.
Care of linen; disposal of soiled and infected linen.
Storage and custody of drugs.
Storage and preparation of lotions and poisonous substances.
Care and use of equipment.
Care and storage of food.

General care of patients and nursing procedures

Reception and admission of patients.
Transfer and discharge of patients.
Recording of necessary particulars.
Care of patients' clothing and property.



Observing and reporting on the general condition and behaviour of patients.
Responsibility for the general cleanliness and hygiene of patients.
Bed and cot making with modification of method for special conditions.
Methods of warming the bed.
Moving and lifting patients, helping patients to get in and out of bed.
Relief of pressure and prevention of skin abrasions.
Care of patients confined to bed.
Bathing and feeding of infants.
Care of ambulant patients.
Serving meals and feeding patients.
Measuring and recording fluid intake and output.
Taking and charting the temperature, pulse, respiration and blood pressure.
Recording weight and height.
Giving and receiving reports.
Observing and reporting on sputum, vomit, urine and faeces.
Disposal and/or disinfection of sputum, vomit, urine and faeces.
Care of infested patients.
Care of patients requiring isolation.
Care of incontinent patients.
Care of patients in plaster or on traction.
Care of unconscious patients.
Care of paralysed patients.
Care of the dying.
Last offices.
Care of patients before and after anaesthesia.
General pre-and post-operative nursing care.
Principles of asepsis, sterilisation and disinfection.
Aseptic technique.
Conduct of surgical dressings and other sterile procedures.
Methods of securing dressings.
Methods of disposal of soiled dressings.
Administration of oxygen and other inhalations.
Nursing of patients requiring assisted respiration.
Intravenous, subcutaneous and other parenteral infusions.
Artificial feeding.

Gastric aspiration and washout.

Preparation and administration of enemas and suppositories; passing of a flatus tube; rectal washout.

Vaginal irrigation; perineal care; insertion of pessaries.

Catheterisation, irrigation and drainage of urinary bladder.

Treatment of eye; bathing, irrigation, instillation of drops, application of ointments and dressings.

Treatment of the ear; swabbing, instillation of drops, insufflation, syringing, application of ointments and dressings.

Treatment of the mouth, nose and antra.

Uses and application of heat, cold, medicated preparations.

Care of patients with pyrexia and hypothermia.

Principles and methods of treatment by baths and sponging.

Human behaviour in relation to illness

Effects on people of coming to hospital as in-patients or out-patients.

How the emotions may affect the body.

Patients' reactions to illness.

Convalescence and rehabilitation.

The nurse-patient relationship.

Administration and storage of drugs

Dangerous Drugs Act.

Regulations under the Pharmacy and Poisons Act.

Weights and measures (Metric and Imperial System).

Rules for the storage of drugs.

Rules for and method of administration of drugs.

Tests and Investigations

Collection of specimens of sputum, vomit, urine, faeces and discharges.

Urine testing.

Preparation and care of patients and preparation of apparatus for:

(a) examination of ear, nose, mouth, throat; of respiratory, alimentary, urinary and genital tracts; neurological examination; X-ray examinations.

(b) Procedures including the examination of body fluids, gastric analysis, renal and liver efficiency tests, investigation of endocrine activity; biopsies; venepuncture; lumbar puncture; cisternal puncture; bone marrow puncture; aspirating the pleural cavity and drainage of peritoneal cavity.

Operating theatre technique

Preparation of theatre and annexes.
Preparation, sterilisation, use and care of instruments and other equipment.
Positioning of patients for operation.
Observation and care of patients during anaesthesia and immediate after care.

First aid and treatment in emergencies

Aims and principles of first aid treatment.
Improvisation of equipment.
Methods of moving and carrying injured persons.
Cardiac arrest.
Haemorrhage.
Shock.
Asphyxia.
Fractures.
Bites and stings.
Burns and scalds.
Poisoning.
Fits.
Emergencies, e.g. fire and accidents in the ward.

Preparation for management

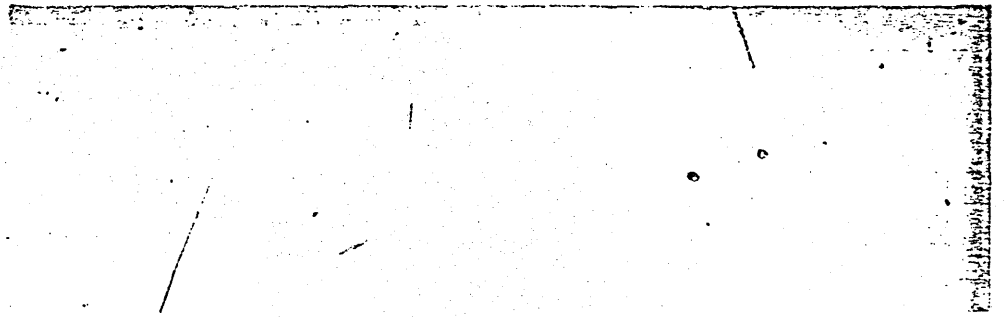
Principles of management.
Principles of teaching.
Communications.

II. STUDY OF THE HUMAN INDIVIDUAL

Introduction to the development of the human individual, physical and mental.
General structure of the body in relation to function; how the body works.
The skeleton and its functions. How joints and muscles function.
Exercise, fatigue, relaxation and recreation.
Need for oxygen and supply to the tissues.
Basic dietary requirements; the use of food and fluid.
The circulation of the blood; the functions of lymph and tissue fluid.
Heat regulation; clothing.
Elimination of waste products.
Reproduction.
Control of activity by the nervous system and hormones; rest and sleep.
The appreciation of environment; the senses of sight, hearing, smell, taste and touch.

How mind and personality develop.
The basis of mental health.
Family relationships and security.
Social development at school, during puberty and adolescence, at work, in courtship, marriage and parenthood.
Maturity. Re-adjustments needed in middle age and old age.

Effect of the environment on health.
Provision of a safe environment.
Community services.
Personal responsibilities for health.



III. CONCEPTS OF THE NATURE AND CAUSE OF DISEASES AND THE PRINCIPLES OF PREVENTION AND TREATMENT

Nature and causes of disease

Congenital abnormalities.

Nutritional disorders—deficiencies or excesses in the diet—failure in absorption.

Endocrine disorders.

Emotional stresses.

Trauma—types of injury and processes of healing.

Inflammation, symptoms and signs—local and general, effects and results.

Allergy and immune response.

Infection—types of organisms and methods of spread of infection; reaction; immunity.

New growths; types and characteristics.

Degeneration.

Poisons.

Undetermined origin.

These general headings setting out in the broadest possible lines the nature and cause of disease should be applied in the study of all types of conditions which will include general and specialised medical and surgical conditions affecting all age groups and all systems and organs in the body.

The study of any condition from which a patient may be suffering either of a general or specialised character should include:

Applied anatomy and physiology.
Cause.
Symptoms and the well-known signs.
Reasons for investigation.
Treatment.
Nursing care to include observations and records.
Normal course of the disease. Complications.
Social aspects and rehabilitation.

Maintenance of health and prevention of disease

Factors contributing to the maintenance of health including health education.

Personnel contributing to the maintenance of health and co-operation between the staff of hospitals, family doctors and the Local Health Authority.

The personnel concerned with physical, mental and social welfare of the community.

Factors contributing to the breakdown in health.

The influence of the patient's home and economic background in the prevention of disease and as an associated cause of disease.

The Social Services.

Treatment of disease

Relevant items from Section I, Principles and Practice of Nursing, and the application of physiological processes included in Section II, The Study of the Human Individual, should be studied in relation to the care required in the treatment of any condition from which patients may be suffering.

Other aspects of treatment

1. Rest

General rest of mind and body.

Importance of environment and planning the patient's programme to include adequate rest.

Physiological rest of affected organ or area.

Complications associated with prolonged local or general immobilisation.

2. Dietetics

Normal diets.

Modification of normal diets in the treatment of various conditions.

3. Pharmacology

The use, dosage, action and side effects of drugs commonly ordered in diseases of:

Cardio-vascular system.
Reticulo-endothelial system.
Respiratory system.
Alimentary system.
Genito-urinary system.
Locomotor system.
Nervous system.
Endocrine system.
Skin and special senses.

4. Radiotherapy

Principles of treatment by X-ray and radio-active substances.
Care and custody of radio-active substances.

5. Physiotherapy

Principles of treatment.

6. Psychiatric treatment

Principles of psychological treatment.
The promotion of a therapeutic environment.
Special treatments and drugs used in mental disorders.

7. Occupational and industrial therapy

Principles and use of occupational and industrial therapy as a means of return to health and working capacity.

GENERAL PRINCIPLES OF MEDICINE AND SURGERY
and associated nursing care

Cardio-vascular and reticulo-endothelial system	Abnormalities of pulse, cardiac action and blood pressure. Diseases affecting the heart, blood, blood vessels and blood forming organs, lymphatic vessels and nodes.
Respiratory system	Abnormalities of respiration. Types of cough and sputum. Diseases of the respiratory tract, lungs and pleura.
Alimentary system	Abnormalities and disorders of appetite, swallowing, digestion, absorption, metabolism, and defaecation. Types of vomiting, diarrhoea and constipation. Diseases of the alimentary tract and its associated organs.
Urinary system	Abnormalities of urine. Disorders of micturition. Diseases of the urinary tract.
Locomotor system	Abnormalities and diseases of bones, joints and muscles.
Nervous system	Disorders and diseases of the brain, spinal cord, and peripheral nerves. Assessment of level of consciousness, sensory changes and types of paralysis.
Endocrine system	Effects of disordered function of endocrine glands.

Reproductive system	Pregnancy; principles of ante-natal care. The stages of normal labour. Post-natal care of mother and child. Family planning; infertility.
	Disorders of menstruation, pregnancy, the puerperium and the menopause.
	Disorders, displacements and diseases of the male and female genital tract.
Special senses	Abnormalities and disorders of sight, hearing, smell, taste and touch. Diseases of the eye, ear, nose, tongue and skin.
Communicable diseases	Immunity. Use of Sera and Vaccines. Mode of spread of infection. Specific fevers. Venereal diseases. Respiratory tuberculosis.
Mental disorders	Inter-relation of mental and physical processes, psychosomatic disorders; psychotic and neurotic states.
Traumatic conditions	Burns; scalds; poisoning; multiple injuries.