CATCHING THE TIDE:

NEW VOYAGES IN NURSING?

by

Susan Read

August 1995

Sheffield Centre for Health and Related Research

AN INTRODUCTION TO SCHARR

SCHARR, the Sheffield Centre for Health and Related Research, is a large, multidisciplinary research centre located near the centre of Sheffield. It forms the northern arm of the Trent Institute for Health Services Research which also includes centres at Nottingham and Leicester Universities. The staff at the Centre are drawn from a wide range of disciplines and backgrounds, embracing epidemiology, health economics, management sciences, medical sociology, medical statistics, nursing research, operational research, primary care, psychology, information science and public health medicine. This broad base of skills, together with the Centre's close ties with local NHS Trusts and Health Authorities, makes it uniquely placed to conduct applied and methodological Health Services Research to the highest quality.

AIMS OF SCHARR

The aims of SCHARR are:

- to conduct and promote within the University, Health Services Research (HSR), judged to be excellent both nationally and internationally;
- to deliver the highest standard of teaching in HSR and related subjects;
- to provide research and consultancy services in HSR to clients outside the University, particularly to NHS Trusts and Authorities but also to other public sector bodies and private organisations;
- to be an active and vigorous member of the Trent Institute for Health Services Research.

Professor Ron Akehurst, Director

The Author

Dr Susan Read is a Research Fellow in the Nursing Section of the Sheffield Centre for Health and Related Research with a particular interest in the interface between nursing and medicine.

Acknowledgements

Susan Read wishes to thank Anna Barrett, Clinical Developments Manager for Trent Taskforce, for her support throughout this project, and particularly for her knowledge of innovative schemes for patient management which contributed helpfully to Chapter One. Dr Read is grateful too for permission to quote the notes of Val McKinley in Appendix Three.

The author acknowledges the work of Karen Collins (nee Graves) on the Trent Taskforce funded project referred to throughout, and to all the participants in that project. Thanks too to Cheryl Williams of SCHARR for her secretarial support.

Further Copies

Further copies of this document are available (price £10) from:-

Suzy Paisley
Information Officer
Sheffield Centre for Health and Related Research
Regent Court
30 Regent Street
Sheffield
S1 4DA

Tel: 0114 282 5420

Please make cheques payable to 'University of Sheffield'.

ABSTRACT

"There is a tide in the affairs of men
Which, taken at the flood, leads on to fortune".

The report takes its title and develops its theme from Brutus's speech in "Julius Caesar," arguing that the rising tide of pressure for change in nursing roles is an opportunity which must be grasped, not resisted.

The report originated in the evaluation of new nursing posts pump-primed by Trent Taskforce for Junior Doctors' Hours, designed to help meet the objectives of the "New Deal". The NHS Executive funded the extra time needed to produce this paper, which seeks to give practical advice about the development of new roles for nurses at the interface between nursing and medicine, based on the lessons learned by participants in the Trent study. Following a discussion of the contributory currents causing the tide of pressure for change to rise, the author suggests questions for providers, purchasers, educationalists and policy makers to answer. If the answers to those questions indicate that nursing developments may be the best way forward, the rest of the report offers guidance about structures, processes and outcomes for those developments, closing with a discussion about safeguards and conditions for successful innovation at the interface between nursing and medicine.

The introduction of innovative nursing roles is not easy, nor cheap, and requires good management support and real enthusiasm for success. The alternative to setting sail and catching the tide, however, is to stay behind the sea wall, and, as Shakespeare said, "to lose our ventures".

CATCHING THE TIDE: NEW VOYAGES IN NURSING?

Susan Read
Sheffield Centre for Health and Related Research
May 1995

Contents

CATCHING THE TIDE: NEW VOYAGES IN NURSING?

by Susan Read
May 1995

Executive Summary

"There is a tide in the affairs of men
Which, taken at the flood, leads on to fortune".

The report takes its title and develops its theme from Brutus's speech in "Julius Caesar," arguing that the rising tide of pressure for change in nursing roles is an opportunity which must be grasped, not resisted.

The report originated in the evaluation of new nursing posts pump-primed by Trent Taskforce for Junior Doctors' Hours, designed to help meet the objectives of the "New Deal". The NHS Executive funded the extra time needed to produce this paper, which seeks to give practical advice about the development of new roles for nurses at the interface between nursing and medicine, based on the lessons learned by participants in the Trent study. Following a discussion of the contributory currents causing the tide of pressure for change to rise, the author suggests questions for providers, purchasers, educationalists and policy makers to answer. If the answers to those questions indicate that nursing developments may be the best way forward, the rest of the report offers guidance about structures, processes and outcomes for those developments, closing with a discussion about safeguards and conditions for successful innovation at the interface between nursing and medicine.

The currents contributing to the tide of pressure for change include

- organisational change in the NHS, including the shift towards primary care and the influence of GP fundholders in purchasing services;
- policy initiatives such as "Health of the Nation" seeking health gain for targeted groups, and the move to more knowledge - based and clinically effective care and practice;
- nursing initiatives from the Department of Health such as the "Heathrow Debate" and "Vision for the Future", and from the UKCC such as "Scope of Professional Practice" and recent papers on specialist and advanced practice;
- medical concerns about hours of work for junior hospital doctors, the context and organisation of their training and the structure of the consultant "firm";
- new initiatives in reorganising the process of healthcare such as "re-engineering", "patient focused care" and "managed care".

These questions might usefully be asked by and of providers -

- are they meeting "New Deal" targets?
- are they moving towards the Calman standards for medical education?
- do they have a good supply of "expert" nurses?
- are they making progress with clinical effectiveness?
- do they have the right organisational climate for innovation?
- could they improve services to patients by re-configuring roles?

Providers might also look at alternatives to re-configuring roles, such as:-

- improving support services (clerical and technical);
- introducing multi-disciplinary records;
- setting up an admissions unit;
- improving policies and protocols;
- improving discharge arrangements;

Only then should they look specifically at changing nursing roles.

Providers deciding to develop nursing roles then need to decide whether to:-

- increase the scope of practice of all their qualified nurses?
- introduce a case management system?
- introduce "nurse-led" care?

  e.g. chronic disease management
  A&E minor injury service

Purchasers need to think whether the quality of the services they buy would be improved by new role developments, and how they could work with service and nurse education providers to see that this happens and is evaluated. Concern for increased effectiveness through role reconfiguration must be balanced by concern for safety.

Purchasers, providers, educationalists and policy makers need to examine the content of pre and post registration education for nurses in the light of changing roles, and to consider the possibility of multiprofessional clinical skills training and education. Educational investment needs to be addressed urgently in order to expedite developments in advanced practice.

Structural aspects of planning new roles for nurses include the need for:-

- a clearly written proposal identifying problems and how the new role will address them;
- a profile of desirable characteristics for the new postholder(s) including qualifications, knowledge and skills required;
- an outline of premises and equipment needed and a decision about uniform, if any;
- an estimation of time needed for development of the role(s), including any pilot studies and time for education and supervised practice;
- a decision about whether new types of documentation will be needed.

Processes involved in creating new roles include

- sharing the vision and gaining commitment from all the multi-disciplinary team;
- setting the boundaries and negotiating protocols;
- communicating widely about the new roles;

- planning education, training, supervised practice and assessment of competency;
- providing mentorship and clinical supervision for post-holders and support for managers in evaluating the impact of new roles;
- monitoring side effects or unexpected consequences of the innovation.

Outcomes to be measured before and after the introduction of innovative nursing roles should be chosen bearing in mind the possible effects on patients, but also on the postholders themselves, other nurses, doctors at all levels, and on the organisational system for care.

Purchasers and providers will be interested in measures which demonstrate that patients are equally safe when treated by specialist nurses or nurse practitioners as when they are treated by junior doctors, and that the clinical effectiveness of their treatment is equally good. In addition, both purchasers and provider managers will compare aggregate efficiency measures under traditional care and nurse-led care such as length of stay, throughput, bed occupancy, theatre use, infection rates, readmission rates and complaints.

The report suggests outcome measures applicable to different types of nursing role development such as:

- pre-operative assessment
- accident and emergency nurse practitioners
- nurse-led care for chronic diseases, analgesia, gynaecology, neonatology, psychiatric emergency care
- general expansion in skills for registered nurses, especially to help in "out of hours" crisis situations

The report concludes by facing the question of the safety of the undertaking - to complete the sea-faring metaphor, whether there will be a prosperous voyage or whether it will end in shipwreck. The principles enshrined in the UKCC's "Scope of Professional Practice" can be used as guideposts for nurses to act within the limits of safety in such matters as accountability and liability, education and competence, patient-centred motivation, management support, public and interprofessional confidence, and orientation to nursing values.

The following factors suggest that proliferation of new roles is likely to proceed rapidly:

- Benefits to patients, nurses and doctors can usually be demonstrated when the roles are introduced under safe conditions;
- New roles can be adapted to meet local needs;
- Limited pilot studies can help to show the way;
- Development of new roles can be compatible with NHS and nursing values when properly thought through.

Nevertheless, the introduction of innovative nursing roles is not easy, nor cheap, and requires good management support and real enthusiasm for success. **The alternative to setting sail and catching the tide, however, is to stay behind the sea wall, and, as Shakespeare said, "to lose our ventures".**

CHAPTER ONE - LOOKING OUT TO SEA - WHY IS THE TIDE SO HIGH?

"There is a tide in the affairs of men

Which, taken at the flood, leads on to fortune;

Omitted, all the voyage of their life

Is bound in shallows and in miseries.

On such a full sea are we now afloat;

And we must take the current when it serves

Or lose our ventures

(W Shakespeare - Julius Caesar).

Introduction

In England in 1995 many currents in healthcare appear to be converging with great force and speed. The rising tide created by the convergence of these currents may be seen as a danger, threatening to wash away the sea defences of professional and disciplinary barriers. Alternatively, the tide may be seen as an opportunity to launch out on new voyages, where co-operation and collaboration between healthcare professions are essential to the process of preparing to set sail. What are some of the currents which are causing the tide to rise so strongly? In broad terms, they can be categorised in the following way - changes in NHS organisation, health policy issues, professional pressures in nursing and in medicine including the publication of research reports, new ideas about the delivery of healthcare, and finally, but importantly, pressure experienced by staff and patients at the "sharp end" - when people exclaim "there must be a better way of doing things!" Inevitably, these issues overlap and interweave with each other, but all influence the way the various healthcare professions work together, and so are relevant to this report, which seeks to give practical advice about developing new roles for nurses in the context of the interface between nursing and medicine.

The origins of this report

The work on which this report is based grew out of initiatives within the Trent Region to respond to the government's commitment to improving conditions of work and training for junior medical staff.

Following the publication of "The New Deal" agreement in 1991[1] regional taskforces were formed to tackle the issues surrounding the intended reduction in hours of work of junior hospital doctors. Trent Taskforce, in common with other regional taskforces, received funds from the NHS Executive to be channelled in various ways thought to be likely to contribute to that reduction, such as additional consultant and SHO appointments in hard pressed specialties. Trent Taskforce however gave especial attention to considering how other health service staff might also contribute, by sharing some of the junior doctor workload, in the case of nurses, and by relieving doctors in training of mundane tasks not necessary as part of their learning experience, in the case of junior doctor support workers. Trent Taskforce set aside a budget for pump-priming innovative nursing roles (£500,000 for 1993-4) and employed a Clinical Developments Manager (Anna Barrett) to advise on such roles. The Taskforce also commissioned an evaluation of the 32 funded posts; the report on this evaluation was published late in 1994[2].

The NHS Executive were informed of this evaluation early in the research process, and recognised the potential for distilling practical advice from the gathered data to benefit both providers, in setting up new roles, and purchasers, in contracting for changes in nursing services. Accordingly the Executive topped-up research funding for the evaluation project to enable the project manager to give extra attention to the processes involved in setting up the new nursing roles, and to write a report about them, tapping the experience of the postholders and their managers. Although this report originated with the "New Deal", the thinking behind it has been influenced by the currents listed earlier, which are now described in more detail.

The current of NHS organisational change

Changes in the way the NHS is organised, managed and financed have been profound in the last ten years. The purchaser/provider relationship, the birth of NHS trusts and GP fundholding, and the intended shift towards a primary care based NHS have all generated new ideas about the delivery of health services, and where and by whom they should be delivered.

The current of health policy

Two particular areas of health policy have stimulated a sharpening of focus amongst healthcare professionals; first the "Health of the Nation" initiative[3] , seeks to move the NHS towards reaching particular targets for health gain amongst the population. A very recent report[4] shows how far some sections of the nation are from reaching those targets. Second, the pressure for the NHS to become much more knowledge based in the way it delivers health care[5-8] has meant that innovations in that delivery are much more likely to be evaluated. The way these management changes and policy initiatives have affected healthcare in the UK has been helpfully summarised by Warner[9] who speaks in terms of new ideas being substituted for old, such as "health" taking the place of "health services", efficiency and effectiveness together taking the place of efficiency alone, new technologies taking the place of old, new organisational frameworks and roles replacing old ones, and the focus of care shifting from hospital to primary care. It is axiomatic that when questions are asked about how to achieve health, and to give care that is effective and efficient, other questions will follow, about which professional groups are best suited to meet those objectives in particular situations.

The current of professional pressure - nursing policies

A further set of currents which contribute to the rising tide, swirl around the professions of nursing and medicine. For nursing, "the Heathrow debate",[10] a consultation of professional

leaders to consider the challenges facing nursing and midwifery in the twenty first century stimulated strategic thinking around the new ideas being substituted for old ones. The following questions were asked, in the context of looking ahead to the year 2010:-

- What will be the context in which nurses will work?
- What will be the contribution of nursing to meeting the needs of individuals?
- How will substitution impact on the role of nursing?

  (in terms of appropriateness and effectiveness for the particular type of care needed - doctor or nurse?

  advanced/specialist nursing practitioner?

  qualified nurse/ healthcare assistant?

- How will the public react to the changed role of nursing?
- How will teamwork be developed with other carers in the health and social care spheres?
- How will professional accountability, authority and responsibility be altered?
- How will regulation impact on quality?
- What will be the implications for initial education and training, retraining and continuous training?

Department of Health[10]

The ensuing debate generated more questions than answers, but did produce a consensus about what is constant in nursing:-

"The work of the nurse, whatever the setting, draws upon a tradition of caring, based around both skills and values, and includes:

- a co-ordinating function
- a teaching function, for carers, patients and professions
- developing and maintaining programmes of care

- technical expertise, exercised personally or through others
- concern for the ill, but also for those currently well
- a special responsibility for the frail and vulnerable"

Department of Health[10]

The participants at Heathrow concluded by posing an agenda for continued consideration, based on five themes:-

1. Models and settings - the continuum of care from hospital to community, possibilities of nurse provider units, nurses as technicians, nurses with greater autonomy.
2. The task and the knowledge base - the core activities of nursing, training for these and research into their effectiveness.
3. Resources - recruitment and funding.
4. Education for new nursing roles, and to spread the Project 2000 philosophy amongst nurses already trained.
5. Leadership - responsive to changing needs.

All these agenda items have relevance to the development of nursing roles at the interface with medicine.

Another initiative stemming from the Nursing Directorate at the NHS Executive is "Vision for the Future"[11-13] and its two sequels. Strategic aims for the nursing professions focused on goals connected with patients' needs, user participation, improvements in health and ensuring a high quality, cost-effective service. In the latest of the three "vision" documents[13] there are two targets (out of the total of 12) which are particularly relevant to the discussion of new nursing roles. These are related to the development of outcome indicators, clinical protocols and clinical audit, and to the development of clinical practice.

Professional pressure - The UKCC

In addition to strong currents in the nursing profession arising from Department of Health and NHS Executive initiatives, there are also regulatory and educational influences coming from the UKCC. The "Scope of Professional Practice"[14] document gave nurses more freedom to expand their roles, whilst sharpening their sense of personal accountability. (This is explained in more detail in the report to Trent Taskforce[2]). The UKCC then developed its definitions of specialist and advanced nursing practice [15-16]. The UKCC says that

> "specialist practitioners will exercise higher levels of judgement, discretion and clinical decision making. They will be able to monitor and improve standards through supervision of practice, clinical audit, provision of skilled professional leadership, and the development of practice through research, teaching and support of professional colleagues.
>
> UKCC[16]

The Council differentiates between nurses practising within a given specialty who may not be functioning with the level of expertise described above and nursing specialist practitioners, who are properly prepared for a higher level of responsibility. Such specialist practitioners should be educated to first degree level, say the Council, becoming experts in clinical practice for their specialty, care and programme management, clinical practice development and leadership.

The later UKCC document[16] speaks about advanced nursing practice, differentiating it from specialist practice, but denying any hierarchical relationship between the two.

> "Advanced practice is not an additional layer of practice to be added to specialist practice. It is an important field of professional practice concerned with the continuing development of professionals in the interests of patients, clients and the health services."

"Advanced nursing practice is concerned with:

- Adjusting the boundaries for the development of future practice.
- Pioneering and developing new roles which are responsive to changing needs.
- Advancing clinical practice, research and education to enrich nursing practice as a whole.
- Contributing to health policy and management and the determination of health needs.
- Continuing the development of the professions in the interests of patients, clients and health services.

Advancing nursing practice in this way will lead to:

- Innovations in practice.
- An increase in nursing research and research-based practice.
- The provision of expert professionals who will have a consultancy role.
- High level professional leadership
- Increased political and professional influence in respect of nursing and health services.
- Expert resources for, for example, education, supervision, management.

The UKCC recognises that many practitioners are acquiring advanced skills and undertaking studies which are likely to be at Masters and PhD level. The UKCC will review these regularly and may consider the recording of such qualification in due course"

UKCC[16]

The UKCC's aspirations for degree level qualifications for specialist practitioners will take some time to be achieved, even allowing that prior experience and learning can be accredited through the CATS[17] system. In the meantime, perhaps Jasper's[18] tentative definition of a nursing expert might help to augment the UKCC's description of a specialist practitioner.

> "A nurse who has developed the capacity for pattern recognition through high level knowledge and skill, and extensive experience in a specialist field, and who is identified as such by her peers."
>
> Jasper[18]

Professional pressure - research

Jasper believes that the creation of clinical nurse specialist posts offers an identifiable structure for the recognition of experts. Wilson-Barnett and Beech[19] call for more research combining structure, process and outcome measurement to evaluate more rigorously the value of specialist nurses. One attempt to evaluate a nurse-led in-patient service is being carried out in King's Healthcare Trust. The beginnings of the project are described by Evans and Griffiths;[20] the design is quasi-experimental and seeks to maintain the ability to make reasonable attribution of cause and estimate the impact of the unit on patient outcomes (such as physical and psychological distress, complications and physical dependence).

These brief descriptions of work by Jasper[18], Wilson-Barnett and Beech,[19] and Evans and Griffiths[20] illustrate how the current of research adds to the height of the tide of interest and expectation around the subject of changing nursing roles. Other research recently reported contributes to the current. The Department of Health commissioned Greenhalgh Report[21] concluded that six activities

Patient history taking

Phlebotomy

Cannulation

Administration of IV drugs

Referring for investigations

Writing discharge letters

took up between 11 and 16% of junior doctors' time (more at night), and that there was no difference in quality when these tasks were undertaken by nurses. The report, which stated that nurses and junior doctors should work together to share these tasks and others, and develop partnerships to deliver clinical care, received a less than enthusiastic welcome from nurses[22], probably because of its "task oriented" approach, and a lack of recognition of the danger of overloading nurses already feeling the gap caused by the loss of student nurses as part of the workforce since the implementation of Project 2000.[23]

Two other studies of expanding nursing roles have been received with more enthusiasm,[24,2] probably in part because the roles were funded as additions to the existing workforce, and because there were some signs of increased quality of patient care resulting from the roles' introduction. Another study of nurse practitioners in acute care is being undertaken in the South West Region but has not reported yet.[25]

Professional pressure - medicine

Yet another set of currents which are swelling the tide for change come from the medical profession. The "New Deal"[1] is the most obvious of these, and has already been discussed earlier in this chapter, and at length in the report from Trent Taskforce[2]. Few nurses would deny that there are overlapping areas in the work of junior doctors and nurses, but there is understandable caution to take on extra duties either in a piecemeal or task oriented fashion, without the provision of additional nurses, and unless the nurses can see the extra duties contributing to quality of care for individual patients and as a true expansion of the nursing role.

Another current in the medical "stream" relates to the implementation of the Calman Report on the training of hospital doctors[26]. One effect of this will be to reduce progressively the contribution of doctors in training to service provision in the NHS. Inevitably this pressure forces mangers to look for other ways to achieve the work - some will be done by consultants and non-training grades of doctor, but nurses will also increasingly be asked to bear the load.

A third current in the medical stream centres around the organisation of medical work, particularly with regard to the role of the consultant and the structure of the traditional "firm". The Audit Commission's recent report[27] states better organisation by doctors could improve patient care, and also recommends a review of the way work is divided between different healthcare professionals. A series of articles in BMJ in the spring of 1995 also sets out views on these matters. Moss[28] includes "changes in the relationship between doctors and other healthcare professionals, with, for example, the introduction of nurse practitioners" in her list of pressures for altering the role of consultants. Moss particularly stresses the need for genuine teamwork, where the consultant is no longer the controller of beds, but the medical contributor to a multi-professional specialist team. The focus, Moss[28] says, should be on meeting the needs of patients.

The current of new ideas about healthcare

This focus on patients leads to consideration of another source of the currents swelling the tide for change in roles at the interface of nursing and medicine. The last decade has seen a number of initiatives, first in the USA and Canada, and then in the UK, based on the idea of re-organising the processes of care by looking first and foremost at the needs of groups of patients with similar diagnoses. "Case Management"[29,30] is one frequently used term which was formerly associated with social and psychiatric care and has been adapted to describe a way of controlling both quality and cost containment in hospital care, although the transition to community care is also covered. Petryshen and Petryshen[29] state that the case management approach is characterised by the following features. It

- "establishes patient outcomes, services and resources within the context of an appropriate length of stay,
- uses a patient-centred focus and multi-disciplinary teams to ensure collaborative planning,
- organises and co-ordinates patient care over an entire illness episode,
- promotes autonomy in clinical practice."

Petryshen and Petryshen[29]

The principal tool used in case management is the care map, which generates for specific case-types (usually associated with diagnostic-related groups) a problem list with expected patient outcomes, and a critical path of expected events day by day. Frequently the appointed case-manager will be a nurse, and charting is often by exception, noting variances from expected outcomes and daily events. Hale[31] reports that claimed advantages for the system are reduced length of stay, improved quality and more efficient use of resources, but that the evidence for these is weak.

"Managed care"[32] is a term which encompasses case management but also covers other similar initiatives such as "Anticipated Recovery Pathways"[33] and "Patient-focused care."[34]

The various forms of managed care all seek to examine in a systematic way the key components of care and typical pathways of delivering it. Laxade and Hale encourage nurses to accept the challenge of case management, extending their accountability from covering only nurses in a single ward area to covering multidisciplinary providers and patient settings; they warn that

> "nurses do not have an automatic right to be case managers, and if they are not willing to extend their current levels of responsibility and accountability, other health professionals will quickly take over the role".
>
> Laxade and Hale[32]

The NHS Executive's Value for Money Unit recently published a study on "patient progress methodology"[35] which has much in common with philosophies of managed care. The study observed that the medical/nursing interface contained much overlapping work and recommended nurses taking on new roles, but also receiving more support in clerical, administrative and housekeeping aspects of their work.

A final tributary of the current of new approaches to the process of healthcare delivery is "re-engineering"[36-37]. This technique, up till now only used in private sector companies, has been defined as

> "fundamental re-thinking of, and radical design processes to achieve dramatic improvements in critical contemporary measures of performance such as quality, service cost and speed."
>
> Hammer[36]

Re-engineering is being implemented currently at Leicester Royal Infirmary[37] and the project evaluated by the Sheffield Centre for Health and Related Research (SCHARR). It is inevitable that such re-engineering will involve radical ideas about changing professional roles.

The pressure of discontent

The final current to be considered as part of the rising tide may perhaps be described as a groundswell, and sometimes an undertow. This is frequently demonstrated in the correspondence columns of nursing journals, sometimes in letters marked "name and address supplied", bemoaning the overwhelming burdens of nurses because of increased patient throughput and turnover, and expressing regret that the writer cannot give the quality of care he or she would wish. The same groundswell is expressed in patient complaints, either formal or informal, particularly about lack of co-ordination of care, about waiting time in accident and emergency (A&E), and at times when patients and staff cry out "there must be a better way of doing things!" Sometimes these feelings show up in patient satisfaction surveys, when the questions are specific rather than global.[38] The pressure here could be described as "bottom-up" rather than "top-down".

There is no doubt, therefore, that the tide of pressure for changes in professional roles has been rising fast in recent years. We turn now to considering in practical terms how these changes may be approached.

The structure of this report

The report is intended to be both practical and useful. Drawing on the lessons learned in the first round of Trent - funded nursing innovations[2], and the issues discussed in this chapter, the author first poses questions that individuals and organisations considering instituting new roles for nurses might usefully answer in the light of their own particular situation and corporate characteristics. If the answers indicate that nursing developments may be a useful way forward, then the remainder of the report offers some guidance about the structures and processes highlighted as important by the first round participants. Suggestions are then made about outcome measures that may form part of the evaluation that should be an

obligation for managers setting up new patterns of working. In 1992, the Advisory Group for Health Technology Assessment recommended

> "the costs of providing unevaluated new forms of care within the NHS should be met only if they are being offered within the context of properly designed research to assess their effects".[5]

How this report was compiled

This report will probably be most useful when read in conjunction with the author's report to the Trent Taskforce[2]. The evaluation of the 32 pump-primed nursing roles took the form of multiple case studies with some cross-case analysis. The individual case profiles themselves reveal many pointers on the setting up of new roles, but for the purposes of this report, the raw data was reviewed again, as well as specific notes made by individual postholders, about the processes they adopted in establishing their roles. Explicit guidance about setting up new posts was extrapolated, whilst the author was also noting factors implicit in the participants' accounts of progress or lack of it. At various points in the research process discussions were held with postholders and managers on the topic of measurable outcomes; these opinions, and any recorded experiences of their application in practice were also used for this report.

In addition the author circulated a questionnaire to study participants early in 1995, two months after the main report was finished. Full details of this are to be found in Appendix 1, but information from the responses to the questionnaire is incorporated in the sections of this report which deal with issues of structure, process and outcome in setting up new nursing posts.

Chapter Two - Deciding whether to set sail - What questions need asking - and who needs to ask them?

Before any decision is taken to introduce new roles at the interface between nursing and medicine, many questions need to be asked, and they need to be asked at various levels, within both provider and purchaser organisations. In addition, as suggested elsewhere[2] questions of policy need addressing at national level by government health departments, by the NHS Executive, by statutory bodies responsible for the regulation of the different healthcare professionals, and by the various professional bodies such as royal colleges, and other organisations that represent the professions. Although developments will continue at a practical level, even if the questions of policy are not addressed, the developments would be much more securely based if a clear policy framework is achieved.

The questions suggested first, however, are those that need to be asked within provider organisations.

Questions for providers

a. Preliminary analysis

1. What problems are we facing now that indicate that reconfiguring professional roles is needed?

   in particular specialties?

   in particular departments?

   in entire directorates?

   in the entire trust?

2. What problems might we face in a year (or two years) when our business has expanded or altered?

3. Are we meeting our "New Deal"[1] targets for junior doctors hours worked, or for work intensity?

4. Are we short of junior doctors because of changes in training arrangements and the implementation of the Calman report?[26]

5. Have we a good supply of skilled and experienced nurses? Are they experts?[18]

6. Are we making progress in terms of clinical effectiveness?[8]

do we have specific programmes?

are we experimenting with "managed care" initiatives?[29-35]

7. Is the organisational climate right for introducing new roles?

have there been any recent crises over quality of care or staff cuts?[2]

is there a multi-disciplinary team approach?[28]

8. Could we give our patients a better service by reconfiguring roles?

b. The range of options

9. Is nursing the answer, or is something else?

10. Could improved support services help?

- clerical support on the ward - amount and timing.

- better co-ordination between medical records, waiting list officers, consultants' secretaries?

- technical services such as phlebotomy and ECG - is "out of hours" catered for?

- is there an IV additive service?

- are portering/message services adequate?

11. Could multi-disciplinary records help?

12. Would better bed management/an admissions unit help?

13. Are new policies and protocols needed?

for nurses to request investigations

for better standing order drug arrangements?

for legal cover generally?

14. Are the workloads of all levels of doctor too high?

are clinics for patients with chronic diseases overloaded?

can staff other than consultants discharge patients from wards or clinics?

15. If nursing developments are thought to be appropriate, is it at the level of all qualified nurses? (ensuring skills such as the "Greenhalgh" six?[21])

or is it by

introducing "case management"[29-32]

introducing "nurse-led" care?[2, 19-20, 24-25, 39-40]

16. Is nurse-led care in particular specialties likely to help?

pre-admission clinics? [2, 41-42]

chronic disease management? [2, 39,-40]

A&E (minor injury service)[43-45]

other acute specialties[2]

e.g. psychiatric emergencies

post-operative analgesia

gynaecology

Questions for purchasers including GP fund-holders

17. Do our providers recognise the need for better support services for the clinical teams?

18. Can the quality of services we need to purchase for our patients be improved by the development of new roles at the interface between nursing and medicine?

19. Can we negotiate with our providers for the provision of more effective care by reconfiguring nursing roles without sacrificing patient safety?

20. How may we best work with our providers to encourage innovation, and the closer teamwork of doctors and nurses?

21. Are we prepared to fund evaluation of new developments?[5-6]

Questions for purchasers, providers, educationalists and policy makers

22. Does the content of pre-registration nursing education need to change?

    e.g. should all nurses be taught to cannulate, do ECGs?

23. Can Project 2000 nursing education prepare nurses for high technology acute care and for community and primary care in the same course?

24. Is there widespread provision of post registration education for

    technical skills?

    specialist roles?

    advanced roles?

25. Can investment in post-registration education be addressed urgently, so that development of advanced nursing practice is not hindered?

26. Is there scope for multi-disciplinary education and skills training for students in medicine, nursing and professions allied to medicine together?[28-32] (particularly in case management and other managed care approaches)

27. How will new specialist and advanced nursing roles fit with existing clinical nurse specialist roles? Is there a need for new patterns of relationship and career structures?

28. Is the time right for radically re-thinking the structure of "the firm", and forming new specialty teams of doctors, nurses and professions allied to medicine?[27-28]

29. Is there a commitment for rigorous evaluation of new roles and forms of clinical organisation?[5-6]

30. Are the skills needed for change management present within the organisations?[46-47]

What next?

If the answers to these questions prompt the decision by providers to move ahead in developing new nursing roles, and this decision is supported by the purchasers, then the ensuing chapters may help to get the voyage under way.

Chapter Three - Chartering the Ship - What are the structural considerations?

Continuing the sea-faring metaphor, this chapter describes the structural aspects inherent in planning new roles for nurses.

If multi-disciplinary clinical teams have taken the necessary time and trouble to discuss amongst themselves the questions raised in Chapter Two, they should have reached some clarity about how best to achieve changes in the way the clinical workload is shared between doctors and nurses. Many of the principal topics discussed in this and following chapters will be equally relevant, whether the proposal is to set up specific new nursing roles at the interface with medicine, or whether to alter the working practices of a whole range of nurses.

a) **A clear, written proposal** should be made, setting out the rationale for the changes based on an identification of the problems which exist and how the proposed changes are expected to contribute to their solution. This proposal should set clear aims and objectives, stating the resources needed, outlining the expected timescale, defining training needs and policy implications, and planning for the management of changing roles. Such a proposal could usefully follow the pattern of an outline research proposal, particularly if funding is being sought from a trust board, a purchasing authority, or a regional taskforce.

Experience in Trent Region has shown that written agreements about objectives for new posts and how they are to be achieved can be very helpful. It is all too easy for assumptions to be made that all team members (nursing, medical, technical and managerial) are in agreement; the discovery that agreement and commitment were lacking may only be made when problems arise. A number of participants in the Trent scheme suggested that the simple expedient of following each planning meeting to discuss new

roles or their implementation, with a quickly circulated paper noting points agreed and requiring assent, should increase clarity of expectation and enhance commitment.

Further discussion about achieving clarity and commitment follows in the chapter headed "process", in the section on sharing the vision.

b) **A profile of desirable characteristics** for the intended postholder(s) should be built up, where specific new nursing roles are planned. Attributes suggested by Trent scheme participants include:- patience, perseverance, determination, resilience, flexibility, hard work, self-motivation, ability to organise self and others, knowledge of how the NHS works, assertiveness without arrogance, clinical skills, skills in communication and negotiation, and the ability to conceptualise. Literature quoted in the Trent Report[2, 48-50] also suggests desirable attributes for nurse practitioners or clinical nurse specialists; these attributes include:-

an ability to use clinical knowledge in a sophisticated way,

a strong awareness of accountability,

skills in clinical assessment, decision making and problem solving,

an appropriate mix of autonomy and interdependence,

an interdisciplinary organisational perspective.

It is important that planners of new posts should be aware too of professional qualifications required by applicants, and whether such applicants are actually available internally or externally. In a few instances within Trent, the start-up of posts was delayed because of lack of suitable applicants. Difficulties can also arise if postholders are appointed under a misapprehension of their capabilities.

c) **A clear picture is needed of the premises and equipment** that are required for new types of post to function. Most of the nurses in the first Trent scheme required as a minimum a desk, a filing cabinet and a telephone line. Many required access to a computer, a telephone answering machine and a "bleep". Some needed a private area to interview and examine patients, space for patients to wait, and a place to display literature. Unless these requirements are resourced and planned well in advance, delays may occur when the role cannot be fully operationalised; one postholder had to join a waiting list to be issued with a "bleep" for several months. Occasionally building alterations may be needed to adapt clinical premises for new ways of working; one post's implementation was delayed for this reason. Another's work was severely disrupted after a few moths in post, because of refurbishment of operating theatres. Such delays cannot always be avoided, but certainly inquiries should be made when a post is being planned , to find out if any contextual disruption is likely.

Another factor relating to premises is that of distance between facilities used; in some cases, postholders have to be available to clinics distant to their own working base, or have access to pharmacy or investigative facilities at a distance. Time needed for transit has therefore to be recognised.

A decision also needs to be made about whether the new postholder should wear a uniform, and if so, what type.

d) **A realistic estimate is needed of how long it will take to implement the new role(s)**. Consideration should be given to the possibility of setting up a pilot study to test the effectiveness of a new role. In any case, during the exploratory stage a literature review should establish the existence of similar schemes, and efforts be made to investigate these. Resources need to be made available so that teams can visit sites for this purpose.

Even where the likely effectiveness of a certain role is not really in doubt, trial may very well be needed of particular procedures or ways of working. For instance, in one hospital setting up a pre-operative assessment service, the original intention was to send written invitations. Given the time constraints imposed by clinicians' delay in drawing up operating lists, telephone invitations were found to be much more effective.

A choice will need to be made as to whether to implement a new role or service in its entirety right from the beginning, or whether to phase in aspects of it in an incremental fashion. Sometimes the latter is inevitable, if totally new competencies have to be acquired which involve training and supervised practice over a long period. But even when this is not the case, too rapid implementation may put so much pressure on the service or postholder that opportunity for reflection is lost. Recognition must also be given that it takes time for a new postholder to develop expertise and confidence, and for new relationships between doctors and nurses to take root. In the post-study survey reported in the appendix, almost half the 21 respondents to the question about time taken to become competent in the role reported that at least 6 months had been needed. It may be helpful to make a timetable for development, with targets to be reached at certain stages included.

When time requirements for implementing new roles are considered, time must be allowed for continuing educational development for the postholders, also time for research involvement. When a new role occupies just part of a nurse's time, care must be taken to protect that time from encroachment of other duties. When a scheme involves altering the duties of a whole range of nurses, for instance adding cannulation skills to night staff's competencies, time allowance must be made, not just for initial training, but also for supervised practice, when such opportunities for practice may not occur very frequently.

e) **The need for new types of documentation** must be recognised early in the planning stages for a new role, also consideration given to the need for clerical support. Multi-disciplinary records, which are shared by doctors, nurses and professions allied to medicine, are increasingly being adopted when new interface roles are introduced. Such records save time and duplication of clerking effort, particularly during pre-operative assessment, and can be especially helpful for discharge planning which should begin before the patient enters hospital. However, negotiation and production of new records can be a very lengthy process, involving many disciplines including medical records and clinical audit departments, and passage through a number of committees. All this should be recognised, and time allowance made.

Just as the need for junior doctors to receive clerical support is fairly widely accepted, so should be the need for this service for nurses in new roles, particularly in out-patient settings such as pre-admission clinics.

Conclusion

If these structural considerations (getting a proposal written, profiling characteristics for the postholders, deciding on the need for premises and equipment, outlining a timescale for development and planning for new documentation) are dealt with then the organisation should be ready to set sail on the voyage of development of new roles.

Chapter Four - Organising life "on board" - What processes are needed?

The structural considerations discussed in the previous chapter are also inevitably involved in the process of creating new nursing roles. Producing a clearly written proposal for change cannot be done overnight, and demands discussion and collaboration between disciplines if it is to meet with any success. Building up the necessary information to make a profile of postholder characteristics, to obtain a clear picture of what premises and equipment are needed, and to make realistic time projections and an assessment of need for new documentation all involves those setting up the role in a succession of processes which are discussed in more detail in this chapter.

a) Sharing the vision and gaining commitment

The process of creating new roles for nurses at the interface with medicine begins with whoever first has the vision of what can be done within a particular situation. That person from whatever discipline, be it nursing, medical or managerial, must engage the commitment and support of all the others within the directorate whose co-operation will be needed, at an early stage in planning. The production of a clear proposal can be a most useful tool in sharing the vision and gaining commitment.

Obviously the number and variety of people who need to be involved will depend on the nature of the role being planned. For instance, if it is pre-operative assessment, then the consultant surgeons whose patients are to be assessed must agree with the nurse manager how much responsibility the nurse or nurses can take. The anaesthetists also need to be committed to the plan, as well as managerial staff in outpatients and medical records, and consultants' secretaries, in order for lists and patients' notes to be prepared in advance. Diagnostic departments also need to be involved in discussions because of the need for nurses to request tests for patients. Clinicians and business managers in the

directorates need to be committed, as they may have to negotiate new contracts with purchasers to cover the service. Ward nursing staff and junior medical staff also need to understand how changes will affect them, otherwise work done at pre-admission clinics will be duplicated.

Planners of new roles must be realistic about what the postholder can be expected to achieve, and how much support she or he will need. The implications for different team members must be spelled out, not just left to the imagination. Again, taking pre-operative assessment, consultant surgeons must be prepared to select their list for elective operations well in advance, otherwise the new system cannot work efficiently; anaesthetists have to be prepared to come to the pre-admission clinic to examine patients where necessary and to draw up detailed protocols so that otherwise fit patients are not required to wait to be assessed.

Taking another example of commitment needed by medical staff - that of the introduction of accident and emergency (A&E) nurse practitioners (ENPs). Medical staff at middle grades in A&E have to be willing to be consulted for a second opinion on occasions, particularly when ENPs are first in post and lacking in confidence.

In directorates where there is already a strong commitment to multi-disciplinary team working, the establishment of new roles at the interface will take place much more easily. Where new policies allowing nurses to sign for investigations and referrals are needed, or alterations are required in pharmacy arrangements over standing orders, ample time must be allowed for policy negotiations, especially where decisions have to be referred to advisory committees, or to the trust board or legal advisers.

Where pump-priming money is being sought for new posts, financial arrangements for recurring costs on a regular basis must also be made, and watertight agreements reached. It is very distressing if a new service is set up with pump-priming finance, only to be discontinued when the money runs out.

b) Setting the boundaries

Aspects of this process have already been touched upon, because some decisions about the level of nursing responsibility have to be undertaken early in the process of gaining commitment. However, there is a tendency for some members of the medical profession to try to delegate tasks to nurses inappropriately and with inadequate preparation and training, and so great care needs to be taken to explain to all concerned how the principles in the "UKCC Scope of Practice[14]" document are worked out in practice. As soon as a postholder is identified or appointed, she or he should be fully involved in the negotiations about the parameters of the role, and at each stage of the discussions following the meeting written summaries should be circulated amongst participants so that there are no misunderstandings about what has been agreed. This applies equally to protocols stating, for instance, which patients require a full anaesthetic assessment, or which A&E patients are eligible to be treated by nurse practitioners. It is important for newly appointed nurses in interface roles to check with investigative departments such as x-ray and laboratories that arrangements for signing forms are properly agreed, rather than just relying on the assurance of the consultant in their own specialty.

In the Trent scheme recently reported,[2] some nurses said that they felt more like doctors' assistants than advanced nursing practitioners. They were expected to perform routine technical tasks with little opportunity to exercise nursing knowledge or make autonomous decisions. Every effort should be made to locate new posts firmly within a nursing framework, not only to avoid the feeling of professional isolation experienced by some

postholders, but also to prevent fragmentation of care for patients when they might feel as though they were travelling along an assembly line.

Communicating, informing, communicating, informing.....

Much of what has already been suggested about writing the proposal for the creation of a new post, defining desirable characteristics for the postholder, sharing the vision and setting the boundaries involves communication. The importance of this cannot be stressed too much. During the research into the first round of Trent- funded posts[2], there was more than one consultant who replied to a questionnaire about the work of the nurse practitioner in his or her specialty, "I do not know of a nurse practitioner in my department". It is obviously important for communication about new roles to be both personal and verbal, as well as written. Information should be circulated to staff on the periphery of the new role's influence as well as to those most closely concerned, including community - based staff where appropriate, and to general practitioners in some cases. (both fundholders and others). Care should be taken to provide information as appropriate to the hospital switchboard and information/reception services, hospital newsletter, and to the staff training department. It is also important to communicate about the new role progressively. In some specialties, junior medical staff rotate every 6 or 8 weeks so constant information is needed.

d) Training and education

The issue of training, like communication, has already been mentioned in the chapter on structural considerations. It is absolutely vital that the instigators of new nursing roles should build into their timetable ample time for training for postholders, and into their budget proper resources for that training and also for assessment for competence. New postholders may benefit from visits to other hospitals, attending conferences and study days, and time to go to their library. Provision for buying reference books to keep in the clinical area may also be needed.

Organisational arrangements for training must be thought through, and made well in advance. Organisers of new roles need to know in detail about the educational and training needs of the postholders, and discuss these with them. Perceptions of medical staff and nurse managers may vary in this respect; in some of the Trent funded posts which were rather medically oriented, the nurse postholders would have liked more education about the rationale and medical context for the tests they were trained to perform. A few posts were delayed in their implementation by many months, because the training was just not available, or was very difficult to arrange. This should have been foreseen and planned for, thus avoiding much frustration. When training needs to be provided by staff in other directorates, commitment to this provision needs to be given at a high level in the organisation.

Training for certain core skills needed by nurses expanding their roles is similar to that needed by pre-registration house officers although PRHOs often do not receive the training they need. It may be possible for nurses and doctors to be trained together to undertake a number of tasks such as venepucture, cannulation, giving IV drugs, ECG recording, catheterisation, and to receive joint education about the requirements for requesting investigations either radiological, pathological or harmotological.

A number of participants in the first round of Trent-funded nursing posts found difficulty in obtaining enough practice in these clinical skills to achieve initial competency, or to maintain competency as a matter of routine. This may be a particular problem for staff working at night or at other times when opportunity for taking blood is limited. Staff in these situations may need to be released for periods to work at different times in order to gain the necessary supervised practice. Proper assessment of skills needed must be carried out - there is no point training a large number of staff for skills they will not use

regularly. It would be better to arrange for cross-covering across directorates for the provision of certain skills, so that those who really need them can practise enough to maintain those skills in a competent fashion.

In some hospitals technical services such as phlebotomy may be under threat, despite their value as a support to both medical and nursing staff, and so particular sensitivity is needed when nurses need training in this skill, that they are not seen as an added threat.

Agreement over assessing competence in clinical skills is needed between nurse managers, consultants and postholders, and time must be allowed for this process. As more nurses become skilled in the activities listed above, peer review procedures will be able to be set up.

As well as making provision for training for clinical skills, the wider educational needs of nurses in advanced practice must be remembered. These could be in clinically related fields such as anatomy, physiology, biological sciences, pathology and pharmacology, or they may relate more to the organisational aspects of their roles, such as knowledge of NHS management and policy, how to negotiate, how to write protocols, how to make the best use of computer technology, and how to carry out clinical audit.

For many nurses, entry into a new post in advanced practice may be the trigger for accelerated personal development; managers planning new roles need to be aware of this, and allow opportunity for such growth to flourish. There may come a point where further role development requires the original postholder to move on; succession planning should ensure that replacements are trained by the original postholder as a matter of routine. Such training ensures that continuity of the new service is assured, as well as leaving the original postholder with the option to expand further.

e) Providing Support for Postholder and Managers

Some mechanism for support, mentorship and clinical supervision needs to be built into the arrangements for setting up new posts. In the Trent-funded schemes, some postholders were extremely experienced in their specialty, sometimes as sisters, or as clinical nurse specialists. But even these highly experienced people felt a kind of isolation in their new roles, and expressed a desire to network with others in similar roles. Some nurses setting up new services, such as pre-operative assessment, would have welcomed opportunities to visit other clinics where this was already established. Particular problems of isolation were experienced by new postholders whose nurse managers left or went on extended sick-leave soon after they took up their new role. Special care needs to be taken by managers to ensure continuing support for staff in these circumstances. Problems too occurred for some post-holders when one or more consultants retired, left or were sick for long periods - often the locum consultants did not have the commitment to see that the flow of work required for the success of the post was maintained.

Nurse managers responsible for new posts also expressed the need for guidance over evaluating effectiveness. Because of the exploratory nature of the research into the posts carried out by the author, some managers felt they were not given clear enough criteria for monitoring their schemes, nor enough feedback during the evaluation of their own or others' progress. Consideration should therefore be given to helping clinical management teams to set up good practices in evaluating their own schemes.

f) Expecting side-effects

It is inevitable that reconfiguring roles at the interface between nursing and medicine will cause a variety of effects - some helpful, some less so, some expected, some unexpected. The recent report to Trent Taskforce[2] spelled out the effect on junior doctors' hours and workload, and to a lesser extent the effect on consultants, and on the quality of patient care as perceived by participants in the schemes. This report explains some of the other effects of the introduction of new nursing roles, not because such effects will inevitably occur in other schemes, but to illustrate possibilities of what might happen, and to alert future role-planners to watch for the unexpected or the serendipitous.

In some hospitals, the presence of the new postholders acted as an inspiration to other nurses, who then considered how their own roles might be expanded. The examples of teamwork between doctors and nurses involved in the Trent schemes also acted as a spur to some consultants, to see how their own team could work better together.

The increases in efficiency achieved through nurses organising the pre-admission clinics and day surgery lists also encouraged other teams to look at similar developments. In some cases, the organisation of pre-admission clinics highlighted faults in the system which were then remedied - particularly in the co-ordination of admissions between waiting list clerks, consultants' secretaries and nurse practitioners. One hospital set up a working group to sort out its admissions system when its deficiencies were revealed following the appointment of a nurse practitioner in surgery.

However, increased efficiency in surgical admissions may increase junior doctors' workloads by raising the bed-occupancy rate. This is good from the point of view of

efficient use of beds and facilities, but may cause consternation because the junior doctors thought the pre-admission nurse was going to save them work, not increase it!

The presence of nurse practitioner roles in A&E or in outpatients may also cause junior doctors extra work if those NPs are not replaced by other nurses. Whilst the NPs are carrying out their autonomous roles, assessing and treating patients, they are not simultaneously available to be a helper to the junior doctor, to apply bandages or clean ears or to do whatever else might be requested.

Another difficulty presents itself when experienced nurses in A&E take on NP roles for part of their working week, or at certain times when the department is busy, or short of doctors. This is the difficulty of balancing the needs of the A&E department as a whole, to which a senior nurse is inevitably drawn, with the needs of particular patients with minor injuries, for which as NP, she or he is responsible.

Some hospitals have found that introducing advanced nursing practice roles for part of the time has raised expectations that cannot be met when that particular post-holder is not present. Others have found that while the postholder extends the quality of service on offer, no-one else's work has actually been reduced.

In the recently reported Trent Scheme[2], a few junior doctors complained that their training and experience was depleted by the appointment of the new nursing post-holder. Planners of new roles must ensure that training opportunities for doctors are not decreased. Finally, some clinical assistant grades of medical staff feel threatened by the development of nurse-led care in outpatient departments - they fear they may lose their jobs.

Conclusion

If the processes outlined above are followed in appropriate ways for the particular organisation, then the voyage will be underway. Consideration must also be given at an early stage, however, to steering the ship, and to charting the progress of the voyage to make sure the destination is reached.

Chapter Five - Looking out for landfall:

what outcomes are appropriate?

Probably the most difficult part of introducing new roles in the NHS, or changing working practices, is measuring the effects of the changes - which is why so often no real attempt at measurement is made. Time after time new services or forms of NHS organisation are brought in and proliferate without proper evaluation.[5, 51-52.] But in these days when "knowledge - based care"[6] is given such priority, we must search for ways of testing whether we are achieving what we set out to do, and whether there are other consequences either good or bad. In the study of the first round of Trent Taskforce funded nursing posts,[2] evaluation was acknowledged to be largely based upon peoples' perceptions about the scheme's effectiveness. Junior doctors and consultants were asked about how the introduction of new nursing posts had affected juniors' hours and intensity of work, and postholders and nurse managers were asked about achievement of objectives and improvement in patient care. Staff were asked for audit evidence of the effects of the changes but very little useful data was delivered. Postholders and managers appeared to have real difficulty in conceptualising the measurement of outcome; in the post-study survey (see Appendix 1) many of the postholders' replies on the subject of suggested outcomes were simply "number of patients seen". Nine of the nineteen managers who replied omitted the outcomes question altogether.

The effect of new roles on junior doctors

It is not difficult to specify some possible effects of the introduction of new nursing working roles and practices on junior doctors. Such things as actual hours worked, intensity of work, number of interruptions because of being "bleeped" during the day, the evening or night, (either when on a shift system, or when resting but on call) are all obvious items to measure. The difficulty here is actually measuring them, because any recording system inevitably

becomes another distraction or infringement of precious time. Such systems are also complicated to set up because of the large numbers of junior doctors impacted by any change in working practices, and the frequency with which some of the juniors change specialties or firms within specialties. However, this quantitative measurement must be tackled.

More qualitative measures are also important in assessing the effects of new roles on doctors - such things as subjective measures of health and stress, job satisfaction, time for education and opportunity for clinical experience are all relevant. It would also be useful to find out what doctors do with the time saved by the introduction of new nursing roles.

To measure either quantitative or qualitative factors in a meaningful way, evaluators need to measure the items before the introduction of new nursing roles, and then repeat the measures when those roles are well established. Therein lies another difficulty - the length of time taken to establish new roles may mean that a completely different set of junior doctors are in post for the second set of measures, which threatens the reliability of the results because of the different capabilities of doctors with regard to the use of their time.[27] Differences in the way hospitals are organised, or even in the organisation of different directorates within the same hospital make comparisons of similar specialties, with or without new nursing roles rather a difficult proposition. "Before and after" studies are more likely in reality to compare like with like, despite the problems of doctor turnover. Such studies may be particularly rewarding when "nurse-led" care is introduced for patients with chronic disorders attending outpatients clinics on a long term basis.

The effect of new roles on nurses

Various approaches may be used to evaluate the effect of role changes upon the postholders, their nursing colleagues and other professional staff. Case study methods, combining interviews, questionnaires, document study and site visits, such as were used in the Trent

study,[2] are one way of tackling this evaluation. Observation and activity analysis, as adopted by the Greenhalgh[21] team studying the interface between nursing and medicine, are other possible methods. As the number of hospitals increases where changes in nursing roles are introduced, survey methods for finding out what is changing and how nurses and other staff are reacting may also be valuable, in conjunction with study of the organisational and financial implications for trusts, and in aggregate, for the NHS.

The effect of new roles on patients

The most urgent questions, however, and probably the hardest, cluster around the effects on patients and their care and treatment, of the introduction of new nursing roles. When nurses are carrying out procedures and making decisions which were formerly the responsibility of doctors, we have to ask first whether this affects patient safety, second, whether it impacts on quality and effectiveness of care, and third, whether it is acceptable to patients, [53] and improves their quality of life.

Donabedian[54] defines patient outcome as "a change of status confidently attributable to antecedent care". In relation to measuring the effects of nursing care, Heater et al[55] describe outcome as "the effects of interventions provided by a professional nurse (not requiring a physician's order) that produced measurable responses in relation to identified criteria." As Bond and Thomas[56] have succinctly put it, "the problem for nursing, then, is determining whether nursing alone can be said to be responsible for a particular patient outcome". So many other variables may also be influencing that outcome - the actions of other health professionals, patient compliance, environmental and social factors, the body's own restorative processes, age, co-morbidity, and the severity and natural progression of the disease. As Long et al[57] put it

"It is one thing to understand the theoretical and methodological requirements for "true" outcomes measurement, quite another to apply them in real life where effects due to different care processes cannot be separated or where it may be impractical to control for severity or co-morbidity".

Despite this pessimistic (or perhaps realistic) view, efforts continue to measure the outcomes of nursing care,[19, 58] and awareness of the pitfalls at least prevents unjustified conclusions being drawn. In the United States, meta-analysis has been used to demonstrate the effectiveness of nurse practitioners in primary care[59]. The present author attempted to compare minor injury care given by nurse practitioners and senior house officers in an A&E department[60] but ran into methodological problems, especially because many minor injuries are self-limiting and will get better in a few days even if untreated.

Perhaps the most appropriate solution to the problem of attribution of outcome for patients when new nursing roles are introduced is to look at overall clinical outcomes. rather than trying to find specific nursing outcomes. If a "before and after" study is carried out, the change in roles would be considered as a process of team intervention, and any difference in outcomes would then be attributed to that whole intervention.

So what practical advice can be given to those setting up new roles for nurses, so that useful outcome measurement is built into evaluation procedures? First of all, brief summaries are given of important approaches to outcome measurement, from the literature, which have practical relevance. This is followed by suggestions of actual measurements that can be used in evaluating outcomes when particular types of nursing roles are introduced. Work on improving outcome measurement in this context is continuing at SCHARR, funded by Trent Regional Research and Development funds, and the suggestions made here have not yet been fully tested.

What does the literature say?

Long et al[57] divide health care outcome measures into four categories:

- quantity of life
- quality (health related) of life
- satisfaction with health care
- process-based measures (sometimes called intermediate outcomes).

The four types of measure have to be considered in relation to the particular nursing role being introduced. Quantity of life (mortality) measures will only be applicable for some roles and specialties where patients' lives are actually at risk and where nursing responsibility is at a high level. Advice will be needed from statisticians about what periods of time past and future should be compared, and what patient numbers make appropriate comparisons. The developing expertise in clinical audit available in trusts will have much relevance in measuring both mortality and morbidity.

Quality of life measurement is another area of evaluation that is developing rapidly [61-63]. Again, advice may be available from experts within trusts, about the use of validated instruments which are also easy for patients to understand. The prospects are good, however, for making comparisons of quality of life measures at regular intervals for patients attending nurse-led clinics for chronic conditions.

Satisfaction with health-care is an area that has seen much activity in the NHS in the last decade [64-66]. A recent study by Bruster et al[38] demonstrated the importance of asking very specific questions about satisfaction. Despite a general level of apparent contentment with recent NHS experience, patients showed disturbing levels of dissatisfaction with information,

pain management and discharge planning. As well as patient satisfaction surveys, using specific questions about care given by nurses which used to be given by doctors, evaluators could also look at indirect measures of dissatisfaction - patients failing to keep appointments, dropping out of health-care programmes and discontinuing care against advice[54] and other non-compliance evidence.

Long et al's[57] fourth aspect is process-based outcome measurement, quoting such ideas as readmission rates, complication rates and so on. Hopkins[67] gives a useful list of possible outcomes, all based on adverse occurrences; many of these are process-based, or intermediate outcomes. Although the list was compiled with medical or surgical practice in mind, many of the indicators are also applicable to nurse-led care, or as general measures of clinical outcome applicable to changes in intervention by clinical teams.

- Hospital mortality - unexpected death, especially when due to remediable conditions
- Injury to previously healthy tissue
- Unplanned return to theatre/unplanned readmission
- Hospital acquired infection
- Drug problems - errors, or inappropriateness.
- Transfusion/infusion problems
- Lack of action on abnormal investigation result.
- Pressure sores
- Falls and other mishaps causing injury
- Complaints
- Litigation

Information on most of these items should already be available through clinical audit systems. Hopkins[67] also suggests disease specific health status measures such as peak-flow measurement for asthma patients, or depression rating scales for psychiatric patients.

Marek[68] writing specifically of nursing outcomes, gives another useful list of types of outcome indicators, some of which overlap previous categories mentioned in this paper.

- physiological - wound healing, pain or symptom control
- psychosocial - attitude, mood, social function
- functional - activities of daily living, home maintenance
- behavioural - activities, skills, compliance
- knowledge - cognitive understanding
- satisfaction -
- resolution of nursing diagnosis/problems
- quality of life and well being
- goal attainment compared with goals set at beginning of episode
- readmission, use of services, cost of care
- mortality, safety

Marek[68]

Some of the process-based outcomes are entirely based on adverse occurrences (e.g. Hopkins[67]) whereas others (e.g. Marek[68]) are mainly based on positive features. The mirror image situation, of positives and negatives has already been mentioned above, with regard to patient satisfaction and dissatisfaction. The well-known five "Ds" of negative outcome, death, disease, disability, discomfort, dissatisfaction all have their opposites in positive outcome - survival, wellness, ability, comfort and satisfaction. The search for outcome measures for nurse-led care may well focus on positive aspects, in line with nursing's emphasis[15] on holistic care.

From theory to practice in measuring outcomes

Evaluators of new nursing schemes will need to identify a range of outcomes applicable to their particular specialty and emphasis and ensure that adequate monitoring and recording of these factors takes place, so that sufficient numbers of measurements can be built into effective data bases. Great care must be taken in recording the dates over which measurements are taken, and the criteria for allocation into positive or negative categories. Data about patient outcomes must include sufficient detail about age, severity of illness, co-mobility and health history to enable adjustments to be made for these factors when comparing sets of data.

Consideration has been given in this chapter to assessing the effects of new nursing roles on doctors, the post-holders themselves, their nursing colleagues and other professional staff, and on the patients. Managers need to look at all these effects to take an overview, and in addition to monitoring safety and clinical effectiveness within the new patterns of care, will want to look at the difference made to efficiency indicators - such as statistics for throughput, length of stay, bed occupancy, theatre usage, hospital acquired infection, readmissions and complaints.

Measurement of cost-effectiveness, which obviously is of concern to managers, can only be undertaken once a workable system of outcome recording is in place.

To help summarise the content of this chapter so far, figure 1 shows the range of factors which may form the basis for audit and development of outcome measures when evaluating the effect of changing roles within the clinical team.

Figure 1 The range of factors to be considered when evaluating changing roles

Junior Doctors	Nurse Postholders	Patients	Managers
Hours of work Intensity of work Interruptions/bleeps a) when working b) when resting (on call) Job satisfaction Health status Stress Education Perceptions of patient care Perceptions of working relationships	Role content Clinical activity Objectives Education Job satisfaction Health status Stress Perceptions of patient care Perceptions of working relationships	Mortality Morbidity Health status Quality of life Satisfaction Dissatisfaction Disease specific measures Process-based measures e.g. infection, wound-healing length of stay use of medication etc	Patient safety Clinical effectiveness Efficiency e.g. throughput length of stay occupancy theatre use infection rates readmissions complaints

Speciality or role specific outcome measurements

The remainder of this chapter suggests outcome measurements specific to particular specialties, or suitable for particular types of changing roles. Many of these have derived from experience in Trent. In each section, suggestions are made about baseline audit data that is needed, and against which changes can be measured.

Outcomes for pre-operative assessment roles

Baseline data - prior to establishing pre-operative assessment

theatre usage

postponed operations - reasons

cancelled operations - reasons

surgical bed occupancy

proportion of elective surgery done as day cases

analysis of anaesthetics given for elective surgery - local, regional etc.

length of stay for different types of case

patient satisfaction with surgical experience

Data to compare, when pre-operative clinics established

Number of patients attending each clinic, as proportion of number invited.

Proportion of patients entirely nurse-managed.

Number of problems detected e.g. infection, hypertension, diabetes

Action taken e.g. referral to GP

Number of operations postponed

Number of operations cancelled

Number of operations changed from in-patient to day-case and vice-versa

Number of patients referred to anaesthetist for full assessment

Effect on types of anaesthetic given (local, regional, general)

Effect on theatre use

Effect on waiting lists

Effect on length of stay

Effect on post-operative analgesia

Patient satisfaction about clinic attendance, waiting time within clinic, information received, effect of clinic attendance on admission experience.

Outcomes for accident and emergency nurse practitioner

Baseline data, prior to introducing ENPs

Time waiting to be seen

Time waiting for x-ray

Time waiting to be treated

Time in department altogether

Patient satisfaction with treatment

Patient satisfaction with waiting time.

Data to compare, after introduction of ENPs

Percentage of minor injury patients managed by NPs and SHOs respectively.

Comparative case-mix of patients managed by NPs and SHOs respectively.

Numbers and outcomes of X-rays ordered by NPs and SHOs respectively, including fractures detected later, having been missed at first attendance

Time waited to be seen*

Time waited to be X-rayed*

Time waited to be treated*

Time in department altogether*

*When NPs are and are not available, with ability to select certain diagnostic groups for comparison.

Patient satisfaction - with member of staff seen

- with treatment

- with waiting time

Outcomes for nurse-led care (adaptable to various specialties)

Baseline data

Information on case mix

Information on hospital acquired infection, problems with IV infusions, symptom control etc.

Patient satisfaction

Data to compare, after introduction of nurse-led care

Number of patients managed by NPs as percentage of all patients in that specialty/ward/department.

Infection and problem rates when infusions set up by NPs/JDs respectively

Outcomes clinically for nurse-managed patients and doctor managed patients, depending on specialty -

e.g. adequacy of symptom control in chronic disease

frequency of clinic attendance

readiness for discharge

Physiological measures as appropriate.

Health status/quality of life measures as appropriate.

Patient satisfaction - specific points as appropriate.

Specific to nurse-led analgesia

Differences in patient perception of pain in nurse-managed and doctor-managed patients.

Differences in patient ability to move, leading to variation in rate of post-operative complications

e.g. respiratory infections, deep-vein thrombosis.

Differences in patient anxiety and stress levels.

Differences in length of stay

Patient satisfaction.

Specific to nurse-led gynaecological care

Proportion of nurse-managed patients (either partially or completely) to all patients.

Patients' knowledge of their condition, their treatment, their health needs and how to meet them (when receiving nurse-led or doctor led care), demonstrated by changed attitudes and lifestyles.

Waiting times, consultation lengths, of nurse managed and doctor managed patients.

For nurse-managed medical termination of pregnancy patients -

complication rates

admission rates.

Patient quality of life, before and after introduction of nurse-led care

Patient satisfaction before and after introduction of nurse-led care

Specific to nurse-led neonatal care

Time taken for NPs/SHOs to respond to delivery suites/theatres.

Action taken by NPs/SHOs in resuscitation.

Outcomes for babies resuscitated.

Specific to nurse-led psychiatric emergency care

Proportion of emergency calls taken by NPs/SHOs.

Type and length of assessment, action taken.

Length of time between referral and assessment.

Referrals made, and to where

Follow-up information relevant to "Health of the Nation" suicide prevention targets. (Does giving more attention to parasuicides reduce the rate of actual suicide?)

Suggested outcomes for schemes where nurses more generally take on some responsibilities from doctors (process measures mainly)

Number and pattern of calls to junior doctors at different times of day and night and reasons for calls, before and after role changes

Proportion of IV drugs given by nurses/doctors and accuracy of dosage and timing.

Proportion of IV cannulations/recannulations done by nurses/doctors and infection rates for each.

Proportion of out-of-hours ECGs done by nurses and doctors (and response times), and quality of recording and interpretation.

Proportion of male catheterisations performed by nurses/doctors, and response times for each.

Proportion of expected deaths verified by nurses/doctors.

Patient quality of life

Patient satisfaction.

The difficulty of outcomes measurement in patient care has already been explained earlier in this chapter; also mention was made of on-going work in Trent region by the present author and her team to find better ways of assessing outcomes when changes take place in the way clinical workload is shared. So inevitably this chapter can only be tentative. The important thing is that when new roles are planned and implemented, that thought should be given early in the planning process to the form that evaluation should take, and what kind of measurement is feasible. The multi-disciplinary team need to liaise with those in the trust responsible for clinical audit and quality and standards, and must remember that obtaining baseline measurements before changes are made is of vital importance in the process of evaluation.

Chapter Six - Calm sea and prosperous voyage?

Taking its inspiration from Brutus's speech in "Julius Caesar", this report has considered the tide of ideas and events in healthcare which has been rising in recent years around the sea defences of the nursing and medical professions. Questions have been suggested for providers, purchasers, educationalists and policy makers which need answering before the decision to set out on a voyage of change in nursing roles is made. Then, based on the experience of nurses practising in new ways in Trent, and their managers and medical colleagues, ideas have been shared about structure, process and outcome considerations in establishing new roles, to make sure the ship is properly prepared, that life on board is well organised, and that the appropriate compass bearings are followed on the voyage. It remains to be discussed whether the voyage will be safe, or whether there is a danger of shipwreck.

Two recent articles[69, 70] have focused on the way the principles in the "Scope of Professional Practice"[14] can help to maintain safety for nurses and patients, if they are properly applied. Dimond[69] reports six items of concern raised at a seminar in Wales in 1993 about the scope of nursing practice. These were:

- Pressure, exploitation and abuse - the need for nurses to be able to refuse to take on new tasks if there is a danger of the standard of care being compromised.
- Liability and indemnity - the need for nurses and managers to ensure that pressure of work or lack of standards and protocols does not lead to the risk of negligence.
- Lack of support from employers - the need for nurses and managers to agree on the boundaries of the role, and for expansion of the role to be clarified in writing.
- Inability to obtain training - the desirability of provision of adequate training for new roles, and the necessity for nurses to refuse role expansion unless that training is provided.

- Public criticism and lack of confidence in nurses - the need for public education about expansion of nursing roles, so that patients consent gladly to be treated by a nurse instead of a doctor when appropriate.
- Conflicts with doctors who criticise decisions - the need for audit and research to demonstrate to the medical profession that nurses can provide an alternative for some patients.

Dimond's[69] article was written particularly with accident and emergency nurses in mind, but is equally applicable to any branch of the nursing professions.

Wright[70] focuses more on positive aspects of expanding nursing roles, arguing that fundamental nursing skills and values may be enhanced by careful role expansion so that patient care is more personal, effective and holistic. He says

> "It seems that the patient has a chance of better deal. Formal approaches to role expansion can replace the previous "ad hoc" methods - providing safer practice and legitimising what many nurses already do anyway".
>
> Wright[70]

Wright also stresses the benefits of mutual interdependence between doctors and nurses, quoting Dowling and Barrett's study[71] which demonstrated how nurses supervise the practical induction period for new pre-registration house officers.

Wright poses a series of questions again based on "The Scope of Professional Practice". He asks whether new nursing roles will mean that

- Patient care will improve in terms of co-ordination and holistic principles?
- The essential caring values of nursing will be preserved?

- Nurses are competent and have the right knowledge and skills?
- Nurses are aware of their own limitations?
- Management support is forthcoming?
- Education and training for new roles is available?
- Nurses are expanding their roles to improve patient care rather than under duress from management or to improve their status?

These lists of concerns and questions come as a timely reminder of the key issues that must be resolved before new roles are implemented, namely liability and accountability, education and competence, patient-centred motivation, management support, public and interprofessional confidence, and orientation to nursing's caring values. As Hunt and Wainwright[39] have said

> "It does not follow that because certain doctors should not do certain tasks, nurses or midwives should do them. The pertinent consideration here surely is that role expansion should be led by patients' needs rather than by medical delegation or cost saving".

The speed with which nursing role innovation can be expected to proliferate may vary depending partly on the complexity of the particular role, and partly on the attributes of the NHS trust in which the role is situated. Rogers[72] states that if the following criteria are met, an innovation is likely to be disseminated rapidly:

- It is perceived to be relatively advantageous.
- It is consistent and compatible with the values and needs of the organisation.
- It is perceived to be easy to implement.
- It can be tried out by limited experimentation.
- The results are really visible.

Stocking[51] after an extensive study of innovation in the NHS, which drew on Rogers' conclusions, added a few more conditions which if present would improve on the take-up rate for new ideas in the NHS. These were:

- There should be identifiable enthusiasts who have good status, time and energy.
- There should be compatibility with national as well as local policy and professional opinion
- The innovations should be adaptable to local circumstances as well as easily financed.

There is no doubt that the expansion of nursing roles at the interface with medicine is seen to be advantageous to patients and both professions, provided that proper safeguards, educational provision and staff support are in place. Such role developments are certainly compatible with the needs and values of the NHS as a whole, as well as local expressions of it. They can be adapted to suit local needs and tried out in limited experiments which should provide visible results when properly evaluated. However, changing nursing roles is far from easy to do, nor is it a cheap option. Prosperous voyages will only be made where developments are led by enthusiasts with wide backing from their multi-disciplinary team and management , and are carefully planned and sensitively implemented. But the alternative to taking the current and setting sail is to be left in a backwater - as Wright[70] has so recently said

> "In the face of enormous economic, organisational and cultural changes in health care, one thing appears certain - a profession which seeks to erect rigid barricades is doomed".

Appendix One

Post-Study Survey

Two months after completion of the study "The Reduction of Junior Doctors' Hours in Trent Region: The Nursing Contribution" a questionnaire was sent to study participants to illuminate some issues about the setting up of the 32 nursing posts. Each questionnaire was accompanied by an executive summary of the study report, and a copy of the case profile for the particular post.

Questionnaires were sent to 20 postholders. In the remaining 12 cases, the postholder had either left, gone on maternity leave or the post had been discontinued or there were other organisational complexities and difficulties. Questionnaires were also sent to 28 nurse managers to whom the postholders were accountable. In the remaining 4 cases, the nurse manager involved in the scheme had left, or the postholder worked in areas where accountability to a doctor was stronger than to a nurse manager.

13 out 20 postholders responded. 19 out of 28 nurse managers responded, giving a 67% response rate. 24 of the 32 cases were represented by either postholder, manager or both (75%). 8 cases were represented by both categories of respondent, 5 by the postholder only, and 11 by the nurse manager only. All postholders, and 17 of the 19 managers felt that their particular case profile represented a reasonable summary of progress. Where both postholder and nurse manager had replied, there were minor differences of opinion in some cases about who had conducted most of the negotiations, about the organisational complexities involved, about clarity of objectives and about how well developed the protocols had been.

There were 32 responses to the first four questions.

The driving force in setting up the posts was acknowledged to be:

The nurse manager	17
A doctor	4
The postholder	4
Some combination of the above	7

The main negotiator of all the details about the post was reported to have been:

The nurse manager	11
The postholder	9
A doctor	1
A combination of the above	11

The degree of complexity of the organisational arrangements surrounding each post was reported to be:

Minimal by	13 respondents
Moderate by	14 respondents
Very great by	5 respondents

The degree of clarity of the objectives for each post was reported to be

Very clear by	14 respondents
Fairly clear by	16 respondents
Not very clear by	2 respondents

The state of development of procedures that the postholder was expected to follow was reported on by 30 respondents.

Well developed procedures were reported by 6 respondents

Partially developed procedures by 9 respondents

Minimally developed procedures by 15 respondents.

The number of months taken to become competent in the new role was reported on by 21 respondents.

These were:

1 month	reported by	3 respondents
2 months	reported by	3 respondents
3 months	reported by	3 respondents
4 months	reported by	2 respondents
6 months	reported by	7 respondents
10 months	reported by	1 respondent

2 respondents reported that they were still gaining in competency.

Respondents were asked to specify **a particular descriptor for their role**, or the role they were responsible for managing. 25 replied to this.

13 chose to identify with "specialist nursing practitioner"

7 with "advanced nursing practitioner"

one with both the above,

one with "doctor's assistant",

one each with "nurse practitioner" "sister" and "nursing practice facilitator".

The overall picture given by the survey is that many new nursing roles take a lot of time to develop and therefore the time-scale for evaluation should not be too short - a minimum of 18 months is suggested. The nurse manager responsible for the post must allow time for regular reviews with the postholders, and points where the post is lacking in clear objectives and procedures should be recognised and remedied.

Appendix 2 - Derivation of evidence used in the report

(numbers refer to the case profiles in Appendix One of "Reduction of Junior Doctor Hours in Trent Region: the Nursing Contribution". 1994[2]).

Chapter 3 - Structural considerations

a) Clear, written proposal
1, 2, 4, 5, 6, 9, 11, 15, 16, 21, 23, 25, 26, 30.

b) Profile of desirable characteristics
1, 5, 11, 16, 23, 26, 28, 31.

c) Clear picture of premises and equipment
2, 4, 11, 12, 15, 18, 19, 23, 24, 27, 32.

d) Realistic estimate of time needed for implementation
1, 3, 4, 9, 11, 13, 17, 18, 19, 20, 22, 23, 24, 25.

e) Need for new types of documentation
5, 10, 12, 13, 14, 17, 21.

Chapter 4 - Aspects of the process

a) Sharing vision, gaining commitment
all except 1, 20, 28, 31, 32.

b) Setting the boundaries
1, 4, 5, 6, 9, 15, 18, 19, 21, 23, 24, 25.

c) Communicating
4, 5, 6, 11, 15, 18, 19, 25, 26, 27

d) Organising training and education
2, 6, 7, 8, 10, 11, 14, 15, 17, 19, 20, 22, 24, 25, 26, 27, 28, 29.

e) Providing support
1, 4, 6, 7, 8, 10, 12, 15, 16, 17, 19, 27, 28, 29, 30.

f) Expecting side-effects
3, 5, 13, 14, 16, 17, 19, 23, 24, 26

Appendix 3

One NPs preparations for a new role and service (ENT and Dental Pre-assessment)

1. Met with staff from wards and departments
   - medical < surgical / anaesthetic
   - nursing
   - waiting list clerk
   - secretaries
   - x-ray, ECG
   - pathology
   - audiology
   - clinics
   - wards

2. Looked at existing practice in relationship to:

   a) documentation
      - medical
      - nursing
      - other

   b) pre-op screening guidelines/practice

   c) admission procedures
      - medical) for both normal patients
      - nursing) and those with learning
      - other) difficulties

   d) difference between general and local anaesthetic

   e) pre & post op information by (written and verbal)
      - hospital organisation
      - medical/dental practitioners
      - nursing staff

   f) physical environment

3. Tried to get paperwork ready for meeting dates (MAC etc.)

4. Tried to catch and talk to junior doctors.

5. Was aware each group was only interested in <u>own</u> problems.

6. Attended both dental and ENT clinics.

7. Thinking, made plan of action - wider, co-ordinated view.

8. Discussed pre-screening guidelines with anaesthetists.

9. Liaised with laboratories and x-ray re NP signing request forms in accordance with agreed protocols.

10. Requested information for evaluation and audit - not always easily/quickly available (not seen as priority).

11. Discovered once clinics started, that surgical list was badly organised.

REFERENCES

1. NHS Management Executive. Junior Doctors: The New Deal. London: NHSME, 1991

2. Read S, Graves K. Reduction of Junior Doctors' Hours in Trent Region: the Nursing Contribution. Sheffield: Trent RHA/NHS Executive Trent, 1994

3. Department of Health. The Health of the Nation. London: HMSO, 1991

4. Benzeval M, Judge K, Whitehead M. Tackling Health Inequalities: an agenda for action. London: King's Fund Institute, 1995

5. Advisory Group on Health Technology Assessment. Assessing the Effects of Health Technologies. London: HMSO, 1990

6. Department of Health. Research for Health. London: HMSO, 1993

7. NHS Management Executive. Improving Clinical Effectiveness. EL(93)115. Leeds: NHSME, 1993

8. Nuffield Institute. Implementing Clinical Practice Guidelines. Effective Health Care No 8. Leeds: University of Leeds, 1994

9. Warner M. Health Strategy for the 1990s: Five areas for substitution in Harrison A (ed) Healthcare UK 1991. London: King's Fund, 1992

10. Department of Health. The challenges for nursing and midwifery in the 21st Century. London: Department of Health, 1994

11. Department of Health. A vision for the future. The nursing, midwifery and health visiting contribution to health and health care. London: Department of Health, 1993

12. Department of Health/NHS Executive. Testing the vision. London: Department of Health, 1994

13. NHS Executive. A vision for the future. Report of consultation exercise on target development. London: NHS Executive, 1995

14. United Kingdom Central Council for Nursing, Midwifery and Health Visiting. The scope of professional practice. London: UKCC, 1992

15. United Kingdom Central Council. The Council's Standards for Education and Practice following Registration. London: UKCC, 1994

16. United Kingdom Central Council. PREP and You. London: UKCC, 1995

17. Sheffield City Polytechnic. Credit Accumulation and Transfer Scheme. Sheffield: Sheffield City Polytechnic, 1988

18. Jasper MA. Expert: a discussion of the implications of the concept as used in nursing. Journal of Advanced Nursing 1994; 20: 769-776

19. Wilson-Barnett J, Beech S. Evaluating the clinical nurse specialist: a review. International Journal of Nursing Studies 1994; 31 (6): 561-571

20. Evans A, Griffiths P. The development of a nursing-led inpatient service. London: King's Fund, 1994

21. Greenhalgh and Co. The interface between junior doctors and nurses. Macclesfield: Greenhalgh, 1994

22. Cole A. A problem shared. Nursing Times 1994 90; (47): 16

23. Elkan R, Hillman R, Robinson J. Project 2000 and the replacement of the traditional student workforce. International Journal of Nursing Studies 1994; 31 (5): 413-420

24. Touche Ross & Co. Evaluation of Nurse Practitioner Pilot Projects. London: South Thames RHA/NHS Executive, 1994

25. Doyal L, Cameron A. South West Regional Evaluation of Four Nurse Practitioner Posts. Royal College of Nursing Research Advisory Group Newsletter 1995; Spring Edition: 19.

26. Calman K (chair). Hospital Doctors: training for the future. The report of the working group on specialist medical training. London: Department of Health, 1993

27. Audit Commission. The Doctor's Tale: the work of hospital doctors in England and Wales. London: HMSO, 1995

28. Moss F, McNicol M. Alternative models of organisation are needed. British Medical Journal 1995; 310: 925-8

29. Petryshen P and Petryshen P. The case management model: an innovative approach to the delivery of patient care. Journal of Advanced Nursing 1992; 17: 1188-1194

30. Zander K, Etheredge ML. Collaborative care: nursing case management. Chicago: American Hospital Association and Publishing, 1989

31. Hale C. Case management and managed care. Nursing Standard 1995; 9 (19): 33-35

32. Laxade S, Hale C. Managed Care 2: an opportunity for nursing. British Journal of Nursing 1995; 4 (6): 345-350

33. North West Thames Regional Health Authority. Anticipated Recovery Pathways. London: NW Thames RHA

34. Morgan G. The implications of patient focused care. Nursing Standard 1993; 7 (52): 37-39

35. NHS Executive Value for Money Team. The patient's progress - towards a better service. London: HMSO, 1994

36. Hammer M, Champey J. Re-engineering the corporation - a manifesto for business revolution. London: Nicholas Brealey Publishing, 1993

37. The Health Supplement. Process re-design at the Leicester Royal Infirmary. The Health Supplement, 1994

38. Bruster S, Jarman B, Bosanquet N, Weston D, Erens R, Delbanco T. National Survey of Hospital Patients. British Medical Journal 1994; 309: 1542-46

39. Hunt G, Wainwright P. Expanding the role of the nurse. Oxford: Blackwell Scientific Publications, 1994

40. Humphris D (ed). The clinical nurse specialist - issues in practice. Basingstoke: Macmillan, 1994

41. Bond D, Barton K. Patient assessment before surgery. Nursing Standard 1994; 8 (28): 23-28

42. Markanday L, Paltzen H. Brief Encounters. Nursing Times 1994; 90 (7): 38-42

43. Read SM. Patients with minor injuries: a literature review of options for their treatment. Sheffield: Trent Institute for Health Services Research, 1994

44. Read SM, George S. Nurse Practitioners in A&E Departments: reflections on a pilot study. Journal of Advanced Nursing 1994; 19: 705-16

45. Read SM, Jones NMB, Williams BT. Nurse Practitioners in A&E departments: what do they do? British Medical Journal 1992; 305: 1466-70

46. Legge K. Evaluating planned organisational change. London: Academic Press, 1984

47. Gibson JL, Ivancevich JM, Donnelly JH. Organisations: Behaviour Structure, Processes. Plano Texas: Business Publications Inc., 1985

48. Sparacino P, Durand BA. Editorial on specialisation in advanced nursing practice. Momentum 1986; 4 (2): 2-3

49. Fenton MV. Identifying competencies of Clinical Nurse Specialists. Journal of Nursing Administration 1985; 15 (12): 31-37

50. Herbage Busch AM. Is the CNS as house-staff an option? Clinical Nurse Specialist, 1993; 7 (6): 287

51. Stocking B. Initiative and Inertia: case studies in the NHS. London Nuffield Provincial Hospitals Trust, 1985

52. Read SM, George S, Broadbent J. Do formal controls always achieve control? The case of triage in Accident and Emergency Departments. Health Services Management Research 1994; 7: 1

53. Lang AF. Guidelines, Protocols and Outcomes. International Journal of Healthcare Quality and Assurance 1994; 7 (5): 4-7

36. Hammer M, Champey J. Re-engineering the corporation - a manifesto for business revolution. London: Nicholas Brealey Publishing, 1993

37. The Health Supplement. Process re-design at the Leicester Royal Infirmary. The Health Supplement, 1994

38. Bruster S, Jarman B, Bosanquet N, Weston D, Erens R, Delbanco T. National Survey of Hospital Patients. British Medical Journal 1994; 309: 1542-46

39. Hunt G, Wainwright P. Expanding the role of the nurse. Oxford: Blackwell Scientific Publications, 1994

40. Humphris D (ed). The clinical nurse specialist - issues in practice. Basingstoke: Macmillan, 1994

41. Bond D, Barton K. Patient assessment before surgery. Nursing Standard 1994; 8 (28): 23-28

42. Markanday L, Paltzen H. Brief Encounters. Nursing Times 1994; 90 (7): 38-42

43. Read SM. Patients with minor injuries: a literature review of options for their treatment. Sheffield: Trent Institute for Health Services Research, 1994

44. Read SM, George S. Nurse Practitioners in A&E Departments: reflections on a pilot study. Journal of Advanced Nursing 1994; 19: 705-16

45. Read SM, Jones NMB, Williams BT. Nurse Practitioners in A&E departments: what do they do? British Medical Journal 1992; 305: 1466-70

46. Legge K. Evaluating planned organisational change. London: Academic Press, 1984

47. Gibson JL, Ivancevich JM, Donnelly JH. Organisations: Behaviour Structure, Processes. Plano Texas: Business Publications Inc., 1985

48. Sparacino P, Durand BA. Editorial on specialisation in advanced nursing practice. Momentum 1986; 4 (2): 2-3

49. Fenton MV. Identifying competencies of Clinical Nurse Specialists. Journal of Nursing Administration 1985; 15 (12): 31-37

50. Herbage Busch AM. Is the CNS as house-staff an option? Clinical Nurse Specialist, 1993; 7 (6): 287

51. Stocking B. Initiative and Inertia: case studies in the NHS. London Nuffield Provincial Hospitals Trust, 1985

52. Read SM, George S, Broadbent J. Do formal controls always achieve control? The case of triage in Accident and Emergency Departments. Health Services Management Research 1994; 7: 1

53. Lang AF. Guidelines, Protocols and Outcomes. International Journal of Healthcare Quality and Assurance 1994; 7 (5): 4-7

54. Donabedian A. Quality Assessment and Assurance: Unity of Purpose, Diversity of Means. Inquiry 1988; 25: 173-192

55. Heater BS, Becker AM, Olson RK. Nursing Interventions and Patient Outcomes: a Meta-Analysis of Studies. Nursing Research 1988; 37 (5): 303-307

56. Bond S, Thomas LH. Issues in Measuring Outcomes of Nursing. Journal of Advanced Nursing 1991; 16: 1492-1502

57. Long AF, Dixon P, Hall R, Carr-Hill RA, Sheldon RA. The outcomes agenda: contribution of the UK clearing house on health outcomes. Quality in Health Care 1993; 2: 49-52

58. Bond S (ed). Outcomes of Nursing. Proceedings of an Invitational Developmental Workshop. Centre for Health Services Research, University of Newcastle upon Tyne, 1991

59. Brown S, Grimes D. A meta-analysis of process of care, clinical outcomes and cost-effectiveness of nurses in primary care roles. Nurse Practitioners and Nurse-Midwives (Executive Summary). University of Texas - Houston - for American Nurses Association, 1992

60. Read SM, George S. Nurse practitioners in Accident & Emergency departments: reflections on a pilot study. Journal of Advanced Nursing 1994; 19: 705-716

61. Brazier J. The SF-36 Health Survey Questionnaire - A Tool for Economists. Health Economics 1993; 2: 213-215

62. Garratt A, Ruta D, Abdalla M, Buckingham JK, Russell I. The SF-36 health survey questionnaire: an outcome measure suitable for routine use within the NHS? British Medical Journal 1993; 306: 1440-1444

63. Brazier J, Harper R, Jones N, O'Cathain A, Thomas K, Usherwood T, Westlake L. Validating the SF-36 Health Survey Questionnaire: New Outcome Measure for Primary Care. British Medical Journal 1992; 305: 160-164

64. Carr-Hill RA. The measurement of patient satisfaction. Journal of Public Health Medicine 1992 14 (3): 236-249

65. Williams B. Patient Satisfaction: a valid concept. Social Science & Medicine 1994; 38 (4): 509-516

66. Avis M, Bond M, Arthur A. Exploring patient satisfaction with out-patient services. Journal of Nursing Management 1995; 3: 59-65

67. Hopkins A. Outcomes of Care. In: Measuring Quality of Medical Care. Royal College of Physicians: London, 1990

68. Marek KD. Outcome measurement in nursing. Journal of Nursing Quality Assurance 1989; 4 (1): 1-9

69. Dimond B. The scope of professional practice and the accident and emergency nurse. Accident and Emergency Nursing 1995; 3: 105-107

70. Wright SG. The role of the nurse: extended or expanded? Nursing Standard 1995; 9 (33): 25-29

71. Dowling S, Barrett S. Doctors in the making. Bristol: School of Advanced Urban Studies. 1991

72. Rogers E. Diffusion of Innovations. 3rd edition. New York: Free Press. 1983