Nursing: Past, Present and Future

Karen Wild
Registered Nurse, UK

Learning Outcomes
On completion of this chapter you will be able to:

- Understand how nursing has evolved through history
- Have an awareness of some of the philosophical theories that shape contemporary nursing
- Be aware of the values that underpin nursing
- Be aware of the drivers that shape nursing policies and guide current nursing practice
- Understand how nurse education is regulated in the United Kingdom (UK)
- Have an insight into the various roles that nurses undertake in different settings

Competencies
All nurses must:

1. Understand the nurses’ roles, responsibilities and functions to meet the changing needs of people, groups, communities and populations
2. Be self-aware and recognise how your own values, principles and assumptions may affect practice
3. Facilitate nursing students to develop competence, using a range of professional and personal development skills
4. Be able to respond autonomously and confidently to planned and uncertain situations
5. Create and maximise opportunities to improve service
6. Work effectively across professional and agency boundaries

Visit the companion website at www.wileynursingpractice.com where you can test yourself using flashcards, multiple-choice questions and more.
Introduction

In the 2016 National Health Service (NHS) nursing framework *Leading Change, Adding Value*, the focus is very much on looking at shared ambitions to connect with each other as nurses, midwives and care staff. The aim is one of achieving more for patients and people, and also for the profession of nursing.

*Though the world has changed, our values haven’t. As nursing, midwifery and care staff we know that compassionate care delivered with courage, commitment and skill is our highest priority. It is the rock on which our efforts to promote health and well-being, support the vulnerable, care for the sick and look after the dying is built.*

(National Health Service 2016, p. 6)

This chapter and the subsequent chapters within this unit will explore the evolution of nursing and highlight the unique roles that nurses play in contemporary society. It will look at past and current structures of the NHS and health provision in the UK and describe the legislation that supports the professional status of nursing.

<table>
<thead>
<tr>
<th>Jot This Down</th>
</tr>
</thead>
<tbody>
<tr>
<td>When you reflect on your role as a nurse, what would you say was your motivation to care?</td>
</tr>
</tbody>
</table>

In this exercise, you may have identified certain traits in your behaviour or personality that motivate you to care. The need to help others and to respect an individual’s dignity and independence can influence the desire to care. You may see yourself as a naturally caring person, so-called altruistic traits. Work that is challenging and varied might appeal to you; job satisfaction and the ability to work in a team may also help to motivate you as a nurse. You may have considered the characteristics of the role that you have, such as autonomy, feedback (people saying thank you), the variety of skills that you have developed and satisfaction in seeing the completion of an aspect of care. You may also relate your motivation to care in terms of the value that you hold in society and the opportunities you have for personal development and growth within the profession. Some may relate the motivation to the relative job security that nursing brings; its salary and peer support may be significant too. The intellectual basis of nursing and the continued development of knowledge, skills and proficiency may also feature on your list.

The fundamental basis of nursing is associated with caring and helping, and nursing can be described as both an art and a science. Caring defines nurses and their work and, as such, there are many facets associated with the role and function of the nurse. The role is constantly evolving and is difficult to classify.

Nursing has faced many challenges over the last few years, with a number of reports critical of the care that nurses provide within the acute setting. The Francis report (see section of the same name) and the Cavendish, Berwick and Clwyd–Hart reports (Department of Health 2013a–c) were all published in 2013. Of these, the Francis report was most critical of the culture of care within acute settings that allowed a lack of compassion to become commonplace. These recent events have influenced the guidance developed by the Chief Nursing Officer (CNO) known as the ‘6Cs’ (Department of Health 2012) and that developed by the Royal College of Nursing (RCN) known as ‘Principles of Nursing Practice’ (Royal College of Nursing 2010). In Table 1.1

<table>
<thead>
<tr>
<th>THE 6Cs OF NURSING</th>
<th>PRINCIPLES OF NURSING PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Compassion</strong></td>
<td>Principle A</td>
</tr>
<tr>
<td>· Relationships based on empathy, respect and dignity</td>
<td>· Dignity, equality, diversity and humanity</td>
</tr>
<tr>
<td><strong>Courage</strong></td>
<td>Principle B</td>
</tr>
<tr>
<td>· Doing the right thing, speaking up if concerned, strength and vision to innovate</td>
<td>· Ethical and legal integrity, accountability, responsibility</td>
</tr>
<tr>
<td><strong>Care</strong></td>
<td>Principle C</td>
</tr>
<tr>
<td>· The core business of nursing, which helps the individual and improves the health of the whole community</td>
<td>· Safety, the environment, organisational health and safety, risk management</td>
</tr>
<tr>
<td>· Caring defines nursing</td>
<td></td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td>Principle D</td>
</tr>
<tr>
<td>· Central to successful caring relationships; listening is as important as what is said and done. ‘No decision about me without me’; communication key with patients and staff</td>
<td>· Advocacy, empowerment and patient-centred care</td>
</tr>
<tr>
<td>· Patient involvement in care</td>
<td></td>
</tr>
<tr>
<td><strong>Competence</strong></td>
<td>Principle E</td>
</tr>
<tr>
<td>· The ability to understand an individual’s health and social needs</td>
<td>· Communication, handling feedback, recording, reporting and monitoring</td>
</tr>
<tr>
<td>· Expertise, clinical and technical skill to deliver effective care based on research and evidence</td>
<td>· Interdisciplinary and multiagency working; teamwork, continuity of care</td>
</tr>
<tr>
<td><strong>Commitment</strong></td>
<td>Principle F</td>
</tr>
<tr>
<td>· To patients and populations</td>
<td>· Evidence-based practice, education, technical skill, clinical reasoning</td>
</tr>
<tr>
<td>· To build on and improve care and patient experiences</td>
<td></td>
</tr>
<tr>
<td><strong>Principle G</strong></td>
<td>Principle H</td>
</tr>
<tr>
<td>· Leadership which contributes to an open and honest culture</td>
<td></td>
</tr>
<tr>
<td>· Nurses leading by example</td>
<td></td>
</tr>
</tbody>
</table>

Cave paintings illustrate life events such as birth and death, and there are images that suggest female interaction. Those who lived in the prehistoric period suffered similar conditions to those experienced by society today, and according to Hallett (2010), tribes in those early years took part in caring for their sick and wounded. The role of spirituality and health linked to strange occurrences, such as sudden flooding or times of drought, have helped shape beliefs around supernatural interventions, for example the visitation of evil spirits. Healers or shamans would employ various brews and magical potions to heal the sick. Those responsible for feeding and cleaning the sick were predominantly females.

Evidence to support the evolution of nursing has been gathered and interpreted from hieroglyphic inscriptions, cuneiform writings, papyri and documented histories in the form of drawings, ancient objects and oral traditions.

Ancient History
In Ancient Greece, temples were erected to honour the goddess of health, Hygeia. Care at the temples was related to bathing and this activity was overseen by priestesses. No mention is made of nurses as a separate entity, but temple attendants probably assisted the physicians by ‘caring’ for their patients. Babylonian civilisations from around 3000 BC acknowledged the role of public health measures, such as large stone drains, to cope with human waste.

The foundation of modern medicine was laid down by Hippocrates in Ancient Greece, who is credited with the belief that diseases were caused naturally and not because of superstition or the intervention of gods.

The first hospitals, or xenones, were established in the Byzantine Empire, and are considered the true ancestors of the modern hospital. Later, as the Roman Empire expanded, hospitals were erected. It was Fabiola, a wealthy Roman, who was responsible for the introduction of hospitals in the West. She dedicated her immense wealth to the sick and served as a role model, nursing the sick herself, despite the repulsive wounds and sores of the inmates. The primary carers in these hospitals were young men on the verge of adulthood, who were called contubernales. Slave girls were known to assist Roman physicians. Valetudinariums – civilian hospitals – were kept clean and aired by bailiffs’ wives, who would also watch over the sick.

In the Middle Ages, medical knowledge and development slowed and many of the influences of the Ancient Greeks and in particular the Romans in this country were destroyed. Rome and the Catholic Church dominated the direction of medicine, and throughout the Middle Ages military, religious and lay orders of men provided most of the healthcare. Some of these orders of men included the Knights Hospitallers, the Order of the Holy Spirit and Teutonic Knights. While these men provided care, charlatans and ‘quacks’ provided treatment for money; examples are diagnoses made by the use of astrology and the widely practised treatment of bloodletting, often doing more harm than good. The Black Death was to kill two-thirds of England’s population between 1348 and 1350, and the commonly held doctrine from the church that disease was a punishment from God for sinful behaviour did little to help the poor and uneducated. Figure 1.1 depicts the experience of
birth and the support given to a woman in labour during this time.

Several hospitals were opened during this period, for example St Thomas’s, St Bartholomew’s and Bethlem. Care that had been provided by nuns was now provided by local women, whose efforts were overseen by matrons. Their duties centred on domestic chores.

The second half of the 18th century saw the evolution of scientific method, the so-called ‘Age of Enlightenment’. Its purpose was to reform society using reason, challenging tradition and advancing knowledge. Scientific endeavour flourished during the Enlightenment and philanthropists provided the means to open charity hospitals around the UK. These hospitals employed nurses, who may have been paid or unpaid, who carried out domestic duties. It was not unusual for so-called nurses to drink alcohol and take money from patients in order to pay for their alcohol. Charles Dickens, in his 1843 novel *Martin Chuzzlewit*, developed the main theme related to ‘selfishness’. One of the characters, the nurse, Mrs Gamp, was an odious individual who was a midwife and ‘layer-out of the dead’ (perhaps one of the first health visitors: ‘from cradle to the grave’).

Sarah Gamp was immoral, self-indulgent, sloppy and generally drunk. A notorious stereotype of untrained and incompetent nurses of the early Victorian era, before the reforms of campaigners such as Florence Nightingale, Mrs Gamp is everything we least expect of a good nurse: selfish, untrustworthy, a bully, nasty to patients and slothful.

Parish nurses and their supposed inadequacies were justification of the need to change the way that nurses were employed and governed, and in 1727 two pamphlets were published to support the creation workhouses. Workhouses were established to employ and maintain the poor, and nursing duties were generally performed by elderly female inmates who were illiterate, fond of a drink and inept in the demands of caring for the sick. The development of the workhouse infirmaries saw a move to the more familiar set-up of providing a separate annex to the workhouse building; this allowed segregation of the sick according to the nature of their illness. It is difficult to differentiate what history tells us about the nature of nursing: that is the difference between ‘nursing work’ and the ‘work done by nurses’. Nurses began to be employed by workhouse guardians and in 1865 William Rathbone, with the help of Florence Nightingale, financed the introduction of trained nurses to the Brownlow Hill Infirmary in Liverpool. Interestingly, the employment of pauper nurses continued under the supervision of a trained nurse (White 1978).

Alongside the Poor Law acts of the 19th century, medical schools began to emerge, as medical knowledge grew. The Royal College of Surgeons was formed in 1800 and, at this time, doctors were required to carry out some aspects of their training in hospitals.

The year 1800 brought about the era of social and political revolution, and many of the great philosophers, such as Emanuel Kant, brought radical intellectualism into the minds of many. In 1784, Kant challenged society to ‘Dare to know! Have the courage to use your own understanding’, which became the motto of the Enlightenment. Science and technical development reached new heights and the Victorian era from 1831 saw the biggest developments in social and scientifi c engagement. During 1853 to 1856, Britain and France became involved in the Crimean War against Russia, and the American Civil War started in 1861.

**Figure 1.1** Early engraving depicting the support of a woman in labour. Reproduced with permission of Everett Collection Historical/Alamy.
In this exercise, you may have thought about more recent developments that you are aware of, such as the installation of a hospital at Camp Bastion in Afghanistan, with its innovations in trauma surgery and nursing care; or the development of triage, to assess those most in need of emergency care. Interestingly, triage was developed in the First World War in France to treat mass casualties. You may have included the use of the tourniquet to limit blood loss; this was known in Roman times and has been adapted by the military today to be applied, if needed, with one hand. Ultrasound is a product of war, first used to detect cracks in armour in the Second World War, by tank engineers. Your list may also include infection control and the use of antibiotics to treat infections. Modern infection control has been influenced by the work of Florence Nightingale during the Crimean War, as she pioneered the cleaning and ventilation of the Scutari hospital, thus reducing mortality rates among the sick and wounded.

**Florence Nightingale (1820–1910)**

Known for her pioneering work in the Crimean War, Florence Nightingale (Figure 1.2) led the way in bringing respectability to nursing. Born in Italy in 1820, she is now celebrated as a social reformer and statistician. From a professional viewpoint, Nightingale is seen as the founder of modern nursing; she spoke with firm conviction about the nature of nursing as a distinct profession, allowing young middle-class women an opportunity to make a meaningful contribution to society. At the time, nursing in the middle and upper classes was defined as caring for sick and elderly relatives, for example a daughter might nurse her ageing and sick father. Nightingale was concerned with what she saw as the all-encompassing plight of the Victorian woman – on the one hand redundant wives of the wealthy, and on the other women who were poverty stricken and forced to toil for long hours at tedious and unskilled work.

Born to a wealthy upper-class family herself, the expectation was that she would marry well and produce a family. However, she defied the wishes of her family and in the first decade of her adult life, fought to use her talents in a productive and helpful way in order to benefit society.

In March 1853, Russia invaded Turkey, and Britain, concerned about the growing power of Russia, went to Turkey's aid. This conflict occurred in and around Scutari and became known as the Crimean War. Soon after British soldiers arrived in Turkey, they began to fall ill with malaria and cholera. Florence Nightingale volunteered her services to the war effort and was given permission to take a group of nurses to a hospital in Scutari based several miles from the front. Here, she was faced with mass infections, lack of medical supplies and poor hygiene.

After the war, she wrote *Notes on Nursing*, where she set out the basic foundation on which nursing was to be based, and expressed the proper functions of nursing. These functions in Nightingale's view included improving the environment of the sick room with clean air and ventilation, making and recording astute observations of the sick and their environment, and developing knowledge around the process of recovery.

**The Evidence How to Ventilate without a Chill**

...with a proper supply of windows, and a proper supply of fuel in open fire places, fresh air is comparatively easy to secure when your patient or patients are in bed. Never be afraid of open windows then. People don’t catch colds in bed. This is a popular fallacy. With proper bed-clothes and hot water bottles, if necessary, you can always keep a patient warm in bed, and well ventilate him at the same time.

(Nightingale 1859)

Florence Nightingale was seen by many historians as ‘The Lady with the Lamp’ after a report in *The Times* newspaper from the Crimea, which depicted her as a lone figure in the night, a small lamp in her hand, checking on the welfare of the wounded soldiers. Interestingly, the lighting of lamps is documented in the *Nursing Mirror* pocket diary of 1913, shown in Figure 1.3, which gives specific times for lamps to be lit throughout the year.

After returning to England as a national heroine, she began reforming conditions in British hospitals (in the first instance this was confined to military hospitals). Nightingale was able to raise £45,000 in funds to improve the quality of nursing. In 1860, she used these funds to found the Nightingale School and Home for Nurses at St Thomas's Hospital.

Her philosophy of nursing was based on the belief that there should be a theoretical basis for nursing practice and that nurses should be formally educated. Resolute in her desire to professionalise nursing, she insisted that nursing schools should be controlled and staffed by women who were trained nurses. She also wanted to develop a systematic approach to the assessment of patients where an individual approach to care provision based on individual patient needs was required. She strongly believed in the maintenance of patient confidentiality.

The philanthropist William Rathbone worked with Nightingale to develop the first district nursing service. This was acknowledged by Queen Victoria with the title 'Queen's Nurses' being awarded to nurses caring for people at home. In the
late 1800s, courses were provided to teach women to develop an insight into sanitation in homes. These women had a duty to care for the health of adults, children and pregnant women (prenatal and antenatal), and the first health visitor was employed in Salford in 1862 (Adams 2012).

In the 1870s, America’s first trained nurse, Linda Richards, was mentored by Nightingale. Richards went on to pioneer the development of nursing in both America and Japan (Doona 1996). In 1883, Nightingale was awarded the Royal Red Cross by Queen Victoria, and became the first woman to receive the Order of Merit. In 1873, Nightingale wrote, ‘Nursing is most truly said to be a high calling, an honourable calling’. She died in London in 1910.

Mary Seacole (1805–1881)
Daughter of a Scottish soldier and a Jamaican mother, Seacole (Figure 1.4) learned her nursing skills in the family boarding house for invalid soldiers. She was well travelled, visiting the Bahamas, Central America and Britain. Despite the War Office in England refusing her application to be an army nurse during the Crimean War, Seacole funded her own visit and arrived in Scutari to offer her services to Nightingale, but these were refused. Undeterred, Seacole set up her own services and established the British Hotel near Balaclava. Here, she provided comfort and convalescence to the British and Russian soldiers, often at the battle front (Anionwu 2005).

Seacole also became involved in the training of nurses for employment in the workhouses. Her contribution to nursing has not always been recognised, and unlike Nightingale she does not feature significantly in the established nursing literature until the 1970s. It is most certainly the case that Seacole’s work in the Crimean War was overshadowed at the time by that of Florence Nightingale; however, there has been a revival of interest in her contribution, with an introduction to her life and works added to the school national curriculum in the UK.

The Development of Education and Regulation for Nurses
Throughout the 1890s, pressure grew for the registration of nurses, and leaders within the profession were debating the need to pass a public examination just as medical practitioners had been required to do since 1858. However, Florence Nightingale was opposed to this notion, worried that central examination might undermine her philosophy of nursing. In 1887, Ethel Bedford-Fenwick...
The Development of Modern Nursing

Despite the TV and media image of the nurse as an attractive female who falls in love with the doctor, the 1960s heralded a sea change in the way that nurses viewed their role in terms of accountability and the consequences of their actions. Theories to support the art and science of nursing began to emerge, and models of nursing were introduced to help describe nursing in a variety of care settings and roles. Chapter 7 explores these developments in detail.

Many of the theories that relate to nursing have a philosophical foundation and will include ideas about the nature of nursing, the nature of the person, the nature of society and the environment and the nature of health. Some examples of the key influencers in relation to this are highlighted in the next section.

Virginia Henderson (1897–1996)

Known as the ‘modern day mother of nursing’, upon graduation Virginia Henderson began her nursing career in Washington DC in 1921, working as a nurse in the community. She soon entered the education arena and wrote about her early experience as a nurse teacher. In the 1940s, she began to develop her personal definition of nursing, her so-called ‘concept’, which focused on the importance of independence for the patient, helping with rehabilitation and progress from hospital to home. She identified 14 nursing components based on human need and geared towards the nurses’ role.

- Substitutive: doing for the person
- Supplementary: helping the person
- Complementary: working with the person.

The Evidence Henderson’s Definition of Nursing

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge and to do this in such a way as to help him gain independence as rapidly as possible.

(Henderson 1966)

The 14 components are, in the main, physiological and focus on physical aspects such as breathing, eliminating, maintaining hygiene and nutrition. However, Henderson also acknowledged the importance of spiritual, moral and sociological needs of the individual. Henderson (1966) implies that nursing is more than a matter of carrying out doctors’ orders. Instead, nursing involves a special relationship with the person (and often the family). According to Henderson, the nurse intervenes with knowledge and skills to meet those needs that individuals and family would not normally be able to provide.

Her concept highlights what the nurse ought to focus on; however, it has been criticised for its lack of in-depth guidance as to how the nurse assists in meeting the individual components (Wills & McEwen 2002). She saw nurses as functioning independently from the physician, promoting the treatment plans prescribed. Her concept encompassed the notion of the life continuum, with nurses helping both sick and healthy people from the newborn to those who are dying. Nurses, according to Henderson, should be knowledgeable in biological and social sciences and must have the ability to assess basic human need.

With human need as the central component of Henderson’s concept, it has paved the way for further theories as to individual needs and how nurses can help in meeting these needs.
Dorothea Orem (1914–2007)

Orem developed the ‘Self-Care Theory’ based on the premise that people should be self-reliant and responsible for their own care and the care of others in their family. Her philosophy focused on the distinct individuality of the person, and the interaction of the person with the nurse, based on the need to meet self-care. In this way, she developed the idea of a health continuum, where the patient moves from dependency to independency. The nurses’ role in the continuum is to help the achievement of independence, act as an advocate, redirector, supporter and teacher, and to provide an environment that contributes to the therapeutic environment. Orem’s philosophy is that nursing is the ability to care for another, especially when they are unable to care for themselves (Orem 1991).

Hildegard Peplau (1909–1999)

Peplau was the first published nurse theoretist since Florence Nightingale. Her work focused on the therapeutic nature of nursing, asserting that the nurse–patient relationship is the foundation of nursing practice. She wanted to revolutionise the established approach to care, where the nurse passively acted out the doctor’s orders and the patient passively received the treatment. She saw a human dynamic in the shared experience of caring and being cared for, where each party experiences personal growth through learning and coping.

This dynamic is achieved through developmental stages in the nurse–patient relationship, and relies on the distinct character roles typical of the nurse. Typical character roles include the nurse as a resource, answering questions and interpreting data; nurse as a technical expert, providing physical care through clinical skills; nurse as a teacher, providing instruction and facilitating understanding (Peplau 1952).

The developmental stages are mapped out as follows.

**Orientation Phase**
- Establish rapport
- Set parameters
- Understand roles and begin to establish trust

**Identification Phase**
- Patient identifies problems
- Nurse helps patient to recognise their role in self-care

**Exploitation Phase**
- Patient trust is established, makes full use of nursing service
- Problem-solving
- Setting future goals

**Resolution Phase**
- Patient needs met
- Relationship ends on mutual basis
- Patient less reliant on nurse, more self-reliant.

Patricia Benner

Benner was a contemporary theorist who introduced the concept that expert nurses develop skills and understanding of their craft through the experience and education of caring. She described five levels of nursing experience and coined the phrase ‘from novice to expert’ in her publication in 1982. Her work is significant, as it changed the perception of the term ‘expert nurse’ from the most highly paid and prestigious, to encompass the notion of the expert as one who provides the ‘most exquisite care’, and that practice itself could inform the theory of care (Benner 1982).

Margaret Newman

In 1979, Newman presented her ‘theory of expanding consciousness’. She presents the notion that disease (ill health) and the absence of disease (health) in the individual are equally important in the human lifespan. She asserts that consciousness is a healthy state; the more individuals interact with their environment and the world around them, the more conscious they are. Crisis such as health breakdown increases consciousness – she describes this as the total response that the individual makes to that crisis: physiological, psychological and social. In this way, no matter how disordered or hopeless a situation may seem, the process of becoming more oneself and finding meaning in the situation is a demonstration of expanding consciousness (Newman 1979).

The theoretical and conceptual philosophies of nursing promoted by the theorists are highlighted in Table 1.2.

**Table 1.2 Theoretical and conceptual philosophies of nursing.**

<table>
<thead>
<tr>
<th>THEORIST</th>
<th>CONCEPTUAL PHILOSOPHY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florence Nightingale</td>
<td>Concepts of society and environment: major emphasis on the environment of care, light, noise, smell and warmth</td>
</tr>
<tr>
<td>Virginia Henderson</td>
<td>Concepts of the person: the mind and body are inseparable; individuals are unique; individual needs are mirrored in 14 components of basic nursing care</td>
</tr>
<tr>
<td>Dorothea Orem</td>
<td>Concepts of the person: the individual as a whole made up of physical, psychological and social structures with an element of self-care ability</td>
</tr>
<tr>
<td>Hildegard Peplau</td>
<td>Concepts of the person: the human dynamic and therapeutic relationship; the stages of that relationship</td>
</tr>
<tr>
<td>Patricia Benner</td>
<td>Concepts of the person: person is self-interpreting and engaged, learning, concern, cultural appreciation, direct involvement in caring</td>
</tr>
<tr>
<td>Margaret Newman</td>
<td>Concepts of health: expanding consciousness through the experience of illness</td>
</tr>
</tbody>
</table>

The Beginnings of the NHS and Nursing

The NHS was established on 5 July 1948 with the aim of healthcare being free at the point of delivery. The 1949 Nurses Act allowed that the constitution of the GNC be amended; the general and male nurse parts of the register were amalgamated. Nurses welcomed the development of the NHS, as they recognised through first-hand experience of caring the suffering that resulted from having to pay for medical care.

Workforce planning was crude and with the development of new hospitals and services came the need for a greater number
of nurses. Sadly at the time of the development of the NHS, no real provision for the education of nurses had been established en masse, and there was no recognition for nurses to help shape the development of services. Services were isolated, in particular the provision of mental health care. Children were isolated from their families, with visiting restricted to weekends only in many wards.

**Early Nursing Research**

The Briggs Committee, a working group, was set up in 1976 to review the training of nurses and midwives, and set the expectation that nurse education would incorporate the latest findings of evidence to underpin practice. The work of this committee led to the Nurses, Midwives and Health Visitors Act of 1979, which dissolved the GNC. The GNC was replaced by the UKCC for Nursing, Midwifery and Health Visiting, with four National Boards for England, Wales, Scotland and Northern Ireland. The UKCC had a specific responsibility for the quality of education of nurses, the maintenance of student training records, the provision of professional guidance and a remit to handle professional misconduct.

The first code of conduct for nurses, midwives and health visitors was developed in 1984 by the UKCC, setting out standards of professional behaviour and accountability. This was an effort at transparency to provide the public with the standards that they could expect and to guide the profession with regard to their duty of care to their patients and clients.

Much of the work of Briggs in the 1970s paved the way for reform in relation to nurse education. In 1984, the UKCC set up a project to consider reforming nurse education, which became known as Project 2000. The UKCC’s report, published in 1986, provided the Council’s strategy (United Kingdom Central Council 1986). The strategy was implemented by the mid-1990s and up to this point, nurse education worked on the apprenticeship model, where students were salaried, part of the workforce and, in the majority of cases, had their education based in one local hospital. Examinations were both hospital and nationally set. Until Project 2000, the whole model of education for nurses was geared towards the needs of the local health services and provided hands-on practical approaches to clinical practice (Royal College of Nursing 2007).

**Project 2000**

Project 2000 introduced a framework for pre-registration nurse programmes which was to radically change the experience of student nurses in practice and in education. Table 1.3 shows a comparison between the traditional style of nurse education and the revolution in education that was introduced with Project 2000.

While presenting a radical change to the way that nurses were educated, Project 2000 had many critics, not least the established workforce in nursing in the wards and departments. Many found the transition from students as part of the workforce to supernumerary status difficult to adapt to.

### Jot This Down

- The introduction of Project 2000, while embraced by some, was a cause of concern to many nurses.
- Why would this radical change in the way that nurses were educated cause so much anxiety?

In this exercise, you may have made the same conclusions that the professional bodies and nurse educators were investigating as Project 2000 began to develop.
Researchers began to look at the experience from Project 2000 (Hamill 1995), and just as importantly the outcome, in relation to newly qualified nurses (United Kingdom Central Council 1999). What they found was concern over the fitness to practise of some qualified nurses following the first round of Project 2000.

The Peach Report was published in response to the UKCC’s desire to conduct a detailed examination of the effectiveness of pre-registration nurse education and determine if students were ‘fit for practice’ and ‘fit for purpose’ (United Kingdom Central Council 1999). The report outlined several recommendations, for example:

- A reduction in the common foundation programme from 18 months to 1 year
- An increase in the branch programme from 18 months to 2 years
- To ensure that students experienced at least 3 months’ supervised clinical practice towards the end of the programme
- Longer student placements
- The introduction of practice skills and clinical placements early on in the common foundation programme
- Greater flexibility in entry to nursing programmes.

Subsequent revisions included more focus on clinical skills acquisition, a closer link between theory and practice, and the development of roles that support mentors in practice such as practice education facilitators (PEFs).

### Table 1.3 Comparison of Project 2000 curriculum with traditional nurse training.

<table>
<thead>
<tr>
<th>PROJECT 2000</th>
<th>TRADITIONAL NURSE TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education in Higher Educational Institutions (HEIs)</td>
<td>Took place in schools of nursing, most likely hospital-based</td>
</tr>
<tr>
<td>Supernumerary status, not counted as ‘numbers’ on wards</td>
<td>Part of the workforce, included on the team ‘off duty’ rota</td>
</tr>
<tr>
<td>Increase of theory content to represent 50% of the 3-year course</td>
<td>Practice component significantly outweighs time spent in classroom</td>
</tr>
<tr>
<td>Includes a minimum HEI award (Diploma) along with nurse registration</td>
<td>No final award but eligible for nurse registration</td>
</tr>
<tr>
<td>Focus on health rather than ill health with emphasis on the life sciences</td>
<td>Illness model focus</td>
</tr>
<tr>
<td>Common Foundation Programme (CFP) of 18 months for all student nurses</td>
<td>No foundation programme</td>
</tr>
<tr>
<td>Four specialist pre-registration branches of 18 months to follow CFP: Adult, Child health, Mental health, Learning disabilities</td>
<td>No branches, nurses start on specific programme at beginning of three-year training</td>
</tr>
</tbody>
</table>

**Drivers for Change**

Nurse education can be seen as an organic element, responding to changes within society, the healthcare setting and the educational system. As such, there are a number of so-called ‘drivers’ that have been identified to help recognise the kind of healthcare that will be needed in the future and, subsequently, the type of nurse needed to support that healthcare (Royal College of Nursing 2004).

Examples of the drivers include:

- Demographic changes, we live in an ever-ageing population
- People living longer with chronic disease and long-term illness
- Lifestyle dictating health, e.g. obesity
- The public expectation of quality care
- Focus on prevention and health promotion
- Primary care and a move away from hospital care delivery towards a community focus
- Supporting patients and carers to self-manage their conditions. Such drivers influence the type of care that can be expected in the future and determine the preparation of the future nursing workforce.

Technological advances continue to shape the way that nurses work, and the need to be computer literate to cope with managing patients’ records and data is a constant feature of the nurse's role. Advances in telehealth and remote patient monitoring are being developed, particularly in the community setting, and telehealth has been seen as an effective tool for telephone triage, an example being ‘NHS 111’ in England.

Telecare is the use of electronic equipment, sensors and aids in a person's home to support independent living. Geared towards home care, the technology can help people with a range of long-term conditions to avoid unnecessary hospital admissions. Technological developments will continue, with an increased understanding and use of new applications associated with biotechnology, bioengineering and robotics. Future developments will see the use of avatars and chatbots to supplement healthcare as more artificial intelligence supports this revolution.

**The Evidence: Telehealth, the Use of Florence (Flo)**

Practice nurses can use the ‘Flo telehealth system’ to convey interactive and positive health messages to selected patients to enhance clinical management. An example is an interactive mobile phone texting service with blood pressure (BP) management. Patients measure their BP, text their readings to Florence, receive an immediate automatic response and have their results reviewed by the GP or practice nurse at least weekly.

(Cottrell et al. 2012)
The demographic pattern of the UK population also has an influence on nursing today. According to the Office for National Statistics, in England life expectancy at birth for boys increased from 73.7 years in 1991–1993 to 79.5 years in 2012–2014. This means that a newborn baby boy in England in 2012–2014 can expect to live 5.9 years longer than a newborn baby boy in the same country two decades ago. Similarly, life expectancy for baby girls increased by 4.1 years, from 79.1 years in 1991–1993 to 83.2 years in 2012–2014. The population is calculated to increase from 62.3 million in 2010 to 73.2 million in 2035; this is in part due to the projected natural increase based on more births than deaths: people are living longer and surviving the chronic illnesses that at one time would prove fatal. The provision of care will see a continued growth and an increasingly diverse role for the Third Sector, as well as reliance on the commercial sector to make available considerable aspects of secondary care provision (Longley et al. 2007).

International migration has necessitated healthcare to adapt ways of working to support cultural differences. Isolation of the elderly is a common feature; stress and the breakdown of the extended family are examples of factors affecting the population’s health.

Patterns of health and disease are influenced by lifestyle, less physical activity and sedentary lifestyles, and coupled with the ‘fast food’ culture, have contributed to a rise in the incidence of obesity. Cigarette smoking accounts for around 17% (78,200) of all deaths of adults over the age of 35 years, compared to 19% (95,300) in 2003 (Health and Social Care Information Centre 2014). The same study highlighted that in England in 2013–2014, there were approximately 1.6 million hospital admissions with a primary diagnosis of a disease that can be caused by smoking. This is a steady rise from 2003–2004, when the number was 1.4 million admissions.

The rise of consumerism has led to a more informed user of healthcare services. Expectations of the care received are high, for example in Islington in 2009, 40% of respondents to the Citizens Panel that investigated health and social care said that better provision of opportunities to take up health screening, (e.g. breast cancer) would improve the health of residents.

The ethical component of care is another example of the drivers for development in nursing. Acknowledgement of individual rights and nursing responses to this and the consideration of mental capacity are discussed in Chapter 3. Diversity and equity and the maintenance of a fair and non-discriminatory health service in which everybody can participate to reach their potential are important drivers for nursing.

From this exercise, you may have considered the need to include a significant placement within the community setting, the ability to assess complex needs and to respond appropriately, work effectively within teams, work in partnership with people and their families to promote health and support self-care, and to recognise opportunities for health promotion.

**Jot This Down**

Using examples of the ‘drivers’ in healthcare we have discussed, what would you say were the important components of nursing programmes of study to equip the nurse of the future to support excellent healthcare?

---

**Modernising Nursing Careers**

In 2006, the four UK chief nursing officers created a vision for the nursing profession in the 21st century, setting the direction for modernising nursing careers (Department of Health 2006). Similar to the RCN in 2004, it too considered the drivers for change in relation to:

- **The context of nursing**: diversity in society, demographics, health patterns, inequalities, expectations of healthcare, advances in technology, economics of care.
- **Changing healthcare**: putting the patient first, integrated care, patient choice, care of people with long-term conditions, health promotion, community focus of care, new ways of working.

The report highlighted that wherever nurses work, there are four elements that are key to the role.

**The Evidence Elements for All Nurses**

- Practice
- Education, training and development
- Quality and service development
- Leadership, management and supervision

(Department of Health 2006)

The vision for the future is for nurses to be able to respond to the complexity of a modern society with all of its demands for quality, cost-effective, technological care. The report identified a need for nurses to be able to meet the elements identified in the ‘Evidence’ box: in practice, the ability to work in diverse care settings; in development, be able to pursue education and training when needed; in service development, be both generalist and specialist skilled as required; in leadership, be able to take on changed roles and responsibilities.

Compassion remains in the spotlight and is the focus for the ongoing development of a national strategy for nurses, midwives and care staff. *Our Vision* (Department of Health 2012) is a working title adopted by NHS England to support this strategy, with a focus on the following themes:

- Population health and prevention
- Personalisation agenda
- Ensuring productivity, safety and effective staffing
- Optimising service transformation, innovation and improvement
- Building and sustaining the future workforce.

**The Nursing and Midwifery Council and Nurse Education**

In 1998, the government initiated a major review of how the nursing profession was regulated. The outcome of this review resulted in consultation with nurses and midwives regarding professional regulation and areas that needed to be addressed. Recommendations were suggested and acted upon regarding self-professional regulation, regulatory mechanisms and procedural rules. The UKCC and the four national boards were abolished; quality assurance elements were incorporated into the work of the Nursing and Midwifery Council (NMC).
The NMC was set up by Parliament to safeguard the public and to ensure that nurses and midwives provide high standards of care to their patients. The Nursing and Midwifery Order 2001 (SI 2002/253) established the Council and it came into being on 1 April 2002.

**Professional and Legal Issues**

The NMC maintains a register of nurses and midwives, setting standards for education and practice and offering guidance and advice to the professions. An overarching aim is to inspire confidence by ensuring that those on the professional register are fit to practise and by dealing speedily and fairly with those who are not.

The Professional Standards Authority for Health and Social Care promotes the health, safety and well-being of patients and other members of the public in the regulation of health professionals and has the job of scrutinising the work of health profession regulators including:

- General Dental Council
- General Medical Council
- General Optical Council
- General Osteopathic Council
- General Pharmaceutical Council
- Health Professions Council
- Nursing and Midwifery Council

The fundamental concern of the NMC is the protection of the public. Its duties to society are to serve and protect by:

- Maintaining a register listing all nurses and midwives
- Setting standards and guidelines for nursing and midwifery education, practice and conduct
- Providing advice for registrants on professional standards
- Ensuring quality assurance related to nursing and midwifery education
- Setting standards and providing guidance for local supervising authorities for midwives
- Considering allegations of misconduct or unfitness to practise due to ill health.

In maintaining the professional register, the NMC provides the profession and public with a database of all registered nurse and midwives. The information shared includes the name and registration status of the nurse on one or more of the three parts of the register, nursing, midwifery and/or community public health nurse. There are currently over 686,700 qualified nurse Registrants in the UK (Nursing and Midwifery Council 2015a).

**Professional and Legal Issues**

**Revalidation**

To stay on the professional register, the nurse must renew his or her registration every 3 years. This is known as revalidation. An annual retention fee is also required at the end of the first and second year of the registration period.

**Nursing Field**  **Mental Health: Professional Values**

Mental health nurses must work with people of all ages, utilising values-based mental health frameworks. They must use different methods of engaging people, and work in a way that promotes positive working relationships focused on social inclusion, human rights and recovery, that is, a person’s ability to live a self-directed life, with or without symptoms, that they believe is meaningful and satisfying. (Nursing and Midwifery Council 2010)

When in 2002 the UKCC ceased to exist, its function was taken over by the NMC, which looked to the future of nurse education in the UK. The NMC mapped the standards of proficiency for pre-registration nursing education, producing its latest version in 2010.

As established earlier, as healthcare changes, so too does the role of the nurse and, as such, so must the education required to prepare the student for the new roles and responsibilities (Carvalho et al. 2011). After extensive consultation, the NMC have introduced new standards for nurse education (Nursing and Midwifery Council 2010) and students must meet these standards to be eligible to enter the professional register. The standards help to ensure parity throughout the UK for any field of nursing (fields replace branches).

The standards identify what students must demonstrate at the point of registration with the NMC, and guide the Approved Education Institutions (AEIs) and partners in the delivery of nurse education programmes. Registration conveys a message to the public that the nurse who is admitted to the register has reached and possesses a satisfactory level of competence along with a certain standard of behaviour – good character and good health.

The latest NMC 2010 guidelines are specifically geared to new programmes of study, which began in September 2011, and set out standards for competence and standards for education. Educational standards are reviewed and maintained by the NMC, and information on changes to the standards for education can be accessed via the website.

Current **Standards for competence** identify the specific knowledge, skills and attitudes the student must acquire by the end of the programme within the context of their particular field of nursing, and are arranged in four domains:

- Professional values
- Communication and interpersonal skills
- Nursing practice and decision-making
- Leadership management and teamwork.

The first domain, **Professional values**, emphasises the need for holistic, non-judgemental caring and sensitive practice. Here, the nurse is reminded of the obligation to respect the rights of individuals, with particular attention to equality and diversity and the needs of an ageing population.
The third domain, Nursing practice and decision-making, reminds the nurse that practice should be autonomous, compassionate, skilful and safe and must be dignified and promote health and well-being. The competency stresses the need for evidence-based care delivered through systematic nursing assessments, recognising risk and evaluating care.

The last domain comprises Leadership, management and teamworking competency, which highlights the importance of accountability in practice and endeavour for improving nursing practice and standards of healthcare. Self-management and the management of others is also a feature alongside ongoing leadership skills development.

Standards for education provide the framework from which programmes of study are approved and delivered. There are 10 standards that institutions and service providers must meet.
- Protect and keep as confidential all information relating to them
- Gain their consent based on sound understanding and informed choice prior to any intervention and that their rights in decision-making and consent will be respected and upheld.

**Organisational aspects of care**

People can trust a newly registered graduate nurse to:
- Treat them as partners and work with them to make a holistic and systematic assessment of their needs; to develop a personalised plan that is based on mutual understanding and respect for their individual situation, promoting health and well-being, minimising risk of harm and promoting their safety at all times.
- Deliver nursing interventions and evaluate their effectiveness against the agreed assessment and care plan.
- Safeguard children and adults from vulnerable situations and support and protect them from harm.
- Respond to their feedback and a wide range of other sources to learn, develop and improve services.
- Promote continuity when their care is to be transferred to another service or person.
- Be an autonomous and confident member of the multidisciplinary or multiagency team and to inspire confidence in others.
- Safely delegate to others and to respond appropriately when a task is delegated to them.
- Safely lead, coordinate and manage care.
- Work safely under pressure and maintain safety of service users at all times.
- Enhance the safety of service users and identify and actively manage risk and uncertainty in relation to people, the environment, self and others.
- Prevent and resolve conflict and maintain a safe environment.
- Select and manage medical devices safely.

**Infection prevention and control**

People can trust a newly registered graduate nurse to:
- Identify and take effective measures to prevent and control infection in accordance with local and national policy.
- Maintain effective standard infection control precautions and apply these to needs and limitations in all environments.
- Provide effective nursing interventions when someone has an infectious disease, including the use of standard isolation techniques.
- Comply with hygiene, uniform and dress codes in order to limit, prevent and control infection.
- Safely apply the principles of asepsis when performing invasive procedures and be competent in aseptic technique in a variety of settings.
- Act in a variety of environments including the home care setting, to reduce risk when handling waste, including sharps, contaminated linen and when dealing with spillages of blood and other body fluids.

**Nutrition and fluid management**

People can trust a newly registered graduate nurse to:
- Assist them to choose a diet that provides an adequate nutritional and fluid intake.
- Assess and monitor their nutritional status and, in partnership, formulate an effective plan of care.
- Assess and monitor their fluid status and, in partnership with them, formulate an effective plan of care.
- Assist them in creating an environment that is conducive to eating and drinking.
- Ensure that those unable to take food by mouth receive adequate fluid and nutrition to meet their needs.
- Safely administer fluids when fluid cannot be taken independently.

**Medicines management**

People can trust a newly registered graduate nurse to:
- Correctly and safely undertake medicines calculations.
- Work within legal and ethical frameworks that underpin safe and effective medicines management.
- Work as part of a team to offer holistic care and a range of treatment options of which medicines may form a part.
- Ensure safe and effective practice in medicines management through comprehensive knowledge of medicines, their actions, risks and benefits.

---

The full document of the 2010 NMC Standards for Nurse Education can be accessed at:

**Current Nurse Education**

From September 2013, all programmes of study in nursing became degree level only, and diploma entry study in the UK has been phased out nationally as a move towards this development. The NMC sees the future nurse as a leader, delegator, supervisor and person who can challenge other nurses and healthcare professionals. In order to develop and sustain change in practice, graduate (degree-level) nurses need to:

- Think analytically.
- Use problem-solving approaches.
- Utilise best evidence in decision-making.
- Keep up with technological advances. (Nursing and Midwifery Council 2010)

In the UK, student nurses qualify in a specific field of nursing, and enter the NMC register as a nurse in one or more of the four fields. The education programme is full time and consists of 4600 hours of combined theoretical and clinical instruction distributed equally. The appropriateness of the four nursing fields has been examined because there is concern that future health services may require a more generic worker, who would be helpful when meeting general health needs. The provision of degree-level programmes has the potential to enhance the status of nursing even further, providing nurses with skills that go beyond diploma level, with the aim of ensuring that the care of the patient is improved and enhanced. The new standards have been aligned with European Union Directive 2005/36/EC Recognition of Professional Qualifications. This sets out the requirements for training nurses responsible for general care and provides the baseline for general nursing in the EU. The Directive includes detailed requirements on programme length, content and ratio of theory to practice, as well as the nature of practice learning and range of experience.
In the future, not just at the Mid Staffordshire Trust but across the NHS. His final report, a public inquiry, was published in February 2013. This report builds on the work and conclusions of the first inquiry. It tells of a culture of secrecy and defensiveness, which led to appalling suffering by many patients and their families (Mid Staffordshire NHS Foundation Trust 2013).

In his findings, Francis highlights a culture of care that failed in its primary concern of protecting patients and upholding the public’s confidence in the system of care provided. In both reports, he sends a clear message that ‘it should be patients, not numbers, which count’. Although focused on one organisation, the report highlights a whole system failure, which has major implications for all healthcare systems across the UK. The 1782-page report has 290 recommendations, calling for a re-emphasis on what is important in care and not, as some might have expected, a total reorganisation of the system. What Francis wanted to do was to use the evidence to focus on the positive values of care and to learn from this so that the failings identified are not repeated. His recommendations focus on a series of themes based around:

- Openness, transparency and candour throughout the healthcare system
- Fundamental standards for healthcare providers
- Improved support for compassionate caring, committed nursing and stronger healthcare leadership.

There is recognition that the focus of compassion and caring in nursing should be emphasised right from recruitment into nursing, through education and continuous professional development (CPD). Francis makes the point that training and CPD in nursing should apply at all levels from student nurse to director of nursing. The challenge will be in resourcing this development.

The message from the inquiry strongly promotes the culture of putting patients first and protecting them from avoidable harm. It also strongly advocates an open and honest approach to patient care, where patients share in the decision-making of their care based on the best information available. In addition, the report identifies the need for a greater role for families and carers of older people.

In response to the Francis report, the NMC has highlighted the core theme of The Code: Professional Standards of Practice and Behavior for Nurses and Midwives (Nursing and Midwifery Council 2015b), which states that in order to uphold dignity the nurse must ‘treat people with kindness, respect and compassion’. The chief executive of the NMC recommends that ‘this needs to be the core principle of the whole healthcare system.’

The RCN has also responded to the report, supporting the notion of transparency and the importance of speaking out in defence of patients in poor care. It supports the notion that poor leadership creates a culture of poor care and is critical of the lack of guidance into safe levels of staffing. Support for the recruitment of the right students who possess the values identified in the review has been made; however, like the NMC, the RCN does not support the recommendation that student nurses should have an extended period of direct patient care as a prerequisite to training. The RCN believes that the current system of 2300 hours in practice for student nurses is sufficient, but emphasises the need to support mentors in practice to ensure positive learning experiences.

The Cavendish Review released in July 2013 looked at the complexity of caring roles within healthcare carried out by non-registered and trained individuals. It found over 1.3 million frontline staff who are not registered nurses, but are responsible for the delivery of the majority of hands-on care both in hospitals and in the community. It highlights the confusion that patients feel when approached by different carers, the assumptions made by patients that all carers

---

**Nursing Fields: Child and Family Nursing**

The fundamentals of child and family nursing are addressed in Chapter 11.

Nurses working in this field understand the developmental needs of children, in particular those who are acutely ill or suffering long term debilitating conditions. Children’s nurses are skilled in working alongside parents and families.

**Learning Disabilities Nursing**

The fundamentals of learning disabilities nursing are addressed in Chapter 10.

In essence, these nurses care for people with a wide range of physical and mental health conditions. The work is demanding and the skills needed include assertiveness to advocate against discrimination; an awareness of legislation and support mechanisms to promote independence; and the ability to work in a specialist support team in a variety of settings that might include schools, workplaces, residential care homes and community centres.

**Mental Health Nursing**

The fundamentals of mental health nursing are addressed in Chapter 12.

Nurses in this field are skilled in supporting patients and families, forming therapeutic relationships and enabling recovery from mental health breakdown wherever possible. The range of mental health problems is vast, and mental health nurses understand the many dimensions that can impact upon a person’s mental well-being. The work is predominantly focused in the community, with some aspects of acute care hospital-based.

**Adult Nursing**

Specifically focused on work with adults, but by its nature will cover all areas of care, from the community to the hospital setting. This is working with adults who have long-term chronic illness or acute illness and also with well adults as promoters of health.

Nurses working with adults need to be skilled in communication, and have an understanding of the sciences on which nursing is based and knowledge of ethics and principles of health. They also need technical and clinical competence.

Adults will present with mental health problems and learning difficulties and, as such, awareness of these fields is essential.

More recent developments have opened the debate for the future of education and training of registered nurses and care assistants. In 2015, Health Education England (HEE) reviewed the current practice of education and set recommendations for the future workforce in nursing. A high degree of emphasis was put on the vital role that healthcare assistants play in the delivery of care, and the need for future investment in the development of ‘home-grown’ workforces.

---

**The Francis Report**

Between 2005 and 2008, there was growing concern over the unusually high mortality rate at the Mid Staffordshire NHS Foundation Trust; this prompted an initial investigation in 2010 (Mid Staffordshire NHS Foundation Trust 2010). Chaired by Robert Francis QC, this first inquiry considered individual cases of patient care, in an effort to learn lessons and prevent mistakes in the future, not just at the Mid Staffordshire Trust but across...
are nurses, the bureaucracy of employment, and the lack of consistency of approach to training and development. It proposes a ‘certificate of fundamental care’ linked to nurse training among its many recommendations (Department of Health 2013a).

The Care Quality Commission (CQC) is an independent regulator of health and adult social care services in England. It ensures that the care provided by hospitals, dentists, ambulances, care homes and home-care agencies meets government standards of quality and safety. In addition, it protects the interests of vulnerable people, including those whose rights are restricted under the Mental Health Act.

By putting the views, experiences, health and well-being of people who use services at the centre of its work, it has a range of powers to take action if people are receiving poor care. Table 1.4 provides an overview of the standards and desired outcomes which the CQC applies to measure care within health and social care settings, and relates to the quality and safety of care. Providers must have evidence that they meet the outcomes (Care Quality Commission 2010).

In addition, public interest in the quality of nursing education and practice has prompted the NMC to review its quality assurance and publish its latest framework.

Table 1.4 Title and summary of outcomes applied by the CQC in relation to the quality and safety of care.

<table>
<thead>
<tr>
<th>Care and welfare of people who use healthcare services</th>
<th>People experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>People benefit from safe, quality care because effective decisions are made and because of the management of risks to people’s health, welfare and safety</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>People are safeguarded from abuse, or the risk of abuse, and their human rights are respected and upheld</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>People experience care in a clean environment, and are protected from acquiring infections</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>People have their medicines when they need them, and in a safe way. People are given information about their medicines</td>
</tr>
<tr>
<td>Meeting nutritional needs</td>
<td>People are encouraged and supported to have sufficient food and drink that is nutritional and balanced, and a choice of food and drink to meet their different needs</td>
</tr>
<tr>
<td>Safety and suitability of premises</td>
<td>People receive care in, work in or visit safe surroundings that promote their well-being</td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment</td>
<td>Where equipment is used, it is safe, available, comfortable and suitable for people’s needs</td>
</tr>
<tr>
<td>Respecting and involving people who use services</td>
<td>People understand the care and treatment choices available to them. They can express their views and are involved in making decisions about their care. They have their privacy, dignity and independence respected, and have their views and experiences taken into account in the way in which the service is delivered</td>
</tr>
<tr>
<td>Consent to care and treatment</td>
<td>People give consent to their care and treatment, and understand and know how to change decisions about things that have been agreed previously</td>
</tr>
<tr>
<td>Complaints</td>
<td>People and those acting on their behalf have their comments and complaints listened to and acted on effectively, and know that they will not be discriminated against for making a complaint</td>
</tr>
<tr>
<td>Records</td>
<td>People’s personal records are accurate, fit for purpose, held securely and remain confidential. The same applies to other records that are needed to protect their safety and well-being</td>
</tr>
<tr>
<td>Requirements relating to workers</td>
<td>People are kept safe, and their health and welfare needs are met, by staff that are fit for the job and have the right qualifications, skills and experience</td>
</tr>
<tr>
<td>Staffing</td>
<td>People are kept safe, and their health and welfare needs are met, because there are sufficient numbers of the right staff</td>
</tr>
<tr>
<td>Supporting workers</td>
<td>People are kept safe, and their health and welfare needs are met, because staff are competent to carry out their work and are properly trained, supervised and appraised</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>People receive safe and coordinated care when they move between providers or receive care from more than one provider</td>
</tr>
</tbody>
</table>
The Quality Assurance Framework for Nursing and Midwifery

Launched by the NMC in July 2013, and updated in 2015, the framework sets out a strategy for assuring the quality of nursing and midwifery education, and the supervision of midwives. The Quality Assurance (QA) Framework’s principal aim is to ensure patient safety.

Professional and Legal Issues

The Quality Assurance (QA) Framework (2013) aims to:
- Ensure that educational programmes for nurses meet the standards necessary for registration in nursing and midwifery
- Set requirements for AEIs to run programmes of study for nursing and midwifery
- Ensure that quality assurance focuses on outcomes of education and midwifery supervision.

(Nursing and Midwifery Council 2013)

The target audience for the framework is primarily the public, and the NMC sees this as a route to transparency, clarity, utility, accountability and improvement. The term ‘public’ encompasses the population of nurses, service users and carers, and the specific community of educators and service providers. Changes to the framework have been informed by a number of factors, not solely a response to the Francis inquiry report into the Mid Staffordshire Foundation Trust, but also data from nurses, service users and carers, educational institutions and service providers.

The QA Framework sets out its approach as follows.

Public Protection
- Ensure new entrants to the register are capable of safe, effective practice
- Ensure the profession knows how and when to raise a concern
- Ensure swift and effective response to fitness for practice concerns

‘Right Touch’ Regulation
- Encourage stakeholder feedback, and comment on, for example, the transparency and accountability of the framework

Focusing on Outcomes
- Shift of emphasis from how standards are achieved towards focus on outcomes of education to better protect the public
- More discretion for the interpretation and meeting of standards in diverse settings

Risk-based
- More scrutiny and support for the practice-based element of the course
- Proposed publication of guidance for educational audit of practice placements

Involving Stakeholders
- Build on the theme of engagement with service users and carers to develop programmes of education

• Seek direct student feedback as a mechanism for quality
• Educators feedback on the application of standards in practice.

All the criteria set out as shown are focused on responding to the strength of public interest in the quality of nursing and midwifery education and practice, and an acknowledgement from our professional body that high-profile failures in care undermine the public’s trust in nursing. The process of raising concerns is addressed in Chapter 3.

Role of the Nurse

The role and function of the nurse has evolved over the years and were explored in the first part of this chapter. In order to meet the healthcare needs of the nation, political and professional pressures have transformed the role of the nurse and other healthcare professionals, with the aim of developing their full potential. Roles are described as both generic and specialist.

Registered nurses working in clinical settings can carry out roles such as:
- Managing caseloads
- Administering and prescribing medications (if qualified as a non-medical prescriber)
- Delivering care which is evidence-based and which follows an agreed pathway or model of care
- Managing teams
- Discharge planning
- Documentation and communication of care.

As society changes, coupled with rapid and important advances in science and technology, so too does the role and function of the nurse and other health and social care practitioners. A reduction in doctors’ hours saw the rise of the nurse practitioner and the specialist nurse (McGee & Castledine 2004). Nurses are advancing their skills and their practice, underpinned by an evidence base and further education. It is not unusual for nurses to undertake roles traditionally seen as medical, for example the nurse endoscopist, specialist ophthalmic nurses performing cataract surgery, and surgical practitioners skilled in vascular surgery and hernia repair.

Many of the new nursing roles identified here exist today because, over time, the nursing profession has sought to advance its professional practice and status. The key issues of clinical competence, clinical decision-making and the awareness of boundaries and limitations are central to the safety of the patient and the success of such roles.

Other key roles that are part of the scope of practice and which can influence the career pathway of the nurse include:
- Mentoring and teaching in practice
- Taking on leadership roles: ward sister/charge nurse
- Advanced practitioners
- Specialist public health nurse
- Nurse consultant
- Nurse prescriber
- Nurse educator
- Nursing researcher.

In order to develop and sustain the caring perspective of nursing, there has to be a theoretical basis for practice. Nurses draw upon the scientific and theoretical perspectives of other disciplines to enhance the nature and safety of the care that they provide.
of thinking and addressing the problems that people may have. Advancing nursing practice ensures that nurses have the knowledge base and practical skills to provide specialist nursing care. Critical thinking allows nurses to see different approaches to clinical situations, and can occur when nurses are faced, for example, with people who have complex needs. Specialist nursing roles and professional development are considered in Chapter 2.

The Evidence The Intellectual Properties of the Nurse

- A body of knowledge on which professional practice is based
- A specialised education to transmit this body of knowledge to others
- The ability to use the knowledge in critical and creative thinking.

(Hood 2010)

In this exercise, you may have considered disciplines such as the life sciences: sociology, psychology and biology. Other disciplines include pharmacology, physiology and microbiology. Themes such as economics and budget management, leadership skills and teaching are influential theoretical principles for the registered nurse. The combination of knowledge related to science and experience has the potential to enable the nurse to make reliable clinical decisions. Professional nursing practice is also based on a body of knowledge that is derived from experience – expertise. The use of expertise should never be undervalued however; having experience may not always be enough to help provide safe care. Nurses derive knowledge through intuition, tradition and experience.

Benner (1982) discusses the subject of intuition as a form of expertise. Intuition can be described as ‘just knowing’ and the ‘just knowing’ comes from the individual. It is internal and can occur independently of experience or reason. It can become validated by experience and interaction with other nurses.

The NHS and Healthcare Reform

On 1 April 2013, the NHS saw its biggest reform in its 65-year history. Hundreds of NHS organisations were abolished and hundreds of others were created, transforming the provision, commissioning and regulation of healthcare.

The Health and Social Care Act 2012 has abolished 153 primary care trusts responsible, up until the new Act, for commissioning healthcare, and the nine strategic health authorities responsible for performance managing the NHS. In their place are 211 Clinical Commissioning Groups (CCGs) led by GPs. Under the plans, GPs and other clinicians have much more responsibility for spending the budget in England, while greater competition with the private sector will be encouraged. The CCGs are held to account by NHS England, who will commission specialist services and primary care operating regionally through 27 local area teams. Originally, the commissioning groups were to be led by GPs, but other professionals, including hospital doctors and nurses, will also now be involved.

The reforms are designed to help ensure the long-term sustainability of the NHS, by achieving value for money and shifting care out of hospital and into the community. The CCGs are expected to use their expertise and clinical knowledge to purchase the most efficient services and the hope is that tendering for these services will drive up competition and so improve quality and standards.

Within this Trust we have initiated hourly patient communication from senior nursing staff. An adult male had been admitted early one morning with a severe asthma attack, he was wheezing and exhausted and we commenced medications and regular monitoring of his saturation levels. Later that day whilst on my hourly rounds, the staff nurse communicated that the patient had suddenly improved; she knew this because he had stopped wheezing and was dropping off to sleep. As soon as I caught sight of him my intuition told me that something was wrong: the patient had stopped wheezing from sheer exhaustion and his oxygen saturation levels were low, he was unresponsive and I immediately called the emergency team.

(Clinical Matron, Medical Unit)

Nurses use their body of knowledge in order to provide care that has undergone critical scrutiny, or a systematic approach has been used to provide that care. Care becomes creative and innovative and provides nurses with new ways...
Chapter 1 Nursing: Past, Present and Future

21st Century Nursing

In their report to the Prime Minister (Department of Health 2010), the Commission on the Future of Nursing and Midwifery stated that:

England’s nurses and midwives are the lifeblood of the NHS and other health services and have always been at the heart of good health care. In 2009 there were well over half a million nurses and midwives on the Nursing and Midwifery Council (NMC) register residing in England. As the largest group of registered professionals in the NHS, they are a huge workforce with great power and potential to influence health and health care. They are ideally placed to improve the experiences of service users and families, and they influence health in a wide range of health, social care and community settings.

In the last decade nurses have acquired greater responsibility as autonomous interdependent practitioners: they lead programmes of care, act as partners and employers in general practice, and also lead their own services and run their own clinics. (Department of Health 2010, p. 16)

This sentiment is echoed and developed in the ‘Leading Change, Adding Value’ nursing framework (National Health Service 2016). Within this framework there is huge emphasis on the nursing workforce as skilled high-quality caregivers who are proficient in managing resources and leading change. It highlights how nurses can develop new ways of working that are ‘person focused’ and challenge the traditional separation of health and social care by providing a seamless service.

In 2014, the NHS presented Five Year Forward View (National Health Service 2014), which set out a vision for change within the NHS. It recognised the needs of patients, the deep-rooted health inequalities, new treatments emerging, and the challenges of mental health, cancer care and support of an ageing population. The ‘Leading Change, Adding Value’ framework (National Health Service 2016) builds on this and has identified three fundamental gaps:

- Health and well-being
- Care and quality
- Funding and efficiency.

Figure 1.6 An overview of the health and care system from April 2013. Source: Department of Health, used under the Open Government Licence v2.0.
The framework directly maps the values of the 6Cs, as seen in Figure 1.7.

The *Health and well-being* aspect of the framework acknowledges that without a better focus on prevention, there will be a widening of health inequalities and a compromise in our ability to pay for new treatments. Examples are given of the prevention of avoidable illness, citing the need for a project to consider a national approach to wound care management aligned to a specific component such as diabetes. In relation to *Care and quality*, there is an acknowledgement that we need to harness technology, reshape care and address variations in quality and safety. *Funding and efficiency* aims to look at the way nursing practice can manage resources well, including the use of equipment, time and referrals.

Ten inspirational commitments are provided as a framework to support the closing of the gaps identified above.

1. Promotion of a culture where population health improvement is a core component of nursing
2. Leadership will be visible in the input of prevention
3. Working alongside families and individuals to equip them to make informed choices and manage their health
4. To be centred on individuals experiencing high-value care
5. Work in partnership with individuals, their carers and others important to them
6. Actively respond to staff in relation to what matters to them
7. Lead and drive research to evidence impact
8. Education, development and training to enhance knowledge, skills and understanding
9. The right staff, the right place, the right time
10. Champion the use of technology and informatics to identify unwarranted variations and support practice.

**Conclusion**

Being a competent registered nurse with the core values at the centre of care brings with it many privileges, not least working with the public and providing them with a service that is safe and of a high quality. From a historical perspective, nurses have come a long way and are now seen as being professionals working comfortably and confidently alongside other healthcare professionals, with levels of education that match many of the allied professions in healthcare.

With regard to the demand for healthcare, there are many drivers, including the types and main causes of disease. Many of these will change over time, for example obesity levels and health inequalities are important factors that must be taken into account at present. There will be a continued need to support the self-care of the growing numbers of people who experience long-term health conditions. The continuing demand from the public to meet health needs will remain high, as well as patient demand for choice, including care packages and treatment options, and access to care provision. All these factors play a part in the modernisation of nursing and are key areas to address within nurse education.

Government reform of healthcare will continue to concentrate on measuring effectiveness, ensuring value for money, reducing disparity in performance (locally and nationally, individually and corporately), improving safety and quality, enhancing productivity, and engaging clinicians and recipients of care in all of this. NHS managerial structures are changing and this will continue, along with the provision closer to home for the more generalist services and consideration given to specialist services.
Regulation of the professions is continuing to come under scrutiny and this is focusing on quality and safety. There is an increase in specialist and advanced roles and with this comes a blurring of professional and sector boundaries (i.e. health and social care sectors). Care provision will increasingly follow the patient pathway, with an emphasis on community care closer to home and multidisciplinary teamworking.

**Key Points**

- The fundamental basis of nursing is associated with caring and helping, and nursing can be described as both an art and a science.
- Caring defines nurses and their work and, as such, there are many facets associated with the role and function of the nurse. The role is constantly evolving and is difficult to classify.
- Care has been claimed to be an essential human need for the full development, health maintenance and survival of human beings in all world cultures.
- Many of the theories developed through the 20th century that relate to nursing have a philosophical foundation, and include ideas about the nature of nursing, the nature of the person, the nature of society and the environment and the nature of health.
- With regard to the demand for healthcare, there are many drivers, including the types and main causes of disease. Project 2000 introduced a framework for pre-registration nurse programmes, which was to radically change the experience of student nurses in practice and in education. New developments have seen the revision of nursing curricula from 2013 onwards.
- On 1 April 2013, the NHS saw its biggest reform in its 65-year history. Hundreds of NHS organisations were abolished and hundreds of others created, transforming the provision, commissioning and regulation of healthcare.

**Glossary**

**Essential skills clusters:** are incorporated into the programme of study throughout the 3 years. These are common to all fields and include care, compassion and communication; organisational aspects of care; infection prevention and control; nutrition and fluid management; and medicines management

**Fields of nursing:** identifies which area of expertise the nurse possesses at the point of entry onto the professional register, i.e. child, mental health, learning disabilities and adult fields of nursing

**GNC:** General Nursing Council (no longer in existence)

**NHS:** National Health Service

**Palaeopathology:** the study of diseases in past populations

**Project 2000:** a framework for pre-registration nurse programmes, which was to radically change the experience of student nurses in practice and in education

**RCN:** Royal College of Nursing

**Standards for competence:** identify the specific knowledge, skills and attitudes the student must acquire by the end of the programme within the context of their particular field of nursing

**Standards of proficiency:** identify what students must demonstrate at the point of registration with the NMC and guide the Approved Education Institutions (AEIs) and partners in the delivery of nurse education programmes

**Telecare:** the use of electronic equipment, sensors and aids used in a person’s home to support independent living

**UKCC:** United Kingdom Central Council for nursing, midwifery and health visiting (no longer in existence)

**References**


United Kingdom Central Council (1999) Fitness for Practice: The UKCC Commission for Nursing and Midwifery Education. UKCC, London.

