What a difference a nurse makes

An RCN report on the benefits of expert nursing to the clinical outcomes in the continuing care of older people
What a difference a nurse makes

An RCN report on the benefits of expert nursing to the clinical outcomes in the continuing care of older people

Authors

Pauline Ford, RCN Geronotological Nursing Adviser
Hazel Heath, former Chair, RCN Forum for Nurses Working with Older People and independent nurse adviser
Brendan McCormack, former Co-Director, RCN Gerontological Nursing Programme. Currently Professor and Director of Nursing Research and Practice Development, Royal Hospitals, Belfast
Lynne Phair, former Project Director RSAS Age Care and former member, RCN Forum for Nurses Working with Older People. Currently Consultant Nurse for Older People, Crawley Primary Care Trust.
Contents

Foreword 2
Introduction 3
Aims of this document 3
Demonstrating outcomes of nursing in the continuing care needs of older people 3
Outcome measurement 6
Alternative approaches to outcome measurement 6
Health and social care 7
Use of the domains 7
Suggested models for identifying and recording your own outcome indicators 8
- An example of the model in use 10
- Further examples of outcome indicators 15
Expert nursing 24
- Background 24
- Consumer perspectives 24
- What is nursing? 24
- What can registered nurses offer to older people? 25
- The benefits of nursing 26
- What does ‘expert’ nursing encompass? 26
- What can expert nurses offer older people? 27
Existing approaches to measuring quality 29
Conclusions and recommendations 31
References 31
Foreword

What a difference a nurse makes has been reproduced at the request of RCN members, who believe that the report continues to assist nurses in demonstrating their contribution to the continuing care of older people. In particular, nurses working in care homes may find this work helpful when needing to identify and articulate their specific contributions to the health and social wellbeing of older people.

**Pauline Ford**

*RCN Gerontological Nursing Adviser*
Introduction

Current health and social care policy has a strong impact on older people, in particular on their need for continuing care (DH, 2001). Historically, health care has been provided free at the point of delivery and social care has been means-tested. Much of the current debate focuses on the provision of continuing care for older people and the health component within such provision. Many nurses are finding that older people, who hitherto had been assessed as requiring continuing care with input from nurses, are now defined as requiring social care. This is sometimes in direct contradiction of assessments conducted by doctors and nurses who have determined on-going health care needs.

Aims of this document

The work presented in this document contributes to the debate at a time of increased emphasis on the provision of cost-effective and cost-efficient care. The importance of outcome measurement to the continuing care of older people is presented. However, the predominant focus on disease-specific outcome measures is challenged.

Generally, such measures focus on longevity, whereas the RCN Forum for Nurses Working with Older People and the RCN Older People and Mental Health Forum believe this ignores a more holistic view of life, which encompasses quality and life-satisfaction as perceived by older people and nursing staff in continuing-care settings. With this focus in mind, an alternative approach to outcome definition is presented that centres on identifying indicators of nursing practice using case examples. A framework for analysing such case examples is offered. The benchmark against which these indicators are presented is that of expert nursing practice.

Finally, this approach identifies specific nursing intervention outcomes. We would suggest that, in order to relate these to the overall quality of care, existing quality measures are used. Available and appropriate audit tools are recommended.

This document replaces the previous version of What a difference a nurse makes (RCN, 1997) and is now presented as complementary to Nursing assessment and older people: an RCN toolkit (RCN, 2004a). Indeed the work on outcome indicators led to the RCN’s work on assessment.

Demonstrating outcomes of nursing in the continuing care needs of older people

In the current nursing and health care climate, the need to demonstrate the value of nursing through the measurement of outcomes from practice has reached a new and important level of interest. Nursing has become vulnerable to inappropriate use because it has been over simplified by non-nurses who do not have a clear idea of the contribution made by expert nurses, or of what nurses do that is different to less skilled, cheaper labour. The result is ‘unfounded assumptions and myths about nursing costs, care-giver mix and nursing productivity’ (Patterson, 1992).

This is particularly evident in the care of older people, where decisions are being made about the most appropriate providers of continuing care services. Since the publication of the government’s guidance on the provision of continuing care (DH, 1995), locally the commissioning agencies have been busy developing ‘guidance criteria’ for the purchasing of continuing care. Coupled with this is the emergence of the ‘care home’, whereby the distinction between residential and nursing home registration is being eroded.

Both of these policy changes pose significant challenges to the care of older people, as interested agencies make the case for the provision - or not - of the most effective continuing-care services. Determination in England, of the registered nursing care contribution (RNCC) to calculate the cost of care delivered by a registered nurse, has created something of a lottery, in which the amount of money available for providing nursing care is decided.
after a locally developed assessment has been undertaken (DH, 2001). Accessing health care in a continuing care setting is a gamble and as consumers of health care, older people may have little choice in where and how this service is provided.

The lack of consistency in the provision of continuing care highlights an example of how older people do not have equal opportunity to access similar services. The current development of local criteria for the provision of continuing health care fails to identify a minimum acceptable level of registered nurses in meeting such needs. Indeed, an interpretation of some available criteria could lead to situations where no registered nursing would be on site, but instead would come from members of primary health care teams. The development of such a situation could lead to erosion of the continuing-care speciality and an overall lowering of the quality of care received by older people. It could also lead to delays in essential health care interventions.

In an ideal world, there is no reason why older people should not be afforded the same right to services as any other person (RCN, 2004b). We would want all older people to have personal and social security, physical and mental wellbeing, justice, information, opportunities for self-fulfilment and life satisfaction. We are aware from our own lives that these are goods to be cherished and it is likely that most of us would support this view. They represent the kind of life that most of us would want to live, even if it is only achievable through struggle and challenge.

However, these are not legal rights but well-established moral ones and thus are open to abuse. Older people have a right to effective and efficient continuing care that meets their individual rehabilitation needs and their needs for social contact and stimulation. They should be able to choose from a range of approaches to meet their social and health care goals. For example, if the need is for maintenance of optimum mobility, then the person should have access to a range of approaches geared to meeting this need, including exercise classes, movement to music, massage, progressive relaxation, swimming and walking.

When expert nursing in the care of older people is threatened, there is an urgent requirement to express outcomes that reflect the input of registered nurses, particularly in continuing-care settings.

The care of older people in continuing-care settings should be based on the maintenance of a normal pattern of life. Such an emphasis requires the nurse to adapt approaches to care to suit the individuality of the older person and the meaning that life holds for them. Therefore an approach to practice based on mechanistic forms of decision-making is usually inappropriate.

Instead, the nurse has to draw on factual knowledge placed in context by engagement with practice experience. This is knowledge that is deeply embedded and yet easily retrieved. Such tacit knowledge allows the expert nurse to engage in holistic decision-making and to avoid sole reliance on linear models (Benner, 1984).

Studies of skilled practitioners clearly demonstrate that much knowledge is embedded in the actions of practitioners, but, when asked, they are unable to describe such knowledge, other than its technical aspects. Also, in breaking down the whole into parts, the whole itself becomes unfamiliar.

Consider the nurse who is trying to calm a patient who has dementia and who is noisy and disruptive. During that process, the nurse engages in a complex collection of cognitive, behavioural and practical steps. However, the nurse does not recognise them as discrete steps and it is only through a complex process of reflection that the steps involved become clear. The deconstructed steps, taken out of the context by an unskilled practitioner, would not necessarily result in an effective outcome.

Benner (1984) and Benner and Tanner (1987) have clearly demonstrated the difficulties expert practitioners experience in describing everyday practice. They do not think in terms of systems and structures, nor do they address problem-solving with a mechanistic, linear approach. Instead, they think holistically. An expert practitioner ‘always knows more than they can tell’ and, by acknowledging intuitive thought, can act on hunches, draw on tacit knowledge and engage in holistic problem-solving (McCormack, 1992).

One of the problems with such knowledge is that it is difficult to quantify. It could be argued that a narrow approach to outcome-definition would only capture the technical aspects of practice - those which can be observed - and would fail to identify the creative decision-making processes involved in reaching a
successful outcome. As Eraut (1985) states: “Practical knowledge is never tidy, an appropriate language for handling much of it has yet to be developed.”

As expert practice is embedded in tacit knowledge, which cannot be identified through the narrow focus of task analysis, then the identification of outcome measures from skilled nursing in continuing-care settings is problematic. Therefore it can be difficult to describe the roles such practitioners play and, as a result, the need for such roles is often challenged. In today’s health care settings, this is evident in skill-mixing, where unqualified staff replace registered nurses, with role definitions based on task performance rather than holistic care. The current focus on health care assistants having a vocational qualification represents such a shift. The emphasis is on task-orientated ‘reactive’ care rather than ‘anticipatory’ holistic practice. The achievement of such tasks is easy to measure and easy to quantify. Gathering outcome data is also easier.

This is not to argue that nurses in continuing-care settings should not focus on hard outcome data - that is the measurement of nursing interventions and their effects on the health status of residents. Mansfield (cited in Seedhouse, 1986) describes health based on the individual’s ‘power to achieve’, writing:

“By health I mean the power to live a full, adult, living, breathing life in close contact with what I love - the earth and the wonders thereof - the sea, the sun, all that we mean when we speak of the external world. I want to enter into it, to be part of it, to live in it, to learn from it, to lose all that is superficial and acquired in me and to become a conscious, direct human being. I want, by understanding myself to understand others. I want to be all that I am capable of becoming so that I may be ...a child of the sun ...

But warm, eager, living life - to be rooted in life - to learn, to desire, to know, to feel, to think, to act. That is what I want. And nothing less. That is what I must try for.”

Seedhouse (1986), in using Mansfield’s work as a means of rejecting mechanistic views of health, offers a definition of health that encapsulates a picture of ‘total health’ that is relevant to older adults in continuing-care settings, saying:

“A person’s optimum state of health is equivalent to the state of the set of conditions which fulfil or enable a person to work to fulfil his or her realistic chosen and biological potentials. Some of these conditions are of the highest importance for all people. Others are variable, dependent upon individual abilities and circumstances.”

Such a definition of health includes individual health status, subjective interpretation of quality of life and individual desire and ability. The emphasis is on the individual’s potential to achieve his or her desired realistic health choices. This means that if a person has a broad and sound set of conditions that fulfil or enable them to achieve certain potentials, then health is good. If the set of fulfilling or enabling conditions is small and the conditions weak, then health is poor.

In setting out his proposals for positive approaches to dementia care, Kitwood (1995) contrasts ‘good’ and ‘poor’ care environments. While it is always difficult to generalise about good and poor practice, the distinctions made by Kitwood clearly highlight the differences between skilled, expert practice and poor practice:

Of the good care environment, he says:

“Those who have dementia are very much alive, responsive, relating to each other, making their presence felt; there is the sense that a lot is going on. The staff seem to enjoy what they are doing; they are satisfied, relaxed and free. Not all is happiness and peace ...but there is vitality, energy, inspiration.”

He defines the poor care environment as:

“There is a sense of deadness, apathy, boredom, gloom and fear; most of those being cared for appear to have given up hope, their last resort being an occasional moan, or shout, or angry outburst. The staff are patronising, cynical, uninvolved, and even relate to each other largely in superficial ways.”

Kitwood’s (1995) work on changing the culture of dementia care provides an example of how a positive view of ‘health as potential’ can change the lives of older people. It demonstrates how skilled and expert nurses, in collaboration with multidisciplinary teams, can achieve positive patient outcome.

The role of the nurse as an enabler of health in older
people, based on their individual life choices and potentials, is paramount in continuing-care settings. It is from this basis that outcomes from nursing in continuing care can be best achieved. But in order to take such an approach, a focus on measurement that incorporates structure, process and outcome is necessary.

As Donabedian (1992) argues, outcomes do not directly assess quality of performance. They only permit inferences to be made about the quality of the processes of care. By matching:

✦ structure - physical resources, including the number and competence of staff
✦ process - the way in which the service is organised and the way care is delivered
✦ and outcome - the end result of care

the ability to demonstrate the effect of the process of care delivery on the outcomes achieved becomes visible and based on evidence rather than inference.

Outcome measurement

Outcome is defined as the end result of care, as ‘changes (desirable or undesirable) in individuals or populations that can be attributed to antecedent health care’ (Donabedian, 1992). They include:

✦ changes in health status
✦ changes in knowledge acquired by patients or family that may influence future health
✦ changes in the behaviour of patients or family that may influence future health
✦ satisfaction with the care and its outcomes by patients and family members. (Donabedian, 1992)

Alternative approaches to outcome measurement

Donabedian (1980) has developed an ‘outcomes classification’ that identifies seven types of outcome:

✦ clinical - for example, the reduction/removal of symptoms, ‘cure’ of disease physiological-biochemical - for example, increased function
✦ physiological-biochemical – for example, the reduction/removal of symptoms, ‘cure’ of disease
✦ physical - for example, performance of physical activities
✦ psychological, mental - for example, feelings (reduction of pain), increased knowledge that is relevant to health care
✦ social and psychosocial - for example, coping behaviours, role performance
✦ integrative - for example, longevity, mortality
✦ evaluative -for example, client satisfaction.

As key clinicians/providers in the continuing care of older people, nurses need to be able to define and measure their unique contribution. However, in general a ‘health gain’ focus towards outcome measurement in all areas of health care provision is taken. This means the intervention results in a gain in health status for the patient (French, 1995).

Many interventions in the care of older people clearly result in a health gain - for example, increased compliance through teaching the patient about his or her medication; individual psychosocial assessment which reduces the need for restraint. However, much of the care of older people cannot be quantified in this way and the focus is on increasing quality of life rather than perceiving health gain simply as increased longevity. The desired outcome in continuing care cannot be based on such measures as morbidity and disease rates. The outcomes of care should be judged by assessing the resultant quality of life of residents (RCP /BGS, 1992).
Because quality of life is difficult to define and even more difficult to measure, particularly with physically and mentally frail people, outcomes from nursing in continuing care are not clearly articulated.

Health and social care

The advent of a single assessment process (SAP), first described in the National Service Framework for Older People (DH, 2001) has prompted local health and social agencies to work more closely with an ambition that assessment and subsequent care planning are person centred, effective and co-ordinated. This offers nursing the opportunity to identify and articulate their contribution to the overall wellbeing of older people who require continuing care, irrespective of the setting.

The measurement of outcomes requires the identification of patient/client outcome criteria specific to nursing, and the development of reliable and valid methods and measurement tools (Bloch, 1975). Bloch suggests that an outcome criterion should include, in good measure, a change in the status of the patient, as a result of the care given, and the level and time at which it should occur. However, Bloch also points out that the goals of nursing interventions are often complex and include multiple domains such as knowledge, compliance, behavioural change and physiological status.

Given this assertion, the need to articulate the processes involved in ‘expert’ nursing with older people, in order to identify criteria for the measurement of effective practice, is paramount. Therefore, a framework for outcome definition developed by four nurses expert in the care of older people is offered. The framework is developed from the work of Seedhouse (1986) and Kitwood (1995), from good practice evidence collected from practice experience, and from a review of the literature on the care of older people. On the basis of this evidence, three domains that encompass the main foci of the continuing care of older people have been developed:

**Maintenance of health status**
- Maximising health status
- Assessing health status
- Preventing disease complications
- Managing risk
- Rehabilitating
- Identifying and relieving symptoms.

**Prevention and relief of distress**
- Providing essential care and palliation
- Identifying problems and coming to terms with life
- Preventing pain
- Treating pain
- Assessing mental health.

**Maximising life potential**
- Offering health promotion and education
- Developing throughout life
- Fostering meaningful relationships
- Contributing to life
- Reciprocating
- Coping with adversity.

Use of the domains

Using a tape recorder, we described and analysed practice examples, using the suggested model for identifying and recording outcome indicators from each of the domains in the framework. In particular, we tried to identify examples where a registered nurse made an important contribution to the care of a patient.

We then applied a matrix analysis (see examples on pages 15 to 23) in order to identify the distinct knowledge, skill and experience that distinguished the contribution of the qualified nurse in each practice example. The analysis matrix had four categories - empirical knowledge, tacit knowledge, skills and experience.
Suggested model for identifying and recording your own outcome indicators

Identifying the contribution of registered nurses in any given situation means the nurse must be able to reflect on practice. To do this effectively, you need to be able to identify aspects of practice that serve as examples of where you, as a registered nurse, made an important contribution. You may not always know immediately why these experiences are important but, when they occur, they tend to make you stop and think for a bit longer than usual.

These descriptions of practice are known as critical incidents (Norman et al, 1992). They are incidents you consider to be important examples of nursing practice.

**Stage 1**

**How do I identify a practice example?**

Identify an incident:
- in which you feel your intervention really made a difference to the care of a patient
- where you observed another staff member practice in a way that you felt made a difference - positively or negatively - to the outcome of care
- that went very well for you and/or the patient
- that, against expectation, did not go well
- that highlights the ‘ordinary and everyday’ practice of nursing you feel expresses what nursing is all about
- that was particularly demanding and stretched your skill as a nurse.

**Stage 2**

**How do I reflect on the practice example?**

Many nurses find it difficult to reflect on an actual incident from practice. This is because, when we are skilled at something, we take for granted all the different components that make up that skill. In order to help you to reflect effectively on practice, and identify the key indicators from practice, we offer you the following framework (adapted from Benner, 1984, and Oxford Community Hospital, 1992).

### 2.1: Describing the experience

Think about:
- the context of the incident - time of day, shift, staff involved, anonymous details about the patient
- a detailed description of what happened - break the incident down into each of its components and stages
- why you consider this incident to be ‘critical’. For example, because it highlights a particular nursing skill, demonstrates the need for up-to-date knowledge in the area of practice, or identifies an essential need for registered nurses
- what your concerns were at the time
- what you were thinking about while it was taking place
- what you found most demanding, interesting or challenging about the situation.

### 2.2: Clarifying the experience

- What essential factors contributed to the experience?
- What were you trying to achieve?
- Why did you intervene as you did? For example, what particular knowledge, skills or experience led you to believe that this was the best course of action?
- What skills did you use when intervening in this way?
- What were the consequences of your actions for you, the patient/family and the people with whom you work?
- How did you feel about this experience when it was happening?
- How did the patient feel about it?
- How do you know what the patient felt about it? Did you use any particular knowledge, skill or experience to help recognise this?
2.3: Learning from the experience

✦ What knowledge influenced your decisions and actions? Was it ‘instinct’ or specific knowledge, such as research findings?
✦ What other choices did you have?
✦ What would be the consequences of these other choices?
✦ How do you know what these consequences would be? Do you have any particular past experience?
✦ How do you now feel about this experience?
✦ Could you have dealt better with the situation - for example, by developing or enhancing a specific skill?
✦ What have you learned from this experience?

Stage 3
Analysing the experience and applying the matrix

From your learning, identify the key elements of the experience under the four headings within the matrix.

**Empirical knowledge** - this may derive from one or more of the fundamental sciences from which nursing knowledge is synthesised - for example, psychology, physiology or sociology - from nursing knowledge or research, or from that of an allied profession - for example, medicine or pharmacology. This category could also include recognition of fundamental codes or principles of nursing, such as confidentiality.

**Tacit knowledge** - the actions you took almost automatically, without necessarily rationalising what you were doing or why you were doing it.

**Skills** - the abilities that nurses use in their everyday practice, including specific assessment skills, psychomotor skills, and ‘being with’ skills such as supporting, facilitating, counselling or challenging.

**Experience** - the understanding that derives from recognising from a previous encounter a similar pattern of events. Identifying the elements of these that help you recognise situations, understand the potential consequences and select an appropriate action.

Stage 4
Identifying the outcome and the indicator for nursing

Having reflected in this way and applied the matrix, the outcomes and indicators for nursing become clear.

You can then make the following statements:

4.1. What were the final outcomes of your intervention for the patient/family?
4.2. What was the indicator for nursing? In other words, what was the distinct contribution that the registered nurse made to the situation, or why did the intervention need to be carried out by a registered nurse rather than by someone else?
Here is an example of the model in use:

**Stage 1**
**Identifying a practice example**

The care of Mr Cox and his family.

**Stage 2**
**Reflecting on the example**

2.1 **Describing the experience**

It was an early shift and the GP asked to admit a patient - Mr Cox - who was being cared for at home. He had now become seriously ill and the family was unable to cope any longer. On arrival at the ward he was very poorly, restless and agitated. His family was obviously very distressed and upset by his sudden deterioration. They wanted to continue to care for him and were struggling to help settle him.

Throughout the shift I stayed with him as much as I could, allocating other aspects of my caseload to other members of the team. I worked with the family to maintain their involvement, as they were clearly unable to let go yet. I did all the usual things – ensured he was on an appropriate pressure-relieving mattress, sorted out appropriate analgesia, and established from Mr Cox and his family how he usually liked to be cared for and what things in his life he valued highly.

By the time I went off duty he was more settled. But I felt uneasy during the evening and eventually I rang the hospital to see how he was. The nurse on duty said he was ‘very poorly’ and that it was difficult to do anything for him without his wife ‘interfering’ and objecting. I felt that his wife, Ann, hadn’t taken on board that her husband was probably going to die soon and decided to go in and talk to her. It was just a feeling, and I needed to do it, but I was unsure how the night nurses on duty would feel about this.

When I arrived on the ward they were a bit off with me, but I explained to them my motives. Mr Cox died at 11pm and I stayed and supported Ann, her family and the ward team.

2.2: **Clarifying the experience**

✦ **What essential factors contributed to the experience?**

He was very poorly and I felt he was going to die soon. I also felt that his wife had not come to terms with this and I knew that, if I was right, then she would need support. I also knew from the time I spent with her that he needed to trust somebody before he could let go. I felt that I had established this trust. I was sure I had gone back to work for the right reasons - therapeutic, unfinished business, something I wanted to do. Help! The reaction of the night staff took the wind out of my sails.

✦ **What was I trying to achieve?**

I wanted to go back and spend time with Mr Cox and his wife. I knew things would be quiet and I would not be disturbed. I had the time and knew no one would call me away. I needed to support Ann. She trusted me and needed my help.

✦ **Why did I intervene as I did?**

The night nurses on duty didn’t know Mr Cox and his family very well. I needed to offer care and support to them and I felt I needed to offer the night staff support too.
What skills did I use in intervening in this way?

- Assessment - recognising the needs of Mr Cox, his wife and family and the staff.
- Decision-making - weighing up the options.
- Negotiating with the staff on duty.
- Supportive.
- Listening.
- Skills of ‘being with’.

What were the consequences of my action?

For me?
I felt I was completing something I had started. I felt I was finishing the job properly and that I was completing the unwritten contract of support that I had negotiated with Ann.

For the patient/family?
Ann was pleased to see me. We sat together with her husband, simply talking about what we felt was happening. I was able to help Ann realise gradually that her husband’s death was imminent. She was able to cry and get angry, knowing she could do this with someone who genuinely cared about her.

The people I work with?
I’m not sure whether they were pleased to see me. Did they think I didn’t trust them, or that I thought they wouldn’t be able to do the job as well as me? They certainly used me to vent their anger and their feelings in general.

How did I feel about this experience when it was happening?
I felt good, satisfied, and that I was offering genuine care to Mr Cox and Ann. I was able to help them make decisions that they felt unable to make at the time. I was surprised by the reaction of other staff. I wasn’t expecting a challenge. I felt hurt and upset. I felt attacked.

How did the patient feel about it?
Mr Cox was settled and relaxed during my time with him. His wife became confident with my support to observe his behaviour and adjust his patient-controlled analgesia as necessary. During short periods when he was alert he would stretch out his hand towards Ann and she was able to respond accordingly. I felt good about this as it showed that she was coming to terms with the situation. I was able to stay with them and be there when they needed me.

How do I know how the patient felt about it?
He was relaxed. His behaviour showed that his pain was under control. He smiled occasionally and requested his wife’s touch.

2.3: Learning from the experience

What knowledge influenced my decisions and actions?
Knowledge of therapeutic nursing; terminal care, and its application to the care of older people; promoting comfort and managing pain; relationships, and the importance of Ann remaining involved; how to negotiate in awkward situations; ‘being with’ somebody who needed support.
**What other choices did I have?**

I could have done nothing. I needn't have rung the ward and, even when I did, I didn't have to go back there. I could have talked more to the night nurses and left them to manage the situation with support from home by me, should they have needed it.

**What would be the consequences of these other choices?**

Ann may have not trusted the staff enough to work with them. As a result, Mr Cox might have been more in pain and less settled. Staff might have tried to take over, and thus cause more stress to Ann and her husband.

**How do I know what these consequences would be?**

I know that Ann finds it difficult to trust people with her husband’s care. I also know how some of the night staff on duty find it difficult to leave control over care with the patient and family. I know that I would not have settled in the night, given my understanding of the situation.

**How do I feel now about this experience?**

I feel I did the right thing in going back. I felt I hadn't finished a job properly and wouldn't rest until I had. I feel that although I tried to defend and support what I was doing, and how I was developing my practice, the attitudes of the night staff show that we have a long way still to go.

**Could I have dealt better with the situation?**

I don't feel I could have cared for Mr and Mrs Cox any better. I could have tried to negotiate more with the staff on duty, but I felt my priority was with the patient. The staff’s attitude is something I can address at another time.

**What have I learned from this experience?**

It is important that I do not allow others’ negative views to affect the way I want to care for patients. I know the importance of patient-centred practice in the care of older people. I know that the opposite means that patients and their families will not be fully satisfied with the outcome of their care. I have also learned that, in developing this way of working, I am going to meet many obstacles. I am able to relate this experience to change theory I have read in my professional development programme. I have learned to believe in my feelings. My supervisor calls this ‘intuition’, but to me they are feelings that I’m convinced are right. I need to read more about this.

---

**Stage 3**

**Analysing the experience and applying the matrix**

What were the distinct skills, experience, empirical and tacit knowledge that I, as a registered nurse, brought to this situation?

**Knowledge**

**Empirical**

- Physiological adjustment to illness and death, and the importance of control over all aspects of this process (Parkes, 1991).
- The physiology and psychology of dying, including the potential effects of this on a family (Hockley, 1991).
- Physiology in pain relief, including nursing measures to promote comfort and rest (White, 1995).
- Pharmacology in pain relief, including combinations of drugs for maximum palliation, and medication delivery methods, such as patient-controlled analgesia (Webster, 1995).
- The scope of the role and accountability of the qualified nurse.
Tacit
This is evident throughout the nurse’s experience of the practice example. It is particularly evident in an instinctive appreciation of, for example:

✦ the changes which precede death
✦ the importance of supporting Ann and Mr Cox’s family
✦ the importance of facilitating the choices of Mr Cox and his family
✦ doing what ‘feels right’ for Mr Cox, his wife and family, despite the personal uneasiness caused by the reactions of the nurse’s colleagues.

Skills
✦ Assessing – recognising the needs of Mr Cox, his wife and family, and the other staff, particularly listening and observation skills.
✦ Decision-making – weighing up the options of the situation.
✦ Interpersonal – supporting the patient in the expression of his wishes, and his wife in her wish to care.
  ‘Being with’ skills.
✦ Clinical nursing – helping Mr Cox achieve maximum physical and psychological comfort.
✦ Using equipment – such as pressure-relieving devices or the syringe driver.
✦ Negotiating – working with and supporting other staff during difficult times.
✦ Intra-personal – appreciating the effects of such a situation on her, seeking help when appropriate. Coping skills.

Experience
✦ Similar situations in the past - either experienced or observed - enabled the nurse to look at all the cues, including the subtle ones, and to prioritise, respond and act accordingly.
✦ An accumulation of experience that enabled the nurse to work competently and confidently with people who are undergoing traumatic and painful experiences.
✦ She had the confidence and competence to support them in a caring and professional manner.
✦ The nurse had the experience to create an environment in which a person can die as peacefully as possible, and in the way in which they would wish.
✦ She had experience that allowed her to expand boundaries in order to give the best care possible - in this example, the predetermined hours of work.
Stage 4
Identifying the outcome and the indicator for nursing

4.1: What was the final outcome from this intervention for the patient and family?
✧ Mr Cox had a peaceful and pain-free death.
✧ He died as he had wished, with his family around him.
✧ With support, Ann was able to accept the situation and offer her husband the care he needed from her. Ann felt satisfied that she had done all she could.

4.2: What is the indicator for nursing?
✧ The registered nurse caring for a person with complex health and psychosocial needs will perform an assessment in order to uncover the complex factors that may cause an altered health state.
✧ The registered nurse understands the significance of presenting symptoms and how these might be relieved.
✧ The registered nurse understands about combinations of interventions/treatments/therapies and their effects, and draws from a range of options for the relief of distress and the promotion of comfort.
✧ In each of these elements, the registered nurse prioritises, balances and works with the needs of the patient, the family/significant others, and other health and social care staff.

(This indicator would be categorised within the domain of ‘The prevention and relief of distress’ on the original continuing care framework.)
Further examples of outcome indicators

**Domain: Maintenance of health status**

**Indicator for nursing:**

The registered nurse understands the complexity of the presentation of everyday physical symptoms. On the basis of these symptoms, they have the confidence to look beyond the obvious, recognise patterns, and initiate a series of complex interventions that collectively lead to improvement in a patient's health or the prevention of further physical and mental deterioration.

**Example 1: Recognising and treating urinary tract infection.**

**Knowledge**

**Empirical**

- Physiology of urinary tract infection (UTI)

**Tacit**

From previous experience of caring for older people who develop UTIs, the registered nurse understood that 'strong smell' is not a normal characteristic of urine. She also looked beyond the characteristics of the urine for other symptoms, such as agitation - a characteristic of raised temperature. The nurse then initiated a series of tests to determine a diagnosis and isolate other causes. These included temperature-taking and mid stream urine (MSU). From her knowledge of working with older people, she further recognised that the patient would need to increase her fluid intake, but that this would need to be explained to the patient so she could comply with the treatment plan. Using all this knowledge, the nurse was in a position to discuss the patient's case confidently with the doctor.

**Skills**

- Observing physical/behavioural characteristics.
- Appropriate questioning of the patient to determine changes in condition.
- Clinical skills - urine testing, temperature-taking, MSU. Patient education.
- Relating abnormal physiology to treatment interventions. For example, increasing fluid intake to enhance renal filtration.

**Experience**

- The nurse's experience of these situations enabled her to look at all the cues, including the behavioural ones, to discriminate between them and follow up those that were important.
- She knew how to prioritise the stages of investigation and treatment, and her experience enabled her to start interventions without the need to seek prior permission from another person, thus preventing further deterioration.
- Her experience of caring for older people enabled her to communicate effectively to the patient what the presenting symptoms meant and the course of actions, thus increasing the patient's compliance with treatment. Her experience also enabled her to recognise an opportunity to undertake health education and to negotiate with others who might need to be involved - for example, the doctor, care assistants.
- The registered nurse would consider the environment and whether the older person can operate within that environment. For example, whether they can get out of the chair to get to the toilet, whether they know where the toilet is and whether any of the presenting symptoms could lead to sudden incontinence.

**Outcomes**

The patient:

- gained increased knowledge of the significance of symptoms
- increased their compliance with treatment
- had their treatment was initiated more quickly
- recovered more quickly and the length of admission was shortened.
Domain: Maintenance of health status

Example 2: Investigating the cause of recurring falls during the night and taking appropriate action.

Knowledge

Empirical

✦ Research on sleep promotion (Hayter, 1983; Clapin-French 1986).

Tacit

It was mentioned in passing to the registered nurse that one of her patients had fallen on three occasions. She overheard a discussion among some care assistants who were trying to decide how to prevent this from happening. They had concluded that cot-sides were needed and that the patient’s night sedation needed attention. The registered nurse reviewed the accident forms recording these incidents and noted that each fall had taken place at the same period in the night - between 1am and 2am. The nurse spent some time with the patient and established that she was trying to get out of bed to go to the lavatory. The patient said she did not like having to get up at this time to pass urine as she could not find her way in the dark, she lacked confidence in walking and she was unable to return to sleep.

The nurse instigated a 24-hour continence assessment, matching this with a recording of the patient’s fluid and nutritional intake. The nurse established that the patient was on twice-daily diuretics to manage her congestive cardiac failure and that one of these diuretics was given at 6pm. The nurse discussed this with the doctor in the context of the patient’s overall condition. The drug administration time was altered to 2pm. The nurse also discussed with the patient how she might modify her fluid intake so that she could have her two drinks slightly earlier, therefore reducing the need to pass urine in the night. The outcome was that the patient developed a pattern of micturition that did not disturb her sleep and she no longer needed to get out of bed at night.

Skills

✦ Not accepting information at face value and investigating possible causes.
✦ Using focused questioning techniques to establish from the patient what had happened and her perception of the cause.
✦ The appropriate use of assessment – in this case of continence - to reach a diagnosis.
✦ Patient-education – helping the patient understand the importance of altering her usual routine in order to reach a more satisfactory outcome.
✦ Negotiating with medical and other staff.

Experience

✦ The nurse’s experience meant she did not accept the view expressed by her care assistant colleagues, and from her knowledge of research, she knew there would probably be a reason for these falls.
✦ Her experience directed her to seek the patient’s interpretation of events and to view this as important.
✦ She integrated the patient’s interpretation with a systematic assessment of the patient, exploring different perspectives: continence; fluid and nutrition; medication. She knew these areas would be interrelated.
✦ She knew from experience the importance of collecting all relevant facts before initiating a discussion with the doctor. This led to a quicker resolution.

Outcomes

✦ The patient was able to sleep for longer periods.
✦ The patient’s drug regime was more appropriate.
✦ The risk of falls was reduced.
✦ Patient satisfaction was increased.
Domain: Maintenance of health status

Example 3: Recognising the potential causes of breathlessness and initiating appropriate action.

Knowledge
Empirical
✦ Theory relating to congestive cardiac failure.

Tacit
From previous experience of caring for older people who develop breathlessness, the registered nurse recognised that breathing sounded different in a patient with a chronic chest condition. She knew that congestive cardiac failure is a common condition among older people, and that the symptoms of such a condition would need to be determined before any other action was taken. She knew the effects of oxygen therapy on people with depressed respiratory functioning and would not automatically initiate oxygen therapy. Nor would she encourage bed rest as this could complicate the condition.

The registered nurse talked to the patient to ascertain other symptoms, for example, tingling in the fingers. The patient talked of increased difficulty with sleeping and said she thought her stockings felt tighter. The nurse sought the assistance of the physiotherapist in order to obtain a sputum specimen, as she knew that such patients do not expectorate easily. She made sure the patient was comfortable and minimised all activities so as to preserve energy and prevent deterioration. She helped the patient to alter her breathing, slowing it down and easing the tension in her shoulders. She talked to the patient to help her relax. She contacted the GP immediately.

Skills
✦ Observing different from usual physiological and behavioural signs.
✦ Seeking out subtle changes in the patient’s normal pattern, in order to reach a differential diagnosis.
✦ Understanding the appropriate use of oxygen therapy and when it should be avoided.
✦ Seeking the skills of another professional – in this case a physiotherapist - in order to obtain a sputum specimen.
✦ Helping to reduce patient anxiety.

✦ Recognising that distressed breathing can cause patient anxiety, which can lead to further breathing difficulties.
✦ Prioritising what was important for the patient at the time and ensuring that strenuous activity was not undertaken.

Experience
✦ The nurse’s experience of such situations enabled her to take immediate action. She knew from her knowledge and experience that the patient’s breathing had changed.
✦ Her experience helped her to elicit further subtle changes in the patient’s condition that would enable her to make a preliminary diagnosis and help her to explain to the doctor what was happening.
✦ Her experience of administering oxygen to older people cautioned her against its use in this case.
✦ She had prior experience of trying to obtain a sputum specimen from such patients and was aware that it required much effort on their part, causing further distress. It often took a long time for the patient to produce it. Therefore, she avoided further patient distress and obtained a specimen immediately.
✦ She knew from experience that older people with long-standing breathing difficulties do not engage in deep, diaphragmatic breathing, but instead compensate by tensing their thoracic muscles. The nurse engaged the patient in relaxation activities to assist deep breathing and release tension.
✦ Her experience also told her that early intervention could be successful in such cases and she sought the assistance of the GP at an early stage.

Outcomes
The patient:
✦ experienced decreased anxiety
✦ had their condition detected more promptly and relief obtained
✦ was able to expectorate more effectively
✦ was prevented from experiencing complications or deterioration in their condition.
Domain: Prevention and relief of distress

Indicator for nursing:
The registered nurse caring for a person with complex health problems will perform an assessment in order to reveal the factors that may cause an altered health state. Knowing about combinations of treatments and their effects, the registered nurse understands the significance of presenting symptoms and how they might be relieved. The nurse draws on a range of options for the relief of distress and the promotion of comfort and combinations of treatments and effects.

Example 1: Identifying and managing challenging behaviour.

Knowledge

Empirical
✦ Role of stimulation in the prevention of distress (Kitwood, 1995).

Tacit
The registered nurse identified noisy and agitated behaviour in a nursing home resident.
The nurse established that medication was not being given and that the noisy and agitated behaviour was being reinforced by care staff, who paid the resident attention by telling him off. The nurse recognised that the care staff compounded the resident’s sense of isolation by leaving him in a room on his own at all times. The registered nurse taught care staff how to give positive reinforcement, centred on normal activities of living. This meant that care staff were providing stimulation and validating his feelings, staying with him while he was not disruptive. As a result, the resident was reintroduced into the community of the home.

Skills
✦ Observing staff attitudes and behaviour.
✦ Observing the environment and how the resident interacted within it.
✦ Listening to the kind of repetitive noise being made.
✦ Listening to what care staff were saying.
✦ Sensitively questioning staff.
✦ Liaising and facilitating to promote change in practice.
✦ Giving constructive feedback to staff.

Experience
✦ The nurse’s experience of dementia enabled him to recognise that repetitive behaviour and noise are not usual behaviour in those residents with dementia.
✦ From experience, the nurse knew the effects of reinforcing behaviour.
✦ The nurse’s experience told him to review the medication chart and to observe what was going on.
✦ The nurse’s experience regarding optimum environments led him to translate those general principles into everyday practice within the home.
✦ Experience of leading, managing and teaching care staff enabled him to adopt ideal strategies.

Outcomes
The resident:
✦ had his distress relieved
✦ became less challenging in his behaviour. The care assistants’ knowledge was increased
✦ settled into the community of the home.

✦ Translating personal knowledge so that care assistants could understand the resident’s needs.

WHAT A DIFFERENCE A NURSE MAKES
Domain: Prevention and relief of distress

Example 2: Supporting a patient with a fungating breast cancer who expresses a wish not to be treated.

Knowledge

Empirical

✦ Psychological adjustment to illness and death, and the importance of control over all aspects of this process (Parkes, 1991).
✦ Physiology in pain relief, including nursing measures to promote comfort and rest, for example, body positioning (White, 1995).
✦ Pharmacology in pain relief, including combinations of drugs for maximum palliation, and medication delivery methods, such as syringe drivers (Webster, 1995).
✦ The physiology and psychology of dying, including the potential effects on surviving family (Hockey, 1991).
✦ The scope of the role and accountability of the qualified nurse. The importance of thorough risk assessment and documentation.

Tacit

While assessing a woman with a fungating breast cancer who had been admitted for care, the expert nurse recognised that the patient was adamant that she did not want any active treatment for her cancer, and wanted to die in comfort. The woman also stated clearly that she wanted to die with dignity, and particularly that she did not want to be seen naked at any time; she had never exposed her body to anyone, not even her husband.

The nurse recognised the importance of adhering to the woman’s wishes, while relieving her pain and actively promoting her physical and psychological comfort. The nurse helped more junior staff to understand the reasons why it would not be appropriate to insist that the woman’s breast lesion should be dressed, but that all palliative measures, such as a syringe driver for pain relief, should be offered.

The registered nurse supported the woman, her family and the other nurses in the team, so the patient could die in the way she had requested.

Skills

✦ Interpersonal – supporting the patient in the expression of her wishes, and her family as appropriate.
✦ Clinical nursing – helping the patient remain comfortable in whatever manner is acceptable to her.
✦ Using equipment, such as the syringe driver.
✦ Team leadership - assertiveness and support of junior staff during difficult times.
✦ Intra-personal – appreciating the effects of such a situation on self, seeking help when appropriate. Coping skills.

Experience

✦ The nurse’s experience enabled her to appreciate the importance of supporting the woman’s decision not to accept treatment, while acknowledging the implications for nursing staff. The nurse’s experience thus helped her to work within the patient’s parameters at all times, and to support her in the risks that she wanted to take.
✦ Her experience also helped the nurse to support her colleagues.
✦ She had the experience to assume full professional responsibility and accountability for the risk elements of the situation. This meant that the nursing team was unable to give full care, such as dressing the breast lesion.

Outcomes

✦ The patient was able to die in the way she wished and in comfort.
✦ The patient maintained her dignity, choice and control.
✦ The understanding of junior staff was increased.
Domain: Prevention and relief of distress

**Example 3: Recognising rheumatoid arthritis and offering support.**

**Knowledge**

**Empirical**

✦ Physiological changes in rheumatoid arthritis and their manifestations.

✦ Physiological effects of lifestyle adjustments - for example, rest - and complementary measures.

✦ Psychological effects of pain and increasing disability - for example, changes in body image, effects on quality of life (Price, 1993).

✦ Pharmacological effects of medication (Webster, 1995).

✦ Knowledge of the roles and services offered by other professionals in the multidisciplinary team (Hill, 1992).

✦ Understanding of ergonomics and safe moving techniques (Slack and Phair, 1995).

**Tacit**

When visiting a newly diagnosed diabetic woman, the community nurse noticed her joints were swollen and that she was showing signs of discomfort when trying to move around.

While talking with her, the registered nurse automatically assessed the degree of joint swelling and tenderness, and the woman's movement. She also listened for indications of how the woman felt about her life, health status and general functioning. The nurse identified the patient's priorities and planned how these could be achieved. She also listened for clues that suggested problems the woman may be too embarrassed to discuss – for example, sexual difficulties - and assessed how best to approach these.

The registered nurse then took time to discuss the woman's feelings, particularly regarding those aspects that may be sensitive or embarrassing to discuss. The nurse discussed what help could be offered by the multidisciplinary community team, and how assessments could be carried out. She also reassured the patient that there were a variety of treatments that could help relieve the discomfort of arthritis, and explained how she would refer her to the GP. She then discussed with the patient how she might adapt her lifestyle to minimise her discomfort and maximise her functioning.

**Skills**

✦ Observing physiological change, movement and dexterity.

✦ Listening, questioning, clarifying and summarising.

✦ Supporting and helping the person to feel valued and heard.

✦ Educating, advising and teaching to explain lifestyle adjustments, supportive measures and the effects of medication.

**Experience**

✦ The nurse's experience enabled her to understand and empathise with the person's feelings about increasing disability and dependency on others, feeling unproductive, and constant physical pain or discomfort.

✦ The nurse was also able to be supportive, while using her experience to suggest ways in which pain and disability can be minimised.

✦ She had the experience to understand the effects of the condition and how pain control can maximise quality of life. She also had an understanding of how rheumatoid arthritis may affect all aspects of life.

**Outcomes**

The patient:

✦ had their comfort enhanced

✦ was able to adapt her lifestyle to enhance her comfort and functioning, and reduce her pain.
Domain: Maximising life potential

Indicator for nursing:
The registered nurse recognises the importance of people being in control of their lives even though they are ill, the significance of maintaining continuity with what they find meaningful, and the need to maximise opportunities for life fulfilment.

Example 1: Identifying the need to express sexuality in chronic illness.

Knowledge
Empirical
✦ Normal ageing process and its impact on sexual activity (Masters and Johnson, 1970).
✦ Physiological and psychological effects of myocardial infarction (Pathy, 1991).

Tacit
An elderly man who had recently experienced heart attacks wanted to continue his sexual relationship with his wife. The registered nurse approached this subject sensitively, discussed it with the couple and was able to talk through how they would prepare for their lovemaking. She also discussed how they would balance this with medication and how suitable positions would minimise strain on his heart.

The registered nurse used her knowledge of the physiological effects of medications and the exertion of the lovemaking. The nurse also had the interpersonal skills to be able to broach and discuss such sensitive areas, while causing minimal discomfort to the couple.

Skills
✦ Identifying the special needs of someone experiencing ageing alongside a chronic illness.
✦ Selecting from a range of options to facilitate the promotion of a fulfilling sex life for the patient and partner. Initiating discussion following sensitive assessment.
✦ Incorporating the discussion of sexuality and sexual intercourse into the rehabilitation plan and health education programme.
✦ Balancing knowledge of physical exertion, medication and emotional state in an acute risk environment.

Experience
✦ The nurse’s experience enabled her to recognise the patient was sexually active.
✦ The nurse had a broad view of health and the ability to incorporate health needs into a plan of everyday living.
✦ She had the experience to identify, with sensitivity and skill, that sexual activity is desired, and the ability to work with the older person to overcome risks and maximise potential for a full sex life.
✦ She had experience relating to ageing and sexuality, understanding its significance in relation to chronic ill health.
✦ She had experience of the physical effects of heart attack and how this relates to the effects of ageing.

Outcomes
The patient felt:
✦ valued and cared about
✦ he could take control, in an informed way, of the sexual aspects of his relationship
✦ empowered to balance his medication and his sexual activity.
Domain: Maximising life potential

Example 2: Preventing depression.

Knowledge
Empirical
✦ Psychological and physiological effect of depression (Jones, 1989).
✦ Indicators of suicide and parasuicide.
✦ Communicating skills with people with depression.
✦ Therapeutic touch (Sayre-Adams, 1994).

Tacit
A woman had recurrent episodes of depression. The care assistant said she was improving as she was eating, sleeping and watching television. However, the registered nurse recognised that a person with depression may start physical activity before emotional feelings have improved. The nurse also knew that people with depression sometimes act in a way to suggest they are better, in order to mask their true feelings.

The registered nurse noticed that the woman sat for only a few minutes at a time and that, when she watched the television, her eyes were glazed. When eating her meal, her feet were constantly moving. The registered nurse sensed that the woman was masking her true feelings. Using counselling skills, touch, verbal and non-verbal communication, the nurse encouraged the woman to talk. The woman said she could not concentrate, that she was agitated and was worrying constantly about her family. The nurse then discussed an appropriate plan of care with the woman.

Skills
✦ Not accepting information at face value and investigating possible alternatives.
✦ Using observation to assist in her assessment of the person's mental state.
✦ Recognising a person's normal activity as an indicator of health state.
✦ Employing counselling skills appropriately.
✦ Employing effective communication skills appropriately.
✦ Sensibly monitoring diet and level of activity.
✦ Using intuition and discretion to develop a trusting relationship.

Experience
✦ The nurse had observed similar situations and noted a discrepancy between what the patient was saying and what she was doing.
✦ She had experience of patients with depression whose physical abilities improve, thereby creating a false impression of their underlying mental state.
✦ She had experience of patients with depression and its impact on eating and sleeping.

Outcomes
The patient:
✦ had their mental health need recognised
✦ received prompt and skilled assessment and treatment
✦ felt valued and listened to.
Domain: Maximising life potential

Example 3: Recognising problems and religious need in a person who has had a stroke.

Knowledge

Empirical

✦ Physiological effects of stroke.
✦ Spatial and visual impairment.
✦ Psychosocial impact of communication.
✦ Knowledge of cultural and religious beliefs.

Tacit

A nursing assistant was helping to feed a Hindu woman. The woman had suffered a stroke and was partially sighted, and the nurse noticed that the patient was refusing to eat. The nursing assistant was getting impatient with the woman.

The nurse knew it was important that the woman should not feel rushed and that she should feel valued. The nurse took over. She explained to the patient where the plate was and the food that was on it. She then gave the woman the spoon in her right hand, in line with her religious custom.

While sitting with the woman, the nurse noticed she was taking a little longer to swallow than usual. The nurse knew the possible effects of a stroke on the swallow reflex, but was aware that something had changed, although at this stage she was not sure what. The nurse contacted the doctor who, after examination, confirmed that the woman had experienced an extension of her stroke. She was transferred to an acute unit for treatment.

Skills

✦ Being able to anticipate how the patient may feel - empathy.
✦ Recognising body language and listening to verbal communication.
✦ Matching theoretical knowledge of stroke with the beliefs and customs of the patient.
✦ Using skills of empowerment to maximise potential.
✦ Balancing self-care and perceptual difficulties with environment to maximise potential for recovery.
✦ Recognising deterioration in swallowing function.

Experience

✦ The nurse had experience of dealing with similar patients.
✦ She acted as a medium for rehabilitation.
✦ She had experience of the subtle changes that can occur with the swallowing reflex.
✦ She recognised that food is necessary for maintenance of life.

Outcomes

The patient:

✦ received prompt recognition, diagnosis and treatment
✦ had their religious choices recognised, respected and facilitated
✦ felt valued as an individual, cared about and cared for.
Expert nursing

Background

Nurses are key providers of health and social care, and their work has come under increasing scrutiny by policy makers, as well as by service purchasers and providers in terms of cost effectiveness and quality of service (Audit Commission, 1991; Bagust and Slack, 1991; Buchan and Ball, 1991 and 2001; Bagust et al, 1992; University of York, 1992).

In relation to older people, nursing services are provided in a variety of settings within the community and also in hospitals, nursing homes, residential care homes and in sheltered housing. Whatever the successes of community care it has been asserted by Henwood (1992), among others, that some form of residential care will always be needed.

In the present climate of cost-driven health services, nursing more than ever before must demonstrate its cost-effectiveness and its value (RCN, 2004b). It has been suggested that this could be ‘the greatest challenge of all time for nursing and the health services’ (Tierney, 1993).

Because NHS trusts are unable to demonstrate a link between the cost of nursing and the quality of care, clear outcome measures are needed to demonstrate the value of the care delivered by nurses (Audit Commission, 2001). But the proportion of registered nurses in the workplace affects patient outcomes such as speed of recovery, incidence of complications, and even mortality (Needleman et al, 2002, in Defining nursing, RCN, 2003).

The Audit Commission (1991) referred to the value and importance of qualified nurses in its report, The virtue of patients. To accompany the statistics on cost-effectiveness, the RCN published The value of nursing (1992), a qualitative record of real-life experiences of nurses whose care had made a difference to patients. Since then, nurses who work with older people have produced studies on their value and skills (1993a; 1993b). Both these publications attempt to articulate the value of nurses’ work with older people and serve to assist nurses in making the case for their continuing involvement in the provision of health and social care services for older people. The major focus of all this work has been on nursing and nurses. What is missing is the perception of the user.

Consumer perspectives

What do older people want from nurses? Several studies indicate that communication and information is of key importance (Jones et al, 1987; Smith and Redfern, 1990; Cornwell, 1989). Older people appear to feel particularly strongly about professional attitudes and about being treated as individuals (Cornwell, 1989; Ford 1996).

The RCN taskforce on older people and nursing (RCN, 1995) identified that older people want:

- **information** on accessing services in order to maintain their health and to cope with disease and disability
- to be **consulted** on the way in which services and individual health care needs are planned, organised and delivered
- the opportunity to **negotiate**, make choices and take risks, both independently and through citizen advocates
- **representation**, by individual empowerment, through national and local organisations, and by ensuring comprehensive development of ‘named nurse’ systems in all care settings
- **skilled clinical care** from nurses working in specialist, integrated and generic services for older people in order to promote and maintain positive health and wellbeing.

What is nursing?

The RCN has defined nursing as: “The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death.”

The defining characteristics of nursing are:

1. A particular purpose: the purpose of nursing is to promote health, healing, growth and development, and to prevent disease, illness, injury and disability. When people become ill or disabled, the purpose of nursing is, in addition, to minimise distress and suffering, and to enable people to understand and cope with their disease or disability, its treatment...
and its consequences. When death is inevitable, the purpose of nursing is to maintain the best possible quality of life until its end.

2. A particular mode of intervention: nursing interventions are concerned with empowering people, and helping them to achieve, maintain or recover independence. Nursing is an intellectual, physical, emotional and moral process, which includes the identification of nursing needs; therapeutic interventions and personal care; information, education, advice and advocacy; and physical and emotional support. In addition to direct patient care, nursing practice includes management, teaching, policy and knowledge development.

3. A particular domain: the specific domain of nursing is people's unique responses to and experience of health, illness frailty, disability and health-related life events, in whatever environment or circumstances they find themselves. Human resources may be physiological, psychological, social, cultural or spiritual, and are often a combination of all of these. The term 'people' includes individuals of all ages, families and communities, throughout the entire life span.

4. A particular focus: the focus of nursing is the whole person and the human response rather than a particular aspect of the person or a particular pathological condition.

5. A particular value base: nursing is based on ethical values that respect the dignity, autonomy and uniqueness of human beings, the privileged nurse-patient relationship, and the acceptance of personal accountability for decisions and actions. These values are expressed in written codes of ethics, and supported by a system of professional regulation.

6. A commitment to partnership: nurses work in partnership with patients, their relatives and other carers, and in collaboration with others as members of a multi-disciplinary team. Where appropriate they will lead the team, prescribing, delegating and supervising the work of others; at other times they will participate under the leadership of others. At all times, however, they remain personally and professionally accountable for their own decisions and actions.

(RCN, 2003)

What can registered nurses offer to older people?

Older people and their representatives say they value nurses a great deal. Nurses are viewed as reliable, sensitive and willing to listen - they care. Nurses are perceived as having the requisite skill and knowledge about health, individuals and families, and the environment. They are considered to be a constant in an ever-changing world. Older people need nurses who have a broad repertoire of skills and knowledge.

Nursing is a complex process founded on the ability to integrate and synthesise appropriate knowledge from multiple sources. In today's health care system, assessing outcomes in terms of value-for-money is a key indicator. The cost-effectiveness of nursing is not easy to assess (Thomas and Bond, 1995). This is partly because nursing is complex and partly because it can be difficult to separate the outcomes of nursing intervention from those of other health care professionals.

Despite these difficulties, studies are increasingly demonstrating that qualified nursing is cost-effective. One literature review demonstrates the benefits of registered nursing in terms of the relationship between cost and quality, and the cost-effectiveness of non-clinical nurse interventions, where qualified nurses have rationalised the use of resources through more efficient stocktaking and the redesign of patient documentation (Buchan and Ball, 1991). Other studies demonstrate that high standards of care depend on using qualified nurses in sufficient numbers and that there is a direct correlation between nursing grade-mix and patient outcomes (Carr-Hill et al, 1992).

Much research has demonstrated the value of expert nurses in the care of older people (Kitson, 1991; Buchan and Ball, 1991; Pearson et al, 1992; Griffiths and Evans, 1995; Carr-Hill et al, 1992). While this research is focused on older people, little of it is focused on continuing-care settings. Therefore, there is a need for further research that clearly defines the role of the nurse in continuing care.

A small qualitative study (Ford, 1996) explored what older people, as patients in continuing care, valued in nurses. The findings clearly demonstrated that the nurse's expertise and confidence was a significant contributory factor in the patient's experience of quality nursing.
Clearly, all nurses should have core skills that maintain a safety net in standards of care. However, because of the complexities of older age - such as age changes, altered presentation of disease, multiple pathology, social influences on ageing and psychological adjustment to growing older - nurses need specific knowledge, skills and expertise to work with older people. They also need a positive approach to health in older age.

The benefits of nursing

In order, to identify the indicators for nursing care - as opposed to trained and competently delivered personal care - it is important to untangle what the nurse is doing, thinking and feeling. This will give an indication of the complex combination of skills being used, in order to undertake what may appear a simple task.

The three main areas that need to be identified in any care scenario are:

✦ knowledge
✦ skill
✦ experience.

Within these three areas the expert nurse would need to:

✦ recognise that there is a problem
✦ identify, review and select relevant clues
✦ prioritise and take action
✦ review the change and progress of the patient.

What does ‘expert’ nursing encompass?

Nursing practice can be related to specific levels of knowledge. For example, when caring for an older person with a leg ulcer:

*a nurse* will know that the leg ulcer needs care, that the patient is in pain and that the ulcer limits the ability to walk. The nurse will also know how to care for the ulcer, administer pain relief and how to help the patient to walk. That same nurse is also likely to know why the ulcer may or may not heal in a particular way, why pain is felt and why it is relieved by particular measures, and why the older person finds walking difficult.

In addition, *an expert nurse* will know what factors might have caused the ulcer to form, what might promote or delay healing, particularly in older patients, what factors might exacerbate or relieve pain, what might assist or hamper the older person’s mobility and what impact these events might have on the older person’s body image, psychological state or life in general.

In terms of psychomotor skills, expert nurses demonstrate ‘embodied knowledge’, where the body takes over the skill. For example, the equipment used becomes an extension of the nurse’s hands. In terms of psychosocial and relationship skills, expert nurses can help people to feel better merely by their presence, by what they say as well as by what they do.

But the concept of expert nursing encompasses more than clinical skills and knowledge, or even experience. An expert nurse has been described as: “The nurse who no longer relies on an analytical principle (rule, guideline, maxim) to connect an understanding of the situation to an appropriate solution. The expert nurse with an enormous background of experience has an intuitive grasp of the situation and zeros in on the accurate region of the problem without wasteful considerations of a large range of unfruitful possibilities,” (Benner, Tanner and Chesla, 1992).

In this description, expert nurses can attend to many aspects of a situation at the same time; for example, how the patient looks - posture, expressions, behaviour, skin tone - what the patient says, how relatives and other professionals react, other indicators such as sounds or smells, and events occurring in other areas. They can recognise patterns that may go unnoticed by less experienced clinicians and know when they have a good grasp of a situation and feel uncomfortable when they do not. They are skilful at managing multiple aspects of a situation at one time - for example, patient, relatives, other professionals and equipment - and of keeping track of what is happening to each of these elements.

Throughout these processes, expert nurses can remain responsive to the patient, relatives or other professionals and maintain an accurate grasp of their experiences, current needs and concerns. They can advocate for the patient and family and augment the clinical assessments of their professional colleagues. Because they have a sound understanding of a situation, with all its nuances, they can be responsive, flexible and adaptable in their practice.
What can expert nurses offer older people?

The RCN’s document, *The value and skills of nurses working with older people* (1993a), describes in detail what nurses can offer to older people. The RCN task force fully supports the content of this document, and emphasises particularly the value of expert nurses in the following areas:

- **understanding the influences on care**
  
  For example, the impact of ageism, the effects of class, gender, culture, ethnicity, religion and sexuality and how it might feel to be an older person or carer in today’s society.

- **maintaining a positive approach**
  
  For example, valuing the older person's life experiences and the meaning of those to the older person; focusing on what the older person can do, rather than on what he or she cannot do; building on the coping skills and strategies accumulated by the older person through life experiences; maintaining a perspective which includes the positive aspects of later life and adjusting to life changes and losses.

- **building and maintaining relationships**
  
  For example, nurses’ skills in communicating in sensory impairment; skills in subtle forms of communication such as body language; supporting skills; counselling skills; motivating and empowering skills; adjusting the pace of communication to the circumstances. Nurses’ skills in therapeutic strategies such as group work, reminiscence and validation therapy are also valuable.

- **assessment**
  
  Assessing an older person in health or illness is a highly skilled, highly complex process because of the interrelated factors of normal ageing - physical, psychological and social - and pathology. Assessing mental health needs in older age is particularly complex (RCN, 1993b), as is the nursing of people who are behaving unusually, particularly when this is due to illness. Expert nurses recognise subtle changes in older people’s health and can take action to help prevent deterioration.

- **intervention**
  
  Expert nurses recognise that function may be more important than the effects of a particular disease. They also understand the effects of environment on an older person’s health and functioning. Expert nurses have sound skills in rehabilitation and in working with other health care professionals in maximising the potential of the older person. Expert nurses can offer psychological support and therapeutic intervention for mental health needs. They act as key workers in professional networking. They are skilled in the care of people who are dying, offering comfort, support and therapy both to the patient and their family. Expert nurses with older people are particularly skilled in planning discharge from hospital/transfer of care and in maintaining their knowledge of local services.

- **developing expert specialist nursing roles**
  
  It has been demonstrated that patients who have access to specialist nurses are more knowledgeable, more proficient in self-care and more satisfied with the care they receive. These findings are clearly attributable to the nursing intervention. Following the appointment of specialist nurses, budget savings have been made because fewer patients have been admitted to hospital, lengths of stay have been reduced and there has been a reduction in the amount of wasted equipment (Wade and Moyer, 1989). Specialist nurse appointments can also attract external funding.

In a study that compared the outcomes of care within a consultant rheumatology clinic with a rheumatology nurse practitioner (RNP) clinic, the RNP clinic patients showed more positive outcomes in terms of joint movement, pain control, morning stiffness, anxiety, depression and overall psychological morbidity, and improved knowledge of and increased satisfaction with the care given (Hill, 1991). Specialist nurses not only contribute to positively towards the care of patients but also to the professional development of their colleagues. Studies have demonstrated that the teaching activities of nurse specialists can involve all grades of staff in both acute and community settings, and a broader audience through the publication of their work (Wade and Moyer, 1989).
It is becoming increasingly evident that, with developments in knowledge and in new technology, excellence and expert practice cannot be achieved without focussing on specific areas of nursing. This is particularly so with areas of practice as highly skilled, complex and specialised as nursing older people. Without the input of registered nurses who have the necessary expertise, the health of older people can deteriorate irreversibly, as the following flow-chart demonstrates:

**Potential consequences of inadequate skilled nursing input.**
Existing approaches to measuring quality

The work we have described seeks to present the specific nursing outcomes relating to expert registered nursing interventions. However, it is recommended that these specific outcomes are developed in conjunction with existing approaches to quality measurement. For example, a group of nurses may choose to use the approach presented to identify the specific outcomes relating to their nursing interventions. In addition, their organisation may wish to undertake audits of quality. The RCN Forum for Nurses Working with Older People believes that the two would complement each other, demonstrating the value of nursing and its effect on the overall quality of care.

For this reason we offer a selective review of some of the tools available that are appropriate for use within the continuing care of older people.

The Royal College of Physicians and British Geriatric Society CARE scheme

This has eight indicators of quality of care, including:

✦ preserving autonomy
✦ promoting urinary continence
✦ promoting faecal continence
✦ optimising drug use
✦ managing falls and accidents
✦ preventing pressure sores
✦ optimising the environment, equipment and aids
✦ the medical role in long-term care.

These are structured from a professional, rather than a consumer view.

Harwood and Ebrahim (1994) carried out a study to assess the impact of this audit package on outcomes in institutional care for elderly people. Patients in audited and unaudited units were assessed for changes in disability, satisfaction with life, relatives’ satisfaction with care, and numbers of deaths. The study concluded that this audit in long-term care was not associated with measurable improvement in outcomes, and that further modification of the CARE scheme should be evaluated.

Monitor and Senior Monitor

Monitor is a quality assessment instrument designed to provide an index of the quality of nursing care in medical and surgical wards. Senior Monitor is designed to assess the quality of nursing care in elderly care wards. Both were both designed specifically for use in the UK and both are derived from the American Rush-Medicus Nursing Process Methodology, one of the most widely used and thoroughly analysed methods for assessing the quality of nursing care in the USA.

Both Monitor and Senior Monitor are based on the same underlying framework of the nursing process, but their structure and content differ to some extent. They consist of two parts: ward monitor and patient monitor. Ward monitor consists of a ward-centred questionnaire and ward profile - interview schedule. The ward-centred questionnaire assesses the ward standard of nursing reporting, patient safety procedures, and the provision of nursing management, clerical, environment and support services. The ward profile documents structural factors in the ward, as well as staffing levels, support services, workload and grade-mix. Patient monitor consists of four basic sections: planning and assessment; meeting physical care needs; meeting non-physical care needs; and evaluation of nursing care objectives.

Three additional sections are found in Senior Monitor: rehabilitation; safety of the severely ill, terminally ill or dying patient; and care of the deceased patient.

Monitor and Senior Monitor evaluate the process of nursing care while the care is in process. They are each applied to the care of individual patients and produce an index rather than a measure of the quality of nursing care in the ward.

Nursing Home Monitor I and II

This is a development of, and companion to, Senior Monitor. It provides a list of quality-related criteria to tender assistance to nurses and home inspectors who are concerned with the care and quality of life of older people. The main sections of the systems manual monitor the profile of the home, home management, patient welfare, nursing care, patient dependency and workload index, and locally specified criteria.
The patient dependency and workload index can be used to calculate nursing workload, and the system produces an index of the quality of care.

**Quality Patient Care Scale (QUALPACS)**

QUALPACS is a 58-item observation scale, developed in the USA, which assesses the quality of nursing care received by patients in any care setting. It is divided into six categories: psychosocial; group and individual; physical; general; communications; and professional implications. For each item, a list of cues is given so the observer can clarify their observations. The observer rates care on a five-point scale, from best to poorest. The standard measurement is defined as ‘the care expected of a first-level staff nurse’ (Kitson and Harvey, 1991).

Wandelt and Ager (1974) describe the development, format, application, administration, scoring, interpretation, validity, reliability and uses of the tool.

**King’s Fund Organisational Audit for Nursing Homes (KFOA)**

This is a project to develop organisational standards for nursing homes, which will provide a reference point against which homes can be assessed by homeowners, managers, staff, users, those who purchase care and those who inspect and register nursing homes.

The principle underlying this audit tool is that there is a correlation between organisational capability and high quality care. It is a developmental process involving the organisation in self-assessment and self-improvement, measured against a set of comprehensive standards. This takes place over several months, with support from KFOA staff. Compliance with the standards is measured independently by peer review and carried out by trained senior professionals. The survey report is the basis for further organisational development.

The project is overseen by a National Advisory Committee, which comprises representatives from organisations such as the RCN, the Nursing and Midwifery Council, the Independent Healthcare Association, the National Association of Health Authorities and Trusts, and Counsel and Care, as well as purchasers and providers of nursing home care.

Selecting and applying methods for estimating the size and mix of nursing teams

This Department of Health-commissioned literature search explores the five most commonly used methods for estimating or evaluating the size and mix of nursing teams. The methods are the application of professional judgements; calculating nurses per occupied bed; the acuity – quality method; timed-task/activity method; and regression analysis methods. The review examines the contribution of 43 articles/books/reports that address the special issues of nursing older people for nursing workforce planners.
Conclusions and recommendations

The indicators developed demonstrate the complexity of the needs of older people. The levels of knowledge and skill articulated in each indicator also demonstrate the need for registered nurses to be co-ordinating such care. While it is possible that more standardised measures could be used to demonstrate such outcomes, the actual processes of care, and their complexities are not articulated, and that is what nurses with older people need to be able to demonstrate.

The indicators offered are not comprehensive, and we would recommend that nurses use this document as a tool in order to develop their own outcome indicators. If nurses were prepared to send these to the RCN, then a comprehensive collection of practice-based evidence could be formulated.

We also recommend that:

✦ commissioners use this work as a guide to inform their purchasing strategies in continuing care
✦ nurses use this framework to reflect on their own practice, as part of their own professional development
✦ the document, and developmental work that arises from it, be used to articulate the need for registered nurses
✦ the document be used to articulate the complexity of the needs of older people in continuing care
✦ the indicators developed should be piloted in order to test their validity
✦ educators of nurses work with nurses to help them to develop their own expertise and to develop practice
✦ indicators for consumers be developed.

References


Bloch D (1975) Evaluation of nursing care in terms of process and outcome: issues in research and quality assurance, Nursing Research 24 (4) 256-263.


Department of Health (1995) NHS responsibilities for meeting continuing health care needs HSG (95) 8 LAC (95) 5 London: HMSO.


Jones A (1989) Depressive illness in the older person, Nursing 3 (37) 9-12.


Royal College of Nursing (1993a) *Older people and continuing care. The skill and value of the nurses*. London: RCN.


