
Becoming a Nurse in the 21st Century

IAN PEATE

With a Contribution by Dr Maxine Offredy



John Wiley & Sons, Ltd

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I would like to dedicate this text to all student nurses past, present and future
– go for it and make a difference.

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Introduction

This text is primarily intended for nursing students, health-care assistants, those undertaking SNVQ/NVQ level of study, or anyone who intends to undertake a programme of study leading to registration as a nurse. Throughout the text the terms ‘nurse’, ‘student’ and ‘nursing’ are used. These terms and the principles applied to this book can be transferred to a number of health-care workers at various levels and in various settings, in order to develop their skills for caring.

A NOTE ON TERMINOLOGY

The term ‘patient’ has been used throughout this text and refers to all groups and individuals who have direct or indirect contact with all health-care workers and, in particular, registered nurses, midwives or health visitors. ‘Patient’ is the expression that is used commonly within the NHS. While it is acknowledged that not everyone approves of the passive concept associated with this term, it is used in this text in the knowledge that the term is widely understood. Other terms could have been used, for example service user, client or consumer, but for the sake of brevity patient will be used.

The term ‘carer’ is also used in this text. The term can be used to describe those who look after family, partners or friends in need of help because they are ill, frail or have a disability. Carer can mean health-care provider; that is, care workers or those who provide care that is unpaid. It is estimated that there are over six million unpaid carers in the UK (Carers UK, 2005). It must be noted and acknowledged that unpaid carers can also be young people aged under 18.

The phrase ‘specialist community public health nurse’ will also be used in the text. The NMC decided to establish a part of the register for specialist community public health nurses, as it felt the practice undertaken by these nurses has distinct characteristics that require public protection (NMC, 2004c).

THE NURSING AND MIDWIFERY COUNCIL (NMC) AND QUALITY ASSURANCE (EDUCATION)

The programme of study you have embarked on, or are going to embark on, must meet certain standards. There are internal standards within your

educational institution, for example your own university's policies and procedures relating to quality assurance and external influences. The NMC and the Quality Assurance Agency (QAA) standards must be satisfied before a programme of study can be validated and deemed fit for purpose (Quality Assurance Agency for Higher Education, 2000). Other external factors that must be given due consideration are the orders provided in the guise of European Directives. Two European Directives, 77/453/EEC and 89/595/EEC, and their implications are discussed.

It is the responsibility of the NMC to set and monitor standards in training (Nursing and Midwifery Order 2001). The NMC has produced a framework for quality assurance of education programmes (NMC, 2005). The framework relates to all programmes that lead to registration or to the recording of a qualification on the professional register.

The Nursing and Midwifery Order 2001 provides the NMC with powers in relation to quality assurance and, as a result of this, the production of a framework by which those education providers (for example universities) who offer, or intend to offer, NMC-approved programmes leading to registration or recording on the register have to abide. There are many provisions in place in the UK that ensure the quality of education programmes. In Northern Ireland, Scotland and Wales, agents are appointed by the NMC. They carry out quality assurance services on behalf of the NMC. In England, visitors are the preferred option. They are registrants from practice and education who undertake the approval and annual monitoring activities on behalf of the NMC.

The NMC has to be satisfied that its standards for granting a person with a licence to practice are being met as required and in association with the law. It does this by setting standards to be achieved in order to maintain public confidence, as well as protecting them. By appointing agents and visitors it can be satisfied that it is represented during the quality assurance process in relation to the approval, reapproval and annual monitoring activities associated with programmes of study.

Each programme of study (for pre-registration nursing) must demonstrate in an explicit and robust manner that it has included the extant rules and standards of the NMC so that those who complete a recognised programme of study are eligible for registration. The Standards of Proficiency for Pre-registration Nursing Education (NMC, 2004a) are examples of some standards that must be achieved prior to registration. See Table 1 for a summary of the standards for pre-registration nursing.

BECOMING A PROFICIENT NURSE

Those who wish to study to become a nurse, register with the NMC and afterwards practise as a nurse must undertake a three-year (or equivalent) pro-

Table 1 Summary of some of the standards for pre-registration nursing (NMC, 2004a)

Standard 1	Age of entry
Standard 2	General entry requirements
Standard 3	Accreditation of prior (experiential) learning
Standard 4	Admission with advanced standing
Standard 5	Transfer with accreditation of prior (experiential) learning
Standard 6	Structure and nature of educational programmes
Standard 7	First-level nurses – nursing standards of education to achieve NMC standards of proficiency
Standard 8	Second-level nurses – nursing standards of proficiency

Source: NMC, 2004a.

gramme of study. The programme of study must by law comprise 2300 hours of practice and another 2300 hours of theory.

The title ‘registered nurse’ is a protected title in law. This means it can only be used by a person who is registered with the NMC and their name must appear on the national register. There are three parts to the professional register:

- nurses
- midwives
- specialist community public health

Four distinct disciplines, each specialising in its own field of practice, are associated with nursing:

- learning disabilities nursing
- adult nursing
- children’s nursing
- mental health nursing

Regardless of the branch the student has chosen, all students undertake a 12-month common foundation programme (CFP). When the student has successfully completed the CFP, having met all of the proficiencies dictated by the NMC, this allows the student to undertake the branch programme. The branch programme is two years in duration – this then becomes a branch-specific programme.

The student who wishes to undertake nurse education must meet the NMC’s requirements for age of entry. Those entering a programme of pre-registration nursing education must be no less than 17 years and six months of age on the first day of the commencement of the programme. However, in certain exceptional circumstances and related to specific programmes, the NMC may agree to an earlier age, but this will never be less than 17 years.

As well as having to satisfy the NMC’s age requirements, general entry requirements must also be satisfied. Educational requirements are set by each

educational institution, and there must also be evidence of literacy and numeracy. How these requirements are set is the prerogative of the educational institution; however, the NMC must agree and permit these requirements. Those wishing to practise in Wales must be able to demonstrate proficiency in the use of the Welsh language where this is required. On entry all applicants must demonstrate, on an ongoing basis and on completion of their programme, that they have good health and good character sufficient for safe and effective practice. It is the responsibility of educational institutions to have processes in place to ensure assessment of good health and good character. Any convictions or cautions related to criminal offences that the applicant may hold must be declared. There are several ways in which this can be achieved, for example self-disclosure and/or criminal record checks conducted by accredited organisations.

Completion of the programme and successful achievement of the proficiencies means that the student will graduate with both a professional qualification – Registered Nurse (RN) – and an academic one. The academic qualification may be at diploma or degree level. The NMC requires a self-declaration of good health and good character from all those entering the register. The good character and good health declaration is made on an approved form provided by the NMC. This must also be supported by the registered nurse whose name has been notified to the NMC as being responsible for directing the educational programme at the university, or his/her designated registered nurse substitute.

Once registered with the NMC the nurse becomes accountable for his/her actions or omissions. He/she is subject to the tenets enshrined in the Code of Professional Conduct (NMC, 2004b). Important issues that must be legally undertaken, such as participating in continuing professional development and the maintenance of a personal professional portfolio, are addressed. This text provides you with insight into how to become a proficient nurse. All of the NMC proficiencies cited in standard seven (NMC, 2004a) are considered.

THE PROFICIENCIES

Standard seven of the NMC's Standards of Proficiency for Pre-registration Nursing Education (NMC, 2004a) contains the nursing standards required to be achieved to demonstrate proficiency to the NMC. There are four domains:

- professional and ethical practice
- care delivery
- care management
- professional development

Table 2 The four domains and the subsequent sub-sections

<i>Domain I</i> Professional and Ethical Practice	<i>Domain II</i> Care Delivery
<div>1. Professional Practice</div> <div>2. Ethical and legal issues</div> <div>3. Diversity and culture</div>	<div>1. Therapeutic relationships</div> <div>2. Health promotion</div> <div>3. Assessment of needs</div> <div>4. Partnerships</div> <div>5. Evidence-based practice</div> <div>6. Sociocultural issues</div> <div>7. Evaluating care</div> <div>8. Clinical decision making</div>
<i>Domain III</i> Care Management	<i>Domain IV</i> Personal and Professional Development
<div>1. Quality care</div> <div>2. Inter-professional working`</div> <div>3. Competence, accountability and delegation</div> <div>4. Key skills</div>	<div>1. Continuing professional development</div> <div>2. Teaching, learning and supervising</div>

Source: Adapted from NMC, 2004a.

THE CHAPTERS

Each chapter of this text addresses the content of each of the domains as prescribed by the NMC (NMC, 2004a). The domains and the subsections provide a framework for this text. See Table 2 for an outline of the domains and the subsequent subsections.

THINK POINTS

Each chapter provides the reader with think points. These are included to help encourage and motivate you, as well as for you to assess your learning and progress. They are recognised by this symbol:



Most of the think points provide you with answers or suggestion for responses. You are encouraged to delve deeper and to seek other sources, human and material, to help with your responses.

The aim of this text is to encourage and motivate you and to instil in you the desire, confidence and competence to become a registered nurse. To become a member of the nursing profession bestows on you many demands, and the key demand is the desire to care with compassion and understanding.

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I Professional and Ethical Practice

1 Professional Practice

Nursing is both an art and a science. It is associated with caring and helping. One aspect of the nurse's role is to help the patient achieve or carry out those activities of living they are incapable of doing for themselves. There are many facets associated with the role and function of the nurse. It is a fluid and dynamic entity and this makes it difficult to define.

There are several definitions of nursing. One is that of Henderson, which has been used since the 1960s:

The unique function of the nurse is to assist the individual, sick or well, in performance of those activities contributing to health or its recovery (or to a 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)

This definition is succinct and to the point. It attempts to encompass and encapsulate many of the roles the nurse performs, such as carer and health educator. Such a definition, although not exclusively, could be seen as the nature of nursing. A more recent definition provided by the Royal College of Nursing (RCN) is:

The use of clinical judgment 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. (RCN, 2003)

This chapter is concerned with professional nursing practice. An overview is provided of the development of nursing from what was an unstructured, *ad hoc* approach to caring to what has become a regulated profession. The student nurse and unqualified practitioners are not subjected to the rigours of professional regulation. However, when you successfully complete your programme of study leading to registration, you will be subject to professional accountability and all that it entails. It is expected that the student nurse commits him/herself to the values of the profession and that he/she accepts and internalises the code of conduct as part of the process leading to registration. The code of professional conduct, performance and ethics will be discussed in detail, with emphasis on commitment to the principle that the primary purpose of the registered nurse is to protect and serve society.

A BRIEF OVERVIEW OF THE HISTORY OF NURSING IN THE UNITED KINGDOM

This brief overview of how the practice of nursing has evolved over the years outlines some key stages in the development of the nursing profession from a British perspective. It must be remembered, however, that the evolution of nursing in the UK did not occur in a vacuum. There are several other international factors that have also helped to focus and shape where we are today and where we may be going tomorrow.

In order to understand contemporary nursing it is important to have an understanding of where nursing has come from, how nursing has emerged and how it continues to evolve (Craig and Daniels, 2004). Having an understanding of the way nursing has evolved and developed over the years may help you to appreciate:

- Why nursing is regarded as a profession in its own right.
- How by becoming empowered nurses are in a position to enable others to do things for themselves.
- That nurses have become autonomous practitioners.
- How nurses are called to account for their actions and omissions.

This aspect of the chapter makes use of a 'time line' in order to frame the discussion regarding the historical overview. A time line provides you with important dates and events that have occurred over the years and that have had an influence on the evolution of the nursing profession. The discussion centres on the significant events and key characters that have influenced the development of nursing over the ages.

THE PREHISTORIC ERA

The practice of nursing predates history, according to Craig and Daniels (2004). Bullough and Bullough (1979) note that those who lived in the prehistoric period suffered similar conditions to those experienced by society today. Tribes in those early years took part in caring for their sick and wounded. Archaeologists have retrieved human remains that demonstrate that fractured limbs have been healed, suggesting therefore that some form of care provision occurred. Healers or shamans used various potions and magical concoctions to heal the sick. Those responsible for feeding and cleaning the sick were predominantly females.

The Bible makes reference to nurses and midwives, for example *Genesis* 35 and *Exodus* 1. In *Exodus* 2 there is evidence to suggest that nurses were paid for their services. *Numbers* 11 refers to males who undertook the caring role.

THE ANCIENT GREEKS

In ancient Greece temples were erected to honour the goddess Hygeia, the goddess of health. Care at the temples was related to bathing and this activity was overseen by priestesses, who were not nurses. The foundation of modern medicine was laid down by Hippocrates during this period. Navel cutters – known as *omphalotomai* – were also practising at this time.

THE ROMAN EMPIRE

The first hospitals were established in the Byzantine Empire, which was the first part of the Roman Empire. 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 devoted her life to the sick and made nursing the sick and poor fashionable in Roman society. The primary carers in these hospitals were men, who were called *contubernails*. After the Roman invasion in approximately 2AD slave girls were known to assist Roman physicians. *Valetudinarius* – civilian hospitals – were kept clean and aired by bailiffs' wives, who would also watch over the sick.

THE MIDDLE AGES

Throughout the middle ages military, religious and lay orders of men provided most of the health care. Kalisch and Kalisch (2003) note that some of these orders of men included the Knights Hospitalers, the Order of the Holy Spirit and Teutonic Knights. While these men provided care, charlatans and quacks provided treatment for money. The standard of care provided by the latter people often did more harm than good.

Several hospitals were opened during this period, for example St Thomas's, St Bartholomew's and Bethlem. Care provision 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 ENLIGHTENMENT

The core period of the Enlightenment was the second half of the eighteenth century. Scientific endeavour flourished during the Enlightenment and philanthropists provided the means to open charity hospitals around the UK. In London for example, the London, Middlesex and Guy's hospitals provided care to the poor who were ill. These hospitals employed nurses who may have been paid or unpaid. These nurses again predominantly carried out domestic duties. Pay was low and it was not unusual for nurses to drink alcohol and take money from patients in order to pay for their alcohol. Nurses at this time were slovenly and lazy and reflected characters such as Sairey Gamp and Betsy Prig,

caricatures devised by Charles Dickens. Alms houses depended on women to clean floors, make beds and bathe the poor. There were no standards for nurses to work towards.

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.

FLORENCE NIGHTINGALE

The founder of modern nursing was born in Italy in 1820 and died aged 90 in 1910. When she was 25 years old she told her parents she wanted to become a nurse. Her parents were totally opposed to the idea, as nursing was associated with working-class women and had historical links to domestic service and vocational work.

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.

Mary Seacole, a Jamaican woman with much expertise in dealing with and caring for those with cholera, arrived in Scutari to offer her services to Nightingale, but these were refused. Undeterred, Seacole set up her own services and provided these to the British and Russian soldiers, often at the battle front.

In 1856 Florence Nightingale returned to England as a national heroine. She set about reforming conditions in British hospitals (in the first instance this was confined to military hospitals). She published two books, *Notes on Hospital* (1859) and *Notes on Nursing* (1859). Nightingale was able to raise 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. She also became involved in the training of nurses for employment in the workhouses.

Nightingale acknowledged the influence of the environment on health. She suggested the environment should be one that promotes health and she campaigned for wards to be clean, well ventilated and well lit. She believed:

- There should be a theoretical basis for nursing practice.
- Nurses should be formally educated.
- A systematic approach to the assessment of patients should be developed.
- An individual approach to care provision based on individual patient needs was required.
- Patient confidentiality needed to be maintained.

Nightingale, together with the philanthropist William Rathbone, set up the first district nursing service in 1861. Queen Victoria gave her support to this

venture and district nurses became Queen's Nurses. Caring for the well person was a concept Nightingale wanted to see developed, and in the late 1800s her thoughts came to fruition when courses were provided to teach women to develop an insight into sanitation in homes. These women, who had a duty to care for the health of adults, children and pregnant women (pre- and ante-natal), could be seen as the first health visitors. In 1873 Nightingale wrote, 'Nursing is most truly said to be a high calling, an honourable calling.' She died in London in 1910.

TOWARDS REGISTRATION

Throughout the 1890s pressure grew for the registration of nurses. In 1887, Ethel Bedford-Fenwick formed the British Nurses' Association, which sought to provide for the registration of British nurses based on the same terms as physicians and surgeons, as evidence of their having received systematic training. Bedford-Fenwick was a staunch supporter of professional regulation. Up until this time nurses remained relatively free from external regulation. In 1902, the Midwives Registration Act established the state regulation of midwives; this Act came about as a response to the concerns about the rising numbers of deaths of women in childbirth (Davies and Beach, 2000). A House of Commons Select Committee was established in 1904 to consider the registration of nurses.

The First World War (1914–18) provided the final stimulus to the creation of nursing regulation, partly because of the contributions made by nurses to the war effort. The College of Nursing (this later became the Royal College of Nursing in 1928) was established in 1916.

Eventually in 1919 the Nurses Registration Acts were passed for England, Wales, Scotland and Ireland. The General Nursing Council (GNC) for England, Wales, Scotland and Ireland and other bodies were established as a result of these Acts. The Councils were established in 1921 with clearly agreed duties and responsibilities for the training, examination and registration of nurses and the approval of training schools for the purpose of maintaining a Register of Nurses for England and Wales, Scotland and Ireland. The GNC had powers to undertake disciplinary procedures and remove the name of a nurse from the register if they were deemed to have committed an act of misconduct or 'otherwise' – conduct unbecoming of a nurse. The Register of Nurses was first published in 1922. The GNC and the other bodies survived intact until changes were made in 1979. These resulted in the creation of the United Kingdom Central Council (UKCC) and the four National Boards.

THE ESTABLISHMENT OF A NATIONAL HEALTH SERVICE

The National Health Service was established on 5 July 1948. The 1949 Nurses Act allowed that the constitution of the GNC be amended; the general and male nurse parts of the Register were amalgamated.

THE BRIGGS COMMITTEE

The Briggs Committee, a working group, was set up in 1976 to review the training of nurses and midwives. The work of this committee led to the Nurses, Midwives and Health Visitors Act 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.

PROJECT 2000

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 (UKCC, 1986), provided the Council's strategy. The strategy was implemented by the mid-1990s.

THE PEACH REPORT

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' (UKCC, 1999). The report outlined several recommendations, for example:

- A reduction in the common foundation programme from 18 months to one year.
- An increase in the branch programme from 18 months to two years.
- To ensure that students experienced at least three 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.

CONTEMPORARY NURSING PRACTICE

Contemporary nursing practice is based on a sound, up-to-date knowledge base, with nurses applying the appropriate skills and attitudes when delivering nursing care. It was Nightingale who suggested that nursing was subordinate to medicine (Holton, 1984). However, this notion of the nurse as handmaiden to the doctor is changing and the various roles and functions undertaken by the nurse are testimony to this.

After the number of nurses became substantial and the essential nature of nursing was established in the UK, the need to regulate the practice of nursing under law grew evident. These laws are aimed at the protection of the public.

NURSING AS A PROFESSION

PROFESSIONALISM

The term 'professional' is used in many aspects of our society, and often its meaning is taken for granted. When the term professional is used it refers to a process that contains some gravitas, in which a group or individual works in a knowledgeable manner and with understanding. The word professional has other meanings in other contexts. A profession is defined and measured by using several sets of criteria and characteristics.

Etzioni (1969) considered occupations such as nursing, teaching and social work as semi-professional. Nursing, he suggested, was a semi-professional occupation due to the inadequate length of time for training and because of the lack of autonomy and responsibility for decision making. The ultimate justification of a professional act, according to Etzioni (1969), is that to the professional's knowledge, it is the best act. Burnard and Chapman (2003) state that there must be a high level of accountability and autonomy in order for an act to be professionally justified.

Salvage (2003) states that the nursing profession has often held an uncomfortable social space, as it tends to lie between being a 'true' and 'semi'-profession. She described the 'true' professions as male dominated, elitist and powerful, for example medicine and law, in contrast to proletarian occupations such as domestic work, health-care assistance and unpaid women's work in the home. However, new professions are emerging and they fit the changing circumstances in which society operates today (Salvage, 2002).

What makes a profession? Many people claim to belong to professions or they say they are professional. Can you make a list of professionals?



In your list you might have included some of the more obvious professions:

- clergy
- doctors
- solicitors
- barristers
- physiotherapists

But what about others who also profess to be professionals:

- footballers
- plumbers

Table 1.1 Pyne's characteristics associated with a profession

-
- Its practice is based on a recognised body of learning.
 - It establishes an independent body for the collective pursuit of aims and objectives related to these criteria.
 - Admission to corporate membership is based on strict standards of competence attested by examination and assessed experience.
 - It recognises that its practice must be for the benefit of the public, as well as that of the practitioners.
 - It recognises its responsibility to advance and extend the body of learning on which it is based.
 - It recognises its responsibility to concern itself with facilities, methods and provision for educating and training future entrants and for enhancing the knowledge of present practitioners.
 - It recognises the need for members to conform to high standards of ethics and professional conduct set out in a published code with appropriate disciplinary procedures.
-

Source: Pyne, 1998.

- teachers
- engineers
- architects
- diamond cutters
- carpenters

The terms professions and professional are dynamic and fluid, changing as time passes and as technology changes. Burnard and Chapman (2003) state that these days to be professional the occupation requires a degree of skill and/or specialist knowledge. Basford (2003) adds that that knowledge is gained through education.

The characteristics of a profession have changed over time. Pyne (1998) compiled a list of characteristics and these are presented in Table 1.1.

NEW NURSING – NEW WAYS OF WORKING

The role and function of the nurse have changed and developed over the years. The first part of this chapter has demonstrated some of the transformations and the influences causing them. In order to meet the health-care needs of the nation, political and professional pressures have transformed the role of the nurse and other health-care professionals involved in the provision of health care, with the aim of developing their full potential. As a result of this, nursing has seen the creation of a number of new clinical roles, for example:

- family health nurses
- nurse endoscopists
- consultant nurses