TRAINING FOR NURSES 1

# District nurse training

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SUMMARY. Training for district nursing is being reviewed. By 1981 district nurses will have a new administrative structure, a new curriculum, and a new examination. Training for nursing, like that for general practice, is to become mandatory. The history of the development of district nurse training is briefly described.

## Introduction

PRIMARY medical care in the National Health Service is based on the concept of the primary health team. Patients are seen, examined, and treated and their progress monitored by members of the team working in surgery premises, health centres, the patients' homes and sometimes in hospital. The Royal College of General Practitioners has fostered the provision of care by the team and has established links with organizations representing other members of it. Although much has been written about the role of nursing members of the team (Smith and Mottram, 1967; McGregor *et al.*, 1971; Reedy, 1972) many general practitioners appear to be unfamiliar with the skills possessed by the district nurse and ignorant about her training.

Approximately 90 per cent of district nurses are attached to general practitioners although at different levels of integration in the health team. There are approximately 10,500 registered nurses in district nursing in the United Kingdom, 75 per cent of whom hold the district nurse qualification. Of the 2,500 state enrolled nurses working in the community, 64 per cent have undergone district nurse training (Elliott, 1978).

This paper presents the views of three general practitioners who have had a continuing association with the Panel of Assessors for District Nurse Training. It is written in the hope that general practitioners who are, or wish to be, better informed about their nurse colleagues will co-operate better with them. A paper cannot replace shared training, case discussions, or joint seminar work, but it may trigger the spread of interdisciplinary activities between the two professions.

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## History of district nurse training

Before 1948, district nursing was a service provided almost entirely by voluntary agencies and district nurse training was the province of the Queen's Institute of District Nursing (now the Queen's Nursing Institute) and the Ranyard Mission, each of whom awarded its own certificate in district nursing, the Ranyard Mission until 1965 and the Queen's Institute until 1968.

In 1948 the NHS Act placed the duty on local health authorities to provide a home nursing service. A central advisory committee was established, on the recommendation of a working party set up in 1953, to prepare a syllabus of training, set examinations, and advise Ministers on matters relating to district nurse training.

The committee recommended the establishment of a Panel of Assessors to examine schemes of training, to assess a proportion of examination scripts, and to continue to advise the Minister on these matters. The Panel was set up in 1959 and now consists of 11 members appointed by the Secretaries of State as representative of the nursing, medical, and educational professions. The Secretariat and Nursing Advisers are provided by the Department of Health and Social Security. Medicine is represented by two general practitioners and one area medical officer. Since 1969 its membership has included representatives from Scotland and Northern Ireland. In due course the Panel will be strengthened by increased membership, in response to proposals that its remit be broadened to enable it to undertake to its fullest degree its functions in promoting the highest standards of training for district nurses.

In December 1967, on the advice of the Panel and after consultation with professional bodies, including the Queen's Institute, the Minister decided to establish unified arrangements for training and examination for district nurses employed in the district nursing service. Local authorities could themselves organize and provide this training, and the introduction of a single national examination paper to be set by the Panel of Assessors was announced. Local health authorities were invited to submit their training schemes for approval. In 1971, the Panel set up an expert examination sub-committee, consisting of five members of the nursing, medical, and educational professions drawn from outside the Panel, with a member of the Panel acting as Chairman. In January 1971, the first examination for the State

Enrolled Nurse employed in the district nursing service was held. Successful candidates are awarded the National District Nursing Certificate (SRN or SEN). The examinations are held three times a year.

There was no clearly defined national syllabus for district nurse training. Each training centre tended to emphasize the points that its teachers felt to be important. The unified examination provided one opportunity for moving district nurse training towards a common set of objectives. Since the examination offered candidates a choice of questions it did not seem unethical to take this opportunity. The Examinations Sub-Committee emphasized two main points: the care with which questions must be worded and the need to standardize marking schedules.

In particular, emphasis in question wording was put on reducing ambiguity and on precision in the operative phrase used, so that markers would give fewer marks to a candidate who provided only a list where requested to describe something and, equally, would not give extra marks to a candidate who provided a description when requested only to list. Also, emphasis was put on the context in which answers were sought, so that questions about the care of juvenile diabetes became not "Describe the care (or your care) of diabetes in eight-year-old children" but "You frequently visit an eight-year-old diabetic boy to supervise his injections and his diet. On what aspects of his care would you concentrate?"

In this way the Panel of Assessors, through its Examinations Sub-Committee, introduced to district nurse training some of the rigour implicit in the use of behavioural objectives for curriculum design, namely that the level of cognition required, as well as its area, should be specified as should the circumstances in which knowledge, skills, and attitudes would be demonstrated.

The problem of standardizing marks was approached by members of the Panel of Assessors who were not members of the Examinations Sub-Committee providing outline answers and scripts.

It was recognized that the new examination with its change of emphasis and greater precision and uniformity would cause stress in some of the training centres. Two steps were taken to make profitable use of this stress: feedback was requested from each centre for each examination question, the marking schedule, and the response of its candidates; and the information was collated and circulated to the centres, tutors and nurse managers, as well as to the Panel and its Sub-Committee.

The second step was to institute a series of national conferences for local examiners and for other representatives of teaching centres. These provided a two-way exchange of information which on the Panel's side was used to increase the relevance of the examinations.

On matters relating to nurse education and training, the Panel of Assessors has over the years liaised formally and informally with the General Nursing Council for England and Wales, the Council for the Education and Training of Health Visitors, the Royal College of Nursing, the Northern Ireland Council for Nurses and Midwives, and the Joint Board of Clinical Nursing Studies.

The Panel submitted written and oral evidence to the Briggs Committee on Nursing (1972) and it has always been alive to the need for a forum for discussion on national matters. Following the advice of the Panel, a new grade of district nurse tutor was established in 1973 to take responsibility for courses of training leading to the award of the National Certificate in District Nursing. Similar arrangements were made for the introduction of practical work teachers, that is, district nurses who are responsible for the practical instruction of nurses undertaking district nurse training.

## New training course

A new, extended training course for registered district nurses will begin in 1981, based on a new curriculum proposed by the Panel and approved by the four Health Ministers of the United Kingdom (Appendix). Training will be mandatory, and this development may coincide with the introduction of mandatory vocational training for general practitioners. This should add impetus to the development of regular interdisciplinary courses which will also include other members of the primary health care team. A working party of the Panel of Assessors is now constructing a new curriculum for the state enrolled nurse working in the community, and its report will soon be submitted to the Panel for consideration.

One can perceive some pertinent analogies between the development of general practice training and district nurse training in primary care and we have found it interesting, especially in the development of the examinations, to see the similarities in the problems encountered in both disciplines and in attempting their solutions. The outline answer system is an example.

District nurse tutors are very much aware of such important developments as problem-orientated records and patient-orientated systems and they are interested in the use of the Nursing Process on which the new district nursing curriculum is based. This is a problem-solving approach to nursing care which encompasses systematic assessment of the individual patient's needs, followed by the planning, implementation, and evaluation of the appropriate nursing care.

It is felt that with improved courses for the registered nurses and enrolled nurses working in the community, and bearing in mind the new structure of nurse training bodies as recommended by the Briggs Committee, the Panel of Assessors will be handing over a good educational programme with effective monitoring arrangements to ensure the maintenance of a high standard of training and assessment.

During recent years one of the main anxieties of district nurses and their representatives has been the lack of statutory status for the Panel of Assessors in

representing district nurse training interests at national level. It is gratifying to learn that the Minister of State for Health has agreed to a reconstitution of the Panel, as already stated, and to an increase in its membership in order to enable it to operate more effectively. Furthermore, the Minister has given an assurance that a Standing District Nursing Committee will be established within any new controlling structure for nurse education when legislation is enacted.

District nurses will therefore have a new administrative structure, and a new curriculum and examination for their discipline. Vocational trainees for general practice should learn about the content of their nursing colleagues' training and all established general practitioners should familiarize themselves with it.

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**Appendix: Outline curriculum**

| *Skills* | *Knowledge* | *Attitudes* |
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| | Principles and practice of district nursing techniques.<br>Development of social policy. | |
| 1. Information gathering. | Interviewing methods.<br>Principles and problems of confidentiality. | Awareness of the need to preserve confidentiality. |
| 2. Observation. | Effect of the environment on the individual.<br>Sociological concepts and their significance in health and disease. | Respect for the values held by all persons with whom nurse comes into contact. |
| 3. Assessment of physical, social, and emotional needs. | Criteria for assessment of total needs of individual and groups of patients.<br>Normal and disordered body functions.<br>Psychological concepts and their significance in health and disease.<br>Needs of crisis groups. | Demonstration of an enquiring mind. |
| 4. Planning of care. | **Problem-solving techniques.**<br>Programmes of care to meet assessed needs.<br>Referral techniques. | **Respect for the patients, and carer's perception of their needs.** |
| 5. Implementing care. | Organization of the nursing environment.<br>Dietetics.<br>Drugs and other therapeutic measures for conditions commonly met in the community.<br>Rehabilitation. | Respect for patient's property. |
| 6. Evaluation. | Methods of evaluating care.<br>Prevention of further ill health.<br>Promotion of health. | Awareness of the need for continual reassessment of care provided and willingness to modify previously made plans. |
| 7. Supportive care. | Determinants of stress in the family situation. | Acceptance of professional responsibility for the welfare of people other than patients. |
| 8. Imparting skill and knowledge. | Introduction to principles of learning and teaching.<br>Skills analysis.<br>Demonstration and teaching techniques.<br>Self-analysis.<br>Assessment of performance of others.<br>Programmes of nurse education and training. | Understanding of the importance of teaching and willingness to accept this responsibility.<br>Appreciation of the value of health education in its widest sense and the need to develop an individual approach as necessary.<br>Willingness to learn and relearn. |
| 9. Communication. | The basic principles of written and verbal communication.<br>Record keeping.<br>Report writing. | Awareness of communication as an important part of total patient care. |
| 10. Establishment and maintenance of effective relationships. | The dynamics of individual and group relationships.<br>The psychological and social needs of families.<br>The role and function of the primary care team.<br>The management structure of the National Health Service.<br>An outline of central and local government. | **Acceptance of responsibility as clinical nursing expert within the primary care team.** |
| 11. Co-ordination of services. | The policies, structure, and contribution of other health, social, and voluntary services. | Appreciation of, and respect for, the skilled contribution of others concerned with patient care. |
| 12. Organization and supervision of the nursing team. | The principles of management as adapted to the needs of community care.<br>**Basic understanding of the principles of motivation.** | Appreciation of the importance of teamwork.<br>Willingness to accept managerial responsibility. |
| 13. Appreciation of methods of critical investigation. | Development of new procedures and techniques.<br>Information retrieval and use of resources.<br>Ethical, legal, and professional implications of research. | Awareness of the value of research and its contribution to better patient care.<br>Respect for human dignity. |