A STUDY OF CURRICULUM INNOVATION
IN
DISTRICT NURSE EDUCATION AND TRAINING

THESIS SUBMITTED FOR THE
DEGREE OF DOCTOR OF PHILOSOPHY

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ACKNOWLEDGEMENTS

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ABSTRACT

A main purpose of this study was to investigate and describe the impact of an innovatory curriculum in district nurse training and education from the participants' perspectives of their experiences. A grounded and evolutionary case study approach was used with the aim of allowing hypotheses about education or practice to emerge.

One such innovatory course was examined over its nine month duration with 'course' being interpreted broadly in order to facilitate a contextually based description and analysis. The main focus in the thesis is on that part of the course taking place outside the academic (university) institution: on students', teachers', supervisors' and managers' conceptions of education and practice in district nursing. A retrospective view of the course was also obtained from former students following entry into practice as district nurses.

The analysis provides insights into a variety of tensions between the expectations generated by the new curriculum and the perceived experiences of practice in the community. There was for example a lack of consistency and clarity over conceptions of role and management in district nursing in the primary health care team setting. Similarly, there were different conceptions and application of theory and method in education which were related to the participants' roles, personal experiences and their motivation in district nursing. Differences found appear to highlight a central dilemma of education in a caring profession where demands for development of an independently responsible practitioner may conflict with demands for a systematic regulation of professional standards for public accountability. This dilemma seems resolved by a Polanyian theory of knowledge which emphasises learning as an an active process: the development of a knowledge base - required for professional status - entails both active processing on the basis of an individual's existing conceptual frameworks and immersion in the field of study with expert practitioners.

There were consistencies in reasoning about district nursing practice and education and practice which were person-centred and reflected the high valuations placed on individual control, interaction and communication through continuity of care. The hypothesis that a theory of rights could be found to provide guidance for decision making is explored further in the concluding chapter through examining its utility at the level of professional ideology, in district nursing practice decisions and in the development of theory and methodology in district nursing.

The general implications of the thesis are that the justifications of district nursing are to determine what is right in terms of individualised patient care and that the focus of education should be based with practitioners in the practice context. This is seen to require developments in the educational resource base in the community which will support continuing learning in the multi-disciplinary contexts of primary health care.
Dear Dr Ragg,

I am writing to you in connection with my work with Sandra Battle on the Evaluation of the New Curriculum for District Nursing Project, 1980-82. I can confirm that my role on that project was purely supervisory and that the initiative for the questionnaire and interview design, data analysis and write up rested with Mrs Battle.

With best wishes,

Dr Brian Salter
Senior Research Fellow.
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CHAPTER ONE

INTRODUCTION TO THE STUDY

INTRODUCTION

The starting point for this study was my involvement in the evaluation of an innovatory curriculum for district nurse training and education. In November, 1980 I arrived to take up a full-time post as research officer in the Department of Adult Education, (later reconstituted as the Department of Educational Studies) at the University of Surrey. The duration of this particular post was two years and the brief was to evaluate the Department's district nurse course of education and training for students in the academic year 1980/81, and identify further research relevant to the needs of the Panel of Assessors for District Nurse Training (PADNT) which had the task at that time of guiding and monitoring district nurse education.

A further contract, arising from the initial evaluation study, enabled me to continue working in this field examining the work and role of the district nurse until November, 1985.

The thesis presents and develops data collected during the evaluation fieldwork between November, 1980 and March, 1982 and data collected while working on the district nurse's changing role project in 1982 to 1985. Findings from these two studies were initially reported to the Department of Health and Social Security (DHSS) which was the sponsoring agency for both studies, and to the PADNT (later absorbed into the English National Board for Nursing, Midwifery and Health
Visiting (ENB)) as the professional body responsible for district nurse training and education. For the original reports, see Battle and Salter (1981, 1982 and 1983) and Battle, Moran-Ellis and Salter (1985).

The implementation of the original evaluation brief for the 1980/81 course, in terms of its design and conduct was very much left to me, with general oversight and support from the senior research officer, Dr. Brian Salter, whilst an advisory committee (made up of members from the PADNT, DHSS, academic representatives from the Department of Educational Studies - including the course tutors - and professional representatives from district nursing management and general medical practice) generally limited their influence to constructive criticism and debate at regular meetings.

In early 1981 I registered as a part-time student for a higher degree to be based on the work being carried out. In these circumstances I found it difficult to separate my own interests for the purposes of study from the expectations of the agencies awaiting results relating to the work being sponsored. For this reason part-time research studentship in relation to full-time work is considered in the end critique of the research in closure of the final chapter.

Critical reflection on data collected during the evaluation (1980-1982) suggested that there were signs of an underlying structure in participants attitudes and approaches to others in teaching, learning, managing or direct caring contexts in district nursing and this becomes a main theme for discussion in the concluding chapters. It was possible to further examine this notion - that the participants
could most often to be judged as basing their actions or intentions on, or with reference to, fundamental principles of individual rights - to a limited extent in the contexts of district nursing working life. This was done through discussion with district nurses following patient visits observed during 1984; several patient visits are drawn on to illustrate a thesis of individual rights in the practice of district nursing in the concluding chapter.

The purposes of this introductory chapter are to:

- define the term 'district nurse' and briefly indicate the participants in the study
- discuss developments in district nurse training, education from a historical perspective
- discuss the influences on district nursing practice
- describe the 1976 recommendations for district nurse training and education, with which this study is concerned, and its' implementation at the University of Surrey
- indicate the general purposes of the study and the research approach adopted in the light of literature pertaining to the problem of defining curriculum study and the emphases in the given district nursing curriculum
- provide an outline of the thesis.

DEFINITION OF DISTRICT NURSE AND THE PARTICIPANTS IN THE STUDY

A district nurse in this thesis is defined as a qualified registered general nurse (SRN/RGN) with an additional post-basic qualification in district nursing. The district nurse, as the name implies, works in 'the district'; that is, in the general community, mainly in the patients' own homes rather than the hospital situation. A memorandum from the D.H.S.S. described the district nurse:

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a SRN who has received post basic training in order to give skilled nursing care to all persons living in the community including in residential homes. She is the leader of the district nursing team within the primary health care services."

(D.H.S.S., CNO (77)8, 1977).

In this respect the district nurse was seen as professionally accountable for the assessment of nursing needs and for delegating and overseeing the work of other SRN/RGNs, SENs or auxiliaries who might be working with the district nurse in the same health care situation.

The participants for the main body of the research reported in Chapters Three to Seven were adults in the process of entering the district nursing occupation through the 1980/81 course at Surrey (the 28 students), or already in it as practitioners (the 28 practical work teachers), or were nurse managers with responsibility for district nursing services in the Surrey area (the 14 nursing officers and 7 divisional nursing officers). Field work with these participants took place between 1980 and 1982. A theme which emerged from those investigations as significant in the processes of education and practice in district nursing was that of the importance given to the individual in different contexts. This theme is illustrated, in the concluding discussions on theory and practice in district nurse education and training, by case study material collected in 1984 during visits to patients with four different district nurses. The general purposes and rationale for the research undertaken is introduced in this chapter's section on research purposes and again in greater detail in Chapter Two.
Nursing care provided in the home, by persons other than informal carers such as patients' relatives, neighbours and so on, has a long tradition (Hampton, 1949; Stocks, 1960; Baly, 1980). In the general context of nursing developments, home nursing can be traced in organised forms to the activities of reformers such as the Quaker Elizabeth Fry (1770 - 1845) - less well-known for her work to reform hospitals and the nursing system including home nursing, than for her work for the reform of prisons and for relief of the destitute.

Florence Nightingale (1820 - 1910), through her work at Scutari during the Crimean War, her subsequent founding of schools for nursing and her writings (e.g. Notes on Nursing, 1860) has been seen as the single most influential individual in raising nursing activity to the order of a profession:

"Florence Nightingale's masterful hand took over the iniquities of the hospitals in Scutari and, in face of intense obstruction, revealed to the public its responsibility and the nursing profession as a public service".

(Feiling, 1950, p. 910).

The 'intense obstruction' stemmed not only from the sense of outrage that a mere female should presume to order the nursing requirements of soldiers but from the fact that:

"the particular profession for which Florence was clearly marked out ..... was at that time a peculiarly disreputable one. A 'nurse' meant a coarse old woman, always ignorant, usually dirty, often brutal, a Mrs Gamp."

"The nurses in the hospital were especially notorious ... and they could hardly be trusted to carry out the simplest medical duties. Certainly, things have changed since those days; and that they have changed is due, far
more than to any other human being, to Miss Nightingale herself"  (Strachey, 1948, pp. 131-132)

Baly (ed. 1981, Appendix 4) provides a synopsis of historical developments in district nursing related to other legislative, nursing and contemporary events of the time. A significant landmark in the development of district nursing was the founding of the Queen Victoria Jubilee Institute for Nurses in 1887 which, in 1925, was renamed as the Queen's Institute of District Nursing. That institute provided training for home nurses (including health visitors) and in 1947 offered such training to male nurses. Stocks' (1960) study showed that from 1859 to 1948, when the National Health Service was born, that voluntary nursing associations controlled and sustained nurses working in patients' own homes.

From May, 1968, the Queen's Institute was to cease awarding their certificate, and the time had come:

"to establish unified arrangements for training and examination for a single national certificate . . . . Accordingly, he (the Minister of Health) has decided that with effect from the examinations following May, 1968, district nurse training and examinations should be conducted under arrangements to be made by local health authorities themselves".


Appendix II to this circular set out the aims of the training as advised by the Advisory Committee on District Nurse Training (PADNT). A few examples from the preamble to the syllabus are given below:

"The purpose of this syllabus of district nursing is to enable the nurse to become efficient in district nursing, but no syllabus of training can cover every aspect of the field of work subsequently to be encountered, so that the aim should be the teaching of essential principles that will serve as a foundation for his, or her, subsequent experience in the field"
"the syllabus, by intention, is not detailed since it is based on the assumption that full use will be made of modern teaching methods with the number of formal lectures kept to a minimum"

"Since the course is intended to be of as practical a nature as possible, demonstrations should wherever possible be given with lectures, and visits covering a wide and varied field should be arranged"

"It is important that the content of both the practical and the theoretical training should be capable of adaptation to meet the needs of the individual nurse ... according to their experience and aptitude".


Having made such broad statements of intent the syllabus then specified the type and number of lectures together with the appropriate lecturers for the two parts. For the first part (health, welfare and social services) the appropriate lecturers were the local authority's Medical Officer of Health (four lectures), the Superintendent of District Nursing Service (two lectures) the Superintendent Health Visitor or Health Visitor Tutor (four lectures).

For the second part (nursing in the home) there were twenty-two lectures, seven of these to be by the Superintendent of the District Nursing Service and the rest by doctors, midwives and health visitors.

The recommended length of training was four months. The length of training had long been a subject of controversy, particularly during and following the 1955 proceedings of the Working Party set up to reconsider the training of district nurses; the result had been a recommendation to reduce the length of training from six to four months and a minority report had recorded its dissent (Stocks, 1960; Kratz, 1983). This recommendation had, however, been ratified in 1959 (Ministry of Health Circular 15/59). The fight continued to re-establish a longer period of training and obtain mandatory training
for practice as a district nurse. Mandatory training had been recommended in the 1967 Ministry of Health Circular (23/67 above) but was not to be achieved for a further fourteen years.

1970 Onwards

From 1968 then, authorities responsible for the home nursing services were also to assume responsibility for the training and examination of district nurses. From January, 1971 these arrangements were extended to include state enrolled nurses (SEN) employed by local authority nursing services. There were three formally recognised changes in district nurse training between 1968 and 1974: the revision of the 1967 arrangements for training of district nurses and the introduction of formal arrangements for the training of district nurse tutors and practical work instructors.

The revision to the 1967 arrangements discussed above came in July, 1972. The rationale underlying the revision was as follows:

"in recent years ..... training authorities are finding some difficulty in adapting it (the syllabus) to meet changes in legislation and rapid developments in the organisation of the community nursing service and nursing techniques. Family health care is increasingly being provided by community health teams based on medical practice and health centres. The district nurse is increasingly being deployed in these health teams and, as a result her functions are changing and the scope of her work is widening. Teamwork has underlined the need for liaison and collaboration with colleagues in other disciplines, such as health visitors and social workers, caring for families in the community".

(DHSS, 1972,Circular 25/72, p. 1)

The Panel of Assessors recommended syllabus, which was to take effect from May, 1973, did away with the two part division, and extended the
areas for coverage in the course through general headings: statutory and voluntary services, special responsibilities of the district nurse, promotion of health and prevention of ill health, nursing procedures, emergency midwifery, teaching and management function, and role in the community health team. An important difference between this syllabus and the old was that:

"Responsibility for determining who should give the theoretical instruction and for allocating study time ... rests with the training centres".  
(DHSS, 1972, Circular 25/72, Appendix)

With regard to the training of trainers of district nurses, the DHSS Circular 11/73 noted that the proportion of home nurses (SRN/RGN) who were also 'district trained' had risen from half to just over seventy per cent since 1968 and was still rising. The centres providing training, and the district nursing officers acting as tutors, were noted to be also providing for the community care experience option under the General Nursing Council 1969 syllabus. This prompted the Secretary of State's conclusion that:

"the time is opportune to institute formal arrangements for the training and qualification of local authority nursing officers ... and the introduction of a new grade of District Nurse Tutor".  
(DHSS, 1973, Circular 11/73, p. 1)

The PADNT would maintain a roll of such tutors and issue a form of certificate to nurses included in the roll.

In 1974 formal arrangements for the training and qualification of 'Practical Work Instructors' (more commonly now known as practical work teachers (PWT) which is the term applied in this study). These were described as:

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"district nurses who are responsible for the practical work instruction of nurses undertaking district training leading to the award of the National certificate in District Nursing (SRN and SEN)".

(DHSS, 1974, HSC (IS) 38, para 2).

No guidance had previously been given regarding the training of such teachers and 'training centres were free to appoint such practical work instructors as they saw fit, but, it was noted:

"Although there was no requirement to provide instruction for these nurses, local authorities themselves felt the need for it and in many cases provided some form of in-service training or seconded suitable staff for a course of instruction provided by various educational establishments, professional organisations and other local authorities. These courses have varied widely in content, form and length".

(DHSS, 1974, HSC (IS) 38, p. 1)

The appendix to this circular is reproduced as Appendix I and sets out the functions, syllabus selection and approval procedures for training of P.W.Ts.

These changes acknowledged the development of the district nursing role and the consequent necessity for changes to the training of those training students in district nursing.

"The role of the district nurse is developing. She now works increasingly as a member of the community health team, has a widening range of nursing functions within the community and is usually the leader of a team of nurses and ancillary staff in the provision of nursing care in the home, general practice and health centres".

(DHSS, 1974, HSC (IS) 38, para 3)

It was also in 1974 (November) that the Panel of Assessors for District Nurse Training were asked by the Secretary of State

"To devise an improved syllabus based on the existing district nursing syllabus, without prejudice to the implementation of the Briggs recommendations".

(PADNT, 1976, Preface)
The above sequence of developments leading to the PADNT (1976) recommended curriculum indicates the long time span from the inception of home nursing to the achievement of mandatory training for practice as a district nurse in 1981. Before describing the curriculum, consideration is given to the broad influences on district nursing work which implied the need for changes in training and education and to some of the reasons for delay in policy implementation.

INFLUENCES ON DISTRICT NURSING PRACTICE AND POLICY

The pressure for change was strengthened throughout the 1970's by the weight of accumulated influences on district nursing practice: such as demographic changes, shifts in broad policy for health care, change in public expectations regarding health care and welfare services and specific changes in health care organisation. It is to these areas I now turn concluding with a discussion of the gap between policy intent and implementation.

Demographic Change

The number of over sixty-five year olds increased by two million from 1961 so that by the mid-1980s that group comprised nearly fifteen percent of the total population compared with being less than five percent in 1901. Projections indicate a continuing increase in this proportion, particularly for the over seventy-five age group, with the elderly population of eighty-five and over growing from 656 thousand in 1984 to 1,047 thousand by the year 2001 (Social Trends, 16, 1986, p.20).
Changes in the age structure of the population can be judged to have a marked effect on district nurses because their work and case-loads are heavily weighted towards the elderly and very elderly (Dunnell and Dobbs, 1982). Official statistics indicate that the proportion of elderly visited by a district nurse at home increases steeply with the age of the clients (from around four per cent of those aged under seventy-five, to nine per cent of those aged between seventy-five and eighty-four, and twenty-six per cent of those aged eighty-five and over utilize district nursing services) (Social Trends, 16, 1986, p.126).

It also seems possible that the proportion of dependent elderly who might benefit from services are underestimated in such statistics. Snow (1981) for example showed that, of those too ill to go out, only a third had the services of a community nurse. Confirmation of the district nurses' work being weighted toward the elderly comes from a number of sources - including Dunnell and Dobbs (1982) national survey of community nursing which was still under-way at the time of the data collection for this thesis. Their study showed that district nursing services staff (registered and enrolled status) are the largest group working in clients' homes and that seventy-five per cent of their time was spent with patients over sixty-five.

Demographic changes prompted documents such as the consultative document 'Priorities for Health and Personal Social Services in England' (DHSS, 1976) to suggest that, in order to care for the increasing numbers of elderly, the district nurse numbers should increase by six per cent per annum. But, as Ross (1987) points out,
the district nurse to population ratio set in 1972 at a level of one district nurse to 2,500 population has never been achieved and is now in any case out of date due to changes in employment conditions (such as longer holiday entitlement and a reduction of the working week to 37.5 hours).

However, during the three years (1977-1980) following the 'priorities for health' document the number of registered and enrolled nurses entering district nurse training was less than for the previous three years (DHSS, 1981). Therefore on the one hand there was ample recognition of the impact that the growth in the elderly population might have on the district nurses' work load but on the other hand little shift in training resource or recruitment to training which might contribute to alleviating the problem.

Public Expectations and Health Policy
The sixties and seventies heralded changes in public mores and public expectations of health and welfare services. This can be seen as partly as a concomitant of the general economic expansion of the mid-sixties to early seventies and of government commitment to policies which extended choice of alternative care arrangements to those being provided within institutions.

Previously disadvantaged groups - including the young, ethnic minorities, women and homosexuals - found their voice and public support in a liberal climate. Greater spending power raised the profile of the young and women in particular whilst liberal
philosophies emphasising individual freedom of choice burgeoned (in campaigns for abortion on demand, freedom of expression for 'gays', anti-racial discrimination, 'flower-power' among others) and in some cases were supported by changes in legislation (e.g. race relations and abortion) and the creation of new protective bodies (e.g. the commission for equal opportunities).

From the 1970's too, there was a renewed growth of voluntary group activity - which had declined following the inception of the 'welfare state' under Lord Beveridge in 1948 - which challenged the current organisation and ethos of health care particularly in relation to vulnerable groups such as the handicapped whether through illness, disability or age. Voluntary groups kept up the pressure on government for health policies which would provide greater scope for choice between options for care.

Government documents and policies reflected a shift towards 'community-based' options for care supporting public demand for good standards of care in local and home environments wherever possible (D.H.S.S.: 'The Future Pattern of Hospital Provision', 1980; 'Care in Action', 1981). Main policy documents on priorities for health reflected changes in public attitudes towards preventative models of health care (in health education campaigning for example) as an important balance for the predominantly influential treatment and curative models of care (D.H.S.S.: 1976, 1977). This shift towards community based care and prevention of ill health is therefore found in many public statements particularly where the focus is on

In addition general changes were noted with regard to public expectations of professional care-givers. Jeffrys and Sachs (1983) point to the 'rising tide of scepticism in society in general about the work of professional groups'. The role of professionals as experts in their field was (and still is) being challenged - by women who want to have their babies at home and not in high technology settings, by those who find natural/organic alternatives to medical prescription and by the raising of consciousness about the effects of the environment and of societal norms and expectations on the individual and families in a locality. The norms of 'professional expertise' and 'public deference' to these were thus being challenged from the 1960's and were supported by the spread of sociological knowledge (Runciman, 1966; Westergaard and Resler, 1975 and Haag and Sussman, 1971).

Changes in Primary Health Care

Apart from demographical shifts and general shifts in public expectations and policy there were changes in allied professional education and organisation and specific health policy all of which impacted on the practice of district nursing. Some of these influences were indicated in an earlier section also.
For example there were changes in education and practice for the general medical practitioner through 'the family doctors' charter' (British Medical Association, 1965) and the Report of the Royal Commision on Medical Education (1968). These encouraged group general practice whilst local authorities were encouraging the building of health centres (Ministry of Health, 1965) and the attachment of local authority personnel - such as health visitors and district nurses - to patients on particular general practitioners' lists (Health Services and Public Health Act, 1968).

Attachment to general practitioners' practices was judged as helping to bring about an extended role pattern for the district nurse. Research on-going at the time of this present study subsequently supported this assumption to some extent. For example in their study of the elderly, Wade, Sawyer and Bell (1982) indicated an extended role whereby the district nurse became the focal point for coordination of domiciliary nursing care and other services for the elderly. A national survey of 9,214 general practices in England (Reedy, Philips and Newell, 1976) confirmed the growth of attachments showing a marked increase in attachments of nurses to general practices following the Health Services and Public Health Act of 1968 and sixty-eight per cent (nearly five thousand from the 7,863 responding practices) of practices had an attached nurse; a less marked increase in the number of GP employed nurses (for whom doctors, from 1966, could reclaim up to seventy per cent of salary back from the N.H.S) also occurred from the around the time of the
general practitioners' "charter" and by the time of the survey twenty-four per cent of practices had an employed nurse.

The case for teamwork and inter-professional collaboration as the best means for delivery and co-ordination of primary health care emerged around the mid 1960's (D.H.S.S., 1967) and was pressed by a number of reports (Royal Commission on the National Health Service, 1979 (the Merrison Report); DHSS: The Primary Health Care Team, 1981 (the Harding Report), and Primary Health Care in Inner London, 1981 (the Acheson report). Continuity of care was stressed as important in community nursing (Royal Commission on the National Health Service, 1979 (the Briggs Report)) and general medical practice (B.M.A., 1979). Policy towards earlier discharge from hospital following minor surgery was a further development which might be expected to influence district nursing work since such patients could require follow-up nursing care at home (DHSS, 1980; Ruckley, 1980); though in practice there was poor co-ordination between hospital and community (Roberts, 1975; Skeet, 1971).

Policy Implementation

There were therefore a number of influences which could be seen as necessitating changes in the district nursing organisation and practice which helped support pressure for changes to training and education. Nevertheless the actual implementation of any change was slow in arriving. This needs to be seen against a generally slow rate of change in health care. For example despite persistent policy
statements about 'community care' options to institutionally based care major resource shifts have not occurred (Vistow and Fuller, 1983; Glennerster, 1983). Health care is largely funded by Government distribution of national funds and the state of the economy is a restraining factor on implementation of policy; this can be noted in White Papers:

'overall policy was to reduce inflation...... the improvement of services for elderly people is largely dependent on that...(but)...we have had the needs of the growing numbers of elderly people - particularly the very old and frail - very much in mind in maintaining a high level of spending in the health and personal social services'.


Apart from national restraints there are marked regional differences in patterns of health care and resources which persist in the face of attempted redistribution (D.H.S.S., 1976, 'Sharing Resources for Health in England : Report of the Resource Allocation Working Party). Thus a study in community care found that:

'there seems to have been little identifiable shift away from hospital and residential care for elderly people on the margins of institutional and community based care'


Training and education requires a commitment of scarce resources so that a lack of influence over or command of such resources would hamper educational development. The above historical overview indicated that district nursing remained largely under the auspices of voluntary associations until 1948 and was therefore dependent on charitable funding. Such funding has the disadvantage of being uncertain enough for long-term planning and commitment to training and education so that priorities would tend to concentrate on funding nurses to work in homes rather than training.
From 1948 the local authorities became the responsible bodies for district nursing services. This produced pressure for national policy and standards of training for district nurses but again central funding was not forthcoming and local authorities had no statutory obligation to commit funds for training. Moreover, subsequent policy initiatives reduced the recommended period of training to four months (from the six months adopted by the Queens Institute) and no legislation was secured to enforce the training. The outcomes were that local authorities remained free to employ nurses who had had no additional training for district work whilst different authorities offered different forms of preparation and in some cases none.

McIntosh (1985) has pointed towards the peripheral status of district nurses and their nurse managers in the making and implementation of policy. Drawing on political theory she argues that from 1948 to the re-structuring of the health service in 1974 nurses had limited opportunity to influence funding priorities:

"The locus of control thus shifted to the arena of local government, and became vested specifically in the office of the Medical Officer of Health. As a consequence, district nursing had to compete for funds alongside other health and welfare services, with its administrative and policy-making structure under the direct control of a sector of the medical profession".  

(McIntosh, 1985, p.47)

In this situation, Ministry of Health circulars of the 1960's and 1970's had limited impact in terms of actual policy implementation at local level or national level. Reorganisation of the National Health Service in 1974 integrated local authority and hospital services under
area health authorities and health boards (in England and Wales and Scotland respectively) and reorganised management structures to reflect management by multi-disciplinary teams. This could have helped give district nurses a stronger voice but in practice:

"The reorganisation led to many district nursing sectors being merged with, and brought under the control of, hospital oriented nurses. Furthermore, community divisions where district nurses and health visitors were jointly managed under one head, tended to have directors of nursing services who had a health visiting, rather than a district nursing, background."

(McIntosh, 1985, p.50)

The NHS reorganisation of 1982 (England and Wales) removed the area health authority tier and the main part of the data collection for this thesis occurred in the run up to this change, creating — as is indicated in Chapter Six — confusion and anxiety as district nurse managers competed for new management posts (often for their own posts) against nurses from other backgrounds; there was little optimism that reorganisation would help improve the status of district nurses amongst nurses in other groups or amongst other professionals in the health services.

District nurses may therefore be perceived as having remained 'marginal to health policy making' (McIntosh, 1985, p.45) but, changes to training and education were to occur in pilot form from 1978 at two centres (one these being the University of Surrey). Influences on the actual implementation of change in education, in line with the PADNT's recommendations, appears to have been the increasingly vocal lobby at district nurse practitioner level which was spearheaded by committed individuals, and finally the more wholehearted support shown
by the Royal College of Nursing (the major professional association for nurses) from the latter half of the 1960's (Royal College of Nursing, 1969). The lack of co-ordinated implementation of official policy statements became ever more visible within the nursing profession as a whole. Commitment to the plans for new courses based in the higher education sector from 1981 was a major achievement so that the last years of the 1970's into the early 1980's was a period of great activity and excitement for those involved in establishing and assessing courses. In the next section the new curriculum on which such courses were to be based is summarised in terms of its general aims and objectives and conceptions of the district nurse implied by these objectives.

THE NEW CURRICULUM

General Aims and Objectives

The PADNT 1976 report on the education and training of district nurses (SRN/RGN) stated the general aims for the preparation of a district nurse:

"at the end of the course a district nurse will be competent to undertake nursing duties within the community and to be held individually accountable for the professional standards of her own performance."

(PADNT, 1976, p. 2)

This was subsequently revised to read:

"The aim of the course is to prepare a district nurse who is competent to undertake nursing duties in the community and able to accept individual responsibility for the professional standards of her own performance."

(Baly (ed), 1981, Appendix 5)
These aims imply that, following a course of education and training, the district nurse will be competent to practise in the community and capable of being individually responsible for standards and her/his actions. This was qualified by a statement contained within the overall aims paragraph:

"To satisfy this aim the curriculum has been designed to emphasise the use of a problem-solving approach to district nursing and reference is made throughout to the 'nursing process'.

(Baly (ed), 1981, Appendix 5)

The general aims of the curriculum were followed by four objectives which were to be seen as guiding principles and not as 'specific units of learning' for the curriculum:

1. To assess and meet the nursing needs of patients in the community
2. To impart skills and knowledge acquired
3. To be skilled in communications, establishing and maintaining good relationships, co-ordination of appropriate services
4. To have understanding of management and organisational principles. Contributing towards future developments

(PADNT, 1976, p. 3)

These general aims and objectives had been arrived at through consultation with a wide variety of organisations including nurse training bodies, professional organisations, and government departments and over a hundred individuals working in ad hoc groups, half of these being practical work teachers. The working party itself was made up of twelve members eight of whom had a district nursing qualification (either the earlier Queen's Institute or the national NDN certificate). None of the party were however currently practising district nurses and represented managers at area level in district
nursing, medical practice and lecturers in district nursing, whilst one was a professional nursing researcher.

Recommendations included extension of the course length to nine months, six of which would be an integrated programme of theory and practice planned by the district nurse tutor at the centre for training, and the further three months to be continued practical experience under the supervision of a nursing officer in collaboration with the tutor. It was such a course, based on this 1976 recommended curriculum which provides the context for of this study. In 1978 the revised course was accepted for introduction but confined the length of the course to the first six months thereby leaving the three months supervisory period as an option (DHSS, 1978, Circular DNT(N)2).

Conceptions of District Nursing Practice

Expansion of the four main objectives contained in the Report gave indications of how a district nurse was expected to conduct his/her practice. For Objective 1:

- to assess and meet the nursing needs of patients in the community

the focus was on nursing process as a systematic means of

"gathering information; assessment of information; planning of care; giving of care; evaluation of care". 
(PADNT, 1976, para 3.3)

For Objective 2:

- to impart skills and knowledge acquired

the emphasis was on the teaching functions of the nurse acknowledging the:
"important role played by the district nurse in relation to health education and teaching of other workers ... in addition to her function of teaching the patient and his family".

(PADNT, 1976, para 3.5)

For Objective 3:

"to be skilled in communications, establishing and maintaining good relationships, co-ordination of appropriate services

it was considered important for assessment (an aspect of nursing process) that the nurse was able:

"to appreciate the psychological, emotional, spiritual and social needs of her patients and their families, in addition to the physical needs"

(PADNT, 1976, para 3.6)

This third objective implies considerable interpersonal and organisational skills in order to marshall necessary services.

For Objective 4:

"to have understanding of management and organisational principles. Contributing towards future developments

acknowledgement of existing first level management courses for nurses (hospital or community) was made in the Report but it was recommended that management education was essential in the proposed new curriculum because

"The district nurse is admirably placed to recognise new trends in illness and treatment but she needs training to perceive, evaluate and take appropriate action".

(PADNT, 1976, para 3.8)

This implies that the district nurse will actively participate in furthering service developments which meet the needs of patients through being able to spot and analyse changes in needs and assess the utility of particular forms of care. There seems to be an
assumption in this objective that an accumulation of knowledge (through research and evaluation) will contribute towards changes in service. However, as an earlier section indicated for the case of educational change in district nursing, there is no simple linear progression from identifying and arguing the need for change and actually getting anything done about it. Perhaps therefore management education was deemed necessary in order that the district nurse could utilise her/his understanding to better effect in the service structure but the concept of management remains unclear in this objective.

These general aims and objectives for district nurses were supplemented in the Report by two Appendices which outlined a recommended course content for training in two ways. Appendix I (PADNT, 1976) outlined the course content for the curriculum, breaking down thirteen areas into the 'skills', 'knowledge' and 'attitudes' associated with each content area. For example the 'skill' of observation (of the patient) was associated with 'knowledge' of the effect of the environment, sociological concepts and their significance in health and disease and 'attitudes' which included respect for the values held by all persons with whom the district nurse comes into contact. The second Appendix to the report took the four objectives described earlier and provided a more detailed guide for the curriculum - again in terms of the skills, knowledge and attitudes which were to be acquired, learned and demonstrated by the district nursing student.
Implementation of the New Curriculum

The PADNT Report pointed up the fact that this was an outline curriculum as opposed to a syllabus; its authors had defined the word syllabus as a list of subjects whereas curriculum was more related to their view, namely a course of study. (PADNT, 1976, para 2.3)

They preferred to recommend a curriculum therefore which would allow educational centres to make changes and update their proposals for their courses in the light of local needs. Similarly the Panel might request such changes at future points. The notion of a 'syllabus' was conceived as too inflexible with a propensity for becoming rapidly outdated whilst a 'curriculum' was associated with allowing scope for relevant changes in education and training.

The proposed new curriculum for district nurse training was first implemented and piloted in the Department of Adult Education (later renamed the Department of Educational Studies) at the University of Surrey in the 1978/79 academic year. The senior district nurse tutor together with academic members of the department were successful in obtaining funding from the D.H.S.S. for the evaluation of this innovatory course and the second course which was to run in the 1979/80 academic year. In the event there was a one year break in the evaluation programme so that the course evaluation continued with new personnel (including myself) for the 1980/81 academic year. The report at the end of the first course (Jarvis and Gibson, 1980) provides a detailed study of the implementation of a curriculum innovation by an educational institution. It details the development
of the curriculum from the course aims and objectives given above. The original aims and objectives were accepted but a further overall aim was added

"To create a learning environment where students can benefit from the educational process, by extending their knowledge in community nursing studies, and related subjects, and further their personal and professional development".

(Jarvis and Gibson, 1980, p. 33)

The decisions made regarding implementation resulted in a modular curriculum with four basic modules (the first three having sub-modules):

1. The Principles and Practice of District Nursing
2. Current Trends in Medical Practice
3. Behavioural Sciences
4. Social Administration

The senior tutor then coded Appendix II of the PADNT's 1976 outline curriculum and assigned the 'skills', 'knowledge' and 'attitudes' to the fourfold modular structure; at this stage the researchers recorded that some of the designations were placed arbitrarily:

"Hence the boundaries of the modules tended to be rather ill-defined but this may have had an integrating effect upon the student's learning experiences".

(Jarvis and Gibson, 1980, p. 35)

This activity was seen as necessary to convert the general guidelines of the PADNT curriculum into an operationalisable syllabus for training and education which was then capable of organisation and scheduling. The 1980/81 course, on which this study is based, remained substantially the same as this first course and is shown in Appendix 2.
THE PURPOSES OF THIS STUDY

Overview

This study explores issues in the education of adults for a professional qualification. Investigation of an innovatory curriculum for the preparation of district nurses provided an opportunity to raise and consider important concerns about education and practice in a caring profession. A central issue in this study is the extent to which the curriculum supports the practice of district nursing. The relationships between conceptualisations and structural features of the curriculum and practice are explored by paying particular attention to the community experiences of students and their teachers. This was judged as likely to provide insights into the continuities and discontinuities between education and practice through the perspectives of participants who were both receiving or giving education and practising or learning to practice district nursing.

The study represents a case study of change in education and training for a specific occupation: district nursing. The changed emphasis of the new curriculum implied changes in the activity and role of the district nurse and the assumption could be made that the education and training processes, where these closely involved the existing district nurse personnel in the practice placements, would influence perceptions of district nursing. The extent to which people in their working contexts perceived the changes in the curriculum as being in line with their own experiences and knowledge could be an influential factor in their commitment to disseminating educational developments such as 'nursing process' in practice.
The outcomes of the study could therefore have implications for the organisation of teaching and learning in the contexts of working practice and might allow discussion of the appropriate basis of education and training where that is to be judged as relevant to the content and practice of district nursing. The conditional tense has been used here because at the start of the study I did not know what might emerge as important and, as the next chapter indicates further, the initial aim was to collect views and information about as many aspects of the curriculum as practicable and, from within this broad context, to particularly focus on teaching and learning in the community.

The research approach adopted was deliberately open in order that as many perspectives on district nursing and education in district nursing could be obtained. It aimed ultimately at arriving at a better understanding of what meanings people attach to their experiences of district nursing in work, teaching or learning contexts. The research does not follow a traditional research paradigm of pre-conceived hypotheses for 'testing' and makes no attempt to emulate experimental or quasi-experimental conditions. Such an approach would have conflicted with the aim of allowing the participants constructions of their experiences to emerge from real situations. The study is a qualitative case study which attempts to capture aspects of relationships, processes and environments experienced by one cohort of students as they progress through their course of education and training and out into district nursing. The rationale for the approach adopted is explored further in Chapter Two.
As my understanding of education and district nursing grew through the experience of carrying out the research, it seemed to me that a key area had emerged. This was that participants conceptions of education and working practices had similarities in referencing action to a common value base. The similarities could be related to theories which recognised the rights and responsibilities of the individual person. This could be shown in relation to education and inferred for district nursing practice and is consistent with theories of knowledge which emphasise the active participation of the individual in learning.

It was possible to explore this notion further in relation to nursing care decisions through observation and discussion with four district nurses from outside the original subjects of the study. This additional data is used in a limited manner to illustrate the use of rights theory as referents for decision and action in the concluding chapter of the study.

In summary therefore the purpose of this study was exploration of an innovatory curriculum in the context of community district nursing in order to raise and reflect on the form of theory or concepts which appeared to be important for the participants in teaching, learning and practice in a caring profession.

The remainder of this section first discusses problems in curriculum study and restates the main aspects of district nursing practice being reflected in the curriculum being researched. The latter are discussed under the headings of teamwork in primary health care, approaches to patient care, and teaching and management. Only
research available at the start of the study is discussed here; research which became available after the field work was completed is raised at appropriate points in the remaining text.

Questions in Curriculum Study

A problem to be faced at the start of this study was that one of the fundamental questions raised in educational evaluation literature is what constitutes 'curriculum'? Stenhouse (1975) succinctly introduced the main dimensions of conflicting or different definitions of 'curriculum' as applied in curriculum studies. He concluded:

"We appear to be confronted by two different views of the curriculum. On the one hand the curriculum is seen as intention, plan or prescription, an idea about what one would like to happen in schools. On the other it is seen as the existing state of affairs in schools, what does in fact happen".

(Stenhouse, 1975, p. 2)

Thus there is the curriculum intention and the curriculum reality. Stenhouse describes mainstream traditional conceptions of curriculum (particularly in American literature) as resting on assumptions of an 'ends-means model' where ends are variously described as 'intended learning outcome' or 'behavioural objectives', whilst means are derived from these prescribed ends. The result of such interpretations tends to leave in limbo questions about the unintended outcomes of a curriculum whilst paying close attention to measurement of student behaviour. But as was indicated above the focus of this study can be seen as going beyond 'student behaviour' in that sense, being ultimately concerned with their conceptions of practising as district nurses. This brings us back to the issue of what constitutes the
Stenhouse put forward a more open definition of curriculum which he described as 'tentative':

"A curriculum is an attempt to communicate the essential principles and features of an educational proposal in such a form that it is open to critical scrutiny and capable of effective translation into practice;"

(Stenhouse, 1975, p. 4)

The earlier discussion of aims and objectives of the PADNT recommended curriculum and their subsequent interpretation, implementation and scrutiny at the university suggests that this new curriculum might meet Stenhouse's criterion that:

"both content and method, and in its widest application takes account of the problem of implementation in the institution of the educational system".

(Stenhouse, 1975, p.5)

The pilot course in the 1978/79 academic year had demonstrated that the new district nursing curriculum had been capable of interpretation and implementation by an educational institution. To this extent the pilot course had faced what he described as:

"the central problem of curriculum study ... the gap between our ideas and aspirations and our attempts to operationalise them".

(Stenhouse, 1975, p. 6)

This leaves aside the issues surrounding judgements about whether the curriculum is effective in terms of its relevance to practice and it is these issues which are at the centre of this study. In other words the effectiveness of the curriculum could, in my view, be only partially judged from within the formalised educational setting since its ultimate effectiveness would be experienced elsewhere in the contexts of district nursing working practice.
District nurse education and training therefore has to be seen in a wider context than that usually considered in the curriculum literature - much of which is concentrated at school age level and immediately concerned with student' performance inside the classroom. The district nursing educational 'system' includes at its most obvious the educational institution per se (in this study a university department), the district nurses acting as teachers of practical work who are sited also in their health service organisations, and the professional representatives who have set the guidelines and monitor the performance of the training centres training students for this particular occupation. Beyond this however there are the ultimate constituents for the training and education - the client groups and individual patients and the quality of care and services they receive.

This opens up the boundaries of the 'gap' to be researched in Stenhouse's terms. For example changes in training for this one sector of workers in primary health care might be predicted to have effects on other personnel such as general practitioners, health visitors or social workers, each of whom may see themselves as co-ordinators and managers of care for their clients. In the first instance, the effects could be felt by existing staff closest to the newly trained district nurses who are delivering district nursing home care whether as established district nurses and/or practical work teachers, and as enrolled nurses or as auxiliaries (care assistants) who are not trained nurse personnel. A further area for examination might be whether changes have occurred in the practice of primary health care in line with the assumptions underlying the changes in the
curriculum; here appropriate exploration would be about perceptions and experiences of co-operation and collaboration between different personnel and the ways in which the district nurse's role has expanded in real situations.

There were therefore many places to examine if seeking for the 'gap' between the ideals of this curriculum and its' realities'. The earlier discussion of the first evaluation of the implementation of the curriculum (Jarvis and Gibson, 1980) serves to illustrate that definition of ideas and aspirations are problematic: whose ideas do we focus on? Those who initially designed the curriculum (the professional body responsible for overall standards), those who implement it (the educational institutional personnel and/or community teachers and managers), those who receive it (the students), those who put the outcomes into practice (the district nurses) or those who experience the outcomes (the clients, the district nurses and those they work alongside)? 'The curriculum' for district nursing, in this sense, could be seen as spanning all these constituents.

This study began therefore with a broad view of curriculum as including content, method, people and structure, but within that, there would be more specific focus on the community based aspects of the course. There were many potentially interesting topics requiring investigation and many imponderables. A general research issue would be to establish the extent of the agreement between the different interested parties about the general assumptions made regarding the purposes of the training.
The main question I was interested in at the start of the study was to what extent did the new curriculum embody 'real' as opposed to 'ideal' conceptions of district nursing practice? That is, how far could the curriculum be judged as in line with, or leading ahead, of practice in the field. The answers to that question seemed likely to have implications for the consolidation of education and training once students left the formal education arena and began to practice.

Relevant literature was therefore sought on specific aspects of district nursing practice as reflected in policy statements supportive of 'community care' initiatives and in the new curriculum taking these as responses to or assumptions about the developing role of the district nurse in primary health care. Aspects of district nursing work roles indicated as of significance were:

- team work with an emphasis on liaison and communication with others working in primary health care and where care patterns were responsive to changes in organisation
- a patient care approach in line with 'nursing process', in which communication skills were important
- a teaching function in relation to patients and carers and other colleagues
- management and organisational functions based on assessment and evaluation of information on practice and trends contributing to future development of care

These areas are considered in turn below. General observations arising from the initial literature search was that it revealed that research in the area of district nursing was of recent origin and 1966 marked its beginning with surveys of district nursing in England (Hockey, 1966) and Scotland (Carstairs, 1966); that there was no
curriculum research in district nursing other than that reported above in the section on implementation of the new curriculum; and, lastly there was little relevant research from the standpoint of the district nurse.

Teamwork In Primary Health Care

A few studies had directed attention at aspects of teamwork amongst the personnel found in primary health care. Gilmore, Bruce and Hunt (1974), from a health visitor standpoint, considered the work of the nursing team in general practice concentrating on health visitors, district nurses and general practitioners in thirty-nine practice centres (three of the nursing teams were subjected to close scrutiny). Findings implied that attachment of health visitors and district nurses to general practitioners should not be assumed to lead automatically to inter-disciplinary teamwork. The study had utilised Luski's definition of inter-disciplinary teamwork:

"a group of persons who are trained in the use of different tools and concepts, among whom there is an organised division of labour around a common problem, with each member using his own tools, with continuous communication and re-examination of postulates in terms of the limitations provided by the work of the other members, and often with group responsibilities for the full product"

(Luski, 1958, pp.9-10)

The study suggested that important underpinnings to the development of teamwork were:

'conscious planning based on the promotion of awareness among all team members of what is involved in teamwork and of the factors which hinder and accelerate the process'

(Gilmore, Bruce and Hunt, 1974, p. 149).
There was a generally 'laissez faire' approach towards contacts with each other and it was the health visitors, more than either district nurses or doctors, who thought that such ad hoc process for meetings and consultations was unsatisfactory, expressed feelings that their work lacked integration with others' work and thought that their preventive role was mis-perceived and under-valued by doctors (p. 150). Doctors appeared to appreciate the district nurse for 'lightening their work load' (p. 153) and recognised the largely domiciliary nature of their work with patients. General agreement between these groups of personnel was found over their belief that closer work relationships enabled better health care services (p.147) and sharing office space reduced mis-understandings over role between health visitors and district nurses.

A potential problem area raised in the Gilmore et al study concerned the district nurses' work within health centres and surgeries where doctors might have expectations that the district nurse would carry out activities similar to those of the general practitioners' privately employed 'practice nurses' (D.H.S.S., STM (75) 13, 1975). That memorandum estimated 650 'practice nurses' for 1975 and this was to double over the neat six years (D.H.S.S., 1982). The characteristics, activities and opinions of these two groups of personnel in the context of general medical practice was considered by Reedy et al from 1974 onwards. The studies confirmed the increasing likelihood of
both types of nurse working alongside each other in the general practice; that district nursing attached personnel spent the major part of their nursing activity time in patients' homes; and that the 'attachment' of nurses to general practices (particularly where a treatment room was available) led to the district nurse spending more time in work at the doctors' surgeries.

A finding contradictory to the researchers' expectations was that practices (with the exception of those in the small proportion of health centres found) with attached nurses were more likely to also be employing nurses. One conclusion drawn was that 'possibly nurses are employed by general practitioners ...because the existing nursing attachments are ineffective and the attached nurses have created an awareness of the deficiencies' (Reedy, Philips and Newell, 1976). Such a conclusion seems however to highlight the influence of specific perspectives when interpreting research findings. In this case the perspective was a medical one which appeared to perceive nursing action in terms of benefits accruing to the doctor. A possible alternative explanation of employment of 'practice nurses' alongside attached nurses, which could also be supported by the findings, would be that this is rational action on the part of general practitioners in recognition of the major differences in work pattern and employment circumstances between the two types of nurse. Attached nurses were found to continue to be mainly at work in patients homes whilst employed nurses remained in the practice premises and the former remained responsible to nursing managers of the local authority whilst the latter were accountable to their doctor-employers. A more
disturbing conclusion would be disagreement about the fact per se of 'attachment' (that is whether doctors recognised when a district nurse was attached to their practice) and such disagreement was in fact indicated for the health authorities and general practitioners in forty per cent of practices (Reedy, 1980).

A further article, from Reedy et al, showed that basic qualifications between the two groups of nurses were similar but that the majority of attached nurses held an additional district nursing qualification; that the attached nurses were younger on average, less likely to have been married and had been employed for longer within the H.H.S. suggesting a commitment to publicly funded nursing. The two groups had, however, similar commitment to children and dependents (Reedy, Metcalfe, de Roumaine and Newell (1980a). A related publication showed that, although the majority of both groups agreed they could work together as a team, a larger proportion of the attached nurses remained 'neutral' and were 'also more likely to disagree that general practitioners always treat nurses as colleagues'; on the other hand nearly all the attached nurses thought attachment helped improve relationships between doctors and nurses in contrast to under three quarters of the employed nurses. The researchers suggested that the 'predominent ethic' of the attached and employed nurse differed to the extent that the attached nurses responses implied they were 'independent caring agents' whilst the employed nurse 'sometimes say that their job is "to help the doctor help the patients"' (Reedy Metcalfe, de Roumaine and Newell, 1980b). It seemed possible from these data that the employed 'practice nurses' were more satisfied
with the status quo of their chosen situation in the sense that they
gave priority to their husbands' careers over their own and had less
career ambitions than did the attached nurses who were perhaps more
concerned to achieve equal status as professionals with general
practitioners.

These studies showed therefore that there was increasing likelihood
that both types of nurse would be working alongside each other in
general practices (outside of health centres) and, in terms of
consistency of 'team' perceptions and possibilities for collaborative
action, indicated potentially important differences between the two
groups of nurses over orientations to work and in valuations of
nursing and doctor-nurse relationships which left room for
misunderstandings over the nature and meaning of team work.

Contact and communication between different personnel and agencies
was a theme which was picked up in many studies on the basis that
collaboration over care is unlikely without these conditions however
few studies examined these as a major focus. Findings tended towards
negative evidence. Hockey (1966) showed low levels of contact between
district nurses and their medical colleagues. McIntosh (1974) showed
that collaboration and contact between district nurses and community
health colleagues was not satisfactory over more difficult patient
care problems. Gilmore et al (1974) found that health visitors were
poor at explaining their preventive activities to colleagues, including
district nurses. Poulton (1977), in a study of district nurses and
health visitors in one district, found that health visitors' contacts
with general practitioners were low, and that communication could be improved between health visitors and district nurses, and was exacerbated where they did not cover similar geographical areas.

The evidence suggested therefore that notions about teams and teamwork in the primary health care situation were emerging but were not to be taken as a matter of agreed fact.

**Approaches To Patient Care**

The new curriculum emphasised assessment and meeting the needs of the patient through nursing care in line with 'nursing process'. This appeared to be the core theoretical focus regarding patient care in the new curriculum. Not having a nursing background, it was some time into the study before I realised that 'nursing process' was a phenomenon of American origin which, in Britain, was in its very early stages in the general basic nurse education field, let alone the post-basic qualification field. The district nursing curriculum was in fact the first to state that 'nursing process' was the approach to be learned and then expected from students and by implication from district nurses. The research aim in relation to this aspect of the curriculum was therefore to explore the conceptions and reactions of the different participant groups (students, practical work teachers and managers) towards 'nursing process' and their views on its utility as an approach to patient care.

By the end of 1980 when this study began there was little directly relevant research about this aspect of the curriculum in relation to
district nursing and studies which highlighted patient care issues were sought. Given that major aspects of direct district nursing care occur between the nurse and patient in the privacy of the patient's home, perhaps the dearth of studies about actual care given was not surprising.

One study which stood out by the nature of its examination of district nursing care was Charlotte Kratz's study 'care of the long-term sick in the community' (1978). She showed, through participant observation and interviews with district nurses and their thirty stroke patients, that district nurses exhibited different approaches - 'models of care' - according to their perceptions of whether patients were waiting to go into hospital, were seriously ill, or were recovering or not. From the data Kratz was able to generate a model of care which related categories of patients to nurses' aims and values. The study indicated that nurses caring for the acutely ill were more able to set objectives for patient care based on an assessment of patients' nursing needs provided more focussed care and highly valued the care they provided to patients. On the other hand unfocussed, minimal care was being provided to the long term chronically sick. The nurses appeared to base their decisions on concepts of 'fairness' of time distribution in relation to the needs of other patients, and conceptions of patients'/carers' obligations to 'managing' their own care. That study supported the notions that hospital based basic training was not an adequate preparation for the care of all the different types of patients found in the community. These findings seem relevant to 'nursing process' in the district nursing curriculum.
because this 'problem solving' approach requires that the nurse assesses needs, plans a course of nursing action, carries through that decision and finally analyses the result to provide feedback into the cycle for further care of that patient.

Hockey's survey found that district nurses were not undertaking the full range of activities they had been trained for (Hockey, 1966). A later study indicated that 'the working pattern of all district nursing staff, showed marked fluctuations throughout the working day; by far the most patient contact periods happened between the hours of 8.30 a.m. and 1300. There was a marked reduction of patient contact at the weekend' (Hockey, 1968 in Clark and Hockey, 1981, p.108).

Such observations of working practice have implications for the way in which district nurses carry out and organise their nursing care if it intended that this should meet individual patient needs rather than their own or those of the service. Findings from different types of studies indicated that there were many unmet nursing care needs in the community suggesting that assessment of needs was generally inadequate. Assessments of needs among elderly patients, which official statistics indicate as forming the main clients for district nursing services, showed that there were unmet needs for services (Barber and Wallis, 1975) and also uncertainty over which personnel should carry out such assessments, as this is more traditionally perceived as a health visitor's role (Wallace, 1975).
One expectation might be that district nurses are involved in particular care 'content' areas such as the care of terminally ill patient at home but a random survey of districts in England and Wales found (retrospectively) that where people had died at home, the district nursing service had often not been involved at all (Cartwright, 1973). Studies of a hospice-based advisory service for the terminally ill found that the statutory services were often not in evidence prior to admission pointing towards the importance of careful assessment of the needs of dying patients and families (Doyle, 1980 and 1982) and attention to communication of information between agencies given the varied arrangements for support services which are found (Wells, 1980; Lunt and Hillier, 1981). Similar issues of communication and liaison arise over patients entering or being discharged from hospital and requiring home care (Skeet, 1970) where discrepancies were found between information given by ward staff and the information needed by district nurses for the purposes of planning care for discharged patients (Roberts, 1975).

There was therefore a somewhat patchy picture of direct district nursing practice with indications of variations in quality or quantity of care. Little light had been thrown on the conceptualisation of nursing approaches used with patients in their homes or in the surgery.

Teaching and Management Functions of District Nurses

There was little research based information which might inform the curriculum's emphasis on the teaching or management role of district
nurses with patients and their carers or colleagues. One of the issues found in the literature is that a teaching and preventive role traditionally comes into the health visitors remit but that the growth of social work services challenges this with children and families and the work of district nurses with the elderly may also be preventive as well as curative (British Medical Association, 1974; Health Visitors Association, 1981).

The literature on the management and organisational functions of the district nurse was similarly sparse. Management implies a degree of responsibility and motivation to take action in relation to control of resources (including information and people) in order to achieve the desired goals. As was indicated earlier the conceptualisation of the management functions of district nurses was not clear in the written curriculum. A few studies, mostly occurring in the context of teamwork in health care, illustrate the issues which could be important for district nurses seeking to establish a management role in relation to nursing care of patients.

The Reedy et al (1976, 1980a and 1980b) studies indicated conflicting perceptions, among different personnel working in the context of primary health care situations about the purposes of nursing action. For example the attached nurses saw themselves working more to meet the needs of the patient than did the practice nurses who saw their work as supporting doctors' work with patients. Organisational attachment of district nurses to general practices also reinforces the fact that most patients come to them via a medical practitioner and,
that unlike health visitors, they do not have statutory rights of direct access to any particular client group.

The growth of larger group practices together with attachment or alignment of nurse personnel theoretically could be seen as providing a base for meetings and collaboration between different professional colleagues and leading to co-ordination over care of shared patients; but, in practice, this did not seem to be developing. Gilmore et al (1974) showed that, whilst nurses attached to general practices believed this gave them more opportunity to develop their services to patients, constraining factors in making use of this opportunity were lack of access to information for various reasons and poor referral systems, while large caseloads were said to leave little time for other than superficial and routine patient care. Bowling's (1981) survey of general medical practitioners and nurses suggests that doctors will exercise a controlling influence over the work carried out by nurses based with them so that, while nearly half the doctors surveyed regularly delegated minor clinical tasks to the nurse, they indicated a less favourable attitude towards the notion of the nurse as an independent practitioner capable of making first visits to the patient. Dingwall and McIntosh (1980) together concluded, from their independent studies of health visiting and district nursing, that there were conflicts between these groups' occupational ideals and the reality of their working situations where their aspirations were unsupported by their own managers and, where primary health care was largely directed by general practitioners; they also perceived a potential conflict between the collegiate structuring of education (at
that time more applicable to health visitor education) and the hierarchical administrative structures found in the health services.

On the surface, therefore, the literature suggested that the district nurse appeared not to be in a position to greatly influence or manage the organisational environment within their practice bases. The implication was that their main sphere of control would remain outside with patient care in the home. In that respect the immediate opportunities for management would come from their patient caseloads and the deployed district personnel. Studies referred to in earlier sections suggest problems in this area stemming from a lack of distinction between work carried out by the registered and enrolled district nurse personnel, erratic deployment and low levels of liaison between other community personnel and resources whether voluntary or state services.

For this study the focus would be on examining the ways in which the different personnel involved in district nursing perceived their management roles and the extent to which there were differences between the 'ideals' of managing and organising nursing care expressed in the implemented curriculum and the experience of this in practice. The indications were that there could be areas of conflict between the notions of the traditional view of the district nurse as an independent but solitary practitioner and the newer concepts of the district nurse as an independent practitioner working in concert with other disciplines and as managing, as much as giving, direct patient care.
OVERVIEW OF PURPOSE AND CONTENT

This first chapter has considered changes in district nursing from a policy, socio-historical perspective and examined the district nursing curriculum (PADNT, 1976) in order to highlight conceptions of the district nursing role and discuss these in the light of relevant research literature.

Overall this study is to be seen as an exploratory investigation of problems associated with a curriculum innovation in district nurse training and education. The aims and objectives of the PADNT's 1976 recommended curriculum can be viewed as descriptions of the district nurse as practitioner; it is implied rather than stated that the students should be helped towards achievement of these ends through a course based on such a curriculum. The broad purposes of the study were to assess the extent to which others shared such perspectives of the 'district nurse' as practitioner by allowing issues which appeared significant to these others (students, PVTs, supervisors, managers) to emerge. Intended outcomes of the study would be to contribute to the general debate regarding the organisation of education and training where this is to be relevant to the practise of an occupational group. Through a broad approach - encompassing historical and policy background and description and analysis of the different participants' perceptions and experiences - it was hoped that significant value orientations underlying education and practice in district nursing could be derived and their implications explored.
Chapter Two develops the rationale for the broad initial approach adopted and methods utilised. A brief background to the researcher's personal, educational and research experience is given as this is seen as being influential in determining the bias of the study being undertaken and reported here. The general methodology of case study in educational evaluation is explored and initial objectives for the study are stated for the student, community teacher and manager groups involved as participants in the study. The relationship of theory to methods in research is raised in the final part of the chapter which discusses particular methods utilised.

Findings are reported in Chapters Three to Seven with each chapter containing a brief discussion and summary. Chapter Three describes the characteristics of the student group, the reasons given for entering district nursing which, together with the areas of work and patient groups they are interested in, provide an indication of motivation in education and practice. Chapter Four continues with the students to present their views on teaching and learning experiences in the academic institution and in the community practice placements. More attention was paid to the latter with students completing work records as well as summary records about their work experience. Chapter Five turns to examine the the practical work teachers' perceptions of changes in district nurse education and practice specifically their conceptions of their teaching role with students and changes in district nursing over time. Chapter Six considers findings from interviews with nursing officers and senior managers in terms of their perceived teaching and management roles in education
nursing. Chapter Seven revisits the students through interviews undertaken three to six months after they had qualified as district nurses and examines their response to their present work situation and their retrospective reflections on the course. Some of their experiences pose problems for the maintenance of change in practice when that has been initiated in education and not validated through practical experience.

Main discussions and conclusions for the study as a whole are found in the closing Chapters Eight and Nine. Chapter Eight considers the variation found between different groups with regard to purposes invested in education and practice. Models and methods of teaching found amongst community personnel are discussed in relation to theories of teaching and learning. Participants are seen to be generally person-centred in their approaches to patient care and to teaching and learning and to highly value independence, communication and interaction. Relevant theory of knowledge for district nursing is found to be that which allows for the authority of individual experience in learning through practice with expert practitioners. The thesis suggests that participants are referencing their action and decisions to theory of individual rights. Rights theory is explored further in Chapter Nine in relation to ideology and practice in liberal professions. The use of rights theory in district nursing decisions is considered and the theme of relevant theory which for district nursing practice is again considered by examining 'nursing process' as a specific innovation in nursing practice and education. The study points towards the need for education oriented work environments.
CHAPTER TWO

RESEARCH APPROACH, OBJECTIVES AND METHODOLOGY

INTRODUCTION

This chapter discusses the general research approach and methods utilised for this study of the 1980/81 course of education and training for district nursing at the University of Surrey. As was indicated in Chapter One, the study comprises a qualitative case study of a specific course designed for a post-basic qualification in a caring profession. The term 'course' is used synonymously with 'curriculum' which has been interpreted as broadly as possible to take account of the students', tutors' and nurse managers' perspectives in education and working contexts as well as course aims, structure, methods and content.

This chapter serves four purposes. First the rationale for the research approach and focus are explored from a personal standpoint because it seems to me to be important that a reader has some indication of the influences on the researcher which have contributed to the way in which the research is developed.

The study is exploratory placing students' educational experiences in a broad context by focusing on community oriented aspects since ultimately it would be the 'community' where they would be required to work as district nurses. The second purpose in this chapter is
therefore to discuss case-study methodology in relation to educational research and evaluation because case-study is seen as the appropriate overall description of the design of the study and education in district nursing is its major concern.

Third the initial objectives for the study are indicated whilst the more indeterminate objective - that as an outcome of the study it would be possible to generate discussion about fundamental value orientations found in district nursing and the implications for education and practice - is introduced.

The fourth and final part of the chapter discusses issues relating to the choice of methods for the case study and describes those utilised.

RESEARCH RATIONALE : LOCATING THE RESEARCHER'S PERSPECTIVE

To me it seems that a discussion of the reasons why one undertakes a piece of research in a particular way is one of the essential parts of writing-up a thesis. It is often the answers to questions such as Why that focus? or Why that method? which give the distinctive flavour of the researcher's thinking. But in the theses I have looked at, not many appear to provide the contextual setting within which the researcher's approach has occurred and this seems to me to be an important area to cover. Here therefore I describe the personal, educational and work experiences which appear to me to be relevant influences on my research approach including the initial and eventual focus, choice of methods and the way in which the thesis is written.
Personal and Educational Background

I entered university in 1973 to read for a degree in human sciences. At that point I had been married for some years, with two children the youngest of whom was about to begin primary education. I specialised in sociology as the major, and psychology as the minor subject for my degree - all students studied these two topics and philosophy during their first year. Regretably, the course no longer exists as such having had the philosophy component deleted by university funding policies over the past few years. The degree course was an exhilarating experience - a major outcome of which was the establishment of a few close friends from among other students also embarking on a degree at a late date.

It was only retrospectively that I began to realise other tangible outcomes from the course. For example, in the year following completion I took a year's post-graduate training for a teachers' certificate. Much of the year was spent trying to come to terms with different teaching and learning environments which contrasted poorly with my university experience. A combination of non-stimulating college situations which gave deja vu sensations of long-distant school days and a dearth of any skills which might have assisted me in responding as I felt adequately to a large number of children (all making demands at the same time it seemed to me!) was a depressing experience. By the end of that year I was grateful to still feel interest in the study of education and sought work in a compatible area.

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Prior Research Experience

In January 1978 I began work as a research assistant at the National Foundation for Educational Research. There I stayed for nearly three years working on two research projects. Both projects enabled me to consolidate and build on parts of my earlier experience in parenting and in education and more general 'life skills'. In particular I drew on my under-graduate research methodology course. An important part of that third year had been the fostering of discussion and some course work in the area of educational research within a broad sociological framework. The NFER projects required the application of interviewing and related communication skills and both required that one sought beyond the formal educational setting for fuller explanation of children's educational and social development. The first study (Cyster, Clift and Battle, 1979) gave in-depth consideration to the extent of parents' involvement in primary schools. The second study (Blatchford, Battle and Mays (1982)) focused on the area of transition between the home and the school for the young child. The latter required the greater variety of methods in that formalised testing and timed observations of individual children were used as well as questionnaire survey, personal interviewing and less formal observation and participation in the home and at school. The dissemination activities associated with that project also enabled an exchange of views with teacher-practitioner audiences.
The Evaluation

From this background it can be seen that I joined the evaluation of the 1980/81 course of training and education for district nurses as research officer without any specific experience in either educational evaluation or nursing, but with a general grounding in empirical research practice in education. My experience - apart from having been a mature student myself - was more related to the education of children rather than adults though the bulk of the verbal interaction during former projects was with parents or teachers. Given these circumstances my initial approach and focus would be rooted in the perspectives I had gained through these prior educational and research experiences.

The educational experience provided a 'human science' perspective nearest to the disciplines of sociology and social psychology, through which I came to value the need for an eclectic approach to the study of behaviour. My research educational experiences as an undergraduate had concentrated on sociological and socio-psychological analysis using observation and interviewing in order to arrive at some measure of interpretive understanding of social relationships in different contexts from the perspectives of participants.

Working research experience enabled me to read and research further in the area of education. Both studies indicated consistent pointers towards the significance of parents in the educational achievement of their children and the potential benefits of closer relationships between the home and the school for the educability of the child. The
first study showed how parents' relationships with the school change with the age of their children (parents feeling progressively less competent in relation to the increasing formality of school structures and curriculum as their children grew older) (Cyster, Clift and Battle, 1979). The second study highlighted, among other matters, that parents' attitudes towards different forms of education rested in part on the value-judgements they made on the basis of quite personal and anecdotal information about educational provision. This study in addition gave as perhaps the 'most important general principle that could be stated concerning transition from one stage to another' as 'that there needs to be continuity of environmental demands' in the learning experiences of children. (Blatchford, Battle and Mays, 1982, pp. 162-3).

For me therefore, at the beginning of the evaluation of the course of distict nurse training and education, it was important that conceptions about the working environment in which students found themselves practising what they had learned should be explored as far as practicable in relation to the learning demands being made while they were in their university environment. A major focus was therefore to be on teaching, learning and practice occurring in the 'working' contexts which students would encounter during their practical work placements and later as district nurses. For the study the 'environment' was to particularly include those personnel with whom students had most contact during the practical part of their course (PWTs and NOs).
Additionally, such a focus was supported on a more objective basis by the existence of the earlier evaluation report from the very first course of this type to be based at Surrey. This report was in fact the sole relevant study to be found in the field of district nursing education and its authors (Jarvis and Gibson, 1980) had suggested that further work could usefully be carried out on the community aspect of the course. That report, as indicated in the previous chapter, gave a wealth of detail on the operationalisation of the new curriculum into a viable programme of training and education but had of necessity paid less attention to the course as it was implemented beyond the university and no follow-up of students into working life practice situations had been attempted.

Overall therefore the 'lessons' from prior experiences provided anchor points for my approach during the study and helps explain my resistance to formulating early specific hypotheses about district nursing and district nurses - the worlds of which I knew little. Any research focus in my terms includes a commitment to methodological eclecticism which allows for empirical collection of data and acknowledgement of the relational construction of knowledge. In this way the research intent can be viewed as to maintain a sense of education as a continuing process of change pertaining to the individual case which can be illuminated through its location in historical, cultural and social contexts. This means in effect that for me an analysis of innovation should include both individual and contextual influences on the meaning we give to our experiences. For this reason the nature and antecedents of this innovatory curriculum
were examined as best as possible at the start of the evaluation in order that it could be placed in an historical and cultural perspective. This first section therefore complements the first chapter from a personal standpoint. That chapter also raised some of the problems in the area of curriculum study to which I now turn.

CASE STUDY IN EDUCATIONAL RESEARCH AND EVALUATION

I would describe this study as fitting into a 'case study' format. The case study as a methodological framework is quite difficult to define except by the terms of reference for each particular study. Thus examples may refer to the 'case' of an individual person, an individual event, a number of persons or events, an institution or more than one, or, in educational research, a particular educational innovation such as a different syllabus. The connecting thread which links case study approaches is usually that one instance rather than a multiple of similar or sequential instances is being examined. In addition case study is seen to involve 'a systematic investigation of a specific instance' (Nisbett and Watt, 1978, pp. 3-4). The particular instance being investigated here is that of a specific curriculum innovation in district nurse training and education for one cohort of students in the 1980/81 academic year at the University of Surrey.

Methods utilised during case studies for the systematic collection of evidence are not circumscribed and may draw on a variety of techniques (Adelman, Jenkins and Kemmis, 1977). However, the methods more frequently include combinations of some methods traditionally used in the social sciences rather than others. These methods
generally fall at the 'qualitative' end of the spectrum rather than the 'quantitative' end (Silverman, 1985, especially Chapter 1) and may include the interview, observation of the event in context and analysis of documentary sources more commonly than experimental designs involving sampling, testing (e.g. of intelligence or grasp of information) or questionnaire surveys. Case study data tend to be detailed and its quality in part is seen to depend on the establishment of good relationships between researcher and researched.

The use of qualitative methodology implies a research stance which will attempt to present variation in the interpretation of events from the perspectives of the participants in the study. Qualitative methodology is indicative therefore of the researcher's belief that individuals, in interaction with their worlds, interpret and create their own realities and are not passively determined by 'objectively' existing structures. The general thrust of qualitative methodology is towards description and illumination and ultimately to the generation of hypotheses.

The above interpretation of 'case study' methodology departs from some descriptions of 'case study' found in relation to educational evaluation and research. One reason for this could be seen to lie in the relatively recent rapid developments in educational research (in the U.K.) and the particular form of debate surrounding 'illuminative' studies of educational innovation. This is considered in the remainder of the section.
Prior to the 1960's there were 'no books published in this country on specifically educational research methods' (Shipman, 1985, p.9). From the mid-1960's onwards there was a proliferation in literature relating to curriculum development and educational research and evaluation fostered through contemporaneous establishment of such bodies as the Social Science Research Council in 1965 and the Schools' Council in 1964. Much of the work was concentrated in the field of school-level curricula development and dissemination based on a centre to periphery model and tended to focus evaluation within the specific educational setting and in addition there was a concentration on specific changes in subject-related content or in teaching methods (eg Nuffield science projects). Studies with a broader thrust (Young and McGeeny, 1968; Midwinter, 1970) were generated following the Plowden report (DES, 1967) which had re-affirmed the importance of general attitudes towards education and the impact of the wider social and economic environment on children's education which had been emphasised in earlier work (Frazer, 1959; Wiseman, 1964; Douglas, 1964). Nevertheless, wide briefs with long term follow-throughs were and are rare. In this context the Schools' Council evaluation of dissemination strategies provides an example of deliberate effort expended in the search for impact of its curriculum projects in the longer term (Steadman et al, 1978).

From the 1970's onwards there was a shift in educational research perspectives away from traditional scientific experimental paradigms towards interpretive paradigms described variously as 'illuminative', 'holistic' or 'responsive' (Hamilton, 1976, p.39) approaches to problems
of curriculum study (Parlett and Hamilton, 1972; Hamilton, 1976; Harlen, 1975) and an increasing promotion of collaborative research activity between researcher and researched (Humanities Curriculum Project in Elliot and MacDonald, 1975 and Ruddock, 1976). This shift could be interpreted as characteristic of 'an immature science in the stage before the establishment of its first generally accepted paradigm' (Mennel, 1974, p.3; Kuhn, 1962).

Hamilton (1976) pointed to the influences furthering the trend away from psychometric approaches to curriculum evaluation as: the tradition of social anthropological and sociological field and case studies (Hargreaves, 1967 and Lacey, 1970 in particular), the tradition of evaluation of legislative or charitable programmes directed at development of local communities (exemplified for education with the Educational Priority Areas projects between 1968-1971) and, more generally, the traditions of history and investigative journalism.

Case study as, as indicated above, when realised through particular methods has the potential of allowing the 'single' instance to be considered as an integral part of the broader social and cultural contexts and for this reason educational evaluation of the 'illuminative' kind has been equated with a case study approach. Adelman, Jenkins and Kemmis (1977) described the essential features of the case study. They suggested that the case study is rooted in reality, that the reader can judge its implications for him/her self, that it is embedded in the world of action, that it allows for the discrepancies between, and the complexities of, different viewpoints.
They also suggested that the case study is a rich source in that it allows generalizations about the particular instance to similar classes of instance.

This last point is of interest since it suggests that the case study is capable of generating theory or hypotheses. A major thrust of Glaser and Strauss' work (1967) was that theory should not precede the design of a research study, but that it should be the product of it, being 'grounded' in the theory of participants and therefore more likely to work as a basis for explaining action. Cronbach (1975) was also arguing for a shift towards the more open style of research found in case study work whilst criticising the utility of attempting precise experimental design in educational research. A decade earlier Cronbach had argued against making comparisons between different course programmes due to the equivocal results usually found. This view was attacked by Scriven (1967) who argued that when it comes to course evaluation then it is more necessary to make comparisons:

"When we come to evaluate the curriculum as opposed to merely describing its performance, then we inevitably confront the question of its superiority or inferiority to the competition"

(Scriven, 1967, p.64)

For evaluations, therefore, there may be a reasonable expectation that comparisons will be made since evaluation is about making judgements about value or worth. This applies regardless of the form which the evaluation might take. At close quarters, the criticism in education regarding 'case study' in fact appears to revolve around the type of methods used in the study of a 'case' and whether in particular a
single 'case' can be representative and allow generalisation through inference to other similar instances. In other words the debate is reminiscent of the much older debate in the social sciences over developing theory and methods for collection of data and how far these either can, do, or should emulate a natural science paradigm.

The debate in education over 'case-study' perhaps comes to a head around educational evaluations because expectations are higher that outcomes will be used for educational decision-making in a more direct manner than other educational researches. What this raises are the issues which surround the activity of applied research generally rather than specifically related to education. These issues relate to the purpose of evaluation and the role of the researcher within this. Sources of influences on the design, implementation and reporting of findings may be concern about the motivation of the sponsor, the ultimate audiences for the work, and means of access to participants all of which may affect the role of the researcher. 'Evaluation' is frequently divided in educational literature into the categories 'formative' and 'summative'. The former is seen to concentrate on examination of the processes of an ongoing course/innovation etc with the purpose of providing feedback to the teachers/tutors etc so that development and amendments can be made to methods, content or organisation. Summative evaluation is seen to concentrate on examining a completed or published (eg Appendix 2) course/innovation; and it is with summative evaluations that the question of comparison with other similar courses most often arise, since in the case of formative evaluation the curriculum is deemed to be still in the
process of development. Quite frequently the funding of summative research will have a political purpose in that parties with vested interests in promoting change may have commissioned the research directly or indirectly and are the effective audience.

There are just two points I would wish to emphasise here though the last section of the final chapter will reflects on issues raised over the course of the study. One is that my earlier definition of 'case-study' centres around this being essentially descriptive of examination of one rather than a number of cases but not necessarily prescriptive of methods utilised. Some usages of 'case-study' in educational research has particularly equated it with styles of 'illuminative' evaluation which are associated with 'a methodological commitment .....which corresponds fairly well to that connoted by the ethnographic approach' and has then been attacked for ignoring the well documented social science debate on such methodology (Atkinson and Delamont, 1985, pp. 31-32 ; Shipman, 1981, p.113). I take the view that in this case study the methodological approach is generally qualitative in conception and in its final interpretations. It does not however rely heavily on observation which is a common method of field work in ethnographic or anthropological case studies. Choice of methods in research includes pragmatic consideration of general purpose to be attained so that case study in the way I use it is an umbrella term for a variety of methods which appear suitable for the task in hand (see Schatzmann and Strauss, 1973, p.14 on field method).
The second point is to do with the distinction often made in educational literature between 'research' and 'evaluation' so that where the study is an evaluation of an innovatory curriculum, as was the basis of this thesis, expectations may be (as mentioned above) that comparison of courses might have been made. There are two issues here. One is whether the distinction is valid initially and, insofar as evaluation is conceived as applied research, I would concur with Atkinson and Delamont (1985) that this is a somewhat spurious distinction which does not absolve the evaluator from attention to how data are collected and this applies whether the evaluation is 'formative' or 'summative'. The second issue is to do with the legitimacy of the political nature of the evaluator role vis a vis the 'uncontaminated' role of the researcher. Here I would argue that pressures on either role are similar but that the social and political process of research activities termed evaluation and the ethical dilemmas it may raise for the researcher are more explicitly recognised (Eraut, 1985; Adelman, 1984). This is particularly recognisable at the outcome end over the nature of the judgements made and the use to which findings may be put and by whom. Such issues will in fact have been present since the inception of an evaluation and ought if anything to increase the researcher's sense of responsibility regarding careful assessment of the nature of the job and including means of control over the use of output. In evaluation therefore the compromises which are to be made are merely perhaps more numerous and more evident to the researcher(s) involved and are exacerbated by the generally short-term funding available combined with an implicit emphasis on short-term results. This acts to curtail
the potential design of a study, regardless of the initial hopes or intentions of the researcher(s), and regardless of the 'open-ness' of the brief; this would be my personal judgement with the benefit of hindsight. A few of the issues raised are considered at the end of the study.

OBJECTIVES

The above discussions have indicated that the research approach was to be as broad and open as possible but with more attention being given to education and training taking place in the community rather than the formal educational setting. The initial objectives were to describe as fully as possible the experiences of participants - the students and their community teachers and supervisors - in the 1980/81 curriculum innovation in district nursing and in that context several objectives can be stated which help indicate particular focuses in relation to the different groups of people involved. These can be stated as follows:

Students
1. to explore students' views on teaching and learning methods and their overall views of the course and their conceptions of district nursing
2. to assess students' opportunities to integrate theory with practice in their work placements during Part 1 (first 6 months) of the course
3. to obtain the students' retrospective assessment on the value of the course approximately six months after completion.
Practical Work Teachers

1. to gain an understanding of the implications of the new course for the role of the practical work teacher
2. to examine the practical work teachers' approaches to their teaching role
3. to elicit the practical work teachers' views of the district nursing role and the changes they perceive to have or to be occurring.

Nurse Managers

1. to gain a fuller understanding of nurse managers in
   1) teaching of students
   2) selection procedures
2. to explore the nature of managers' preparation for
   1) their role as teacher
   2) their service role
3. to obtain their views on the necessity or not for change in the training and education of district nurses and their conceptions of district nursing.

As stated in Chapter One, the way in which the study meets these objectives is largely covered within Chapters Three to Seven which report descriptive data collected and interim conclusions drawn in relation to the different participant group' perspectives. Such particular objectives are to be seen as contributing towards the broader overall research aim which can be described as 'emergent', therefore less amenable to objective setting, in that I did not have advance expectations of what might be found about the nature of
approaches towards teaching, learning and practice in the field of
district nursing. I hoped therefore that an eventual outcome would be
a better understanding of the meanings and expectations which district
nurses have of district nursing and that this would allow emergent
hypothesis about participants' orientations, including value structures,
towards district nursing practice, management and education and that
this would help inform the theoretical principles on which such
practices are, or could be, based. I believe that overall the findings
indicate that a regard for the individual's rights is of central
importance in determining action related to teaching learning and
practice in district nursing. Such a statement in effect forms a
tentative hypothesis arising from the study. Given that this was an
outcome rather than a determining focus for the study it was only
possible to carry out limited further work for the purpose of 'testing'
this notion out. This further work consisted of observation and
discussion of visits to patients by practising district nurses. Due
to the secondary nature of this work vis a vis the main study the
outcomes are incorporated into the concluding discussions. This
serves to provide corroborating support for conclusions drawn from
the main study and is also in keeping with my idea of the
chronological and iterative development of the research process.

METHODS AND ISSUES

Previous statements in the section on educational evaluation and case
study methodology suggested that case study methods characteristically
utilise field research methods (interview and observation) rather than
survey research methods such as the questionnaire, report or record.
On the other hand it was seen that case study per se has been viewed as open to a variety of methods for collecting data. For this study it seemed essential that a number of different ways of collecting information should be tried for sound methodological reasons. These reasons included recognising that for this particular study no single method would provide adequate coverage of the informant groups to be involved and the broad areas being explored. A variety of methods were called for in order to be responsive to the different target groups and the different contexts in which they were teaching, learning and working. It was not sufficient that only the student perspective should be obtained for a course of education which fundamentally was concerned with improving nursing care delivery for people living in their usual habitats. For example conceptions of primary health care team membership elicited through the first questionnaire from students needed to be considered again through their comments during subsequent interviews as well as in the light of actual contact with other colleagues reported in records kept for practical placements whilst managers and experienced district nurses' opinions on their work roles and interaction with colleagues would provide other valid perspectives on the same issues.

The use of one method of investigation, rather than a number of different methods has in fact been under attack for many years particularly from anthropological and sociological researchers. For example Denzin (1970) used the word 'triangulation' to describe a main methodology in social research whereby multiple methods are brought to bear in collecting data on different aspects of an issue or event.
and spaced out over the time, contexts and individuals involved. Malinowski (1922) earlier had argued for a three-way approach to ethnographic research incorporating quantitative analysis of occurrences, attention to and recording of characteristic ways of speaking and thinking about life and the recording of actual observed behaviours. A key methodological issue found in such work is the relationship between theory and research in the general social science field. Burgess (1982) for example quotes from Watson's The Double Helix:

"Science seldom proceeds in the straightforward manner imagined by outsiders. Instead its steps forward (and sometimes backward) are often very human events in which personalities and cultural traditions play major roles"  
(Watson, 1968, p.13)

and from Wright Mills seminal work The Sociological Imagination (1959) in support of the challenges such work presents to social scientists

"to shift away from set procedures ... towards integrating theory and method"  
(Burgess, 1982, p.209).

This leads towards positions which argue that implicit or explicit theories are present through all stages of the research informing choice of topic, methods for data collection, analysis and the way it is reported and contributes to the re-shaping of theory (Merton, 1968). It is this that provides the rationale to the 'grounded theory' position of Glaser and Strauss (1967) whereby theory is not seen as a stable entity for testing but as a developing process which allows grounded substantive theory to be derived from data - theory is in this way judged on their criteria of 'fit, 'works', relevance and easy modification'(Glaser, 1978,p.142). This seems closest to my own
position since this study's ultimate aim was, if possible, to generate concepts or theory through inductive methods following collection and analysis data about a number of different aspects of district nursing and district nurse education.

A number of different methods were therefore utilised in this study all of which are relatively familiar in the social sciences. Together these were to provide descriptive and qualitative data in relation to the objectives indicated above and the several sources enabled cross-checking of impressions gained. These are discussed in turn under the headings documentary sources, questionnaires, interviews, work and summary records and observation these being the main ways of collecting data.

Documentary Sources
The main methodological problems in using documentary sources are that the information contained has been collected for purposes other than one's own and identification and access to documents which may be relevant. Taking the last first it was not until 1985 when about to leave the university that I located the research instruments relating to the first pilot course (Jarvis and Gibson, 1980) which had been lost in a filing cabinet since the departure of a researcher. On the whole I was fortunate in being based inside the educational institute and in the willingness of course tutors to provide access to internal documentation.
There were a number of specifically relevant documentary sources used in this study. There was the comprehensive report from the pilot course (as above) and this with the written curriculum provided a starting point for suggesting aspects of the district nursing and education which were currently thought to be important. The outcome was discussed in Chapter One together with other literature relating to district nurse education and to care in the community. These sources were mainly of use in giving an ideational representation of district nursing practice and/or education and would be of use when examining actual experiences and opinions of students and practitioners in the field.

Documents relating to students were made available to me by course tutors during the course of the study. Student entrance applications were analysed in order to provide some base-line information such as educational background, nursing experience and in particular the reasons given for wishing to enter post-basic district nurse training and education. These records were regarded as confidential and not taken away from the site. Use of such personal documents at second hand can raise ethical dilemmas and to overcome this the students were subsequently asked by me if they had objections to any such information being used on the same confidential and anonymous basis as any other information and opinion sought from them during the study. These documents helped cut down interviewing time.

Ideally such records would have been examined prior to constructing first interviews or questionnaires (see below) but time constraints...
meant that these occurred in parallel towards the end of the students first term. Even so the records provided insights into the ways in which students regarded district nursing prior to entering the course and had the advantage of giving current as opposed to retrospective data which could be used to compare and contrast with their later responses. Students' course results (course work, written and practical) were also available to me at the end of the first six months of the course and some limited use was made of these (see Chapter Four).

Questionnaires/Interview Schedules

The problems and pitfalls of the construction and use of questionnaires have been discussed thoroughly in social research literature (Oppenheim, 1966; Moser and Karlton, 1971;). The questionnaire as a research tool should reflect in the questions the issues being addressed in unambiguous language and the format also is important since the subjects are to be helped towards a good response rate. Difficulties of terminology or meaning should be ironed out through piloting. The first main questionnaire (Appendix 3) was put together at the same time as I was familiarising myself with general background information about district nursing. Due to the timing problems faced there was little time for pilot work - by the time this could have been done the course might have been over - and the strategy adopted involved firstly a rapid search for relevant research literature for usable instruments and secondly utilising any willing and available 'experts' (a key informant technique) for the purpose of revision.
The most useful and relevant research instruments located were those being used for the then on-going study into nurses working in the community (Dunnell and Dobbs, 1982); this had not at that time reported but I adopted several forms of questions (see Q.1,2 and 3 Appendix 3) from their instruments because these had already been piloted and could be expected to be comprehensive and reliable in format. The questions used provided comprehensive listings of types of patient groups and community personnel with whom a district nurse (or student on practical placement) might expect to encounter and helped counteract my lack of factual knowledge in these areas. Similarly it was possible to discern, from the report of the 1978/79 course (Jarvis and Gibson, 1980), the spread of methods used within the educational institution this helped construction of items (e.g. Question 5, Appendix 3) which could allow comparison between the current student responses with those from the earlier course. These works assisted the construction of the main questionnaire which was then discussed with the university tutors, a former student and a practical work teacher.

A second problem with the use of self completed questionnaires can be misinterpretation of motives and questions by respondents. One positive advantage was that the student subjects for this first, and any subsequent, questionnaire were mature adults and, although it could not be assumed that they were at all familiar with completing questionnaires, it might be assumed that they were literate and capable of readily grasping what was being required of them. I was also located on the same site that they used for the theoretical part
of their course so that they could be readily contacted to persuade them to participate and to provide help should they ask for this.

However an additional tactic was to use the questionnaire as the basis for interviewing half the student group while it would be self administered by the other half of the group. The interviews would serve to highlight any major problems over interpretation of the questions as well as providing opportunities to meet the students. I selected the halves of the group using a randomised number method and arranged with the tutors to attend the closing stage of two seminars (thereby covering the whole student group) in order to ask for their co-operation in the study and read out the names of students who were to receive questionnaires and those remaining who were asked to agree to be interviewed. Scheduling of interviews was arranged at the end of the seminar session with an hour being allowed for each person interviewed. The questionnaires were subsequently delivered to the appropriate half of the student group with a covering letter and an envelope for return direct to me. Students were assured of anonymity in any subsequent verbal or written report(s) and that the information given through questionnaire or interview would be treated as confidential.

This procedure worked well and as is indicated in discussion of results in the following chapters, the interviews were helpful in obtaining information on where difficulties occurred regarding questions. For example interviews revealed that the question on teaching and learning methods (Appendix 3, Question 5) designed to
result in an order of preference of methods was unclear for a few items in that not all of the students had the same understanding of what a 'seminar' consisted of, as against 'tutorials' or 'half-group discussions'.

The questionnaire was designed primarily to "obtain your opinions on certain aspects of the present course, paying particular attention to practical work issues" and this statement was incorporated at the top of the questionnaire by way of introduction. The introduction also indicated that questions "require you to either circle appropriate numbers, or to put ticks in boxes, or to cross out the word which does not apply and, finally, some require comments in your own words". The questions were to draw out student opinion on a number of areas which seemed to be relevant to judging their educational experiences in the light of their nursing interests, their conceptions about and experience of district nursing practice. Their general work interests were explored by asking for views on the type of patients and general areas of work they would prefer to work with (Appendix 3, Q.1, 2 and 3). These would also provide an idea of what patients and areas of work they expected district nursing to involve. Additional conceptualisation of district nursing work were to be generated through open questions such as that asking for their reasons for choosing district nursing as a career (Appendix 3, bottom of page 2); and more structured items designed to obtain views on membership and collaboration in primary health care teams (Appendix 3, Q.11, 12, 15) and attitudes toward management, teaching and counselling as features of the district nursing role (Appendix 3, Q.13, 14, 16 and 17).
Opinion on educational experiences were covered for the institutionally based part of the course for teaching methods (Appendix 3, Q. 5) and the core theoretical component of 'nursing process' (Appendix 3, Q.18, 19 and 20) and for the community based experience including relationship with main teacher (Appendix 3, Q.6 and 7). Transition between the two contexts was explored by questions on preparation for practical work and coping with academic and practical work load (Appendix 3, Q.8 and Q.9) and on the structuring of practical placements for purposes of assessment and the overall balance of the course (Appendix 3, Q.10 and 4).

The second questionnaire (Appendix 4) was administered to all the students after the end of their six months on-site based course but was to cover also their subsequent field based practice in their posts in the community. A self-addressed stamped envelope was sent out with a covering letter accompanying the questionnaire.

Unlike some questionnaire surveys (eg by post) there were no problems such as wondering if these were reaching the right people and it was always possible to follow up any peculiarities in the returns. Nor were there problems of sampling frames since the whole group of students and teachers were to be included.

Response rates for the questionnaires was good in that two students failed to respond on both occasions (not the same two). The second questionnaire was designed to repeat some questions asked in the first for comparative purposes; for example those dealing with students
overall view of course balance and their application and understanding of 'nursing process'. Primarily it was to gain impressions of the way in which the first six months of the course had prepared them for examinations and for different aspects of practice and their views on relationships with their community teachers during the first six months (Appendix 4, Q.3, 5 and 6) and the following three months supervised practice period (Appendix 4, Q.9 to 16).

Interpretations of responses from the first questionnaire enabled refinement of questions used in the second. For example the relationship questions were broken down into general work and social relationships and more specific relationships in relation to practical, academic, social, communication and contact contexts; similarly, responses from work records and my growing understanding of what students were expected to carry out as a district nurse enabled a more structured question on adequacy of preparation received (Q.6).

Informal discussion with students also tended to suggest that they saw previous experience of community nursing as helpful in coping with the course and a question was included to gain all students views on this issue (Appendix 4, Q.1 and 2).

Interviews

The range of interviewing techniques are wide. I used a combination of relatively formal interviewing and less structured interviewing techniques with the balance towards the latter overall.
Some of the advantages of interviews over questionnaires have already been indicated. It was said above that the first questionnaire for students (Appendix 3) was also used as the basis for interviewing half of the students. In that respect it comprised an interview schedule. Since the aim for this first questionnaire cum interview schedule was a basic gathering of views on the same questions across the student group the interview was formal in the sense that the questions were asked in the same order as they appear in Appendix 3. Particular comments by a few students were that they found it difficult to answer the more open questions without time to think. As it was the interviews took a good hour and points up the labour intensive nature of interviewing over self administered questionnaires (for the researcher that is). Nevertheless the advantages can outweigh the costs. They did so in this case in enabling me to discover problems associated with the construction of questions and also explore some areas in more depth. Another problem with the questionnaire which emerged during interviews was that items 13 to 17 (Appendix 3), which were put in to try to establish students' perceptions of priorities in the district nursing role (in relation to management, teaching, liaison with primary health care team members, and counselling of patients/clients) failed to discriminate to any great extent between student priorities.

The remaining interviewing carried out was less formal in that I constructed lists of areas to cover when talking with students following completion of training and the different groups in the community. A substantial amount of semi-structured interviewing was
undertaken usually at the respondents home or work premises and required considerable travelling. The bulk of the outcomes of these interviews are reported in Chapters Four to Seven. Appendices 8 to 11 show the interview guidelines I used as prompts in my interviews with:

1. Students in following them up after completion of the course (Appendix 8);
2. Practical work tutors who were supervising the students during their practical placements in the first six months of the course (Appendix 9).
3. Nursing Officers who supervised students in the twelve weeks at the end of the six months' university based course (Appendix 10);
4. Divisional Nursing Officers (Appendix 11).

The informal and semi-structured approach used for this interviewing seemed most appropriate for my aim which was to cover a wide range of areas in order to illuminate how the different personnel viewed district nursing as a profession, their own experience of practice and teaching roles and their views on the new course in terms of its general relevance to district nurse practice and patient need.

Similarly the semi-structured approach is appropriate for allowing respondents to explore those issues they regard as important even though the researcher may have set an agenda in terms of areas for coverage there is nothing, apart from the researcher and researcher relationship and rapport, to preclude the respondent raising issues which they perceive as important for them in their work. Such a method tends therefore to provide richer data in terms of the range of issues which come up and in eliciting problems in their context.
whereas interviews with set questions, set the agenda and may pre-
destine the response according to the researchers' conceptualisation
of the issues.

A main methodological problem with informal interviews comes later
since much of the data may be individualised depending on the variety
of interests raised and this makes subsequent interpretation more
difficult in that one does not have everyone's views on each topic.
The analysis is painstaking reduction of this variety to categories
which seem to make sense of, and adequately reflect, participants'
viewpoints.

A major advantage of interviews over postal questionnaire surveys has
been said to be that that better response rates can be obtained. But
Cartwright's critical review of health surveys indicates that this is
not the case for health surveys (Cartwright, 1983, pp.156-161).

Response rates therefore are partly dependent on the approach used by
the researcher to the subjects, the subjects perceptions of importance
or relevance of the study to them (ie their interest) and the
subsequent rapport established. All those asked for interview either
over the telephone or in person agreed, except for one former student
at the follow-up stage, and, given the fact that these were all busy
people either working or studying in a demanding profession I was
very satisfied with this response. In fact the response was fairly
enthusiastic and it seemed that the different groups of personnel were
extremely pleased to have an opportunity to discuss and reflect on the
changes occurring in nursing generally and on district nursing in
particular. This is perhaps a reflection of the conclusions in this study which suggest a tension between the relatively isolated circumstances in which the district nurse works and the motivation they find in satisfactory relationships with patients and colleagues.

Work Records

Since my focus was on the community aspects of the students' course experience I devised a number of work records for students to record their actual work experience. These are shown in Appendices 5 to 7. Appendix 5 entitled Practical Work Record Sheets was the most complex exercise in that I was attempting to obtain a sample of work patterns from as many students as possible for a period of six days. This amounted to a diary format and one sheet was to be completed for each day. It covered number of visits to patients made alone and accompanied, different types of activity which students might undertake such as clinical surgery work, administration etc., and also attempted to gauge the quality of theoretical study possible in terms of time spent in discussion with their community tutors or in private study. The record for each day also had a contact list of fifteen different personnel and the student was asked to put a circle around those (other than already recorded) with whom they had 'purposeful' work or study contact (i.e. excluding social occasions). Following their return to on-site study the students were asked to complete a brief questionnaire (Appendix 6) to summarise the number, age, sex and problems of patients they were responsible for, and to whom they were expected to report back about these patients and their opinion of support received from the practical work tutor.
The students' comments point up the general difficulties in researcher imposed record keeping of this type. The long diary record was found to be very difficult to complete particularly in the requirement to give length of time spent on the activities. Students found also that the record was time consuming. A reasonable response rate was achieved however and the diary data gave very helpful insights particularly over the relatively poor rate of contact which students had with members of other professional groups and helped corroborate opinions being expressed elsewhere. Appendix 6 complemented the work record in summarising patient work load characteristics, reporting requirements regarding patients and general support from Practical Work Teachers. Appendix 7 indicates the brief summative record which students completed for their final (fourth) practical work period. This record included questions on the students' response to the opportunities offered to practice skills such as managerial skills, nursing care, administrative and interpersonal skills.

Informal Observation and Discussion

Non participant observation of some lectures and seminars was carried out in order to obtain a clearer impression of the general tenor of the university based part of the course. Informal conversations with students, tutors, practising district nurses, nurse managers and key individuals in district nurse education at different stages in the work contributed to my interpretation of findings, as did attendance at study days and conferences related to district nursing. I attended several meetings of the PADNT including its final meeting prior to becoming absorbed into the new structure of the United Kingdom.
Central Council and its four national boards responsible for nurse education and training.

It was possible to follow up some emerging notions about the way in which district nurses might make decisions regarding nursing action through more structured observation and discussion with four female district nurses when on visits to patients during the study of the district nurses role (Battle, Moran Ellis and Salter, 1985). The observation was again non-participant. Specific guidelines about the nature of my role during these visits were agreed with the nurses. First it was understood that as a non-nurse I could not be expected to provide any clinical assistance even if asked. Second the aim would be for me to observe during a visit with questions or discussion to occur before and after the visits. Third the nurse would ask the patient if I might accompany her on this visit and explain that 'this was for research about what the district nurse does' and that this was just for one visit. This procedure worked reasonably well with each nurse adapting the form of introduction to her own satisfaction and that of the patient. No patients in their own homes refused though in two cases permission was sought from a carer as the patients were not conscious or able to speak for themselves. A pre-natal group practice surgery session occurred during one of the nurses' days; the general practitioner agreed my presence in one case (and then the patient's permission was also requested) but the other refused.
Methodologically the most interesting finding was confirmation that non-participant observation was extremely difficult to sustain other than in respect of not exercising my non-existing clinical knowledge or skill. Previously my experience of non-participant observation was in nursery classes with at least twenty children and usually more than three other adults present (one of these being another researcher) and we had found that after a short while of behaving in a minimally polite way that we were treated as part of the furniture. Whilst we had longer spells of observation in that study (Blatchford, Battle and Mays, 1982) for this absorption into the background to occur we found that at the end of the nursery days we appeared to be 'compensating' for lack of response to the children by helping them with shoes and coats and taking an interest in whatever they were doing as soon as our task of observation ended for the day. Similarly teachers were engaged in conversation outside the periods of observation. For the visits with nurses the situation was different in that my presence most frequently meant that only three people in all were there in a room. I found it impossible not to answer when spoken to by patients and also found that as the day progressed the nurses began to include me more and more in the conversations with patients and particularly a participant role with carers where these were present increased on my part as well as being fostered by the nurse. I would therefore say that I experienced difficulty in achieving a clearly defined observer role.
CHAPTER THREE

PROFILE OF THE STUDENT GROUP

INTRODUCTION

This chapter describes the characteristics of the student group. Data is drawn from examination of students' pre-course applications and the first questionnaire or interview administered during the evaluation. The following sections cover the objectives of

1. describing the student group in terms of age, sex, general education and previous nursing experience;
2. eliciting students' reasons for entering district nursing;
3. describing their particular nursing interest areas.

These areas are addressed in separate sections and summarised at the end of the chapter.

CHARACTERISTICS OF THE STUDENT GROUP

The October 1980 intake was comprised of 30 students and was the largest entry to the once-yearly course since it had been based on the new curriculum (see previous chapter). One student dropped out at an early stage to return to private nursing and another student was required to retake part of the course. The data utilised here relates to the remaining group of 28 students for whom the most complete information is available throughout the course.
Age, Sex and Status

All but two of the twenty-eight were female and all but three were married. Their ages ranged from twenty-three to forty-five years with a quarter of the students under twenty-five, twelve between the ages of twenty-five and thirty-four and nine students aged thirty-five and over.

Academic and Nursing Background

The students had a varied academic and nursing background and showed a wide variation in nursing experience. There were four students without any school leaving qualifications but the remainder had attained G.C.E. 'O' level standard. Twelve students had between one and four 'O' levels and eleven had five or more including three students with 'A' level G.C.E's. At this time the Surrey course was similar to other training centres in having its own entry test for the SRN/RGN course and was prepared to accept satisfactory attainment in their own entrance tests as an alternative to formal examinations.

State Registration - the essential nursing entrance qualification to the course - had been obtained over a span of more than twenty years from the earliest student in 1959 to the most recent in 1979. Over half had however qualified in the ten years preceding the 1980/81 course. Nearly half the students (thirteen) held their state registration as their sole nursing qualification.

The most common other nursing qualification was the SCM which eight students held while two others had completed Midwifery Part I. Two
students were RMN's and another had completed part of a diploma in nursing studies. Various certificates were in evidence such as in intensive care and obstetrics (two students each), family planning (three students) and one student each held certificates in thoracic nursing and orthopaedics and one student had taken a management course.

Experience in Community Nursing

In terms of nursing experience in the district, as opposed to the hospital situation, there was again a variation among the students from a matter of days preceding the start of the course in one case to over two years experience. There were however only three students with less than eight weeks experience and only one with more than two years. Table 3.1 below indicates the spread of experience.

Table 3.1 Students' Previous Experience of Community Nursing (n=28)

<table>
<thead>
<tr>
<th>Experience in months</th>
<th>No of students (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 1</td>
<td>3</td>
</tr>
<tr>
<td>2 - 6</td>
<td>8</td>
</tr>
<tr>
<td>7 - 12</td>
<td>12</td>
</tr>
<tr>
<td>13 - 24</td>
<td>4</td>
</tr>
<tr>
<td>24 &amp; over</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>28</strong></td>
</tr>
</tbody>
</table>

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REASONS FOR ENTERING DISTRICT NURSING

Two perspectives were obtained on the students' reasons for entering district nursing. The first was obtained by carrying out a content analysis of their original application forms completed by them when requesting entry to the course and the second perspective through the interview/questionnaire (Appendix 3) following their entry to the course.

On Application for Entry to the Course

Prospective students' were asked to state their reasons for wanting to train as a district nurse. Students gave more than one reason in most cases and Table 3.2 lists the five most frequently mentioned groups of reasons.

Table 3.2 Students' Reasons for Wanting to Train as District Nurses

<table>
<thead>
<tr>
<th>Reasons given</th>
<th>No of students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training necessary/desirable; training mandatory for practice and for maintenance of standards</td>
<td>18</td>
</tr>
<tr>
<td>Wants closer relationship with patients/carers; total care regime possible in home environment</td>
<td>14</td>
</tr>
<tr>
<td>Desire to specialise/professional development</td>
<td>10</td>
</tr>
<tr>
<td>Desire responsibility/autonomy</td>
<td>7</td>
</tr>
<tr>
<td>Involvement wanted in preventive medicine/health education</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total number of respondents = 28</strong></td>
<td></td>
</tr>
</tbody>
</table>
Not surprisingly, in view of the question format, the students' response emphasised the advisability and value of training on their applications for entry to the course. On the one hand they saw training as necessary due to it becoming mandatory for practice as district nurses; on the other, they saw it as desirable in that - through increased knowledge of available services, the roles of other members of the primary health care team and the social factors involved in illness - they would be able to provide better care for their patients.

Two students, who had experience of district nursing wrote as follows:

"My colleagues who have completed the training are able to help the patients more fully and know where to go for help when necessary".

"I wish to undertake district nurse training because I noticed my trained colleagues have a faster, more efficient approach and a good knowledge of how to use the facilities available, thereby offering the patient a better service".

Another student with little experience in the district wrote:

"I feel it is essential, in order to be able to give the highest possible standard of nursing care, to undertake the district nurse training and thereby increase my knowledge and practical ability within the field".

Training was seen therefore as the means of providing higher standards of care in the community and contact with trained personnel reinforced the students' view of the benefits of training. The third group of reasons - specialisation and professional development - might be seen as complementary to that of training itself. Seven of ten students mentioning such reasons also gave reasons falling into the training category making these categories one of the two most frequently mentioned combinations. The other combination of reasons also mentioned by a quarter of the students were those ranked second and
fourth in Table 3.2 relating to closer relationships with patients through nursing care given in the home and the opportunity for greater responsibility for their work.

**Following Entry to the Course**

The second perspective was obtained following their acceptance onto the course when the students were asked (during the first interview or by questionnaire) why they had wanted to come into district nursing. Their answers were analysed in a similar fashion to their original applications and present a different slant on their choice of district nursing. Table 3.3 lists the five most frequently given groups of reasons for their choice.

<table>
<thead>
<tr>
<th>Reasons Given</th>
<th>No of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wants closer relationship with patients/carers; total care regime possible in home environment</td>
<td>23</td>
</tr>
<tr>
<td>Desire for responsibility/autonomy</td>
<td>10</td>
</tr>
<tr>
<td>Hours more suitable/dislike of hospital routine/shift work</td>
<td>9</td>
</tr>
<tr>
<td>Desire to specialise/professional development</td>
<td>4</td>
</tr>
<tr>
<td>Extrinsic rewards/financial improvement/promotion</td>
<td>3</td>
</tr>
</tbody>
</table>

With the education and training aspect of district nursing filtered out by the changed emphasis of the question, it is easier to see what it
was about district nursing itself that the students saw as desirable. The first three major groups of reasons indicate what is seen as the attractive features of community nursing when contrasted with hospital nursing. Hospitals were seen has having a confining influence on the way nurses work; three students' commented as follows:

"I wanted to get out of hospital work because I felt too closely confined by the rules and regulations. I wanted to work more closely with patients"

"I felt restricted in hospital. It is more free in the community. I am not pestered and am my own boss."

"you have to conform to the boundaries of hospital management and to their wishes and requirements".

The structure of hospital nursing was seen as affecting the kind of nursing care that the students wanted to be able to provide. District nursing was seen as enabling them to practice in the way they wanted to:

"I felt there was a place for me in the community, helping people on a one-to-one basis and giving them the kind of care I wasn't able to do as a ward sister"

"In a nutshell I wasn't getting job satisfaction in hospital. District nursing appealed as I felt I would have more time with each patient".

Community nursing was seen as allowing continuity of care, the thought of 'seeing the end result which you don't in hospital' was what district nursing offered while another student commented:

"The patient turnover in hospital was so rapid I felt I did not have enough time with my patients".

The new curriculum emphasised the role of the district nurse as manager of the primary health care nursing team and of working closely with others involved in primary health care such as health visitors,
social workers and voluntary helpers. These aspects of district nursing were relatively understressed by the students during the earlier part of the course. There was, as indicated above, a desire to organise their own work activity and this was in some cases seen as possibly in conflict with the idea of managing staff:

"I wanted to work more on my own initiative ... be more responsible for what I did. I didn't see district nursing initially as involving managing other people. I saw it as an isolated job ... there is interaction but it seems to me there is more a personal responsibility than a team one at present."

"I like working basically on my own and liked the thought of meeting people in their own homes".

"I like to work alone but now they're trying to make district nurses into team leaders ... I am not very happy at the thought of managing because I have had no experience in the field ... it will take me all my time to organise myself let alone anyone else".

The intrinsic rewards of community nursing were thought to arise from the opportunity to establish a total care regime for the patient in her/his own home and closer understanding of a patient's needs and these considerations out-weighed more extrinsic features of the job. However, the hours of work and lack of shift work were positively valued particularly by those students who were married with children. Shift work was seen to interfere with one's personal life and living in hospital accommodation was not particularly enjoyed by those who had had that experience. Financial rewards were little mentioned but, the view of one of the students who did so, suggests how the image of district nursing might be changing:

"I chose district nursing initially for promotion and financial reasons and to be able to spend more time with my husband. Since then my reasons for continuing and my belief in community nursing have come from finding out
more about the role and potential it holds. I no longer believe it is a second best or for the drop-outs of any field. Had it been enough only to satisfy my immediate needs I would have resigned by now."

PARTICULAR NURSING INTEREST AREAS

Further light is thrown on the way students viewed their future district nursing career by considering their response to the questions on their interests in patient groups and counselling and health areas (Question 3, Appendix 3). Of the twenty-six responding, twenty-two said they had a specific interest in the care of the terminally ill; nineteen students were interested in the elderly generally, sixteen in the elderly living alone, seventeen in post-operative discharge and fifteen thought they had a particular interest in the relatives of patients. The first three groups mentioned were those they they most wanted to spend time on in their future career.

Their interest in counselling and other health areas tended to reflect the students' previous work experiences; over half expressed interest in physical health problems; and over a third in the areas of family planning, marital and psycho-sexual problems and nutrition. Nearly a third of the students were also interested in mental health problems, health education in schools and immunisation and vaccination. Counselling for bereavement and the health and safety of the elderly were mentioned most often in the 'any other' category.

Physical health problems and screening of the elderly in relation to these, was the main area that a minority of students said they wanted
to be able to spend time on if possible during their careers (Question 3a) and 3b) Appendix 3). However, the majority of the group felt unable to choose one particular health counselling area for specialisation at that stage and remained open to development of such interests.

**SUMMARY AND DISCUSSION**

This chapter has indicated that the student cohort for the 1980/81 district nursing course at Surrey were of various ages, mainly female and mainly married. Apart from their State Registration the most commonly held nursing qualification was in midwifery and most of the students had also gained some experience (two months or more) in community nursing. The students' perceptions on the value of their community nursing experience is considered further in the next chapter.

Among the main reasons given for wishing to train for district nursing were that training was necessary to practice as a district nurse and contributed to professional standards of care; this was associated with a further group of reasons which emphasised a desire for professional development and specialist practice; a third main group of reasons for training suggest that district nursing was envisaged as allowing a more satisfactory nurse-patient relationships (one-to-one and having continuity over time) and the establishment of 'total' patient care. When students were asked directly about their choice of district nursing the major reasons related to the type of patient care that was believed to be possible in the home environment; the emphasis again was on interpersonal relationships between nurse and patient. The second main group of reasons related to district nursing being
perceived as allowing greater control over nursing care given, more scope for autonomous practise and as involving greater responsibility for the nurse than appeared possible in the hospital environment. There were signs that some students had ambiguous feelings towards the general trend towards an emphasis on the district nurse as a collaborative team-worker in primary health care with management and co-ordination functions. This was noted for further exploration and will be returned to in subsequent chapters.

The twenty-eight students saw district nursing as providing the possibility of developing their interests in the care of the terminally ill and the elderly at home. A wide variety of other interests were shown from physical health problems to family planning, nutrition, counselling for bereavement and the screening of, and safety of, the elderly.

Two surveys of teaching centres for district nurse education and training have been carried out from the Department of Educational Studies at the University of Surrey. One was initiated during the time of the evaluation and surveyed courses leading to the March 1982 examinations (Oates and Salter, 1982); the second developed this further providing an in depth coverage of the majority of centres in the United Kingdom (Lopez and Radford, 1984). Comparison with the findings (for the thirty-eight institutions in England) from this second survey (Lopez and Radford, 1984, pp 41-50), indicate that the group of students in my study was larger than the average (twenty-two students per course being the average size of course). The
The overwhelming majority of students on courses were female as they were in the above group. The Surrey group however appeared to have a higher proportion of married students (all but three compared with around a quarter of the students in the survey) and to have a larger proportion of the younger age group (a quarter of the group were under twenty-five compared with under a fifth for the whole survey). There were similar proportions in the older age ranges (over thirty-five years of age), and, as for the institutions surveyed, the largest group of students were in the twenty-five to thirty-four age group.

The Surrey course was, and still is, one of the few placed at a university, the majority now being in polytechnics and colleges of higher education. The 1984 survey showed that most institutions expected candidates to have a minimum of five G.C.E. 'O' level qualifications and some post-registration experience; however Surrey was similar to two thirds of these institutions in having alternative selection procedures for those candidates without the minimum academic qualifications.
CHAPTER FOUR

STUDENTS' VIEWS ON TEACHING AND LEARNING

INTRODUCTION

The district nurse course comprised a six month course leading to written examinations, followed by three months practice under the guidance of a nursing officer. This chapter considers the first six months of the course of which approximately two thirds were spent in the university and one third in the community when the students were placed with a practising district nurse who was also a practical work teacher.

The main focus of the evaluation was the students' community experience. This needs, however, to be placed within the context of the rest of the course. The first section of this chapter considers the students' views on the course methods used while they were based in the university. Data is taken from the first questionnaire or interview. The second section considers the results from the questionnaire and record keeping exercise during the students' third and final work placements. The third section gives students' general impressions of the whole course and discusses criteria related to assessment outcomes. The chapter ends with a discussion on students' views on the importance of their experience in coping with the demands of their course, raising some of the issues involved in the
evaluation of curriculum organised to attain specific (i.e. examined and assessed) outcomes.

STUDENTS' VIEWS OF UNIVERSITY COURSE METHODS

As for the initial innovatory course of 1978/79, the Surrey course for 1980/81 continued to utilize a variety of teaching methods in order to stimulate a broad learning environment for their students. The 1980/81 student group were asked to consider which teaching/learning methods they found useful while in the university setting. Their replies are summarized in Table 4.1 below.

Table 4.1 Students' Response to teaching or learning methods (n=26)

<table>
<thead>
<tr>
<th>Teaching/learning method</th>
<th>agree strongly</th>
<th>agree to some extent</th>
<th>don't know</th>
<th>disagree to some extent</th>
<th>disagree strongly</th>
<th>non-response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lectures</td>
<td>17</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Private study</td>
<td>16</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Small group discussion</td>
<td>13</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Presentation of projects</td>
<td>12</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Individual tutorials</td>
<td>10</td>
<td>10</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Self-directed study</td>
<td>8</td>
<td>12</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Whole class discussion</td>
<td>3</td>
<td>17</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Film</td>
<td>4</td>
<td>15</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Half-group discn/tutorials</td>
<td>5</td>
<td>12</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Video tapes</td>
<td>2</td>
<td>5</td>
<td>8</td>
<td>7</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Role play</td>
<td>0</td>
<td>7</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>
Comparison of the list of methods in Table 4.1 with the listing offered to students (during interview or by questionnaire (question 5, Appendix 3) will show that 'seminar' and 'tutorials' have been omitted. This is because during interviews it became clear that the students were either unsure of what 'seminars' were or they tended to equate them with the 'half group discussion' category. The separate category 'tutorials' was included without the additional 'small group' by a proof reading oversight on my part and created subsequent confusion. It seemed likely therefore that the responses in either category on the student questionnaires were suspect, and I have left them out of the analysis.

Apart from this hitch the 1980/81 students ranked the first four methods in the same order as the students on the 1978/79 course: lectures followed by private study, small group discussion and presentation of projects. Video tapes and role play, ranked at the bottom of the list by the 1980/81 group were also put in these positions by the first set of students. Differences occurred where the 1980/81 group of students ranked individual tutorials and self-directed study above that of class discussion (the first group of students were not asked about half-group discussions (tutorials)). The first group had, however, been asked about 'tutorials' as a separate category and these had been ranked fifth above the category 'individual tutorials'. It should be noted here that Table 4.1 used a different ranking system to that of the first report. This makes no difference in the case of the top six methods in the table, but it
does for those ranked below these since the first two positive groups of responses have been totalled (whereas the first evaluation ranked on the basis of the single most positive response). The rankings on Table 4.1 appear, however, to be corroborated by students responses to the further questions regarding what they thought were the 'most useful' and 'least useful' methods. They were asked to state up to three for each and the top three and bottom three were as stated in Table 4.1. in that same order.

The problem of interpreting such a table is that students arrive at university or other academic setting with a set of expectations about the type of teaching they will receive and how they are expected to study in this situation. 'Lectures' and 'private study' might therefore be seen most positively because these are the kind of situations familiar in concept, if not in practice, and the lecture is possibly the predominant type of learning situation which any adult experiences. Student comment and discussion of these methods is given below under the separate headings.

Lectures
As with the group of students on the first course at Surrey the 1980/1 students were not without criticism of the lecture as a teaching and learning method. A few criticised content of lectures, suggesting that some of the medical lectures were pitched at 'too high a level' or 'over my head'. In contrast, many students had found the lectures on first aid far too simplistic in content and therefore a waste of time.
The students also criticised the way some lecturers structured their lectures:

"some people aren't very organised or clear about what is being put over to us".

"I appreciate some of them want to get us making comments but it's no good coming in and saying 'I don't know much about this but I'll have a bash' - I expect a nurse lecturer to know the subject".

This last speaker was directing her comment mainly at the district nurse principles and practice module. The impression I got was that the value of the lecture to the student lay with the quality of the lecturer. Other students' comments support this; for example that

"it depends on the lecturer what you get out of it"

"( - ) eggs you on, deliberately says outrageous things and gets us thinking . . . it gets out of hand sometimes".

Students said also that they found visual aids used in lectures useful for summarising content and points being made.

Private study and self-directed study

The students ranked private study second and self-directed study sixth (Table 4.1). Through the interview cohort I was able to explore this more and found that the reason for these two is interesting because students tended to interpret 'private study' as the work they did following up guidance by tutors or lecturers or study for course work assignments. Private study was seen as vital:

"It's absolutely essential. I find I have to work all the time to keep up and without that time I'd be in trouble".

While most students appreciated the whole day free for such study a few students said they would prefer 'free periods' during the
university day, mainly because they thought they would make better use of the time. One student said:

"I need to be pushed into study and tend to fritter away my study day and see it as free time".

This gives a clue to the lower ranking of 'self-directed' study perhaps. Mature students such as those in this group are possibly very conscious of the short time they have in which to learn a great deal and feel they cannot afford to wander too far from the point in any of the subjects they are studying. They prefer therefore directed study, to feel that they study for a purpose, for example background reading for course work, and they think they 'need to be given something specific to do'. Nearly all students worked at home rather than come into the university on study day.

Presentation of projects

Students presented their projects of 1500 words to a small peer group. The arrangements for these presentations were generally criticised, there being a number of groups in the same room. However, it was still a highly rated activity. The majority of students said this was most useful when they were presenting their own projects since the experience helped them learn about their own teaching skills (a similar outcome was also noted by the 1978/79 group of students), and through the study and work they had had to put into their projects. In terms of learning from other people's presentations the reaction was mixed. Reaction appeared to have similarities with their reaction to lecturers - "it depends on who was doing it" and "some of the topics didn't interest me". Other students considered this in a different light:
"we learn much better from each other . . . They (other students) put a lot of work in and you are more conscientious about listening than if you are there with an (outside) lecturer you don't know".

Students also mentioned the stress that such situations could create for the presenter and the need for sympathetic support from peers and tutors.

**Whole class discussion/halfgroup discussion**

Whole class discussions generally occurred following presentations by internal tutors or lecturers who more or less made efforts to involve students. Encouragement to active participation was clearly appreciated by students and one reason given for this was that points of interest can be brought up but also, in contrast to project presentation, the reticent or quieter student can remain in the background and stress is reduced. A further reason may be that in such situations tutors or lecturers had provided focal points for discussion and to some extent it was the lack of 'content' which led students to find the half-group discussions/tutorials relatively less useful. "It's not very well structured. It's left to the spur of the moment" and "the idea is that topics come up but in my particular group it doesn't seem to happen . . . it depends on how they are directed or arranged beforehand". From general non-participant observations made during these sessions (led by course tutors) I had noted that the halfgroups were indeed more enthusiastic and responsive with one tutor rather than the other, but the potential effect of this was minimised by the fact that the half-groups switched tutors from week to week. However, this switching also had the effect of
curtailing any planning on the students' part unless tutors co-
ordinated their activity and ensured preparation well beforehand.

**Video-tapes and role-play**

The number of students opting for the "don't know" category is
probably a reflection of their small amount of exposure to these
teaching and learning methods. They had only experienced one role-
playing session. The latter produced a great deal of negative
reaction among the students. They had felt embarrassed and
unprepared for the session in which some students took the part of
'counsellor' and others of 'client'. One of the students participating
commented:

"it was a false situation I didn't feel you could be
honest, be yourself without having built up trust in each
other and knowing that what you say will be spouted out
again to others in the class".

One of those who had watched and listened said

"it (role-play) happened on the spur of the moment and I
didn't have time to feel strongly about it, earlier
warning and preparation would have been beneficial . . .
it ended up with a general chit-chat".

Another student, who was an observer in this session thought that the
class had

"misunderstood what she (tutor) wanted and we made too
much fun of it, she took it in good part but we were a
bit silly really".

The lack of preparation and limited opportunity for role-play tended
to leave students with an impression of 'how not to counsel' but no
clear idea of what they should do instead. This type of learning
situation was seen therefore as unfamiliar and threatening but
potentially very rewarding. The potential usefulness of role-play was
mentioned, however, even where students rated it poorly "I don't like it but you do learn from it". They saw it as a way of learning about themselves in relation to patients, learning interviewing skills in order to get the information needed for patient assessment and tips on how best to provide guidance; it was therefore a useful means of obtaining feedback from other students as well as an opportunity to give feedback to others.

Small group discussions

The small-group discussion tactic was used frequently throughout the course by tutors to stimulate discussion and participation among all students, including those who would not speak out in front of a larger group. The two students who found this method useless believed it was wasting time - time which they felt could have been better spent receiving further information and instruction from tutors. Most students had found the initial experience of splitting into small groups an unexpected one and one that had taken time to get used to. By the halfway stage they were 'reconciled' to small group work. A few students mentioned the groans and laughter which arose from the group whenever they heard 'get yourselves into small groups' but this had died away once they found it could be useful to work in groups:

"we can share experiences and try and relate what we know to what we've heard about in class".

OPPORTUNITY TO PRACTICE

During their third two-week work block twenty students kept records for six days and completed a brief questionnaire (Appendix 5). The
responses to the records helped to give some actual detail of the type of practice opportunity while the questionnaire provided a useful overview of student opportunities during the fortnight. During the fourth (final) block, it was expected that students would have their fullest opportunity to apply the knowledge and skills of all aspects of the district nurse role under the continued supervision of their practical work teachers; the students completed a questionnaire following that practical experience (Appendix 6). The results are discussed under sections covering: patients, extended role opportunities, contacts and perceptions of primary health care teams.

Patient Workload

Analysis of the records kept by students showed that an average of 5.7 patients per day were visited by students. Just over sixty percent of these visits (60.7%) were made alone by the students; of the remaining proportion most visits were made with the PWT (27.8%) and some with a number of different personnel (11.6%) such as other district nurses (six patient rounds), nursing auxiliaries (5 rounds), health visitors (4 rounds), social workers (2 rounds), while a general practitioner, community psychiatric nurse, state enrolled nurse, nursing officer and another PWT went on single rounds with students.

The records also enabled me to arrive at broad breakdowns of time students spent in particular activities. For example the average total working day was 7 hours 50 minutes (128 whole working days only analysed). Average times spent were: on patient visits just over three hours; in discussion with PWT 37 minutes (excluding time with
PVT visiting patients); in private study 53 minutes; and, in administration 20 minutes (excluding time spent in any record keeping done in patients' home).

It must be said that the accuracy of these detailed time breakdowns is questionable as, without prior job/activity analysis or observation checking procedures, it was difficult to provide clear categories for students to use in an unambiguous way. The students said that time-keeping in particular was difficult ('a bit hit or miss') as well as being time consuming. Nevertheless, at a conservative estimate, it seems safe to say that students spent a large proportion of their patient contact time working on their own with patients, or in private study.

The other main problem with averaging of experience in this manner is that it obscures the variation recorded by individuals. For example whilst students were accompanied by their PWTs for twenty-eight percent of all visits over the recorded time, five students recorded no visits accompanied by their PWT in this period analysed and several recorded many whole rounds jointly undertaken with their teachers.

For their final work placement the students were asked about the number of patients they were responsible for, since a caseload is obviously one vital prerequisite in being able to practice their skills and take responsibility for decisions on care. During this placement it was expected that they would carry a 'mini' load of their own while the formal responsibility for patients remained with their PWTs.
Table 4.2 shows the distribution of caseloads by size with the numbers of students saying they had responsibility for these. The table shows that half these students had nine or more patients for whom they were responsible, one of these having twenty patients.

Table 4.2 Size of caseload allocated to students in 4th practical block

<table>
<thead>
<tr>
<th>Numbers of patients:</th>
<th>0</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>13</th>
<th>20</th>
</tr>
</thead>
<tbody>
<tr>
<td>per caseload</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numbers of students:</th>
<th>2</th>
<th>1</th>
<th>1</th>
<th>4</th>
<th>1</th>
<th>1</th>
<th>2</th>
<th>5</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>with this caseload</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Number of students responding = 20

The two students recording no patient 'case load' of their own explained that the work during this fortnight was so light that in each case the PWT 'shared' her patients on a day to day basis. One remarked:

"If it (allocation of work) had been done individually there would not have been enough work to keep us occupied for the day".

In both cases the PWT had made efforts to assign 'patients that required the most care' and had decided on allocation in conjunction with the student taking into account 'priorities of care, geographical area and unusual features' in order to provide the greatest variety of opportunity possible. The students having a caseload were able to assume responsibility for 'their' patients while remaining aware that the patients were part of their practical work teacher's caseload. All but two students said they received adequate support and advice from
their teachers. Of the two dissenting students, one commented that she had not had a large enough caseload (four patients), had not worked very often with her practical work teacher and had found the block 'bitty', not allowing continuity of care. The other students thought support was adequate for actual nursing care given, but that there was "not much support or help regarding time for study or for making special visits".

Extended Role Opportunities

Variability of opportunities was also noted regarding aspects of the 'extended' role of the district nurse. In the third work block students were asked about working in general practitioner or health centre clinical sessions. On average they were involved in two such sessions a week. But five students took no such sessions (where patients call at the surgery for attention) whilst seven students took between ten and twenty such sessions. Such discrepancies in opportunity would be expected to become more crucial in future as students entering courses are less likely to have had previous experience in the community to draw on.

The questionnaire relating to the final work placement provided the opportunity to ask students' opinions about their opportunities to put into practice particular skills expected to be exercised by the district nurse as taught through the course curriculum. The brief questionnaire required them to do this for six broad areas representing several of the dimensions of the extended role as
embedded in the curriculum and the results are summarised in Table 4.3 below.

**Table 4.3 Students' response to question whether the 4th practical workblock gave sufficient opportunity to practice particular skills**

<table>
<thead>
<tr>
<th>Skills:</th>
<th>No of Students Responding:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>to a great extent</td>
</tr>
<tr>
<td>Interpersonal skills - patients, relations</td>
<td>18</td>
</tr>
<tr>
<td>Nursing care in the home</td>
<td>16</td>
</tr>
<tr>
<td>Interpersonals skills - other colleagues</td>
<td>12</td>
</tr>
<tr>
<td>Nursing care in surgery/ treatment room</td>
<td>9</td>
</tr>
<tr>
<td>Administration skills</td>
<td>5</td>
</tr>
<tr>
<td>Managerial skills</td>
<td>3</td>
</tr>
</tbody>
</table>

Number of students responding for each category of skill = 20

The 'skills' have been re-ordered for presentation according to the frequency of response by the most positive category and shows clearly that the further students moved away from nursing and related activities taking place at the bedside or in the home, the less satisfied they were with their opportunities to practice. For example, administration and managerial skills are seen as crucial in the new curriculum if the district nurse is to develop her full role as the leading clinical expert in the primary health care team. Taken together with the relatively small proportion of time recorded by students on administration (in the third work block) this may be an
area requiring further emphasis during placement. It would not be realistic to expect that students are able, while being trained to exercise a complete management function, particularly as the PWT remains responsible overall for the patient work and caseload. Nevertheless this is a crucial area of training if the demands of the job are to be met and points to the need for PWTs and NOs to consider ways of enabling students to have more satisfactory learning opportunities in this area.

**Reporting Back Systems and Contacts**

Communication between students and other personnel regarding patients during practical blocks can be viewed as a precursor to actual practice as district nurses within the community. Students were therefore asked about their system of reporting back on patients and, for sixteen of the students, the usual way was through daily meetings with their practical work teachers, either at lunchtime or following completion of work for the day. Only three of these students said they had regular opportunity to discuss patients with general practitioners, one of these having daily meetings which included GPs and district nurses. Two students said that when the PWT was 'off duty' they reported to another district nurse or in one case to the nursing officer or another district nurse - whoever was available.

The four remaining students said they "reported back as necessary" to practical work teachers or G.Ps and no regular system was in operation. The criterion for 'necessary' appeared to be changes in patients' conditions, so that these students reported 'improvements' or
'important changes' and in one case the death of a patient. Records of contacts for work purposes show that after their practical work teachers, the students saw other district nurses, GPs, receptionists and SENs more frequently than other personnel (and in that order) but the incidence of contacts generally appeared low. For example, over a three day period (the middle Wednesday, Thursday and Monday of the block), the students between them recorded just twenty-eight contacts with district nurses (other than PWTs), twenty-two contacts with GPs, seventeen with receptionists and thirteen with SENs (trained and untrained for the district). Contact with other personnel for the purposes of work was more limited. For the same period, the students between them recorded six contacts with home helps and social workers.

Perceptions of Personnel Involvement in Primary Health Care Teams

The low incidence of contact with others outside the immediate nursing or medical environment would have implications for the ways in which students perceive and understand the concept of primary health care team work. Question 11 (Appendix 3) was designed to illuminate whether students held distinguishable images of 'the primary health care team' as far as personnel were concerned - whether in fact they made distinctions between personnel seen as included in theory or in practice. Table 4.4 overleaf summarises their response.

Table 4.4 shows that based on their understanding of practice three-quarters or more of the students think of the district nurse, the G.P. and the health visitor as being included in the P.H.C.T.:
### Table 4.4. Student Views of Primary Health Care Team Personnel (n=26)

<table>
<thead>
<tr>
<th>Personnel</th>
<th>No. of Students including in PHCT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>'in theory'</td>
</tr>
<tr>
<td>District Nurse</td>
<td>26</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>26</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>26</td>
</tr>
<tr>
<td>S.E.N.</td>
<td>21</td>
</tr>
<tr>
<td>Social Worker</td>
<td>23</td>
</tr>
<tr>
<td>Community Psychiatric Nurse</td>
<td>23</td>
</tr>
<tr>
<td>Nursing Auxiliary</td>
<td>21</td>
</tr>
<tr>
<td>Midwife</td>
<td>17</td>
</tr>
<tr>
<td>Hospital/community Liaison Nurse</td>
<td>12</td>
</tr>
<tr>
<td>Nursing Officer</td>
<td>10</td>
</tr>
<tr>
<td>G.P. Practice Nurse</td>
<td>10</td>
</tr>
<tr>
<td>Home Help</td>
<td>2</td>
</tr>
</tbody>
</table>

From a theoretical standpoint the same proportion of students (three-quarters) thought a wider range of personnel - midwife, community psychiatric nurse, S.E.N, nursing auxiliary and social worker were ideally to be included in the PHCT. Bearing in mind the results of the students' working experience whilst on the course as well as the fact that many had already had previous experience in community nursing, it seems probable that the students were reflecting a realistic picture of who makes up the vital core staff in district nursing teamwork in practice.
OVERALL IMPRESSIONS OF THE COURSE

Students were requested to give their overall view of the course at the halfway stage and then at the end of the first six months (Question 4 Appendix 3 and Question 4 Appendix 4). Table 4.5 below compares the responses at different stages.

Table 4.5 Students' impressions of the course as a whole: at an early stage (A); and at the end (B) (n=26)

<table>
<thead>
<tr>
<th>SCALE</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>2</td>
<td>10</td>
<td>8</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>7</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Balance</td>
<td>A</td>
<td>Uneven</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated</td>
<td>A</td>
<td>Bitty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Useful</td>
<td>A</td>
<td>Waste of time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The distribution shows the majority of students still finding the course as 'useful' - rather than a 'waste of time' - at the end of the course as at the earlier stage of the course. However, their opinion shifted toward a more negative impression of the course in terms of how well its different parts were 'balanced' and an even more negative shift occurred along the 'integration' dimension. These terms are admittedly vague but, with the benefit of other findings and information given by the students, it can be said that the type of
'integration' they found difficult was that of relating theory to practice: of shifting their inputs and outputs between the course as experienced in the university and the course as found in the community.

The shift towards seeing the course as less well balanced by the end than earlier on is probably related to the structure of the course; that is, in the way it is weighted (during the first six months) towards theory rather than practice. This could effect the way students perceive the time, or lack of time, they have to try or test out what they are learning in the practice situation and also to provide continuity of care for patients. The 1978/79 evaluation had shown that students found the pace of the course 'too rapid' at times, it being hard to keep up with the background reading (Jarvis and Gibson, 1980). During the evaluation of the 1980/81 course the students also appeared to be under pressure at particular times. For example, early on in the course, they found organising their care studies of patients difficult. The course tutors advised students to 'practice' assessment on three patients and ultimately choose one for a full patient care study. One student, for example, had problems when her first choice then her second patient died while she was back in university blocked time. This created obvious time pressure but more importantly was emotionally upsetting for the student in that she had felt 'helpless' in the university situation and unable to assist the patients' families. She had in fact made subsequent visits to these families in her own time. The care study is an important part of the coursework since it is the one in which students are expected
to show nursing process in practice (the issue of nursing process is considered in subsequent chapters). Towards the end of the first six months of the course, students felt under pressure of imminent examinations and this, combined with its aftermath of anti-climax, would tend to lead to a more negative appraisal of the course even while appreciation of its general utility remained stable.

**ASSESSMENT**

An overall intention of the Panel's 1976 district nurse curriculum, and in the way it has been developed at Surrey, is that the end product will be a district nurse:

"competent to undertake nursing duties within the community and to be held individually accountable for the professional standards of her own performance" (PADNT, 1976, p.2).

On the way towards this end the Surrey students' competence was to be assessed through four course assignments, continuous assessment of practical work and internal and external examinations. This section considers how they performed in relation to a number of variables.

Jarvis and Gibson (1980) found four factors which consistently correlated with the 1979/81 district nursing students' results. They were: age of student, the period of time since the student gained her State Registration and both pre-interview essay grades awarded by tutors. A number of other factors (e.g. number of children and time spent in district nursing prior to training) were not found to be correlated with students' grades (Jarvis and Gibson, 1980).
For the students of 1980/81 the relationships examined were those between students' grades on course work, their final practical grade and the internal examination results with: student's age, length of time in district nursing prior to course entry, time since gaining SRN/RGN qualification and students' academic (e.g. 'O' level G.C.E.s etc) qualifications. A broad statement can be made to the effect that no consistent relationships were found between these four variables and student grades, but a general trend was that the younger the students, the better their basic academic qualifications and the more recent their basic nurse training (to RGN) then the more successful they were in overall terms on their course assessments and examinations.

There was a strong negative relationship between (a) the student's age and (b) the final grades received for practical work and her marks for the internal examination (the older she was the lower the mark). For example, five of the seven students under the age of twenty-five received marks of sixty-five and over in the examination; while four students from the youngest group and none in the oldest group obtained grade A for their practical work. There was a similarly strong relationship between the year the students had completed their RGN qualifications and their marks for the internal examination. For example, six of the eight students scoring sixty-five percent and over had trained in the year 1976 or subsequently. There was also a positive relationship between the number of basic 'O' level G.C.E's or equivalents students had and the internal examination results - the more 'O' levels students had the higher their marks.
The only other statistically significant relationship found was between the students' care study and their previous district nursing experience: the longer they had spent in the district prior to coming on the course the better they did. The patient care study is the major piece of work in which students are required to show how their professional knowledge relates to the actual care of a patient, show their awareness of the nursing process and show how the role of the district nurse relates to others providing care in the community.

In terms of their continuous assessment in the district placements, students expressed a variety of opinions on how this was handled by their PWTs and on course arrangements for practical work were satisfactory for continuous assessment to take place. The information for this section is taken from interviews with fifteen students chosen on a random basis. Ten of the fifteen thought that the way in which the practical work blocks were arranged could be improved. The major complaint was that two week periods were not long enough:

"I discussed this with the nursing officer and we came up with what we thought would be a better arrangement. That was to have two four-week blocks approximately one third and two thirds of the way into the course. Two weeks is not long enough to settle down"

"Within the group (student) we've been discussing the possibility of having a three-week block initially ...to get all the visits over with...and then in the next blocks of three and then two weeks, we could get down to seeing patients properly"

"A two-week then two three-week blocks might be more useful. You don't get any continuity with patients over two weeks at a time....as with visits (to clinics etc) to fit in you may only get to see a patient, who receives daily visits, once or twice."
A few of the students thought that they would have preferred all the practical experience in one single block following the course theory. The second quotation shows recognition of the potential difficulty with this type of split:

"It might be better to have the practical at the end in order to put into practice what you've learned. It's difficult now as as soon as you get to know the patient you've gone back again - it's not continuous as you don't get that amount of time with the patient."

"I once thought it better to have the practical block all together but see now it can't be done that way...ther's the problem of integrating the learning during the course.....it might be better to split it into two lots of four weeks simply because of the problems of adapting from 'high key' in the university to 'low key' in the practical work placement."

STUDENTS' VIEWS ON THE IMPORTANCE OF PREVIOUS EXPERIENCE

In this section the students' views on the importance they gave to their previous working experience in a health district when coping with the demands of their course. In formation is drawn from the questionnaire administered at the end of the first six months of the course for return towards the end of the supervised practice period (Appendix 4). Casual conversations with students are also drawn on.

Twenty-four of the group responded to the two questions requesting them to mark five-point scales extending from 'very important' to 'not very important'. The first question asked them to rate the importance of their prior district nurse experience in relation to their practical course work and the second question in relation to the course theory. The responses to each question are summarised in Table 5.5 over the page. Students not responding to these particular questions stated
that they had had insufficient previous experience and were unable to make such a judgement. Results are summarised in Table 4.5.

Table 4.6 Distribution of students' opinion of how important their previous district nurse experience had been

<table>
<thead>
<tr>
<th>Scale</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>In coping with Course work:</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>In coping with Practical work:</td>
<td>11</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Number of students responding to this part of questionnaire = 24

The distribution shows that more students regarded their district nursing experience to have been important in helping them cope with practical work than their course work. Nevertheless, half the respondents thought it had been important for coping with course work. This was, they wrote, because they had found they were better able to relate theory to practice:

"As the course theory is very academic I feel you need some district nursing experience to try and help you relate theory to practice"

"I think it would have been difficult to assess situations and theory without prior knowledge of the district as the approach is very different to hospital nursing".

Those not responding because of their lack of earlier experience wrote that they believed that a broader working knowledge would have helped them and their views are summed up by this comment:
"I found it difficult to understand community situations when they were discussed (in class) and tended to relate back to my experience in hospital. I felt that the tutors did not always 'gear' their thoughts to those of us without community experience"

The point to be emphasised here is that a majority or large minority of students perceived their previous experience as important for them in coping with both the externally and internally based parts of the course. Those with little prior work in a district also believed this to be so.

Casual conversation with students' throughout the course indicated that views on the value of previous experience varied widely. Leaving aside the few students with less than one month (or no) experience, both experienced and less experienced students offered the disparate views: that experience was either 'important' or 'not important'. It was clear that 'experience' requires further definition in this context.

'Good' experience was believed to help interpretation and application of theory while 'bad' experience was seen as interfering with this process. 'Experience' was not seen as a simple matter of just 'doing' or 'having done' but was being interpreted by the students as necessitating an adequate knowledge base and reflection on practice if it was to contribute to their learning on the course. The characteristics qualifying the nature of 'experience' which students referred to most often were time (to carry through work in a satisfactory manner), location (relating again to use of time, such as that spent on travel), physical resources (adequate practice base facilities), personnel (relationships, communication and personality) and patients (circumstances and resources for care of). The quality
of experience was therefore indicated as being a vital issue and this is compatible with the students' attitude toward their practical work placements as described above where among the main anxieties expressed were the nature of the care that they were able to provide for patients and the ever present problem of continuity of care.

The quality of past experience and current experience during the course were therefore indicated as a vital issue. Nevertheless, previous experience, whatever it's quality, was nearly always thought to have some value in terms of providing an orientation towards the quite different nursing environment found in the community than is found in hospital. For example it would help give a better general idea of the conditions under which the work would be carried out and of the type of nursing required. For this reason a number of those who had spent a longer period in district work prior to training expressed unease at the thought of 'raw' recruits coming onto district nurse courses straight from basic training. They thought this would lead to a high 'wastage' rate following completion of courses.

**SUMMARY**

This chapter considered the students' perceptions of the first six months of the course. The students were seen to favour the lecture and private study as methods of teaching and learning. Over a third found small group discussion, presentation of project work to peers and individual tutorials of value. Individual personality and the quality of presentation influenced students' perception of lectures and tutorials. Students indicated that they had little time to waste
floundering around and appreciated well structured sessions with clear guidelines for following up in private study. Small group work was a new experience for the majority of students and it had taken several months for them to settle into this manner of working.

Students practical work experience was very varied in terms of size of caseload and opportunities to practice patient care. Most said that PWTs provided adequate support and advice regarding nursing practice but that there was less satisfactory support from PWTs for study or course work or over the arranging of special visits to fit in with the university based part of the course. Few students had regular contact with community personnel (eg GP, HV or Social Worker). Contacts were limited largely to their PWT and a small number of other nursing staff.

Students generally thought the whole course was useful. The practical work placements allowed practice of interpersonal skills with patients and colleagues but there was less opportunity to practice administrative or managerial skills. All the students passed the course academic and practical assessments. Analysis of results suggested that the younger, more recently trained (basic nurse training) nurse with higher numbers of 'O' level GCEs performed better in the written examinations; whilst those who had spent longer in the community prior to training as district nurses had a slight advantage in the nursing care assignment. Most believed however that experience assisted them in coping with practical work to a large extent and theoretical work to some extent.
CHAPTER FIVE

THE PRACTICAL WORK TEACHER

INTRODUCTION

In this and the following chapter the community context within which the students were placed is explored from the standpoint of those personnel who influence the students' experiences during training.

All the PWTs (twenty-eight) involved with the students on the course were interviewed during the course and I followed some up after their formal teaching of students had ended. The analysis of the information collected focuses on illuminating two areas: first the perceptions of the district nurse role per se and second the judgements of these personnel regarding the appropriateness of the new course in relation to their own preparation for training others or for the service role more generally.

The personnel covered in this chapter are those district nurses who were also acting as Practical Work Teachers (PWTs) to the students in the first six months of the course. Results from the students questionnaires and interviews are brought in to indicate the relationship between the PWT and the student. Some of the dimensions of the PWTs interpretation of their teaching role are discussed including relating theory to practice.
Chapter Six considers two other groups of personnel forming part of the contextual influences on the students' experiences: 1) the nursing officers with local responsibility for district nursing and auxiliary personnel and who acted as supervisors for the students' final three months of their course and 2) the divisional nursing officers - those nurse managers with broader managerial responsibility for the district service.

**PVT VIEWS ON CHANGES IN THE DISTRICT NURSING ROLE**

There were twenty-eight practising district nurses teaching the students on a one-to-one basis during the practical placements. Working with these teachers in the community was when the student came closest to the real life working situation that she/he was being trained for and it was here that the student would attempt to put theory into practice.

In terms of their district nursing role there were general changes which this group of practitioners saw as having occurred particularly over the past decade and also certain stable features of the role. The image emerging from analysis of the interviews was of a nursing role heavily weighted towards giving basic physical nursing care to patients in their own homes. This was perceived as requiring sensitivity towards the patient's social and emotional state; working in these particular circumstances the nurses saw themselves as guests and as unable to carry out care unless the patient allows them to. This was the major contrast highlighted between nursing in the home and nursing in the hospital environment. The latter was thought to be
generally organised for the convenience of medical and nursing needs rather than for the patients needs once these went beyond the treatment or diagnostic stage. The larger scale nature of the hospital enterprise was thought of as constraining the capacity of nurses to provide continuity of care for the patient and as reducing the possibilities of building up the close relationships which allow trust and confidence to be placed in each other.

The practising district nurses said that the one-to-one relationship with clients was an important factor in their job satisfaction. This corroborates the view that students' held of community nursing. Certain features of district nursing which were seen as relatively unchanged over time were therefore the specific nature of the relationship with patients and the context of the home in which care is given. The role was also seen still as 'bedside' nursing predominantly, allowing the full exercise of nursing skill in giving clinical care. The role also was seen as allowing greater scope for autonomous decision-making while in the home since it was being carried out largely alone in the dyadic situation of the patient and the district nurse. The PWTs, as district nurses, thought that they were able to decide how their caseloads will be managed during the day having due regard to constraints on ordering of visits (such as that diabetic patients are to be visited early in the day and that other patients may require assistance getting up or going to bed).

The changes affecting the role which the PWTs mentioned mainly fell into three broad categories. First the rapid developments in medicine
and in nursing had influenced the detail of the care to be provided (in matters of types of drugs, types of treatment, e.g. for leg ulcers) and types of resource available (such as sheepskins to help prevent bedsores and other practical home aids to assist mobility and independence of the patient). A second area was the change in what might be described as 'public awareness' of services. As services grew so too had the public demand for access to these services. General changes in family support systems were seen to have occurred so that daughters and/or other relatives appeared no longer as ready to become involved in caring for elderly relatives and, as one PWT put it:

"they (patients and carers) are extremely demanding sometimes, it is as much as you can do to satisfy them, the more you try the more they ask for."

A third area of change was the different structuring and organisation of services. Attachment to General Practitioners had progressed so that most of the district nurses were regularly working with particular practices and these practices could provide a base where the district nurse met regularly with related support personnel. In practice however these district nurses said that they still worked from their own homes having regular times to visit the practice and discuss changes in care or additions to their patient list with the GP. The proliferation of, and increasing specialisation of welfare service functions – health visiting, social services, peripetatic chiropodists, outpatient facilities, voluntary and other support agencies such as meals on wheels, night nursing for the terminally ill etc., and increasing sophistication of administration were seen to have
affected the district nurse role. More time was spent now than before in administrative work - filling in forms, writing letters or liaising by telephone and in person with other health and social personnel. The district nurse, being away from the 'office' base for most of the time often found liaison difficult when other personnel worked on more regular routine systems - such as health visitors who frequently spent the early part of the day in their offices awaiting calls from clients before setting out - the early part of the district nurse's day was however the most intensive period for home visiting with a consequent lack of time or access to telephone facilities.

PWT TRAINING AND ROLE
This group had received additional training to support students. Two thirds had undertaken their preparation for teaching in the three years prior to the study and were therefore relatively recently trained. In addition, all but four of the group had been trained at the university by the Department in which the students were now undergoing their course. Their training therefore could largely be expected to have reflected changes to the main district nurse curriculum which the department had begun in 1978. Comparison with the earlier study (Jarvis and Gibson, 1980) indicated a slight shift towards a group of more recently trained PWTs. This possibly provides confirmation for the view expressed by some of those interviewed that those trained under the time of the older curriculum were opting out of training activities due to feeling 'out of touch' and unable to cope with the additional demands made of them in their training role.
The main dimensions of their role were elicited through open questions asking them to state what they saw as their main role and responsibility in training students. Ordered by frequency of mention the analysis indicates the following main dimensions:
1) the teaching of applying practical nursing skills in the district: teaching by example;
2) discussion with student at all stages;
3) linking theory with practice;
4) counselling and support to students.
(Note: Assessment of student was a set requisite of the teaching role and was explored separately).

Teaching by Example

Over half the PWTs mentioned (1) above directly and all obliquely. They thought that it was important to 'get across' to students the differences between nursing the patient in the home and in the hospital. Teaching here could extend from practicalities such as helping students to use domestic equipment for sterilisation procedures, to instilling particular attitudes by encouraging the student in a less direct way to adopt particular approaches toward patients and their families in order to arrive at attitudes and behaviour which recognised the patient at home as having legitimate control over their working environment. In community care it was seen as much more important that the nurse should be accepted by the patient or other carers in the home. Those working in hospitals would challenge this perhaps because theoretically the best possible patient care would be the object of their work in whatever situation. But the fact remains that institutional care can, and often does, disempower the 'clients' of the institution partly through the increasing problems of the scale of the numbers of people involved
(carers and cared for) and the consequent necessity for organisation of mealtimes, bedtimes, drinks times, doctors 'rounds' or bedmaking on a less flexible basis than could be accommodated or desired by the individuals concerned. In those circumstances individuals lose the climate in which to express their individual personality and circumstance and the individuals associated with the most powerful status group (in hospital this would be the consultants) of the institution will exercise control over the environment.

Discussion

Discussion with students was regarded as important at all stages of 'the learning process'. The PWTs emphasised discussion of patients before and after visits, discussion of broader issues such as what other services could contribute to the patients' well-being and how this could be achieved; discussion also of the nursing procedures most or least likely to achieve the optimum patient care, and discussion of the role of others in the primary health care team.

In both these areas PWTs were highlighting what might be regarded as part of their 'normal' role. They were attempting to pass on their own, intuitively based, knowledge and practice by demonstrating and discussing the rationale underlying their work. PWTs saw this as challenging since the process involved making them 'think about' and analyse why they do what they do whereas in the normal course of their everyday workload they had neither the time nor the inclination to do this. This illustrates also the difficulty which district nurses have in isolating different aspects of their role: above it was shown
that they see themselves as essentially practical care givers whilst other aspects of their role, administrative or managerial, appear more difficult to articulate, or may even be seen as problematic or even not seen as a legitimate part of their role because any time spent on anything other than literal care giving would be construed as time wasted. One of the 'benefits' therefore of involvement in training of students was said to be that:

'it pulls you up'

'makes you think'

'keeps you in touch with the purpose of what you are doing'

'makes you realise how much you know'

'helps me to reassess my own practice and reflect on whether I understand why I do what I do'.

Linking Theory with Practice

The group's overview of 'linking theory with practice' indicated that they felt on less secure ground than they did when expressing their roles as 'teaching by example' or through 'discussion'. The PWTs saw their task here as providing linkages between the students' theoretical studies occuring through course teaching and the practical realities of nursing patients within the resource constraints of community nursing services. Two aspects were explored further. First the PWTs' perception of feedback and information from the university and second their own practice in relation to nursing process.
Information Needs

The majority of PWTs said that they attempted to utilize the course tutors guidelines and other information which might be sent out in their teaching. This type of information was seen as necessary in order to enable some forward planning for when students came out into their practical work placement. The type of activities PWTs undertook might then include arranging visits which were relevant to the students' theoretical experience such as visits to hospices when terminal illness was part of the past or current course, arranging visits to social workers or health visitors when liaison issues were being discussed and much effort was taken over the organisation of a varied caseload for students which tried to reflect the variety of circumstances which students were learning about.

Information from the university based tutors was seen as adequate though sometimes too late to make the best use of their time with students. Some of the PWTs said that the course tutors did not always appear to be aware of the practical constraints that the PWTs worked within - it could require the co-ordination of a number of personnel and several letters or calls and advance warning of a few weeks to try and arrange some visits for students to fit appropriately with course work. Speedy advance information was therefore appreciated.

Nursing Process

The second matter explored was the PWTs attitude towards 'nursing process'. This phrase is used to describe an approach to nursing care
which has an underlying philosophy of the patient as a whole person and not as a collection of specific illnesses requiring application of specific nursing tasks. Nursing process therefore demands assessment of the social, emotional, psychological and physical state of the patient in order that aims for nursing care may be set in context. In operation it requires the systematic recording of care given against the objectives set and evaluation of achievement leading to re-assessment of care needs and continuation of the process.

The theory and application of nursing process is central to the new curriculum and, given that this application would occur during practical work experience, it could be hypothesised that learning would be perceived by students to be facilitated where their teachers carried out their work in this manner - particularly when taken with the PWTs' emphasis on teaching by example and through discussion - and where they had understanding of the process and held favourable attitudes towards it.

Findings indicated that the PWTs had ambiguous attitudes towards nursing process. Only a few said that they applied it regularly in their practice whilst five of the twenty-eight said that they had been asked to, and agreed to, implement nursing process by their nursing officers (three saying that this was on an experimental basis only). The PWTs' response indicated defensiveness towards their own and their profession's past and present practice and eight of them suggested that they followed this process anyway as part of their normal practice:
"we've always carried out the nursing process...in our heads if not on paper"

"It has been the case since the year dot that patients in our care are treated as individuals ... you can't just look at symptoms without seeing whether they are cold or undernourished or lonely ... and this affects how you look after the patient as a whole".

On the other hand two PWTs indicated that the nursing process was 'a waste of time' or 'a pain in the neck'. Such outright hostile reaction was modified by others who appeared to have given more serious thought to the matter. For example three PWTs thought that it was more useful in hospital nursing environments and fifteen maintained that following through (from full patient history to care plan to application and evaluation) in the community was 'too time consuming' to be utilised for all patients. In particular it was seen to be inappropriate for the short term cases which district nurses deal with.

Over half of the PWTs said that they considered a nursing process approach to care as a useful teaching aid providing a structured approach to discussion of patients and their care needs. Therefore, although it was the case that the majority of PWTs were not implementing nursing process in their own work, this did not prevent many of them trying to help students approach care in this manner as well as discuss it with them.

The students' views on this are of interest here (I explored this matter with them during the course and again later during a follow up after they returned to practice as qualified district nurses). During
the course students explained that they had difficulty in implementing nursing process whilst on their practice periods due to general absense of example and consequent lack of documentation and grounding among their PWTs. The students as a group were generally convinced by the theory of nursing process approach to care. During the follow up study some months later this attitude still persisted and all former students said that they used nursing process. Four of the twenty-three traced said that they used this approach for three-quarters of their caseload while a further sixteen said they did so for between half and three-quarters. In addition over half of the former students reported that appropriate documentation was readily available and this seemed to be an improvement over the PWTs situation at the earlier date where a common complaint was lack of suitable recording forms and slowness in the district development of these.

The former students' response shows that they found it time consuming to put into operation but that they were prepared to find the time to carry out more detailed documentation of patient history, assessment, care plan, action taken and evaluation. They believed that, given time and practice, this would become easier and result in good standards of care which were discernable to others. Advantages of such an approach were that other carers could see what the previous person had done and read for themselves what was being expected of them in relation to caring for the patient. This was seen to provide continuity of care from day to night services or from one staff member to another when off-duty or periods of absence occur.
Further probing revealed, however that they were using modified forms of nursing process. Modifications were mainly designed to reduce paperwork (again particularly so for the post-operative patient anticipated as for on short term care) where this was seen to be a waste of their time and resource. In this way their experience of actual work situations was bringing them closer to the views expressed earlier by their former PWTs. At the time the course was underway students were less able to make such allowances without jeopardizing their performance towards course assessments. The potential consequence for students of their PWTs' failure to organise relevent experiences or exhibit expected practice in relation to the theoretically based part of the course is that students might become disillusioned and the relationship between student and PWT could be adversely affected. This is also raised in the later section on the PWTs' relationships with student.

Counselling
The fourth main dimension of the PWTs' role as teacher was that of counselling and supporting students. This was mentioned directly by less than half the group. They saw this as involving helping students through the 'initial culture shock' of higher education environment, as 'easing the strain' over the first practical work placement, and trying to help students with course work - particularly that relating to the patient care study (a main course project) and helping students with personal problems related to home or university or their practical work while in the district.
The PWTs saw their role in this respect as increasing in the future when the students they were dealing with would be supernumery, with higher proportions of direct, less experienced and mature, entrants. They were unsure that their own training had adequately equipped them for such a supportive, counselling role with students.

Assessment

Assessment of students was required in two parts: one 'theoretical' by examination and course work marked by university tutors, and one 'practical' as judged by the PWTs. During the time spent with them they were to complete a record booklet, while at the end of each placement PWTs completed a summary assessment card for each student. All PWTs said they utilized the record card and completed appraisal as required by the university. This was a marked improvement from the earlier study which showed less than a third (of the then PWTs) were completing forms as required by the university. Between the two studies the forms had been revised to take account of the PWTs comments. Nevertheless, assessment of students was among the least looked forward to activities for the PWTs. It was seen as a customary part of the teaching role but also seen to throw into relief the tensions between the generally facilitative role of the PWT with their student in the community and the judgmental aspect of their role as required by the university.

This dual nature of the role also highlighted the PWTs views on the appropriateness, or not, of the new curriculum and its demands assumed to be expressed through the type of assessment required. PWTs found
it difficult to distinguish between 'teaching' and 'non-teaching' hours since they saw all of the time they spent with students as part of their teaching commitment. This perhaps mirrors the concommitent difficulty they had in elucidating different aspects of their nursing role vis a vis patients - it being seen as multidimensional with each aspect of their activity having intimate/embedded relationships with the other aspects. In particular, if PWTs see their role as mainly teaching by example it could be hypothesised that they would experience problems in separating 'teaching' from 'non-teaching' roles since one was absorbed into the other.

The completion of the assessment cards following each practical work block appeared to arouse more anxiety among the teachers than did the record booklet. The latter was seen as providing a general guide to teaching and assessing the student but the practical work teachers were aware that this booklet would be used as 'evidence' only in borderline cases whereas the cards were the assessments available to course tutors and seen by the countersigning nursing officers during the time the students were on the course. Practical work teachers generally disliked completing these cards and their distaste seemed to stem largely from having to write their assessment of the student. It was over the completion of the cards rather than the booklet that practical work teachers raise the issue of 'jargon' or as one put it they have at the university what I call 'WORDS'. The major stumbling block seemed to be that the practical work teachers believed that the course tutors wanted something from them that they were unable, or more accurately believed themselves unable, to give:
"I find it difficult to write in the language the tutors seem to want"

"I realise they (tutors) want these filled in a particular way, but this makes me anxious because I become more concerned about pleasing the university, than writing down what I really want to say . . . worrying over how little, how much, the phrasing to use rather than the more important part of the content".

These practical work teachers were persistently worried that they were failing to meet tutors' expectations and that failure on their part could reflect badly on their students. Two practical work teachers quoted above had arrived at some conception of the tutors' expectations; others had not, "I am not sure what the tutors expect of me". Apart from this broad problem of translating their thoughts into a written form which would be 'acceptable' to the university, the practical work teachers mentioned two features of the assessment format which might be considered as pertinent by the tutors. Firstly the layout is the same for all four practical work blocks. During the first block the teachers said they were concentrating on introducing the student to the district, colleagues and some patients but primarily attempting to get the observation visits completed. They then found it difficult to assess the students' use of the nursing process (as mentioned on the cards) since little has been achieved. Similarly 'relationships' with colleagues and/or patients had hardly got under way and the student had had little opportunity to demonstrate her 'attitudes'. Secondly, some practical work teachers have suggested that the assessment headings were so vague that one could virtually write anything down. For example 'attitudes' and 'relationships' are not defined in any way and it is left to the
practical work teacher to decide to whom and what it is about these that the tutors are interested in learning. To aid completion of the cards practical work teachers are asked to refer to their initial student assessments in their record books but as was explained earlier these pages are seen as difficult to complete and as possibly optional.

PWT RELATIONSHIP WITH STUDENT

The interviews and discussions with students, PWTs and others showed that the PWT was in prime position in terms of influencing the students' practice of district nursing and thereby would or could have a potential for acting as a role model. PWTs indicate that they saw their major teaching function as to teach by example and demonstration of good practice with students alongside them. In this situation the relationship between PWT and student can be crucial and the students were asked to 'rate' their relationship with their designated PWTs (Question 7, Appendix 3). Table 5.1 below summarises the response.

Table 5.1 Student Perception of Their Relationship With Their PWT

<table>
<thead>
<tr>
<th>Relationship</th>
<th>No of students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good to very good</td>
<td>15</td>
</tr>
<tr>
<td>Fair</td>
<td>6</td>
</tr>
<tr>
<td>Poor</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
</tr>
</tbody>
</table>

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Over half the students described their relationship with their PVT as either 'good' or 'very good'. Around a quarter said it was reasonable and a similar proportion described it as 'poor' or 'very poor'. In discussing what the students meant by these descriptions of the relationships the focus is on the factors most pertinent to the PVT role.

Students who describe the relationship as 'good' were aware, firstly, of the ease of communication on social and nursing topics which existed between themselves and the PVTs. This was reinforced by open discussion of the more formally prescribed elements of practical work such as course aims, objectives and assessment. Secondly, the PVTs were respected for their experience, knowledge (they were seen as up-to-date in their knowledge of nursing techniques) and standards of nursing care. Thirdly, the PVT was regarded as having a positive attitude towards her role. This was manifested in the PVTs willingness to help a student in all aspects of the course, including course work, to either provide information or the means of access to it (i.e. to act as a facilitator), to have an open and friendly manner towards the student, to accept suggestions and discuss issues without friction (i.e. to see learning as a two-way process) and to link practical work with the course theory wherever possible.

Students who considered the relationship to be 'fair' thought that in terms of knowledge and experience the PVT was insufficiently prepared for her role and, generally through lack of confidence, did not meet the students' expectations regarding her teaching function. Indeed,
two students called into question their PWT's standards of professional care. Secondly, the PWTs did not link the work arrangements, particularly the visits, to the course and generally were not seen as very good at liaison and organisation.

Factors highlighted in poor relationships were usually, not surprisingly, the converse of those described for good relationships. Thus students emphasized the lack of communication between the PWT and themselves, the insensitivity of the PWT to their worries and their inability to discuss differences of opinion amicably. Secondly, the PWT was considered out of date in her knowledge and experience compared to the student: she did not use the nursing process or take much interest in it. Further, students were critical of the PWTs standards of care and in two cases this led to direct confrontation. Thirdly, the PWT was viewed as lacking confidence, as providing insufficient guidance and as not working with the student to set objectives. Fourthly, students felt that they simply 'did not get on' with their PWT. This was manifested in the inability of three PWTs to show awareness of the students' needs or meet their demands in students' judgements and three students thought they had stronger personalities than their PWT who consequently failed to cope with them; one student felt 'insecure and overwhelmed' by her PWT's 'bulldozing tactics'.

SUMMARY

In this chapter I have explored the work of the PWTs responsible for teaching students during the practical work placements in the first
six months of the course. This group of personnel were also experienced practising district nurses. They saw the main stable feature of the district nursing role as giving practical nursing care at the patients' discretion in the patients' own home. The one to one relationship was again significant in terms of job satisfaction. Over time the nurses' role in the community was seen to have broadened in some ways through greater participation in work at health centres or doctors' premises and to have become more complex in terms of developments in medicine and clinical treatment and aids available to the patient, the proliferation of services and of the public's awareness and demand for these.

PWTs had for the main part been trained for their teaching role fairly recently and at the university so that their training should have reflected changes in the new curriculum. They saw their role with students as predominantly teaching by example and discussion while attempting to link theory with practice through organising relevant experiences for students. Counselling was seen as an increasingly important but was mentioned specifically by less than half the group and PWTs were uncertain that their training had prepared them adequately for this. Assessment of students was seen as a customary aspect of their work with students but threw into relief the dual-nature of their role as teacher/assessor and as supportive district nursing colleague.

Given that the practical placement was the closest that students would get to 'real life' practice, the PWTs' role in linking theory with
practice in the case of the 'nursing process' was explored further. It was found that PWTs were not practicing this approach to nursing care at the documented level. Students therefore experienced difficulties in finding examples of practice while in the district and this was seen to have implications for the students' perception of their relationships with PWTs and for the PWTs' potential value as a role model for the student.
CHAPTER SIX

NURSE MANAGERS

INTRODUCTION

There were fourteen nursing officers and seven divisional nursing officers interviewed in the study (Appendices 10 and 11 respectively). The nursing officers are the first line managers of district nurse working in the community and those interviewed were acting as supervisors of the students following the first six months of the course being evaluated. During the earlier part of the students’ course they acted as countersigning officers for the PWTs’ assessment of student performance and gave general support to the district nurses teaching students (see previous chapter). The divisional nursing officers had responsibility for general management and training in their divisions and were the nursing officers managers. Due to reorganisation of the service at the time of the interviews the latter group were more or less in a state of anxiety because they had been placed in the position of having to compete with others (for their ‘own’ jobs) in order to continue working within the new system. First the views of the nursing officers and then those of the divisional nursing officers are discussed.
The nursing officers

Response to Change in District Nurse Training

Interviews with the nursing officers showed that they recognised that
the district nurse role had undergone dramatic change over the past
decade. From being 'the soap and flannel brigade' or the 'lady on her
bike', district nursing was now on its way to becoming 'a profession
in its own right'. The nurse was seen as having the clinical
expertise in, and responsibility for, meeting the total nursing care of
the patient in the community situation.

In terms of their own district nursing experience, the interviews
revealed that all but two had a district nursing background and ten of
the fourteen had worked also as practical work teachers. This
experience was seen as helpful when faced with assessment of district
nursing students but, as some pointed out, their own training had been
under the old four month narrower curriculum and they acknowledged
that updating on the new curriculum was a more important foundation
for supervision.

Their views were that, apart from a thorough knowledge of the course,
they needed to be skilled in observation in order to assess students'
manner and relationships with patients, carers and other colleagues.
The fact of their own earlier experience in district nursing was seen
as a helpful but not a sufficient preparation for supervision. Among
the aspects of supervision which caused anxiety were their newness to
a supervisory role as a nursing officer. This meant 'having to learn
through making mistakes' and feelings that they should 'try to find
out as much as possible about the course and student. The university provided study days for nursing officers which were seen as useful in the light of experience and for exchanging views, learning more about the course and for discussing issues arising over the earlier part of the course. Study days alone were seen as inadequate preparation for nursing officers new to that role due to variable content and presentation. Nearly all the officers said they themselves needed training or updating - particularly in the areas of counselling and assessment. Many saw a major part of their role as providing support to the newly trained district nurses: 'supportive, giving guidance in order to help them develop management and co-ordinating skills within the whole team'. This aspect was seen as a substantial part of the role with students. Not all officers thought training was essential in this respect: a few thought this should be seen as part of the on-going, normal responsibilities of the nursing officer as line manager in the locality. One said that provided she had an understanding of the philosophy, ideals and structure of the course, she should be able to cope; in addition a few days' training in observation skills might be far more useful than a week or more of 'academic' courses.

The nursing officers on the whole believed that the innovation in district nurse education, together with its mandatory implementation, was necessary for the service to meet the present day needs of the district nursing service in maintaining standards of care in the community. The 'appropriateness' of different emphases of the course was questioned by those who interpreted the district nursing role in a traditional way emphasizing the practical nature of the job and seeing
little need for excessive extension through 'academic' learning relating to psychology and sociology or where a bias towards 'theory' rather than 'practice' was to be discerned. Most however saw the course as enabling the nurse to appreciate the possibilities of their role and become 'more aware of what is needed for the job'; and, although students may find the course difficult or see it as irrelevant at the beginning 'by the end ... they seem to be seeing how it could help them in carrying out their work'.

Half of the nursing officers gave greater weight to what they perceived as the still developing aspects of district nursing in terms of management and liaison functions and four said they would particularly encourage and give priority to students' implementation of the nursing process. In addition many of the nursing officers believed that the students' practical work experience (during Part 1 of the course) was designed to cover teaching of clinical skills and this was not therefore part of their role during supervision.

Purpose and Planning in Supervised Practice

Nursing officers frequently characterised supervised practice as a time for 'filling the gaps' and gave examples of what they wanted to instil such as the importance of record keeping and prompt returns, knowledge of local personnel, providing support services to complement their general awareness that such services exist, learning to assess priorities of care in a caseload, creating deeper awareness of the importance of relationships with patients and carers, the formation of
such relationships and developing listening skills and teaching skills with clients.

From the students' point of view, fourteen (of the twenty-five who returned the final questionnaires) reported that they had had a meeting to plan a programme for the three months and eleven said they had not. Thus although nursing officers were concerned to identify areas in which students needed further experience, they had not all made this explicit by setting objectives with the students at the beginning of the practice. The university tutors' assessment form merely 'invites' nursing officers to set such objectives and, given the differences in conception and intention among nursing officers, it was not surprising that some students were left in doubt over the planned or unplanned nature of their experiences. Some nursing officers believed they knew both what supervised practice was about and how to organise it while others were less certain and more passive in their relationship with their students. This latter group tended to wait for their student to contact them: 'she knows where I am if she has a problem' and were prepared to allow the nature of the supervised practice 'to work itself out' as things went along.

For the purpose of planning the students' supervised practice all the nursing officers recognised that an initial meeting with the student was necessary. They also said it was crucial that each student be approached as an individual and her needs assessed. It was the nursing officers' intention therefore to attempt to determine what supervised practice should achieve in the light of student need during
these first meetings. By the time they were interviewed however two had not yet had such a meeting even though all interviews took place after the start of supervised practice; in one case this was due to illness and in the other 'simply lack of time and pressure of work'.

Variation in Student Experience of Supervised Practice

These variations in outlook and organisation contributed to producing quite different experiences for the student. For example, one nursing officer within the first week of supervised practice shifted her student from an 'unsuitable' placement to 'a situation where she could be completely in control ... she needed to be in a management position and in the practice originally chosen this had proved to be difficult'. Another nursing officer, however, saw her first task as ensuring that the student was competent to work alone in the treatment room and the first two weeks were set aside for the student to attain a proficiency certificate endorsed by the nursing officer.

The students had been asked to record and report the number of meetings between themselves and their nursing officers during the three months (Appendix 4) and these ranged from three to over fourteen in the course of the three months. And of these meetings, the number combined with a patient visit ranged from none at all (two students), through one to three such visits (twenty-one students), to four and five visits (one student each). In the course of these meetings students perceived their nursing officers as either implementing an agreed programme of objectives with counselling where appropriate or as merely responding to ad hoc student problems.
Frequent meetings did not necessarily mean that suitable guidance was being given. One student wrote on her questionnaire: "Whilst I had weekly meetings I felt I was very much left to get on with my 'lot' and did not have any guidance on how to manage my caseload". On the other hand, a group of nursing officers in one district collaborated to provide their students with the different kinds of experiences (in terms of size of practice, type of patient, size of caseload, type of primary health care team, specific training such as in ECG and haematology) which they knew their students needed. This was an interesting initiative because it got round the more intransigent resource and manpower constraints on nursing officers.

The variation in the organisation of supervised practice was expected by, and evident to, the nursing officers themselves, and among the more self-critical served to produce doubt and self-questioning about what they were trying to do for or with the students.

A number of the officers mentioned the probability of the lack of uniformity in the management of supervised practice by different nursing officers, and saw this as a problem for students where training was seen as one way of smoothing out differences in experience and practice to the benefit of students: 'students, quite rightly in my view, go back to the university and tell them so'. One experienced nursing officer as well as two of those new to supervised practice felt that it could be unsettling for students and themselves to hear of differences in practice:

"there appears to be no common denominator in the supervised practice. When I hear from others that they
are doing it differently I begin to think am I right or am I wrong?"

The students were asked in their final questionnaire (Appendix 4) to provide an overview of how well they themselves were prepared by the end of Part I of the course for actual practice during the supervised period with the nursing officers. Table 6.1 below summarises their responses according to different types of activity stressed during the course (particularly management of work and caseload, work in surgery, assessing patient need, administration, communication and co-ordinating activity).

Table 6.1 Student Perception of Their Preparation for Supervised Practice (n=25)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Very Well</th>
<th>Reasonably Well</th>
<th>Not Very Well</th>
</tr>
</thead>
<tbody>
<tr>
<td>managing own case load</td>
<td>6</td>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td>carrying out nursing process</td>
<td>9</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>conducting surgery sessions</td>
<td>4</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>assess and meet nursing needs</td>
<td>18</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>prepare/write reports on patient</td>
<td>15</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>liaison and communication (PHCT)</td>
<td>15</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>co-ordination appropriate services</td>
<td>18</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>continuation of personal and professional development</td>
<td>9</td>
<td>16</td>
<td>0</td>
</tr>
</tbody>
</table>

The table indicates that most of the students felt reasonably well prepared following Part I of the course, the least satisfaction being found with regard to the conduct of surgery sessions in general practice cases. This is perhaps particularly of interest due to only a few nursing officers giving priority to clinical practice - it being seen as having already been taken care of during the first six months of the course; in addition it was pointed out in the previous chapter.
that student opportunity for such experience in their practical work placements was extremely variable.

**Implications of Changes in Training**

The nursing officers had their own ideas about how well prepared students were for supervised practice and, to an extent, their comments can be seen as illustrative of how nursing officers were having to cope with the implications of the changes brought about by the introduction of the new curriculum at Surrey University. The impact of the course was frequently characterised as having generated high expectations in the student regarding her district nurse role: high expectations which were often manifested in an enthusiasm for change. Students were seen as more outspoken. 'They no longer sit back and let things happen to them but will talk when in groups, speak up at meetings, and have a lot of self-confidence'. But the problem many nursing officers faced was how to translate these expectations into practical action, in the context of limited resources, while avoiding the development of frustration in the student. One example cited of this 'adjusting to reality' concerned the nurse attending a patient needing general nursing care.

"The patient may need meals on wheels and other services, etc. The nurse therefore 'phones the home help and other services. Perhaps a home help isn't available because it is the summer holidays. Equipment loans are needed but there is no transport that week to get the loan of equipment".

Other examples concerned the problem for students when they recognise that the patient may need psycho-geriatric care, but at the same time, realise that 'nobody wants to know'.

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An alternative difficulty identified by nursing officers was in controlling the effects of students with high expectations on surrounding staff. Not all nursing officers saw the impact of the course in a positive light. Some felt that 'as managers they were apprehensive that what they were getting back on the district were university egg-heads who couldn't practice their skills properly'. A more favourable example concerned the student who was 'all for approaching the G.P. to do an age and sex register and also to start a system for screening the elderly in a whole district'. The nursing officer had to intervene to stop the student upsetting the G.P. - 'you have to be very careful over how you handle G.P.s.' By the end of the practice the G.P. liked the student though he thought she still had 'big ideas' not always practicable. Nonetheless, the nursing officer thought that in time, by making haste slowly, the register might become a practicable possibility.

THE DIVISIONAL NURSING OFFICERS

Seven Divisional Nursing officers (DNOs), between them covering Surrey and North East Hampshire were interviewed. Here I concentrate on drawing out their perspectives on the district nurse role, their views on the necessity for changes in training, their part in selection of students and the main implications of change for the service.

Views of Community Nursing and the District Nurse's Role

There were a number of changes in community nursing which were pinpointed as important influences on the district nurse's role. First the increasing emphasis on primary health care team (PHCT) working.
This generally was seen to have increased pressures on the district nurse through two main ways - the development of attachment to general practices and the latters' expansion of care at the surgery, and the growth of health centre working. The growth of 'treatment' rooms in the former case and the location of a number of different professional groups in one place in the latter case, had brought greater use of the nurse's clinical and other skills including liaison. For example, general practitioners were seen to be increasingly 'passing on' work to the district nurse at their surgeries:

"more nursing and preventative care using surgery facilities"
"screening activities"
"preventative work with elderly"
"venepuncture generally"
"vaccination and immunisation for which the doctors then received the fees".

In the home situation the nature of the work was also changing and increasing through:

"faster throughput of hospital cases (e.g. hernias, appendectomies) requiring immediate home nursing services for post-operative care"
"More very elderly staying in their own homes when dying"
"fewer hospital beds for the elderly now"

Such changes were seen as requiring adequate liaison with general practitioners, health visitors, home help services, and social workers in particular. PHCT work was seen to require particular skills on the part of the district nurse. One officer summed this up as requiring 'interpersonal skills' since:
"If people are to work in primary health care teams they need to be able to relate to each other".

Working in teams was seen as having had particular implications in terms of efficient utilisation of each person's skills. It was seen as wasteful of professional skills that the district nurse should be expected to hand over certain areas of responsibility to the health visitor.

"The district nurse should be able to deal with 90% of the problems arising in home nursing care cases"

This officer saw the health visitors in her division as having little time to carry out geriatric care, there being a generally young population taking up their concentrated effort. Another officer said that in working together with other carers, the district nurse:

"needs to consider clients as members of family groups from sociological and psychological perspectives. This is very necessary when district nurses are working with health visitors who have this stance at the heart of their work".

The majority of officers considered the primary health care team to include nursing (including health visiting) medical and paramedical service personnel, but one officer had to be prompted a number of times before mentioning the health visitor or the social worker as possibly part of the team situation in the community. Most DNOs therefore saw the district nurse operating in a wider work situation than in previous years.

The Need for Change in Training for District Nursing

Given the context of change in delivery of care, the divisional officers all thought that there had been a need for change in the training and education of district nurses.
"Community nursing is different to any other kind of nursing . . . there was definitely a need for this new training".

"My own training (for district nursing) bears no resemblance to the new training . . . you (as a d.n.) need to keep up with general changes taking place in society . . . community nursing is a very different type of nursing to nursing in hospital . . . it's no good going in and doing a dressing for a patient if the patient is frozen and needs a cup of tea first".

"there was a great need for district nurse training to be updated. I have seen district nurses becoming the 'Cinderella' in the training field".

"the district nurses' role has become extended . . . they are involved now in screening, clinical and family planning and preventative work at health centres or surgery, for such work in a primary health team situation the training needed to reflect such changes".

"statistics indicated (in this division) that the district nursing service was taking on more and more patients while giving less and less nursing care . . . the extended training (new course) came along at about the time when discussions and reviews of caseloads were going on . . . training helps the d.n. set caseload priorities (e.g. not to take on 'bathing of patients') . . . it is intolerable that patients dying at home should not receive the care that is required . . . the development of the d.n. role as reflected in the new syllabus for training is very exciting . . . it has taken into account the changing role of district nursing".

The officers recognised that a general shift towards the nurse (in whatever specialism) being seen to take responsibility for her own actions led towards a professional 'model' to which the district nurse also should aspire:

"They must be able to work independently to take appropriate decisions on nursing care in the home . . . to be actively seen to be practising their profession in their own right".

The new curriculum was seen to be reflecting this emphasis insofar as it led the district nurse toward taking the lead in the community nurse forum, through planning and supervision of patient care
undertaken by other staff such as those RGNs. without training in
district nursing, SENs. and auxiliary staff. But ambiguity over the
role of the district nurse as practical nurse and as manager was also
indicated:

"I see the qualified district nursing sister to be the one
who assesses, plans the utilisation of the rest of the
staff but who is primarily involved with patient care".

"I do not expect the district nurse to be sitting in an
office at the health centre or to be organising the
auxiliaries' work".

"they (district nurses) must be able to work responsibly
and independently and be acceptable in peoples' homes ..
I do not think of her as heading up a team for
organising and planning on a broader front".

Implications of Changes in Training and Education

The district nursing service was perceived generally as being in need
of enhanced status in the community care service. The new training
was succeeding in:

"raising (district nurses') credibility vis-a-vis the
health visitor for example; the training these two groups
now receive is virtually identical . . . except that the
district nurse also has clinical experience. The academic
requirements for district nurses and health visitors are
now virtually identical and, allowing for stand-by and
on-call duty the pay level was similar".

In terms of staff management issues the extended training had had the
effect of not only enhancing the status of the D.N. with 'peer' groups
such as health visitors and social workers but also within the
immediate working team. There were major implications arising from
this for the status of the enrolled nurse and the registered nurses
working in the district.
The majority of officers believed that all personnel nursing in the community, whether registered or enrolled nurses or non-nursing personnel such as auxiliaries, required training to cope with the work. With mandatory training on the horizon for the RGN the officers thought this should be extended to the SENs. This was in order to help motivation and job satisfaction of the SENs. The latter were often 'abused' in that they carried out work they were not trained for due to manpower shortage. Training was necessary for them to protect themselves as well as the patient.

"there is a need to give SENs a rewarding role - through training for example ... this helps keep up standards ... good 'bedside' nurses could be future S.E.Ns. ... there should be a career structure of some kind for SENs".

The enhanced status and therefore focus on the district nurse was perhaps bringing to a head problems within the service regarding distribution of staffing:

"As a general ratio I would want one SEN to three RGNs. This means while one RGN is off duty another can be off (on holiday or sick) while one remains to supervise. There are arguments over this with my senior personnel officer who says we have enough RGNs. ... I feel however that I have inherited a situation where we have not got enough RGNs vis-a-vis SENs".

Change in the training was seen to have other manpower implications particularly for PWTs. These personnel not only took on the district nurse student but were increasingly asked to provide programmes for students taking up the 'community option' during their general training. PWTs. often, therefore, were involved in training students who were not necessarily district nurse students, while trying to cope with their normal workload.

"We never have had enough PWTs in the service generally ... as soon as people (from the divisions) find we are
unable to send our students for training we get 'phone
calls from everywhere to 'borrow' our PWTs'.

"We could do with more training places for PWTs. This
year we were only allowed two for field work teachers
(the health visitor equivalent of the practical work
teacher) and two for PWTs . . . we do not have enough to
go around the students".

The change to district nurse education and training was thought also
to be threatening some PWTs:

"some of them feel threatened by what they see as the
high quality of students coming out now . . . in addition
the P.W.T. is not paid (for teaching activity) and with
staff shortages it means they are extremely overworked
without relief while they have students".

One of the officers appeared to have the situation under control
through past efforts made to ensure enough PWTs received training:

"We have enough trained PWTs and some to spare. It is
possible to allow PWTs to have time off from students at
the discretion of the Nursing Officer . . . We have sent
two district nurses for training as PWTs for each of the
last four years".

The majority, however, said they were short of practical work teachers
and one commented on the problem of getting people to put themselves
forward for training. One of the issues, as mentioned above, was that
the new curriculum was unfamiliar and those trained earlier were
reluctant to take on the 'bright new students'. The lack of monetary
incentive was not seen as a major influence:

"I don't think a training allowance would encourage any
more to come forward for training".

The reluctance was seen to be more to do with the fact that district
nurses were often either 'young and just married or older with teenage
children' and neither group would particularly want to take on extra
responsibilities and might have problems in coping with extra
training:
"single women like me are no longer available to take on this work and the married - who might have more to offer in terms of training others - are reluctant to put themselves forward. Often we are not able to give the PWT support to the extent we would like to give it"

Other major implications were related to the training of part-time staff for training roles, and the training of nursing officers for supervising students in the final three months of the course. Part-time staff often worked part-time due to family commitments and were not in a good position to attend a full-time course. Frequently this applied to night-duty staff who worked nights 'to keep their hand in' and would find it difficult to attend a day-time course. One officer said that ten of the twelve night shift registered nurses were untrained. Another that their 'minimal twilight' service is staffed by untrained staff, while a few of the thirty-hour a week staff had been trained on the new course. Most of the officers had the development of night services as a priority, so that mandatory training was arriving at a difficult time while services were still being built up with scarce resources and sometimes against opposition of day-time staff:

"One of my main problems at the moment is how to train the evening staff. This night service has been going for a year in this division . . . This coincided with the reduced working week (down to 37½ hours) when we needed five extra staff to make up the establishment. I wanted a good night service . . . not just a skeleton staff . . . it was quite a struggle to encourage a small number of militant nurses that it would be better to employ these staff in the night service rather than put them into the day service. The night service has nine RGNs, two SENs, . . . all but one of these need training (in district nursing)".
Selection of Staff for Training

As with most courses designed to cater for post-basic education, the district nurse courses will predictably have a high success rate in terms of personnel qualifying at the end stage. From the 1980/81 course, all students who took the National examination in the Spring of 1981 passed it, while one candidate failed the internally set examination. The designated changeover to internally set examinations by 1984 might be expected to result in increasing differences between individual training centres around the country. A study of health visitor training centres' decentralised examination system, for example, showed that individuals might well have achieved 'better' results in one centre while failing to do so in another in view of differing degrees of expectations from centres and the degree of difficulty of examinations set (Fader, 1977).

The selection end of the training system in such post-basic education is consequently important given that the ultimate 'end' of the training is individual competence to practice and the capacity to evaluate care given. The alternative is counselling out of the services at later stages resulting in loss of resources invested.

The evidence from the Surrey evaluation indicated that the selection system appears to work reasonably well. The university set its own selection procedure requiring two short essays from all candidates regardless of their academic background and the results of this entrance procedure correlated consistently with students' subsequent performance (see Jarvis and Gibson, 1980). The interesting issue is
whether there is consistency in what is being sought during the recruitment and selection stages at the training centre and in the district. The divisional nursing officers in Surrey considered that they had an important role in the selection of nurses for training as district nurses. There are written guidelines regarding selection criteria between the university and the community. These on the whole appeared to have reduced inconsistency in the selection of people for training.

"I feel that the Division and the University are following similar criteria. Sometimes I'll send someone I am not sure about for an interview and not be too surprised if the University refuses them".

"I try to counsel any unsuitable (e.g. those unable to work co-operatively) people out of the service if possible . . . I wouldn't want to keep putting unsuitable people forward for training".

Some divisional nursing officers, despite written criteria, expressed doubts over the way selection was organised:

"We are looking for something quite different in the service compared with the (university) tutorial staff. The university is looking more at academic background and professional expertise. From the service side we are looking at nursing background. We tend to assume that they can make the grade academically as they have already to have got SRN to get this far. Nursing experience is primary and the personality of the nurse plays a big part - they mustn't be too dogmatic and must be able to fit in with the team or group you have in mind for them".

and

"I don't find it too difficult to place people for training. Sometimes (other centres) will take those Surrey rejects and vice versa. The entrance procedures could be rethought. The centres appear to be looking for different things".

or
"I can think of three that have been trained from the Division who then decided they didn't like district nursing".

So from the cost benefit side alone it seems essential that selection procedures are rationalised. This may well be an extremely difficult exercise. In the first place one would want to select those who are likely to stay in district nursing. To partially predict this outcome, the potential student would need experience of the district. But, once training became mandatory for practise, the opportunity for such experience will become progressively less likely. An initiation period prior to secondment for training would appear desirable. Appointment at staff grade (though disliked by many in the service) for a limited period prior to training might serve to limit wastage from the service after training. This period would need to be accompanied by adequate counselling by managers.

In the second place, if the service side is giving greater consideration to practical skill and attitude of candidate than the educational institutions, they may well have to be prepared to put more people forward than at present and risk failure of selection at the education centres.

"I believe in encouraging people who come forward of their own volition rather than the paper chasers".

From this manager's viewpoint, those wanting to be in district nursing are 'the best bet in training terms'. This element of self-selection was also seen as advisable for those coming forward for practical work teacher training though, as was shown in an earlier chapter, district nurses sometimes thought they were being pressed into
training by managers in order to keep up the supply of PWTs. The resolution of selection criteria will need to balance service needs in terms of quantity and quality of nursing care. A potential for academic achievement in terms of passing examinations may be usefully predicted from the entrance qualification of a minimum of five 'O' levels at present being put forward for the future. But on the evidence of the evaluation of Surrey course results (for a course which requires not merely specific outcomes in terms of knowledge and skill but also more intangible outcomes of attitude change and greater autonomy of the individual) such formal educational qualifications are not necessarily adequate selection criteria. It might therefore be desirable for the alternative selection procedures at present in use to be developed and standardised.

The Changing Role of Management

At the time of interviewing the divisional nursing officers were plunging into the re-organisation of the N.H.S. and interviews for posts in new staffing structures were imminent due to the removal of the Area health tier. Devolution of responsibility from area to district was well under way and in these circumstances it was not surprising that the officers were experiencing mixed feelings of curiosity, enthusiasm, insecurity and uncertainty over their futures.

The role of the community divisional nursing officer was regarded as having developed and changed particularly over the past five years involving personnel in reassessment of priorities of care in the community and the active promotion of district nursing services. The
latter were seen as having been generally under-funded in the past in terms of staffing policy and education and training. Re-structuring into the proposed new 'management units' was seen as likely to alter their roles further. In future, divisional nursing officers would be working alongside administrators and medical personnel as well as nurses. One officer described what this would mean for her:

"From next year the day-to-day running of the service will pass out of my hands. In a management unit you will need the time to sit and fight for your rights with the medical and administrative staff. You will have to say what you want and need to be seen to mean business by the others . . . particularly administrators . . . We have got to learn to work as a team and not just as a nursing team".

Another pointed to a future need for:

"training of the management units which will be coming into existence . . . so that all people involved in these would train together. The sort of thing I'm in need of is learning how to manage for change".

This last speaker had 'sent herself' on a number of courses during her time as a divisional nursing officer studying consensus management, computing and statistics in order to keep abreast and even ahead of developments. Other managers said that there was no specific training for their job. It was something 'you learned as you went along' and it was up to the individual to recognise their own training needs and find ways of meeting them. Changes in budgeting responsibility was seen as creating future expansion of the traditional role of the divisional officer. Budgets had already devolved to the seven districts from the Area Health Authority. Variation was already apparent in the way this was being achieved and consequently affecting the divisional nursing officer. All had staffing budgets and five of the seven had responsibility for training budgets. In two
cases directors of nurse education continued to hold the training budget. Disquiet was expressed at this state of affairs since there would be no-one directly involved with district nursing as well as responsible for district nurse training.

These divisional nursing officers were closely involved in the recruitment and selection of personnel for district nurse training. Following this stage they tended to delegate all day-to-day management of students on courses to nursing officers, but three of the managers were regularly involved in giving lectures to students and others on their nursing specialities or aspects of the role of divisional nursing officers. They visited the university at least once a year to review progress of students and the course and were satisfied with their contact with the course personnel. With mandatory training those located in areas furthest away from the teaching centre saw themselves having greater choice for student placement; though here these opportunities were seen as difficult to take in practice because, if a student was refused for Surrey, it was often too late to try for a place elsewhere. Perhaps districts and the centres in such multi-centre areas could some sort of clearing system to ameliorate this state of affairs.

The community divisional nursing officers' role will continue to change in response to demands being made on them and training and education of district nurses is an integral part of their responsibilities. On a broader level one manager summed up the main functions of her role as:
"Controlling, co-ordinating and spear-heading the service ... in two directions: firstly the service to patients and secondly to staff".

In discussing the skills, knowledge and attitudes towards her role she added that she should have:

"a democratic approach, be critical and analytical, show foresight. I must be able to budget and this is linked in my mind with the setting of standards of care and monitoring. We all think we are setting a standard of care. This goes for the nursing officers and sisters. But I feel that the decisions that I make, for example on staffing policy, affect the standards of care all the way down the line".

SUMMARY AND DISCUSSION

For more than a decade key issues in health and personal social services have been community care (DHSS, 1981a), joint planning for and collaboration between, services (DHSS, 1981b) and prevention (DHSS, 1976, 1977). Priorities for the health and personal social services have been placed on vulnerable groups: the elderly, the mentally ill and mentally handicapped and children. In the context of this study quotations from just two of many documents addressing these issues, serve to suggest some of the reasons why district nurse training, education and practice will continue to remain of importance:

"Effective community care provision requires an input from various sources of care. This reinforces the importance of collaboration between health and social services and of the relationships with the support networks and resources located in the informal and voluntary sectors". (DHSS, 1981, p. 46)

And in discussing the difficulties faced by the informal carers caring for the elderly in the community a recent research report states:

"Quite clearly the services most appreciated by these carers were those of the home help and the district nurse. Indeed the community nurse emerged as the lynchpin in community care, often initiating and informing relatives of other services" ... "Community care hinges
on a complex network of formal and informal support systems... it would appear from the foregoing that, for the most part, co-ordination of service rests, by default, on the shoulders of the community (district) nurse". (Wade, Sawyer, Bell, 1982, pp. 306-7)

Both these reports were concerned with care provisions for the elderly and these form the bulk of the district nurse's workload. With the trend away from long term hospitalisation towards day care hospital and maintenance of patients and clients in their own environment, the demand of the district nurse can be expected to grow for the foreseeable future, particularly in relation to the elderly who form their major client group.

In this and the previous chapter I have presented data obtained from those groups of district nurse practitioners and managers working in the community contexts where the 1980/81 cohort of students undertook their practical placements. Common themes can be drawn from the findings. There was seen to be a wide variation in both the planning for, and the reported experiences of, the students during the early part of their course when with their PWTs and during their twelve week period of supervision by the nursing officers. For those involved in teaching or supervising students, lack of experience in teaching and supervision and lack of knowledge of the changed curriculum were seen to contribute to PWTs and nursing officers' anxieties and this was expressed in a desire for training and preparation for these roles. The changes in the curriculum had brought nursing officers in particular into a formal supervisory role with district nurse students for the first time. Training in identification of students' individual requirements and assessment can
be highlighted as the areas for emphasis in any such courses and 

skills in counselling and interpersonal relationships a major 

requirement.

Managers as well as practitioners highlighted changes occurring over 
time in the provision of community nursing services and the majority 
said there had been a need for comparable changes in the training and 
education of district nurses in order that this group could contribute 
fully to the service and cope with their jobs. The new course of 
training for district nurses was generally seen as necessary to 

enhance both the education and status of district nurses in 

recognition of the growing complexity of their vital role in primary 

health care.

Change in the curriculum in its outcome for students was also regarded 
as proactive by fostering changes in approach to nursing care which 
went beyond the students' own personal experiences to their colleagues 
and future working contacts. Education and nursing care were not 
therefore seen as static concepts and this is returned to in the 
concluding chapters. A conclusion to be drawn at this point is that 
the changes in district nursing education and practice appeared to 
have helped generate a situation where many practitioners, managers, 
tutors, students and others involved in district nursing are ready to 
reflect on their practice and search for the means to ensure the 

continuing development of the profession.
A number of specific issues were identified as arising, or likely to arise, as a result of changes in training and the fact that it was to become mandatory for practice as a district nurse. Among these was the issue of raised expectations among students newly off the course coming back into the community: changes in practice in a context of finite resources and established staff and routines could not happen overnight and students did not always find this easy to accept. A further issue was that the longer full-time course, being more costly when based in higher education establishments, had implications for the training of other groups in the district and allocation of resources. Management of such changes alongside other developments—such as 24-hour nursing or twilight cover services—were major issues among the district nursing officers spoken to. The enhanced training of district nurses by implication could be seen as leading towards enhanced status and changes in the relative balance of staffing in the community. The SENs and RGNs working in the district could find their work more restricted and feel threatened by change resulting in poor job satisfaction and low morale. A number of managers saw the need for careful counselling and support for such staff.

In the absence of imposed requirements for continuing professional development—such as exist in the United States if nurses wish to retain their licenses to practice—the future of the service might be seen to depend on each individual reflecting on their actions. The problem-solving approach of nursing process fostered in the new curriculum may go some way towards equipping district nurses with the
capacity for the evaluation of their practice and their role. The problems associated with nursing process in district nursing care are considered in the final chapter. Findings above show that at nurse management level in particular that it was largely left to the individuals involved to first identify their own training needs and then seek ways of meeting these; this is not a simple matter because, even if there were readily available training opportunities, the earlier comments from students showed them to be struggling to identify their needs where there was insufficient guidance and feedback. The same might be assumed to apply at any level of employment. The move towards regular appraisal of staff discerned as developing at the higher management level could contribute to the development of such analytical skills and help provide a supportive structure for all staff in the community.
INTRODUCTION

In this chapter I discuss some of the outcomes from the students' experience of the curriculum during their nine month total course in the light of information collected subsequently when they had entered a working situation. The former students were traced and approached for interview (Appendix 8) approximately six months after the end of their supervised practice period. Twenty-four of the original twenty-eight were interviewed (one refused, one had moved abroad and time restrictions meant the remaining two were not contacted), one of these was not and had not been employed since the course ended and for this reason is not included in results relating to work as a district nurse.

The broad question being addressed here is how far could the new curriculum be seen to be meeting the needs of the district nurse? To answer this question it seemed necessary to explore the new district nurses' working statuses and working environments and how they reflected on their experience of actual practice when compared with their preparation for practice. The chapter is divided into sections covering work status and environment, management of patient care, contacts and liaison with others, reflections on the course, future aspirations and a summary.
WORK STATUS AND GENERAL ENVIRONMENT

Twenty of the twenty-three district nurses were employed full-time (seventeen as 'attached' to general practices, three working in a relief capacity) and the remaining three working as part-time relief staff. Eight were based at health centres, ten at individual doctor's practices while five said they had no permanent base. One was combining district nursing and midwifery duties. The majority, therefore, were working as district nurses attached to particular groups of general practitioners.

Premises varied greatly from the health centres which were mainly modern, with facilities perceived as adequate (e.g. including nurses' room and treatment room), to GP practices based in old or poorly converted houses. Six nurses considered that the facilities provided were inadequate allowing very little privacy. The physical environmental features influenced the nurses' perception of their work and the nature of their activities. For example, one full-timer worked to three separate practices in a widespread rural area. She felt 'very isolated' seeing few nursing staff and drew a contrast with her previous experience based in a larger town practice where 'communication was very good ... for sharing problems'. Another said that the purpose built practice with two GPs to which she was attached had 'marvellous' facilities; these included a large room divided by a moveable partition for herself and an attached health visitor; the arrangements and proximity of other staff had enabled joint activities between the district nurses and health visitor such as presentation of films and talks for patients/clients.
MANAGING PATIENT CARE

Caseloads and Work Activities

The district nurses estimated that seventy-five per cent or more of their patients were over the age of sixty living in their own homes, with there being a high proportion of females (except for the male district nurse who saw largely males, this being 'policy' in his area - though he had managed to retain visits to one female following the death of her spouse). The records kept by nurses in one district for the role study mentioned earlier showed that nearly 90% of patients visited at home were over 60, with 71% over 70 and 5% over 90.

Changes in patterns of hospital treatment (such as increasing short-stays leading to early discharge in the case of, for example, hernia cases) appeared to be a relatively small part of the case load for the former students - around four cases a month being mentioned by half the students and fewer among the rest. Again, however, the locality in which the nurse worked was a factor here as one, working with patients in the vicinity of two large hospitals, said she was kept 'very busy' with early discharge or day cases.

Twelve nurses said they carried out clinical work regularly at their practice bases. The district nurse/midwife carried out a three hour ante-natal clinic each week. There was a wide range of time spent in these activities, from half-an-hour to twelve hours per week, with five hours a week on average. It was found also that, where there was a practice nurse employed by the GP, the attached district nurse concentrated on home visits to patients.
Management of Care in the Primary Health Care Context

Findings from the earlier stage of the study (especially Chapter 4) showed that management and administrative functions were main areas where students had perceived a necessarily limited opportunity during the lifetime of the university directed course (first six months), due to the absence of responsibility for a caseload of their own. The supervised practice period provided some, but this again was not always perceived as sufficient, opportunity to practise management and administration of other staff and/or work and caseloads. Differences in approach to supervision was a contributory factor; only four of the nursing officers, for example, had prioritised support for students in implementing nursing process which, as well as being the core of the curriculum, was also the major means of assessing, planning and evaluating care given. It could therefore be interpreted as a strategy for management. (I have already pointed - Chapter 5 - to the problems encountered by students over nursing process during their earlier practical work experience).

The way in which the new district nurses face the 'reality shock' of the established working context they enter (see McClymont, 1980, p30; Kramer, 1974) can tell us something about the nature of the longer term impact of the course, and perhaps point also to means for alleviating pressures and problems as the new professional adapts to her role.

Beginning with nursing process nearly all said that they were implementing this, but only four of the twenty-three were doing so for
most of their patients. A majority of the nurses (sixteen) said that they carried through nursing process for around half their patients. The students' opinion of nursing process at the end of their supervised practice (Questions 7 and 8, Appendix 4) had indicated that whilst two-thirds believed nursing process to be 'useful', over a half experienced it to be 'difficult' though almost a half also believed it to have 'practical' utility with a further five of the twenty-six students believing it to be equally 'practical' and 'academic'. At that point in time only two students thought that they had not grasped the nursing process satisfactorily. Exploring this area with former students suggests that some difficulties in implementation were said to be due to poor access to adequate forms; around a third did not have easy access to documentation suitable for extended records. A further main problem was the time-consuming nature of the process when dealing with, for example, either known, or expected to be, short-term patients; in this they echo the views found among PWTs.

Their evidence and moderate enthusiasm suggests, however, that the course had been largely successful in inculcating a different way of approaching care which was seen by the majority to be worth trying to establish through implementing nursing process in practice. A number thought that continued practise would reduce the time they currently took to firstly set aims and objectives and then to satisfactorily document patient care given. On the whole, therefore, they appeared prepared to find the time to carry out more detailed documentation of patient assessment and the care plan, implementation and evaluation, believing that it would become easier to cope with eventually.
Issues about the conceptualisation of nursing process at a deeper level were suggested by the fact that the majority of students said that they carried out a 'partial' form of process in which the care plan might be a minimal record, or where assessment was still being done 'in my head' and not recorded except for a few key facts. In these circumstances the questions remain those about the theoretical notions which underpin nursing action and are the very same issues which which nursing process has sought to address. The findings on nursing process are thus ambiguous and, as this is a central aspect of the curriculum, I explore it in depth in Chapter Nine.

Their response to questions on leadership and the nursing team showed that over half (thirteen of the twenty-five) thought these questions were not applicable to them in their present situation. Their reaction to this circumstance varied from depression that they had no-one to relate to in their work situation to confidence that regardless of their present situation, the course had given them a foundation of requisite ideas and skills to delegate work efficiently given the opportunity in the future. From those who saw themselves in situations of potential leadership there came observations on having to think about how they would deal with existing staff in order to arrive at a co-ordinating position. One district nurse raised the problem of a well-established district nurse who was part-time, came into their workbase only half a day each week and who persistently ignored approaches made by the new district nurse toward teamwork.
Another aspect of the concept of management, therefore, in the context of primary health care teamwork, is that it involves taking responsibility for nursing care decisions and there was a general determination among this group of district nurses to insist on doing so in the face of ignorance or obstruction by 'others'. As I indicated above 'others' could include other district nurses and established nursing staff. The district nurses showed awareness that an educative function with other staff could be, or should be, part of their role in this respect and a few had, for example, given talks about their education and training to their fellow nurses, auxiliaries and general practitioners.

Other 'others' requiring information/education could include those from different professional groups, particularly general practitioners and health visitors, these being perceived as the two main contact groups outside district nursing for district nurses (see Battle, Moran-Ellis, 1985, and Chapter 4 in this study).

Two of the respondents thought the general practitioners with whom they worked attempted to dictate nursing care suggesting that 'they can't help themselves, can they?' Others thought that misunderstandings and overlap of care - particularly that arising between health visitors and themselves - was symptomatic of a lack of understanding of the 'new' district nursing role as well as related to the structural position they held within the general practices. For example, the relief workers found it more difficult to avoid overlap due to general lack of access to continuous information regarding
patients they worked with; they sometimes found they were spending
time on activity which was duplicating that either undertaken by the
regular member of staff they were relieving or which was being taken
care of by a health visitor. This was seen as being avoided through
accurate records on patients' home notes to some extent but not
entirely avoidable unless all related staff working with the same
patient were actually collaborating in keeping those records; the
location and security of different personnel's confidential patient
notes is also an important consideration here.

Decision-making about care involves making judgements about
appropriate action; about allocation and monitoring of work to
subordinate staff where these exist, about discharge of patients from
the case-load and prioritising care, for example. These types of
decisions may conflict with others' perception of what is needed
including those of patients. One of the district nurses suggested
that the problem she experienced when relieving for another district
nurse's caseload (on days off) was that in her judgement some of the
patients she was visiting in this capacity no longer required clinical
nursing care. In nursing care she included the totality of patient
care involving counselling, support and education, but above all,
clinical care. If the latter was no longer necessary, then in her view
referral of the patient to the health visitor and/or social worker was
an appropriate decision. Such decisions could not, she believed, be
made by her in her relief capacity to the regular case-holder.
Others in this position believed that if they did not continue to visit a patient - more for counselling and support than for clinical reasons - then no-one else would:

"the health visitor only visits every three months"

"when it comes to the elderly I go in to visit myself. You could say you won't do it any more but it is the patient who suffers. I just get on and do it".

Another district nurse working in a full-time capacity had begun working closely with a health visitor (newly appointed for geriatric services) to avoid overlap and conserve their resources; the problem arising was avoidance of overlap with social service personnel particularly in instances where the patient/client had been assessed by a social worker and was going into a home for a short period to provide relief for his or her family carers. On the whole decisions about referrals were seen as non-problematic in the sense that the new district nurses recognised when to make referrals; the problems arose more often because it was thought that such referral would not be effective; the moral dilemmas therefore remained.

CONTACTS, LIAISON, TEAMWORK.

At an earlier stage in the study (see Chapter 4) the concept of the primary health care team was explored and in practice this was perceived by the majority of students to normally include other district nursing services, the general practitioner and the health visitor. To check this perception the new district nurses' patterns of contact and liaison with others for work purposes was explored during the follow-up. They were asked again to place the originally offered list of personnel in rank order according to the frequency they saw
them for work purposes. The response indicated that face-to-face communication was a function of opportunity offered by the existence of, and proximity of staff.

General practitioners were mentioned by all but two of the nurses, these two not perceiving themselves as 'attached' to a practice and working largely through the telephone. Where, however, other district nurses worked in the same practices then these were seen most often (i.e. more often than the GP) and eighteen nurses gave this response. Similarly, where SEBs formed part of the nursing team they were seen very frequently, but only six district nurses said that this was the case. Nursing auxiliaries and health visitors were seen less often than other district nurses but were mentioned by a majority of the nurses (seventeen and nineteen respectively). Few other health or social service personnel were mentioned as being seen at all regularly.

Where they worked from a particular base with other nurse personnel the usual pattern of contact was a daily meeting either early in the morning or just before a lunch break. Eleven of the district nurses said they had such daily meetings, three said meetings occurred twice a week, three once a week, two said once a month and four said they had no such meetings. 'Meetings' here are those defined as the more formal, established occasions when discussions and/or delegations of work regarding patients occurred, and those with few meetings included those working in relief capacities and the one in her isolated, rural attachment. In addition to such meetings, informal contacts occurred
where other nurse personnel or professionals worked together in a practice. Auxiliaries were seen face-to-face less often - around once a week or a fortnight - contact being made by telephone if necessary and supervisory visits made on a monthly basis. Auxiliaries, where they were part of the district nurses' team tended to be shared between practices working to two or three RGNs. The RGNs would meet and allocate work on a fair basis between themselves, and inform the auxiliaries of any changes occurring in baths required or new patients to be visited. SENs, where they worked to district nurses, were usually included in regular meetings.

Eleven of the former students said they had regular meetings with GPs (again meeting here is defined as a well-established procedure) for purposes of discussing patients. Six said they had weekly meetings, and five had daily meetings for these purposes. These meetings usually included all GPs and nurse personnel in the practice or health centre.

The twelve not having such regular meetings saw doctors when necessary and some doctors were said to be more available and willing than others to discuss patient needs and treatment. Again in the case of relief workers, personal contact with doctors was more limited or non-existent. Apart from these meetings with nurse personnel and doctors, the district nurses - with the exception of the three who said they had no nursing officer at that time - attended the monthly meetings of all nurse personnel for information on local policy and other significant matters arising elsewhere. In two cases such
meetings were held every two months, but in addition three saw their nursing officers weekly, and one saw hers three times a week at lunchtimes when he attended the base in the nurses' home and made himself generally available for discussion and involvement with all personnel. This officer was also available in between times by means of a 'bleeper' communication system.

From this it can be concluded that liaison for work purposes occurs at a number of different levels. The most established regular meetings occur between staff internal to delivery of the district nursing services, the next most regular liaison is with the general practitioners, followed by regular meetings with line managers for the district nursing services. Taken together with the previous discussions, it is possible to draw further conclusions. Factors such as the existence and proximity of other staff, the general work environment, the employment status (attached/not attached/full-time, relief etc.) of the district nurse, and the interpersonal relationships and patterns of working among already established personnel are all potential influences on the way in which the new district nurses implement their education and training in practice, and have implications for the way in which district nurses are able to manage care.

The concept of multidisciplinary teamwork - apart from with general practitioners - was more of a myth than a reality for these new district nurses. In addition it can be noted that they did not mention or include informal carers or the patient when the issue of
primary health care was discussed. This may be due to the list of personnel offered, though the respondents were asked to mention any others not on the list that they would want to include as part of the team.

REFLECTIONS ON THE COURSE

Methods and Content

Findings from the follow-up of the 80/81 student group highlight in the longer term the response to methods utilised on the course. In Chapter Three I discussed students' opinions of particular methods of teaching utilised by course tutors and others during the university based part of the course. The personalities and attributes of individual tutors and lecturers were seen to be influential factors in the students' perception of the value of content and outcome.

The follow-up showed that some of the least liked (at first) and least familiar methods of teaching and learning at that earlier time had in retrospect become the most favoured. Group work involving small numbers of students, was remembered for its having resulted in 'things sticking in the mind' whilst the experience of role play, traumatic at the time, was seen as useful in mirroring the types of participation and response they could now be expected to enact with patients, peers and others. Similarly, the 'peer group' exercise, which around half the students had carried through during their supervised practice period was thought to be valuable. (This was an optional exercise involving pairs of students teaming up during patient visits: each would take the part of observer and practitioner and exchange
explanation and comment on practice). Here the necessity to articulate reasons for action and observation was seen to 'pull you up' and 'make you think' about what you were doing. Learning to assess, explain and reassess their own and others' performance in a supportive environment was therefore seen as a valuable foundation for further professional development.

One aspect of course methods which did not receive much attention was the opportunity provided in the University for shared learning with other students - other than district nurse students - who will eventually work in the community. The reason for the lack of information on this is that so little occurred. Where it did occur the students held mixed views on its value. The session organised with health visitors was generally not seen as leading to much in the way of shared understanding at either a personal or professional level since 'they sat one side, we sat the other' and 'it was like two separate groups, really'. The district nurses were of the opinion that such opportunities were necessary if they were to build up an understanding of other people's roles and communicate their own role and function. This type of activity was seen to have potential for breaking down professional barriers and myths about what each person was trying to do in their work. They saw it as a way of improving communication and co-operation and would have liked more sessions of this sort with health visitors, social workers and trainee general practitioners.
The problems of actually organising shared learning are obviously reduced if other personnel are trained in the same department as district nurses. The potential benefits occurring from the better understanding of others with whom they may soon be working are worth the persistent effort. It is of interest to note that the 1984 survey of institutions training and educating district nurses (Lopez and Radford, 1984) showed the majority of centres involved had joint teaching activities most often with health visitors but also involving social work and general practitioner trainees.

As another way of identifying possible gaps in the course I asked former students to state their present or future training needs - I was particularly interested in the areas of advisory, education and/or counselling functions with patients and carers. The majority of former students saw counselling activities as a major or large part of their role and over half expressed a wish for further training; a minority (four) did not see counselling as a large part of their job. In probing this area with those who said counselling was a major area of their work, nearly half of the group said the areas they were most often involved in, in an advisory capacity, were counselling terminally ill patients and advising and educating relatives or other carers of patients. General health education functions were mentioned by over half the group. Around a quarter mentioned different specific areas such as diet, safety, diabetes, social problems, hypothermia and smoking whilst the district nurse/midwife spent a large amount of her time with mothers on 'counselling and advice for mothering'. The type of training need identified was therefore reflecting the type of
caseload that the district nurses were carrying: largely the very elderly frail. The training they felt they needed was for specific skills in counselling techniques.

The former students recalled many aspects of course 'theory' as being useful. Specific mention of medical lectures were made by a quarter (six) of them, but interestingly seven also said that these were the least useful parts of the course. The explanation for this split seemed to be that the content and presentation was 'over our heads', and this particularly was so for pharmacology lectures; however, those mentioning medical lectures as useful were all referring to one presenter who spoke about venous ulcers - this was seen as very relevant to district nursing work and appreciated highly.

A quarter of the district nurses had found work on nursing process useful, particularly aspects of assessment and planning. One said that she was better able to plan work allocation for colleagues and was using a teaching plan with a student SEN and a new auxiliary; no-one specifically mentioned evaluation of care. Their evaluation of the teaching of nursing process highlighted two general issues. One was that process was generally perceived as four separate stages having been taught in that way. Students commented:

"we did it in four bits, spread out over the course, they could have put it together sooner ... it took me a long time to consolidate it all"

and

"The teaching was done well, there was enough on the four different parts but the difficulty comes in putting it
into practice in the field . . . evaluation is the most difficult".

Another general issue was that some students appeared to be applying the formats they had come to associate with nursing process in an uncritical manner. Several, for example, said that as regards patient history (assessment) either the patient did not like giving details (especially of finance) or they themselves did not like asking such questions; five students said they found this the most difficult part of the process. More students, eight in all, said that planning care was the most problematic and this view was related to their perception of its time consuming nature; one found writing down nursing action difficult and three found evaluation of outcomes difficult due to problems associated with planning. Only one mentioned using care plans specifically to help patients see what they were achieving, another had taken up a patient's suggestion that she use different colour pens and a third said care plans in the home 'were being used like message cards by others'. The issue of nursing process in a broader context is taken up in Chapter Nine.

Two had found some aspects of 'principles and practice' of district nursing not very useful or boring; 'early on talk about the district nurse role went on and on and on until I switched off'. No-one mentioned first aid as useful whilst four found this not very useful due to 'too little in the early part of the course' and 'taking up too much time in the course'.
Sociology and social administration were mentioned as 'very useful', 'of very high order' by a quarter of the former students - this had often been an 'unexpected' reaction - for helping in understanding why people reacted in particular ways or for dealing with people generally. Psychology received one positive mention and four negatives and this appeared to be related to their perception of the low level content - 'too surface', 'insufficient content' or 'not very well done' - rather than the subject being seen as irrelevant. Social service benefits and related resource and facility information was said to be most useful by four of the former students. One, however, said this was not very useful and the reason given was that, having practised for a year in the community, in a situation where there was relatively close proximity between social workers and nursing staff, she had sufficient knowledge and information already.

It is difficult to draw firm conclusions from this type of breakdown. A number of students, for example, said that 'all' of the course was useful 'now', even when 'at the time' they had thought 'none' of it was; a few also said it was difficult to recall specific aspects of the academic parts of the course or that they had tended or tried to 'forget' things that appeared 'useless' at the time.

The response does seem to show, however, that students and practitioners respond in individual ways and that there are a number of influences on this response. One group of influences stem from existing states of knowledge and experience which helps them assess the relevance of the content of the course; where this 'content' is too
far outside their frames of reference (as appeared to be the case with medically based lectures), they found it difficult to associate the content with district nursing practice. The medical lecture on venous ulcers was an exceptional case and its acceptance was due to it being seen as very practically relevant to the work of the district nurse. It could be added that 'interest' in subject matter had been generated by the presentation and style of the lecturer or tutor; here the students appeared to recall most positively those lecturers perceived as having well-organised material, clear presentation and enthusiasm. (This is similar to findings from studies such as Cohen et al, 1973, and Hildebrand, 1973, and see also Chapter 4 for earlier discussion of course method and content).

INNOVATIONS AND ASPIRATIONS

To gauge how far the new curriculum could be seen to be influential as a change agent rather than as a response to already perceived change, the former students were asked about any new initiatives they had taken or would want to take since taking up their posts, and what their views were on their future nursing careers. (The expected initiative - nursing process - has been previously highlighted). Taken together such initiatives could allow some judgement to be made of the students' level of motivation. Two students showed signs of settling down and being happy as they were, but the remainder had either succeeded in some fresh initiative or were considering something.
The range of interesting initiatives was wide, with a quarter of the students wanting to start screening the elderly, particularly blood pressure and urine checks and capability assessments. Four students had initiated new procedures for staff meetings, one being for the purpose of exchanging views on counselling, while the others were general practice meetings for nursing, medical and allied staff. Two had begun work on age and sex registers and another had already remodelled the practice's filing system for patients.

A quarter of the students wanted to increase their understanding of, and provide better care for, the terminally ill, and one was about to begin a course on this. One was working with a group of nurses to develop an assessment/dependency scale for use with the elderly. Another was hoping to start an obesity clinic. One student had initiated a self-help group for mothers of two handicapped children in her patch which was about to become a support group on a national scale; this nurse had also started a local district nurse association meeting every two months, was giving lectures about her work and had begun a system of systematic documentation of work carried out in the treatment room. These initiatives provided a generally encouraging prospect of enthusiastic district nurses committed to active participation in organisation of, and delivery of nursing care.

What of their future aspirations in district nursing? Four students thought they would like to go into health visiting and by doing so concentrate on advisory work. These, therefore, and another five students, said that they were unsure whether they wanted to be PWTs.
The students shying away from teaching (apart from those uncertain about their future career) gave reasons which reflected the views of PWTs in this study. These were that there was little incentive in terms of payment, recognition, or help with workload, when students were with practical teachers. A PWT's qualification was thought to be potentially useful in career terms if a move into higher management was wanted. Most of the district nurses, however, wanted to stay in a situation where they were involved in giving district nursing care to patients. Eight of the twenty-three were actively looking forward to becoming PWTs in the future; one had already made enquiries about this and had 'been rudely shouted down' due to the fact, she believed, that only full-time case carrying nurses are considered suitable for this role and she was part-time. The outcome of the course here was again encouraging in that the majority of those trained were keen to pass on to others the benefits of their training and education in order to help maintain high standards of care in district nursing.

Whilst there were problems arising for the former students in carrying out some of the role prescriptions encouraged through the course, it was noted earlier that the former students still felt generally capable of doing so at some future point. Thus, knowledge of team leadership had taken hold so that even where it did not apply:

"This is difficult it doesn't really apply now . . . I realised I wouldn't be going into an ideal team situation. But the course brought out the idea of delegation and I would feel quite competent if I was in a position where I had to manage a team",

they recognised the potential of this role:

"The course helped me realise the extent of the role. I don't let things go over the top of me as I used to. I
feel a bit anti sometimes about how it is here... it's supposed to be a team but I am having to work to a part-timer (trained district nurse) who's been here forever, only comes half a day a week. I'll have to take over soon... It can't go on much longer".

The course might be seen from these speakers as at least having indicated the possibilities of the district nurse role in terms of management but the gap between learning and practice can be depressing for the enthusiastic:

"It's very disappointing. All I manage is my own caseload. If no-one is willing to communicate I can't do anything".

In this sense the course, seen as an initiation into new knowledge, can be seen as injecting fresh ideas into the community through the trainees and, if they keep their enthusiasm for change and keep trying to achieve their 'ideal' standards of care then the barriers they are encountering may crumble. Among those who believed they had established themselves there was a strong impression that 'making haste slowly' would eventually work to overcome any lack of awareness of their capabilities and function which existed. Generally these nurses were determined that their expertise would be recognised and were making efforts to ensure this in cases where their role and responsibilities were misunderstood.

SUMMARY AND CONCLUSIONS

Findings suggest that overall the new curriculum, as experienced by the 1980/81 cohort of students, had been relatively successful in instilling confidence in the students which carried through into the work situation. Confidence was exhibited in the manner in which the new district nurses thought themselves capable for a nursing
management role in primary health care even in situations where there was a relative absence of other nursing staff and a general paucity of contact with other service personnel. Nursing process with its requirement for evaluation of objectives in nursing care was partially accepted as a way forward for many, if not all, of the new district nurses but problems appeared to remain over articulating theory and practice.

A determination to exert the influence of their perception of the new images of district nursing could be discerned. Here the new district nurses can be seen as innovators and to this end a variety of initiatives had been taken from starting self-help groups to promoting health education, beginning age-sex registers in practices to a variety of screening and other activities. Furthermore, the new district nurses expressed training and support needs which of itself suggests the reflective approach necessary for evaluating practice, and for enabling the continuing development of themselves as professionals.

Factors influencing the establishment of a district nurse's role were found in the environmental context in which the nurse worked. These included physical space and the availability and proximity of personnel - this influenced liaison patterns, for example. Another influential factor circumscribing role was the defined position of the district nurse: as full-time 'attached' or as 'relief', for example, or as subordinate or not to other more established staff holding district nursing roles, or as dual-role capacity district nurse-midwife. Among
other factors influencing behaviour in the role of the district nurse were local policy decisions (such as that which curtailed the caseloads of male district nurses to males), or where there was a perceived lack of management direction or support for implementing changes in documenting care.

There were, therefore, discrepancies and discontinuities to be found between what the district nurses as students expected to be able to achieve as a result of their training and education and what they were actually able to do in their world of working reality. Further research would be useful to identify more clearly these discrepancies and to explore their significance for the individuals concerned and the ways in which they cope with these. As a contribution to this area, I highlight in the next chapter features of role analysis when applied to the findings because this is one form of 'middle range' theory which appears to be useful.

The findings suggest, however, that detailed case-studies of individuals are necessary because a major aspect of the district nurse role is carried out with the patients in their own homes, and secondly that these patients are from a largely very elderly, sick population. This raises issues of patient dependency and vulnerability in situations where the nature of the relationship between patient and nurse is crucial. It also raises questions about the 'content' of the curriculum - could it perhaps be organised around themes of care of the elderly and patient advocacy principles? This would perhaps shift the curriculum towards client-oriented processes and outcomes but
would also provide a challenge to the current professional imagery and practice of district nursing as found in this study.
CHAPTER EIGHT

DISCUSSION AND CONCLUSIONS: PART I

PERSPECTIVES ON CHANGE IN DISTRICT NURSING PRACTICE AND EDUCATION

INTRODUCTION

The new curriculum (PADNT, 1976) addressed in this study was designed to prepare already trained nurses for work as district nurses in the community. Chapter One indicated that the purposes of the study were to raise for discussion those issues which were found to be significant for those participating as student, teachers and managers in the course of 1980/81 at the university of Surrey. The focus of the study was directed more towards how students perceived their practical (that is community based) work placements together with the perceptions of those personnel with whom the students worked during these periods because it seemed important to me to assess the differences, if any, between educational ideals and practice in the curriculum and those found in the practitioners' working contexts. Ultimately the study was to address the form of education appropriate to practice in a caring profession such as district nursing.

An open approach utilising different social science methods within a case study format (Chapter Two) was to provide information about ways in which the different participants perceived experiences of education and practice in district nursing. With a methodological perspective based closest to 'grounded theory' it was further hoped that
theoretical principles underpinning teaching, learning and practice would emerge for discussion in terms of their implications for district nurse education and practice.

The discussions and conclusions in this chapter and the next point towards participants in district nurse education and practice finding general guidance through reference to theories of rights. A main conclusion therefore is that theories of rights do and could provide theoretical guidance for district nursing education and practice. Rights theory is about individual rights - to autonomy, equal consideration before the law, and so on - and is consistent with theories of education which assume that a person learns through active participation.

This first concluding chapter presents a broad analysis with the first part concentrating on delineating perspectives on change in district nursing practice and contexts of community care and the second part concentrating on variation in patterns of teaching and learning as found in this study. Areas of tension due to mismatches between what is conceived or expected to be the case and what is reported or dealt with in practice and education are highlighted in the course of the chapter. For example working in primary health care teams was envisaged and expressed in the aims of the district nursing curriculum and in public statements but, whilst findings confirm that this is a general expectation in district nursing, there are discrepancies between this expectation and what is actually found in practice and also variation in attitudes and goal directed behaviour towards this
expectation. Also noted is a lack of consistency in the exercise of professional and managerial roles in district nursing.

The second half of the Chapter considers student and teacher experiences of teaching and learning in the community in order to isolate the models and methods being put into practice together with role dimensions and values. Practitioner attitudes and behaviour towards students and students' judgements about standards of the practitioners' district nursing care are found to be important factors in the students' valuations of satisfactory practical experiences. Consistent criteria in the valuations of care are found in this study to centre on concepts of continuity in relationships and the establishment of good communication.

A predominant set of assumptions underlying the attitudes towards practice, teaching and learning can be seen as referenced concepts of the person as capable of self-directed, autonomous behaviour. Central value is given to the idea of self-direction and control in the practice, teaching and learning contexts.

Such valuations are consistent with rights theory and this is examined further in the final concluding chapter in relation to ideology in liberal professions, decision making in practice and the theoretical innovation in nursing and district nursing - 'nursing process'. The purpose is to show that such theory has relevance in providing yardsticks against which theory and practice in district nursing may be judged.
Aspects of district nursing practice and education were examined in Chapter One. It was shown that care in the home by those other than family, or the often used term 'informal', carers has a long tradition. District nursing was encouraged and supported by voluntary associations until 1948 and then made advances in education and training under the auspices of the Queens Institute. The Panel of Assessors for District Nurse Training worked alongside that institute from 1957 and by 1967 proposals for a single national certificate were made. That chapter indicated that this recommendation was not to be achieved until 1981 and pointed to the marginal status of district nurses vis a vis other nursing groups and in relation to controlling influences of medicine as regards their capacity to influence policy and, more importantly, policy implementation.

From the 1960's there was a succession of public reports on the nation's health and welfare services and implementation of change in organisation of health services which included encouragement for group medical practices and nursing attachment schemes to general practices. The general thrust of proposals and discussion documents were towards supporting and caring for those who were elderly, disabled or sick in ways which maintained these vulnerable groups in in the community wherever possible. However, analysis indicates that whilst the general health of the population improved, little change has occurred to reduce relative inequalities between different socio-economic classes (Trades Union Congress, 1981) or to address the imbalances in health and medical provision found between different localities.
Expectations that 'care in the community' would lead to improved staffing in the district nursing services - due to their role in the care of the elderly at home and the projected growth in the proportion of elderly in the population - have not been met.

A key area addressed in this study is how subjects conceptualise changes in district nursing practice: did they in fact perceive that change had occurred, or was occurring, and where were problems being met or anticipated? First the type of changes noted by participants are briefly stated and discussed.

**Perspectives on Primary Health Care**

Findings reported in Chapters Three to Six indicate that students and others recognised that change had occurred, was continuing, or was expected to occur, in the role and function of the district nurse. There was general agreement over the type of changes over time amongst the different groups. The extensions to the traditional role mentioned by participants are:

- attachment to General practitioners
- membership of primary health care teams
- liaison and referral functions
- management of nursing team
- counselling services
- prevention of ill-health
- positive promotion of health
- clinic and surgery work.
The first four listed can be subsumed in a discussion of changes in organisation and infra-structure of primary health care in the community, whilst the last four listed are more to do with changes in the direct care service provided by the district nurse to the patient.

As regards changes in organisation of district nursing services findings indicate that attachment to general practices was accepted as a prevalent trend and was expected to be the case by students looking towards their working life as a district nurse. It was also found (Chapter Seven) that the potential advantages of such attachments varied according to the quality of the premises where nurses were based, the proximity to other professionals such as health visitors and social workers and whether the nurse was working with a number of different doctor's practices or group practices where doctors were working in partnerships. The practising district nurses (Chapter Five) indicated that whilst they regularly worked with particular doctors' practices they more frequently saw their 'base' as their own homes. In practice therefore, attachment had meant that it was now possible to make regular forays into practice and health centre premises and that this was usually for specific purposes of catching doctors between patients and between surgeries for discussion of patient care, prescriptions and for meeting up with other district nursing colleagues. The practice base was not always found to be a suitable environment for district nursing activities since they often either shared rooms with others which made telephone contacts a problem or they did not have a room where private discussion could
occur - I spent many hours in odd corners as well as cars when carrying out interviews during this study.

It was suggested in Chapter One that attachment was viewed as helping bring about an extended role pattern for the district nurse whereby the district nurse becomes a focal point for the co-ordination of domiciliary care and other services and research lends support to the key role which such nurses may have in the organisation and delivery of care, particularly with the very elderly at home (Wade, Sawyer and Bell, 1982). However, findings herein suggest that attachment appeared to be viewed as satisfactory where district nurses catchment areas coincided with doctors' patients in geographical terms so that distances between different premises whether patients' homes, nurses' homes or practice and health centre premises were limited to particular geographical areas. Such features helped enable face to face contacts and liaison between the different groups providing services to the same patients. Even where such ideal conditions prevailed the contacts and liaison between district nurses others involved in providing care and support in the home has to be described as limited.

From the discussion of liaison and primary health care team concepts in the previous chapter and Chapter Four, it was noted that the majority of district nurse students included the general practitioner, health visitor and other district nursing personnel as 'core' members in primary health care apart from themselves. This concept of core membership held once they began to practice as district nurses. It
was found that, on the one hand, individual practitioners recognised change had occurred by the proliferation of caring agencies and increasing specialisms, and, on the other, that broader notions of the team in primary care (which included those from other groups working in the community such as social workers and home helps from the personal and social services, and other nurse specialists such as community psychiatric nurses and midwives (Chapter Four)) amounted to an 'idealistic' conception which had not much foundation in reality.

The study indicates therefore that some aspects of the new conceptions of the role of the district nurse found in policy statements and the curriculum would be only partially reinforced in the community working situation. In these circumstances it is important to consider what factors may contribute or inhibit progress towards balancing ideals with practice.

Major contributing factors are the general aims and purposes held on the assumption that holding concepts of goals will or may influence action taken towards achievement or satisfaction of such goals. The concept of goals is frequently used in theory-building in the social sciences and particularly in the area of management science in analysing decision-making processes and outcomes. Simon (1964) defined organisation goals in that context as 'value premises that can serve as inputs to decisions'.

Findings in this study indicate that priorities in motivations towards changing aspects of district nursing varied depending on the status of
personnel in district nursing structures. Behaviours and expectations directed at achievement of service oriented goals were indicated more often, and given greater priority, the further one moved away from the student and practising district nurses towards those involved in management and administration rather than giving direct patient care. Service-oriented goals is utilised here to describe goals which are service oriented in the sense that they may express aspirations and intentions to improve, extend or maintain the structuring and functioning of the service. They may be goals for the district nursing service per se or have a wider focal point regarding health optimisation for the whole community or society. The latter would include goals referring to policy objectives regarding accountability eg the implementation of recommendations for the collection of health services information scheduled by March, 1988 (Korner, 1984) or objectives relating to the 'attachment' of district nursing staff to general practitioners (Health Services and Public Health Act 1968, section 10 and 11).

Examples of service type goals found at the management level in this study were to establish new services (such as 24 hour care for particular patient/client groups) or to obtain an effective information base for service decisions or to recruit appropriate staff to fill vacancies or to find ways of measuring efficiency/sufficiency of services and to balance resources against service need. An important service goal at the nursing officer level was to select compatible staff when creating whole new teams or expanding established teams. Service goals at management level in relation to
education might be to increase in-service training opportunities for specific groups (e.g., those in the same job for more than five years, or those who have little such as care assistants and auxiliaries) or to allocate budget equitably between the different grades of staff or to ensure that criterion for the selection of staff for training are compatible with service requirements.

Findings indicate similar differential weighting of purposes and thought where these are directed towards achievement of professional goals. Characteristic professional goals found in this study are those which refer generally to standards for district nursing in particular or for nursing more widely. It is at the policy creation level and senior management levels within the district nursing profession that greater emphasis is placed on goals such as:

- to hold/raise standing and image of nursing profession as against other professional groups;
- to extend opportunities for the profession as a whole;
- to extend education, research and evaluation achievement in order to justify and enhance professional status.

Amongst middle managers, practitioners and students more weight was given to ensuring competence for practice and maintaining standards of nursing expertise and practice and, whilst the latter was seen as necessitating enhanced training and education opportunities in the broader sense, they were justified by reference to enhancing care of patients rather than that they served to enhance the status of the nurse.
There appears therefore to be 'internal' and 'external' dimensions in the concepts of professional goals in district nursing as seen in this study. This reflects the dilemma of professional development where the passing on of a normative body of knowledge and skill is seen as necessary for overall accountability whilst it is also necessary that each individual takes personal responsibility for that knowledge. For example there is an emphasis on professional development through education as a way towards 'external' public recognition - particularly from those professional groups most closely perceived as functioning in a similar arena such as health visitors and general practitioners. There is also the emphasis on individual 'internal' acceptance of responsibility for maintenance of professional standards of practice - this being a general aim for the district nurse as stated in the PADNT report on the curriculum - because this is believed to lead to better care. 'Externally' referenced goals of a general public nature appeared more often at advisory and management levels than they did at student or practitioner level; the common 'external' reference point for the latter appeared to be the individual patients for whom they wish to provide care and at this level the 'professional' goal comes to have a personal meaning.

The study finds that there are tensions arising in the role of the district nurse as professional practitioner and manager of services the sources of which which are reflected also in the nurses' professional code of conduct:

"Each registered nurse, midwife and health visitor shall act, at all times, in such a manner as to justify public trust and confidence, to serve the interests of society,
and above all to safeguard the interests of individual patients and clients"  (UKCC, 1984, 2nd edition)

Such statements are similar to the expressed purposes and goals above and, whilst not prescribing actual conduct, may be expected to assist in directing decisions about action and behaviour. The code in the above case is reflecting a duality of ethical imperatives: towards the public, or society generally, and towards the individual in particular. These involve different theoretical assumptions and the findings in this study suggest that practitioners, whether as students, practising district nurses or teachers, are person oriented and personally motivated in their attitudes towards district nursing. This issue is important and is taken further in the final chapter.

Changes in District Nursing Functions
The other aspects of change in district nursing practice which were given above as extensions to the district nursing role and closely related to direct care with patients were counselling, prevention of ill-health and positive promotion of health and clinic and surgery work. The first three aspects of care were viewed more positively than the fourth. Surgery work had its adherents in that this could give added variety to the work contexts. More saw this as a potential mis-use of the district nurses' skills and a potential threat to their independent mode of practice since doctors would be controlling their clinical work through delegating tasks. Ambiguous attitudes towards surgery work extended also to notions of team working, increased administrative work and management in district nursing.
Such ambiguity and tension can be explained in relation to other findings in this study which show clearly that the district nurses and students placed high value and priority on first autonomous practice and second on the particular quality of care which they believed would be possible in district nursing in the community and not necessarily to be found in other forms of nursing. The underlying themes to expressions of anxiety and ambiguity over changes in their work role were that the achievement of these highly valued goals appeared threatened by activities perceived as secondary which took up the district nurse's time, presented challenges to her/his control of the working day and in doing so took time away from the patient home visits and away from bedside nursing activity.

The above discussion of changes in concepts and experiences in organisation and direct care in district nursing suggest that different purposes may be being pursued at any one time but that decisive reference points when conflict occurs will relate to centrally held assumptions about the nature of district nursing - that it allows independent practice and continuity of care - and that these assumptions reflect values held about the self as well as about others.

The initial decision to join an institution (such as nursing or district nursing in the present case) can be conceived as a bridge between organisational role enactment behaviour and personally motivated behaviour. Having recognised this 'bridge', studies of organisation then normally abstract personal goals and motivation...
from their analyses, even though such a separation is generally untenable (see Etzioni, 1969, p. 167-168). The findings in this study would support a conclusion that in caring professions the separation of individual motivation from other goals, whether professional or service, cannot be sustained in any valid way and attention must be paid to the way that individuals are reflecting their own beliefs and goals through their choice of occupation because this is probably intimately related to the ways in which they will continue to perceive and interpret these other goals, and their personal motivation will provide a vital component in their action during work.

A few quotations from Shotter's 'Images of Man' are helpful here:

"...it matters whether we believe our actions to be 'caused' ...or whether we believe that we ourselves can determine what we do"

"we have to form our own principles to shape our own conduct as agents in an intrinsically indeterminate world"

"Such reflection and deliberation is impossible unless one possesses certain prior beliefs: beliefs about the world, other men, and oneself. Only in the light of such convictions is it possible to determine a preference in theory for one line of action over another."

(Shotter, 1975, p 134-135).

The evidence in this study shows that the students' choice of district nursing and the practitioners' continuation in district nursing, support a view that a) they saw themselves as able to control their nursing practice and b) they had definite notions of what that practice of district nursing should include. The first is found in the emphasis or desire for 'autonomy' in practice. This element appears related to a basic value premise of respect for, and belief in the
possibility of, autonomy and of persons as being actively in control of their actions. The second is found in their expressed wish for closer relationships with patients in a context of bedside nursing; this includes the concepts of 'holistic' care in the home environment and that of 'continuity of care' with patients both of which were seen as more difficult to achieve in the hospital.

Further research confirmed these features as major motivational factors in the initial choice of district nursing as an occupation and as continuing sources of satisfaction, with other main factors being a liking for the elderly and a perception of community nursing as varied, challenging and interesting (Battle, Moran-Ellis and Salter, 1985 pp.36-38). That study indicated clearly the practising district nurse's respect for individual autonomy extended to others as reflected by their emphasis on the patient's rights as an individual for example to choose 'to be able to live out their lives in the privacy and dignity of their own homes' (Battle, Moran-Ellis and Salter, 1985 pp. 102-3). As regards retaining nurses in their jobs a recent survey of nearly three thousand nurses (not just district nurses) suggests that retention of nurses in the profession depends more on 'realistic' staffing levels, flexible hours and creche facilities than pay (IMS Report 170, 1989) and staffing levels in particular may have a bearing on the reasons why PWTs were leaving or apparently struggling with the extra workload of having a student on placement). From a motivational point of view it is also of interest to note that 'primary care nursing' is being seen in hospital nursing as offering a shift away from task oriented care, greater
satisfaction for nurses (who are assigned to be responsible for the care of a group of named patients) and more individualised care for patients (King's Fund Newsletter, March 1989).

Change in Community Care Contexts

The study indicates therefore a potential conflict of interests where education is to serve both 'service' and 'professional' or personal; needs and such conflict may in fact be endemic in most public sector or non-profit enterprises. Pressure in recent years on institutions and professions engaged in caring activities - health or social - has been exerted by government policy towards more monitored and economically 'managed' services where services are based on collaborative and/or contractual bases where major state providers become facilitators rather than providers of services (National Health Service Management Inquiry (Griffiths Report), 1983; White Paper: 'Working for Patients', January, 1989; anticipated autumn White Paper, 1989). (This last is an expected policy response for autumn 1989, following the Griffith's report 'Community Care': An Agenda for Action, 1988 and the Secretary of State's Announcement in the House of Commons, 12th July, 1989)

Such pressures require action to identify criteria against which progress towards efficiency and effectiveness can be judged and management tasks become more difficult in a situation of increasing fragmentation of services. In such a situation a major rethink of training and service priorities and directions in district nursing may be required because the anticipated government's White Paper may
provide for co-ordination of care in the community through the lead agency of local government social service departments with strong incentives to become a contractor of services, rather than a provider, including extending collaboration with private and voluntary agencies. In such circumstances the district nursing service could find itself contracted to carry out nursing care in the home and engaged in creating mechanisms to allow accountability of an individual or team of district nurse personnel to a non-nursing agency. The anticipated changes require individual assessment of client need but it seems improbable that social workers will able to take on more than they already undertake in the absence of increased resources; and at present, speculation does not indicate any substantial shift of revenue to enact the change towards better coordination of community care any more than in the past.

The thrust of the 'Working for Patients' White Paper (January, 1989) has proposals which, if implemented, could actually further inhibit joint working between public service health and social sectors; for example the local authority will no longer have representatives on the new slimmed down health authorities though will have representation on Family Practitioner Committees which will become accountable to the Regional Health Authorities. The bulk of that White Paper's proposals is in any case about hospitalisation of patients and fails to reflect on care occurring in the community except from the standpoint of general medical practice. Amongst the proposals for changes in general practitioner management and budgeting roles are a number which could well affect the role of the district nurse if attachment
is to continue: GPs will be encouraged to provide more information about their services to patients whilst it is also to become easier to change one's GP, they will also have greater freedom to allocate resources between types of services, prescribed drugs and employed practice staff and it is the GP who is seen in that paper as the patients' key adviser 'the gatekeeper to the NHS as a whole'. One possible effect of such proposals if implemented will be to create a competitive culture in primary health care contexts and district nurses could become marginalised vis a vis practice employed nurses.

This current debate regarding community health and social care brings back the issues raised by the Cumberledge review of health authority services outside hospitals (DHSS, 1986). That review recommended 'that for the time being' district health authorities should continue to manage community nurses and rejected the idea that Family Practitioner Committees or general practitioners should have a greater role in this preferring 'to see the roles and responsibilities of family practitioner committees and district health authorities combined to give a more cost-effective and coherent service' (Baker et al, 1987, p.106). To some extent the proposals of the White Paper appears to be supporting that option. A major problem with policy formation regarding health and social service provision in the community is that it appears to go along different tracks and discussions are largely separated (Hunter and Wistow, 1987). Thus the proposed future lead role for local authorities in community care, and how this might be integrated with others who hold or believe themselves hold 'gatekeeper' roles remains unclear. There remains a
great deal of scope for the continuation of professional boundaries bolstered by separated political and financial arrangements, and different organisational arrangements for management, administration, delivery of services, training and education.

Such changes therefore pose great challenges for liaison, collaboration and management between and within different groups in the public sector services. Analysis identifies a specific problem which could be addressed through education and training. This is that concepts of management, either in the curriculum or at work in field or higher levels, are not well defined in district nursing. Amongst the nurse personnel in management positions there was a lack of specific education or support towards meeting management roles except where a few individuals had identified their own needs and sought out courses to meet these needs and practising district nurses tended to see their own management needs as confined to day to day workloads with relatively few or no immediate district nurse personnel to whom work might be delegated and fewer colleagues in other professions who could actively become involved in the care of their patients.

On this general issue of management writers specialising in management education highlight one of the dilemmas to be faced in district nursing:

"management is inherently a risk-taking occupation, and so does not lend itself to the shackles of rigid professionalism"

(Hamblin, 1987)

and:

"the public sector is a particularly hard place for people to take risks - and therefore to learn - without punishment. Accountability often has been interpreted to
mean the minimalization of mistakes, rather than learning how best to achieve desired outcomes effectively and efficiently."

(Bryson, 1988, p.203)

'Service' directed behaviour in a traditionally hierarchical organisation, such as nursing, is often likely to be based on end-goals which maintain or achieve established directives seen as beyond the control of any particular individuals who may be affected. By implication management styles (whilst they may vary) may well lean towards 'doing things the right way' (ie following the laid down procedures) rather than 'doing the right thing' (ie trying to ensure that clients receive services which meet their needs) and innovation will be hard to create and maintain without persistent effort on the part of those in positions of influence (managers) and adequate support for staff who show signs of generating new initiatives. A frequent complaint heard from staff at direct care levels over the years is that no one tells them when they are doing well - they only hear when something has gone wrong and 'discipline/punishment' is the remedy rather than alternative strategies of education and training in order that they might learn from mistakes or learn how to better achieve what they were attempting to do. The findings in this study suggest that the new district nurses were not always finding sufficient encouragement or guidance to accomplish change in practice (Chapter Six and Seven).
PERSPECTIVES ON EDUCATION AND TRAINING IN DISTRICT NURSING

The first part of this chapter has considered concepts and experience of changes in district nursing practice. This second part analyses patterns of practice in district nurse education and training in the community (Chapters Three to Seven) and discusses these in relation to educational theory and practice. This is directed at achieving a central aim of the study which was given, in Chapter One, as being to allow discussion of the appropriateness of the education and training of district nurses where that was to be judged as relevant to the context and practice of district nursing. First I review the purposes of the innovatory curriculum; second, features of models and methods of teaching and learning are discussed; third, roles and values are explored from the perspectives of students and teachers. Whilst different models of practice can be delineated there are consistencies in conceptualisation of critical 'satisfiers' for participants in the teaching and learning community contexts and the implications of these are discussed last.

Overview of Educational Innovation

The initiation of the new curriculum for district nursing was seen in Chapter One as an active stance being taken by the profession to inject 'education' into the 'training' of the profession, and through its visible products (students and new district nurses) influence changes in the present and future district nursing contexts (see Chapter Seven). Chapter One indicated the broad aims and objectives for education and training in district nursing.
at the level of the advisors to the profession as a whole. These were seen as concentrated largely on goals for 'the district nurse' as ideal outcome from innovatory programmes of education and training and in addition these goals were bound up with other goals aiming at raising the status of district nurses and district nursing vis à vis other nurse trained groups (particularly health visitors and midwives) and other professional groups (particularly doctors and social workers).

It was at that professional 'national' level that educational policy decisions were taken to a) shift district nurse training away from nurse 'training' oriented institutions towards 'educationally' oriented institutions, such as colleges of higher education, polytechnics and universities b) devolve examination to local institutions. These goals were achieved within a few years following the introduction of mandatory training for practice as a district nurse in Autumn 1981. Through a system of inspection and validation of courses, for periods of three to five years, the PADNT retained a general control over the institutions delivering this education; subsequently the responsibility for the provision of education and training devolved to four separate nationally based boards under the umbrella of the UKCC (for structure and functions of National Boards and the UKCC see Nurses, Midwives and Health Visitors Act, 1979).

The justification for changes were that district nurses needed to be responsive to changing demands stemming from broad changes in
conceptions of health and sickness and the increasing complexity of society. District nursing was perceived as stagnating in a changing world. An extension of 'education' was perhaps envisaged therefore as one way of enabling the practitioner to acquire skills of self-generation. Such capacity for self-generation could be regarded as an essential criterion for any professional practice where that practice is to be based on a sound knowledge base (United Kingdom Central Council for Midwifery and Nursing (U.K.C.C.), 1983, pp. 2-4; Clark and Hockey, 1981).

The thrust towards an extended education and training should be seen as part of a general trend across nursing as a whole and has accompanied the slow shift away from a perception of nursing as task oriented occupation requiring training in specific skills, to one which should include a broader education in order to foster the transference of learning to meet need. Pursuit of the goal of education appears as intimately bound up with the goal of enhancing the professional status of nurses and nursing, and movements in the United States and then in the United Kingdom made more explicit the professional ideal of the nurse as practitioner in her own right, of the nurse as accountable and responsible for her own actions, as distinct from the image of the nurse as doctors' handmaiden.

The case of district nursing is not therefore unique in that it is part of a general movement towards professionalising nursing with a growing emphasis on 'education' as well as the traditional
'training'. McClymont (1980) for example noted the addition of 'education' to the title of the Council for the Education and Training of Health Visitors in 1977 as a significant symbol of change for that profession and the main professional body for district nurse 'training' (PADNT) were careful to emphasise 'education' in their proposed curriculum for district nurses even though this word did not appear in the PADNT's title. This trend has continued in more recent years so that strong pressure has been exerted to bring about changes in basic nurse training and education. The debate has centred on achieving a higher profile for education in the balance between 'training' and 'education. Amongst proposals have been raising educational entry requirements to basic training; placing nurse students on a par with post-secondary graduate entry having supernumerary status; that courses shift from schools of nursing into the higher education sector along with the training of post-basic community staff; a single initial two year programme followed by specialisation (mental illness, mental handicap, children, midwifery and nursing of adults) leading to first registration as a registered general nurse (U.K.C.C., 1986). These proposals involve a phasing out of training for the state enrolled grade nurse who would be replaced eventually by care aides; as a result a number of conversion courses designed to upgrade the enrolled nurse to registered nurse are underway and this may go some way to alleviating the lack of opportunities for development noted for the enrolled nurses in this study.
The new curriculum from the perspective of general educational theory can therefore be interpreted as symbolising both 'corrective' and 'preventative' functions (Benne, Chin, Bennis, 1969, p136): the former to revitalise and maintain standards to meet present needs and the latter to meet future, continuing needs, by addressing perceived problems of earlier training and practice. Through such an interpretation the innovatory district nursing curriculum becomes an example of planned introduction of change in the education, training and practice of district nursing which is believed to occur through the education and training of specific individuals because they are assumed to then be able to respond adequately to fresh demands, generate continued change, act as future role models for district nursing practice and disseminate the education and training received to others in the field. The previous section on practice and management in district nursing has suggested some of the problems in achieving a supportive climate for implementing change in the public sector.

The specific issue of purpose and meaning of education for a vocational profession is taken up again in the next chapter. Next the aim is to consider the practices of teaching and learning in the working contexts and see whether it is possible to discern the most appropriate basis for district nurse education and training in the light of practitioner and student experience of teaching and learning.
Models of Teaching and Learning

'Model' conveys a general concept which assists in locating or describing relationships, events, behaviours, or roles which are related to the achievement of a desired end, purpose or goal. However, I am concentrating in this section on the broad structural positioning of student and teacher and the general direction or purpose implied by different models whilst associated methods and roles are considered later on. The reason for this split will become clearer by the end of this section.

There were three models of teaching and supervision more clearly discernible than others from the data. These conceived teaching or supervision as: instruction, as consultation or counselling and as administration or organisation. None on their own adequately represent the critical features of the structure of teaching and learning in the community and this is returned to later on.

'Teaching as instruction' was a typical construct for practical work teachers in describing the ways they thought about their teaching role with students. Here a major purpose of teaching is conceived as passing on established skills and knowledge: the accepted ways of thinking and doing district nursing care. This is closest to the 'classical' authoritarian model of education which envisages teacher as expert, whose role is demarcated from that of student in hierarchical terms, with content related to specific subject matter or designed. Here the student is a recipient of given modes of experience, taking as given the
teachers's knowledge. The classic form would be associated with teacher directed methods to control and direct students towards specific learning to meet the demands of the wider community and where assessment is by public examination. This would be represented by the formal lecture in the educational institute or the PWTs direction of student activity in line with course assessment requirements and direct instruction in technical skill.

A 'teaching as consultation' model implies a collaborative approach to teaching or supervision from an early stage so that the student and teacher relationship is more equal, decisions regarding objectives and aims are shared, knowledge and skills are shared and consultation over ways of arriving at assessment and evaluation of practice are discussed fully. The important elements implied by such a model of teaching and learning were clearly in evidence for around half of the PWTs and were characterised through students' and teachers' perceptions of the student-teacher relationship as colleague to colleague (e.g. as open, trusting, sharing etc.) rather than one where teacher was superordinate and teachers' efforts to ascertain students needs regarding the theoretical parts of the course in order to meet student expectations. This model is closest to the traditional 'romantic' or progressive liberal concept of education which is person-centred stressing the 'leading out' of innate potential through motivation of student's interests and abilities and general development of the person.
Analysis suggests that a shift occurred over time from student expectations for instruction very early on in the course towards expectations that they would be dealt with on the basis of such a consultative model. This was quite clear during the supervised practice stage and was reciprocated by nursing officers. The latter indicated their expectations that the student would be generally competent in practical and/or clinical skills by this time and that their own role would be to add the finishing touches by ensuring adherence to and knowledge of the wider implications of local and other influential policy direction. Possibly, because a greater social status distance existed between the NO and the student than between the PWT and student, actual practice of this model appeared less often at the supervised practice stage. For example students reported a general lack of consultation and agreement over objectives during the supervisory stage. It seems that the growing confidence and expertise of students as the course progressed led to changing expectations of themselves in their anticipatory roles as district nurses and clearer notions of their needs in relation to performance in community nursing settings and that these factors modified student and teacher expectations of each other in the teaching and learning context.

Purpose in this model is therefore conceived as student directed with the emphasis on building on the students existing knowledge and experience so that they become capable of making increasingly
appropriate judgements in relation to the further experience in
the working environment.

'Supervision or teaching as administration/organisation' was most
in evidence as the nursing officers' model of supervision. Its
features emphasised the 'filling in gaps' by nursing officers
regarding students' performance or knowledge which was considered
necessary to ensure optimum service functioning (e.g. ensuring
grasp of local or other policy guidelines and legal rules and
regulations, broadening the students' perception and understanding
of management and administrative functions). Purposes are again
largely focused away from the student to pass on specific
knowledge in the interests of service and the supervisor-student
positioning is relatively unequal. This model is a limited form
(limited content of knowledge) of, and can therefore be
assimilated into, the instructional model given above.

These three models of supervision are abstractions and in reality
the teachers and supervisors tended to adapt their approaches in
the light of their judgement of student need against appropriate
methods and skills available and taking into account other demands
on their time. At this theoretical level it can be observed that,
as for the situations given above for the conceptualisation of
practice in district nursing, the individual motivations or
purposes ascribed to 'education and training' are or may be
different in any given context. At the practice of education
level this means that people were being required to weigh the
advantages and disadvantages of particular courses of action against the anticipated outcomes they are hoping to achieve. Thus practical work teachers would operate an administrative model—perhaps when explaining recording systems, or, for general guidance, over ways and means of contacting other personnel and allied services; or nursing officers an instructional/teaching model where they were concerned about lack of specific skills or the more general adoption of 'nursing process' as a methodology for district nursing practice.

As I stated at the start of this section the predominant model was a combination of instruction and consultation and is to be taken as reflecting teacher and student conceptions of the end purposes of education and training for district nursing. The purpose was two-fold with a competent practitioner being conceived as one who has not only acquired specific skills but has also existing and developing ability to make independent judgements in complex contexts. When considered separately the educational purposes of these models are in potential conflict since one purpose is served by the teacher in the classical authoritarian position as as a vessel of expert knowledge and the other is served by teacher in the classical romantic/liberal tradition where acknowledgement is made of students' own expertise. It is this duality of purpose which gives pause for thought since generally speaking one would expect nursing to fall into the liberal and vocational tradition of adult education.
Thus Jarvis' (1983, 1985) analyses of adult and professional education suggest that whilst liberal adult education has traditionally emphasised meeting the needs of the individual:

"the situation may be different in vocational education where meeting the needs of society as interpreted by certain people was the concern of educational provision"

(Jarvis, 1985, p. 64)

Yet, as this study has indicated (Chapter Three), the students on this course were mature adults with features similar to those adults taking part in usual adult as opposed to undergraduate education activities. They have a limited 'academic' background in scholastic achievement through public examination and are not typical of those normally entering higher education sectors with their lack of 'A' level qualifications. This lack is not untypical for nursing generally and is unlikely to change substantially in the near future with the UKCC searching for ways to widen the entry gate into nursing careers and the projections by the Department of Employment 'that by the mid-nineties there will only be around 22,000 female school leavers with between five 'O' and one 'A' level' (NHS Management Bulletin, July, 1988, p.10).

These issues are important in that it raises the problem of what is to count as relevant learning for a profession such as district nursing. This study provides insight into this dilemma by indicating the critical features in the perception of satisfactory educational experiences, which are also consistent with valuations of district nursing practice (noted in the first part of the
chapter) and the fact that it is such features which provide the consistency in the teacher and student fusion of instructional and consultative modes in the community contexts. When these critical features were violated there were perceived learning or nursing problems. It seems therefore that certain features of education practice have authoritative relevance in relation to conceptions of district nursing practice. It is the concepts found to be relevant for practice and education which are being highlighted and confirmed in this chapter and the next.

It is the features of the consultation model which best illustrate the consistent critical features related to purposes and general approaches in teacher-student learning contexts. The first feature is that of attention to the individual student. This was particularly evidenced among teachers or supervisors who were concerned to relate to a student as a 'person' as well as a budding 'professional'. Operation of such a model indicates concern to establish prior individual education and work experience and necessitates discussion and sharing of perspectives on needs and values in order that an agreed programme can be acted upon. (Discussion as a method in the teaching and learning contexts is very important in this model and is considered further in the next section).

Smith (1977) examined a wide variety of supervision in teacher education, and this feature of the consultation approach can be fitted into what he terms the 'counselling model' of supervision.
This 'counselling model' has a view of the supervisor as a counsellor whose philosophy is to help the teacher (student) clarify who he or she is both as a person and as a teacher; the purpose of supervision is seen as personal fulfillment; its focus is examination of personal feelings and beliefs; and the relationship between supervisor and supervisee is that of colleagueship (Smith, 1977, pp. 90-150). It is significant therefore to note that PWTs, NOs, students and the newly practising district nurses identified counselling skills among their further training needs. This can be seen as recognition of a need for such a counselling communication framework when dealing with teaching, learning and practice contexts in district nursing.

For the teaching of some district nursing clinical skills a solely counselling model could be seen as less appropriate; for example, specific practical expertise such as catheterisation cannot be acquired entirely in this mode nor could a patient learn to utilize aids entirely in this mode. However, the majority of district nursing situations, in practising education or nursing, do appear to require communication with others and models based on consultation - a sharing of understanding, aims and methods - would appear to be appropriate in a generalised way. For example it is appropriate in situations where the aim is cooperative action, establishing good communication and encouraging motivation: where the nurse is helping a patient to be receptive to new ideas for healthy eating, or to the need for an aid, or where the student and teacher are concerned to explore reasons for poor team
functioning with others in order to facilitate improvements in liaison in health care.

One NO had a 'laissez faire' model and this is of interest since it was a deliberate strategy of non-intervention, of 'playing it by ear'. The student found it quite hard to come to terms with this learning situation as, even though she held expectations of herself as progressing through to greater independence in her future district nursing, she also expressed a need for active direction, found it hard to identify her own needs without some feedback and hard to make approaches or demands on the NO's time; Smith (1977, p.119) described this type of model as 'letting things slide' more of a 'non-model'. It can in my analysis be seen as an abrogation of teaching responsibility having little relevance for learning the application of technical skill in a social-psychological nurse-patient context.

A further interesting model of education which illustrates the features of individual motivation in learning and the quality of communication between teacher and learner was where practical work teachers expressed part of their rationale for teaching students as providing continuing education for themselves. They saw this as enabling their own learning through contact with the student. This helped them in three ways: by refreshing their existing skills and knowledge, the passing on by students of new information, and by them having to make their own practice more explicit which enabled critical self-reflection. Pertinent observations are that the 'teaching as learning' model has features consistent with the 'consultation' model because underlying
assumptions are related to according to the other person the respect for their knowledge and experience that one might wish for oneself: both models have expectations of reciprocity and equality in relation to others. This 'teaching as learning' model is in fact indistinguishable from the combined 'instruction-counselling' model. Furthermore it supports a conclusion that learning which is relevant for the practitioners perceived purposes in district nursing occurs social contexts.

The models being applied by teachers and supervisors as well as students in the community can therefore be judged as related to theories held about the ways in which people learn and ideas about what it is important to teach or pass on to students. Theories of knowledge and education which help explain the synthesis of practical and theoretical skill - the 'interpenetration of thought and action' (Jarvis, 1983, p.23 and 75) - are those of Polanyi (1959 and 1969) and Oakeshott (1933). Their theories of knowledge emphasise the significance of 'master-apprenticeship' relationships in teaching and learning for a profession (Brownhill, 1983, pp.58-63 and pp.99-91). It is within this relationship that the student acquires access to the 'public forms of experience' (Hirst and Peters, 1970, p.32) as embodied by the master of such knowledge (the PWT in this case of district nursing knowledge and skill). A Polanyian theory, unlike that of Hirst and Peters proposed synthesis of polar conceptions in education, does not however give precedence to these normative, communal bodies of knowledge. Great weight is given to the individual's ability through her/his existing conceptual frameworks, to process and make sense of
therefore to make decisions about alternative, conflicting, complex or incomplete information. The motivation and commitment to the field of study is crucial in such a theory of knowledge which helps explain why shared perspectives on district nursing care (e.g. for independent modes of practice, more equal exchange between patient and professional marked by respectful attitudes towards patients in high standards of nursing in the home) between the PWT and student facilitated perception of 'good' relationships as opposed to 'poor' relationships in the teaching and learning contexts. In addition the concept of individual ability in such theory of knowledge is akin to authority, in the sense of an individual right to act, to exercise the ability and is therefore compatible with theory of rights explored further in the final chapter.

Delineating different purposes and structural relationships in approaches in teaching and learning can therefore be seen as helpful in exposing potentially conflicting theories about the ways in which people learn and where the priorities lie in deciding what students should learn. It would be expected that the specific choice of methods including organisation of teaching would be internally consistent with the teachers concepts about what education and training was to achieve and such methods are considered next.

Organisation and Method

Chapters Four, Five and Six detailed these 'hows' of teaching. Analysis indicates that there was a wider variety of organising methods of teaching and learning in the university from the formal
lecture to individual tutorial with a heavy reliance on students working together in small groups. Certain types of teaching resource found in the formal educational settings (such as the use of videos) were not found in the community contexts. The commonest structuring of teaching and learning found in the practice placements for the PWT-student was the one-to-one pairing of teacher and student whilst the most frequent third party present would be the patient; this contrasts with the formal educational contexts where students were frequently in large or small groups with a lecturer or a course tutor being present.

As the community based part of the course progressed, the pairing up of teacher and student on visits declined, and students increasingly made visits to patients on their own. This pattern persisted into the supervised practice period with nursing officers. By the end of the course therefore the student was spending the majority of time with patients unobserved by any third party other than other carers in the home. This mirrors the normally expected district nurse-patient circumstances found in the home and is consistent with the implied 'ground rules' noted whereby taking groups of students (or others) into a patient's home would be judged as unacceptable.

There were some team methods in evidence whereby NOs or PWTs collaborated in sharing their teaching functions taking on others' students in turns; and a few NOs worked in this manner with PWTs during the first sixth months of the course (e.g. NO would arrange visits to social services or have students for a day during the practical work block). Important influences on the perception of such
approaches to teaching as successful were the extent to which both parties, whether teacher to teacher or teacher to student(s), agreed about purposes and whether the parties believed the situation of group work allowed sufficient attention to individual needs in the given contexts. Conflicts and tensions arose for example where students thought their individual requirements were being submerged by attendance to matters generally determined by others or where teachers saw their autonomy being undermined by insufficient consultation.

Some group work was in evidence in the community but was most often seen to arise from necessity — such as in the case of officers with more than one student to supervise. Lessons drawn from student evaluation of the group work in the university suggest that time is needed for the group to establish understanding of purposes and build mutually satisfactory interpersonal relationships. These conditions were as important in home nursing contexts and helps explain the attachment to the principle of 'continuity of care' with patients.

What these findings illustrate are the complex issues underlying the establishment of effective teaching and learning contexts. The implication is that practitioners and managers who take on teaching roles in the community require further education and training in the management of group work. To some extent the community personnel were recognising this for themselves by emphasising their need for 'counselling' skills.
I would also argue that group work and a greater variety of paired work in the community setting should be encouraged as a positive option in the district nursing curriculum as it is in the formal educational setting. One reason for this is that such situations were judged, - by students, as well as teachers and managers who were able to participate in study days - to provide peer support and valuable learning experience 'learning from each other'.

The subjective evidence in support of peer and group activity as learning comes from two sources. One method used in the community was initiated by one of the two university district nurse tutors and involved paired peer groups and this went into operation among some of the students during the supervised practise period. The previous chapter indicated that those who carried this through (taking it in turns to observe the other's practise during patient visits and afterwards discuss this together) had found it a valuable learning experience and a few 'pairs' continued to want to do this into their future as district nurses. These experiences seemed to reveal processes involved in learning highlighting the importance of firstly discussion as necessary to establish a clear understanding between the two over their respective roles and goals for themselves as much as for the patient during patient visits and secondly the time it took to gain a mutual basis of trust between practitioners. The laying down of ground rules was seen as essential if conflict and misunderstandings over action and motivation were to be avoided.
The second source of support comes from the students retrospective evaluation of methods in teaching and learning (Chapter Seven). This showed how their preferences and perceptions for particular modes of teaching changed over time. Early on in the course the students indicated preference for 'didactic' methods (e.g. the lecture) over small group work (where groups of four or five students worked together whilst the tutor circulated among the different groups) which was extensively used for the university-based part of the course. Retrospectively, however, the former students reported remembering most from, or thought more about, what they did during work carried out in small groups and their own and others' project presentation. Their initial reaction against group activity could be seen to be compounded by their expectation of 'traditional' methods of teaching taking place at a university and by their initial shock and fear of active participative learning contexts. The latter were seen as needing to be got used to but once acclimatised the students enjoyed them.

These findings are consistent with other studies about group work as a means of bringing about change which may persist over time and which may be carried over into different contexts. However, note that 'may' is used twice in that sentence due to the difficulty in interpreting a very diverse field of studies including differences in definitions of 'group' (even in this present study of one course there were several forms), different processes being considered in different contexts and different outcomes being measured in different ways over different timescales. For such reasons Smith, for example, concluded
his review of group studies in the field of social psychology for the particular area of sensitivity training by commenting:

"...it cannot be meaningful to ask researchers whether sensitivity training works or what are its effects. The best that one could hope for would be a description of the effects which the various approaches can achieve...[and] seek an understanding of the circumstances which would make it more likely that these effects would in fact arise"

(Smith, 1980, p.33)

One tends to be left therefore with having to believe that the experience of group work leads to students better understanding of social relationships, their own and others standpoints and increased confidence in their own judgements because this is what they believe and this is also what experienced trainers working with adults believe. The linkages between this and sustained change in practice will remain a matter for continued research and argument. Peer and group activity appears to work because it makes people think about possible alternatives in relation to their own observations and action. Such active forms of learning (apart from the community placements) were not immediately appreciated by students. Retrospective views of students (Chapter Seven) showed the longer impact of such methods and it is this type of finding which appears to support the probability of learning being sustained over time and in different situations. Abercrombie was making this point in his studies of group discussion as a teaching method with medical students:

"The most common favourable statement students made about the course was that it made them think....class discussion itself only started the process....the effect seems to have been considerably delayed....students told me on meeting some months....after the course....that they only now understood it"

(Abercrombie, 1960, p.156)
Further work developed ideas that the unique contribution of learning in small groups to education 'is in encouraging students to become more autonomous as learners' and that 'a teacher's manner ... subtly and powerfully influences what goes on ... is conditioned by his basic assumptions about the nature of his job, his responsibilities, his philosophies about areas of education or of professional and personal development' (Abercrombie and Terry, 1978, p.1). These areas are considered further in relation to findings about teaching and learning roles and the values underpinning the community based practice between students and practical work teachers.

Roles and Values in the Teaching and Learning Context

Findings in this study help illuminate the processes and applied values in the community teaching contexts particularly in relation to the PWT-student relationship. The features highlighted in this study in relation to the teachers and students are that the students' perception of the general quality of the teaching and learning relationship was influenced by interested focus on the individual's needs and experiences and the quality of the communication in the relationship. This was associated with the teachers' willingness to encourage and support them and discuss issues in an open manner. Second the students' perception of their teachers included judgements based on conceptions about the overall quality of care being provided for patients.

Students reacted most negatively towards situations where the teachers' general approach had given rise to expectations which were
then not met. Overall the findings indicate the influence that the teachers' general style of approaches to nursing care and teaching in the community can have on students whilst acting as role models for the students, and that conceptions of teaching, learning and district nursing practice roles in the community include similar valuations of autonomy and prioritisation of quality of care.

In Chapter Five it was shown that the practical work teachers expected their teaching to include 'linking theory and practice' and the methodology for achieving this included:

- demonstration of practice in students' presence
- discussion of patient care
- arranging relevant visits and other experiences for students
- supporting students' course assignment work.

The first two could be integrated into the normal care contexts of the district nurse role; the third was found to be time consuming particularly for those new to the teaching role and tensions arose where PWTs did not meet their own or the student's expectation (e.g., where it was not possible to arrange appropriate visits to co-incide with course content; the fourth was a difficult area when teachers were uncertain of the nature of expectations arising from the academic course tutors regarding written work and tended to resolve this through allowing students to lead the way and respond as best they could. This last applied particularly in the case of 'nursing process' where PWTs were lagging behind in their application of this in line with the theoretical teaching in the university. This is taken up as
a particular case of problem solving approaches in teaching and
learning in the final chapter

Demonstration and discussion with the purpose of assisting student
integration of 'theory in practice' were the PWTs main concept of
teaching and organisation of this was most often on a one to one
basis, with a patient being the most frequent third party in the early
practice placements.

As has been said above, the predominant model for teaching and
learning amongst PWTs and students included notions consistent with a
'master-apprenticeship' relationship including assumptions that
learning was a combination of active and interactive cooperation -
 hence the PWTs concept of teaching as learning through their own
observation of students' practice (sometimes this demonstrated new
technical skill recently acquired) and of listening to new ideas about
district nursing which students brought into the community with them
is also consistent with .

Findings suggest some of the processes involved for students as they
take on the role of district nurse and highlight valued concepts about
district nursing care, the self and others in cases where role
conflict or tension arises. Conceptualisation of the dimensions of
different roles in the same enterprise has been found useful and
comprises a major facet of middle range theory in the social sciences.
The reasons for this are fairly obvious in that the concept of role
theory provide theoretical linkages between the actions of any
individual person and the wider societal structures in which he/she functions. For that reason the ideas in role theory have been widely utilised in the study of broad social structures (Linton, 1936; Parsons, 1952; Parsons and Shils; 1951, Merton, 1957); and as a focus for the study of complex administration (Simon, 1957). Role theory has been used in social psychology (Newcomb, 1951) having its roots in Mead's thesis of the development of self-consciousness, of the self, as a social process involving the internalization of others' attitudes as an attitude towards oneself (the second stage of the process giving rise to the concept of the 'generalised other') (Mead, 1934; Strauss, 1956, Emmett, 1966, pp 156-157). Analyses using the conceptualisations of role has therefore been particularly useful for the study of organisation and management where the complexities of human relations, its conflict and tensions, are being analysed - for example Dalton's analysis of public conformity and private manipulation where he suggests that 'perpetual harmony is alien to all life' (Dalton, 1959, p272).

'Role' is the expected behaviour associated with a position and is a relational term in that a role is structurally related to another counter-poised role. Emmett (1966) defined the concept of role as:

"relationships which are sufficiently structured to be classified under common names, which have some pattern of conduct associated with them, recognised in the breach as well as in the observance".

(Emmett, 1966, p169).

General role analyses help show the differences or similarities between perspectives and behaviours of those working together in associated enterprises. In the health field, general practitioners
working in the same group practice have been shown to have different philosophies of care, different views on diagnoses and clinical practice, different perceptions of their relationships with patients, different concepts of the boundaries of care, and different perceptions of other related staff (Jeffrys and Sachs, 1983). Nor are health visitors or social workers any more agreed over their roles, functions and philosophies (Clark, 1976; Vargus, 1977). Even where there might be seen to be basic agreement between two groups (e.g. between district nurses and general practitioners about the district nurse role (Battle et al, 1985, Chapter six) the particularised differences can be expected to remain, resulting in a variety of response in terms of action, expectations or demands.

Role conflict is the term used to signify the conflict which may arise when one is playing one role with one (person or set of associates) and another role with another (person or set of associates). In theoretical terms most people can be seen as holding more than one role (e.g. as spouse, employee, parent, child) and this fact gives rise to the notion of multiple role-holding. The fact of multiple role-holding complicates analysis of social action. This is because, in itself, it can be a source of tension or conflict in that the same person will have expectations of him or her self which are different for each of the roles (e.g. conflict may arise over the issue of child care depending on whether one was acting as 'spouse', 'parent' or 'employee'). Multiple role-holding is a significant issue in this study because, in their working contexts most of the participants are clearly at least dual-role holders: the district nurse is also a PWT,
the nursing officer is district nurse manager and also a supervisor and the student is already a trained nurse and potential district nurse. The findings throw light on the type of tensions which arise in the PWT-student relationships when balancing the teaching and district nurse role and how these are resolved in a master-apprenticeship model.

The dual-roles of PWT and district nurse can in theory be distinguished: minimal criteria would be that the former teaches district nurse students while the latter does not. However 'district nurse' is used advisedly here to qualify 'student' as many district nurses (as well as other personnel) participate in training programmes for basic nurse student and pupil training or for general practitioner and other training. District nurses generally - whether as PWTs or not - might be expected to conceive part of their role as a district nurse in training and education terms (whether for colleagues or patients). In practice, the findings in this study suggest that PWTs had difficulty in separating the different facets of their roles in relation to their patients, their students and their normal working lives. Perhaps factors for weighing here are that training for their teaching role was relatively brief, generally was not a certainty (such training being a recommendation for the profession as a whole and not enforcable in any specific locality), and no specific emolument was received in recognition of this teaching role. This would mean that conceptions of oneself as 'teacher' would be less predominant than those of oneself as district nurse.
An explanation could however be that teaching for the PWT means being a district nurse. That is that their role is to be a model of expert practice and this fits in with their conceptions of teaching function as demonstration and discussion 'talking to learn' which was included at the top of their methods for helping students learn. The integration of teaching into district nursing practice is perhaps an interesting case of immersion in and commitment to ones' subject matter which Polyani sees as crucial processes in his theory of knowledge. Certainly the PWTs seemed to me to be highly committed and I gained a clear impression of a vast amount of time, energy, ingenuity and innovatory activity occurring in the exercise of supervision and teaching to achieve and facilitate student learning.

Motivation for taking on and carrying through a particular role would seem to be as important in balancing the teaching and learning roles as it was argued above to be an important factor in the conduct of district nursing practice. Personally held goals or purposes seem likely to enclose an element of self-regarding interest as a component in any consciously or unconsciously held goal and would influence the strength of the individual's attachment to goals set or suggested by others whether by other individuals or by other groups eg educationalists, professional advisers or managers in the context of this study. Thus the teachers drew personal satisfaction from having students to teach, believed such contact contributed to their own practice and in a wider sense thought this was a contribution to the profession.
The students' personal educational goals can be judged in this study as partly instrumental in so far as they saw the ultimate qualification as an unavoidable and necessary condition of their entering community nursing as a district nurse. The study indicates that students had narrowly focussed educational goals such as passing their examinations, course and practical assessments which may be conceived as 'hurdles' to be jumped on the way to being a district nurse. They were immediately concerned about what they are taught and how they are taught in relation to these target goals in the circumstances of their practical placements. But, following through the argument in the first part of this chapter - that the students' most highly valued goals as future district nurses were autonomy and the particular quality of care through continuity of relationships with patients - one would expect that in difficult circumstances the student would prioritise these valued purposes against shorter term educational goals. This was found to occur: for example one student continued to visit a bereaved family after her return to campus even though this added to her busy schedule because this seemed to be the 'right thing to do' in the circumstances. A more general observation was that many students disliked the shorter spells out in practice placements for the reason that these inhibited establishment of relationships with patients and disrupted continuity of care. In a free choice situation therefore it is probable that patient-centred goals and values would be referrants for action rather than educational goals.
The community teachers and supervisors in their teaching roles are found in this study to have largely student-centered educational goals. This is noted in their expression of perceived problems such as over the organisation and management of learning experiences for their students where they acknowledge difficulties in 'fitting' what they are doing with what the university is teaching (particularly PWTs) and concern that there is variation in the way they approach their teaching task (particularly N. Os) because this implies differences in end-goals vis a vis the student. Their major concern was to provide a satisfactory education and training experience for their students.

Students' for their part seemed to share the practical work teachers' values and expectations for the teaching and learning experience in the community context. Also the qualities that students appear to seek or expect in their practical work teachers are similar to those which could be assumed to be expected qualities in district nurses in assessing and meeting patients' needs:

- technical and professional expertise of a high standard
- capacity to identify problems, take effective action and assess outcomes
- effective communicator
- knowledgeable, resourceful and interested
- a caring confidant both personally and professionally

Such interpretations of teaching, learning or practice are found in this study to develop over time through relevant experience in district nursing situations. This can be shown by comparing
comments made by students with more or less experience of nursing in the community context. Those with little or no experiences to refer to found it hard to 'fit' what they were learning at a theoretical 'knowing that' level, into the frameworks for nursing which they had to draw on. Those with more experience to draw on found it easier to relate or integrate new experience and knowledge into their existing understanding. The type of knowledge or information found difficult by those without experience in the community was not of a specifically technical nature since these students already had a level of such skills and knowledge. The problem was learning about the different ways of, for example, helping a patient follow required instructions in your absence or knowing how to manage sterile procedures in unhygienic circumstances. These are forms of cultural knowledge the languages of district nursing contexts, knowledge of what Oakeshott terms 'modes of experience' (Oakeshott, 1933, p. 7) in which experience is characterised as a single entity of thought and practical application. His argument is that we can only recognise what we can give meaning to - and that is knowledge: 'where there is a meaning or significance there is judgement' (Oakeshott, 1933, p.16).

Such notions link with the ideas found in discussions of role-taking and role-modelling. Role-taking is essentially conceived as a metaphor for the process by which people learn new roles and has therefore been particularly utilized in studies of the socialisation of the child. For example the work of Piaget (1932) suggests close relationships between intellectual and social development with role-taking ability as a crucial factor in that development as well as for
the growth of moral judgement. Through role-taking the students project themselves into the role of another - in this case that of the PWT as a role model of a district nurse. In the PWT-student interactions the students can be seen as tentatively exploring what it means to be a district nurse. Ultimately, in the 'master-apprenticeship' relationship the teacher's role in relation to student's shifts away from teacher as authoritative source of, in this case district nursing knowledge, towards student as authority in her/his own right. When the student arrives at this stage she/he has the ability to re-create this body of knowledge in an inimitable style.

This arrival at discovery corresponds to Turner's concept of internal validation of role (Turner, 1962, p.62) and is similar to Polanyi's concept of knowledge as 'indwelling' involving a process - elements of which remain inexplicable (implicit knowledge) - of 'tacit integration', or assimilation, of information into patterns which make sense to that individual (Brownhill, 1983, p.40; Polyani, 1966, pp.16).

Given that there was a degree of shared perspectives it is the 'breakdown' situations which provide insight into the crucial influences on perceptions of satisfactory education and training experiences. The findings indicate that tensions were severe where mutual respect for achieving high standards of care for patients could not be established. Practical work teachers and managers emphasised the need for 'good' attitudes towards patients and these included recognition that the district nurse was a guest in the patient's home, therefore dependent on the patient's cooperation in enabling care, and paying due respect to the patients right to autonomy. Additionally
there was a conception that nursing care in the home was, or could often be, problematic in that creativity and adaptability was required to overcome generally non-sterile conditions without the backup of supplies, services and personnel which might be found in the hospital. Breakdowns occurred where these expectations were not perceived as being met. The students as students could cope with the fact that PWTs were less knowledgable than they hoped (vis 'nursing process') but could not as nurses and potential district nurses accomodate in situations where principles of care were threatened. Perceptions of teaching and learning as unsatisfactory were found to be related to failure to establish mutual respect and trust between teacher and student.

The crucial indicators for students in their conceptions of satisfactory learning experiences appeared to be the quality of communication and understanding established between the student and teacher: open-ness to exchange of opinion, conceptions of knowledge and skill which in principle and action implicitly or explicitly recognised the rights of each to exercise independent thought and action; and an observation of a high quality of care. Such generalised interpretations of the teacher as a person and as a district nurse mitigated otherwise poor matches between expectation, image and theory on the one hand and the reality of practice and observation on the other.

Supporting the utility of a master apprenticeship model of teaching, Oakeshott (1933) made a strong case for learning through
understanding the teachers 'style' whilst learning a 'style' of one's own as crucial to gaining knowledge. Smith (1977) showed that research, (mainly American) in the specific area of teaching styles in professional education, suggests conflicting results on supervisory style and student expectations: "High indirect styles (in Flanders' terms) are generally regarded as more effective, but high indirect styles fit into students' expectations for criticism" (Smith, 1977, p 102). Flanders (1960) had described 'indirect' approaches as those behaviours toward students including 'acceptance feelings, praise, encouragement, accepting and using ideas of the other person'; 'direct' styles were behaviours such as 'giving information, opinions or critical comment'. There are however different ways of communicating criticism and I would not see these approaches as necessarily incompatible in this study since the manner of the communication between student/teacher appeared more crucial than specific content and the favoured 'indirect' approach in that sense would not preclude more direct instruction provided the central concept of valuing the other's opinion is honoured.

Tension seemed to occur where students' perceived a lack of coherence in the PWTs' manner or style of teaching. The best examples of this arose over the issue of assessment and evaluation of practical experience. Students found some PWTs' approach to evaluation unacceptable in that it exhibited no critical judgement (e.g. where a PWT asked a student to make her own assessment of herself, perceived in itself as a 'good' technique by the student, and then said "that's fine then that's what I'll put on the card" without fulfilling
expectations of further discussion, or where for the majority of student, when with PWTs or NOs, no objectives had been mutually agreed around which assessment criteria might have been created). This highlights a case of mis-match between assumptions being made by students from the teachers'style or manner and how the teacher behaved reality. The teachers style is, on the surface, in accordance with a consultation or counselling model. This, as discussed earlier, implies that responsibilities rest on teacher and student to contribute to decisions, entails active participation, and implies that learning is speculative requiring discovery. In turn this is concerned with development of critical reasoning for the purpose of autonomous practice. In the circumstances described the students' expectations for feedback are not being met.

There were constraints on the PWT's achievement of their own role expectations for themselves and their students. These were sometimes of a temporary nature as, for example, with those new to the supervisory role where time and energy expended would be expected to reduce as experience was gained over time. Other constraints were longer term problems. For example pressure of work-loads which led to reluctance to ask colleagues for assistance or problems in trying to find patients who would 'fit' with the previous content of the academic course and to poor support in terms of relief from colleagues in order that the PWT had time to teach.
Creating and sustaining a learning context for students therefore required management of a complex set of circumstances and required persistency, negotiation skills - such as for a reduced workload or help from hard pressed colleagues, and a broad comprehension of the give and take of human relations within the local contexts of health care. What this activity indicates again are the intentions of teachers and supervisors in the community to do their best to meet the expectations they held for themselves in the role of teacher and the reciprocal role expectations of the student. It also indicates that multiple role holders frequently find themselves balancing different needs against one another and taking decisions which provide as satisfactory a resolution as possible when all circumstances are taken into account.

The 'master-apprenticeship' relationship between teacher and student has been interpreted here as of vital importance for learning to take place in the field of district nursing. It is being argued that it is in the student-PWT relationship that the student learns the role of of the district nurse. This occurs through students and teachers integrating the process of teaching and learning by reference to their existing concepts and experience gained away from the specific educational circumstance which has brought them together. Teachers and students and their patients are not islands. Institutional, political, economic, work, social, emotional and environmental relations and circumstances will be more or less explicit as well as implicit considerations in judgements and decisions. The inference made herein is that in choosing priorities and making decisions in teaching and
learning the individual processing framework includes refers to basic values which include reference to notions of individual rights. This is consistent with theories of knowledge which emphasise the authority of an individual's construction of reality as the means of gaining, maintaining and adding to a body of knowledge which is relevant for them as an individual and for the wider community in which they are engaged. It is such notions of individual rights and their relevance for education in district nursing which are discussed further in the concluding chapter.

EDUCATION FOR PRACTICE: SUMMARY

District nurse students, practitioners and managers agreed that changes had occurred and were occurring in the community care contexts in which they practised particularly in relation to demographic change, consumer needs and demands, changes in the organisation of primary health care via attachment and the proliferation and specialisation of caring agencies. There was therefore a strong prima facie case for changes in education and training which would prepare and support district nurses in meeting the challenges of an extended role. From that perspective the practitioners concurred with the professional body responsible for district nursing that changes in education and training were necessary if the district nurse was to cope adequately with such change. Policy changes related to community care since the beginning of the study emphasis individualised 'packages of care' arrived at through collaboration between health, social services, voluntary and private agencies and presage further substantial changes in the provision and delivery of public health and
social service care for people living in the community. Educational changes which presage a lessening of distinction between different branches of nursing and widening investment in support workers in health and personal services in the community also mean continuing assessment of education which will support the practice of district nursing.

The new curriculum recommended by the professional body for district nurse training and education marked an extension over the old in terms of length, proportionately more time on 'theoretical' issues in a higher educational setting, fresh emphasis on an holistic, problem solving approaches to care to meet the needs of patients and assertion of independent professional practice. The district nurse role was envisaged in the curriculum as entailing collaboration with relevant associated groups such as health visitors, social workers, voluntary agencies and so on, and implied an increased management function for district nurses in the delivery and organisation of health care for the patient in the community.

Change in the curriculum for district nurse education and training is perceived in this study as having implications for others working in the same or allied services and as making more explicit the potential or real tensions between different role holders ostensibly working towards primary health care and personal social services for patients and clients at home. Dingwall and McIntosh (1978), in considering developments in British community nursing argued:
"a mistaken equation has been made between the system of practice attachment and the concept of the 'health care team'".

(Dingwall and McIntosh, 1978, p119)

They suggested that community nurse educators had committed themselves to the notion of egalitarian teamwork whilst nurse managers had become 'committed to practice attachment and its prestige in medical terms for nursing:

"In consequence field staff are caught in an unenviable pincer between their training and expectations and the realities of their work situation".

They argued further that it was the health visitors with their tradition of extensive education and strongly autonomous practice who would 'feel the greater pressure', whilst for the district nurse:

"The limited nature of the district nurses' training, the more purely clinical character of her work and her structurally ancillary role to the doctor as source of referrals limit the impact of the district nurse in the field".

(Dingwall and McIntosh, 1978, p.119)

This study would not support such a conclusion now in relation to district nursing practice. The study indicates that district nurses have consistently valued their independent mode of practice - it is a major reason given for entering and staying in district nursing - and the changes in the education and training of district nurses have meant that district nurses increasingly acknowledge and face the dilemmas and pressures which exist in the delivery of nursing care in the community.

Findings suggest difficulties in establishing educational innovation in practice. There were perceived problems in resourcing community
teaching practices (manpower, training and suitable environment); the educational centre remit only extended to guidelines following professional body advice to try to influence placement environments, recommended ratios of staff to students and/or qualifications of staff; and at the service end there was differential commitment to education in the light of competing service goals and limited resource. Support from professional tutors to community teachers was forthcoming through study days, for example, where practitioners came into the institution, but there were said to be manpower problems involved in making more than a minimum of visits out to such service personnel and additional interventions occurred only at crisis points (such as when student-teacher relationships were falling apart). The traffic between the educational institution and the community settings therefore placed the onus on the movement of community staff into the institution rather than vice versa; this is reminiscent of the contact pattern for the district nurse in the working situation where it often seemed that they were attempting to establish and maintain contact with other professionals - sometimes losing motivation to do so due to lack of feedback or interest from others.

The analysis closely resembles Schon's 'proliferation of centres' model (Schon, 1971, pp.10-12). This model as applied to district nursing finds an already existing innovation, centrally managed by the educational institution with 'secondary centres' out in the field which assist in disseminating the innovation through practical teaching. Schon's theory suggested that in application such a model will fail when 'the network of communications of money, men, information and
material is inadequate to the demands imposed upon it', leading to overtaxing of the available infrastructures. It may also fail, he said, where the centre has insufficient resources to develop its leadership and management roles vis-a-vis the secondary centres, or where the people in the secondary centres lack incentives to promote the innovation.

The study shows differences between the images of the ideal conceptions of the district nursing role and the practical realities of the working district nursing role. These same tensions are found in the curriculum and appear to centre around potential and actual conflict of interests which may arise between practitioners' conceptualisations of autonomous practice and high quality care and the concommitent pressures to change their practice towards a management of care focus and multi-disciplinary working when incentives and resources to do so may be perceived as minimal or beyond their control. These issues remain pressing so that any light the study sheds on what is valued in terms of health care in the community remains relevant.

In a number of respects the students expectations of multi-disciplinary teamwork engendered by the ideal images of the district nurse role in the curriculum were not being met in the practice situation or in the level of support shown towards their teachers and related colleagues. This was seen to pose problems for the teachers when attempting to meet curriculum expectations in the practice situation and in some cases appeared to have led to withdrawal from
the teaching situation. For the students it led to feelings of disillusionment.

Generally findings from the students' placements with district nurses in the community settings suggest that the major conceptualisations of teaching and learning are the passing on of skills and knowledge which have been gained through experience in particular contexts over time. Analysis suggests that much of the 'content' of this knowledge could be termed social or psychological, being concerned with developing attitudes and feelings towards patients and others in the community, and as involving value judgements.

A general finding is that supervisors and teachers in the community exercise creativity in adapting methods in the light of circumstances. Again the skills required are broadly based in that they involve looking for alternative ways of doing things which fit the particular circumstances of patient at home. The general tenor of their approaches appears focussed on end values of patient care and student achievement of personal and professional autonomy. The weight is towards a consultation model of teaching which gives importance to the general development of the person particularly emphasising affective dimensions and where the individual is acknowledged as an active participant in their own learning. This is supported by the finding that community personnel identified 'counselling' skills as a training need. Service and policy needs influence the content of the teaching context more as students participate in the supervised practice period and this is influenced by the interests of the nursing
officers. At the practitioner level the content is focussed on skills necessary to nurse patients in unique circumstances.

There were ambivalent views expressed about the purposes of service, educational and personal goals for district nursing care amongst the personnel seen in this study. The essence of the divisions sums up the problem of the divided thrust of education in a caring profession. Jarvis' analysis of contrasting models of education as 'education of equals' and 'education from above' (Jarvis, 1985, pp. 48-55) helps to illustrate the problem. The notion of 'education from above' is similar to that of traditional 'classical' authoritarian education where education is conceived as initiation into existing social systems, as meeting system needs, perhaps utilising specific or behavioural objectives, where teacher controls learning outcomes and has a demarcated role vis a vis student; content is preselected prior to students entry to study, methods are didactic, there is an emphasis on standards, and assessment is by competitive public examinations. All of these features of an 'authoritarian' educational model can be seen to exist in the curriculum for district nursing: key individuals devised the aims and objectives of the curriculum for the future students and personnel in the educational institution guided the operationalisation of this curriculum, setting the format for the conduct of the course 'theory' and 'practice' together with guidelines and support structure for the latter. On the other hand an 'education of equals' epitomises liberal and romantic tradition where the emphasis is on the interests and potential of the individual and elements of the district nurse curriculum are consistent with such a
model when the emphasis is on problem solving and inquiry based project work methods of learning and continuous assessment of practical work since these are aiming towards generating a critical approach relevant to individual needs. Similarly the predominant teaching and learning models found in the community indicate respect for two-way 'equality' of communication between teacher and taught and is particularly indicative of liberal traditions in education (Friere, 1972 and Hostler, 1981).

The study emphasises that with an adult and trained student clientele one must ask why students were entering or practitioners staying, in district nursing. Does not their reasoning about this count more than any other rationale which might be produced for perpetuating the district nursing culture and service? And should not education and training meet their judgements of what is essential for the improvement of the service to patients as much as any others' judgements? (see Knowles, 1980, for a discussion of the concept of androgogy in adult education). This study shows that students were choosing to enter district nursing for positive reasons related to desire to control the practice of nursing patients in the community in the way they believed was possible in district nursing. Practising district nurses confirmed this opinion of their work and could also be judged as having vocationally oriented aspirations for education directed at the quality and delivery of high quality care to patients. Job satisfaction 'satisfiers' depended to a large extent on their conception that they were able to achieve these aspirations.
Practitioners valued their work because it allowed close contact on a regular basis with the same clients over time. They emphasised the practical 'direct care' nursing component of their role and saw themselves as enabling patients to retain independence by staying in their own homes. It was recognised that patients would be largely referred by general practitioners but, once in receipt of a referral, district nurses saw themselves as having scope to develop their care and autonomy to exercise professional skills in the way they wished. They did not, in this study, tend to see themselves as 'managers' of care in any broader sense beyond their case-load whilst attachment to general practices appeared to have made little contribution to making team working a reality (in the sense of equal contributions in sharing of information, planning and delivery of patient care between doctors, nurses and others) though the provision of a physically identifiable base is seen to provide some opportunities for contact and liaison with nursing and medical (general practitioners) colleagues when necessary. Practitioners appeared to enjoy in a positive way the opportunities district nursing gave in looking after a largely elderly population in ailing health.

Generally, the teachers and students were experiencing very variable conditions for their work in terms of teaching or practice of district nursing resources. Given such variability district nurses and students could be judged as aiming towards prevention and stabilisation of chronic, as opposed to acute, ill-health amongst a largely adult population. The progression towards a better quality of life on that person's terms was a fundamental assumption underlying
practice and there was a strong sense of personal commitment to achieving valued outcomes of independence in the context of community care.

Managers as well as the district nurses emphasised the importance of practical skill and 'good' attitudes toward care and to a large extent mirror those ideals and aims which district nurse practitioners and students hold for themselves and their patients. However the study showed that above practitioner level the staff involved in selection and training were increasingly concerned about general service implications of new training and education vis a vis other priorities - such as the additional cost or the potentially negative effect on other staff working in the same community nursing team contexts. At managerial levels in terms of team working the emphasis was on getting the nurse and auxiliary balance 'right' to provide cover and ensuring that the district nurse 'fitted' into the structure and personalities of general medical practice. There were thus differences in attitude towards innovation appropriate to district nursing needs from newly trained district nurses or students in practices and managers seemed concerned to dampen enthusiasm where this might upset the general practitioner(s).

The significant findings in this study, about actual practice of teaching and learning, point towards approaches which are based on notions of learning from each other's experience and a sharing of knowledge as far as possible. The PWT-student relationship particularly early on in the course - characterised herein as a
'master-apprenticeship' model following Polanyi and Oakeshott - is one where the student watches and learns by demonstration, repeated practice and through discussion with an expert. The disadvantages of a 'sitting by Nellie' model have been argued:

"It tended to encourage accountants to react to a problem by asking how similar problems had been handled in the past rather than by asking what is the best way to deal with it. It would tend to preserve tried practices and avoid stimulus which would provoke the development of new practices. It gave little incentive to fresh thinking about fundamentals" (Carsberg, in Turner and Rushton, 1976, p.10).

But such argument does not allow for the features found in this study where the teacher is also learning through contact with different understandings put forward by students from their own experiences of the world, or from new information being received during study on the 'academic' part of the course. Nor in fact does it allow - as Polanyi does - for the fact that no thinking individual can copy without reservation, or critical application, the knowledge and action of another. One has to make learning one's own or it will not be true for oneself and will not count as knowledge.

Important teacher conceptions of teaching and learning methods in the working situation were demonstration and discussion and provision of experiences which might allow the student to adapt their practices in ways appropriate to the particular features of each case. The main structuring of the educational context was one-to-one (PVT-student) with some group activity (mainly student group- NO with less often groups of teachers or supervisors grouping together to provide more
variety of activity for the student or students). The teacher as role
model for the student was an important aspect of these teaching
strategies.

This means that the practical work experiences tended to mirror future
community patient-nurse one-to-one interaction patterns whilst
supervised practice sometimes mirrored the interaction between a
number of individuals in which a student could gain understanding of
wider influences on their own and others' behaviour in relation to
patients and colleagues. The community work-based education and
training did not therefore particularly reinforce a major method of
learning used in the educational institution which was small group
work following a variety of input of information nor could it be
viewed as necessarily supportive of multi-disciplinary or inter-
professional working. What most community learning situations tended
to reinforce was the importance of communication in inter-personal
relationships in the immediate district nursing contexts and the fact
that understanding occurs in social contexts.

Theories of knowledge relevant to adult, vocational and professional
learning (Polanyi and Oakeshott) give strong support to the relevance
of a 'master-apprenticeship' model since this allows the student to
absorb the implicit and explicit forms of knowledge which are
appropriate for that discipline. Findings in this study indicate that
PWTs and students found the practical experiences to be generally
satisfactory as a learning experience for students and also for some
teachers. PWTs were prepared to encourage students in new methods
(especially nursing process) and try to meet student expectations halfway even where their own academic knowledge was limited or where they did not use such rigorous forms of case planning and record keeping. The teachers were partly motivated towards teaching because it provided them with stimulation through having another person there to reflect with about practices in district nursing. 'Talking to learn' was a vital experience for students in their paired relationships with PWTs in the community settings and in the small group situations frequently encountered at the university, and the peer exercises undertaken later. Individual styles of teaching varied — and in fact it is such individual styles which appear as important channels for students' understanding of implicit 'unknown' forms of understanding in a cultural context — but fundamental similarities were found in referencing the purposes of teaching and education as to allow students to achieve independent and critical thought and to take responsibility for their action. These were seen as ultimately necessary qualities for responsible community nursing where the nurse must be self reliant and capable of creative working alone to meet individual patient needs.

The study overall suggests that relevant knowledge for practice rests in knowing how to go about work as a district nurse is more important that gaining specific technical knowledge. 'Knowing how' is used here in Ryle's sense of knowing and understanding how to carry through a course of action which is to be distinguished from theoretical knowledge or 'the knowing that' (Ryle, 1949) something is, or may be, predicted to be the case. The reason for this conclusion is that
District nursing practice is conceived as taking place in many various social contexts and its content and organisation is similarly varied. For practice to be skilled and knowledgable in these circumstances it seems essential that the practitioner has an educated understanding of context so that she/he is able to create and integrate new occurrences into existing conceptual frameworks which can guide and encompass the relevant nursing care decisions and generate new knowledge.

District nurse education and training in this study can therefore be seen as having elements of classic 'diametrically opposed' educational models (Jarvis, 1985, p. 49) one emphasising the liberal, progressive tradition of the development of the person and the other a more specific targeting of development in order to meet external demands of the wider community, institution and society but appears weighted towards the former - towards a model of equals. A Polanyian theory of knowledge resolves the contradiction through the methodology of the 'master-apprenticeship' model of learning and teaching. Such theory gives credence to the interests and authority of each individual's construction of their world whilst allowing for the initial superiority through mastery of particular 'modes of experience' by the teacher in these circumstances. The educational aim remains to provide relevant knowledge as applicable to the discipline whilst leading the student towards independent practice.

Analysis suggests that concepts underlying practice in education are frequently being based in theories of individual rights acknowledging an individual's right to equal consideration and respect (for their
person and for their knowledge and experience). The implication, therefore, is that these should be the dominant principles for district nursing practice and education and the elements of a model based on collaboration, consultation and equality would be the most relevant and appropriate model in district nurse education. This is examined further in Chapter Nine which attempts to illustrate that issues of rights and responsibilities are crucial issues for district nursing ideology, theory and practice. The suggestions for education and training arising from this study are summed up towards the end of the following chapter.
CHAPTER NINE

DISCUSSION AND CONCLUSIONS: Part 2

THEORY FOR EDUCATION AND PRACTICE IN DISTRICT NURSING

INTRODUCTION

Creating change in practice and knowledge of district nursing may be seen as a purpose of educational innovation in this study. The problems of disseminating and sustaining new learning have been indicated in the previous chapter and in chapter seven. In this chapter the theme addressed is the construction of relevant theory and method for district nursing education and practice. Basically the argument being advanced is that new frameworks of knowledge will be useful and appropriate to a discipline or profession where these are developed through the examination of meanings and concepts found in the practices of that discipline because practice is 'the intelligent execution of an operation' (Ryle, 1973). This perspective denies the separation of 'theory' or thought from 'practice' or doing, seeing these as inextricably synthesised in an informed act.

In different ways in this study I have attempted to explore the meanings attached to conceptions of district nursing practice and district nurse education by those who either would be (students), or were already (PWTs, NOs, and DNOs), most closely involved in the delivery and management of district nursing services to clients in the community. That there were differences in the way in which the
different groups prioritised their concerns, depending on their role status and personal motivation, was indicated in the previous chapter. There it was also suggested that there was a general consensus regarding the significant elements in the meanings attached to district nursing and particular continuities between past and present regarding the role or the district nurse when placed in context.

Briefly these amounted to conceptions of district nursing practice as optimising direct care in the home with patients and their carers, as enabling continuity of care through development of close one-to-one relationships with patients and as facilitating an independent nursing practice. The students gave these as reasons for choosing district nursing as a career and the PWTs (as the group of practicing experienced district nurses) held these features of their work in high esteem. Patient contact and independent practice emerged also in a national survey of district nurse education and training as reasons for entering the profession. (Lopez and Radford, 1984, p.236).

Major conceptualisations of education and training in the community were found to be largely person-centred, focusing on the development of the person as well as on more technical skills seen as necessary for maintaining standards of care in the home. The district nurse was seen as having to be resourceful and adaptable and able to take responsibility for her/his nursing action and predominant conceptualisations of education and practice could be frequently judged as involving reference to individual rights such as to independence and autonomy and to equal respect.
In this final chapter the aim is to provide further perspectives on the construction of theory and methodologies which would be relevant to education when this is conceived as the creation of knowledge in district nursing practice. This is done by discussing rights theory in the context of professional ideology and practice in district nursing and by discussing the specific innovation of 'problem solving' or 'nursing process' approaches to education and practice. The concluding summary covers both discussion chapters in indicating what theories, of rights and of knowledge as an active, interpretive process, imply for an education which is to be relevant to professional practice. The chapter ends with suggestions for further research including comment on this study in the light of experience gained.

RIGHTS THEORY AND PROFESSIONAL PRACTICE

The theme explored here is in the nature of a hypothesis arising from the study: that reference to rights theory helps justify and explain individual judgements made by district nurses during district nursing practice. Exploration of this area helps fulfil an 'undetermined' objective for the research which was stated in Chapter Two as being

"to allow emergent hypotheses about participant's orientations, including value structures, towards district nursing practice, management and education and that this would help inform the theoretical principles on which such practices are, or could be based"

The previous concluding chapter has already indicated that notions of rights pertaining to the individual could be related to images of the person as an active and independent agent and of community nursing as maximising potential rights of autonomy and independence for both
nurse and patient. Educational practice in the community was found to be relatively consistent with such ideas as are theories of learning which emphasise the central authority of individual experience in organising knowledge in an interactive framework.

Discussion of the concept of rights is mostly found in relation to jurisprudence (Rawls, 1971; Dworkin, 1978; Waldron, 1984,) and has a long tradition in political philosophy since the time of Plato's discussions of justice in relation to the state and the individual in The Republic circa 400 B.C. (Plato: The Republic, translator Lee, 1955; Tuck, 1979; Raphael, 1970) and less utilised notions of rights found in doctrines of natural rights (Paine's The Rights of Man, 1791; Ritchie's Natural Rights, 1894; Macdonald, 1949) and social contract theory (Rousseau, 1762; Rawls, 1980) with their tenuous philosophical links with concepts of human rights (Nickel, 1987; Brownlie, 1971; Rawls, 1971 and 1980). As for most philosophical analyses of abstract concepts there is no consensus over the meaning or justification of the term rights (Wringe, 1981).

It can also be said that modern day discussion of rights-based theory has tended to be controversial due to its emphasis on the rights of the individual as opposed to those enshrined in the legislative or normative guidance of state or society. Particularly when applied in welfare and social fields, rights theory challenges the justifications of acts and decisions by the outcomes they achieve such as the common good, general utility or communal welfare. What I aim to do here must therefore be appreciated as limited to the purpose of illustrating the
main differences between rights and other theoretical perspectives in the context of liberal ideology and practice. To make the case for rights based theory in district nursing per se I draw in illustrative comments from observations undertaken in 1984 whilst working on the study of the district nurses' role but which did not feature in the subsequent report (Battle, Moran Ellis and Salter, 1985). Bringing in this material at this stage is in keeping with the chronological development of the study and also acts to substantiate reference to rights theory in actual practice contexts in district nursing, as collection and interpretation of data did not include observation of district nursing practice with patients in the community contexts. I begin however with a discussion of justifications found in relevant ideology as this helps bring out the main points and will also help, I hope, to show that discussion of abstract philosophical concepts such as rights are relevant to the knowledgable practice of district nursing since frequently one reads or hears opinion to the effect that theory is not the concern of a 'practical' occupation such as nursing.

A main thrust of the discussion overall points towards denial of any clear distinction between thinking and doing.

The area addressed first is therefore the type of justifications which can be noted for liberal 'vocational' professions on the assumption that district nursing is one such profession or has aspirations to professional status.

First of all one can illustrate the fact that the basis of ideological justifications or definitions of vocational professions has changed
over time. The base has shifted away from moral justifications based on religion towards an ethic based on educated and knowledgable skilled practice. What we are looking for here are the deeper meanings embedded in codes of practice and reference to such general codes and the work of Hamilton (1987), from an educational standpoint, and Williams (1978), from a nursing standpoint, will help make out the case.

Drawing on Weber's analyses Hamilton (1987) has examined the concept of 'vocation' in education from the standpoint of its usage in the past and present and the way in which it has been distinguished from 'academic' curricula. He writes

"By the beginning of the seventeenth century, then, the net result of these theological and political initiatives was that the term vocation had acquired a double attribution. It referred both to a 'sphere of action' and to a 'broader mode of life'. Thus, those who had a vocation from God did not merely practise an occupation or profession, they also took up an active ethical stance (cf. the protestant ethic) within their families and their communities."

(Hamilton, 1987).

There was, then, the assumption that continuity of practice in a calling or vocation would extend to all spheres of the individual's life and could be justifiable in individual and common good terms:

"The specialisation of occupation leads, since it makes the development of skill possible, to quantitative and qualitative improvement in production, and thus serves the common good, which is identical with the good of the greatest number. So far the motivation is purely utilitarian, and is closely related to the customary viewpoint of much of the secular literature of the time"


Weber's analysis of ascetic Protestant conduct continued:

"Irregular work.. [is] .. always an unwelcome state of transition. A man without a calling thus lacks the

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systematic, methodical character which is...[ ]...demanded by worldly asceticism"

(Weber, 1968, pp. 161)

Subsequently, argues Hamilton, occupational proficiency became more associated with 'a set of specific activities' rather than with 'possession of God's grace' - this interpretation being part of a secularisation process occurring through division of labour and development of the economy during the industrial revolution as well through increasing state intervention in welfare and health. In further considering vocation in relation to education and schooling he concludes:

"Only two of these debates seem to have made a sustained use of the terms 'vocation' and 'vocational' - those surrounding marriage and motherhood on the one hand and the 'liberal' professions on the other. This convergence arose, it seems, because both sets of 'occupations' were discussed in quasi-theological terms."

(Hamilton, 1987).

Such analyses leave room therefore for nursing to be left betwixt and between the pressures towards distinctive specialisation, if not to be left behind others in educational and professional terms, and a long standing belief that such work could be generally justifiable as 'good' or pure in intent when judged by the general standards of meeting the common good of societal needs. The expectations are that the traditional and residual ideologies of 'vocation' will be incorporated into modern professional codes or thrown out as inconsistent with current beliefs about the purpose of the profession. At this general level one could expect to find signs within nursing, as a 'liberal' profession, of a 'calling' more or less secularised by time and leaving room for contradictions between the older images and the new. At a less abstract level the eventual resolution of such conflict will
parallel the Kuhnian conception of how paradigms gain ascendancy where they 'promise success discoverable in selected and incomplete examples' (Kuhn, 1962, p.24) as, the more secular society becomes, less value will be invested in theological or altruistic explanations and justifications for human action. Perhaps the rise of general interest in theories of rights is pragmatic and relative within an historical timescale.

There are therefore inherent tensions in the conceptualisation of nursing action as having meaning vested in 'professional' (as skilled, specialised practice) and 'vocational' terms since these are not synonymous. This is particularly in evidence in the caring professions where the concept of 'vocation' (literally meaning a 'summons' (latin derivation) and theologically meaning 'God's calling or invitation ... to a life of salvation by grace' (Wyld, 1952)), remains alive and is frequently taken to signify a special aptitude for a particular way of life (eg nurse as 'angel').

The Code of Professional Conduct for the Nurse, Midwife and Health Visitor highlights the problem:

"Each registered nurse, midwife and health visitor shall act, at all times, in such a manner as to justify public trust and confidence, to serve the interests of society, and above all to safeguard the interests of individual patients and clients". (my underlining)  
UKCC (1984, 2nd Edition)

The underlining shows how the image of nursing today reflects the historical antecedents of nursing as a 'vocation' justified as a calling rooted in a moral, if not religious, ethical base, which
extends into all spheres of life and is not confined to the immediate practice situation of skilled professional activity.

These twin focii are frequently intertwined in codes and descriptions of professional ethics applied to liberal professions:

"a profession is a vocation whose practice is founded upon an understanding of the theoretical structure of some department of learning or science and upon the abilities accompanying such understanding....This understanding and these abilities are applied to the vital practical affairs of man. The profession...considers its first ethical imperative to be altruistic service to the client."

(Cogan, 1953)

Statements in professional codes can thus encapsulate the dilemma raised in the previous chapter regarding education for a caring profession. The dilemma is that there is a potential conflict of interests between meeting individual needs through the development of the individual as an educated, autonomous and responsible person and meeting also the general demands of society through a systematic and standardised approach to skilled practice (the latter half of the chapter concentrates on one such approach in discussing 'nursing process'). As has already been intimated in the previous chapter the educational demand-need of the first appears best met by practice based on principles that acknowledge the individual's authority or right to his/her own knowledge whilst the educational demand-need of the second will stem from arguments relating to meeting the needs of others where both the justifications of needs and the methods of meeting these needs may have been determined elsewhere.

Justifications for the ideologies which prescribe meeting general
professional, communal or societal demand-needs are likely to rest on
duty-based and goal-based theory rather than rights-based theory.

Where the different rationales are found alongside one another, as in
a 'vocational' profession, this can create vascillating explanations
for action. It is this conflict which Williams (1978) brings out.
Given that the participants in this study stressed the value they
placed on practical, bedside nursing care with the patient her
discussion is particularly relevant because she considered the
implications of having either an ideology of nursing as a 'profession'
or as a 'vocation' in the context of bedside nursing - particularly
with reference to 'helplessness in a sick adult'. She indicates how an
ideology of vocation:

"retrieves the status of nurse performing the tasks as
well as the status of the adult for whom they are
performed. For to be 'called' to such work, to perform it
sacrificially, is to sanctify and consecrate both task and
person."

(Williams, 1978, p.40)
Here the 'tasks' referred to are those related to 'washing, feeding and
cleaning away bodily excretions' which an adult would normally perform
in private; such tasks necessitated by the condition of helplessness
are seen to 'violate the normal relationships between adult men and
women in our society' (Williams, 1978, p.40). In contrast an ideology
of nursing as a profession is seen to raise the profile of skilled and
complex nursing tasks while those tasks which can be carried out by
any able-bodied person are delegated. She continues:

"An ideology of vocation becomes dysfunctional or
obsolete where skilled tasks require independent judgement
rather than obedience, and since the acquisition of skills
has to be paid for, the tasks to which they relate cannot
then be regarded by society, doctors or nurses as menial.

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Since they are not seen as menial then they do not require a sacrifice of self, but seen as skilled they require rather, an assertion of self in creative and innovative action".

(Williams, 1978, p.41)

Williams argues that 'professional' imagery particularly during acute stages of illness is focused on highly skilled clinically oriented tasks, rather than the more fundamental tasks of traditional bedside nursing, and that this influences definitions of the context within which such tasks occur. Nursing definitions thereby become closely aligned to medical definitions of the sick person whilst 'social behaviours of a sick person are given divergent definitions by doctors and nurses' (Williams, 1978, p. 44).

Arguing from a rights-base exposes this as a conflict of interests between professional groups with the longer and more powerfully established medical profession getting the upper hand and in this thesis it is being suggested that the participants' action is more consistent with right-based action so that an understanding of right-, goal- and duty- based justifications for action could help refine guidance for district nursing action and hence provide guidance for judgement of nursing theory and methodology. Before continuing with the implications of a rights based theory in situations of conflicting interests I will reiterate the dilemma.

The discussion so far has drawn out ideations of action which can be related to notions based on duty and obligation being referenced to what can be seen as generalised goals such as the public 'good' or welfare and, it has been suggested that, these may conflict with
notions of action which are based on fundamentally different rationales for individual behaviour which conceive the person/professional as capable of choice and independent judgement. A statement from the Royal College of Nursing suggests more of a rights-based justification for nursing action than is found in statements which appeal to altruism or self-sacrifice or meeting an indefinable ideal for the common good of patients in general:

"The primary responsibility of nurses is to protect and enhance the well-being and dignity of each individual in their care."

(RCN, 1976)

Here the nurse's responsibility could be interpreted as derived from the individual patient's rights and are not referenced to theory which supports it being the nurse's duty to pursue an ideal state of general well-being for all. With this in mind the difference between action based on rights theory and action based on goal or duty referenced justifications and its implications can be brought out more clearly.

Rights-based argument presents challenges to notions of altruism or obedience or utilitarianism as rationales for pursuing a 'vocation' in that the justifications (beliefs and theories) of individual rights-based action are inconsistent with assumptions made about either 'professional' or 'vocational' action (as knowledgable intervention) where that is based on notions of doing one's duty in the attainment of a generalised goal (even where such goals are conceived as being attained through rule referenced acts - see discussion of rule-utilitarianism by Smart, 1956). The clearest exposition of the differences between duty-, goal- and rights-based theory for action is
found in Dworkin (1977) and his work on jurisprudence and political
theory is a primary reference text used hereon.

Dworkin has 'tried to show that a theory which takes rights as
fundamental is a theory of a different character from one that takes
duties as fundamental' (Dworkin, 1971, pp. 171). In his argument
'goals' are defined as being general (eg public welfare) or specific
(eg respect for authority) and a goal is:

"some state of affairs ....within a particular political
theory if it counts in favour of a political act, within
that theory, and that the act will advance or preserve
that state of affairs, and counts against an act that it
will retard or threaten it" (p.169)

A 'right' is defined as where:

"an individual has a right to a particular political act,
within a political theory, if the failure to provide that
act, when he calls for it, would be unjustified within
that theory even if the goals of the theory would, on the
balance, be disserviced by that act" (p.169)

A 'duty' is defined as where:

"an individual has a duty to act in a particular way,
within a political theory, if a political decision
constraining such act is justified within that theory
notwithstanding that no goal of the system would be
served by that decision." (p. 170)

When applied to district nursing, rather than political action, 'taking
rights seriously' provides a useful perspective on the type of
illustration given by Williams (1978) above in the case of conflicting
ideologies and in cases of everyday practice given below. All three
concepts - of goals, rights and duties - can be used to justify or
repudiate particular decisions/action 'but it remains open to ask why
the goal, right or duty is justified' (Dworkin, p. 170) and his
argument is that theories which take either rights or duties as fundamental are different both in their conceptualisation of goals, rights and duties and also in the way that the theory relates these; at some point therefore either goals, rights or duties will be given 'ultimate pride of place' in a well formulated formal theory.

Nursing theory is not formalised or particularly well articulated (in relation to mathematics or law for example) as will be indicated further in the second half of the chapter in the discussion of 'nursing process'. Nevertheless this study of district nurse education suggests that participants consistently reference decisions and action to fundamentally rights-based theory.

Analysis of findings in this study indicate the dilemmas which arise where 'new' meets 'old' and where neither has been fully articulated or acknowledged in theoretical terms. However, I think that it also shows that the participant's reasoning and choices made about district nursing is more consistent with rights-based conceptualisations of practice and education in district nursing. For example, structural and environmental constraints (goal and normative rule generated by and large) were perceived as working against a realisation of independence in practice in the formalised hospital institution. Participants in the study perceived constraints of general rules and regulations as weaker (being more various, diffuse and idiosyncratic) in the community nursing environment and this applied particularly to nursing in the patient's home. Participants' statements indicated expectations that an individual can and does have a right to make
choices and control their pattern of work and this reflects not only the 'surface features' of a profession ('self-direction and control over the pace and scheduling of work' (Scruton, 1982)) but can be seen as a deeper reference to the individual's assumptive right to make such choices.

Returning to the illustration from Williams (1978) given earlier we can consider what a rights thesis would imply as justification for nursing action. To begin with a rights thesis would allow the assumptions that the nurse is capable of (has a right of action to) exercising control over her domain of experience as a nurse; the patient has a right to care in this patient-nurse context, the quality of which (procedures and outcomes) can be judged against principles and criteria which recognise and advance the patient's rights to equal respect and concern for example. The nurse's 'goal' in this situation is patient care but only in so far as this does not infringe the prior claim that the patient is capable of consenting to care; it is no part of the nurse's 'duty' to act in ways which would infringe such fundamental 'right' based principles. In this way the intimate bodily care of a patient does not require justifying by concepts of 'self sacrifice' in the interests of some abstract and generalised goal, it can be justified by reference to the patients rights and by the tacit and explicit agreement arrived at by the interested parties in accordance with these rights.

I said earlier that I saw the nurses' problems of finding meaning in the acute care situation (high level of clinical/technologically
oriented task based care) as a conflict of interests where others
definitions (medical in particular) were in ascendance. The survey by
Bishop (1981) of intensive care units showed that main stressful
factors for nurses were lack of human relations with patients and lack
of involvement in decisions concerning patients. If nurses in such
situations are to establish a more appropriate nursing model of care
it will help if they are clear about what the issues are and arguing
from a rights base will assist in establishing their priorities for
patient care, then in determining which of these may be being
undermined by a medical model of care, and then deciding what
controlling action could be reasonably taken after weighing up the
circumstances. Lets take the case of a comatose patient who is unable
to co-operate or make any choice about care whether nursing or
medical. On the basis of what I said in the previous paragraph, it
would remain the nurse's duty to provide skilled, clinical care carried
out with due respect for the individual (right to privacy and personal
dignity being maintained for example). If the patient's right to basic
respect is being contravened by the way necessary procedures are
being carried out by others then it would be argued that it is the
nurse's responsibility to advocate that right on the patient's behalf
as well as being his/her own professional right to make the judgement
that nursing care is being compromised in some way (by
whomever/however). It would be the nurse's responsibility to try to
do something about such a case. This is not to say that such
assertion of action will succeed in nurses' favour since discussion
may reveal stronger claims for retaining the present care regime than
changing it - for instance a supported case that that patient's
condition could deteriorate further could be one such claim. What it would mean is that the interested parties in this case (other professionals and relatives) could end by having clearer notions of each individual's perspective and of the fundamental meanings that nurse has about the right of individuals to 'equal concern and respect' in which

"the idea of equality is meant to suggest content for the ideas of respect and autonomy: those in power are meant to treat others as they treat themselves....and in the more fundamental sense of attempting, so far as it is possible, to see the situation of each person defined through the ambitions and values of that person, just as he must see his own situation defined through his own ambitions and values in order to have that grasp of himself as an entity that is necessary to self-consciousness and therefore to self-identity." (Dworkin, 1978, pp.356/7)

Consideration of rights-based theory applied in practice and the content of these for district nursing contexts is explored further below.

The Relevance of Rights Theory in District Nursing

It has already been argued that this study indicates referencing of action to abstract individual rights to equal concern and respect. In the context of the patient's home, nursing was more explicitly perceived as interdependent since even though the patient could be seen as dependent on the nurse's skill, the nurse was also dependent on the patient's willingness to be nursed such as by agreeing to entry to the home and to subsequent treatment and intervention. The resolution of differences came through attendance (shown in attitudes communicated towards student, teacher and patient) to rights for equal respect for one's own and other's experience and interests. This is
also perhaps illustrative of tacit acknowledgment of 'rights of recipience' in Raphael's terms (Raphael, pp. 68-70) whereby patient and nurse each have rights and responsibilities towards the other which are mutually recognised. On this basis, where the nurse is accepted by the patient as having authority of nursing knowledge and is welcomed into the home, it would be the patient's responsibility to enable the nurse to exercise that authority. Duties and rights are not, however, always correlative and where they are not I would depart from Raphael's somewhat all inclusive concepts of 'rights of recipience' and 'rights of action' because I would see the nurse's duties and obligations in the nurse-patient context as stemming from the patient's right to nursing care.

Here the philosophical concept of 'social contract' as ultimately rights-based is perhaps more useful than Raphael's 'rights of recipience in the way that Dworkin elaborates this (Dworkin, 1978, pp. 150-183) in relation to Rawls' (1971) analysis of a hypothetical social contract. Rawls posits a hypothetical situation between ordinary individuals who are in the 'original position' of being ignorant of their own knowledge, experience, opinion etcetera and who 'must agree upon a contract before his self-awareness returns' (Dworkin, 1977, p.150). On the further assumptions that the people are rational and acting in their own self-interest Rawls has attempted to show that they will act in accordance with principles of justice which together allow for maximising each individual's liberty, as far as this remains comparable with all others' amounts of liberty, whilst inequalities (of distributed resource, power and so on) 'will not exist
except in so far as they work to the absolute benefit of the worst off members of society' (Dworkin, 1977, p.150). Dworkin's argument concludes that the Rawlsian analysis of 'justice as fairness' ultimately rests on the assumption of a natural right of all men and women to equality of concern and respect, a right they possess not by virtue ... but simply as human beings with the capacity to make plans and give justice' (Dworkin, 1977, p.182).

A theory of rights-based social contract, if fully developed (which it is not), would suggest that the prime goal of a rights-based theory of justice would be 'to enable all the members of a society to justify to one another their shared institutions and basic arrangements for distribution of benefits and burdens' (Waldron, p.20). If this is applied in the district nursing context at a substantive level it would assume that each interested party has a right of consent in such contracts made between nurse and other(s) and each would also be accountable in a public manner for the justifications for particular decisions and options. One sees here therefore the possibility of constructing theories of district nursing action which allow for the ideas of autonomy and independence of the individual in interdependent and interactive contexts and as requiring public and external as well as individual and internal validation.

It is the dimensions of autonomy-independence and interaction-interdependence-communication which emerge in this study as prime motivators in district nursing care. Coombs (1984) in a study of home nursing in Australia also identified similar 'central concepts' of
'aloneness' and 'interaction' finding that these were the 'recurring and unifying themes in the home nurse's practice'. She argued that the apparent contradiction of these dimensions is resolved by these concepts being seen 'as an on-going process where the products of 'interaction' feed back into the 'aloneness' concept and influence further interactions via the effect upon other factors' (Coombs, 1984). Whilst I have no disagreement with this my thesis is also arguing that at a deep level the resolution of apparent conflict occurs where action, whether individual or interdependent, is consistent with rights-based theory. Resolution is also possible when human action is referenced to philosophical theories of knowledge which allow that learning is about initiation into the meanings which others find in their worlds. This is Polanyi's and Oakeshott's position so that 'as such, human beings are essentially dependent on teaching by someone who is already initiated in the tradition of those meanings, and therefore inevitably dependent on the resources and efforts of others for their education' (Wringe, 1981, p.145).

In this study, it was such apparent contradictions between conceptualisations, of the autonomous individual also acting in concert with others, which seemed to create problems of nursing confidence when removed from the immediate intimate nurse-patient or nurse-nurse contexts into, for example, the more public arenas of inter-disciplinary teamworking or when facing the idea of district nurse as manager of nursing practice in its broader team sense and assessment of practice. This is taken up again to some extent in the discussion of 'problem-solving' approaches to care, which if referenced to
fundamental principles which acknowledge and respect the experience of the parties involved in arriving at 'best bet' types of solutions, could be helpful in generating knowledge in teaching, learning and practice situation.

Educational innovation in this sense sharpens up the debate over definitions of care, the purposes of care and the role of the professional in care. Expectations arising from the imagery of 'team work' in the curriculum (leaving aside the issue of real opportunity to develop such approaches) were therefore being challenged by some in this study who saw a conflict between their expectations for, or extant, individual control and that which could be exercised by others. This thesis would suggest that such individuals were equating independent practice with images of isolated, hence 'invisible' practice and were not fully recognising the possible relationships between their own practice and the capacity of others to reflect on, and contribute to those practises.

One of the issues in this context is who district nurses perceive as their reference groups during care. The routine rounds and visits I made with district nurses in 1984 brought helpful corroborative insights into several aspects of district nursing practice as found through the initial study of the curriculum innovation in district nursing. Observation of fifty-two patient home visits and informal discussions with district nurses confirmed that the practice of district nursing in the community is perceived by district nurses as allowing the district nurse to acheive a more personal satisfaction in
nursing care through closer involvement with patients (interaction-communication) and through scope to exercise control over their practice (autonomy-independence). Both dimensions were seen to contribute to job satisfaction and motivation at work; but, as would be expected from the above discussion, there were signs that the exercise of 'autonomous' control over work – which brings with it the professional expectation regarding accountability for nursing care through development of nursing knowledge – was being variously interpreted. There were differences in views of what this meant and how this might affect the individual practitioner. The tensions which emerged were the same as those given earlier and were to do with the resolution or accommodation of the potentially contradictory notions of independent practice taking place in a health care situation which requires collaborative inter-dependent action and in which many different professional groups make claims of control over patient and client care. Some students and other participants and one of the four district nurses accompanied during their days were equating autonomy with the older imagery of the district nurse as an isolated practitioner who, by virtue of her/his invisibility, might remain non-accountable in any public manner (Kratz, 1978, p. 92).

On the whole, however, the indications in this study would not support Kratz's findings that district nurses central concepts were those of 'managing' and 'fairness' referenced to notions of what people in general 'ought' to do (Kratz, 1976, 1978). There are in my study, as with Coombs' study, many signs that the participants recognised at a basic level the rights of patients to help determine the care.
received consistent with those patients' valuations of themselves in the world. Observation of patient visits also indicated that district nurses are aware of the contribution made by patients themselves and family members or other 'informal' carers and their capacity to 'manage' care in Kratz's sense. But, when making visits, they did not seem to take this for granted as a fixed resource. Where carers were present the district nurses always asked if they had had any difficulties or changes in circumstances since the previous visit. In a number of cases the district nurses mentioned that the informal carers (mainly mothers or wives, but also a few husbands, a father and a septuagenarian daughter) provided a level of care that they could not begin to match with the resources available in the service. The district nursing task in these situations was focused on skilled clinical intervention in a few cases but more often their role was an advisory and counselling one with carers to support their role in patient care. District nursing action is therefore informed by reference to the patient's context and significantly includes reference to informal carers.

It is from this perspective, too, that the conflict between working with doctor's surgery patients and working in the patient's home can be better understood. The 'continuity of care' and intimacy of 'bedside' nursing care were highly valued by district nurses and surgery work is hardly conducive to reinforcing these valuations and is in effect similar to short term acute contexts found in hospital interventions. Yet, the rationale for valuing 'continuity of care' can be seen as sound in that it is through continued interaction over time
that the nurse and patient (and carers) are able to reduce misunderstandings and learn through each other to control and predict the process and outcomes of the care situation. These possibilities are reduced where the district nurse's access to patient may be not only initially filtered through the general practitioner (as is the case for the majority of patients in district nursing) but where the subsequent intervention occurs on premises under the control of the general practitioner rather than that of patient or nurse. Anderson (1969) considered the notion of patient determined-access to primary health care professions and Ross (Ross, R.M., 1980) established that in such patient initiations with nurse contact the vast majority of referrals (eighty-percent) appeared appropriate and did not require re-referals by the district nurse. As Ross (Ross, F., 1987) points out, this has implications for the information provided to patients about primary health care personnel and services, and raises issues about the development of the district nurse role in primary health care. Rights-based theory can help in focusing attention on the rights of the patient to health and personal care rather than on the on the different contributions which differently trained personnel may be able to make in providing or facilitating care. It is then possible to visualise different contributions as 'complementary' (Ross, 1987) rather than competitive in order to work towards achieving care which actually meets patient need rather than the needs of the different professionals in each context.

The significance of district nursing care as embedded in a conception of the contextual features of the patient's life was highlighted by a
policy decision which was being thrust upon the district nurse personnel in one patch by a nursing officer. The latter had decided that in future the nurses would rotate patients; the rationale was that this would prevent patients becoming 'dependent' on any one nurse and on any one nurse's routine. This policy was unacceptable to the district nurses but they seemed unable to challenge this management decision. As a policy decision it could however be attacked in a number of ways if arguing from a rights-basis. The policy could then be seen as ignoring the practitioner's right to assess and determine nursing action in the context of the patient's right to consent to treatment and to have a say in access to services. It also ignores the basic interdependence of the nurse-patient situation and the fact that it is the continuous nature of the human relationship which may contribute to sound, as opposed to ad hoc, decisions when meeting patients needs.

Constant switching of personnel in care situations can reduce the level of shared understandings about care and the known about circumstances which affect delivery. It might easily also increase rather than reduce patient 'dependency' because the patients in these circumstances will be less able to predict the care processes which can be built up from ground-rules established between a particular nurse. The prospect of individualised care could thus become fragmented through increasing the levels of uncertainties in the worlds of patient and nurse. It is such circumstances which contribute to feelings of powerlessness and helplessness, that is 'dependency' on others. Where people are ill they are necessarily
already dependent on the skills of others and being placed in a social context which is governed by rules of general utility frequently increases helplessness. It is this which has been seen as a consequential feature of hospital care: 'what is particularly worrying is that chronically ill people have been found to retain a sense of helplessness following discharge' (Button, 1988, p. 96). Such learned dependency can be a problematic feature for all those (such as the mentally ill and handicapped) being discharged after long stays in institutions, and is seen by participants as avoidable where patients are being dealt with in their own homes.

One can sympathise therefore with a 'goal' of reducing patient dependency since this is consistent with rights theory in asserting a right to individual autonomy but one must challenge a general policy as put forward earlier because in following this through the individual rights of nurse and patient may be undermined. Given a theory based on individual rights such policy decisions could only be justified where it was shown that in a particular case(s) nursing action was undermining patient rights and leading to unnecessary dependency: that is, the policy must be rights referenced and not referenced to goals for achieving an ideal, or general, goal. If the nursing officer thinks that 'dependency' is being fostered in the above illustration then the removal of the nurse from the situation will not resolve the problem but merely pass it round to other situations. What one would prefer to find therefore is policy which provides support for the nurses in improving their understanding of concepts such as patient dependency (since it would seem that management and
practitioners have different understandings of what such a concept means in terms of its consequences for care and also the type of practices which can inhibit or increase unwarrantable dependency when judged against principles which defer to the individual's right to equal respect and consideration. Where practices of care are based on these 'deep' theoretical propositions, any action which then denies those rights (which would be the case if individual patients were neither consulted nor considered about the decision to rotate in a random manner the person from whom he/she will receive care) could be contested legitimately by nurse and patient. It would require an attempt to establish the principles being used to judge 'dependency' and more importantly to show that any policy was consistent with (derivable from) fundamental principles that the patients or the district nurses were concerned to uphold. Among the principles of care that district nurses would wish to uphold might be the right to decide on matters of care and the rights of patients to make their own judgments about care services received.

In general terms the district nurse's practice in this study of curriculum innovation, backed up through visits with district nurses, is seen as characterised by care of specified patients with any changeovers for days off and holidays being planned and occurring among a smaller number of staff drawn from fewer different levels and grades than found in the hospital context, whilst a closer involvement is found between nurse and 'informal' carers in the home. The result is an apparently greater level of satisfaction drawn from a more effective continuity of contact in the nursing care situation. One
sidelight on this issue is the terminology used by respondents in speaking of patients. 'My' patient(s) was frequently heard whereas when speaking of their hospital training they often referred to 'the' patient or merely patients on 'the ward'. Thus working in the community environment appears to bring with it a more personalised conception of care and more explicit recognition of patients, as well as themselves, as individuals in their own right.

Practical work teachers, in speaking of their work, consistently reflected a desire for control over particular aspects of nursing practice: such statements involved mainly references to time and pacing of working days (when to visit, how often to visit) and to the general nature of work to be undertaken (involving negotiation with patient, with other staff, with general practitioners and with other potential carers in the home). The non-participant observation confirmed that the district nurses value high standards of nursing care, independence and control over their work in the manner they see fit, and interpersonal relationships with patients. The visits made, and the study of the district nurse's role, enabled a clearer idea of what district nurses saw themselves as doing through their work: major emphasis was placed on maintaining patient's independence in their own home and on the rights of individuals to dignity and respect regardless of circumstances or age (Battle, Moran-Ellis and Salter, 1985).

The visits enabled me to gain a measure of understanding about the situations which the district nurse copes with on a day to day basis.
The first observation would be that one could not characterise a 'typical' patient for district nursing. A number of patients had some physical condition which could on the surface be seen as similar, for example varicose ulcers, that was as far as the similarity went. Whilst most of those with ulcerated legs were also elderly, that again is as far as one would wish to go. Some were in good living circumstances, others were in poor, and yet others in desperate straits. Some had kind neighbours, others had family about them, others had no-one so that the district nurse, home help or meals on wheels person were their only regular visitors. There were varying degrees of mobility and quite different 'patient' orientations towards states of health or incapacity. Each, in other words, was different from the other. Within any day therefore the same nurse professes her/his practice with different patients in a multitude of circumstances. Each of the nurses I accompanied made an observation at some point in the day that one of the things they liked about the job was the variety and that you never knew quite what to expect or what might turn up during the day. Another work study of district nursing (McIntosh and Richardson, 1976) also showed the varied nature of the job and the complexity of everyday decision-making.

The observations that Dworkin makes about the Judge's pattern of work is therefore reminiscent of that of the district nurse: They 'do very little bits of the same job, as and when the occasion arises' and in these circumstances they do not produce 'some general theory, but at best only pockets of a general theory, or, as is no doubt often the case, pockets of different theories' (p.309). Moreover:
"In doing even this, they rely not on formal training in philosophy, but on intuitive ideas of what a more general scheme would justify, made more articulate by such experience of defending their intuitions against actual and hypothetical cases as their practice has provided" (Dworkin, 1978, pp. 359)

The district nurse's work is seen in this study as requiring unique nursing assessments for each individual and methods of nursing which are tailored to fit the individual circumstances. In this way it is difficult to separate the content and method of district nursing since these are interactive. In practice this means that the district nurse must be sensitive to changes in the patient's situation, aware of the possibilities for helping and supporting patient and carers and will need to draw on her/his experience and knowledge in the widest sense if the appropriate decisions are to be made.

It is in such work contexts that rights theory has relevance for providing the consistency of reference points for finding the right course of action for a specific individual when there are many possible alternative solutions. The use of rights theory in practice can be illustrated by two cases.

The first case brings up a relatively common generally met situation in district nursing: that of dealing with the approaching death of a patient. An extended visit to patient and spouse lead to the nurse concluding that the time had come when the patient wanted to hear the truth of his condition i.e. terminal within a short space of time and the spouse had guessed this already. The district nurse decided that she would discuss this issue with the patient's general practitioner.
as soon as possible with the intention of conveying the current state of the patient and spouse; this was in order 'as a matter of courtesy' to acknowledge the fact that the doctor had in the first instance referred this case to her. What, I asked, would you do if the doctor decides to leave things as they are? In that case she said she would inform him of her decision to tell the patient and spouse what they wanted to know. Her view was that both needed to know in order to prepare as best they might for death; it was their right to be able to do so and it was not part of her duty to deny that right, any more than it was the doctor's.

Another case was that of an elderly woman living alone whose condition was agreed by nurse, general practitioner and the hospital consultant who eventually visited the patient at home, to be more likely to to be better looked after in hospital. But the patient refused to entertain that idea because of her conviction that in her absence her relatives would take over her home and refuse to allow her re-entry. In these circumstances the patient continued to exercise her right to stay where she was, thereby choosing her place of treatment, and the district nurse continued to treat her foot (the latter seeing the lack of gangrene as a 'miracle' given that a bit more of the foot fell off each time she dressed it and the generally unhygienic state of the patient's home). Here the joint care decision, that the patient would be treated in the place of her choice, was resting ultimately on the principle that it is the patient's right to make this decision, even though this might jeopardise her physical recovery.
In the helping professions it will often be 'duty' and 'rights' based theory and argument which are being appealed to at a deeper level. In the first case above the nurse's duty (to tell the truth) is being derived from the patient's right to be treated as a responsible person entitled to dignity and respect; it is not the case that the patient's right to the truth is derived from it being the nurse's duty not to lie. Nor, on a rights thesis would it be part of a nurse's duty to conform to or condone a pattern of care which will effectively constrain the content of care for a particular patient insofar as such action would negate or deny the patients rights and the understandings built between nurse and patient during their relationship in that particular care situation. The second case can be seen as one of patient non-compliance with professional advice. There are competing rights here: those that the professionals have in asserting their informed opinion regarding clinical care and those of the patient in asserting her right to remain in her home. It is the latter which has been determined as the primary right.

Practices based on rights theory means that goal-based and duty-based theories of action are subordinated to action based on individual rights. Justifications for decisions and action will be required to be consistent with principles derived from fundamental individual rights and no appeal to policies, legislation or rules designed with the 'general' good in mind can over-ride the rights of the individual to treatment as an equal and to dignity and respect as an independent person. It is this that forms the basis of Dworkin's well-used analogy of a card game with 'rights as trumps'.
"Rights are best understood as trumps over some background justification for political decisions that states a goal for the community as a whole."

(Dworkin, 1981)

In the overtly political context one can see the current action by general practitioners as a rights-based stance with their vigourous challenging of contractual control of their hours of patient contact time largely on the grounds that such a general regulation will be detrimental to individual patterns of patient care. There is here a conflict between claims to generally systematise frameworks for care when 'care' is in fact conceived as an social compact between professional and client requiring responsive interaction and attention to individual patient need. It is this issue which is further examined in the context of 'nursing process' in the following section.

An appropriate framework for district nursing action is one which conceives human interaction as as interpretive process in which 'meanings evolve and change over the course of interaction' (Wilson in Douglas, 1970, p.67). The previous chapter's discussion on role-taking (Turner, 1962) is an example of an interpretive paradigm where the perspective shifts away from enactment of a prescribed role (which is more Merton's position) towards the individual devising action on the basis of the individual interpretation he/she makes of his/her relationship with others so that meanings of social 'roles' remain tentative. It seems to me therefore that a rights thesis assists in providing a reference framework for decisions in nursing care and can be found to be useful in practice. Rights-based theory will not ensure that the same decisions on care are made by different people.
It can however provide guidelines for the process by which decisions are arrived at. In this thesis it is argued that this process, if it is to be consistent with rights theory, is to determine and support the relevant patient's rights in each care context. This would seem to be relevant therefore where care is to be individualised and can have an important function in providing the necessary consistency in the the processes of practice where outcomes cannot be prescribed.

Reference to rights theory also provide a framework for liaison with others in relation to care and for discussing policies on care. Moreover in this study it is suggested that action, on the whole, does reflect reference to such fundamental theory in the basic valuations placed on by the participants in their interpretation of themselves and others and particularly in the way that a patient, in his or her total care context, provides the main focus of district nursing care.

This has implications for the education and practice of district nursing. The district nursing curriculum would need to reflect throughout discussion of the fundamental rights of the individual and this would also fall naturally into any specific component of the principles of district nursing or nursing ethics (see Rumbold, 1987, for the only book to date on ethics geared toward district nursing).

The thesis implies theories of education and of nursing which are based on principles of equality and human dignity where the evaluation of the individual - as student or patient or as district nurse - places primary weight on these rights including the authority of an
individual's concepts of experience when making decisions. This advocates a model of 'education of equals' and a theory of knowledge as an interactive process as discussed in the previous chapter. This has implications for the district nursing curriculum in so far as aims would be to help students toward articulation of argument and acquisition of research and evaluation skills including self-evaluation. This would facilitate the development of justifications for models of care which describe more closely what is actually happening in practice in individual cases; from this might be derived clearer notions of the principles underpinning nursing action and knowledge about whether these are consistent with one another and consistent with a theory of individual rights. This is explored further in the following sections in relation to the theoretical and methodological issues raised by the innovation of 'nursing process'.

INNOVATION : THE CASE OF NURSING PROCESS

'Nursing process' has been a major innovation in nursing education and practice in the United Kingdom over the past decade. Nursing conceived as a process of care, rather than as a set of task-oriented activities, began to emerge in the United States in the 1950's. By the 1960's more detailed descriptions of different facets of nursing as a problem solving process were to be found. Illustrated elements of this process found in the literature - corresponding to a sequence of 'assessment', 'planning', 'implementation' and 'evaluation' as interpreted for the curriculum being studied herein - were primarily: patient-centred approaches to nursing (Abdellah et al, 1960), nurse-patient relationships (Orlando, 1961), assessment of care (McCain, 1965), care
planning (Little and Carnevali, 1967) and evaluation of patient care (Phaneuf, 1966).

Analysis of findings suggests conflict and confusion about what 'nursing process' means for district nursing. The sources of confusion are part of a wider context than district nursing and stem partly from the fact that 'nursing process', as a symbol of change in nursing, has been seen as representing different end purposes. There are also then semantic and methodological problems in the usage of 'nursing process'. The problems centre around the conflation of 'nursing process' with 'nursing models' rather than any conflict per se over the use of problem solving approaches in professional education or nursing care. Particular forms of 'problem solving' approaches in education and models of intervention appear more likely to meet a criterion of relevance to district nursing practice and carry implications for the types of 'problem' which can be usefully brought into the curriculum for district nursing, for the role of teachers and students and for the organisation of learning.

The discussion in this final part of the chapter is therefore continuing to address the issue of developing theories and methodologies for district nursing by examining the case of 'nursing process' as an innovation in education and practice in nursing. First 'nursing process' is briefly considered as a symbol of change in order to emphasise the different purposes such change can represent for a profession. Then specific problems are raised regarding the usage of 'nursing process' and 'nursing model' and the utility of 'problem
solving' approaches for professional education and practice in
district nursing is discussed in the light of theories of rights and
theories of knowledge. The aim is to indicate how the application of
principles drawing on rights theory helps explain some of the
ambivalent reactions found amongst practitioners and students towards
'nursing process', and how this, when allied to particular theories of
knowledge can provide guidance for assessing and developing models of
education and intervention in district nursing.

The Purposes of Innovation
The beginning of discussions of 'nursing process' in the United
Kingdom to the early 1970's show that this was preceded by a time of
general unrest in nursing giving rise to critical re-appraisal of
nursing claims to professional status and of patient care (De la
Cuesta, 1983). Others (see especially the thorough review undertaken
Hayward, 1986) indicate the very rapid dissemination and adaptation of
the American conceptions of the process in the United Kingdom.
Analyses suggest that this rapid spread was fostered particularly
through activities at higher education institutions involved in nursing
at degree and diploma level (particularly the University of
Manchester) and the World Health Organisation. The latter had
identified 'nursing process' as a priority for study, stimulating DHSS
activity in the United Kingdom (DHSS, 1979; Farmer, 1983; Ashworth,
1985), and was endorsed by the General Nursing Council for England
and Wales as follows:
"nursing process 'provides a unifying thread for the study of patient care and a helpful framework for nursing practice''

(G.N.C., 1977)

From this therefore one can see that 'nursing process' has been conceived as serving a number of purposes: from raising the profile of nursing as a profession through higher education, as a means of studying care, and of changing nursing practice with an underlying assumption that patient care would be improved. The D.H.S.S. Working Group on 'nursing process' adopted the following definition:

"The nursing process is a planned, systematic approach to the care of the individual patient"

(Hayward (ed), 1986, p.8)

That Working Group considered that such a definition encapsulated the ideological and practical implications implicit in many other definitions and reflected the commonest understanding of the process. In more detail the implications were spelt out:

"A nursing assessment is carried out with the patient and/or his family to identify needs and problems requiring nursing action. The nurse then sets objectives, often with the patient, and decides upon the care appropriate to meet each need or problem. Finally a regular review and evaluation is carried out to try to determine the effectiveness of the care given"

(Hayward (ed), 1986, p.8)

This definition and features of 'nursing process' were seen as applicable to both nursing in hospitals and nursing in the community.

De la Cuesta's (1983) review of the literature suggested that there were differences in ideological emphases depending on whether developments of the process in the United Kingdom or the United States of America were under consideration. That analysis suggested that developments in the United Kingdom had added little to American
conceptualisations whilst placing less emphasis on nursing process as a means of achieving professional status, the autonomy and accountability of the nurse, the intellectual skills required for decision-making or problem solving, or patients' active involvement in decision-making regarding care. Her conclusion was that, for this country, the process was emphasised more as a method to improve quality of care and the nurse's satisfaction.

Overall, the concept of 'nursing process' could thus be seen as culturally influenced in inception and adaptation for dissemination and as aimed at achieving different ends in different contexts - those of the profession, of nurse education, of the patient, of the nurse, or of nursing practice.

Against such a background, the new curriculum for district nursing - proposed in 1976 and adopted nationally in 1981 - can be appreciated as being in the forefront of educational developments in nursing in the community in its emphasis on 'nursing process':

"we have analysed the nursing skills required by district nurses using a problem-solving approach to their work, commonly referred to as the nursing process"
(P.A.D.N.T., 1976, p.4)

For district nursing the integration of nursing process into the curriculum by the responsible professional body can therefore be seen as both a reaction to changes occurring elsewhere (as suggested in Chapter One) and as an active stance to maintain and advance their claims to professional status through their grasp on unique bodies of knowledge these being one sign of a profession. Educational
innovation frequently has an assumption that the changes it presages can be not only maintained amongst those most closely concerned but also, through cascading or percolation, extend such change to others in similar positions. Those exposed to innovation may thus be expected to act as change agents by implementing their 'new' knowledge of ideas, terminologies, methodologies and improved outcomes in the area they have been prepared for. Such expectations are regularly unmet in practice and this study provides insights into why this is so for the case of district nursing.

Analysis of findings herein indicates ambivalent attitudes and difficulties in implementation which are similar to those found more generally across nursing specialisms by the D.H.S.S. Working Group (which was drawing together general issues from wide sources on adoption and implementation of the process). My study shows that, whilst there was a generally positive attitude among former students towards 'nursing process' (Chapter Seven), it was also the case that students experienced problems in relating learning on campus to what they could observe and achieve in practice (Chapter Four), other practising district nurses (Chapter Five) had not gone far towards changing their approach to care in a 'nursing process' manner, and managers had variable intentions towards facilitating or promoting such change (Chapter Six). Such findings appear validated by the generally patchy adoption and support for nursing process amongst nurse practitioners found elsewhere (Hayward, 1985).
'Nursing process' was therefore conceived by respondents as serving different purposes: practical work teachers suggested the potential of 'nursing process' as a means of teaching; students saw it as a possible means of organising care for some patients; some managers stressed its importance in enabling better record keeping for the purposes of professional accountability; and the professional body responsible for education saw 'nursing process' as central in the education of district nurses for generating professional practice and as a theoretical means of gaining the unique body of knowledge essential to the establishment of a profession.

'Nursing process' represented a challenge to existing practice and established practitioners exhibited defensive behaviour: 'we do this any way' and 'we do treat the patient as an individual' were common statements. The practitioners' general attitude was one of scepticism due to their perception that establishing the elements of 'nursing process' required additional record keeping and generated quantities of paperwork. These seem to be legitimate perceptions based on a perceived lack of administrative support for changes in approaches to nursing care which stemmed from sceptism at managerial levels about the 'foreign' origin and top-down imposition of 'nursing process'. At managerial levels there was a tendency to 'go slow' and 'wait and see' and to try to learn from others experiences before embarking on changes which would be necessary (requirements for different paperwork and administration in particular).
Defence for existing practices and 'wait and see' attitudes are amongst the predictable constraining factors on the dissemination of education where the educational innovation is perceived as designed at one level to lead to real change in practice at a separate level (see Schon, 1971, previous chapter). For practical work teachers in this study the challenge posed by 'nursing process' was two-fold in that it questioned their existing district nursing expertise and, by implication, their skill and utility as a teacher. Such 'de-skilling' was leading to loss of motivation for teaching amongst longer serving practitioners who saw themselves as being out of their depth in relation to the new curriculum; others have found similar problems amongst teachers involved in innovatory curriculum (Whitehead, 1980, pp.58-60).

So far I have considered 'nursing process' generally as a symbol of change in nursing, as a whole entity which has entered into the ideology of nursing professions as a nursing innovation which could result in achieving different nursing action and outcomes. An important outcome for practitioners and students in this study would be that 'nursing process' would lead to improving standards of care for patients; this was not an established interpretation amongst experienced practitioners or those newly trained. I see this omission as a very important value judgement being made by practitioners based on their experience of practice. Application of the meaning of rights theory as illustrated above and the analysis of purposes of their practice amongst practitioners and students provide guidance towards weighting their conceptions more highly than demands of education or
profession: that is that innovation should serve the purpose of effective patient care in their terms. If it fails to do so then it negates the personal meanings which practitioners invest in their work as district nurses and fails to provide a rationale for changes in practice. In addition it seems probable that the methodology proposed by 'nursing process' does not 'fit' the nature of their practice.

An analysis of the reservations found amongst practitioners and students about 'nursing process' as an ideal image of care practice is by no means simple, nor in any way complete, on the evidence of this study. Findings are ambiguous suggesting that on the one hand students and practitioners think that the concept of 'process' has theoretical and practical potential - eg for approaching care and teaching - whilst attached methodological requirements for recording information in a particular format and addressing a particular sequence of nursing behaviour were not seen as necessary for all cases nor sufficiently individualised. Newly trained personnel who saw themselves as using different approaches to care as appropriate in the given context were basing their care on their judgements of what was needed in each case. Taking such reservations seriously leads to the suggestion that 'nursing process' was not seen to be representing the reality of their conceptions of district nursing practise. This is a significant problem if the aim of the innovation is furtherance of knowledge of nursing and examining aspects of theory and method of 'nursing process' further may help clarify the issues involved.
Theory, Method, Models of Care

Amongst perceived difficulties arising over implementation of 'nursing process' were that many practitioners, including those newly trained district nurses, interpreted aspects of nursing process as a waste of time, or as not suitable for organising care of all patients, and by implication as achieving little towards either the ends of the profession or of patient care. In other words 'nursing process' as put forward in district nursing education was not always found to be relevant or applicable in practice. The issue therefore is why not?

"It was the wide application of the process in practice which confirmed for many nurses that the process is merely a method of carrying out nursing, but does not shed light on what comprises nursing"

(Roper and Logan, 1985)

This statement highlights the first problem by making an essential point about 'nursing process'. It has been interpreted as a process of nursing but in fact says, on its own, nothing about nursing. The process as such includes the concepts of assessment (alternatively diagnosis/patient history), planning (aims and objectives/care plans), implementation (nursing action, treatment) and evaluation (including review and monitoring). Such component elements are not the prerogative of nursing being also descriptive of a particular form of commitment to a theory of knowledge which is dependent on rational or logical sequencing of thought and action: such a process is the classic problem-solving paradigm found often in research and multitude of scientific disciplines.

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For 'caring' services, Foeckler and Deutschberger (1970) for example, compared the research process, social work process and supervisory process to show how all three shared the components of 'study, diagnoses, treatment and evaluation' - only the terminology is different, reflecting its' American origins and is readily transferable to the context of this study for district nursing.

The first task is therefore to separate 'process' from 'nursing' and to view 'process' as a generalised methodology which provides no guidance as it stands for either education or practice and actually represents a particular paradigm of knowledge which is akin to the classic paradigm of the natural sciences. By the mid-eighties this conflation of processes of care with models of nursing during implementation was becoming more clearly recognised in the writing on 'nursing process'.

Roper and Logan (1985) exemplify such recognition of the problem when they write that in order to particularise this logical process as a

\[\text{nursing process:}\]

"It has to be used along with a model...it is the model which provides the guidelines for using the process of nursing"  
(Roper and Logan, 1985)\]

From this point of view it is the 'model of nursing' which gives life to the process as such, enabling its' practical application in nursing situations. There are now a large quantity of such models on offer (for example: Riehl and Roy, 1980; Roper, Logan and Tierney, 1983; Aggleton and Chalmers, 1984; Neuman, 1982; Ross and Bourbonnais, 1985). Insofar as such models assist in conceptualisation of nursing
they too, as 'nursing process' in the above section, have been seen as serving multiple functions in education, research or the practise of nursing. Ross and Bourbonnais (1985) thus noted the value of 'models of nursing' as 'vehicles to professional accountability', for 'delineating the boundaries of nursing', for serving as 'a framework for the development of nursing knowledge'. Webb (1984) pondering the confusion of 'process' or 'model' suggested this had been 'resolved in favour of the more modest term 'conceptual framework' to describe the schemes of Orem, Roy and others'. However in my usage that term when, used in relation to the rights thesis and theory of knowledge above is not 'modest' in the sense that such conceptual frameworks carry assumptive references to quite abstract concepts.

One seems to have arrived back at the same sorts of problems which are associated with 'nursing process': that is, the differential perception of the utility of such models for knowledge in theory and knowledge in practice. This may act as an added cautionary note for psychiatric nurses who are required to incorporate and implement a nursing model into their 1982 syllabus (Loughlin, 1988). An experienced lecturer and tutor for district nursing noted that, during the course of education of district nurses, it was possible to dispel 'doubts about theories and models when their contribution to the quality of professional practice was understood'; but that they as tutors continued to register perceived problems of trying to 'link such theories to practice' which remained 'challenging and frustrating'; their students debating the issue 'that the essence of nursing is not addressed by the proliferation of nursing theories and
models' suggested that more time was now being spent on theorizing about, than giving care to patients, that relatively few models were actually used in practice but that theory and modelling helped to redress the balance of nursing from 'doing as central' to 'thinking' (Akinsanya and Campbell, 1987).

This is an extremely helpful illustration of a central problem since the argument being put forward in this thesis is that 'doing' is central in the sense that it is necessarily inclusive of 'thinking'. The problem of education is to find methods and models of teaching and learning which enable such synthesis to occur particularly for a profession which encompasses potentially opposed teaching and learning demands where developing the person as an autonomous, responsible agent capable of complex judgements is as important as development of requisite technical skills. It was argued in the previous chapter that this dilemma is resolved where teaching is provided in real work contexts by those already experienced since it is in these situations that the student is able to absorb the implicit or tacit meanings which underly the meaning and concepts of role practice. It should be restated here that the argument is that action is the implementation of judgement sic knowledge, that not all relevant knowledge can be given through explication, and that such tacit forms of knowledge can only come to the student through exposure or immersion in the world the student is to understand. Teachers based in an educational institute would need continuous refreshers in the field of practice if their teaching is to embody relevant practical knowledge.
As has been suggested in the discussion of rights theory earlier, it is possible to tease out important 'deeper' referents which help explain or justify care action through observing and discussing difficult practice decisions. The study suggests that practitioners are utilising rights theory in their practice and that the way to knowledge in district nursing would be to continue to examine such 'theory based action', eliciting the beliefs, values and attitudes underlying decisions in care in order to create standards against which both district nursing practice and elements of models and theories drawn from other disciplines can be judged. The suggestion from this thesis is that students could learn by developing criteria from rights principles and use these to assess any theories and models proposed.

An extreme example may illustrate what I am trying to say here about the problem of knowledge when 'nursing process' is effected through specific 'models' of knowledge about human development and change. First I would argue that semantically, the association of 'nursing process' with a 'systematic' and 'rational' approach to nursing knowledge cannot be seen as incidental but has to be considered in the light of its origins and the same applies to 'models' of nursing. Critical reflection can help expose theoretical frameworks or schema which are consistent and their relation to particular theories of knowledge. Similarly 'models' of nursing cannot be divorced from their underlying rationales: they cannot be applied without thought encompassing their origins and their implied consequences for action. The extreme illustration is the coupling of 'nursing process' with a
behaviourist modelling of action. Berns and Fordyce (1973), in their 'Behaviour Modification and the Nursing Process, base their work on a behaviourist theory of human action following Skinner (1953); this on their account is perceived as a major 'simple' solution to 'human performance problems' (preface) through which 'the reader can be advised' that the focus is on 'behavior and actions and not on indirect matters, such as feelings, motivations, or attitudes' (Berns and Fordyce, 1973, p.6). Criteria based on rights theory - or on theory of knowledge that credits an individual capable of choice - would be inconsistent with pre-ordained, prescribed courses of action. In this study, district nursing is conceived as very much to do with such 'indirect matters' such as individual motivation so that at a general level and the implication is that prescriptive, behaviourist or deterministic theories of knowledge will not suffice in generating district nursing knowledge - nor perhaps any other forms of nursing knowledge.

I am not suggesting that the general aims to professionalise nursing and nursing care have not, or will not, benefit through approaches which emphasise a logical sequencing and critical understanding of what is going on in nursing situations. What I am suggesting here is that there are major pitfalls awaiting those seeking certainties of understanding through methodologies which ignore fundamental interpretations found in practice. This may seem a self-evident conclusion but is one that is frequently obscured in abstract discussions where second order concepts are divorced from their first order realities.
The contention in this thesis is that judgements of the utility of theory are being made and will be made against existing conceptual frameworks and that such schema are capable of expansion and refinement through the medium of practice. It is in these contexts that 'knowing how to do' is achieved along with 'knowing that' and learning may arise.

‘Nursing process' taught and conceptualised as four separate elements applied through alliance with particular models of nursing in an academic setting is difficult to relate to particular nursing tasks and decisions. For this to be found relevant to practise, the explicit or implicit assumptions underlying such models - about what it is for, who it is for, and what it implies about human action - need to be discussed in relation to real examples and observed in relation to exemplars of behaviour. Without generation of such critical application in the working context, the dangers are that general classifications and categorisations - for example Maslow’s hierarchy of human needs seems to be popular (Webb, 1984) - may be passively received and applied in a mechanistic manner having been reduced to checklists assumed to represent universal characteristics from which general working diagnoses can be formulated for any individual. An example of the elderly person who eats very little in order to buy writing paper and stamps - shows a limited utility for the predictive capacity of hierarchical conceptualisations of need since they fall down against an individual's valuation of contact through letters and the exercise of choice. Without critical reflection it is not surprising if 'sacrifices to 'nursing process' were 'the individualised
and comprehensive approach', the 'psycho-social aspects' or the 'patient's coping mechanisms' (De la Cuesta, 1983, p.369).

**Education for Relevance**

Having criticised 'nursing process' to highlight some of the problems with it this can be reinforced by considering 'problem solving' as a means of education in the district nursing profession and as an approach to care. Analyses of problem based, problem solving approaches in education for professional practice (Boud, 1985) shows some interesting parallels with the analyses of teaching and learning in this study.

Problem-based problem solving approaches can emphasise student autonomy through student-centred learning paradigms (Barrows and Tamblyn, 1980) with an emphasis on self-directed learning without a teacher and where teachers' role is to provide guidance and expertise to facilitate student learning transference in real practice (Perry, 1970). Generally the approach conceived as a process emphasises the interdependence of cognition, skills, attitudes, beliefs and emotions in the process of finding appropriate solutions in a given case and 'places greater value on the perspectives and expertise of practitioners and bringing aspects of professional practice into courses' (Boud, 1985, pp.18).

Similarly a problem based approach in education is not found to necessarily raise student expectations that any one solution was 'right' in practice: problems in such approaches are 'those situations
where there is no immediately apparent solution' (Woods, 1985). In such approaches it is important that the issues which are relevant to the problem are explored in order that an approximately 'best' solution can be determined in that individual case. The overall aim of problem solving approaches is therefore conceived as bringing the student towards confident practice where knowledge of context is vital for judgement and where the skills of critical self-evaluation and shared evaluation learned through contact with others are essential elements for learning, retaining and enhancing professional skill. These would seem to be the legitimate aims for professional practitioners and such attributes accord well when considered in conjunction with the theories of knowledge suggested earlier as relevant to professional education (previous chapter - Polanyi and Oakeshott).

There are however important riders in all this in that comprehension of problem solving in the way I have described it is not necessarily supportive of a formal or systematic approach to knowledge such as might be suggested by the elements of assessment, diagnoses and evaluation (found as descriptions of problem-solving/nursing process. Theory is not in this thesis seen as separate from its use but as being drawn into knowledge through problem solving (Argyris, 1982; Schon, 1983). The implications of this study and findings on problem solving approaches in education are that teaching and learning is a dynamic process and that it occurs through intimate involvement with the practice 'problem' environment and particularly through communication of essential awareness of 'style' of management of the
area of expertise. It is that involvement or engagement of the self with the environment (especially through the aegis of the 'expert' or 'master') which appears to motivate real learning - the knowing how to do - and which ultimately allows the creation of an individual style of expert professional practice. Polanyi's analysis posits initial learning on a trial and error basis which develops - becomes articulated - with experience and over time into interpretive frameworks which incorporate relevant language (symbols and their relationships) for the discipline (in his case the scientific community). Polanyi's description of what is happening in mathematical problem solving is that it involves 'two operations which must always be tried jointly'; the concurrent operations involve first setting out the problem in 'suitable symbols' and reorganising this 'with a view to eliciting some new suggestive aspects of it' and second 'ransack our memory for any similar problem of which the solution is known'; importantly;

"The scope of these two operations will usually be limited by the student's technical facility for transforming data in different ways, and by the range of germane theorems with which he is acquainted."

(Polanyi, 1958, p.128).

Baldamus (1985) points up the similarity of this description of working practices in one of the most formalised sciences (mathematics) with the ways in which the ostensibly less exact sciences (sociology) also work.

The point here is that in seeking systematic or formal theory it is necessary to allow for the intuitive or tacit knowledge and previous experience which belongs with the individual. Thus, formalised
problem solving approaches will only represent partial explanations of what is happening and research suggests that student and teacher must be able to communicate their assumptions and goals for learning to take place. Jacques (1984) has argued that even in highly technical areas students learn that in order to acquire knowledge and communicate understanding they need skills which go beyond the specific area they are engaged in; these skills are those acquired by attention to human relation skills. For this study it is the community placements which allow observation and sharing of perspectives in the relevant contexts and provides checks and challenges to each person's theories/expectations. A conclusion drawn elsewhere was that 'diagnosing and confronting inappropriate theories may be important aspects of problem oriented teaching' (Lawrence et al, 1985, p.227). This is because diagnosing inappropriate theory requires use and refinement of one's own notions of what is or could be appropriate. A similar argument was being made by Argyris and Schon (1974), in their discussion of theory in practice; they suggested that the likelihood of change in practice is greater where the individual's 'espoused theory' (which contributes to the image of self and is thus vital for self-esteem) is adequate since this will allow discrepancies between what one believes and what one does ('theories-in-use') to surface and provide a stimulus for change; where individuals hold espoused theories which may be congruent with otherwise inadequate theories-in-use then such incongruities will not be present for discovery.
This study suggests that notions of what is relevant will be best found through examination of practices with the individuals most closely concerned. Rights theory has been suggested as being used as referents— theories in use—by practitioners and as capable of providing possible yardsticks for judging theory or knowledge of practice in teaching, learning and practice for district nursing. Main criterion for judgements would be whether concepts, methods and outcomes are consistent with each other and in upholding or enhancing an individual's rights to self-determination, autonomy and control. One of the advantages of rights theory in the context of problem solving approaches to practice is that this helps provide consistency in the process of finding solutions whilst not prescribing the solution and this is what one needs where one is seeking uniquely appropriate judgements for an individual involving interpretation of factors which are relevant to that person in context.

The educational and research task would be to establish the parameters of these and other concepts found to be grounded in practice in order to achieve further yardsticks against which judgements of district nursing action in any sphere may be made. Theories of rights were demonstrated as useful in arguing courses of action and solutions in district nursing in different circumstances and at different levels from the policy to local level and individual level. Theory of rights, without prescribing conduct, could therefore provide a welcome note of consistency of interpretation of practice in a field of practice which at the present time, and more so in the future following implementation of changes in basic nurse training and 'community care'.
policy changes, will have to work hard to maintain the sense of a unique professional identity it has fought for over the years.

Achieving control of spheres of action and knowledge would be assisted if identifying and meeting patients' needs is conceived as the main purpose of district nursing and if these are referenced to consistent principles based on rights theory. This is because the 'problems' identified will then be relevant to individual care rather than service or nursing needs. Taking responsibility for action in line with solving patient defined problems could lead to a more proactive stance for developing appropriate strategies and models of care. For example at a broad level a significant district nursing problem (in their preventive role) could be to determine the numbers of elderly at risk and unknown to the service living in the locality - all those hidden needs of patients and carers which do not at present reach the district nurse. It would become of central concern to develop collaborative information systems with other relevant professionals which help identify the individuals and provide knowledge of agencies able to offer services from transport to night sitting and to examine others' experiences of delivery of multiple care services relevant to meeting the needs of clients and families.

At a specific level individual patient concepts of what constitutes problems will contribute to the nurses interpretation of required nursing action. Within the contexts of patient care the patients' perspective and the interactive nature of nurse-patient relations are crucial so that evidence of this would need to be collected and built
in to policy and action frameworks. There has been little work in these areas (Ross, 1987) and what there is supports this study's findings of the centrality of relationships in emphasising the social and psychological factors as crucial influences in determining perceptions of satisfactory care (Poulton, 1981) and the interactive nature of home nursing (Coombs, 1985).

There seems to me to be no inherent contradiction in sharing a similar conceptual framework for action with another professional group whilst demonstrating particular skill in one direction. I say this because it seems likely that others working in the primary health and social care field also see the maintenance of their own and client autonomy as a principle for action. If more sharing of perspectives on substantive roles and action with clients could occur this might lessen the fears and crippling barriers at present existing between different professional groups and between different branches of nursing.

In summary, then, the advent of 'nursing process' has given rise to confusion about conceptions of it as theory, as method and as model of practice. The 'process' as such has been interpreted here as a logical sequencing leading to action which is held in common by many disciplines; models of nursing care thus become significant in defining nursing activity. For theory and models of nursing it is essential to recognise that these will not provide guidance for practice until mediated by concepts of what are seen as appropriate nursing concerns and action. The paradox of 'nursing process' from
the above discussion is that whilst emphasising 'individualised' care it has often been implemented using particular types of models which purport to generalisations of human action and behaviour; additionally the imperative to set objectives and goals for patient care appears to be often translated into setting behavioural objectives based on these models. As with the use of behavioural objectives as educational outcomes (see Gibson, 1980 for a discussion of these applied to district nurse education and training) the effect will be to prescribe patient outcomes of the nursing action. In nursing action terms this is akin to a model of 'education from above' (see previous chapter) and does not assist in resolving the problem of combining a thrust towards systematising methods of care in situations which in reality require a high degree of empathy, responsiveness and attention to the individual. Systematic methods, unless placed within a broader interactive and interpretive paradigm, will not enable individualised care of the patient and may well leave out the very facets of what other theorists would suggest as the essence of what it means to be an individual human being: someone who is participating in his own creation and the creation of meaningful action and that the individual actively construes his experience (Kelly, 1970; Schutz, 1953; Berger and Luckman, 1967; Pope and Keen, 1981).

The message therefore is that models or methods of care may have the appearance of standing alone but in fact should be interpreted in relation to the content of action, that is as 'working' hypotheses to be discarded if they fail to deliver the goods: in this case individualised care. I have argued, on the basis of this study, that
knowledge and theory is being utilised in district nursing practice. To me it seems that evidence of rejection and/or modification of 'models' of nursing action suggests not merely a healthy scepticism or a burying of heads in the sand, but that practitioners are applying criterion of working theory in practice against which, and with which, they carry out their work.

It has been argued in this and the previous chapter that what counts as 'knowledge' in district nursing is related to the existing constructs of practitioners and students and must allow for the relational construction of knowledge in real nursing contexts. In teaching and learning contexts it will be important that fundamental differences in the basis of theory, modelling and methods of care are discussed fully and challenged where they present stereotypes of practice and of patients. It needs to be recognised that there may be no single 'given' solution available but a number of alternative interpretations and that such acknowledgement seems essential for making sound judgements in the face of incomplete information. It is in the practical work context that teachers and students are able to experience the importance of communication in contributing to the processes of interventions and outcomes in patient care whether these are in nursing, educational or other contexts. In dealing with real issues in practice, solutions and strategies come to be 'known' as consistent (or not) with other known or hypothetical cases whilst also being uniquely applicable in the individual case. In particular it is found that theory of individual rights can assist in focusing care on
the individual and providing consistency in the way nursing decisions are arrived at for meeting patient need.

CONCLUDING SUMMARY: IMPLICATIONS FOR EDUCATION IN DISTRICT NURSING

This thesis suggests that if learning is to be relevant to the experience of professional practice, and is to be maintained following training for that practice, then education needs to be conceived as an active process which should emphasise opportunities for the development of grounded concepts with reference to real practice issues and contexts. A concomitant implication is that the educated practitioner will enhance the development of theoretical constructs and a variety of methodologies for district nursing care which can feed back into the design and organisation of education for professional practice.

Learning and progression for the district nursing profession is found in this study to be an interpretive act in which the motivation - the right - to control over one's world is to be taken as a 'given' and where understanding can be enhanced and expanded through contact and discussion with others closely involved in the same or similar enterprise including patients at the top of the list. The main purpose of education and training in district nursing would therefore be to assist the development of the individual as an autonomous, responsible and accountable individual. This seems to me to be the likeliest means of achieving appropriate individualised patient care as the focus of nursing action because it envisages an active concern on the part of the nurse to critically reflect on practice and advocate
on patients' behalf where they are unable to act or where needs are not being met by the service.

Analysis suggests that a basic concept can be identified - that of individual rights - which either helps explain or could act as guidance for decisions in education and care contexts. This means that theoretical principles developed from rights theory will or could act as yardsticks when developing or considering theory and models for district nursing care and education. Such general principles - the right of autonomy and equal respect for example - help provide consistency for decision-making whilst not providing specific prescriptions for systematic action.

Theories of knowledge which emphasise learning as an active and interpretive process are compatible with rights theory because the individual is perceived as having control over new information and knowledge by being able to draw it into his existing constructs: uniquely appropriate judgements can then be made within broadly authoriatative conceptual schema. Learning is in this way self-determined in that new knowledge is realised through the confident use of what we already know. Polanyi's theory, and that of Oakeshott, is particularly useful in showing that for professional education the best way of learning relevant knowledge is through a student being with an expert practitioner. This is because it is necessary for the budding professional to acquire the forms of thought, language and action which are identified as unique for that profession. But, because not all such knowledge can be made explicit, the practitioner's
style of practice becomes an important influence on the student’s acquisition of tacit as well as explicit knowledge.

This is not a prescription for maintaining the status quo in a profession because of the fundamental proposition that each individual achieves control of knowledge – creating it in his own image or style by applying it in practice. The implication again is that the educated practitioner will actively seek control over his practice by attempting to assimilate the newly met into existing conceptual frameworks and, where this is not possible, by modifying these frameworks with alternative judgements which better provide coherent and consistent conceptualisations. Such individual responsibility for mastery over a body of knowledge, which is also largely shared by others in the same profession, constitutes the personal meaning of self-regulation for a profession.

Teaching, learning and practice consistent with rights theory could thus provide a general reference framework for action. District nursing in this study is perceived as characterised by a focus on individual care taking place in complex psychological and social contexts. Acknowledging this suggests that district nursing models or strategies for care must be eclectic since they will necessarily draw on ideas and methods from different disciplines – particularly psychology and sociology. The unique nature of district nursing professional skill will be vested in judgements about the value of different working strategies and this is where rights theory is of assistance.
The development of concepts and appropriate methodologies based on research and evaluation of practice are considered vital to the growth of knowledge about district nursing and for establishing the meanings in district nursing practice at professional and personal levels. At present the curriculum has a place for 'appreciation of research' but this study implies that students could learn by actually carrying out research. This could initially focus on identifying and describing nursing action in order to raise patient care 'problems' and identify methods and solutions which are relevant to the discipline. It is argued that successful dissemination of problem-solving approaches to care, and by implication other innovations in education, will depend on practitioners' perceptions of its relevance to their practise experience. Student's experiences are seen as mediated by both contextual features and the personal motivation found in their conceptualisations of prior experiences which they bring to their nursing study. Practitioners' conceptions of relevance can be found in their reasons for entering and staying in district nursing and examination of their styles of practice and practice environments could allow development of education which is appropriate and applicable in the working context.

Conceptualisation of rights as a fundamental basis for decisions in practice and problem solving approaches modified for application in the practical context in education for practice have implications for the content and organisation of education for district nursing in the community. A general implication is that the greater balance of education should be in the community work environment. This would
assist learning which is culturally relevant and create teaching and learning oriented work environments which will better support the work and skills of practical work teachers with students and provide continuing educational opportunities for a wider range of related staffs. This will help the process of establishing and integrating principles for care into practice with patients through validation of practises by individual practitioners and the relevant 'community' which includes others in the same profession, those in related professions, and those excluded from the profession. The most important 'others' here are the patients, informal carers and other care workers in district nursing. Such a shift could assist in creating a supportive environment for research and continuation of learning which is rooted in practice and which will lead to development of a variety of conceptual schemas which are descriptively appropriate and capable of generating grounded hypotheses about those issues which are important in district nursing care.

The study finds that the general tenor of teaching and learning approaches in the community appears focussed on the individual in patient care and student achievement of personal and professional autonomy. The weight is towards a consultation model of teaching which gives importance to the broad development of the person particularly emphasising affective dimensions where the individual is an active participant in their own learning. This is supported also in the practical community work contexts by the finding that community personnel and new district nurses identified 'counselling' skills as a continuing training need. Service and policy needs
influence the content of the teaching context more as students move towards becoming district nurses whilst at the practitioner level the content is focussed on nursing patients in unique circumstances.

Important factors in satisfactory teaching and learning experience were internal and external coherence of teaching styles and methods and the quality of interaction and communication. The implication is that in the teaching and learning context the students and teachers must discuss and share their perspectives and the roots of these. Clarification of such perspectives involves addressing differences in theories and models for nursing in terms of what teachers and students think they are about, whether in relation to their goals for the district nursing service, or the profession as a whole, or whilst in pursuit of education and, most particularly, in terms of the achievements they seek for themselves and their patients in the caring situations.

The study has I hope been able to demonstrate the significance of the individualised nature of district nursing care taking place within interactive social and psychological contexts. District nursing has at least a triple focus - social, psychological and physiological - and this strongly suggests that seeking a single theory or model of care is not an appropriate means for gaining knowledge in district nursing. At present the district nurses' basis for practice is not clearly articulated; and, whilst it remains more or less implicit, it is not possible to fully explore assumptions and value premises, actions and outcomes for consistency and effectiveness. The
implication for practice is that development of a variety of models should be sought. These could be primarily case oriented, descriptive and interactive in intent and occur within a general framework in which intervention can be justified by reference to theoretical principles based on individual rights. Such models could have utility in education and training as well as in practice since they would allow for conceptions of individual differences and individual practices which have general consistency by reference to rights theory.

The discussion points toward development of specific intervention strategies within a broader psycho-social framework based on rights theory and which emphasises the central significance of interaction and communication. The development of such frameworks for care may allow for the complexity of everyday nursing contexts in the community, provide a major focus on each patient's identification of need, allow for the element of unpredictability in practise and for theories of nursing action which are not duty or rule-based. An implication is that care decisions which are rights referenced will usually take precedence over action which is either referenced to duties or which appeals to communal or general grounds (such as rules and legislation) for justification. This means that the theories underlying patterns and models of care need to be made as explicit as possible in teaching and learning in terms of their relation to practice contexts.
The rights thesis ultimately implies a proactive stance from practitioners based on their taking responsibility for meeting patient need. Together with problem-solving approaches this will mean determining patient needs in terms of patient-defined problems which present challenges to establish nursing action which will assist the patient in overcoming or resolving problems. This implies a commitment to providing patients and/or carers with information about what treatment is being planned and why, what services are, and are not, available and generally sharing decision-making about care as far as possible. Development of criteria for measuring care process and outcome becomes essential for the self-regulation which marks a profession and this can be established through development and use of evaluation and research techniques. In this study such development is seen as necessarily tied to practice and as achieved through discovery of the district nurses' theory: the working concepts being utilised during the district nursing process.

The study implies that learning is a continuing process facilitated through shared experience and practice. Support for an initial and continuing education closely based on and in practice based contexts is reiterated as the means whereby students and practitioners synthesise theory and practice through the process of 'becoming' and being expert practitioners in their own right. Such learning needs to be supported throughout professional practice in order that the practitioner can continue to make appropriate judgements about, or to otherwise take account of new information and problems raised by the professional association to which they are affiliated, by local or
national legislation, or by local management structures, or the immediate availability of local resource.

The study suggests that sustaining motivation for change could be difficult due to the weight of organisational prescription and everyday practicalities of the work situation. Similar conclusions have been drawn regarding innovation for other professions (Shipman et al, 1974; Houle, 1980; Cervero and Scanlon, 1985). Innovation has knock on effects in that new students were seen as message carriers in their future roles. The community working contexts were not on the whole reinforcing important messages about collaborative and multi-disciplinary working nor those relating to evaluation of practice quality through self and peer assessment in relation to client needs. In this situation new district nurses were struggling to fulfil their own expectations of themselves in a context of a growing work load, an increasingly demanding public and shrinking resources.

This implies that managers and educators should constantly be involved in monitoring and evaluating change and be working towards the creation of dynamic work-education environments which will support the continuous self-directed development required for independent practice in district nursing. This will mean fighting for resources which support appropriate educational activities. A consultancy model of education in the community would be seen as appropriate in this study. Tutors and other lecturers from the educational institute would visit the field more often and act as consultants or facilitators in the student work placements. This
would ensure tutors remain in close touch with practice and would support the teaching and learning of students, PWTs and supervisors.

By taking educational resources and expertise into practice environments it might be possible to engage a larger number of practice staff in teaching and learning with students. This would provide opportunities for discussing central notions such as independent practice and team working, the aims for patient care and the roles, rights and responsibilities of different care workers.

The advantages of learning through group discussion and through feedback from peers were generally missing in the community placement placing even greater weight on the crucial relationship between teacher and student. Professional isolation remained a possibility - and was being experienced by some new practitioners - communication outside immediate district nursing personnel was often perceived as one way from the district nurse to others with a lack of feedback. This particularly applied to social service personnel where liaison was generally poor. Such contact will become increasingly important in the proposed future directions for community care as will standards of practice of support workers during the phasing out of the enrolled nurse. The limited nature of different disciplines sharing learning contexts in this particular course suggests that attendance at lectures with others is not very fruitful. Perhaps some type of educational exchange system between services could be organised so that students can 'shadow' different role holders as part of their

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training, especially general practitioners, health visitors and social workers.

Service managers clearly have a major role to play in staff development and can take an active lead in encouraging newly trained personnel in a teaching and learning approach with other staff and research based approaches towards patient care. There are training implications here for managers since the study indicated relatively unplanned career progression and poor opportunities for training in relevant skills. Practitioners and managers were identifying their own needs such as for counselling skills and broader management of changes skills which they identified as important. This indicates a promising sign of self-reflection and critical appraisal of one's own practice (Schon, 1983; Stretton, 1985). The achievement of an education oriented work environment is a challenge for managers and practitioners (Curnock, 1975; Cervero et al, 1985) but could provide them with essential support as they seek to tackle problems raised by resource constraints in community care contexts and the effects of policy directives. The district nursing curriculum can be responsive to meeting the needs of the individual and the profession but only if district nursing concerns are firmly embedded. This will only occur if local and other issues are communicated to educational centres. Co-ordination of this would seem to be a joint education and nurse management responsibility but also an individual professional responsibility if district nurses are to advance and maintain control over their practice, education and training.
SUGGESTIONS FOR RESEARCH AND REFLECTIONS ON THE STUDY

During the course of this study a sense of district nurses and district nursing as 'emergent,' rather than established, grew on me. This was probably due to a combined effect of self-reflection, in that over time I too was functioning and adapting to change at personal and 'professional' levels as a researcher, and increasing empathy with the worlds of students and practitioners some of which I came to know better than others. I say this here because I know that of the many possible suggestions which could arise from this study the ones I am about to give reflect my own interests and thinking about research and I am conscious that my perspective lacks specific understanding of clinical nursing procedures.

I would like to see district nurses continuing to develop through education and training which is appropriate for facing challenges presented by organisational or clientele change. Even more so I would hope they can exercise their prerogative as independent practitioners to create their own challenges - set their own agendas - by framing the real problems that concern them and pursuing these through their own efforts at evaluation and research in, and about, the practice of district nursing. The few suggestions I give are given in a spirit that is consistent with a theory of rights: it is your right and responsibility as district nurses to establish what is important for district nursing.

The main implication is very broad being for research and evaluation of district nursing action in a wide variety of
contexts. The general thrust of the discussion suggests that there
is a need for more basic research into the process of patient care
in the community which is non-experimental in design and is
concerned with the interpretations leading to choice of action in
individual cases. Action based research and an eclectic
methodological approach seems appropriate given the central
emphasis found herein on interaction and communication in patient
care. The references attached to the suggestions may provide a
useful starting point.

Particular 'gaps' in district nursing research have been noted
during the course of this study which would seem important for the
development of relevant knowledge. These are given below with a
reference(s) which may provide a starting point for study.

Patient and carer perspectives - there is a great deal that these
could contribute in the development of interpretations of community
services (their existence, variations and gaps) generally (Barker
and Peck, 1987); and conceptualising care and services for the
elderly in particular (Hunter and Cantley, 1984).

Associated with this is a need for the development of innovative
methods in research which are client and contextually appropriate
(e.g Willcocks et al, 1985, on pictorial methods for use with the
elderly in residential homes and Ross, 1986 on development of a
drugs guide for reducing mis-understanding between practitioners
and patients).

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Priorities, policy and planning for district nursing services are broad areas which would benefit from sustained, longer term research activities at a local, district and regional level. This study and others indicate poor supporting structures for liaison and co-ordination of services. The current and proposed changes at national level seem likely to directly influence the medical and nursing cultures of primary health care whilst also changing the balance of organisation and planning for community care so that knowledge of, and ways for, coordinating activity with personal social services and the voluntary and private sectors will be even more crucial. (Hunter and Wistow, 1987)

Associated with this is an assumption that managers will actively support district nursing teaching, research and evaluation activities in a positive manner. In this respect the research suggestion would be for studies of managerial roles in district nursing services and of training opportunities since the general ethos of management in the health service has been changing - albeit slowly it seems - over the last few years whilst training opportunities in human resource development appear thin on the ground.

As for training and education for district nursing I would suggest further research on the practical work teacher-student relationship in order to elaborate and extend understandings of this interaction and learning outcome.

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Specific case studies of nurse-patient-carer interaction and communication would also be very helpful as this remains a neglected area. This again would help clarify and extend the consistencies and differences in conceptual models which district nurses use to guide their practice.

I hope that this study has contributed to the understanding of district nursing in relation to education and to round off I give my thoughts about the research process as experienced during the past years.

This study has provided an opportunity to realise and consider issues which may arise in the case of research where this is to serve dual purposes. For the initial study, as a commissioned evaluation, the main purpose was to fulfill the contract and in that sense my personal need to satisfy the requirements for a postgraduate degree was secondary and part-time.

For the first purpose the objectives were to carry out an evaluation which would contribute to judgements about whether the new curriculum was adequate in terms of preparing district nurses for practice and whether the placing of such courses in places of higher education was workable, realistic and satisfactory for participants and the profession as a whole. Ostensibly the 'outcome' of the evaluation would help decide whether or not public commitment would be made to support the extension of similar courses nationally in further and higher education institutions.
Whilst the professional body (PADNT) and the sponsoring body (DHSS) provided an open brief and little interference (see Chapter One) there were practical considerations which immediately constrained the overall design of the evaluation if the researchers were to fulfill what they saw as their obligations. The major constraint from my perspective was that the time scale which was short; the students would remain in a training and education context from October 1980 until July 1981 and, as indicated previously, I took up post in November 1981 having had no research experience of adult professional education. The time-scale restricted preparatory work.

Thus among the factors which influenced design and conduct of the commissioned evaluation were consideration of the needs of the effective audience for the research (the PADNT) and of the purposes they were trying to achieve. A second factor was the time scale available under real, as opposed to ideal, conditions for work to be carried out given the immediately available resources including deployment of manpower in terms of relevant research skills and other experience. Other considerations were the size of the student, community teacher, supervisor and manager populations and the geographical location of these for coverage during community placements. A combination of these factors meant that some possible design options were not feasible; for example data from comparable or different courses might have indicated similarities and differences attributable to course construction, environmental, student or staff differences but this would have gone well beyond
the manpower and time constraints built into the evaluation (an additional factor was that only one other new course was in existence and this was in Kent - too far away to involve effectively).

It became clear very early on that courses based on the 'old' curriculum were on the way out and that short of total disaster for students on the course there was very little which would prevent the already planned and scheduled national implementation of the new curriculum. This gave rise to mixed feelings which were stressful since in one sense the rationale for the evaluation appeared negated. Later on it seemed that perhaps some outcomes would have an influence on future courses and on the preparation for teachers in the community and this retrieved some of my motivation. At this level therefore I learned at first hand the political nature of evaluation and about the need to make realistic compromises regarding design and collection of information.

Whilst this was going on at one level at another I was becoming increasingly interested in the 'subjects' for the evaluation and began to realise that it was the practitioners and students who were high on my list as a priority audience. I therefore spent considerable time over the next few years in responding to people from other newly set up courses to provide feedback from the research to students and others. This activity was very helpful in providing a wider relevant audience against which to validate findings from the single case study.
The second purpose which the study was to serve as the foundation and context for a part-time higher degree. This meant that the constraints indicated above were in operation and as I interpreted it my task was to combine the two purposes as far as possible. The reason for this was not merely due to pressure of time impinging on the researcher but was as much to do with the fact that I believed that the participants should not be expected to give more time to the study than was reasonable. This mainly perhaps applied to the students who were people coping with the experience of higher education usually for the first time and the majority of all participants had major social and family commitments. The combination of purposes and methods means that much of the data reported varies little from that already reported for the purposes of the evaluation. The main distinctions are to do with the longer period of time - far too long - over which it was possible to reflect on the findings and learn through carrying out different research in related areas. With a student hat on it was possible to explore the possibility of discerning unifying orientations towards teaching, learning, and practice through firstly further reflections on the findings in the light of other research and the addition of supporting argument found in discussions and observation with the original participants and district nurses carrying out patient visits and, as I said above, with people from a wider range of courses.

Obviously there are enormous advantages in terms of access and proximity in being in the position to combine work as researcher
and study as a research student. There were however disadvantages in that I was rarely able to participate in the weekly post-graduate programmes and was somewhat isolated from peer support except for spells during 1983-84. A further disadvantage was that it was hard to maintain a critical stance with the course tutors within the department and they were never formally interviewed though one in particular provided a great deal of support. The main disadvantage in combining operations as I found it was that it was difficult to develop a separate sense of purpose directed at a thesis but this seems to me to have been perhaps unavoidable if schizophrenia was also to be avoided.

Thus there can be advantages in solely pursuing research for study purposes in that it is perhaps possible to be more focused as well as more adventurous in approach and technique. For example at one stage I considered the use of repertory grid techniques which seemed particularly appropriate for patterning roles and also focus on the individual (Kelly, 1955; Fransella and Bannister, 1977). However there was insufficient time to get to grips with the theory underlying the construction of such a specific technique and it would have been far too time consuming to elicit constructs and apply these with the number of people involved. Nevertheless I think that this could be a fruitful method for exploring the meanings and perspectives of different individuals and groups involved in local care contexts, particularly perhaps those between nurse and patient in the home.
DISTRICT NURSE TRAINING

TRAINING OF PRACTICAL WORK INSTRUCTORS

1. FUNCTIONS OF THE PRACTICAL WORK INSTRUCTOR

A practical work instructor is a district nurse who accepts full responsibility for the practical work instruction of nurses undertaking district training leading to the award of the National Certificate in District Nursing (SRN and SEN).

2. SYLLABUS OF TRAINING

The basic requirements for a 15 day course, preferably in a 3 weeks block, are:

- Principles of teaching
  - Psychology of learning

- Communications
  - Interpersonal behaviour and relationships
  - Job analysis

- Use of professional skills and modern procedures in the provision of total nursing care

- Study of the environment in which the district nurse will work including developments in the health and social services

- Study of community and hospital nurse training syllabuses

- Methods of practical work assessment

- Planning of practical work training programmes.

Responsibility for determining who should give the instructions and for allocating study time to the various subjects rests with the training institutions. Adequate time must however be allocated to item (a) of the syllabus which deals with the principles of teaching and learning. If necessary individual tuition on the updating of the application of modern procedures should be given by the employing authority prior to the course.

3. SELECTION OF STUDENTS FOR THE COURSE

The minimum qualifications for entry to the course will be SRN/RGN and NDN Certificate (or equivalent) with not less than two years' district nurse experience after qualification as a district nurse.

Selection of candidates should be by the employer and training centre and should include an evaluation of the candidate’s effectiveness as a district nurse.

4. APPROVAL OF COURSES AND ISSUE OF CERTIFICATES

Training authorities and educational institutions proposing to offer a course of training will be required to submit details to the Panel of Assessors for approval including the method of student assessment to be adopted during the course.

On the advice of the approved institution the Panel of Assessors will issue a certificate to nurses who successfully complete the course.
Guidelines about the third course:

This paper contains information on the Aims and Objectives of the course, plan and dates, course syllabi and assessment procedures. Details of the modifications made in the light of knowledge gained from the first two courses are outlined.

Aims of the District Nurse course (SRN/RGN) at Surrey:

To create a learning environment where students can benefit from the educational process, by extending their knowledge in district nursing studies, related subjects, and in furthering their personal and professional development. At the end of the course the district nurse student will be competent to undertake nursing duties within the community and be held individually accountable for the professional standards of her own performance.

These include the Aims specified in the Report of the Panel of Assessors, "The Education and Training of District Nurses (SRN/RGN) 1976". This Report indicates that the objectives of District Nurse education and training are:

i. To assess and meet the nursing needs of patients in the community.

ii. To apply skills and knowledge and to impart them effectively to patients, relatives, other carers and the general public.

iii. To be skilled in communications, establishing and maintaining good relationships and able to co-ordinate appropriate services for the patient, his family and others involved in the delivery of care.

iv. To have an understanding of management and organisation principles within the multi-disciplinary team and a positive approach to future developments to meet health care needs.
Course Plan - Part I

Six months duration plus 13 days Annual Leave and 6 Bank Holidays. This period will comprise an integrated programme of Theory and Practice (ref: Report Page 4). Students will attend the University for lectures, seminars, workshops, private study, etc. For practical experience students will be placed with practical work teachers to whom they will be introduced during the three-day orientation period.

Course Plan - Part II

The period of supervised practice will be of three months duration and students will work the normal duty rota covering the full range of nursing duties. This part of training will be supervised by a Nursing Officer. The student will attend the University for 2 Study Days and will have the normal annual leave entitlement of 6 days plus one Bank Holiday.
COURSE DATES: 1980/81

The following inclusive dates will form the Study Blocks: 1980/81:

Block 1  15th October - 31st October  1980
Block 2  17th November - 5th December  1980
Block 3  5th January - 30th January  1981
Block 4  16th February - 20th March  1981
Block 5  21st April - 8th May  1981

The following inclusive dates will form the Practical Learning Blocks: 1980/81:

Block 1  3rd November - 14th November  1980
Block 2  8th December - 19th December  1980
Block 3  1st February - 14th February  1981
Block 4  22nd March - 8th April  1981

The following inclusive dates will form the Annual Leave: 1980/81

Part I  21st December - 4th January
       9th April - 20th April

Part II  Six days during the period of Supervised Practice
         plus one Bank Holiday.
1. During the six months training the course dates have been planned to allow for the integration of theory and practice.

2. The three day orientation period will allow the student to become familiar with both the University environment and Practical Work Placements. The third day of this period will be spent in the field with the Practical Work Teacher.

3. A period of concentrated study has been programmed at the beginning and end of the course, in line with the recommendations laid down in the Report.

4. A variety of learning experiences will be programmed into each Study Day (10 am - 4 pm).

5. Time for private study will be allocated on the basis of one day per week in each Study Block.

6. During private study students will be expected to
   (a) read widely and prepare for course exercises;
   (b) undertake in depth study of subjects covered in course programme;
   (c) prepare the four Assignments required as part of the Assessment procedure of the course.

7. During Practical Work Blocks students will be given ½ day each week for private study.

8. During Practical Blocks 1 and 2 the student will observe and practise the skills of district nursing. During these Blocks the student will work from Monday to Friday with the weekend off duty.

9. During Practical Blocks 3 and 4, the student will be allocated a controlled caseload by the Practical Work Teacher. This will enable the student to gain experience in its management. During these Blocks the students will have the same off-duty as the Practical Work Teacher.

10. During the period of Supervised Practice the Student's off duty will be in accordance with the local off-duty rota.
Course Syllabi have been developed from the objectives contained in the "Report on the Education of District Nurses (SRN/RGN)" into four inter-related modules; these form the framework of the course, and though of unequal length have been planned to run concurrently throughout.

1. The Principles and Practice of District Nursing.
2. Current Trends in Medical Practice
4. Social Administration.

SECTION 1 - PRINCIPLES AND PRACTICE OF DISTRICT NURSING

Basic Nurse Training:

Knowledge of Training Syllabi: SRN and RGN
Community Experience

Bereavement:

Reactions to bereavement
Counselling
Promotion of mental health

Communication: Written, verbal, non-verbal

Principles of verbal and non-verbal communication
Principles of written communication
Office Procedure
Record Keeping
Recording Systems
Report Writing

Counselling:

Self-awareness
Listening, supporting and facilitating problem solving of others.

District Management:

Area and District Policy on Professional Practice
Disciplinary and Grievance Procedures
Leadership Styles
Legal Aspects
Management Skills - managing patient care, caseload, clinic, treatment room, nursing team, self, change.
Principles Underlying Teamwork: Promotion of Good Relationships
Understanding of District Nurse Management Structure
Use of Aids and Equipment.

Emergency Midwifery
Ethics:

Ethical Concepts Applied to Nursing

First Aid:

Principles
Resuscitation

Health Education:

Evaluations of Reactions to Health Education
Life Style and its Effects on Health and Disease
Prevention: Primary, Secondary and Tertiary
Promotion of Health Education in One-to-One and Group Situations
Use of Resources to Obtain Information: Visual Aids
Care of Own Health: Posture and Lifting
Family Planning

Epidemiology:

Sources of Health Statistics
Interpretation of Health Statistics
Use of Epidemiological Methods in Planning Health Services
Use of Epidemiological Methods within a Practice Population

Interviewing Techniques

Microbiology:

Infection Control - in community and home.
Immunisation - Schedules, Policy, Legal Aspects.

Non-Accidental Injury: Children/Elderly

Identification
Cause/Effect
Policy
Legal Aspects

Nursing Process: Concept of Care Relating to Physical, Psychological, Social, Financial and Spiritual Needs of All Age Groups:

Assessment
Planning
Implementation
Evaluation

The Nursing Process as Applied to Long Term Disabilities, Degenerative Disorders and Terminal Illness, including:

Cerebral Vascular Accident
Diabetes
Fistulas
Incontinence
Malignant Conditions
Multiple Sclerosis
Paraplegics
Rheumatoid Arthritis
Rehabilitation
Varicose Ulcers
Nutrition:

- Dietetics
- Home Economics
- Budgeting

Primary Health Care:

- Primary Health Care Teams
- Concept of Primary Health Care
- Liaison with other Agencies

Research Appreciation:

- Ethical, Legal, Professional Implications of Research in nursing
- Uses of Research in Developing and Evaluating New Procedures and Techniques.

Role Appreciation and Skills Analysis: Insights into the Role of:

- Community Psychiatric Nurse
- District Nursing Sister: Charge Nurse
- General Practitioner
- Health Centre Administrator
- Health Visitor
- Midwife
- Nurse Managers
- Nursing Auxiliary
- Social Worker
- State Enrolled Nurse

SECTION 2 - CURRENT TRENDS IN MEDICAL PRACTICE

Physiology:

Student directed revision

Conditions Commonly Met in the Community:

- Chronic Aspects of the Following:
  - Cardio-vascular and respiratory disorders
  - Gastro-intestinal disorders
  - Multiple Sclerosis
  - Parkinsonism
  - Mental Illness
  - Osteo and Rheumatoid Arthritis
  - Urological Disorders
  - Skin disorders
  - Infectious/Communicable/venereal disease
- Eye Conditions
- Ear Conditions
- Malignant conditions
- Philosophy of geriatric care in the community
Conditions Commonly met in the Community, Cont'd:

Conditions affecting the elderly in the community
- Diabetes
- Varicose Ulcers
Introduction to:
- Genetics and congenital disorders

Pharmacology:

- Effects, side-effects, interactions of common drugs, iatrogenic disease.
- Sources of information
- Drugs in terminal illness

SECTION 3 - BEHAVIOURAL SCIENCES

Educational Studies:

- Communications Theory and Skills
- District Nurse's Teaching Role
- Introduction to methods of Learning and Teaching
- Individual differences in Learners
- Self Assessment of Own Performance

Psychology: Introduction to:

- Psychological approaches to understanding human behaviour
- Normal human development:
  - Birth to maturation
  - Maintenance of psychological well-being
  - Psychology of ageing
- Factors which make each individual unique:
  - Personality development; theories of personality
  - Motivation and behaviour
  - Nature of human intelligence
- Mental defence mechanisms: including denial, repression, projection
- Applying Maslow's Hierarchy of Needs to Health Care
- Role of the clinical psychologist and the district nurse
- Significance of above concepts for Nurse, patients, and carers.

Sociology and Social Psychology:

- An introduction to:
  - Social Class and Structure
  - Family and Kinship Networks
  - Cultural definitions of health and illness
  - The sick role, the process of becoming ill
  - Social problems as related to the elderly, loneliness, poverty
  - Professionalism
- An approach to interpersonal dynamics - transactional analysis theory
- Group dynamics applied to team situations: leadership styles, role theory

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SECTION 4 - SOCIAL ADMINISTRATION

Introduction to:

Central and Local Government
NHS: structure; roles; place of district nurse
School Health Service
Current Issues in the NHS
Social Services: history; structure; roles; referral techniques
Social Service provision: financial constraints
Role of the social worker
Social Security Benefits: contributory and non-contributory
Role of Disablement Resettlement Officer
Role of Environmental Health Officer
Public Health Aspects of Housing
Voluntary Societies: development; role in Welfare State
Referral techniques
Chronically Sick and Disabled Persons Act 1970
Mental Health Act 1959
Vital Statistics: use of sources of information to collect relevant statistics
1. The Report stipulates that during the course the students will be required to undertake four assignments and it will be for the Centre to determine the type of assignment used (ref: Report Page 6). The following will be set:

(a) a project on a Health Education or Nursing Topic;
(b) two extended essays, i.e. one on the behavioural sciences and one on social administration;
(c) a Care Study implementing the Nursing Process.

2. **Internal Examination**

As yet there is no national examination for the extended form of training. Students will sit an internal examination at the end of Part I which will be marked by two external examiners.

3. **National Examination**

The National Examination in District Nursing will be taken by the students at the end of Part I and marked by two external examiners in accordance with the present procedures approved by the Panel of Assessors for the examination of district nurses.

4. **Practical Work Assessments**

The Practical Work Teacher will make a continuous assessment of the student's progress throughout the first 6 months, and report upon student competence to practise as a district nurse.

5. **Supervised Practice**

A satisfactory report from the Nursing Officer supervising the 3 months continuous practice will be required.
## Course Dates - Part I

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**Key:**
- S = Study Day in University
- PW = Practical Work Placement
- DO = Day Off
- BH = Bank Holiday
- Int = Internal (Exam)
- Nat = National (Exam)

During Weeks 17 and 18, and Weeks 24 and 25, the student will have the same two days off duty each week as the Practical Work Teacher.

### Course Dates: Supervised Practice - Part II

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<td>wk 36</td>
<td>14 Jun -  20 Jun</td>
<td></td>
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<tr>
<td>wk 37</td>
<td>21 Jun -  27 Jun</td>
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<td></td>
</tr>
<tr>
<td>wk 38</td>
<td>28 Jun -  4 Jul</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>wk 39</td>
<td>5 Jul -  11 Jul</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>wk 40</td>
<td>12 Jul -  18 Jul</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>wk 41</td>
<td>19 Jul -  25 Jul</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>wk 42</td>
<td>26 Jul -  1 Aug</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

The Annual Leave allowance of 6 days for the period of supervised practice can be taken at any time to suit the service and district nurse student, provided he/she is available for attendance on Study Days.
The following questions are intended to obtain your opinions on certain aspects of the present course, paying particular attention to practical work issues. Questions require you to either circle appropriate numbers, or to put ticks in boxes, or to cross out the word which does not apply and, finally some require comments in your own words. Please note the time the questionnaire takes to complete at the end of the last page.

Interest Areas

1. Please read through the following list of patient groups, and circle the appropriate number or numbers where you feel you have a specific interest (or would like to develop such an interest).

- Elderly, generally ..................................................... 1
- Elderly, living alone .................................................. 2
- Mothers and new babies ................................................. 3
- Pregnant women ........................................................ 4
- Under 5's .............................................................. 5
- School children ........................................................ 6
- One parent families .................................................... 7
- Ethnic minorities ...................................................... 8
- Relatives of patients .................................................. 9
- Mentally handicapped ................................................ 10
- Physically handicapped .............................................. 11
- Mentally ill .......................................................... 12
- Terminally ill ........................................................ 13
- Post operative patients/hospital discharges ....................... 14
- Other(s), please specify ..............................................

Look again at the list before answering the following:

a) Choose one group you think is most in need of more care from nurses in the community.
   Write your answer here ................................................

b) Which one group would you most like to spend time on in your district nursing career?
   Write your answer here ................................................
2. Please read through the following list of clinics, and circle the appropriate number or numbers where you feel you have a specific interest (or would like to develop such an interest).

Antenatal, postnatal, relaxation, psychoprophylaxis .................... 1
Well woman, cytology .......................................................... 2
Well baby, infant welfare, child health ................................. 3
Developmental assessment .................................................. 4
Immunisation and vaccination ............................................. 5
Family Planning .............................................................. 6
Hearing and vision screening ............................................. 7
School medicals ............................................................... 8
GP surgery sessions ....................................................... 9
Slimming/obesity ............................................................. 10
Blood pressure screening .................................................. 11
Parentcraft/Mothercraft .................................................... 12
Other(s), please specify ....................................................

Look again at the list before answering the following:-

a) Choose one type of clinic which you would most like to do more studying about, or receive more training in, or information about.
Write your answer here ..................................................

b) Which type of clinic have you had most experience in?
Write your answer here ..................................................

Please give your main reasons for choosing district nursing as a career.
3. Please read through the following list of counselling and health areas, and circle the appropriate number or numbers where you feel you have a specific interest (or would like to develop such an interest).

Immunisation and vaccination ........................................ 1
Family planning including sterilisation ............................. 2
Marital and psychosexual problems .................................. 3
Physical health problems ............................................ 4
Mental health problems .............................................. 5
Health education in schools ......................................... 6
Pregnancy and labour ................................................ 7
Child care/child development/parent craft ............................ 8
Nutrition ....................................................................... 9
Other(s), please specify ..............................................

Look again at the list before answering the following:

a) If you had time, which one area would you most like to spend time on in your district nursing career?
Write your answer here ..............................................

b) If you circled 4 above (physical health problems) what particular problems are you interested in?

4. Please record your impression of the course as a whole at this half way stage (including practical work experience). Put a cross in the appropriate space on each of the scales.


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5. Below are a number of teaching or learning methods. For each one, please indicate, by ticking the appropriate box, how far you agree with the statement that such a teaching/learning method is very useful to you personally.

<table>
<thead>
<tr>
<th>Teaching or Learning Method</th>
<th>I find this method very useful</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>agree strongly</td>
</tr>
<tr>
<td>Private study</td>
<td></td>
</tr>
<tr>
<td>Small group discussion</td>
<td></td>
</tr>
<tr>
<td>Lectures</td>
<td></td>
</tr>
<tr>
<td>Tutorials</td>
<td></td>
</tr>
<tr>
<td>Whole class discussions</td>
<td></td>
</tr>
<tr>
<td>Individual tutorial</td>
<td></td>
</tr>
<tr>
<td>Seminar</td>
<td></td>
</tr>
<tr>
<td>Self-directed study</td>
<td></td>
</tr>
<tr>
<td>Role-play</td>
<td></td>
</tr>
<tr>
<td>Presentation of projects</td>
<td></td>
</tr>
<tr>
<td>Half group discussions/tutorials</td>
<td></td>
</tr>
<tr>
<td>Video-tapes</td>
<td></td>
</tr>
<tr>
<td>Film</td>
<td></td>
</tr>
<tr>
<td>Other(s) please specify</td>
<td></td>
</tr>
</tbody>
</table>

Please look at the list of methods again and answer the following:

a) On the whole, which methods (please limit yourself to three) do you find most useful?
Write your answer here: ........................................
.................................................................
.................................................................

b) On the whole, which methods (please limit yourself to three) do you find least useful?
Write your answer here: ........................................
6. Please describe briefly your practical work placement (from your experience in the first blocks) using the following guidelines:

a) **Premises/base**

b) **Personnel e.g. P.W.T. and other members of P.H.C.T.**

c) **Extent and Type of Communication/Liaison with those at (b)**

d) **Socio/economic area (e.g. rural, urban, class composition)**

e) **Main Patient Groups dealt with**

7. Please outline your relationship with your P.W.T. and describe any difficulties (concerning work or personality) you may have had in establishing a good relationship.
8. a) Do you consider that you were adequately prepared by the university courses prior to your first two work blocks?

b) Prior to your third work block?

9. Please comment on the amount of course work (e.g. projects, essays, care studies) which you were required to do, or found it necessary to do, during both the first and second practice work blocks.

10. When looked at as a period for 'continuous assessment' do you think that four two week practical blocks are a satisfactory arrangement? YES/NO
    If you answered NO can you suggest improvements
11. Here is a list of personnel. Please consider the list and decide
1) firstly, which personnel you believe in theory form the basis of a
primary health care team and tick the appropriate box or boxes in
column (A)
2) secondly, by drawing on your own experiences or observations, which
personnel in practice make up the primary health care team and tick the
appropriate box or boxes in column (B)

<table>
<thead>
<tr>
<th></th>
<th>A Theoretical P.H.C.T.</th>
<th>B Practical P.H.C.T.</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing auxiliary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liaison nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home help</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family planning nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP practice nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Night sitter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health visitor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State enrolled nurse (DN Cert)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bath nurse/attendant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community psychiatric nurse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. Are there any others, not mentioned above, whom you consider are vital
members of the primary health care team?

a) in theory
   If yes, please specify here ..............................................

b) in practice
   If yes, please specify here ..............................................
The district nurse must be committed to managing the primary health care team.

14. Teaching patients/clients is an essential part of the district nurse's role.

15. To carry out her/his work effectively the district nurse must co-operate closely with other members of the primary health care team.

16. Teaching trainee staff (S.E.N's Auxiliaries G.P. trainees etc) is an essential part of the district nurse's role.

17. Counselling patients/clients is a necessary part of the district nurse's role.
Below are two statements and a question relating to the nursing process. Put a cross in the appropriate space on each of the scales relating to the statements. Please be frank.

18. In my opinion applying the nursing process during patient care is:

<table>
<thead>
<tr>
<th></th>
<th>easy</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>useful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>waste of time</td>
</tr>
<tr>
<td></td>
<td>practical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>academic</td>
</tr>
</tbody>
</table>

19. The presentation/teaching of the nursing process on this course so far has been:

<table>
<thead>
<tr>
<th></th>
<th>confusing</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>clear</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>stimulating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>boring</td>
</tr>
<tr>
<td></td>
<td>rushed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>drawn out</td>
</tr>
<tr>
<td></td>
<td>practical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>academic</td>
</tr>
<tr>
<td></td>
<td>skimped</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>thorough</td>
</tr>
</tbody>
</table>

20. How well do you feel you have grasped the concept of the nursing process?

|          | very well |       |       |       |       |       |       | not very well |

***

Thank you for your help.

Time taken to complete ..................
1. How important do you think your district nurse experience prior to coming on the course was in enabling you to cope with:

   a) the practical work (blocks and supervised practice)

       very important : : : : : : : not important

   b) the course theory

       very important : : : : : : : not important

(Please mark the scales at appropriate points for a) and b).

2. Please give your reasons for giving these opinions:

   a)

   b)

3. How well do you feel the course prepared you for:

   a) the internal examination

   b) the external examination

(Please tick appropriate column)

Please comment on the main differences, if any, which you found between the two examinations

4. Please record your impression of the course as a whole (including practical work experience and supervised practice). Put a cross in the appropriate space on each of the scales.


5. Please tick the columns below to describe your relationship with your P.W.T. by the end of the 6 months (You may add further comments if you wish)

<table>
<thead>
<tr>
<th></th>
<th>good</th>
<th>fair</th>
<th>poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>working relationship (general)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>social relationship (general)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>practical guidance offered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>theoretical guidance offered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>openness of communication</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. How well do you feel the first 6 months of the course prepared you for the following? Please tick the appropriate column.

<table>
<thead>
<tr>
<th></th>
<th>Very Well</th>
<th>Reasonably Well</th>
<th>Not Very Well</th>
</tr>
</thead>
<tbody>
<tr>
<td>managing your own caseload</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>carrying out the nursing process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>conducting surgery sessions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>assess and meet the nursing needs of patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>preparing/writing reports or case notes on patients</td>
<td></td>
<td></td>
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<tr>
<td>liaison and communication with other members of the p.h.c.t.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>communication with, and co-ordination of appropriate services for patient needs</td>
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<td></td>
</tr>
<tr>
<td>continuation of your personal and professional development</td>
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</tr>
</tbody>
</table>

7. Put a cross in the appropriate space on each of the scales relating to the statements. Please be frank.

In my opinion applying the nursing process during patient care is:


8. How well do you feel you have grasped the concept of the nursing process?

- very well : : : : : : : not very well
9. Did your N.O. plan a programme with you (including objectives) at the start of the 3 months.

YES/NO (please delete)

If yes, what were the major agreed objectives:

10. How far would you agree that these objectives have been achieved at the end of the 3 months? Please mark the following scale at an appropriate point


11. Please state the total number of occasions you met with your N.O. in the 3 months.

Please enter number in the box

12. How many of these occasions involved the N.O. visiting a patient (or patients) with you?

Please enter number in the box

13. Please tick the columns below to describe your relationship with your N.O. during the 3 month supervised practice. (You may add further comments if you wish)

<table>
<thead>
<tr>
<th>working relationship (general)</th>
<th>good</th>
<th>fair</th>
<th>poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>social relationship (general)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>practical guidance offered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>theoretical guidance offered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>openness of communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>frequency of contact</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
14. How far would you agree with the statement that the 3 month supervised practice is a necessary part of district nurse training and education (Please mark the following scale at an appropriate point)

agree
disagree

15. Please give the main drawbacks, if any, which you feel are associated with your 3 month supervised practice.

16. Please give the main advantages, if any, which you feel are associated with your 3 month supervised practice.

17. At the end of the 9 months how far would you agree/disagree with the statement that the course has provided you with a far deeper understanding of the role of the district nursing sister in relation to others involved in primary health care.

agree
disagree

Student Number

***

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Thank you for your help.
Appendix 5

PRACTICAL WORK RECORD SHEETS

Purpose
The information you give on these record sheets will enable us to build up a clearer picture of students' experiences during their practical work blocks and provide an insight into the variation of opportunity students get to practice their skills as district nurses.

Instruction for use

General
1. Please put your name on the first sheet.
2. Begin recording on your third working day from the start of your practice. There are six sheets numbered 1 to 6 which should be completed for six consecutive working days.
3. Circle the appropriate day of the week for each day and state approximate time your day started and ended. Take these times from the time you enter or leave your practice base e.g. surgery, health centre etc. If, however you go straight from your home to your first patient visit take this as your start time and similarly at the end of the day. Please enter H above either time if this is a 'home' time.

Activities
4. Enter numbers and other information in the appropriate spaces for activities 1 - 9. You may find it helpful to record in pencil half way through your day.
5. The time column requires estimated time spent at different activities to nearest quarter hour. You may however give actual time if this is possible for you.
6. Any additional information may be written on the back of the sheet.

Contacts
7. Please circle the personnel with whom you have had purposeful contact/discussion relating to your work or study as a district nurse student. Do not include those contacts which have been recorded under activity columns 2, 3 or 7.
Students Name:  

Appendix 6

Case load during 3rd Practical Work Block

1) Total number of patients you were responsible for during the last work block

2) In your opinion was this number satisfactory/too few/too many (please delete as applicable)

3) Please list the patients and give brief details:

<table>
<thead>
<tr>
<th>Number</th>
<th>Sex (M/F)</th>
<th>Age (years)</th>
<th>Visits required (e.g., daily, twice daily, weekly etc)</th>
<th>Illness/Problem (e.g., diabetic, H.S. etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
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<td>7</td>
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<td>8</td>
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<tr>
<td>9</td>
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<tr>
<td>10</td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

(If you had more than 10 please continue overleaf)

4) Did you normally report back to the P.W.T. or GP or other person regarding these patients? Please give brief details

5) In your opinion, did you receive sufficient support from your P.W.T. in the care of these patients e.g. in terms of discussion etc.

   YES/NO (please delete)

6) If 'NO' to Q5 what would you have liked?

M.B. Reduced size
Appendix 7

Experience during final work block

1) Total number of patients you were responsible for during this work block

2) Please list the patients and give brief details

<table>
<thead>
<tr>
<th>Number</th>
<th>Sex (M/F)</th>
<th>Age (years)</th>
<th>Visits required (e.g. daily, twice daily weekly etc)</th>
<th>Illness/Problem (e.g. diabetic, M.S. etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td></td>
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<tr>
<td>4</td>
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<td>5</td>
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<td>6</td>
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<td>7</td>
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<td>8</td>
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<tr>
<td>9</td>
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<tr>
<td>10</td>
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<td></td>
</tr>
</tbody>
</table>

(If you had more than 10 please continue overleaf)

3) Do you feel that this block gave you sufficient opportunity to practice the following skills? (Please tick appropriate boxes)

<table>
<thead>
<tr>
<th>Managerial skills (e.g. allocation of work)</th>
<th>to a great extent</th>
<th>to some extent</th>
<th>not really</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing care in the home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing care in surgery/treatment room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal skills - patients &amp; relatives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal skills - other colleagues in P.H.C.T.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

W.B. Reduced size

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4) If you were not given an individual case load, please explain how your work was allocated and say whether this was a satisfactory arrangement.

5) Did you normally report back to the P.W.T. or the G.P. or other person regarding these patients? Please give details.

6) Did the Nursing Officer visit you during this block?  

   YES/NO (please delete)

7) In your view did you receive sufficient support from your P.W.T. during this block? If not please say what you would have liked.
Appendix 8

Students Follow-up Interview Guidelines

Work Situation
Full-time, part-time, attached or not, evening duties, hours in surgery work.

Practice Details
Same practice as for 3 month supervised practice?, personnel in practice, premises.

Work Contacts
Persons communicated with most frequently/least frequently for work purposes, meetings with other personnel.

Perceived Need for Further Training eg Counselling
Importance of in work, areas where required to provide most guidance, need for further training.

Course
Which aspects of course theory found to be useful/not very useful, methods of learning found to be of value, usefulness of self/peer assessment, evaluation of teaching of nursing process.

Roles and Relationships
Clear idea of d.n. role and others in P.H.C.T.; relationship with G.P.s; supports and constraints in job development.

Organisation of Work
Management functions including delegation, overlap, liaison procedures, access to patients notes.

Patient Care
Type of work load, use of nursing process, initiatives since leaving course.

Future
Aspirations, development of job, desire to specialise, wants to be a PVT.

Y.B. The main topic areas are underlined and followed by examples
Appendix 9

Practical Work Teachers Interview Guidelines

Background experience

nursing qualifications, year of D.N. and P.W.T. training; previous students from Surrey courses;
motivation to train as P.W.T.;
selection for training as P.W.T..

District Nurse Role

definition of role as D.N. now and in past, changes occurring;
use of nursing process in work.

P.W.T. Role

definition of role in relation to student and other members of P.H.C.T.;
effect of curriculum innovation in district nursing role;
sources of advice/support channels for newly trained P.W.T. and others;
is support etc. forthcoming on formal or informal basis;
need for allowances (time/payment) for training activities.

District Nurse Training

aspects of teaching role which P.W.T. sees as causing difficulties;
views of new course: necessary or not/its relevance to d.n. role/needs of patients;
liaison with tutors satisfactory or not, study or review days sufficient or not, any difficulties in attending.

N.B. The main topic areas are underlined and followed by examples
Appendix 10

Nursing Officers Interview Guidelines

Experience

Concentrate on teaching/tutoring qualifications/experience;

Training in supervision of students/updating/usefulness of study/other days;

Previous experience of supervising Surrey students; knowledge of course.

Role

In relation to P.W.Ts this year;

Involvement in P.W.T's supervision of student, conflict? Do they know what is expected of them by tutor;

How is changeover from P.W.T. to N.O. managed.

Three Month Supervisory Period

Forward planning;

Effect of other commitments, disadvantages and advantages of student supervision;

Formal or informal supervision.

Role of D.W.

Attitude toward - extended course;
   - P.H.C.T.;
   - nursing process.

W.B. The main topic areas are underlined and followed by examples.
Divisional Nursing Officer Interview Guidelines

Role: General

main functions; priorities; changes anticipated in future training needs;

Role: in relation to training

selection; staff development; policy particularly in district nursing;

personal involvement in d.n. course and/or students;

effects of shorter working week, manpower problems.

Primary Health Care

views of P.H.C. team concept and community nursing in general;

role of d.n. in and role as projected through new d.n. curriculum;

effect of mandatory training on others in community care (e.g. H.V. and S.E.N.) and on employment policy.

D.N. Course

communication and contact with course tutors;

agreement over selection and training objectives (esp. nursing process);

need for extended training and training for community work.

N.B. The main topic areas are underlined and followed by examples.
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