KF REPORTS

Number KFC 82/125

THE MANAGEMENT OF THE NURSING PROCESS

A conference at the King's Fund Centre

Friday 23 April 1982

Reported by Charlotte Kratz

June 1982

50p

King's Fund Centre
126 Albert Street
London NW1 7NF

Tel: 01-267 6111

King Edward's Hospital Fund for London is an independent charity founded in 1897 and incorporated by Act of Parliament. .It seeks to encourage good practice and innovation in health care through research, experiment, education and direct grants.

The King's Fund Centre was established in 1963 to provide an information service and a forum for discussion of hospital problems and for the advancement of inquiry, experiment and the formation of new ideas. The Centre now has a broader interest in problems of health and related social care and its permanent accommodation in Camden Town has excellent facilities for conferences and meetings. Allied to the Centre's work is the Fund's Project Committee which sponsors work of an experimental nature.

INDEX

THE MANAGEMENT OF THE NURSING PROCESS

This conference, whilst forming the second of two day conferences directed towards the same theme (the first one - Nurse to Nurse Reporting, took place on the 4 March 1982) could be appreciated as an independent unit. About 50% of the participants had attended the previous conference.

In his opening remarks, the Chairman for the day, John Birch PhD, Divisional Nursing Officer, Gateshead Area Health Authority, referred to the fact that nursing process while the problem-solving approach to nursing care, had undoubtedly added to the anxiety which was always present in hospitals and the community. He thought that there was a general commitment to the introduction of this new approach which would, for the first time, enable the profession to establish better communication systems and, through them, lead to improvements in nursing care. There appears to be a suspicion, rightly or wrongly, said Dr Birch, that nursing managers of senior rank, both service and education, had failed to give a lead in this and had been slow to provide adequate facilities for its introduction. If this impression was correct, it was a serious indictment of all. If on the other hand there had been help and support then the conference could act as a stimulus to continue this, for there was little doubt that it would take at least a decade to accomplish the introduction of the nursing process.

Dr Birch introduced the first speaker Miss Gladys Law, Adviser - Nursing Process, Department of Health and Social Security, as someone who had been with the DHSS since 1979 and was therefore known to many members of the audience. Prior to that she had worked as a Nursing Officer at King's College Hospital and there, had become aware of the need to change certain nursing practices. Her expertise was therefore based, not on an academic approach but on sound practical experience.

MISS GLADYS LAW, ADVISER - NURSING PROCESS, DEPARTMENT OF HEALTH AND SOCIAL SECURITY

What is the Nursing Process?

Miss Law said, that looking around she could identify many people fully committed to the nursing process. Around the country, however, it continued to be viewed with suspicion, fear and confusion, as to what it really meant. Because of this she felt that it was important to start with a discussion of what it was and, more important perhaps, of what it was not.

Miss Law thought that diagrams often appeared to show the nursing process in four main stages, assessment, planning, implementation and evaluation of nursing care.

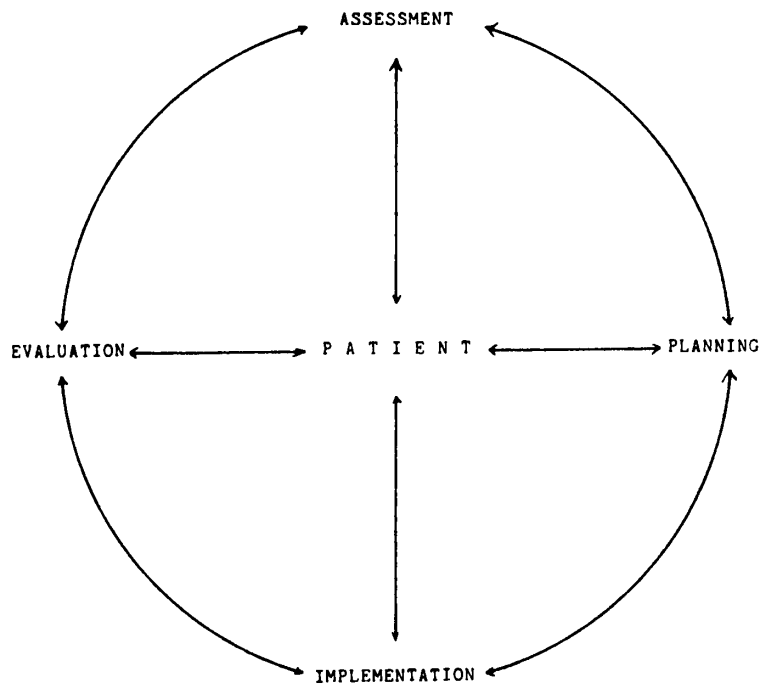

Figure I.

Although they appeared separate, in use they were often interrelated and overlapping. All stages could occur simultaneously in one patient. Often also, nursing process was shown as a cycle, making it possible to go through the stages more than once, adding or subtracting from them in the process if the desired outcome had not been achieved or if some aspect of care had been completed.

Most important in all this was the inclusion of the patient and the swing from a disease orientation to one which included the patient and his own welfare. This inclusion of the patient was not always welcomed by the nursing staff who worried about what doctors would think if they talked to patients about their welfare, or what would happen to their relationships with patients if these were asked their opinions.

The assessment stage involved gathering information in a variety of ways such as observation, interviewing, listening, and which might include the patient's family, friends, colleagues and other people, including doctors at this stage. The length and depth of the assessment depended on what had to be explored, e.g. cognitive, emotional and language development might be appropriate to explore with an adolescent psychiatric admission, but not necessarily for a middle aged woman who was being admitted for 48 hour surgery.

Most assessments dealt with activities of daily living and any change which had arisen in these were very important. The assessment stage led on to the interpretation of data which included the drawing of inferences and the identification of problems. This in turn led to:

Planning which included the need to identify priorities - those areas which needed most urgent attention. It was important to include here the patient's views, as his priorities might be different. All these considerations led on to the formulation of a nursing care plan - the prescription of nursing care which the patient should receive. In this was included the formulation of objectives and all this was included in the preparation of the written care plan which was a permanent nursing and, possibly, legal record.

The third stage of process was the giving of care according to the written care plan. This should reduce omissions and duplications and at the same time ensure that the care given was in fact that which had been prescribed. It was, of course, important that giving nursing care was done in conjunction with the medical prescription. Nurses sometimes were worried that nursing process was something that went on in isolation from this, but this was, of course, not so.

Evaluation quite often started fairly soon after and alongside implementation to see if expected outcomes were being achieved and, if not, one could start on the cyclical process of re-assessment, re-planning and re-evaluation, previously indicated. If nursing care was being effective then it was nice for nurses to see this at this stage.

Nursing process was often described as the scientific problem solving approach to nursing. Miss Law preferred to think of it as the framework necessary to give high quality, appropriate care to each person. It enabled nurses to get greater job satisfaction through, seeing patients as individuals with not

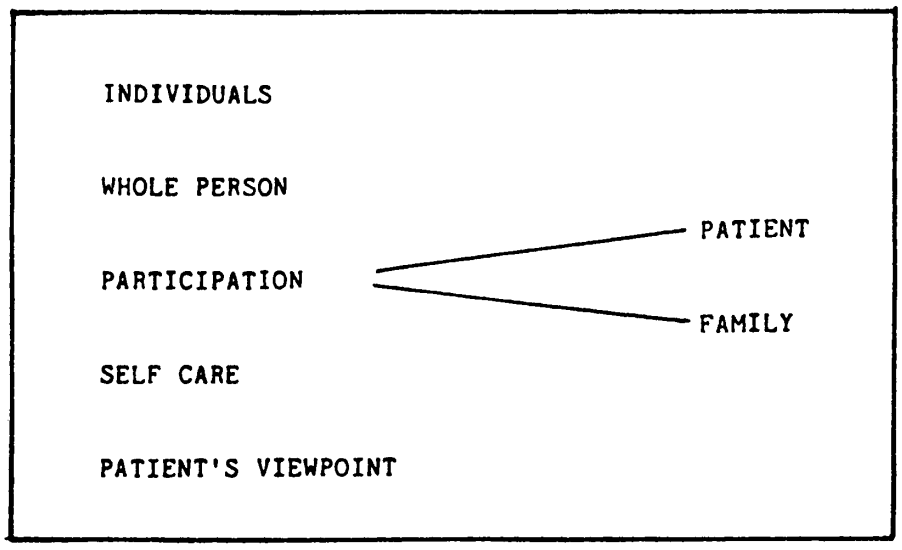

Figure II.

only physical but psychological, social and spiritual needs, i.e. as whole persons. It also allowed them to estimate, in conjunction with the patient and the family, the degree of self-care which each individual could safely be given. Additionally, it made sure that things were seen not only from the nurse's viewpoint but from that of the patient.

There were also certain benefits for the staff, resulting e.g. in greater job satisfaction. In a time of scarcity it was a useful tool in helping to set priorities and could result in the more efficient and effective use of time. It lead to greater efficiency and accuracy within communications and was particularly useful in ensuring continuity of care - a problem especially familiar to those who had been used to working with bank and agency staff. It also helped with the co-ordination of care, a task which seemed to fall more heavily on nurses than on any other group of staff and, last but not least, it provided a good tool for learning and teaching.

Miss Law went on to say that there was much confusion by people who thought that nursing process was synonymous with a variety of ways of staff allocation. Nursing process could be combined with task allocation but it was not synonymous with patient allocation, team nursing, or even primary nursing.

There was also a move to hide nursing process under other titles e.g. total patient care, though she was aware of at least three interpretations of this title. She therefore recommended

TOTAL PATIENT CARE INTERPRETATIONS

- Psychological, social, spriritual etc. aspects of care taken into account as well as physical.

- Patient allocation - A nurse carries out all the care for a patient.

- All aspects of care are completed on one patient before the nurse moves on to attend the next patient in the ward.

Figure III.

that people should stick to the term 'nursing process' to distinguish it from other, possibly related, influences on nursing care.
Miss Law referred to changes such as the organisation of the in-patient day which had not been generally implemented over the past 21 years; patterns in the way nursing work was organised, e.g. during hand-over reports, where students were sometimes excluded, or where contact between day and night staff had broken down completely. Miss Law continued that local policies sometimes made nurses unsure about how much, if any, information they were allowed to give to patients and relatives, or which made them question their personal responsibilities if anything went wrong during self-care of a patient, or even instances where a reduction in visiting time led to difficulties in implementing family involvement with patient care.

Often these matters were based on misapprehension and misunderstanding by staff but in each case they needed the involvement of senior nurse management to sort them out.

Nursing process for the first time provided a framework which allowed nurses to give long standing consideration to nursing matters and which should in future lead to early implementation of improvements based on examples previously cited. Miss Law said that she knew there were many nurses up and down the country totally committed to the improvement of patient care through the use of nursing process.

Discussion

The discussion which followed started with a question about levels of staffing - how low could you go and still carry on?

Miss Law pointed out that staffing levels did not influence the introduction of nursing process. Nursing process helped people to make the best possible use of limited resources - decisions on what to leave out had to be made with any system. Because of this it was wrong to talk e.g. about not doing nursing process at night - once introduced, it had to go on at all times. In any case it was no easier to introduce where staffing levels were high because motivation and commitment were more important.

Several members of the audience referred to the necessary documentation - how could it be introduced to all - right down to nursing auxiliaries?

Miss Law pointed out that documents had to be printed and there was therefore some time for introducing staff to it during this period. In any case, there was a need to make this a continual process, for example, for induction of new staff.

There was no doubt that staff became more skilled in the use of nursing process. In the beginning many continued to give the traditional care and only increased their writing. Ultimately, there was probably no more writing with nursing process than there had been without.

On developing documents, Miss Law suggested that as many authorities were short of cash it was easier to have one assessment sheet for everyone with bold headings and then have operational guide lines for different departments on how it was to be used. Care plans could be similar throughout a hospital. It was difficult to write on a blank sheet of paper, and in any case, information was easier to retrieve under headings.

It was important not only to convince people that the change to nursing process was necessary and was not just change for change sake, some reward, perhaps in the form of improved patient care, was essential. Implementing nursing process well with, perhaps, one patient to demonstrate this sometimes worked.

Somebody wanted to know what you did with people who thought they were actually doing nursing process?

Miss Law suggested that the treatment depended on the cause. Were they confusing nursing process with the various forms of staff development she had described? Or did they think that they had done well anyway and therefore did not need to change? It was important to start from where people were. The use of a special nurse for introducing nursing process was growing, though she did not think it essential. The Nursing Officer might be as good a person for the job. She might also be the right person to support staff who felt insecure. Support could come from a variety of people. Often peer support was neglected and yet, this could be very useful. Altogether, there was general agreement that introducing nursing process gave an opportunity for staff to talk together in a way which had not been possible for some time.

PROFESSOR R W REVANS, FORMER PRESIDENT, EUROPEAN ASSOCIATION OF MANAGEMENT CENTRES

The Nursing Process as Action Learning

(This paper was available on the day of the conference - further copies available on request.)

Professor Revans' main point was that nursing process was the scientific method based on rational decision-making, percolating to the bedside. Whilst it was original, it was certainly not new. If done properly, then the learning process was bound to follow for the action process was inescapably also the learning process.

Professor Revans saw sound advice as the basis of team work, to which he referred as comradeship in adversity. He also thought it was likely that those introducing the nursing process in one hospital would get the most powerful support from those in another, involved in the same exercise. He based this on his experience that when practical people got together when they were united in trouble, they formed into action sets. He suggested that people should ask themselves three basic questions:

What are we trying to do?
What is stopping us?
What ought we to do about it?

These three questions formed the basis of scientific analysis. The answers to these led on to three further questions:

Who knows?
Who cares?
Who can?

Only people responding to all these formed the basis of action and could be seen as a form of micropolitics i.e. where power was to be found. They formed the foundation for improvement in any setting.

The morning concluded with the showing of a video on goal planning, showing health visitors in Wales using a problem -solving approach for the care of mentally handicapped children. This film forms part of the Open University course 'Handicapped in the Community'. Although it was concerned with health visitors it was felt that the approach was useful in other situations.

We're all in this together - Observations from experience

The afternoon session was dedicated to learning from each other and was introduced by a team from West Cumbria, consisting of the District Nursing Officer, Pamela Grosvenor, a Tutor, Jo Anderson, and a Nursing Officer, Dorothy Raper.

Miss Grosvenor emphasised this perspective by saying that they had come in a spirit of wanting to share, all those present were comrades in adversity. Their contribution would describe how they had gone about introducing nursing process from the point of view of management, teaching and practice.

Cumbria was an industrial and semi-rural district with a population of about 130,000. It had 1,165 nursing staff and a slimmed down management structure - there were no Divisional Nursing Officers and no staff posts. They also had some difficulty in attracting teaching staff at the time under discussion.

They had introduced nursing process in stages. The first of these was obviously;

Assessment

This consisted of collection of information and started in October 1979. They set about this stage by

a) inviting outside speakers to talk to them on general principles;

b) arranging for their own staff to go and visit other centres who were already using nursing process; and

c) by collecting and circulating relevant literature.

All these stages had overlapped.

Planning

The planning stage had started in January 1980. They had formed a working party and it was open for anyone to come who was interested, people had come from a variety of settings. These were:

Paediatrics
General Medicine
Geriatric Assessment
Geriatric Long Stay
Cottage Hospitals
Orthopaedics
Psychiatry, and
Community

There had been no interest from midwifery and surgery and they had experienced particular difficulties with short-stay wards. Their greatest problems had arisen with regard to the assessment of patients in the planning of forums. They decided to draft a booklet and a record form to let everyone know what they were doing. They were anxious to produce documents which would be read and one of the administrators had demonstrated a particular talent for illustration. The production of these documents was followed by the organisation of staff seminars.

The next stage, executing the plan, took place in September 1980.

a) They circulated the booklet on nursing process to all wards and departments and to community staff.

b) They held monthly seminars for all staff (repeated eight times) between September 1980 and May 1981.

c) This was followed by the introduction of the new printed record sheets and folders in June 1981.

d) Sessions on nursing process were included in basic training and in all staff induction courses. These had been rather theoretical and a bit dull at times.

They decided to review the records at the end of one year. The psychiatric division designed their own records.

Finally, they had made plans for revision and for problem identification. They had:

a) established a steering group for this
b) started to collect information on practical difficulties
c) produced guidelines
d) arranged for further teaching sessions/study days.

They had enjoyed having visitors and had found them useful, particularly as they had asked questions which showed that they understood their problems. Miss Grosvenor was not sure whether they should have undertaken some of their activities sooner than they did, she was however, quite sure that they had started on a cycle of activity which could go on for ever.

They had now started to introduce nursing process into the community. They had begun by having initial meetings with groups of staff - the District Nurse Tutor, the Senior Nursing Officer and Nursing Officers. The tutor had been particularly keen because of the new curriculum. They had promoted experiment with different kinds of record systems which had been followed by feedback sessions. This is turn had led to the formation of district nursing work groups with representatives from each centre.

One development had been the provision of lockable files so that nurses could carry process forms around with their cards. These had been considered a bonus. Updating sessions, which district nurses had to have anyhow because of the new curriculum, had been used to teach the principles of nursing process and of problem identification.

The district nurses had decided that the records designed for the hospital were not appropriate to their needs. They had designed their own, insisting on having five separate sheets, one of which was similar to the one also being used by the liaison nurse. They themselves decided how much information they needed for each patient and filled in the appropriate number of sheets.

Miss Grosvenor then turned to some general points under two headings - practical considerations and general principles.

1. Practical considerations

a) Support for clinical staff - this was vital.
b) Co-ordination - it was helpful.
c) Cost - this was really quite a lot.
d) Provision of facilities - this included space to think, time, staff and somewhere to keep the records.
e) Interest.
f) Assessment.

Because all the staff had to get involved, they got to know each other better.

2. General Principles

Nursing process produced conflict with hallowed nursing tradition in that it required a total change in the way in which nurses faced their jobs.

a) It interrupted established routines.
b) It undermined the position of authority. The most senior of staff did not necessarily know best.
c) It was based on a very shaky knowledge foundation - staff had to be given confidence in themselves.
d) It placed responsibility squarely on the individual nurse.
e) It brought the whole area of quality of care into question, particularly in relation to getting through and getting done.

Jo Anderson spoke in her capacity of clinical teacher, which she had been at the time of the introduction of nursing process. She had had to get involved early as she was employed in practical teaching in the wards. In order to understand the problems which clinical staff were facing she had to see it from their perspective. As she was an outsider, she knew the patients less well, it was easier for her to identify omissions and thus show up weaknesses.

Mrs Anderson felt that education departments were too often situated in ivory towers, to the detriment of patient care. Bridges had to be built and it was vital to understand the actual problems. She was not sure whether this was more easily done by having clinical teachers in the classroom or by getting ward sisters to teach.

Tutors had always been aware of the need to include things like interviewing and communication skills in nurse training but the introduction of nursing process had made it quite obvious that these things needed to be taught.

She realised that students, who had never known any other system of training, found that nursing process helped them to answer questions and to evaluate different approaches to nursing care. There was no doubt in her mind that the introduction of nursing process helped to bring clinical departments and the education department more closely together.

The final speaker of the day was Dorothy Raper, who saw herself very much as a grassroots representative. At the time of implementation of nursing process she had been ward sister of a 60 bed acute geriatric assessment unit. There had been a nucleus of interest and some opposition. Those who at the start had been ambivalent were still the most difficult now.

Introducing nursing process had required courage in that she felt she could not control the situation because she did not know enough about it for that. But she knew she had the support of those in authority who were prepared to give it a go.

The staff had quickly learned that they needed each other to supply the necessary perseverance and determination to work through the problems together. The staff had learned the need to be available, flexible, stable and accountable. In the beginning they only managed to get enough information on paper to enable the next shift to cope safely. They had organised workshops for shared learning - some at 8.00 p.m. so that the night staff could join as well. They had been very critical of each other's efforts and sometimes felt threatened because junior staff and auxiliaries had the best answers. One insight they had gained was that it was better to negotiate care than to dictate it.

They had gradually developed into more thoughtful nurses. Ward reports became more meaningful - they ceased to be merely vehicles for transfer of medical directives but became more nurse orientated. The benefits, particularly in terms of team work, had been so great that the acute geriatric wards also wanted to join them. They uncovered a number of real skills in persons where they had not previously suspected them.

There was more talk about care now and they were more involved with patients socially. The physiotherapist and occupational therapist also now joined in to complete care plans.

Altogether they had overcome their feelings of inadequacy and supported each other when they felt most at sea. Because of this they had created a true learning environment.

GENERAL FORUM AND SUMMING UP

The general forum looked at the problems associated with the introduction of the nursing process, such as identifying the needs of qualified staff in order to improve their knowledge base. What were the negative sides of nursing process? These were identified as individualising care for short term patients and the many sheets of paper which made finding essential information difficult at times. There was also the change inherent in moving from a very structured to a much more individualised system in which the ward sister had an important role to play. In answer to one question, examples were cited where health visitors too had used nursing process though, Miss Grosvenor said, in her area they were not yet interested.

In summing up the conference, the chairman said that the main emphasis throughout the day had been on looking at whole persons, whether patients or staff. In essence, introducing change in nursing was no different from introducing change anywhere else. At present, we had few tools for evaluating the effectiveness of our own interventions. The nursing process would provide us with the tools for doing this job.

The Nursing Process as Action Learning

This article was written for a conference organised jointly by the King Edward Hospital Fund for London and the Department of Health and Social Security, on April 23, 1982. Its references to the nursing process, as such, are scant enough, since others on the programme dealt with that topic in a detailed and professional manner. My task, as I saw it, was more to offer a historical account of the studies out of which the nursing process, no less than other ideas of importance to the future of health care management, have slowly emerged.

This accent was chosen, not in order to emphasise any claims for originality, but to encourage all who, in 1982, may still be pioneering with innovation in the field of nursing care. My paper is intended to illustrate the monumental difficulties of introducing fresh practices of almost any nature into administration in Britain today----especially any that call upon those at the summit of their professions to ask themselves unusual questions. Perhaps the only consolation we may draw, albeit less than reassuring, is that our future is now so dark and so uncertain that many of us will be obliged to ask ourselves questions that, in more affluent times, could safely have been dismissed. Yet, if the future of the National Health Service will certainly not be comfortable, it may, nevertheless, be extremely thought-provoking.

R W Revans
ALTRINCHAM, Cheshire
April 1982.

The Nursing Process as Action Learning

Post-War Nursing Problems

When I left the coal industry, where I had been studying the incidence of colliery accidents, to become a professor at the University of Manchester, the nursing profession seemed to be very short of recruits. This was as long ago as 1955, when I was asked by the Vice-Chancellor (who was also chairman of the Manchester Regional Hospital Board) if I would be interested to study the problem. Since I had written on the topic as long ago as 1938, in a memorandum for the Essex Education Committee headed 'The Entry of Girls into the Nursing Profession', I could hardly refuse the Vice-Chancellor's invitation. In the 27 years that have since passed, my attention has never been very far from what I was on about even 17 years before that. The problems, I am afraid, are still with us.

Paris, September 1959

I was asked to talk about my studies at the Sixth Annual Conference of The Institute of Management Sciences, and chose as the title of my paper: The Hospital as an Organism. I had begun to suspect that the nursing problems were much worse in some hospitals than in others and that it was to the improvement of the particular institution we ought to look. I had discovered that it was not only the nurses who seemed to be better off in some hospitals than in others, but also the patients----even although they came from the same kinds of community with the same complaints. This led me to suggest making a model of the hospital and in my paper I said this:

The Hospital Model

16. It is proposed to examine the flow of patients through the hospital by identifying the following stages:

(a) admission, including relations with outside agencies like other hospitals or general practitioners, as well as internal agencies like bed bureaus or admission or casualty wards;

(b) diagnosis, including the collection of records, examination of specimens, X-ray photographs and other preparatory material;

(c) treatment, including pre- and post-operative procedures, and most of the other patient care provided by the ward staff;

(d) control, or how the outcome of the treatment is compared with what was expected when the diagnosis was made; and

(e) discharge, including any special arrangements for convalescence or recovery.

....

The Ascendency of Human Factors

18. It is unlikely that the construction of logical models, either of the hospital as an organism, or of the particular systems through which the patients pass, or of the physical departments contributing to those systems (eg., X-ray as part of a diagnostic system or medical records as a general focus) will, in itself, prove difficult. Information will, of course, be incomplete and inaccurate, as it is in any human institution, even in banks or precision machine shops. Nor is it likely that the reduction of our many observations will be excessively difficult. But what will test the skill of the field workers will be their task of convincing the hospital staffs---medical, nursing and lay administrative alike---that there is here a field for objective analysis.....Hence progress on these comparative studies will be very largely controlled by the success of the research team in making its objectives, its methods and its questions intelligible to the doctors, and the other senior staffs of the hospitals, whose decisions and whose systems are, in fact, being analysed and evaluated.

This report to the operational research workers, back in 1959, is saying that it is not hard to see the treatment of the patients in an orderly and systematic fashion, using a five-fold cycle of very general application, but that it may be more difficult to persuade those running the hospitals to look at things in the same organic fashion.

The Five-Fold Cycle

I had selected the hospital model of 1959 because it lies at the heart of all useful human experience; it can be used to describe intelligent behaviour (rational action), sound advice (wise counsel) and true learning (new knowledge); the cycle is, in itself, also the structure of the scientific method upon which all technological progress must necessarily be founded. Whenever in the course of our long hospital studies we were able to report that we had found something out, we at once tried to describe whatever it might be in terms of the same five-stage cycle (to which the name System Beta had been given). Our belief by the early 1960s was that the 'good' hospitals (at which all the nurses tended to stay longer than average and in which the patients tended to get better more quickly than average) used the five-stage cycle in shaping important transactions more than did the 'bad' hospitals (with rapid nursing turnover and long patient stay). The significance of this to the tasks of the nurse on the ward was set out seven years after the Paris conference; it is quite important to mention the precise dates, just to show how long it takes to clarify one's thoughts in these matters. It does not take very long to think up new ideas, perhaps; the problem is to get them tested out in the real world and to carry others along into accepting them.

Stockholm, September 1966

A symposium was called by the Organisation for Economic Cooperation

and Development to discuss the contribution of operational research in the public domain. My own paper was called Studies in the Adjustment of Staff and of Patients: The Hospital as an Organism. It contained the following paragraph:

> Communications and Learning Processes
>
> The communication system of a hospital is normally intended to bring rapid and accurate information about patients, or about services provided for patients, to the attention of those in senior positions; both the consultant and the matron wish to be quickly aware of emergencies that arise on the ward. If, from time to time, serious trouble develops that is not effectively dealt with, the management committee or the senior officers will hold an enquiry and any faults revealed in the communication system will be treated at least in a formal way; new instructions may be issued or new forms of report may be devised. But it is not generally recognised that the junior members of the hospital staff and the patients alike are also in need of information; and, what is more, at the moment that it is important to them, rather than at some time not inconvenient to their superiors. A patient who is anxious about his condition, or a junior nurse who has been given incomplete or contradictory instructions, may experience serious anxiety as a result. This anxiety can be relieved only if an explanation intelligible to the patient or the nurse is forthcoming; whether or not this is possible depends upon the relations existing between the patient and his nurse or between the nurse and her superior. An explanation that is intelligible and convincing to a staff nurse or a registrar may be harmfully incomprehensible to a first year student or to the average patient. Our research suggested, by many incidents reported during the attitude surveys, that, where the junior nurse is unable to approach the sister, the patient cannot approach the junior nurse. Moreover, where the sister is not on easy terms with the consultant she cannot be on easy terms with her own ward staff. The mechanism is a simple one: if the consultant appreciates the suggestions of his ward sisters or will even seek their opinions, the sisters will be anxious to have ready for him the maximum information about the patients. This means that they will encourage their own nurses to discuss the patients with them, the sisters. This, in turn, will mean that the nurses will tend to communicate more with the patients, and such communication will, of itself, encourage the patients to ask more questions. If, on the other hand, the consultants do not regard their sisters as important sources of information or advice about the patients, the sisters in turn will have little cause to encourage the nurses to report about the patients in detail. The nurses will, therefore, hardly be motivated to observe closely the patients. In these conditions, the junior nurses and the patients will be deprived of those conversations which are the chief media of their learning and of their adjustment. There is a simple cycle known as the feedback loop; a machine is controlled by a device that monitors its performance, slow-

ing the machine down should it be too fast, speeding it up should it be too slow. Learning is also a feedback process, and it consists essentially of seeing the effect of one's own behaviour. Unless one receives intelligible responses to, or clarifying information about, what one is trying to do, it is impossible to learn. Somebody in doubt may have his doubt resolved if he gets an answer to his own question about his doubt; his doubt is not removed if he is given a lot of data, in whatsoever quantity, not in response to his statement or his question about that doubt. Sometimes he may even need help in the framing of his question, because the doubt is of so deep an order that he is unable to express it. Hence, if his superior is too busy, too impatient, or too authoritarian, to help him in the framing of his own questions he will not learn. This is essentially the predicament of many patients and of many nurses on the hospital wards today (1966).

We see that all the aspects of our five-stage cycle are called up here. Rational action that is the essence of scientific medicine; sound advice that is the basis of confidence between the different levels on the ward; and learning as the processes of adjustment, alike of junior nurse and of transitory patient (and, of course, of sister and consultant, too) Thus, the lesson we had learned between Paris in 1959 and Stockholm in 1966 was very simple----even starkly so: How to ensure that the five-stage cycle (System Beta) will develop in all hospitals, particularly the 'bad' ones?

A Dual Approach

The quotation above, Communications and Learning Processes, suggests that learning needs to take place at two levels: the patient is sick and must learn to get better, and so, also, must some entire hospitals. Our studies seemed to emphasise the pathological condition, not only of the patient receiving some traditional treatment at the hands of the individual doctor and his nurses, but of the hospital as a sick organism itself----although not one in receipt of any apparent therapy. What was becoming clear was the need for treating the institution as a whole, as well as improving what went on at the bedside. Our studies had proved that the understanding between the patient and the nurse depended upon how well the nurse got on with her sister, and that this was most powerfully influenced by the confidence the sister had in her consultant; we had also shown that this was correlated with the ability of the consultants to work together, and with the administration. Thus, it dawned on us that, unless things could be improved right at the top, there was not much to be gained by concentrating on 'human relations in the ward' alone. We had to take a larger and more organic view of the whole hospital; our clue was to envision it as a learning community, and it was for this reason that our experiment, with ten London hospitals, became known as The Hospital Internal Communications Project. To ensure that those at the top were brought in up to their necks, and so became part of the learning community, we planned that members of the staffs of different hospitals would work together, on their own and on each other problems; it was impossible to do this without involving all the senior

officers----matrons, secretaries, medical committee chairmen and so forth----at each of the ten hospitals. To reduce the shock of putting across this idea, we had our first meeting at the seaside, in a hotel at Hastings; there cannot be many still alive to remember the expressions of astonishment as some of the top people walked up the steps to discover others present from their very own hospitals. I simply do not believe that, before 1965 or so, it had ever crossed anybody's mind that the quality of bedside care might be affected by misunderstandings between those at the top of the hospital.

Diagnosis and Therapy

But how to reduce such misunderstandings? How to start the learning processes? One cannot lecture busy people carrying grave responsibilities about how they ought to listen more attentively to each other. Whatever may be the evidence collected by the professor and his research students that communications ought to be a lot better, it is quite out of the question for the academics to tell the others what to do. In this life real people learn only if they want to do so, and not because somebody else tells them. We must ask "Why should anyone at the top of the hospital want to learn? Is there anything going on that they would like to change, but that, up to the present moment, they have found hard to? Do they have some persistent trouble they would be glad to see the back of? If so, would they consider tackling it in a new fashion, working with a few pals (perhaps from other hospitals) who are also quite anxious to get shot of some troubles of their own?".....This is the approach of action learning; it was developed by a consortium of colliery managers, who also are busy and responsible top people, and who were persuaded to work together on their own and on the problems of their colleagues.

As soon as we are ready to accept the idea that the hospital itself may be sick, because its poor communications afflict it with all manner of problems, we can at once turn to the five-stage cycle referred to in the Paris paper of September 1959. In that, the stages are

(a) admission: while it is clear enough whether or not a patient ought to be admitted to hospital, it is by no means so evident what is meant by the 'admission' of a sick hospital. We interpret the term to mean that those in charge of the hospital are ready to agree that it has problems sufficiently serious for something to be done about them. If they are not prepared to do so (or if they insist that nothing can be done to cure any troubles they are ready to acknowledge) the sick hospital cannot be 'admitted' for whatsoever care may be suggested. It is an unhappy fact about Britain today that those in charge of its institutions, not only of its hospitals, are very reluctant to concede that they may be in trouble, but, as Johnson observed: "Depend upon it, Sir, when a man hears he is to be hanged within a fortnight, it concentrates his mind wonderfully". There is some concentration now apparent in the NHS, but not a great deal----just yet.

(b) diagnosis: once it has been agreed, however reluctantly, that the hospital may have a problem or two, there is then a need to identify how it arises and what course of action may be called for to treat it. Since our researches, spread over many years, suggest that poor communications lie at the heart of many hospital troubles, it is obviously rash to accept the first diagnosis----even if it has been made by the most important persons in the whole hospital. When the majority are out of step who can claim to be in? Many, of course, may put forward their own claims, but how are they to be judged? Not simply because they are in charge and so have the right (and the responsibility) to tell the others; if this were enough they would have settled the business long ago. Action learning suggests that it is only by discussing the facts of one's own troubles with those interested in doing something about the facts of theirs that personal bias is swept away and real truth likely to emerge. In the words of Leonard Cheshire: "The best way to deal with your own trouble is to go to somebody else's help".

(c) treatment: it is one of the more agreeable facts of human nature that, once an effort is made to tackle a real problem, all who have been tormented by that problem will come forward to help in its cure. It is equally true that little cooperation will be forthcoming in some campaign to attack what is not seen to be a source of trouble, but once those in charge of a sick hospital start to tackle what is seen by those who work there as its real afflictions, they will find three kinds of backers: those who are reliable sources of information, those who are anxious to get something done, and those who are qualified to get on and do it. But all this depends, first, on admitting that trouble exists and, second, on identifying what that trouble really is; as Goethe put it: "There is nothing so terrifying as a bad plan efficiently carried out".

(d) control: there is always a risk that, when some quite new approach is made to an old problem insoluble by traditional methods, those who could do nothing about it in the past will now do everything they can to prove that the new method cannot possibly work. Evaluating novelty calls for patience and a stout heart, and, when one starts out to treat the troubles of a sick hospital afresh, it is essential to examine every outcome of the experiment with care; things may be happening for reasons very different from those predicted, and other things that were expected may not take place at all, or, at least, more slowly than was hoped. For example, the benefits of the action learning programme with the ten London hospitals did not start to appear until two years after the consortium was officially wound up; to the great delight of the traditional advisers about how to improve patient care, the hospitals showed no improvement whatever by the time the programme was

wound up in 1969, having run for nearly four years. Not until the learning processes had had time to sink in, to permeate the whole organism that we call the hospital, were there improvements in clinical performance apparent from the official records of the participant medical and surgical divisions. It must be at the control stage of any learning cycle that the proof of achievement is looked for, so that it may be well to take a wide view and to be ready for the unexpected. More than often, the outcome is not quite what was anticipated because the problem that was first tackled turns out to be (during the tackling of it) part of a much bigger one; the control stage therefore tells a lot about the completeness of the first diagnosis----and one must always be ready to learn a little that is quite new altogether, as well as to learn a little about the trouble one is trying to clear up.

(e) discharge: just as the time always comes for the patient to be sent home, or to another hospital, so as to make room for another patient, so the senior staff of such-and-such an institution will decide they have gained enough from the study of one piece of trouble, and they will turn their attention to another. The ten hospitals in the Hospital Internal Communications Project worked on about forty separate tasks---- average four to each participant. In practice (as para. (d) suggests), the group that formed to tackle the local problem learn to work together; they may be reluctant to break up, and the more they continue to cooperate the longer they will go on looking for new forms of cooperation; this they will do on their own, without needing to call upon the senior staff any more.

This, then, on the scale of the whole hospital, displays the five-stage cycle proposed in the Paris paper of September 1959. It would be equally possible to illustrate the learning processes of the individual nurse by the same cycle, but that is the mission of others.

Ann Arbor, Michigan, USA; March 1981

Seven years elapsed between Paris and Stockholm; fifteen years after Stockholm came the publication from the Health Administration Press of the University of Michigan of the matured consequences of the Hospital Internal Communication Project, 1965 to 1969. We learned that change takes longer than you think----even although, from the very outset, we had hardly expected these stolid memorials to Victorian London, crusty with administrative arthritis, to become rejuvenated overnight. Yet the official evaluator, appointed by the DHSS to ask whether, and to what extent, any of the ten might have learned with and from any of the others to improve the quality of the care it strove to offer its patients, had this to say:

Discussion and Conclusions

Perhaps the most important outcome of this evaluation study

is the demonstration that Revans' self-help approach to management improvement is indeed effective. In more specific terms, this evaluation study shows that hospital management efficiency can be systematically improved in hospitals, no small matter in these days of spiralling health costs.

A key to improvement in efficiency was the participation of physicians in the project hospitals. Many of the physicians in the HIC Project did not feel they had enough time to participate or were not so inclined. But those who did participate supplied sufficient medical expertise and medical legitimacy to make the project a success. Comparing this effort at improving the efficiency of hospitals with similar efforts indicates that self-direction was essential to the success of the HIC Project. Physicians were not only able to say "yes" or "no" when asked to participate; they were also able to decide upon the nature of the change effort.....The general point is that physicians vary considerably in the kinds of work that they do, as well as in their personal predilections toward their work, and an improvement project that is to be truly comprehensive must address these different requirements. A narrow or one-sided effort at change and improvement is doomed to failure.

In conclusion, evaluation research on the ten hospitals of the HIC Project shows that major improvements in hospital efficiency are feasible. Furthermore, comparisons of hospitals within the project as well as with other projects seem to show that a successful effort at improving management efficiency must include a variety of forms of help, including help which facilitates psychological change and better understanding, as well as help which facilitates managerial action. Provision of different kinds of help and the opportunity to control and direct the providers of help would seem to be essential in encouraging physician participation, without which relatively little can be done to improve hospital management. Being able to choose and control the methods of help will allow physicians----and nurses and administrators----to select those forms of help which they need, and which they feel are congruent with their own styles of organization and management. (Prof. George F Wieland: Improving Health Care Management, Health Administration Press, Ann Arbor Mich. USA March 1981. pp 439-41)

This passage, although unambiguous about the success of action learning as a method of improving hospital effectiveness, gives no idea of the size of the improvements actually achieved. It does, all the same, stress the true learning process behind the approach, and attributes the superiority of action learning over professional consultancy and academic 'research' to the willing involvement of those who remain responsible for the running of the hospitals. It is because all the key decisions remain with the doctors, nurses and administrators that action learning works; the role of any outside

helpers is merely to supply what those in charge feel they need. The outside 'experts' do not at any time suggest what needs to be done, unless in response to some clearly formulated request from the staff in charge. For this staff will learn to run the hospital more effectively only if they control the course of the action by which that learning accrues; none of us learns at the will of others but only of our own volition. Hence it is that the learning process has also been offered as 'the nursing process', in which we see the same five-stage cycle; as in the HIC Project, the learning comes out of the task that is being done. Nursing the patient and learning to nurse the patient are one and the same thing; curing the sick hospital and learning to cure the sick hospital are both the same as the HIC Project. Prof. Wieland makes the point in another way, writing to Janet Craig, formerly Assistant Director of the King's Fund Centre, and to all intent and purpose also the assistant director of the HIC Project from 1965 to 1969, when I lived in Belgium; Prof. Wieland, sending from Ann Arbor to the Centre on June 18 1981, says:

> .....The improvement did not start until the very end of HIC (in the case of surgery) or two years after HIC ended (1970) in the case of medicine. No wonder everybody wanted to forget about HIC back in 1968----there was almost nothing to show for all the anxiety, agony, conflict, etc. To most observers, it seemed to be sheer wasted effort.
>
> However, one can roughly calculate the amount of savings by the HIC hospitals taken as a whole.....I have assumed that shortened stays did not reduce treatment costs, only the "hotel" and capital costs. Using this conservative assumption, the savings add up to £2 millions in pre-inflationary, 1969-73 money. I cannot calculate the savings from 1974 forward because of the re-organization, but they most likely continue onward for a few years more.
>
> By my research design----using other hospitals in the London Metropolitan regions----I eliminate all other explanations for this obvious improvement. I have to confess that I once viewed HIC as a great learning experience, but as nothing more: you know "The operation was a great success but the patient died (or, at least, did not improve)".....But now it is clear that Revans was right all along: it is the managers themselves, not outside experts, who can make really significant improvements in their own organizations.

The agony and conflict referred to in Prof. Wieland's first paragraph is that accompanying all novelty, especially in any professional field; unless one's suggestions are ridiculed by experts and resisted by administrators they are not worth pursuing, since there can be nothing new in them. The savings estimate in the second paragraph, since it omits treatment costs of at least £100 per day, is grossly inadequate; the official budget for the whole project was £62,500, so that the benefit/cost ratio must be of the order of

one hundred-fold. This shows the immense value of using more effectively that most precious of all our assets, the lived experience of those in responsible posts. The third paragraph explains the cause of so high a ratio: action learning applies that asset directly, and does not ask that it be constrained by the theories of non-involved academics or commercially motivated consultants. Nor is that all. The most important need of those in positions of power at the present time is that they are obliged to ask themselves a few more questions, questions determined by the conditions in which they find themselves, rather than questions drawn from the syllabus of some professor or from the repetitive countermarches of some management expert. We must see the crises by which we shall become increasingly beset each as a fresh opportunity to learn something new.

Altrincham, Cheshire.
April 10 1982.

Bibliography

R W Revans: Standards for Morale; Cause and Effect in Hospitals. Nuffield Provincial Hospitals Trust/OUP 1964

R W Revans (ed): Hospitals; Communications, Choice & Change; The HIC Project seen from Within. Tavistock Publications London 1972

R W Revans (ed): Action Learning in Hospitals; McGraw-Hill London 1976

George F Wieland: Improving Health Care Management; Organization Development and Organization Change. Health Administration Press, Ann Arbor, Mich., USA 1981

Leslie Paine: Coordination of Services for the Mentally Handicapped King Edward Hospital Fund for London 1974