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C 11/12 June 1980)

CONTINUING EDUCATION - DEVELOPMENT FOR NURSES

Report by Laurence Dopson

Continuing education is the mark of a profession. How, then, to enthuse British nurses, who generally are not committed to the concept? Why the difference in attitude between them and American nurses, who on the whole are more continued education conscious? And should continuing education be mandatory, instead of being optional as, except for midwives and tutors, it is in this country today?

A colloquium at the King's Fund Centre, 11 and 12 June 1980

August 1980

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

HOGI:FQ (Dop)

FIRST-TIME CONFERENCE ON CONTINUING EDUCATION FOR NURSES

A first time King's Fund Centre conference on continuing education for nurses was how Hazel Allen, the Centre's Assistant Director (Education and Training), described the colloquium in welcoming members.

The last time the Centre even attempted to look at the subject was in 1971, when there were two small seminars to examine in-service training - which was only one part of staff development. Recalling these, Miss Allen said that at the end of them, the question marks were still as firmly entrenched as they had been at the beginning.

Two people who were attending the present conference - Jean Heath and Christopher Mullen - had, by their publications, shifted the question mark a bit, even if some thought they had brought an explanation mark into continuing education!

The colloquium had taken about two years to arrange because a lot of people had said how desperate they were when considering in-service training, continuing education, any form of post-registration training at all.

> "Christine Davies, my Assistant, has been talking to people both north and south of the border as to how today might be organised and how we might look at the whole problem," reported Miss Allen. "And I think the one thing she has come away with is that people are beginning to think that continuing education is, or should be, obligatory and not optional in this country. So we felt it would be helpful to examine that possibility."

THE CAUSE LIES UP-RIVER

It remined Miss Allen of the following story told in the Journal of Continuing Education in Nursing:

> "Being a nurse I feel like I am standing by the shore of a swiftly flowing river and, I hear the cry of a drowning woman. I jump into the river, pull her to shore and apply artificial respiration. Just when she begins to breathe, there is another cry for help. So I jump into the river again, reach her, pull her to shore, apply artificial respiration and then, just as she begins to breathe, another cry for help. So back in the river again, reaching, pulling, applying, breathing. And then another yell. Again and again and again without end goes the sequence. You know, I am so busy jumping in, pulling them to the shore, applying artificial respiration, that I have no time to see who is up stream, pushing them in."
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> "This simple story illustrates how often we in the health field devote almost all our engeries to working down stream on endeavours which are superficial - categorical tinkering in response to almost perennial shifts in problems." declared Miss Allen.

Secondly the story demonstrated the need to begin to focus attention up stream where the problems lay. Professional concerns with quality, accountability, professional responsibility were truly up stream and education directors were to be congratulated on giving them some serious considerations.

These considerations included, of course, the questions which had been devised for syndicate work at the colloquium. Hopefully there would be some lateral thinking to help look at old chestnuts, of which finance was about the oldest.

FINANCE: CHESTNUT OR SCAPEGOAT

Was finance a chestnut - or an ever present scapegoat? For example, how might it be possible to influence the shifting of budgets?

Barbara Lewis's recent PhD study in the marketing of nursing from Manchester pointed out that government, through the Central Office of Information, was the biggest advertiser in the country. In 1975 £15 m. was spent on advertising. This included advertising for recruitment to the Navy, Army and Air Force and nursing.

National publicity for nursing had gone on since 1965. The first goal was to improve the image of nursing to attract more recruits. The second goal was to assist the individual health authorities with direct recruitment. And a sub-objective was to encourage trained nurses back into the profession.

WHAT NURSING ADVERTISING COSTS

The expenditure on the nursing advertising budget itself was historical. Figures currently available, which were for the beginning of the seventies, were in excess of £500,000. But that was only direct advertising. The real costs were unknown, because the data associated with salaries, overheads, market research and media evaluation were not known.

In 1973, when Briggs was asking for further information, Clifton showed that the allocation for nurse recruitment at local level was not known. But advertising for hospital staff increased from £1.6 m. in 1967-68 to £2.56 m. in 1970-71, of which 40 per cent was advertising for nurses - £1 m. for nurses and midwives - and 88 per cent was spent to advertise posts to <u>replace</u> staff.

Commented Miss Allen: "May I emphasise that the evaluation of advertising is not known and, may be, a little lateral thinking on how we may influence government budgets might be related to changing that little jingle that we have in our advertising, which says:"

"People remember nurses"

to something more effective:

"Nurses sustained are nurses retained."

OVERVIEW AND APPLICATION

The American View

BARBARA MILBURN

This is the culmination of an exciting six weeks that I am spending here in England, with the assistance of both my hospital, which paid for me to be absent from my desk for one week and the Denver branch of the English Speaking Union, which gave me a scholarship to see what English nurses are doing and what we can learn from each other. The frosting (or the icing) on the cake for me is being here. I spent time up in Blackpool, at the kind hospitality of Joyce Wiseman, went to Southampton visiting Anthony Smith, been at Guy's with Mrs Hyde White, gone to St Thomas's and will be at St Bartholomews. So you see I am getting a smattering as I can.

INTRODUCING BARBARA MILBURN

It has become a feature at the King's Fund in June to invite nurses from the U.S. or Canada, "to help us with thinking that they have done, maybe before us and, that might be coming back around the circle, to help us with their ideas", explained Miss Allen.

"We don't always appreciate American ideas and, I have explained this to our speaker, Barbara Milburn. She was asked to come as she was recommended by the doyen of continuing education in the United States, Elda Popiel."

Miss Milburn had been around the country meeting many people. She was aware of the British approach. She spent some time in England in her childhood and went to an English school in North London for two years. She appreciated that the English thought Americans drove on the wrong side of the road, that they used their forks the wrong way - and that they were divided from the English by a common language.

I have been reminded that I have been going to the big institutions. Unfortunately, that is what happens when one is not familiar with all the outlying areas. I am getting an overview this time and then I shall apply for another scholarship to see what is going on in some of the outlying reaches.

SHARING IDEAS IS IMPORTANT

I am a nurse educator from Denver, Colarado. I work in an eight personnel department which is very busy with the concept of continuing education. It is an honour to come over and share with you what we are doing, some of our thoughts, our concerns, our problems, because I think sharing is so important.

Some thoughts which I would like to initiate before I really get started. First of all, I am going to be sharing with you what we are doing in the United States and more specifically in Colarado, in Denver and in St Luke's Hospital, where I work. The United States is a very big country and every state, every city, every hospital, has its own idea of how to approach matters.

I would hope that you listen to me with a very open mind and listen to the concepts I am presenting and see if there is anything which can be applied here, because I am a great one for not re-inventing the wheel.

True, we come from different countries, but I feel that our common bond is first of all nursing and second education. No way will I be telling you what I think you should be doing.

A good way to start, I thought, would be to review with you my objectives in this talk. That way you will know what I am trying to convey to you. I would hope that at the end of my presentation you would be able to describe in your own words the terms of continuing education and staff development and the components of staff development - orientation, in-service education and continuing education within staff development.

I thought it was important briefly to look at the historical background of why we are getting into continuing education and staff development. One thing I have discovered about nursing during the 15 years I have been in it is that we do discuss the same things. Technology changes but in nursing we hang on to some of our concepts.

Then I think we have to look at the pros and cons for mandatory continuing education.

My last hope is that at the end of this presentation, if nothing else, it will have spurred you on to do one thing. That may be no more than that you are going home to do some more reading and thinking. In two days we can't hope to share the world too greatly. It will be a matter of sharing with colleagues.

The one thing I have learned is that language between the U.S. and England is different. I discovered this as a child here. Coming back I have found it even more so in nursing. Certain terms form a common bond but many more that mean totally different things. When I was introduced to 'head nurses' in Britain I realised that they were third year nursing students but in my country they are ward sisters.

THIS IS CONTINUING EDUCATION

So I want to start of with definitions that I will be using. The definition which I will be using when talking of 'continuing education' is the planned, organised learning experiences designed to augment the knowledge, skills and attitudes of registered nurses for the enhancement of nursing practice, nursing education, administration, research so that they can improve health care.

'Staff development' is simply a term for a process that includes both formal and informal learning opportunities to assist individuals in performing competently. There are some components to this process - orientation, in-service education and continuing education within the staff development process. I have a friend who goes up the wall if I use the term 'in-service training'. She says: "Barbara, we train dogs, we educate human beings."

DEFINITIONS

Based on the American Nurses' Association
Continuing Education in Nursing 1979

CONTINUING EDUCATION

Planned, organised learning experiences designed to augment the knowledge, skills and attitudes of registered nurses for the enhancement of nursing practice, education, administration and research, to the end of improving health care to the public.

INSERVICE EDUCATION

Learning experiences provided in the work setting for the purpose of assisting staff to perform their assigned function in that particular setting. In-service education is one aspect of staff development; the terms are not interchangeable.

STAFF DEVELOPMENT

A term describing a process that includes both formal and informal learning opportunities to assist individuals to perform competently. The components of staff development include:

a). Orientation

b). In-service Education

c). Continuing Education

'Orientation' is the means by which new staff are introduced to the philosophy and goals of an institution, its policy and procedures and role expectations. (How much time do we really give in orientation to role expectations?) Orientation gives information on physical facilities and special services. Orientation is provided at the time of employment and at other times when there is a change in role responsibility. It is something which is often done routinely but is

very important. We should let people working in orientation know what a key part they are playing. Then their greeting to the newcomers might be a little warmer, rather than a "here we go again" attitude.

'In-service education' another component of continuing education, is learning experience provided in the work setting for the pupose of assisting staff to perform their assigned function in the particular setting. An example of this would be new policies or philosophies that the hospital may be implementing, the necessity for change, lets say. How to operate new equipment is very definitely in-service education. In-service is just that - in service. It can be very informal, perhaps just two colleagues working together. It is not interchangeable with 'staff development', but is a component of this.

'Continuing education within staff development' is planned and organised learning experiences designed to build upon previously acquired knowledge and skills of that learner. Very definitely it is planned and it is organised.

The purpose of the activity may not be directly related to the role expectations of the individual. In-service education and orientation is related specifically to the institution. Staff education can be taken and used anywhere. It is planned and organised and certainly in my country, evaluation is undertaken. We could spend a long time discussing the effectiveness of evaluation - we are certainly not happy on that score and from talking to my colleagues in Britain I know that you are suffering the same dilemma.

MISS PEPPERCORN FOUND IT IN 1928

Before we go on, let's stop to reflect on some of the historical background of staff development. An American Journal of Nursing articles in 1928 contained an article by Peppercorn which said that although in-service education - education was the term used even then - had long been a part of nursing, it was still in its infancy. I thought when I read that: "Dear Miss Peppercorn, or Mrs Peppercorn, if only you could see us now! You thought it was in its infancy in 1928. In 1980 I think we are still a little bit at that point."

To find the reasons for the movement for staff development, I think you have to look at the developments of the 20th century. We have a very vocal population, asking for more education and more needs. They are not sitting back as before and simply taking what is given to them. They are sitting up and saying: "These are the things we want."

We also have to look at what world wars did in terms of moving us all into continuing education. On both sides of the Atlantic, hospitals were depleted of trained nurses. We had to get unskilled workers moving along so they could replace trained nurses.

We have to look at scientific advances. It has been suggested that about every two years we have a new body of knowledge to work on.

Administrators facing ever increasing costs have to look at employees in terms of keeping them qualified to provide the best care. If the money return is not good, we have to look at that employee and tell them at assessment that it is costing us too much to keep them on.

All this adds up to the fact that whatever the basic programme is, we must build on the basic knowledge.

MAKING CONTINUING EDUCATION MANDATORY

In the United States a number of states demand mandatory continuing education for revalidation of qualifications. All fifty states have different expectations of nurses. Each state decides the requirements for licensure. In the state of Colorado, I have to re-apply for a licence every two years.

In talking about mandatory or non-mandatory continuing education, I think we want first of all to look at what we mean by our profession. Barbara Stevens, a nurse educator/administrator in New York, wrote an article about the characteristics of a profession. She gave the definition of a profession in terms of education as that the practitioner is first of all indoctrinated into a role model that includes self-responsibility for learning relevant for the tasks assumed in the professional practice. If we are a profession, as we say, we have got to be 'indoctrinated' that part of our responsibility is to keep up with education. The nurse practitioner must not be satisfied with basic education.

When we talk about mandatory continuing education, I think we have realised that if it is necessary to make it mandatory, somewhere we have missed the boat - that we have got people who call themselves professional nurses but, they haven't embraced the full concept of being a professional person. Somehow we are failing to indoctrinate people into the role. I may not shaking any fingers at those in charge of schools of nursing; I think it is a total responsibility within the profession. From the start we must make it clear that while we teach the student this and this, she must realise it will only stand her in good stead for a certain period of time and, she must continue to keep up to date. But it does not rest solely on the nurse educators in the basic programmes, it rests on all of us.

PEER REVIEW

I am a great advocate of peer pressure and peer review. In my country we have given it lip service certainly since 1928 when Miss Peppercorn was writing her article. But actually implementing it within an institution is at best extremely difficult. It is, however, something to which I would like people to give serious consideration.

When you talk about mandatory continuing education, it is a move, certainly on my side of the Atlantic, to remove internal professional control, in favour of external societal control. I would like you to give that some serious thought. If mandatory continuing education is going to come about, keep in mind: who is going to govern it?

In the United States, basically it is our state legislators who are governing our licence and deciding whether we will have continuing mandatory education. True, in Colorado, it was the nurses who went to the legislators when they were writing a new act and said they wanted mandatory continuing education in the bill.

Going down to the legislature and listening to the debate was a real eye opener for this nurse educator who thought she had a good idea of what was going on in nursing and society. It caused me a great deal of concern. I listened to these elected legislators deciding my practice - what I should do, what my education should be. It was scarry, because they don't know what we do. I am finding that society does not know what nursing is all about.

ARGUMENTS FOR MANDATORY CONTINUING EDUCATION

Some of the 'pro' arguments for mandatory continuing education in the United States centred around the fact that making it mandatory would mean more people undertook it. Another argument was that employers would have to give serious thought to provision of continuing education and not just have little service programmes. It would also force employers to give people time off - if the employer could not provide the training, the staff would have to go elsewhere.

Now we are getting into the pocket book. What interested me when I was in the legislature committee room was the lobbying by the hospital society, the medical society, the pharmacists, the physical therapists - all wanting a word about the nurse practice act. I thought: "Holy Toledo - It was just incredible."

The 'pros' also felt that if continuing education for nurses was mandatory, universities would find it easier to get allocated money for it.

The people who have been dead set against continuing education were concerned whether the programmes would be assessible to everybody.

In many states geographical remoteness has been a real problem. I am sure it would be the same in England - everything happens in London or Leeds or other major cities but what about the nurse at somewhere on Thames? "How am I going to get my education? I've got a family to take care of. I can't just leave for the day and go into London, or stay overnight."

With education we have had to do a lot of thinking about this. Some states with sparse populations have had to be innovative. Signe Cooper, a leading figure in continuing education in the USA, and her group at Madison, Wisconsin, have done a great deal on disseminating information in rural areas, she writes in the Journal of CE.

Another consideration is: who is going to decide what is appropriate? Is orientation a part of continuing education? What about in-service education, staff development? What about measuring the effect of continuing education? Who is going to evaluate whether we are getting value for money spent on it? We try to do evaluation but it is very costly to do. We can do immediate evaluation at the end of the programme - I call it the 'happiness index': "Did you like the food?" "Did the speaker really meet your needs?" - but what do participants take home from a programme? It would be very expensive to phone everybody up six months later to ask what use they have made of what they learnt. I would be interested in any views on this point.

MAKING CONTINUING EDUCATION MANDATORY

Ten states in the US are talking about mandatory education. In Colorado we had a struggle last year in getting our nurse practice act through the legislature. We were concerned at the attempt to limit the role of the nurse and, after we had marched on the legislature, the politicians asked the nurses to get together. It was the first time that I saw that nurses could work together! We are now happy with the act which we got and it says that there shall be mandatory continuing education. It is going to be the State Board of Nursing which will determine this continuing education - the statutory body, not the professional state nursing association.

The number of hours which each state requires in mandatory continuing education varies from 10 a year to 30 for two years. Kansas state board has to approve all programmes. I would hope that Britain could have a much more uniform provision.

We have an organisation called the JCAH - the Joint Commission on Accreditation of Hospitals- a private organisation which reviews hospitals, sending a team of three people - a physician (doctor), nurses aand administrator. (Interestingly, the last time the team was at my hospital the physician got bogged down with a number of problems and sent the nurse to look at a number of areas which were regarded as the medical province!)

One of the requirements for recognition by this body is an 'in-service department'. In the past they have not said what this department should do. They are getting more specific now. They want details of programmes. They require cardio-pulmonary resuscitation instruction for all employees and that we keep up the skills of persons working in critical care areas.

Approval is not compulsory but, without it, the government will not make Medicare and Medicade payments to the hospital. The JCAH come every two years - it is more an invasion than a visit. They look at patient care plans and they check whether the nurses have documented them in the patients' notes. It is a great education for the staff in the need for accurate note keeping!

A SEPARATE BUDGET FOR CONTINUING EDUCATION

Budgeting for continuing education is something which we are going to have to do a lot of thinking about. I realise that in Britain it is difficult to get the money. It has been no easier in the United States. This does involve our failure to make public what we are about and what we expect. It is vital that we talk about who we are, what our role is, what we can do.

QUOTABLE QUOTES

CONTINUING EDUCATION - DEVELOPMENT FOR NURSES

PAUSE/CAUSE FOR THOUGHT

'Let us never consider ourselves as finished nurses.....
we must be learning all our lives.'

Florence Nightingale

Individuals must be responsible for their own continued learning as well as the learning of others.

Continuing education has become so necessary that it must be accepted as a human right and a social need - not a luxury.

A well planned effective in-service programme can contribute substantially to the practicing nurses education. Conversely, poorly planned programmes lead to a negative reaction towards learning.

..... the information gained from the questionnaire suggests that peoples' interpretation of 'In-service Training' varies considerably (re titles and designations).

From the 205 who answered the question 'do you have responsibility for the community as well as hospital staff?' 162 said they had some involvement with community staff and 43 said they had none.

Do you meet other In-service Training Officers on a regular basis?
90 respondents said they did - mainly on an 'ad hoc' basis, 117 said they did not.

The title 'In-service Training has evolved to cover many activities. It would appear to be inadequate as so many alternatives have been offered .... a term which embraces the wider concepts of Continuing Education and Staff Development both personal and professional would be more useful.

Changing practice - by choice rather than chance.

Quotations taken from:

The Journal of Continuing Education in Nursing
The Journal of Nursing Administration
In-Service Nurse Training in England & Wales - Survey by Jean Heath,
Sheffield L R U

In the US budgeting is handled in different ways. My own hospital, St Luke's, has some 480 beds and, because it has always had directors of nursing who were dedicated to continuing education, we have a well defined department. My department is independent - it does not come under nursing administration but has its own budget. The Director of the department is responsible for the budget. In contrast, in another hospital in Denver, which has recently amalgamated with us, I noticed that the education department worked to the personnel department.

We are an integral part of the hospital, we work closely with the other directors and with the ward sisters but, we are a separate entity with its own budget and this, I feel, is how it should be.

We really need to do research into documenting our achievements with education. Nursing must now go to administration with hard facts.

Unkind as I have been to the federal government, they have been very kind in many ways, giving matching funds to the state. But again, it is only because nursing has gone to the government and said: "This is what we need." Pharmaceutical and other companies supplying hospitals can be very helpful in terms of sponsoring programmes. In the past they have been concerned with doing this with doctors but they are becoming more interested in helping continuing nurse education.

QUESTIONS

A questioner concerned with getting nurses back into nursing asked about the effect of mandatory continuing education on this in the United States.

Miss Milburn replied that the requirement was not, at present, a problem but clearly would be in the future. Getting nurses back was, however, a very real problem. In the US nurses were leaving at a rapid rate. Patricia Harris, Secretary of Health Education and Welfare, felt it was necessary to look at who was being educated in nursing. Why, she asked, spend all this money educating a nurse who two years later turns into a secretary? Research had now begun into the loss of nurses to nursing.

Marlene Kramer and Claudia Schmalenberg had written on training graduates as nurses and the frustration that arose because of the dichotomy between what was taught in the classrooms and practised in the wards.

What would be the effect of the changed economic climate? Miss Milburn thought more people would come into nursing. But she told the cautionary American tale of a town near Colorado where a meat packing factory had closed because of the economic situation, with aloss of 800 jobs. The senior nursing officer was concerned because there would be more nurses applying for jobs but she would not have the money to engage them at a time when there would be fewer patients in hospital - "because who can afford illness if you can't keep up your health payments?"

Asked about part-time nurses, Miss Milburn said that her hospital employed a number of nurses who worked one or two days a week, a full eight hour shift.

"We do refresher courses for those who have been out of the Profession" she continued. "These are very often based at community colleges, where public funds were available for them."

BASIC EDUCATION GOES TO UNIVERSITIES

Was the continuing education department separate from the school of nursing? Miss Milburn explained that hospital schools providing the three year course for registration were on the way out in America, because of cost to the hospital and the desire to put basic nursing education in a university setting. Students from the university and community college were allowed to come for clinical experience but St Luke's no longer had a school of nursing of its own.

A fund left over from this school, however, enabled continuing education to be provided at a low cost - but it was the philosophy to make some charge to students.

In reply to a question about the status of learner nurses in the USA, Miss Milburn said: "I had no idea that your students were part of the work force. In my country the hospitals are staffed, well in some cases, in others poorly, by trained staff. Learners are there in a student status to gain experience. They are not counted officially in determining manpower levels - but when you get down to the short straw, faced with a crisis, they do get considered in manning terms."

MAKING CONTINUING EDUCATION FINANCIALLY WORTHWHILE

Are expertise from continuing education reflected in salaries? In some institutions, yes, in others, no. People ought to be rewarded for excellent clinical practice and their interest in remaining a good practitioner, Miss Milburn thought.

Were there problems in keeping nurses in specialties? Could people be kept in intensive care after they had been trained for it, for instance?

The question of whether people should be paid more for working in certain areas was a big debating point in the USA at the moment, replied Miss Milburn. Some hospitals did pay the critical care staff more in order to get the nurses. Colorado was a scenic state but the cost of living was as high as on the coast, where nurses salaries were higher. California was having great difficulties and was recruiting nurses in Canada.

PURSUING POSSIBILITIES - FOSTERING OPTIMISM

SUE STUDDY

To give a balance to the programme, Sue Studdy, who had a scholarship to study continuing education in America, was asked to give her English worm's eye view of the American scene and explain what she had done with the ideas she had assimilated there. Sue Studdy is Senior Tutor, Staff Development Education Unit, St Thomas' Health District, London

Barbara Milburn has given an excellent account of the system for continuing education for nurses in North America, both locally and to some extent nationally. My brief is to share my impressions gained on a study tour last year.

I would like to begin by explaining how I came to go in the first place and to outline the present facilities that we have here in England, so that we can get things in perspective.

I was appointed to my present position as senior tutor, post basic education, in 1978 and my job description stated, amongst other things, that I would be responsible for Joint Board of Clinical Nursing Studies courses and to provide some on-going education for all the trained nurses in the district. At that time, there was just myself in post, with clinical teachers for the Joint Board courses.

BRITAIN HASN'T A NATIONAL CONTINUING EDUCATION SYSTEM

So I thought I had better look at the national system - and discovered that we do not really have a national system. But I did find we had courses available, to which I could send nurses as appropriate.

After taking the first basic statutory qualification, a nurse can undertake another statutory training. Some nurses, who want to specialise, may undertake a Joint Board course and we have these in

over 40 specialties. For the nurse wishing to go into management or teaching, there are now numerous courses and there are also courses leading to the diploma in nursing or the various degrees relevant to nursing. I also found there were a number of study days and workshops available in subjects such as safety at work and various clinical topics.

Statutory refresher courses were necessary only for midwives and tutors - I wonder what happens to all the other nurses who work in the Health Service? They can be qualified for 20 years or more and never have to attend a course.

INADEQUATE FACILITIES

At first sight, the national facilities that we have in Britain look impressive but, I would like to suggest to you that they are not. Continuing education is statutory for only two small groups of nurses. There are no guide lines for setting up or approving courses. And the number of courses and their availability is inadequate, considering that we have over 340,000 qualified nurses working in the Health Service.

American nurses often said to me: "You are lucky, working in England." Whilst I agree that the Joint Board courses are really excellent, only 4.3 per cent of all trained nurses have attended one and obtained either a statement of competence, attendance or certificate. What about the other 95 per cent? What's available for them?

After looking at what was available nationally, to try to gain some ideas and inspiration, I looked at what other people like myself were doing. What I found was a great variation from health district to health district. Generally the emphasis was on management training, skill training or initiation courses, with a small number of general study days and, of course, the Joint Board courses. The variation that I found was not only on the types of courses but in the qualifications of those running them, the number of courses that they ran and the amount of money they had to spend.

Where was I going to begin? How should I plan my work? How should I develop it? It was at this point that I began to discuss with colleagues who had recently returned from America the system there. They had been suitably impressed and said things were more organised in the USA, although we have learnt from Barbara today that things are still not perfect.

HOW AMERICA AND CANADA DO IT

I applied for a scholarship to go to America and was fortunate enough to be granted one. Last year I packed my bags and went west to see for myself. I visited six centres, five in America and one in Canada. In each of the places I visted, I went to a continuing education department in nursing at the university, a staff development department in a hospital and a community nursing centre and the state nurses association. I believe that I gained a fair idea of what was happening throughout the country.

The aim of my visit was to investigate the total system of continuing education in North America and, hopefully from what I learned, to be able to improve the work that I did and increase the provision made for the nurses working in the St Thomas's health district.

I returned with many impressions, both American culture, as well as nursing. The first thing that I noticed was that in each of the places I visited, the departments had similar objectives and philosophies and the structure within which they worked was much the same. Which was different from what I found here. I believe that this was due to the influence of the American Nurses Association, a similar organisation to the Royal College of Nursing. The American Nurses Assocation in 1970 set up a Council for Continuing Education and from that a committee was formed to investigate how they could set about promoting standards for continuing education. The committee has produced several booklets called Standards of Continuing Education. In staff development it has defined the terms which we saw earlier. So everyone that I met was working around the framework set up by the American Nurses Association.

POSITIVE ATTITUDES

The second thing was the positive attitude towards continuing education. I think that as educationalists we would all agree that the ultimate responsibility for continuing education rests with the individual. It is not the educator's responsibility. But I did find that North American nurses were more positive - they were in favour of continuing education. And a survey by an American nurse - Shurn - in 1979 showed that 68 per cent of the nurses sampled were in favour of mandatory continuing education. Certainly at the workshops and courses I personally attended and, in speaking to nurses in wards and departments, I also gained that impression. There were, of course, also negative attitudes. One nurse said to me: "Look, I'd attend any course in order to get the hours necessary to renew my licence."

Why nurses have, in general, a more positive attitude to continuing education in America, I do not really know. One influence might be the fact that most nurses there now are educated in university. So from the word 'go' there are 'into' education. They expect to continue their learning - I think this is instilled into them more than we instil it into our students.

The other thing which I noticed was that all universities which had a department of nursing had a department of continuing education in nursing as well. These departments provide not only on-going education in the form of degrees and higher degrees but, also short courses, study days, workshops for any nurse.

STAFF DEVELOPMENT WELL ESTABLISHED

We have heard that staff development departments are part and parcel of every hospial because they have to be but, I wonder, does it matter why they are there? The important thing was that the hospitals had them, and that these departments were well established. The nurses working in that hospital or community nursing service were provided with some form of on-going education.

That brings me on to staffing - something very dear to my heart, with my 1,800 trained nurses to provide continuing education for and no staff. I found in Denver one educator to 80 trained staff. And this was not an unusual ratio. One to 80-100 is obviously very much better than one to 1,800 and, I think it illustrates the importance attached to continuing education in America as compared to Britain.

The nurses who were working in these departments were very well qualified and highly motivated. All had degrees in nursing. Some had a Master's degree, which would include an education module, or a Master's degree in education itself and, many of the directors of departments in universities had a PhD. Again, I felt this added a great deal to the status that continuing education had in America, compared to Britain.

SHOULD THE NURSES PAY?

We are all concerned with finance and Barbara has told us that it is not easy in America. There were two things that I noticed about finance. The first was that nurses paid for their own continuing education. They paid their course fees and expenses and, frequently attended in their own time. And they didn't have any more days off than we have, either! I thought when I was there: "That's fine, they earn considerably more than we do, so perhaps they ought to pay." I was talking to Barbara last week, when she came to visit us at St Thomas's about this very thing.

"But look," she said, "even if our nurses earned what your nurses earn, we would still charge them for their continuing education, because we believe that if you pay for something you appreciate it and you think it is worthwhile. Therefore, they should still contribute something, even if it's only 50p per handout." I am still thinking about this.

The second thing I noticed about finance was the fact that in the American hospitals the patients were definitely footing the bill. I was told very definitely that the way they finance staff development was to increase the fees charged to patients. There was not other way of raising money. This was alien to me in the Health Service and I wondered if patients should pay. But I noticed that patients were different from patients here. They are generally more demanding and more aware. Maybe in that case they should pay more.

PATIENTS DEMAND CONTINUING EDUCATION

In some states patients have been quite influential in demanding that nurses - and doctors - prove that they are still competent. They have said this forcefully to the state legislature, which has influenced the introduction of mandatory continuing education. This was particularly the case in California.

The pros and cons of mandatory continuing education, to which Barbara has drawn attention, is a very interesting issue. I met many people in America who were for and against. Most of those whom I met were in favour. I visited two of the states requiring continuing education - California and Colorado. I had read about it before I left Britain and felt that I was in favour of it.

I went to California first - and quite frankly, it put me off mandatory continuing education completely, because things were chaotic: that is the only word by which I can describe it. There were various organisations running courses for nurses which might have had nothing to do with nursing whatsoever: really they were in it just to make money. Nurses went to get their 30 hours a year and the organisations made their money. When I went there several thousand courses were put on in the state of California. With this large number, the course approval system had collapsed. Therefore there was no guarantee of quality.

MANDATORY CONTINUING EDUCATION MUST BE THOUGHT OUT FIRST

So, I went to Colorado, thinking it would be the same there. Fortunately, it wasn't; and it did renew my interest in mandatory continuing education, because things were far better organised and more controlled. I was told that it had fallen down in California because in the first place, it had not been adequately thought through. No one had thought out how it would work in practice. Money had not been allocated for it. The end result was disaster. Whereas in Colorado it seemed that more thought had been given initially and, certainly the courses approved by the Colorado Nurses Association were of a very high standard and went through a vigorous approval process.

Lastly, the planning of programmes. What interested me here was that the courses concentrated on the learning needs of the individual nurses.

The universities would conduct a state wide assessment of the needs of all qualified nurses working in the state and plan their programmes accordingly. In hospitals, the staff development departments would also do a learning needs assessment within the hospital to find out the needs of the trained nurses. They would, of course, consult the nurse mangers about the needs. But they would mainly ask the nurse what she thought she needed - after all, it is her responsibility and, who, in many ways, can know better than the nurse herself? I had not come across this learning needs assessment before I left Britain. I did not know anyone who has done something similar here, although since my return I have been interested to read that something like this was done in Wessex some years ago.

From the needs surveys the programmes for the coming year would be planned. They would be planned on an educational basis. Objectives would be set and a variety of teaching methods used.

NURSES, NOT DOCTORS, SHOULD TEACH NURSES

One thing which caught my eye was who was doing the teaching. It wasn't the doctors who were doing the teaching but the nurses. Nurses that I spoke to in North America were horrified when I told them that in this country the lecturers on a nurses' study day in Britain were all doctors. (Cries of: No, no.) Good, I am delighted. I am very glad to know this is not the case throughout the country but, it is in many cases. Even in the basic education programme it is the same. You see many doctors involved in the education of nurses. You don't see many nurses involved in the education of doctors.

The Chairman: "You probably have got the converted here."

Sue Studdy: "That's right! I'm sorry if I have offended anyone."

After a course was over in North America, assessment did take place, although, as we have heard, this is a difficult area. I was interested to see that testing was quite frequently used. Nurses attending a two-day workshop would be given a test on the second day to see whether they had achieved the objectives. I must say, that if I introduced that into my programmes, I don't think people would come. I have not tried it, so maybe they would. I will be interested to know if anyone has tried it.

These were my main impressions. The over-riding impression, however, was of the sheer enthusiasm that the educators in the field of continuing nurse education in North America had for their work. It inspired and encouraged me to try to change things in my own area of work, which I think I have succeeded in doing to an extent.

WHATS WRONG IN BRITAIN

Can we learn anything from the Americans? Do we need to use any of their methods or are we happy with what we have at the present time? I personally do not thing the present situation is satisfactory. Firstly, we have no national system. Secondly, there are many nurses still who do not expect to continue their education once they have qualified. Thirdly, the local and national facilities are not always adequate in quantity or sometimes even in quality.

I think it is necessary to have a national system and in 1975 the International Council of Nurses issued a policy statement on continuing education, which said:

> In the light of rapid scientific, technological and social changes, the ICN is convinced of the importance of continuing nursing education, in order to ensure safe and effective nursing care. The ICN urges member associations to take the lead as needed in initiating, promoting or further developing a national system of continuing nursing education.

The statement goes on to say that we should utilise the resources of the schools of nursing and universities and continuing nursing education should be available for all levels of nursing personnel.

Nearer to home, the Briggs Committee thought that continuing education was also important and stated in paragraph 300:

> We wish to stress that registration is not the end of the story for the modern nurse and midwife or for the nurses and midwives of the future. The education of nurses and midwives is a continuous process. Knowledge and the social contect are changing and, new experience can and must, be acquired beyond this stage. This approach to learning is fundamental to our proposals.

I too feel that nurses and midwives of the future will need continuing education more than ever before, because they now work in more clinical areas as students, spending less time in each one and, on registration, they may have skills to work in a ward of a general nature but, they are certainly not equipped to work in specialist clinical areas or, indeed, to know all their is to know about nursing.

CENTRAL COUNCIL'S ROLE

There has also been a vast increase in nursing knowledge over recent years and, I expect this will continue. There have been rapid advances in medicine and technology also. Soon we are going to have the formation of the Central Council for Nurses, Midwives and Health Visitors as a result of the recent nursing legislation. Perhaps this is the time when we, as nurse educators, should be considering what we would like for continuing education, when the new statutory body comes into being.

I have given it some thought and have some ideas which are my personal ones, although I have discussed them with colleagues. I would like to share these with you.

NATIONAL CONTINUING EDUCATION NETWORK NEEDED

Firstly, I think it would be valuable if a committee could be formed by the Central Council to investigate how a national network for continuing education could be both financed and organised. In doing this, I feel they should develop a course approval system, because many of the courses that are run now are not approved in any way, so that there is no guarantee of quality. We want to avoid what has happened in America, where some courses are of very poor quality.

One way in which this might be achieved would be to extend the duty of the national boards, under the Central Council, to approve schools of nursing for statutory training, as the GNC does now. They will also be taking over the function of the Joint Board and approving their courses. I feel they should look at all staff development courses to ensure (a) that they are being provided and (b) provided in an educational manner.

There are courses for nurses outside the schools of nursing and hospitals. I would suggest that they too should be approved. We have statutory courses for health visitors, nurse teachers and shortly for district nurses, which will have to go through an approval process. We have non-statutory courses in management and the diploma in nursing, which I know is in the process of change and will be much more rigourously inspected in the future. And, there are workshops, like this. I feel they should be looked at too.

STAFF DEVELOPMENT DEPARTMENTS IN ALL DISTRICTS

The Central Council, I think, should recommend that staff development departments be formed in all health districts, if they are not in existence already. The Central Council should produce guide lines on how to do this. The qualification for staff working in such departments should be stated: my own view is that all staff should have an educational qualification.

The Central Council should foster a positive attitude towards continuing education - indeed, we should all be doing that. It could also issue guidelines on the granting of study leave. We all know that whether a nurse gets study leave at present is a matter of chance and some nurses are in areas where study leave is not given for one reason or another.

GUIDE LINES FOR STUDY LEAVE WANTED

Perhaps here we should take a leaf out of our medical colleagues' book, because the British Medical Association set down guide lines of how much study leave doctors should be allowed. It is not a right that they have it, but I know that many of them do get study leave without any difficulty - and also fees and expenses. It might interest you to know that a registrar, for example, can be allowed day release each week or 30 study leave days per year, which is considerably more than nurses I know receive: they are lucky if they get one!

Lastly, perhaps the Central Council can look at introducing mandatory re-registration, possibly every five years and, following from that, mandatory continuing education.

You may say: "That is all very well but, it is going to be very expensive. We are going to have a 37½ hour week. We are not going to he able to spare the nurses to go off to attend courses."

CONTINUING EDUCATION IMPROVES PATIENT CARE, PROFESSIONAL STATUS

I think we must go back to the central aim of continuing education. I believe that the central aim of continuing education for nurses is the maintenance and improvement of patient care. In achieving the central aim, we may achieve several others. We may raise the morale of our trained staff. We may increase job satisfaction. And, hopefully, get inquiring, stimulated and motivated nurses to look after our patients - up to date practitioners. This may lead to a lower staff turn over, something our nurse personnel department is very concerned about. Finally, it will, perhaps, increase the status of the profession.

We are the poeple who are in a postion to do something about it, if we feel there is a need to change what we have already. So I would like to say to you: "How about it?"

NURSING IS A 'PROGRESSIVE ART'

Okay, there'll be a lot of opposition, I am sure - lots of moans about 'No money'. 'It won't work'. etc. But in the end it will be worth it, both for the profession and for the patients. I would like to end with a quotation from the most distinguished of English nurses, Florence Nightingale, who said all those years ago - in fact before America's Miss Peppercorn, if I may say so! - that nursing is a progressive art, in which to stand still is to go back!

> A woman who thinks to herself "Now I am a full nurse, a skilled nurse, I have learnt all there is to know" - can take my word for it, she does now know what a nurse is and never will know. She has gone back already. Progress can never end but with a nurse's life.

The Chairman commented that there was no doubt that the session had brought a challenge from across the Atlantic and also from the British side as to definitions of the problem, objectives, questions of what nurses thought about education and whether they should be educating the government, the public and, maybe, themselves.

WHAT THE SYNDICATES FOUND

The afternoon of the first day was devoted to syndicate discussions. Each group was given a different question. These are the rapporteur's answers.

How is the function of in-service education viewed by nurse managers in relation to the other activities needed for the provision of patient care?

Group A. decided to accept Barbara Milburn's definition of continuing education. There was then debate as to who was a nurse manager. A person managing nurses. Directors of nurse education obviously were concerned ultimately with patient care, although it was acknowledged that nurse managers were anyone above ward sister. But, in the context of the question, the group decinded that the service manager, that is the unit nursing officer, was the person concerned.

The function of in-service education, from the nursing officer's point of view, was clearly patient-care orientated, involving such aspects as clinical up-dating, where ward sisters could attend study days on new developments in nursing care; the extended role of the nurse, where skills particularly to units - defibrillation in coronary care, for example - would be taught; and knowledge, skills and attitudes, the knowledge required by the person to do the particular job which they were in post to do, not knowledge which would be of value to them in any other activity. Smilarly with skills and attitudes - although perhaps attitudes could not be taught: they could be developed and would be manifested in a person's behaviour.

There was a discussion on how managers saw the value of in-service education but realised that it was not part of the question - important though it was.

How and by whom are the educational needs of qualified staff determined?

Group B. decided there was no national method of determining educational needs but that there were good local methods, which varied in quality. The qualified staff - all those with a statutory qualification - probably had different needs at different levels of experience.

The group identified the needs as management, clinical, technical and, very important, teaching techniques and communication skills. Broader issues also featured, such as studies in cultural differences. The availability of courses affected the perceived needs of individual nurses.

Determination of needs was a shared responsibility between teachers in post-basic nursing education, who were mainly under the Director of Nurse Education, sometimes the District Nursing Officer and sometimes the personnel department and, nursing officers at all levels from DNO downwards. Peer groups were important and also the responsibility of the individual nurse.

In determining the needs, did the aims meet the educational needs? Should role changes not be planned for and needs anticipated before they actually arose? Needs were sometimes determined in a haphazard way in formal and informal discussion. Some people were attempting a scientific learning needs survey which could be evaluated. Audit was considered, where the individual had the opportunity to look at the organisation itself; and appraisal, where the organisation looked at the individual. The requirements of the Health and Safety at Work Act and of the individual clinical specialties were considered.

On broader issues, the group concluded that educational needs were determined within a changing society, for example, the new needs arising from drug addiction and alcoholism will represent a need for the trained nurse to expand his or her skills. There was also the expressed views of the consumer, a big feature in America, where the consumer had a loud voice: the great British public were not very vocal, as yet. The professional body also had a large say in determining what trained nurses should know and where they should develop.

What are the arguments for and against mandatory qualification in a nursing specialty?

Group C. produced six arguments for mandatory qualification in a specialty:

1. It should and, in the group's opinion would, improve standards of care,
2. Professional self actualisation.
3. It would raise the status of the profession,
4. Cost effectiveness.
5. Allow for the development of a clinical career structure.
6. Provide opportunity for research and study.

The first argument against mandatory qualification was the shadow of 1984. The second a proliferation of certificates could lead to a devaluation of all qualifications and a fragmentation of the profession. Thirdly, it would be difficult to evaluate the value of any course. Fourth was the problem of cost effectiveness. Fifthly the amount of diversification required could be astronomical. Sixthly, where were the staff required to be obtained?

How should in-service training be considered within a programme of continuing education? Should continuing education be mandatory?

Group D. remarked on the use of the word 'training' instead of in-service 'education'. The group discussed whether auxiliaries should receive in-service education. Trained staff of course must have it and also the people coming back into nursing. The in-service education must be related to the role. The individual must come to terms with what he or she needed. The legal aspects of the Health and Safety at Work Act should be covered and also the extended role of the nurse. It was also important to prepare people for changes - structural changes within a health district or new policies or new procedures.

In the group some of the teachers were structured to the education division, others to the personnel division. It was agreed that both could be involved in the monitoring and teaching. Nurse managers should also be involved in the teaching. How to prepare people to teach is another subject!

Proof of attendance in a register and personal files was important, to monitor what people had done, not only for legal purposes but in terms of personal development.

Midwives, who were regarded as practitioners in their own right, had statutory refresher courses. What about nurses? Should they regard themselves as practitioners in their own right and have statutory refresher courses? The group realised there would be immense diversity of courses, so it decided that instead of attendance at courses being mandatory their provision should be mandatory. There should be national standards of amount of study leave and central funding of courses.

> How might national guidelines for continuing education be organised? Who should control them?

Group E. accepted that there were national guidelines at present in managerial courses and therefore looked at clinical training guidelines which were not laid down and, the possibility of incorporating both. The group felt that education should be on-going, cover all aspects of nursing and, be under the aegis of one body. Education and staff development should start on qualification. Since a nurse automatically became a staff nurse on registration, the first promotion of a nursing career was to sister. There was an in-service educator associated with the staff development and performance review. Already, staff that were being appraised were able to set down their key tasks and put their case for further education.

All responsibility for education, basic or post basic, should come under the Central Council for Nurses, Midwives and Health Visitors. The group concluded that there should be an element of compulsion on the NHS regions to provide a structured, statutory post-basic clinical education, monitored at local level.

Taking into consideration the present financial position of the U.K. what arguments might be made for diverting finances within the NHS to continuing education in nursing?
What contribution might be made from the nursing services budget?

Group F. thought arguments for diverting money could be produced in terms of the development of the profession but, it might be more effective to give factual information about where existing expenditure could be avoided or reduced through continuing education. One of these was wastage - in training or turnover. Another was compensation paid out as a result of litigation, which might be avoided if continuing education improved the standard of nursing and, the hidden expenditure of investigations of complaints. Whether nurses were correct in their belief that their profession was an independent one, the reality was that it followed medicine. Changes in medical knowledge required extension of the nurse's knowledge. A further argument for continuing education was the rising level of patient expectation. To meet these expectations, well educated nurses were needed.

If more emphasis was placed on the nurse's role in health education and prevention, it might reduce the number of people who became ill. Again, for every change in legislation or recommendation that had to be implemented, in-service education was needed.

The expanding role of the nurse meant that nurses were now doing things which at one time expensive doctors used to do. In patient management people responsible for health care management were beginning to review the need to have specialist units.

The group differed among itself as to the interpretation of the second question and therefore thought it was wrong!

CONTINUING EDUCATION -

A CUP HALF FULL OR HALF EMPTY?

"The Americans see a cup half full - and we see it half empty," declared Hazel Allen, describing the difference in philosophy between the American nurse's attitude and that of the British, when she opened the second day of the conference.

At this session she acted as question master, putting questions which had been handed in by members, to Barbara Milburn, Sue Studdy and Chris Hunt, Assistant to Sue at the Staff Development Education Unit, St Thomas' Hospital, London.

Chris explained that she had started her general training in a small hospital in Dorset, practiced for a few years and then went on to do her midwifery training in London. Most of her professional life had been spent in midwifery. It included a period when she worked as a midwife in the Edinburgh Medical Missionary Society's Hospital in Israel. As well as working in the small missionary hospital at Nazareth, she went round the Israeli hospitals, including the Hadassah, which was a hospital with forward looking educational programmes.

"It was really while I was there that I thought about going into teaching". she said. "I came back to England, practised as a midwife for a period, then did my midwives' tutor diploma, in a one year course linked with the RNT course at Surrey University. I taught in two very different hospitals. One was an area school of midwifery, the other was a hospital with a school all on one site. I taught Part I and Part II and then we changed to the single period training. I helped set up Joint Board courses and run some of those!

After being in teaching for six years and midwifery for twelve, she looked at her career. She had become interested in what she then thought of as continuing training - she now preferred the term continuing education - and at this point saw the job advertised at St Thomas's.

IDENTIFYING STAFF NEEDS

The first question was for Sue: How did you start identifying staff needs when you took up post?

Sue Studdy said that in the year before she went to America most of the courses were based on comments of nurse managers, from sisters and other nurses and, one or two ideas of her own. She noticed when she went to America that the nurses themselves were asked what they wanted to do in continuing nurse education programmes. So when she came back she wanted to ask her nurses, although she could see that managers should be asked about what needs they saw for their staff.

It was obviously impossible to ask all 1,800 nurses, so a 13 per cent sample across all grades was taken: this, a statistician assured me would give a satisfactory statistical result. It numbered 230. There was quite a lot of discouragement to undertaking the survey but eventually the statistician in the department of community medicine agreed to help. He assisted in formulating the questionnaire, so that the results could be computerised and so that the questions would not be ambiguous.

The results had taken nine months to obtain and analyse - Sue had thought it would only take three - and from them it was hoped to plan next year's programme of continuing education, along with the opinions of nurse managers and, the department's own ideas: informal comments were also used as much as possible.

"Our biggest problem has been communication," confessed Sue. "We communicate quite well - at least we thought we did - with the nurse managers, They then pass on information about courses to people working in their unit."

"What we discovered was that in one or two units - and it was only one or two - the managers were not passing on the information. The sisters, particularly, would come to us and say: "We didn't know you were running that course." When we pursued this, people said: "If we give them a list of all these courses, they will want to attend all of them - they won't

be able to select what they really need and, if they want to go to all of them, who is going to look after the patient?" It was rather a shame the managers felt this about our staff and, I must say in our experience we have found that nurses are very responsible and only come when they are able to leave the ward well covered."

SISTERS DO ATTEND COURSES

Chris Hunt said that it was interesting that when the results of the questionnaire were obtained some of the evidence conflicted with what they had been given to understand was the position. For instance, the managers said that the sisters were the people who never attended the courses because they always sent their staff nurses or enrolled nurses. This was not borne out by the survey at all. The groups that were most dissatisfied were staff nurses and enrolled nurses and, it seemed that sisters attended pretty well, by and large. The managers seemed to misunderstand what the staff were actually doing.

Sue Studdy explained that the survey asked what courses had been attended and the grades had been noted, to provide this information.

It's all very well for you. You come from a centre of excellence. You've got money and you've got staff. You've got good staff in the school and probably more staff in the service situation than a lot of hospials represented here.

Sue Studdy replied that so far as staff in the department was concerned, she did not think they were very well off. There was just Chris and herself. She had also managed to obtain finance for someone with a psychiatric nursing qualification but, unfortunately, it had not been possible to fill that post. And she had managed to obtain funding for a secretary - after two years - from the Special Trustees, a source admittedly not available to a non-London teaching hospital.

As regards the other salaries, the District Nursing Officer and Director of Nurse Education were fortunately committed to continuing nurse education. The DNO allocated a sum of money to the director for use for this purpose. This also provided the money to run courses and to send people out on courses.

CONTINUING EDUCATION IN CLINICAL AREAS

In Britain we have a tradition of tuition in clinical areas. Would you see that some aspects of continuing education should take place in clinical areas or do you envisage that all continuing education should be in the teaching establishments?

Chris Hunt thought it essential that some of it took place in the clinical situation. "For one thing there are two of us and 1,8000 staff: we can't possibly provide for all their clinical needs." she pointed out. "I see this largely as the responsibility fo the nursing officers to provide in-unit clinical education for their staff, with help if necessary. This is one of the things we are keen to promote but, funnily enough, it seems very difficult to get any enthusiasm for it at that level."

Sue Studdy agreed that there was a lot of learning opportunity in the clinical area, which was perhaps not always utilised to the full. Much more use could be made of this.

"We ourselves would like to have more time to go around and help nursing officers to set up programmes. Indeed, we have offered - but very few have taken us up on this offer."

NURSING ASSISTANTS NEED INSTRUCTION

Do you believe in training and/or educating nursing assistants?

"I don't think we ought to have nursing assistants at all but, we have got them and if you removed them a lot of hospitals just couldn't function." replied Chris Hunt. "I think they need some form of instruction - and I use that word rather than education or training."

"We have just started this. New nursing auxiliaries have a week's orientation, part of which is tacked on to the district orientation programme, part of which is separate, just for them. A part-time clinical teacher is going to follow them up in the ward situation and they will have

a series of study half-days initially and, then refresher days. But it is in no way intended as a training in the sense of their being awarded a certificate or that they will be led to think they are qualified, in some way, to do nursing. It is simply basic instruction, because some knowledge is better than none. But, it should be emphasised, that a little knowledge can be a dangerous thing."

As far as the unit based orientation was concerned, this should be done by nursing officers for all staff. The nursing officers had certainly been involved in the planning.

Sue Studdy did not believe in employing nursing assistants either. But she too realised this was unrealistic and that in many areas hospitals would close without them. Registered nurses and enrolled nurses should be giving patient care. It was unforuntate when one saw in a ward asistants doing exactly the same work as nurses. They admitted patients and carried out procedures with very little knowledge.

<u>What qualities are required in the educators carrying out continuing education</u>?

Willingness to listen to other people's opinions, said Sue Studdy. Ability to relate to others and see their role as well as your own. Tact. Educational expertise, because programmes should be planned in an educational manner.

THINK BROADLY, BE FLEXIBLE

Chris Hunt added the need to think broadly, rather than in a narrow field and ability to be flexible. "If you antagonise people and force things on them, then you have lost before you start," she added. "You need to generate enthusiasm for what you are doing, because that is catching. If you can motivate people, you are half way there. You have to be sensitive and know when you cannot push - to have the wisdom to change those things which you can and to know the things you have to leave alone."

Isn't there a limit to flexibility - you don't want to be a 'bendy bunny'?"

Chris Hunt explained that what was needed was flexibility within the boundaries of a philosophy. Sue and she had written a philosophy for the continuing education unit.

Sue Studdy added that it had been written after her return from America. Before she had not had a philosophy. She had put on programmes almost like a zombie being told what to do.

In the philosophy they had defined what they meant by in-service education and continuing education. They took this to the nursing policy group, where all the divisional nursing officers, with the district nursing officer and the nursing personnel officer, discussed it. "We didn't put jargon in, because we knew that would put people off," said Sue.

They had to be very firm sometimes and say they could not do something because they just did not have the time,

All new nursing staff had an orientation programme. The work of the unit was explained to them and they were given its philosophy. It was one way in which it was hoped to enthuse staff and explain what was available to them for continuing enducation.

A CHANGING PHILOSOPHY

But Chris Hunt added that the philosophy was changing all the time and needed now to be re-written. Ideas were taken all the time from people in the district and these would be incorporated in the revised version. It would again be discussed before it was re-issued to make sure that all nurse managers were happy with it.

Changing the name of the department to staff development met with approval of managers. It was thought to be much better than post basic education, which meant just Joint Board courses - only part of the work - or in-service training.

If it was necessary to have nominations rather than a course being open to all comers, it created paper work for managers. But there had been few complaints.

Suggestions for courses were taken up. Recently, sisters had been concerned about the new complaints procedure and the divisional nursing officer asked the unit to provide a study day on this and one or two other topics which she was worried about.

COURSE SUBJECTS

Can you give us some idea of the subjects which you have taken?

Sue Studdy said that what was emerging was a core of programmes run on a regular basis, for example a course on teaching in the clinical situation, for all nurses working there, so that they could develop their skills in teaching; and of course in counselling for nurses. These - and it was hoped to develop more - were repeated several times each year.

In addition there was, at present, one study day per month on wide ranging topics. One coming up was the application of research into nursing practice. Another had been on developments in cancer nursing. Next year's subjects for the study days would come from the learning needs survey. Other study days had been held on the Health and Safety at Work Act and on the implementation of the job and performance review system, which was being introduced into the district. (Hence it had not been possible to use it for assessing learning needs: hopefully in the future it would give the unit more information on what the learning needs were.)

Chris Hunt mentioned the three day orientation programme each month, for all new staff starting on the same day. Also all the student nurses, once they received their results, had a post registration study day, which would become a week in 1981.

Core could become bore. What are you building into your system to prevent that happening?

Evaluation, replied Sue Studdy. They particularly tried to evaluate the core programmes. They did not use tests but they asked if the content had been relevant to the needs of the participants and whether the teaching methods were appropriate and how they were going to apply it to their work situation. For all courses a course conference evaluation form had been produced which participants filled in a month after attending the course, whether it was an internal one or an external one. The nurse managers also discussed it with the participants and filled in a section which was kept in the nurse's personnel file, a copy being sent to the department.

It was important not to make it a bore. This was why it was necessary constantly to assess the learning needs. There was a high turnover of staff, so maybe it would not be as boring as it could be.

Looking at the high turnover of staff, was it intended to see whether continuing education reduced the turnover?

It was an idea, agreed Sue Studdy, but a year was probably a little too early to undertake it.

TAKE 'FINAL' OUT OF STATE EXAMS

Would it be desirable to remove the word 'final' from the state examinations?

Yes, replied Chris Hunt. It originated from the time when there was a preliminary state examination and, a final. People thought that they had arrived when they passed the final, although she soon disillusioned them on courses and study days.

Sue very clearly said that there was not national system of continuing education. But there is a national system of staff appraisal, we think. How could this be harnessed to continuing education needs?

Sue said that in St Thomas' Health District appraisal was only now being introduced. When it was in operation it would be one way of assessing the needs of the individual. What would be necessary was the development of a good system of communication, so that nurse managers communicated the needs which they identified. There had been much opposition to the appraisal from the nursing officers.

MULTIDISCIPLINARY - BUT WHAT DISCIPLINES?

Could the cost of education be shared by other disciplines, if there was a part to be played in continuing education for multidisciplinary groups? And might this increase the awareness of the essential teamwork?

Chris Hunt said that she had talked about this with the sisters. On first line management courses the disciplines of the nurse was mixed with were not necessarily the ones she needed to mix with. She needed to mix with the primary care team, the doctors, physiotherapists and radiographers. The needs of portering and catering staff were so different that to put them together on a course was not very helpful. At middle management level it was different.

But if at the other level there could be multidisciplinary courses with physiotherapists and other professionals it would be a good idea. Sue Studdy had introduced such a course, not necessarily with a view to cost saving but to have a multidisciplinary study day.

Hazel Allen pointed out that in Exeter, study days were being run for district nurses, health visitors, physiotherapists together. In fact, a study was being made of this.

Sue Studdy said that she was running a course on helping patients with physical handicaps who had sexual problems. This resulted from a request from a number of ward sisters who did not know how to communicate or what to say to patients who had had a stroke or a myocardial infarction, about what their sexual activities could possibly be in the future.

"We decided to make it multidisciplinary and invite medical staff and physiotherapists to come along. We have just published the details and two doctors have so far applied. If it is successful I think more could be done."

What are the reasons behind not only the apathy but also the resistance to staff development in this country?

Chris Hunt thought it went a long way with an attitude in nursing of "your's not to reason why. Your's but to do and die." A questioning attitude did not seem to have got over yet to nurses and it appeared as a threat to many.

NURSING 'IS HARDLY A PROFESSION'

"Is is a very important matter when we consider whether or not we are a profession," she continued. "We are hardly a profession at the moment. We could be - and we should be. This is one of the ways we could achieve it. But it needs effort and enthusiam and cohesion - and we have not got that either: nurses do not seem very good at making a unanimous voice."

Sue Studdy agreed. She thought nurses were trained, as opposed to educated, in many instances. They were taught to do specific things.

Intervening, Hazel Allen asked how Sue defined training and education and if she thought it important to separate the two?

DEFINING 'EDUCATION' AND 'TRAINING'

Sue Studdy quoted from the Oxford English Dictionary: 'To train - to bring a person, child or animal to a desired state of efficiency by instruction and practice.' There was not much of a cognitive element to training. It was more related to skills and questioning was not encouraged. Whereas education involved questioning what one did, finding out all the possibilities and making an informed decision on the basis of these, rather than doing as one was told. Training involved moulding people into what

the instructor wanted them to be - a 'turning out the sausages' approach.

"I must say, when I taught general students, I looked at them and thought: "when they came in, they came as very inquiring individuals, questioning, lively people and, at the end, they all thought exactly the same and they would not question anything." it was incredible."

QUESTIONING ATTITUDE SEEN AS THREAT

This did not happen so much with the graduates and undergraduates. They were more able to cope with the situation and retained their ability to question and not just do what they were told. They were often disliked in nursing for that reason. Nurses seemed unable to cope with a questioning attitude.

Could we know from both of you the positive feelings about the work you have done in the last year and what has excited you most?

Sue Studdy reported that their colleagues said they were enthusiastic. The positive thing had been the great increase in awareness and interest of all the nurses working in the district and the very positive response they had from them. When the nurses came to programmes, they said "This is marvellous - what are you doing next?" We are really enjoying this. We are keeping up to date and, it's keeping us motivated.

Hazel Allen remarked that some directors of education - and having been one, she added, she could say it - found it difficult to give a free hand to those arranging continuing education.

Sue Studdy agreed that her director, although she consulted her, let her get on with the work. Chris Hunt added that although Sue and she worked together, they largely worked independently. The work had been divided quite clearly 'down the middle'.

Chris added that she had enjoyed all that she had done during the year. When they sat down and looked at what they had achieved, it had been considerable. What excited her was when people communicated enthusiasm among themselves.

Do they have to attend study days in their own time?

Sue Studdy explained that time was allowed off for study days, by permission of the immediate manager but, there were nurses who came in their own time - two staff nurses were doing this at the study day on sexual problems because they had no sister for the ward and could not, therefore, come in duty time.

Hazel Allen wondered whether it should be accepted that with a $37\frac{1}{2}$ hour week, part of the free time should be used to pursue an individual's continuing education.

Chris Hunt reported that the learning needs survey indicated that few people would be willing to come in their own time. If continuing education was mandatory, they would obviously had to do so, as in the USA.

In principle, perhaps they ought but in practice, Sue Studdy was not sure they would, she said.

Would you be willing to share your learning needs assessment questionnaire and your philosophy with anyone who might be interested?

Very happy, replied Sue and Chris. An article on the learning needs survey was published in the Nursing Times on 19 June 1980

'A computerised survey of learning needs'

Studdy and Hunt.

A FORWARD LOOK AT

CONTINUING EDUCATION IN BRITAIN

Vera Darling

Principal Officer, Joint Board of Clinical Nursing Studies

I am delighted to be able to try to put a forward look at continuing education in the United Kingdom. I entirely agreed with Barbara Milburn's definition of continuing education:

> 'Planned organised learning experiences, designed to augment the knowledge, skills and attitudes of registered nurses for the enhancement of nursing practice, education, administration and research, to the end of improving health care to the public.'

Let me remind you of those last few words. We are all in the business to look after people who are ill and to prevent people becoming sick.

Like Barbara, I feel that we have 'been here before'. A document that cost 2s.9d in 1966, The Post-Certificate Training and Education of Nurses, stated that the responsibility of post-certificate education was that of the registered nurse - and we have heard this repeated today. The publication of so long ago indicated problems, to which I will refer later, under headings that included 'finance'. It uses the expression 'numbers in training and mobility', which we would call 'manpower planning'. It talks about in-service training, preparation for specialised work, preparation for posts. It indicates that proposals should be realistic - and we have heard that term used this morning.

PROFESSION SHOULD TAKE INITIATIVE

The other point which this 14 year-old document makes and, both Chris and Sue have underlined here, is that the initiative for continuing education should come from the profession. In 1966 they talked about it the other way round: they referred to the possibility of apathy.

Since the initiative should come from the profession, I suggest that we have a unique opportunity within the new statutory framework, which so soon will be enacted. Let me remind you of some of the things which are stated in the Nurses, Midwives and Health Visitors Act. We cannot wipe everything out and start again. We cannot, either, go on as we have been going since 1919, in nursing, and before that in midwifery. We have to do a good British compromise and take the best of what we have, put in some new ideas and produce something better.

The new act states that the principle function of the Central Council is to establish and improve standards of training and professional conduct for nurses, midwives and health visitors. The encouraging word there is 'improve'. It means that we have a clean slate on which to write the improvements which we think are necessary.

NEW ACT: AN OPPORTUNITY FOR CONTINUING EDUCATION

Having got the Act there will ultimately be rules. Another splendid thing about the act is that the rules may also make provision for the kind and standard of further education for persons who are already registered. Therefore, in the new legislation we have the opportunity to provide for the needs of nurses who are currently registered and wish to develop in the future.

The initiation composition of the Central Council is going to be 33 persons. There will be five nominations from each of the national boards - two practising nurses (in the terms of the Act 'practising nurses' means a person for whom a nursing qualification is necessary for her post: it does not necessarily mean 'working in the clinical situation'), one midwife, one health visitor and one teacher of nursing or midwifery or health visiting or district nursing. In addition, 13 members will be appointed to the Central Council by the Secretary of State: seven of these will be nurses, midwives and health visitors and must include two enrolled nurses - the idea is for the Central Council to have adequate representation of these categories other than those put on by the national boards - and in addition two educationalists, two medical practitioners, one finance person and one 'general' person.

Such is the initial compostion. Three years after the Central Council is set up there will be elections to the Council and National Boards.

The Joint Board, because it has responsibility for England and Wales, has been able to make nominations for the English and Welsh Boards. I am sure that our Scottish colleagues will have made their nominations to the Scottish Home and Health Department.

Each National Board, irrespective of the country, will consist of two registered general nurses or state registered nurses, one registered mental nurse, one registered nurse (mental subnormality/deficiency), one registered sick children's nurse, one enrolled nurse, three registered teachers; two midwives, two health visitors, two district nurses (but one of each of these three groups must be a registered teacher of that specialty); a nurse who has experience in management; a doctor; an educationalist; a financier: and a 'general' person.

AN OPEN-ENDED ACT

What is exciting is the fact that the Act is so open-ended. This gives a unique opportunity to make use of the time which is available - particularly, I would suggest, from now until the end of the year - to put forward constructive ideas for the future. I use the word 'constructive' advisedly.

We do not quite know how clinical nursing studies will fit into the new bodies because there are three possibilities under the Act. We hope that we will get the best. In the usual parliamentary jargon, the Act states that the Secretary of State 'may by order constitute standing committees of the Central Council.' There may be one for training, there may be one for clinical nursing studies. There is also provision for a standing committee for mental nursing and occupational health.

Section 8. of the Act has a heading: 'Joint Committees of the Central Council and Boards'. Under Section 4.(b) it states that the Secretary of State may, by order, authorise any such committees to discharge such functions of the Central Council or National Board, including those mentioned in the previous section dealing with the setting up of standing committees of the Central Council.

So you could have a standing committee of the Central Council with responsibility for clinical nursing, or a joint committee of the Central Council and the National Boards. And if you ferret around a bit further, you find that one of the functions of the boards is to provide, or arrange for others to provide, at institutions approved by the board, courses of training with a view to enabling persons to qualify for registration as nurses, midwives and health visitors and courses of further training for those already registered.

CONTINUING EDUCATION DEPENDS ON BASIC EDUCATION

Thus, within the Act there is plenty of opportunity for continuing education of nurses, midwives and health visitors. The Act does not state whether it should be mandatory or otherwise and, I will come to this later. Whatever continuing education does come out of the new legislation must depend upon the basic education. The basic training will be the responsibility of the National Boards. These may on their own, or with the joint committees of the boards and the Central Council, be involved in producing courses for nurses already trained.

I would like to indicate some things which have to be decided. As nurses of considerable experience, we ought to be discussing and putting forward our views for the benefit of those people who are going to have a great responsibility when they are appointed to these new bodies. Some may be people who are already serving on one or other of the present statutory or non-statutory bodies. Some will be people who have not done so before. Hopefully, both groups of people will have a reasoned feedback from the grass roots about what is actually needed.

We need the same sort of survey of requirements as that carried out at St Thomas' Health District and described here by Sue Studdy, in order that the new statutory bodies may best meet the needs of the nurses of this country for continuing education.

MANPOWER NEEDS

One of the problems that is, I think, obvious to us all, is that we really ought to think about the manpower needs in terms of the whole of continuing education.

We should think of what the profession needs under two main headings:

1. What manpower do we need in order to provide a service to the pepole in our care in the United Kingdom?

It is difficult to predict manpower needs. Many health authorities are wondering at the moment, for instance, how they will get sufficient people qualified to work as community psychiatric nurses. This is because of the policy of patients being encouraged to move into the community from the psychiatric hospitals. Nurses need to go into the community to care for them. Such a need is not going to go away with the new legislation. Another example is that in Wales there is a dearth of registered sick children's nurses.

Looking at it the other way round and thinking of the people with the right sort of qualifications, I happen to know that there are only seven enrolled nurses who have Joint Board cardiothoracic qualifications. I find that surprising.

Therefore, we have to tackle the problem of what sort of people do we need with the right qualifications and expertise to meet the service needs of the Health Service in this country. It is very difficult to work out.

2. What manpower do we need to provide help for other countries?

In addition to the manpower needs for this country, I think we also have to recognise that there are many people abroad who still look to the United Kingdom to provide experience for their nurses to take back with them to their countries. It is no good just thinking about the manpower need in order to provide a service in this country.

On top of that we must consider that other people look to us to provide help. It is not that they cannot do it in their country: it is that they need at least some people to come here to gain the experience to go back to run courses in particular specialties. I was discussing last week with three ladies from the Far East a possible course that could be put on in their country. They had already organised to send two people here to do a clinical nurse teachers course and get experience in the specialty in order to go back to set up a course.

HOW TO GET THE MONEY

I would like to raise a subject which was discussed yesterday in reasonable depth about the money problem - the financial implications fo continuing education. Wearing my Joint Board hat, I find people do have difficulty in obtaining money to mount our courses. The way the money is obtained varies very much from one region of the country to another. But one of the things we ought to be talking about now - and you will have read in various nursing journals that this is a topic currently under discussion - is the need to budget for the whole of nurse education, in its widest sense, with a separate budget.

There are many financial implications which get tucked away and not thought about. For example, in many schools of nursing the staff responsible for Joint Board courses benefit from the regional training committee budget in some way or another. In budgeting for continuing education one has to remember that. We heard that at St Thomas' money was obtained for a secretary from the Special Trustees fund. I suspect that it is unusual for most of us but it is quite amazing where money can be found. If you have the idea that it isn't decent to ask people for money, you won't get any. And I think there are some of us who still hesitate to ask - and then grumble because we don't get it.

ASK AND IT SHALL BE GIVEN

I let it be known clearly that if anyone offers me money, I shall not turn it down. I would like to share with you - I think it will encourage you - how we have found money recently in two very unexpected sources. Some time last year I had a letter from someone who must remain

anonymous but holds a high position, offering money which had been obtained from writing an article, to form an award for nurses undertaking the Joint Board Courses, 400 and 402. That in itself is continuing education, because it is saying to these people: 'You are doing a course on the special and intensive care of the newborn. If you produce a care study which is good or an essay, you may get a prize. Not only may you get a prize but the school of nursing or midwifery which puts forward the case history or essay will also benefit to the tune of £25.00 which means that can be spent on books for the library, which will provide continuing education.'

Somebody heard about that first letter and, we got money added to the first amount and another small piece of money added to that, so that it is now called the Acorn Award, because out of small beginnings came something slightly bigger.

A NURSE'S TRUST COMES FORWARD

Then, one day I got a telephone call from a gentleman whom I had never heard of before. "Money was available", he said, "for nurses to undertake a piece of work." He wondered if the Joint Board would be interested. I met him. He was the administrator of the Elizabeth Clark Charitable Trust. Elizabeth Clark was a nurse - I understand she trained at St Thomas' Hospital. She is a member of the Sainsbury family and some of you may recall that it was the Sainsbury family trust which set up the welfare service which was associated with the General Nursing Council.

The Elizabeth Clark Charitable Trust has made available for 1980-81, £10,000. The Joint Board will be doing the publicity - this is the first time it has been mentioned in public. The money is available for nurses, midwives, health visitors, district nurses, who are in the clinical situation, to enable them to carry out some investigation that they wish to undertake into the problems of patient care. It comes under the heading of enhancement of nursing practice, in the definition of continuing education which we had at the beginning.

So there is money available and, it comes from the most unexpected sources. That is on a national basis and, I suspect, that some of you may find money where you least expect it, locally if you look round and let people know.

SECRETARY OF STATE MAKES GRANTS

In the new legislation, continuing education does not seem to be in too unhappy a situation either, because section 19 states clearly that the Secretary of State may make grants to the Central Council and Boards for expenses in connection with the initial establishment of these bodies, their promotion of improvements in education and training of nurses, midwives and health visitors and, the performance of the Central Council and national board's duties over training.

If we feel that a separate budget for the whole of continuing education is important, then we must say so quite clearly now, because the Act is loose enough for the money to be available.

That's enough about money. We need to look at the running of courses in relation to personnel development and job satisfaction. The ICN statement about continuing education does say that it should meet the needs of the service and those of individuals. The development of individuals can take place here and how, without any financial involvement or legislation. Some of us have been developed because somewhere we met a nurse who was professional enough to be able to assess us as an individual and suggest to us that we did something or other. The ward sister who says to the staff nurse: "I do this - why don't you do it?" and gives staff the opportunity to develop.

Having said all that, there is need to consider what aspects of personnel development and job satisfaction we ought to be thinking about. Going back to the example I have just given - I was very fortunate in 1955 to work in a hospital where the then matron said to me one day: "Now, my dear, what are you going to do? Are you going to go into administration, or are you going to teach?" "Teach", I said, thinking I couldn't be an administrator. "Right, if you think you'd like to teach, you'd better try it," she said. (How very wise she was!) "But if you find you don't want to teach and would like to try administration, we could let you try that too - Try both!" That individual was a very enlightened person.

UP-DATING OF COURSES

We need to think of our personal development and those of our colleagues in terms of what courses should provide for our careers and their careers. To give a Joint Board example, there must be courses to train people to be theatre sisters. Equally, if you have been a theatre sister for X number of years, anything else, you need courses to up-date you. I have said previously many times, I happen to hold two qualifications in specialist areas of nursing. I would equally say, quite categorically, I would be useless in both of them, because the first qualification I got in 1948 and the second in 1952 - and medicine and nursing has changed.

Courses to up-date people are very important. They also enable people to come back into the profession having been out of it - there is a large, untapped source out there waiting for that information. How often are they needed for those in post? I suspect the answer is, as often as the individual feels she needs them, or the manager feels the individual needs them.

MANDATORY CONTINUING EDUCATION - OR VOLUNTARY?

Should continuing education be mandatory? I would prefer to see well controlled courses to which people can go if they wish, rather than making renewal of a license to practise dependent on possessing mandatory continuing education units. (Incidently, the new Nurses Act does not say whether we will have the English/Welsh system of a life-long registration or the Scottish system of an annual retention fee for the new register.)

As well as the courses for career development and courses for up-date, there should be courses to explore in depth, for nurses to be able to focus down tightly into some special aspect of their work. This is where I can see the benefit of those Elizabeth Clark Trust awards - they would be ideal for the nurse in the clinical situation who wants to look in depth at, say, problems associated with getting a hemiplegic patient out of bed.

THE BRIGGS REPORT IS RATHER OLD NOW

How are we going to achieve personnel development, provide the courses that we think there ought to be to further individual's careers, to up-date them, to enable them to focus down to details of nursing? Well, we have another clean slate, because this legislation, which many people call the Briggs legislation, is one tiny aspect of that report, which is now getting rather old. The Briggs report, you remember, was really emphasising the changes in the education of nurses. The bit where it said there should be one unified statutory body has been achieved. What we have not yet got is the educational aspect of the Briggs report. May be, the curriculum outlined in Briggs is already out of date. Therefore please do not think that the new statutory bodies will necessarily implement the suggestions for training that were in the original report because I suspect that there may be other things which we ought to be thinking about.

Chris, this morning, indicated that there was a common core which should not be a bore. She said it should cover such things as teaching, counselling, application of research. Those are objectives in Joint Board courses and if we have continuing education at this moment in time, we need them desperately.

CURRICULUM DESIGN AND METHODS OF LEARNING

By the time the Central Council and National Boards have been going for three years and we get the elected bodies, hopefully, some of those objectives will be replaced by others. This is what we have to think about. We have to think about curriculum design. We have to think about methods of learning. These are changing. We keep on hearing about silicon chips and micro-processors. Are we thinking about how we could use them? I suspect not. Yesterday, Barbara mentioned Signe Cooper, an American who is very realistic in her approach to continuing education. I had the privilege of spending a week in her company. She works in Madison, Ohio.

In America the distances between one continuing education unit and another are far greater than in Britain, and I had great fun because you could dial a telephone number to obtain recorded information which, as a nurse, you might need. Would it not be marvellous if, within a health district there was a similar system. It is a method of continuing education and in-service training - it provides something which is required immediately, something which you really cannot wait for a study day to learn about.

Self-instructional packages are another form of learning method. They are coming. Another innovation which I saw in America and which we might think about, although it could be expensive, is the telephone conference. It saves the expense of travelling.

USE NEW CONCEPTS

For heaven's sake, let's grasp some of these new concepts and use them. In Wisconsin, they use the expression 'inactive nurse' if you are actually not working. To up-date such nurses they have a telephone service, which they call the 'Wins Scheme'. The nurse who has been out of nursing can go to a public library or similar institution and listen with others to a telephone teach in. The topic when I sat in was common skin conditions. There was a dialogue between the dermatologist and the teacher and the students were able to break into the discussion and ask questions. I wonder when such a back-to-nursing service will reach Britain?

I am not suggesting that all teaching should be based on these rather sophisticated aids. Teaching can also come out of the work situation which is totally unstructured. I would like to see development from, on the one hand, the sister saying to the staff nurse: "Why don't you practice doing this?" to the sort of technological aids that I have indicated, which are being used in continuing education in the States and some of which are being used here.

In conclusion, I would like to reinforce the point that we really must take that which is best in the present and build on it innovations for the future. None of us in our lifetime are going to have the opportunities that we have now. We were not alive in 1919, when there was all the hassle over the first Nurses Act. Despite the hassles, people grasped the opportunity for registration and - I use the word advisedly - a training for nurses. May we take the opportunity of the new legislation to produce an education for nurses, midwives and health visitors and a continuing education, in the widest sense, for everyone?

QUESTIONS

A speaker from the floor said he had not realised there was so much scope and open-endedness in the 1979 Act: he thought there might well be a brighter future.

The Chairman commented that it was the opportunity of the century.

Miss Darling agreed that if the people nominated to the new Central Council and National Boards were briefed constructively, there was indeed a unique opportunity.

The Chairman added that whilst there was provision within the act for further education, this had to be worked at.

Miss Aston said that one of the losses this year was continuing education for post basic senior teachers. Miss Darling replied that the Joint Board was aware that the senior tutors were upset that it could not continue the London meetings. The reason was that the Board had run out of space. Also there was an optimum group size and when it became too big, there was not exchange. She hoped the regional meetings would make good the deficit felt but, of course, they could not take the place of a national meeting.

TRAINING AS WELL AS EDUCATION IS IMPORTANT

A speaker from the floor said she was worried at the way high powered educationalists denigrated the word 'training'. There was a strong training element in anything. A pilot being educated in the principles of flying was trained in which knobs to pull at the same time. She thought nurse education was missing out because people were unhappy about the word training. To take a simple precedure, like bedmaking, it was only possible to concentrate on what was really important - the patient - if one was trained so that one could make the bed without thinking about doing it. Nurses who had been taught about the 'concepts' of bed making had a complex about which end to start, before they could get on with the task in hand. She suggested that educationalists were treading on dangerous ground here.

"I think that when we are teaching nurses we are both training and educating them." Miss Darling answered. "If we think of the skills required to remove sutures from a wound, part of the task is training in the manipulative skills necessary to remove the sutures and it is also necessary to overlay this with knowledge of the principles of asepsis. That is a training process. There is also the educational process involved in the other nursing skills which are far more complicated and, which go to looking after the patient whose sutures have been removed."

"Every action which a nurse does, falls into a hierarchial framework. Some things we have to train people to do, for example, make an empty bed. Other things, like looking after the patient in bed, are far more complex and I hope we are educating nurses to be questioning."

ENROLLED NURSES: CONTINUING EDUCATION CINDERELLA'S?

A question was asked about the few state enrolled nurses taking the cardio-thoracic courses. Miss Darling said there were many reasons why it was difficult for enrolled nurses to take Joint Board courses, not least that many of these nurses had family commitments and

were not able to travel to another health district if a course was not available locally. Enrolled nurses had a considerable contribution to make. If they worked in a specialty and would wish to be trained or educated in that specialty. In certain places they were not given an opportunity to obtain that training, nor were they given the career guidance that they ought to receive. There were many cardio-thoracic beds and to have only seven SENs with the certificate in the specialty seemed a shame.

The questioner suggested that this was because the BTA had only just finished their programme and centres would move over to the Joint Board courses.

Miss Darling thought they would not and, there were many other specialties where SENs could do a course but were not given the same chance that registered nurses had to undertake one.

AN AMERICAN'S IMPRESSION OF THE BRITISH SCENE

Barbara Milburn

Barbara Milburn explained that she had been asked to give an over-view of the syndicate work and her impressions, not only of the conference but of what she had been seeing and hearing during her visit to Britain. Sometimes, she said, she had had to ask herself: "Am I in England, or am I back in Denver?" - the problems were so much the same.

"We've not been training these last two days, we've been educating - because people are questioning," Miss Milburn quipped.

It was important to learn to listen to each other and recognise what the other person was trying to do. In discussion on continuing education it was important not to take up rigid 'territorial' positions. Nursing did not need other enemies: it had enough among itself. There was so much in-fighting and nit-picking.

DEFINE TERMS

Terms needed to be defined. There was a tendency to confuse in-service training with staff development, for instance.

She detected concern at who was to do continuing education and how the educators should be educated. "As a profession are we not all 'teachers' to begin with?" Barbara suggested. "In our basic programmes we are taught that we have to teach the patient. You probably have some dandy educators right under your nose that aren't going to have to be sent off on some grand course initially!"

At Guy's Hospital she attended an on-site programme on cardiac catherisation. It was led by a staff nurse who had worked on the unit for a year. This staff nurse made an excellent presentation. In the audience she had nurse tutors but was not intimidated.

Miss Milburn said that at her hospital she sought to find people on the unit who could educate. It was time consuming, because it involved much hand-holding but, that meant it was educative for her too! It involved helping people to develop their behavioural objectives. And it increased the individual's view of their self-worth and job satisfaction.

The Chairman interjected that the term 'behavioural objectives' struck a sour Pavlovian note to some.

Miss Milburn agreed that it annoyed many educators and others. It was a concept that was widely used for a number of reasons. The objectives for putting on a programme were written in behavioural terms: it helped participants to understand its limitations and to evaluate. They had to be measurable.

Determining needs, Miss Milburn continued, had to be done at grass roots. The enquiry which Sue and Chris had described was a perfect example. Certainly managers should be consulted as well as individuals - and they could be involved in releasing people to come to courses which they suggested.

Sue Studdy asked whether Barbara used audit in assessment of needs? Barbara replied that she had read Joyce Wiseman's article in the Nursing Times about audit and this was one of the reasons she had come to Britain. After discussing it with Miss Wiseman she had discovered that audit as used in Britain was different from that in the United States.

KINDS OF AUDIT

The audit which was permeating through the NHS from Blackpool allowed staff to verbalise their feelings and needs. It was an excellent way of deciding learning needs. The audit in the United States dealt with patient care, using the notes and seeing whether the care was recorded.

There was a process audit and an outcome audit. The former was an audit conducted while the patient was still in hospital, the latter looked at the records after the patient had left.

On the question of where should continuing education take place - in the clinical situation or the classroom? - it was necessary to look at the behavioural objectives. Often the class room was an appropriate venue but often continuing education needed to be carried into the clinical setting. Miss Milburn said she would like to see America doing something similar to the Joint Board courses. It had been tried there but failed through difficulty over finance - a problem in the US as in Great Britain.

NURSING AUXILIARIES HAVE EDUCATIONAL RIGHTS

Turning to the 'age-old' problem of nursing auxiliaries, Miss Milburn agreed that these should not be at the bedside but, they were there because, in the United States, nurses had allowed them to be there. "I want to see the nurse at the bedside, with the nurse auxiliary assisting her," declared Miss Milburn.

But, as nursing auxiliaries were a fact it was necessary to decide upon the level of responsibility which they should be given and educate them accordingly. If such education would help them to have job satisfaction, could it be denied them? St Luke's had a 10 week initial training for them.

Trade unions were just coming into American Hospitals. The American Nurses Association had been representing nurses at the bargaining table on both the east and west coasts. Some of the major trade unions in the United States were wakening to the fact that nurses were a lucrative group and that they should seek to recruit them. Colorado had recently been hit by a wave coming in of trade unions. The nurses in many hospitals were joining. Interestingly, the American unions were only going for the nurses: nursing auxiliaries were not being considered in the bargaining unit at this point, in Colorado, although they had been elsewhere.

USEFUL READING

Miss Milburn commended the following:

Nursing and the process of coninuing education - Elda S Popiel

The Process of Staff Development - A Tabrim, P Wise and P Hull
Components of change

Journal of Continuing Education in Nursing An American Journal but, perhaps, schools could share a subscription. (Helpful for concepts).

The NLA publication on Approaches to Staff Development for Departments of Nursing A collection of articles.

The American Nurses Association has published various booklets on continuing education and staff development.

There was not a national salary rate for auxiliaries as in Britain, Miss Darling pointed out.

Miss Milburn agreed there was no American equivalent to the national agreement of salaries in the NHS through the Whitley negotiating machinery. The Federal Government laid down minimum salaries but these were considerably in excess of those of nursing aides. Not only were salaries different in different states but as between different hospitals in the same state. And rural nurses were not making nearly as much as those in cities.

A speaker from the floor, who had worked for two years in America said that a great deal of time and money was spent there on in-service training. If managers wanted nurses for intensive care, rather than advertise for them, they would train their own and, train them very well. He felt that more continuing education was offered in America than in Britain and, another particpant agreed.

"We believe very much in education," agreed Miss Milburn. But, while good hospitals in the States did a great deal, not all were so advanced.

Miss Darling said that she had been to America recently and found they were having to cut down continuing education programmes because of lack of money. "I am not saying there was not an enthusiasm for education which perhaps we have not got but, they were having difficulty in funding it," added Miss Darling.

Sue Studdy thought the Americans were doing more than the British in in-service and continuing education. They might, however, be lacking in the specialist programmes: she found much interest in the Joint Board courses.

A questioner asked whether Miss Milburn thought the fact that nurse educators were well qualified helped in obtaining funds from finance committees? He suggested a problem arise when medical colleagues particularly looked down upon nurses because they did not have university degrees.

Miss Milburn said it gave nurse educators more knowledge. It was more than being respected: they knew what they were talking about.

A member pointed out that in Britain, Area and District Nursing Officers and Directors of Nurse Education handled very large budgets. They were equals in teams with doctors and administrators.

Miss Milburn discussed a suggestion that continuing education should be made mandatory through being part of the contract of employment. She thought it was not necessary for it to be in the contract. It could be made clear that peer review was part of the employer's expectation of the employee.

Terminating a person's employment because they were not doing a good job was not a pleasant task and she would expect managers to do a great deal with a nurse before that nurse lost a licence because of inability to keep up with continuing education. But if role expectation were clear, it would be accepted that failure to meet this would mean a parting. "What concerns me for nursing is that it takes one rotten apple to make it bad for everyone else," commented Miss Milburn. The nurse who has not kept up affects patient care in an adverse fashion."

A questioner asked whether continuing education was written into a nurse's contract in America and whether they had disciplinary and greivance procedures as under the British Protection of Employment Act?.

Miss Milburn thought it would be more likely that a hospital would have to offer so much education, rather than that the nurse had to accept so much education. Many hospitals had job descriptions which had to be signed: most did not specify attendance at continuing education. However, at St Luke's Hospital in the critical care situation - the intensive care unit, the coronary care unit, the post coronary unit, the recovery room and the emergency room - she had to attend a certain number of staff development programmes. Everyone had to sign an undertaking accordingly. At the end of the first year, one staff nurse had not met the requirement, although she was counselled prior to the end of the year and, consequently was moved out of the area. Attendance after that was really enthusiastic.'

Miss Milburn explained that staff generally were allowed two days with pay to attend continuing education courses - although they generally had to pay for the courses themselves - and a system was being instituted whereby on return they mounted a programme to share what they had learned.

Miss Milburn concluded,

The new Nurses' Act gave the nursing profession in Britain an opportunity to stand up and be counted. She envied British nurses this.

CHAIRMAN'S SUMMARY

Concluding the conference, the Chairman underlined the urgent need to pay attention to terminology and clarifying concepts of continuing education. And to begin by clarifying the problem. There was an old West Country saying: "The bigger the muddle, the more thou can'st hide." "I feel that maybe, we are doing a lot of hiding under our muddle," suggested Hazel Allen.

The government, the public and professional peers had to be influenced.

"The challenges are there. The challenge of these two days is: will you go back and do one thing?"

The June editorial of Nursing Focus carried some of the things to be done: In it Anne Potter stated:

> 'In the next decade, nurse managers need to pursue the objectives of providing an educationally stimulating environment within the establishment or the enlargement of post basic education departments. The future establishment of national boards and the Central Council will give nurses, midwives and health visitors the organisation to negotiate for separate finances, divorced from service allocations.
>
> Now is the time, with the imminent reorganisation of our basic and post basic educational systems for our training institutions to press for separate educational funds. They must press for facilities to develop post-basic educational schemes, because the professionalism of our service depends on it, now and in the future.'

This summed up what had been said both from the United Kingdom and the United States during the conference. Perhaps, participants should organise peer groups locally, or knock on the door of the Ren to ask them to convene a group to examine continuing education. The King's Fund might help - it was always there with resources.

"But the ball is in your court," concluded Hazel Allen. "Your's is the responsibility. It's going to be your service, your education, and not 'their's', whoever 'they' happen to be."

CONTINUING EDUCATION IN NURSING

Suggested Book List

POPIEL, Elda S.,(Editor) -

NURSING AND THE PROCESS OF CONTINUING EDUCATION
Mosby, 1977 Price: £3.15

TOBIN, Helen M.; HULL, Peggy K.; YODER WISE, Pat S. -

THE PROCESS OF STAFF DEVELOPMENT - Components for a Change
Mosby, 1979 Price US$10.50

AMERICA NURSES' ASSOCIATION, 2420 Pershing Road, Kansas City, Missouri 64108 -

GUIDELINES FOR STAFF DEVELOPMENT)
SELF-DIRECTED CONTIUING EDUCATION IN NURSING) 20 page booklets
CONTINUED EDUCATION IN NURSING : AN OVERVIEW) Price unknown

THE JOURNAL OF CONTINUING EDUCATION IN NURSING -

Published bimonthly by Charles B. Slack, Inc.
Subscription rates US$21 per year
US$35 per two years
US$47 per three years