Shape of Nursing World to Come Through Standard Care

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Mrs. Harriet Chabook, President, Trained Nurses' Association of India, read a paper on 'Shape of Nursing World to Come Through Standard Care' during the panel discussion at the ICN Congress, 1981 at Los Angeles, USA. The panel was chaired by Mrs. Merel Hanson of Jamaica. Others who took part in the discussion are: Mrs. Enid Jenkins (Australia) and Mrs. Winsome Stern (Jamaica).

Mrs. Chabook made certain perceptive observations that should be noted by all nurses in the country. The text of her paper is being reproduced here:

IN a space age it is appropriate to discuss on the subject, 'The Shape of Nursing World to Come through Standard Care'. Since the world has become small by means of communication system, any idea mooted from an industrially developed and affluent part of the world finds its quick way into industrially backward, poverty stricken and overpopulated parts of the world. Standard Care is one such idea in the Nursing world. While it is good to plan for the future keeping in mind the highest standards already achieved in nursing care by some member countries, I have deliberately accepted to be on this panel, to humbly put forward, what my dream of standards of nursing care in our part of the world are. I draw my thoughts into the practical experience in Nursing I have in India.

Health Needs and Nurses' Role

The health care delivery system in India emphasizes the policy of making minimum needs health services available in a package form to a large population in the shortest possible time along with a supporting strong structure for supervision and training (education).

Quantitative and qualitative aspects of Nursing manpower must be taken into account to meet the basic health care needs of the population.

Expansion of nurse training programmes must keep pace with the growing needs for better Nursing care at the peripheral, intermediate, and central levels. This would take care of the quantitative aspect.

For improving the qualitative aspects of the existing nurse manpower, leadership of a high order would be required in every health sector—the strengthening of higher education in Nursing, with appropriate opportunities for advancement in service needs equal emphasis, if not more, to counteract the frustration, stagnation, and neglect in this key component of public health and hospital Nursing services.

Standards are predetermined criteria for nursing care that all people who receive the services of a nurse, have a right to expect, whether the services of nursing care are given in a highly sophisticated Intensive Care Unit, in a chronic medical unit, in a rural sub-centre of a Primary Health Centre or in a health centre of the urban slum area.

These standards of care are envisaged by the Nursing leaders or experts. The envisioned Nursing leaders in the past and at present have been able to put down only the necessary educational standard, which if imparted, hoped that the graduates of these programmes will have the necessary potential to give quality (standard) Nursing care. Very little has been done in the actual measurement of standard care by the practising nurse.

Four Main Roles

Nursing emphasises on four main roles of nurses. The **first role** is that of liaison and interpretation. It relates to health education, to the habits and understanding of people. Its significance is primarily on the expressive-integrative functions. The desirable role characteristics of Nursing are the emphasis on care component, i.e., emotional-supportive care which meets the needs of patient/family/community through problem solving techniques.

The term 'care' needs to be interpreted carefully as opposed to 'cure'. Cure is concerned with an episode, e.g., illness or a crisis. Care, on the other hand, is a much broader term, and expresses the concern that nurses should have for the individual, family, and the community throughout the life-cycle through all stages of development. Autonomy of a health functionary calls for accountability of work done. Nurses have to exhibit self-responsibility for the care component. This was the principle behind recommending four Public Health Nurses at the Primary Health Centres as early as 1946, a year before India became independent.

There will be a professional identity which will exhibit the independence and interdependence of the health profession (at least not total dependence on another partner in the health team). It would show better drawn limits of the nurses' role, increased authority and the collaborative status of Nursing in the health team.

The Instrumental Function

The **second role** is the Operative Role of Nursing. Here, the nurse assists in the fulfilment of normal functions of the individual, such as, eating, breathing and elimination. She carries out treatment in cooperation with doctors. In sociological terms this would be called as the instrumental function of curing and getting the ill patient in the hospital well. Therapy is viewed as anxiety-provoking, tension arousing, frequently necessary to achieve the goal but primarily in the doctor's domain. By virtue of the availability of a nurse round the clock in the hospital, she takes up the responsibility of other health workers in the health team, i.e., the dependent orientation role, and by this she barters away the essence of Nursing role. This seems to form the traditional role of the 18th century nurse and not the expanded role of a modern nurse in free India with its constitutional assurances.

The **third role** is the Educational Role in Nursing. Health centres must take roots in the villages. Village participation in the health care delivery system is imperative and long overdue. They must form a part of the health care system. To train these village health workers or primary health workers or family health workers, the Community Nurse must be held responsible. Depending on the socio-economic, cultural and educational background of the villages the Community Nurse has to select the health worker. The Auxiliary-Nurse Midwife, who is less qualified than the Community Nurse, also needs supervision and guidance to do her job effectively. The Community Nurse is responsible for education of nursing personnel, the indigenous and formal, and for health education to the public.

Since changes bring about development, and development brings about issues, nurse educators have to be alert in keeping the curriculum for preparing dynamic nurses. The educational system will need to be reorganized so that learning starts in the community, a process that will help students to understand the working of the community life, the nature of social structures, and the contribution of each to individual family and community functions.

The unqualified acceptance of Community Nursing as the foundation of all Nursing practice is implicit in the new concept. A great many teachers are needed to prepare primary health workers, ANMs, Community Health Nurses, teacher trainees, administrators, also speciality nurses and nurse researchers at different educational levels of the Nursing profession.

Foundation for Future

There is an urgent need for flexibility in the Nursing education system. Continuing Education and Research in Nursing are gaining momentum in India. The nurse has to play an important role in using these mechanisms to lay the foundation for future Nursing practice. There is also the urgency of bringing Nursing Education under the national system of education, i.e., the 10+2+3 system. The role of nurses in all the States to implement this scheme calls for their test of ingenuity and innovation, i.e., giving work experience in Nursing for 9th and 10th class students, vocational Nursing (A.N.M.), at 10+2 and professional Nursing at 12+3. We should be able to bridge the gap between the demand and supply of nursing personnel.

The **fourth role** for nurses is the Administrative and Advisory Role of Nursing. Nursing is a conscious practice of human relationship. There is the established health team of doctor-nurse-patient/family/community. The role implementation of this team has been confused and misunderstood. The leadership of a team is determined by the nature of presenting the problem and not by professional status of a group. It cannot be the prerogative of any one profession alone specially in our country.

Nurses have to play the role in policy making and planning. At every level of administration, be it the sub-centre level or a ward level, the nurse administrator needs to have factual data on the outcome of Nursing services as a basis for improving the level of health in the community as it relates to men, material or money.

The Education Commission, 1964-66, highlighted the need to transform education so as to relate it to the life needs and aspirations of the people and to make it an instrument of social change for this purpose. Whatever be the pattern of Nursing education, it should be within the framework of national education of the country for keeping open the career ladder for every individual.

Into the Mainstream

While the experts highlight the specific goals the nation wants to achieve, we as nurses are more concerned with the introduction of these changes from another important angle. In the past Nursing Education has kept itself aloof from the mainstream of education resulting in a low status for Nursing and preventing nurses from moving up as in other professions. The few collegiate education programmes made some attempt in this direction but the bulk of nursing education programmes continue to be outside the national sys-

tem of education. Since far reaching changes are taking place in the structure of education, this is the right moment to bring Nursing into the mainstream so that the folly of the past can be rectified. If we fail now to understand the implications of these changes, adjust ourselves and act, we will again miss the opportunity placed before us with the disastrous consequences of our profession.

It is not the structure but the philosophy behind the structure which is more important. We must clearly understand the position of the various courses in Nursing, namely, Auxiliary-Nurse Midwifery HW(F) HW(M), General Nurse Midwifery Course from hospital Schools of Nursing, and university programme in Nursing in the new pattern of education. In this respect it may be noted that an element of Nursing has found a place in the core curriculum taught to every student upto class 10th as a physical and health education subject. This could be an exploratory to the development of a sound attitude to Health and Nursing in the growing students. A beginning has been made to bring ANM and other unipurpose health workers' programmes under the Multipurpose Health Workers' Scheme in the 10+2 educational system. Primary concern in curriculum development is for rural care and care of people in urban slums. The health needs of people in rural areas, urban slum and communities in remote areas are very different. Thus emphasis in curriculum content as well as process would be different.

A Proper Evaluation

To begin with we need to realise where we have failed, to motivote professionals from cure orientation to care orientation. What are the problems of working in rural areas so that professionals can adjust to work situations? Shifting of emphasis in the curriculum should be

from cure orientation	to care orientation
from institutional based learning	to community based learning
from traditional approach	to problem solving approach
from viewing health professionals as sole agents of care provider	to community health workers i.e., community participting in health promotion activities and to increase self care potentialities.
from independent or dependent various health workers.	to interdependent role of health workers.

The present Schools of Nursing, which at present **earn no academic credits for their entrants,** will have to decide whether they would like to convert themselves to meet the requirements of the +2 part of the school programme, or upgrade to a baccalaureate programme. Obviously, not all schools can be upgraded. The baccalaureate programme itself will have to undergo changes, e.g., it will have to design its course in such a way that students coming from the +2 stage find a continuity in it, and for such students it will be their most obvious choice. However, it does not mean that no other person can join Nursing at university level and +2 level nurses (vocational stream) have no other options. The present GNM programme could be brought under general educational system, that is 10+2+2 where at a later stage the nurses can get a B.Sc. degree with an additional one year of education. I have expanded at length to give you an understanding of educational changes urgently needed before us which are in the future, essential for establishing standards more than the specific subject of measuring quality nursing care.

The Systematic Structure

It is commonly accepted that the frame of reference for setting standards for the interaction in quality of health care are the interconnected and interdependent aspects of **structure, process** and **outcome.** The structure of the care promoting system first needs to be well founded and broadly understood by the recipients of the health care in a country. The structure invites both effectiveness and efficiency, i.e., output and input. It is not the structure but the philosophy behind the structure which is more important. A total commitment to standard Nursing care is basic. In a country like India if the material and money is ineffective, an efficient Nursing of the highest standard care is possible if the men employed within the structure are committed and their actual Nursing activities involved in providing care are crucial in determing the standard care.

These Nursing activities belong to the second frame of reference called process in setting standards of care. As mentioned earlier, the term "care" needs to be interpreted carefully as opposed to "cure". Cure is concerned with an episode, i.e., illness or crisis and seems to form the traditional role of the 18th century nurse. On the other hand, 'care' is a much broader term involving sociological and psychological concerns of the nurse for the individual, family and community throughout the life style of a citizen and which I believe is the expanded role of the modern nurse.

No manual of standard will be sufficient for exercising judgement in selecting the appropriate Nursing care. The nurse has to solve the problem in a given situation.

The third frame of reference in setting standards is the outcome or consequence or result or shape of health of the people who received the care, i.e., alteration in the health status of the individual/family/community caused by goal directed Nursing activities.

To establish a cause and effect relationship with reference to Nursing activities in a setting where many health workers including the nurse function, calls for a sound research programme. In India dent has been made in this area, to find out the relationship between nursing activities and the changes in individual/family/community health in the rural setting and in Intensive Care Unit.

In my country where the literacy percentage of the population is low it is difficult and unwarranted to expect people to know their rights and sources of needs for maintaining health. The socio-cultural components make it more confounding. Neither the medical nor nurse practitioners' act has been passed by legislation. There is legislation only to control the standards of education for all health personnel.

Maintenance of Records

Auditing of Nursing standard care could be done retrospectively to take note of and to plan better Nursing care in the future, i.e., for better standard. One of the major sources of data collection for doing this is the nurses' records maintained clearly and accurately by competent nurses. This rich source of information needed for the primary growth of nursing profession is totally absent and neglected in my part of the world. In the process of setting standard care, the Nursing leaders are beginning to realise the basic lack of essential information for nursing research. Steps are being taken to ensure that nurses record their nursing activities in a meaningful way and ensure that these records are maintained along with the medical records of the patient. In my vast country one or two institutions in Nursing have achieved this record keeping system. Concurrent audit of Nursing activities are done in a small way only in Colleges of Nursing while students are under training. Neither retrospective nor concurrent auditing is done by practising nurses.

In a country like ours where nursing as a profession, has a short history and still many good things have been achieved there is no need for legislation to set standard nursing care. If an awareness is created in each practising nurse to develop leadership qualities in her respective position, she would make efforts and show responsibility to her individual patient care standards/family care standards or community care standards. Towards this the Trained Nurses' Association of India, in collaboration with the Indian Nursing Council (Statutory Act), is committed.

Nurses in Health Policy Planning

Ms. Eunice Muringo Kiereini of Kenya was installed as President of the International Council of Nurses at the 17th Quadrennial Congress at Los Angeles recently. She called on nurses throughout the world to become more active in health policy planning and implementation. The text of her address follows:

THE world expects results—the baby—and is neither interested nor fascinated by elaborate details on the labour pains. For the next few moments let us concentrate on what we would like to see happen during the quadrennium; how to accomplish this, we can elaborate later. While I shall do the talking and you the concentration, if you finish before I do, please, just put your hand up!

Over the years, many good, noble suggestions and plans have been made by the International Council of Nurses. In honouring me so highly with the privilege of presiding over our organisation for the next four years, I believe, with you, we shall carry through some activities that I am recommending to you, the nurses of the world, during my term of office.

The historical election to this high office is not only an honour to me but to Africa and indeed to all the developing countries. My choice of activities arises from the association, experience and opportunity I have had with the President of the International Council of Nurses and the Board of Directors. May I take this opportunity to record my deep appreciation to Olive Anstey and to all those Board members who have given me the inspiration and courage to face the challenges of the International Council of Nurses.

What We Want?

What International Council of Nurses do you want?

The International Council of Nurses through its composition, must reflect, represent and symbolize the pinnacle of nurses' ideals, beliefs and commitment. It should characterize, inspire and perfect the professional qualities that nurses are well known to cherish. The International Council of Nurses, in its actions, must not be con-