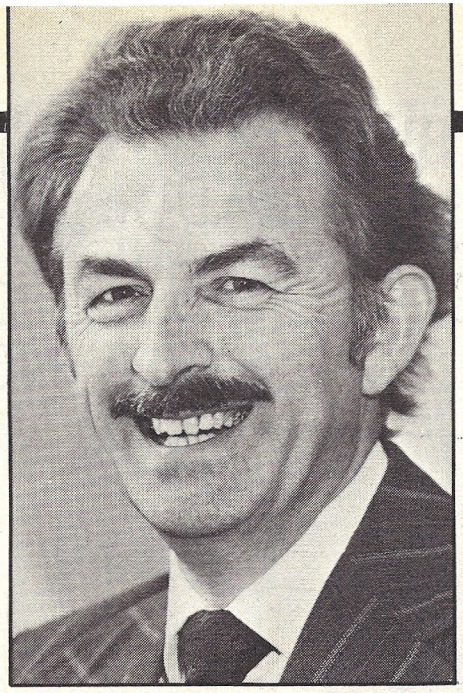
Anthony Carr



Well, are standards of care falling?

Next time someone tells Anthony Carr, Area Nursing Officer for Newcastle upon Tyne, that patient care standards are slipping, that person had better have some concrete evidence to justify the claim.

HARDLY a week goes by but one hears or reads that "standards of patient care are falling". It is either said just like that, with no other explanation, or it is related to the lack of supervision of learners or the increasing numbers of nursing auxiliaries.

In discussing something like this, it is hard not to be subjective. We talk of standards of care as if the standard of proper care was known and understood by all those engaged in nursing a patient.

It is true that the standards of care relating to medical prescription, such as drugs, dressings, preparatory procedures, are generally understood, written in procedure schedules and taught at ward level. If essential treatments are not undertaken on time, or are missed, then of course this is easy to assess. What is much more difficult to prove, however, is the reduction of the standards of nursing care as prescribed by either the nurse in charge or a team leader.

I do not believe that all nurses know exactly what standards of patient care they are required to give at all times. Where standards are known, it is often standards that a ward operates irrespective of the patients.

I am not being critical by saying this. I would rather have a sister lay down a fairly strict regime relating to standards of patient care in general than none at all. What I do hope, however, is that a move is being made towards a more realistic assessment of each patient.

I think district nursing has always had this individualist approach to people. While a sister of a ward may have a strict system of bathing patients daily, the district nurse would have to be selective by the very pressure of her caseload.

Having to be selective on a ward may appear to the sister as evidence that standards of patient care are falling. The patient, on the other hand, may feel that they have improved since his last stay.

What I am asking the profession to do is to be a little more realistic. If, for instance, a patient bathed once a week before coming into hospital, why does he have to be bathed once a day in hospital if his condition or treatment do not require it?

The first question I would ask is: "What standard is being challenged and what is it matched against?" Is it true that standards of care three years ago were higher than now? Then, pressure areas were treated every two to three hours. Now, in the increased rush of things, it is not always possible.

A more intelligent approach, in my opinion, would be to assess the needs of the individual. What sort of patient is he? His weight, height, frame and build, and his diagnosis and type of treatment? What sort of bed and mattress are provided? What is the quality of the bed linen? How often is it changed? Does the bed linen deliberately create conditions conducive to causing bedsores? Is the patient's protein intake sufficient to promote healthy tissue? Can he, and will he, move his position in bed regularly, either to a prearranged programme or on request?

I may, after that investigation, be able to decide what level of nursing care is required for his pressure areas.

If a ward sister is driving herself into the ground trying to maintain artificially high standards not relating to individual patients, then I believe it is rather a useless exercise. What one is forced back to time and time again, is that the most satisfactory approach is to assess each patient's needs and compile a plan to fulfil those needs.

Even wards that have reorganised into this pattern of care do just sometimes forget the ability of the patient to take part in his own care. In the district nursing report by the Panel of Assessors in 1976, we indicated that the patient should take a part, sometimes a leading one, in his own care, if he is able to do so. A sound approach is to assess regularly the ability of the patient to become independent of nursing support.

When nurses look back to the old days and describe the high standards then, they often fail to take into consideration the different type of medical treatment. There is so much more activity and machinery and advanced technology now.

It is understandable if today's nurse finds it very difficult to choose between monitoring by machine and basic nursing care. But perhaps there should not be a separation between these two. Nurses have to decide for themselves what is a nursing duty. Having decided what it is, then they have to attempt to plan the priorities accordingly.

Standards, of course, can be eroded by the employment of large numbers of nursing auxiliaries. But this depends on how they are trained and subsequently employed. If they are trained in a few skills to a very high order of efficiency, auxiliaries are assets to any ward. But if they are allowed to undertake a whole range of nursing duties without the necessary nurse training, then they will lead to lower standards of care.

It is a very useful exercise for the sister in charge of a ward to look objectively at a ward from time to time and compile a "minimum standards of patient care" programme. This proposal must not be misunderstood. It is not so that management can reduce staffing levels to meet the minimum standards, but rather to safeguard them.

Having completed the exercise, then, for the first time, the sister has written criteria to prove that patients are at risk. Action is much more likely from senior nurse management when faced with such an appraisal.

But what can be done when standards have fallen to unacceptable levels? It is the responsibility of senior nurse management to act to rectify the situation. I believe all health authorities should have an agreed procedure to reduce patient intake or patient mix, or even to close a particular ward.

It may just be that when I hear the next person say that standards of patient care are falling I may ask him for his objective evidence □