



is it that matters most in the practice of nursing children?

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Summary

This article discusses the results of a workshop designed as an action research cycle to ascertain what matters most in the practice of nursing children in South Africa today. The workshop was convened at the University of Cape Town (UCT), in order to guide and direct the newly established post- basic, children's nursing pathway in the Bachelor of Nursing for Registered nurses [BN(RN)] programme. The participants were eight experienced paediatric nurses, currently practising in a variety of settings in the Western Cape. The results show that the participants move from their original task- and procedure - based perspective to a more processive one in which the focus of the learning is relational, emphasising the family and culture of the child.

Opsomming

Hierdie artikel bespreek die verigtinge en uitslae van 'n aksie leer en navorsing siklus wat ontwerp is om die essensie van die prakteik van die pediatriese verpleegkundige in die huidige konteks van Suid Afrika te ondersoek. Die deelnemende verpleegkundiges is by die Universiteit van Kaapstad byeen geroep om inspraak te lewer in die nuwe na-basiese pediatrie modules wat deel vorm van die Bachelarius graad in Verpleegkunde vir reeds geregistreerde verpleegkundiges [BN(RN)]. Die navorsings groep bestaan uit agt ervare pediatriese verpleegkundiges wat tans in 'n verskeidenheid posisies en plekke in die Wes Kaap praktiseer. Die analise dui aan dat deelnemers beveeg van 'n oorspronklike posisie van taak en prosedure gerigtheid, na 'n meer prosesiewe benadering en verwagting waarin die fokus van leer meer verhoudingsgerig is. 'n Benadering waarin die kind as lid van 'n gesin met 'n eie kultuur milieu belangriker is vir die beste versorging van die kind word duidelik deur hierdie groep verpleegprakitsyns beskryf.

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Introduction

More than 40% of the South African population is younger than 14 years and yet only 1.3 % of all registered nurses hold a Paediatric/Child Nursing qualification (SANC, 1998). The South African Nursing Council recognised Diploma in Child Nursing Science is currently offered in only 5 centres in South Africa. Limited resources restrict intake of learners and completion of the course. Increased opportunity for the education of registered nurses in this priority area is imperative. In addition, adaptable curricula are necessary to ensure that nurses emerge cognisant of their particular context and are suitably equipped to serve this country's children and their families into the next century. In these changing times, what are the priorities in this vital area of expertise?

Eight registered nurses, with varying levels of experience, were invited to participate in a workshop to identify and explore these priorities. This was to contribute to shaping the newly established post- registration, children's nursing pathway in the Bachelor of Nursing for Registered nurses [BN (RN)] programme planned at UCT. Participants included:

- a manager and resource developer in primary care and clinic settings;
- the designer and presenter of a current post-basic Child nursing science course;
- 3 unit managers: one managing an in-patient medical ward and another the outpatient and emergency care unit, both in a government tertiary hospital,

the third leading a general paediatric unit in a private hospital;

- a paediatric psychiatric nurse specialist;
- a clinical nurse specialist facilitating home care of children who require chronic care;
- A nurse lecturer and researcher (the author) who has designed and presented child related course work to undergraduate students, subsequent to 8 years practice experience.

The cumulative experience of these nurses was vast: almost 140 years in total!

Method

The participants convened and were introduced to the proposed programme for RNs. The central concern of the workshop was: "What matters most in the practice of nursing children?" This question enabled us to consider the issues more widely than simply asking: "What should be included in a post basic children's nursing programme?" The workshop was designed to elicit, from the participants' experience, the central issues in this field of nursing practice.

The principles of Action Learning (AL) were utilised in the design and accepted by the participants as appropriate not only for the purposes of the afternoon but also as guiding principles for the curriculum. According to Revans (1984) the definition of learning is:

Learning = Programmed knowledge + Questioning insight

Revans asserts that programmed knowledge (P) is the concern (and expectation) of traditional curricula. On the whole, however this is insufficient for keeping abreast of our constantly changing world with its current information explosion. The most important task of learning is thus not only that Programmed knowledge must be expanded but also that it be supplemented by Questioning insight (Q). Revans (1984) calls this the capacity to identify useful and fresh lines of inquiry. He defines action learning as the process whereby *groups of people* (nurses, managers or learners) *work on real issues or problems, carrying real responsibility in real conditions*. The solutions they formulate may require changes in the organisation and could pose challenges, but the benefits are clear because people (the learners – in this case nurses) own the problems as well as their solutions. This definition of learning excited the workshop participants who could recognise the process in their own experience of learning.

It is recognised that by working and learning actively together, groups of people can transform their organisations or programmes into "critical action research systems" (Otrun Zuber-Skerrit, 1996). Thus research is not an esoteric activity confined to academics, but one which we all do, with varying degrees of rigour.

The process of action research was first conceptualised by Levin (1952) and further developed by Kolb (1984), Schön (1983) and others. In brief, it comprises a spiral of cycles of action and research with four major phases: plan, act, observe and reflect. Action research is research into practice, by practitioners, for practitioners (Grundy & Kemmis, 1988 cited by Zuber-Skerrit, 1996). The aims of action research are to improve practice and, if warranted, to suggest and make changes to the environment in which practice takes place. This is especially important to practice that may impede desirable improvement and effective development (Zuber-Skerrit, 1990). In the practice of nursing, a major discrepancy seems to exist between what is proven, by experience or research, to be the best way, and how people are cared for in a clinical setting. Benner and her research colleagues (1996) propose that clinical learning is the dialogue between principles and practice. They maintain that we need a larger, legitimate space for teaching *practical reasoning in transitions*, as this is the hallmark of any clinical practice (my emphasis).

It was with this in mind that we set out to identify the clinical practice of the child nurse in South Africa. The experience of the participants would help to distil what it is that matters most in professional practice. This would include our current circumstances and the future we anticipate. The discussion of the eight participants around this common concern was transcribed in order to guide the implementation of the new child-nursing programme at UCT. This is only the beginning of the process of designing and implementing this programme. It is reported at this stage as we believe it is important to open the debate about how learning happens, and what professional nurse learners need in the area of children's nursing practice at this time.

Discussion

Four questions were designed prior to the workshop to guide the discussion and assist in exploring the issues as widely as possible. These were:

1. Is there anything you find particularly challenging, concerning or worrying

about current paediatric nurse practice?

2. What has changed in the last 5- 10 years?
3. What are the paediatric nurse's areas of responsibility, influence and relationship?
4. What does she or he need to be, to know and be able to do in order to act skilfully and ethically in her or his nursing practice?

What concerns or challenges are there in current paediatric nurse practice?

Participants wrote their personal concerns down and a lengthy discussion followed. The concerns raised are real and certainly similar in the various settings of practice. The sense of shared concern rather than blaming amongst participants was encouraging. The concerns, so clearly evident, are mentioned here to assist the reader in understanding that these concerns about the practice of registered nurses working with children were significant. These have been categorised into four prevalent themes.

First is the general sense of lack of vision and direction amongst nurses. This seems to be characterised by a dispassionate non-involvement and an unwillingness to "sit it out". We recognised this lack of vision and therefore lack of perseverance as pervasive in nursing and the health services at this time. This is also seen in an apparent inattention to the importance of taking responsibility for the registered nurse's own learning.

Secondly, a general knowledge and clinical skills deficit is apparent. A fundamental lack of primary care knowledge, sometimes as basic as the recognition of common childhood ailments was identified. There seems to be some ignorance about differences between adult and paediatric indicators like cardiovascular indicators and fluid and electrolyte norms. In two settings it was concerning to identify that nurses seem to be unable or unwilling to predict in a clinical situation: they wait too long to speak up or intervene and therefore do not advance the care of the child. A discrepancy between theory and practice was identified. It was generally believed that nurses in these settings may do some things the "easier" way as opposed to the "safer" way. Inadequate knowledge and cognisance of the child's particular developmental stage brought about a lack of caring for a child's emotional well being. The apparent absence of rela-

tional skills to involve, reassure and teach parents was repeatedly mentioned as a concern.

Thirdly, it seemed that nurses in these settings were unable or possibly unwilling to work together. This was seen in the context of working as part of a health team, especially when asking or offering input about a child's care. The lack of parental or family involvement in care decisions could, as mentioned before, be simply an inability to relate. There was also concern that children's nurses seem unaware of the value of involving relevant others (e.g. teachers) in care.

Finally, there were issues of attitudes amongst nurses. Amongst those identified was the apparent lack of commitment and caring for children. The lack of warmth and nurturing of children was compounded by staff who sometimes appear irritated with parents. The group felt that nurses in these settings may be struggling to "get to the level of the people" - including the children and adults. This seems to be related to attitude and communicational skills, resulting in misunderstandings of not hearing and not being heard. One participant said that children are not treated as you would treat your own children. (This does of course raise the issue of our expectations of care, which we did not discuss at length. It is included here for full reporting and probably warrants further in-depth discussion).

A common theme attributed to attitudes, was that generally nurses seem to have little faith in their own ability. It seems as if they are not able or willing to bring their own life experience, own mothering or experience of being children to bear on their practice. It may be that the nursing community and hospital culture have not welcomed this aspect of experience into settings of caring. Most nurses have traditionally been schooled to remain "professional". Warned not to become "emotionally involved", we may have taught one another that there is a different set of interpersonal norms which apply. In this hierarchy of the strong and the subordinate, our confidence, our assertiveness and our being may not be expected to work in the same way as when we are "off duty". Maybe it is therefore to be expected that there was also the concern that as children's nurses we are not supportive of each other as caregivers.

These categories were summed up as the **challenges facing the practice of nursing children** at this time. This list could have been demoralising, even paralysing to consider. This was not, however, the purpose. We realised if we

did not start by describing the context as we were experiencing it, we could be making plans blinkered by our ideals. The challenges of the current context are significant to learning in these settings and therefore to learners and the curriculum of the proposed programme.

The next question followed easily from the initial discussion as we had already recognised that there were specific aspects of current child nursing practice and health care provision that had changed in the period of our experience.

What has changed in the last 5 – 10 years?

Participants of this group identified the following as the most important aspects of change in the past decade.

- Parents are doing more of the "nursing" or care of the ill child.
- There is more home based care.
- There is an increased focus on primary care.
- An increased turnover of children means a shorter hospital stay and sicker children in hospitals.
- Ill children have an increased life span. – both the chronically ill and the critically ill child have a longer life expectancy.
- National and regional priorities for child health and paediatric care have been determined.
- The International Declaration of the Rights of the Child has been accepted and ratified by the South African government.
- The care of the critically ill child is a recognised priority.
- The role of the professional nurse has changed to that of a more independent practitioner who carries more responsibility.
- Resource management is becoming an expected competency of the registered nurse.
- There is an increased need for nurses to manage themselves.

This last statement was emphasised by all the participants. It included the professional nurse's responsibility to consider her/his own career path, manage his/her financial situation, her time and personal resources and also to maintain her/his health.

These factors can be described as the **context in which the nursing care of children occurs**. It is also the context in which learners must be able to learn and function as they work within our health care structures.

What are the child nurse's areas of responsibility, influence and relationships?

The last point of the previous section led the discussion easily into this next question, which was formulated from principles used by Stephen Covey of the Franklin Covey Institute (1989). He maintains that what matters most depends on how we respond to what we experience. We had explored what we were currently experiencing in our practice of nursing children and needed to identify our role in the care of children. Defining our responsibilities (ability to respond), areas of influence and key relationships was guided by this principle of how we respond.

What are the key responsibilities of the registered child nurse practitioner?

Care of the ill child is seen as the first responsibility of the registered child nurse practitioner. This depends on a sound clinical knowledge base, astute assessment and management of the ill child, safety of the child and includes prevention of complications and recurrence of illness. Although this all seems to relate to the ill child, the practice must have a sound base in the Primary Health Care philosophy. Nursing practice always aimed at the child or children's best health and optimum development. Prevention of harm and disease as the nurse acts as the clear advocate of children and parents, must remain a priority. The nurses' responsibility of sharing knowledge requires a commitment to personal development, educating other nurses and sharing knowledge in appropriate ways with children and parents. Resource management is a responsibility that has become important in recent years and is certainly not a task for which nurses have traditionally been equipped. The professional nurse's task now includes the cost effective planning, ordering and utilisation of equipment and supplies, in recognition that profit is a shared responsibility.

What are the most important areas of influence of the registered child nurse practitioner?

In this position she/he can change behaviour, by example and design. She/he is able to influence parents in their caring practices. This influence is widened by the specific knowledge base,

especially if she/he takes the impact and importance of this specialised area of expertise seriously. In this area she also carries influence to raise the profile of nursing education, thus facilitating the recognition that it is equal in importance to medical student training, especially in the culture of undervaluing nursing practice. As the child nurse practitioner is able to facilitate formal learning, she facilitates change.

The wider areas of influence of this nurse practitioner include her/his role:

- as a representative on lobby groups, e.g. Child rights
- as a voice when public policy is being debated and made
- as a participant on Community health forums
- as a member of local religious organisations and churches

Invariably the child nurse practitioner also has influence in her/his own neighbourhood as she is known and willing to assist.

What are the most important relationships of the registered child nurse practitioner?

This area was easy to distil from the discussion. Participants had referred to the devaluing of nurses on numerous occasions and we immediately felt that probably the most important relationship was that of nurses with nurses. The next priority was relationship with children and their parents. In this context, relationship with the whole family and the broader community was important. Relationships within the health team as well as with relevant others needed to be fostered at various times (e.g. School-teachers, police, and the press). Other relationships are with management and employers. As the responsibility for formal learning has been discussed, it follows that a relationship needs to be developed with students.

What is needed in order to act skilfully and ethically in child nursing practice?

In the discussion thus far, we had identified what we perceived as the challenges to learning and practice as well as the context where these occur. The consideration of the role of the children's nurse practitioner in the light of this enabled us to consider more fully the last question: *What does she/he need to be, to know and be able to do, in order to act skilfully and ethically in her/his*

nursing practice? (The descriptors *skilfully* and *ethically* come from Benner's work, 1996.) Initially participants questioned the need to use *ethically*, but as one participant after another used scenarios from their experience to illustrate a point, we recognised the clearly ethical implications of our everyday work. We realised that this aspect was vital to consider as an integral part of the practice and therefore of learning to work with children.

What does she/he need to be?

Participants readily identified these aspects. The child nurse practitioner needs to be motivated, must want to nurse and must love and understand children.

What does she/he need to be able to do?

In answer to this question one participant said: "She needs to be able to help troubled children." Another said that she must be able to assess well and to help. In discussion we expanded on this aspect of her skills and realised that to be able to listen and to assess the child's background - especially the social and cultural background - were very important. Along with specific relational skills with children and parents, it seems of great value to understand and facilitate peer involvement, for both children and parents.

At this point it was interesting to note that there were no typical 'procedural skills' on the list. We realised that skills on our list may often be neglected as clinical skills, because in the traditional education of nurses we had focussed on specific measurable procedures, maybe taken for granted that nurses are able to listen, to relate and understand..

As we re-looked the list of procedural skills, we added three specifics to the accepted list of skills. The first two could be expected: proven resuscitation competency and familiarity with the Essential Drug List. Discussion ensued surrounding the suggestion that registered Child nurses should be proficient in the inserting and management of an introsseus infusion. Some participants were clearly surprised by this proposition and we were not all convinced. The debate will continue outside this forum and will only be seriously considered if a clear evidence base for implementation can be established.

What does she/he need to know?

This part of the discussion was broad and resulted in the following list:

- clear understanding of the child in the context of family
- childhood development & behaviour
- family habits and cultural awareness
- knowledge of and a commitment to Child Rights
- the contextual issues surrounding child abuse as well as the registered nurses' responsibilities and resources in intervening
- childhood accident prevention
- care of the critically ill child
- a good knowledge base of the aetiology, pathophysiology, assessment and care of the nationally defined paediatric priorities in SA.:
- Diarrhoea and vomiting
- Tuberculosis
- Acute respiratory illness
- Malnutrition
- HIV /AIDS

This list does not obviously include the initial commitment to practise skilfully and ethically, but these aspects seemed to be the language of the discussion rather than the results. The challenge of this will be worked out with the learners as they engage with the new course.

The steps of enquiry proposed for action research cycles will be completed and the process of data collection will continue as this programme at UCT gets underway. Learners will become participants as we endeavour to track and maximise their learning opportunities. Expert practitioners in the field will also be approached to participate as we evaluate and refine the curriculum and its methods.

Conclusion

So what is it that matters most in the practice of children's nurses? In this discussion the expectations of nursing care were certainly relational, with an emphasis on the child and family and their culture. Children's nurses should be committed to helping troubled children, able to engage people –both children and others, able to think about and take responsibility for their actions. The encouraging feature of this discussion was the active involvement of the expert practitioners who participated. It was clear that participants started to consider their own practice and were bringing to the discussion what they had learned there, rather than in previous formal educational settings.

In the current climate of dramatic change challenging our health services, it seems that we no longer have the time or op-

portunity for extended study leave or sadly even mentoring of neophyte nurses. Nurses are required to step into positions of unit management and leadership soon after or even before completion of post-basic qualifications. As we consider this challenge, the information gathered at this workshop correlates with the findings of Benner et al (1996) in their recently published research. This extensive research describes the acquisition of clinical expertise and examines the clinical knowledge, clinical enquiry, and judgement and ethical conduct of expert nurses. One of their significant conclusions is that the expert nurse's central concern is her involvement with the family. In their discussion of clinical judgement they draw two very significant conclusions:

Firstly, that the clinical judgement of experienced nurses resembles much more the engaged, practical reasoning first described by Aristotle, than the disengaged, scientific, or theoretical reasoning promoted by cognitive theorists and represented in the nursing process.

Unfortunately many current curricula, in South Africa and elsewhere, are structured using the latter principles

Secondly, that experienced nurses reach an understanding of an ill person's experience and response to an illness, not through abstract labelling such as nursing diagnosis, but rather through knowing the particular patient. This includes knowing his typical pattern of responses, his story and the way in which illness has constituted his story. This understanding is enhanced by advanced clinical knowledge, which is gleaned from experience with many persons in similar situations.

In South Africa we may argue that in our current situation of limited resources and overwhelming demand for health services we cannot afford the time or luxury of this kind of "knowing of patients". Yet the plethora of short content-based courses we design and offer does not seem to have significantly increased the number of expert nurses with clinical judgement in our services. This may be related to a combination of the above two research findings.

The challenge is therefore to enable or at least facilitate nurses to begin this learning in their formal educational settings and places of work. The emerging theory base of Action Learning and Action Research are certainly tools which we can use to achieve this goal of involved relational learning.

Recommendations

Even though this article describes the first cycle of an Action research process, there are some clear recommendations which can be distilled from this initial process. It is evident that what matters most in the practice of nursing children is not what we find or have learned in traditional curricula.

The first recommendation would be that we make **a commitment to recognising the life experience of nurses who care for children**. More than this that we celebrate it and give voice to this aspect of their expertise, both in educational programmes and in clinical practice.

Secondly, that we **actively encourage a culture of questioning to increase the practical reasoning skills** amongst nurses. This would contribute to practice as well as the knowledge development of the discipline of nursing children.

Lastly, and probably of most significance at this time **is a real commitment, by educators and hospital administration, to active participation of nurses**. This means welcome participation in decision making about care giving, policy and curriculum development. This is no longer an ideological prerequisite or a luxury we cannot afford. A culture of involvement, listening and care is likely to be the most important gear that will shift out current deadlock of apathy, disillusionment and dropping standards.

The Chinese way of writing the word crisis is by using two characters, one meaning "danger" and the other "opportunity". At this time of crisis in nursing education and practice this concept seems to hold very appropriate challenge for us as child nurse practitioners and educators. Let us risk looking at things a little differently and recognise the opportunities these times bring.

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