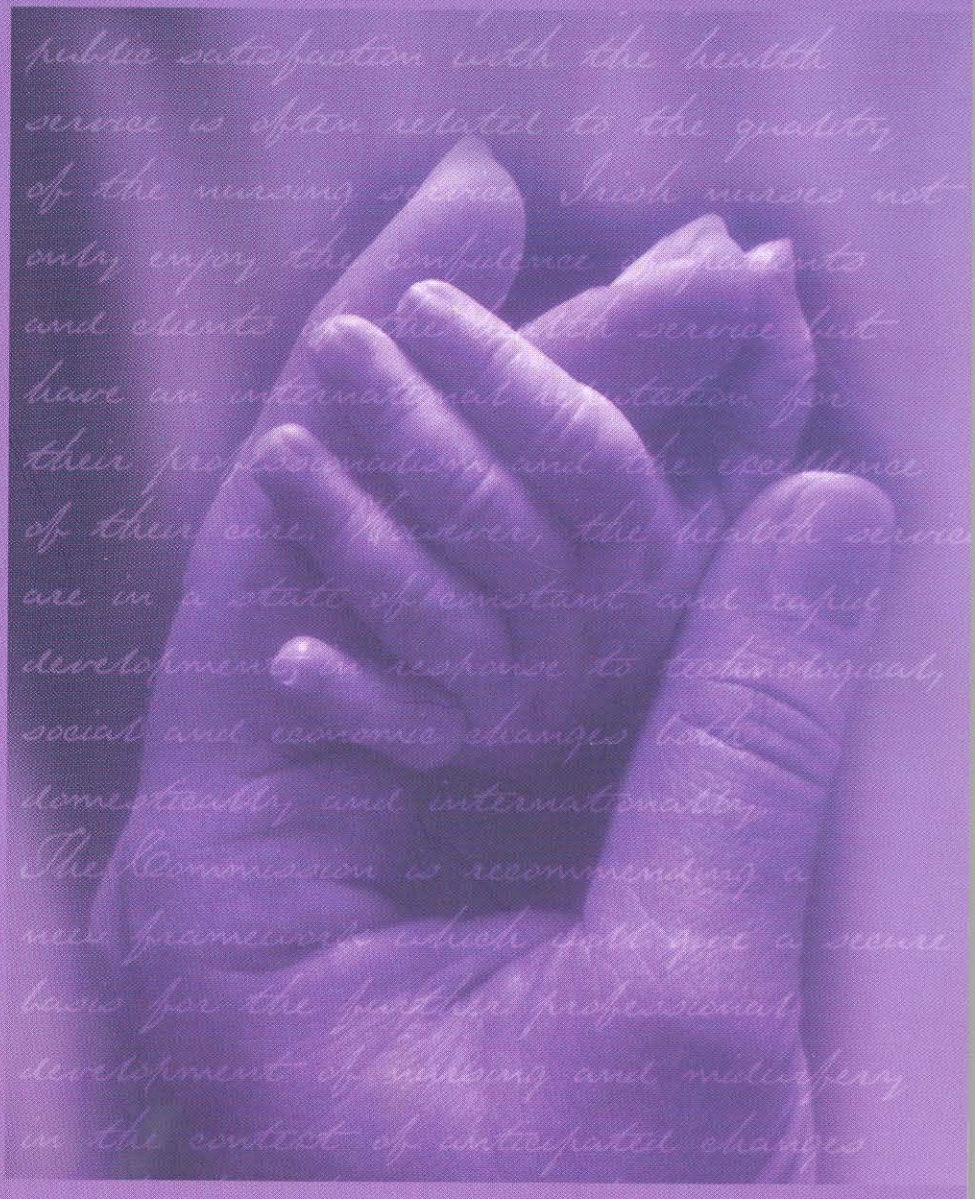
# Changes in the Professional Role of Nurses in Ireland: 1980 - 1997

*A report prepared for the Commission on Nursing*



*By Sarah L. Condell*

*Edited by Dr. Geraldine McCarthy-Haslam*

# Changes in the Professional Role of Nurses in Ireland: 1980-1997

Report Prepared for The Commission on Nursing

July 1998

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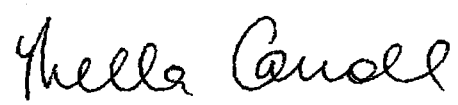
# PREFACE

On March 21st 1997, the Minister for Health, Mr. Michael Noonan, T.D., established the Commission on Nursing. The terms of reference were: to examine and report on the role of nurses in the health service including:

- the evolving role of nurses, reflecting their professional development and the overall management of services;
- promotional opportunities and related difficulties;
- structural and work changes appropriate for the effective and efficient discharge of that role;
- the requirements placed on nurses, both in training and the delivery of services;
- segmentation of the grade;
- training and educational requirements; and
- the role and function of An Bord Altranais generally, including, *inter alia*, education and professional development, regulation and protection of the citizen.

As part of the preparatory work a number of reports were commissioned. This report entitled "Changes in the Professional Role of Nurses: 1980-1997" has been prepared by Sarah Condell and edited by Dr. Geraldine McCarthy-Haslam.



Ms. Justice Mella Carroll
Chair of the
Commission on Nursing

July 1998

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# INTRODUCTION

This report was written for the Commission on Nursing in 1997. The remit was to review the literature pertaining to changes in the professional role of Irish nurses since the Working Party Report of 1980. The main social, demographic, legislative, educational and technological developments impacting on the role were to be identified.

The report contains in the introduction a brief overview of how the literature review was conducted and the historical context to the report. The first chapter reviews the literature on the main influences affecting the role of the nurse. The second chapter examines literature pertaining to each branch of the discipline of nursing and discusses more specifically how the social, demographic, legislative, educational and technological developments have impacted on midwives and nurses in each branch. Concluding statements and recommendations are made. The report is written with acknowledged thanks to the generosity of many nurses, midwives, nurse teachers, librarians, Commission on Nursing members and staff and colleagues in the Adelaide Hospital who all contributed in their own way to this report with enthusiasm, time, energy and commitment.

In preparing the report a number of difficulties arose in relation to Irish nursing research. There was no Irish database to which the author could refer. Whilst one librarian had done some work in this area it was incomplete. The author conducted a computer database search on CINAHL and Medline and manual searches of the existing Irish nursing journals, periodicals and newsletters. There was a dearth of published material in Ireland and a paucity of articles discussing Irish nursing published outside the state. A manual search of available conference proceedings was conducted. The author contacted key nurses and midwives in university departments and hospitals and through such networking, identified seminal unpublished work. The author also carried out manual searches of some library catalogues to source theses and dissertations which could be included in the report. Many Irish nurses are undertaking further education through distance learning and part-time degree courses offered by U.K. institutions. This means that some research about Irish nursing is held outside the state. Within the limited time-frame of this project (eight weeks) and the diffuse nature of the data gathering, it is recognised that pertinent work may not have been accessed. Much of the research undertaken appeared to be on an ad hoc basis. This was due to the fact that a majority of studies were undertaken as components of degree programmes. That very nature meant that many were pilot or small studies with limited follow-up and the conclusions drawn from such work can only be tentative.

## Historical Context of the Report

In order to contextualise this report, an introduction consisting of a brief historical overview of nursing in Ireland is included. Institutionalised health care started in the early eighteenth century in Ireland. Voluntary hospitals were founded by philanthropists, for the relief of the poor and sick, and by doctors, for practising the technical skills that surgery and medicine were developing. Scanlan (1991) describes the nurses' rules which were drawn up in 1733 for one Dublin hospital–

> ...the ward nurse was obliged to keep her ward clean, to prepare and wash the rollers, and to assist in washing the large linen and bedding belonging to it. It was her duty also to carry out the orders of the physician and surgeon, to distribute the medicines, and to report to the Steward the diet and drink prescribed for the sick of her ward and to carry these to the cook (Scanlan, 1991, p. 55).

This description shows the types of relationships that nurses had with others within the hospital. Women were barred from entry to universities and so all doctors at the time were male and it is likely that the Steward was also a man. Hence this shows a sexual division of labour occurring in these early hospitals. In 1838 the Poor Law Act established an administration to provide relief for the poor and which became responsible for the development of a number of the health services (Hensey, 1988). Under this Act the Poor Law Commissioners provided workhouses in geographical districts known as Poor Law Unions. Within the workhouses, infirmaries for the sick developed.

The evolution of the health service has had many influences including that of the religious orders. Nuns entry into the public arena of providing nursing care came through their initial work of visiting the sick (Luddy, 1995b). McCarthy (1986) states that "Religious influences played a significant role in emphasising the plight of the sick, the poor and the need for human dignity in health care" (p.4). Religious Orders associated with nursing, such as the Irish Sisters of Charity and the Sisters of Mercy, founded their own hospitals. They also negotiated access to the Poor Law Unions. Whilst there were undoubted benefits of the involvement of religious orders to nursing, there may also be encumbrances. For example, the involvement of religious orders provided value for money as the nuns were willing to have limited remuneration in comparison with lay nurses (Clear, 1990; Luddy, 1995a, b). The value of training may have been denigrated as in some cases nuns with no formal training in nursing were put in charge of existing nursing staff some of whom had certificates of training from English Hospitals (Luddy, 1995a). The value of such training was questioned by some. This is illustrated by Luddy (1995,b) who quotes from the Annals of the Sisters of Mercy in Limerick when referring to a Nightingale nurse invited to give the nuns some instruction – "though very well trained she knew more theory than practice" (p.50). The religious orders had a hierarchical structure which mirrored the social order of the times (Clear, 1987) and it is suggested that this had implications for the nursing service that nuns provided (Condell, 1995a).

The Irish Sisters of Charity commenced nurse training in the 1830's although secular training in Ireland was unavailable for a further twenty years. By the end of the century thirty-nine hospitals had nursing schools (Scanlan, 1991) reflecting Nightingale's promotion of the value of such training. There was also a monetary benefit for the institution in providing training (Condell, 1995a). In addition to instruction in specific nursing skills such as bandaging, the training programmes were heavily influenced by the expanding medical sciences with emphasis on anatomy, physiology and bacteriology.

Lectures were given by consultants and were, for a large part, attended in a nurse's off-duty time. As health care knowledge developed the medical model came to predominate in nurse training programmes. However housekeeping issues were not ignored, with hygiene and invalid cooking lectures being given, initially by the matron and later by the designated "sister-tutor" (Scanlan, 1991). McCarthy (1986) details one hospital report of this time which considered that nurses undertake procedures which had previously been the domain of trained and trainee medical staff, thus extending the nurse's role.

In the first quarter of the present century strides were made in relation to the registration of nurses. This strategy of occupational closure was provided by the Nurses Registration (Ireland) Act of 1919 which established the General Nursing Council of Ireland and the Midwives (Ireland) Act 1918. There was also a number of associations formed with the general aims of advancing the profession. For example the Irish Nurses Association was founded in 1900 and the Irish Matrons Association four years later. Also in 1904 the National Council of Nurses was established from the amalgamation of the Matron's Council of Great Britain and Ireland and the Society for the State Registration of Nurses in Ireland. The Irish Nurses Union (later to become the Irish Nurses Organisation) was formed in 1919. However apart from the aforementioned registration the achievements of these associations in advancing the profession were limited (Condell, 1995a).

For the mentally ill, specific institutionalised care came into being in 1745 with the opening of St Patrick's Hospital, Dublin. Robins (1986) outlines the subsequent growth in public asylums over the next century and a half. Many of these institutions undertook the care of the mentally ill and the mentally handicapped. The Royal Medico-Psychological Association (RMPA) of Ireland was responsible for training attendants nurses under the guidance of a training manual called "The Red Handbook". By 1908 training had extended to 3 years duration and a Certificate of the RMPA allowed eligibility for entry to the Supplementary Register of Mental Nurses under the 1919 legislation (Anon, 1993). This continued until 1935 when entry was through the General Nursing Council of Ireland's own examinations (Robins, 1986). Whilst a Supplementary Register of Sick Children's nurses was also formed in 1919, it was not until 1960 that the first nurse for the mentally handicapped was registered following the opening of this part of the register in 1958 (Working Party Report, 1980). Robins (1986) describes the evolution of the mentally handicapped service. The contribution of religious orders such as the Daughters of Charity (Robins, 1992), the Brothers of St. John of God, the Brothers of Charity and the Sisters of La Segesse, was in the form of monetary assistance as well as organisational commitment (Robins, 1986). Subsequent parts of the register which opened included the nurse tutors in 1964, the public health nurses in 1966, and the clinical teachers in 1973 (An Bord Altranais, 1991).

In 1947 the Department of Health was established with a Nursing Officer appointed in 1949 (Working Party report, 1980). Subsequently there was major growth in the health service (Hensey, 1988). In 1950 the Nurses Act was enacted in Ireland, forming An Bord Altranais. This absorbed the previous registration bodies and was empowered with powers to grant approval for nurse training. The specified membership of An Bord under this Act gives an indication of the lack of power nurses had obtained over their profession. The Nurses Act of 1950 specified that 12 of the 23 Board members were nurses but only 10 were elected by registered nurses, a majority (13) being appointed by the Minister of Health. Also 6 members on the Board were from the medical profession. This was further eroded by the 1961 Nurses Act which enabled the Minister of Health to appoint the

President of An Bord Altranais. Even with a slim majority of nurses on the Board it was not until 1979 that a nurse was appointed President of An Bord Altranais.

The apprenticeship style of training in separate disciplines within hospitals, legalised in the 1919 Nurse Act, continued amidst calls and attempts at reform as McCarthy (1986) and Scanlan (1991) show. Certificates of training had no external educational recognition or accreditation. Service demands superseded educational needs under this model. An Bord Altranais insisted that Directors of Nursing maintain ultimate responsibility for student selection and education; a stance that continues under the present Rules of Training (An Bord Altranais, 1994d).

Against this background the Working Party on General Nursing was established in 1975. Prior to its report in 1980 it commissioned the Attitude Survey of Irish Nurses which was carried out by McGowan (1979) for the Institute of Public Administration. The Working Party Report (1980) stated that

> the main areas of discontent among nurses related to staff structures, communication difficulties with management for senior hospital nurses, lack of nursing input to manpower and hospital planning, deficiencies in training programmes for student nurses, involvement in non-nursing duties and, again for senior nurses, the absence of a meaningful role in overall health services administration (p. 2).

This literature review aims to describe the developments that have since occurred and which have impacted on the professional role of the nurse in Ireland.

CHAPTER 1

# TRENDS AFFECTING THE NURSE'S ROLE

## Introduction

This chapter outlines the trends that have affected the nurse's role since 1980, including the social, demographic, educational, legislative and technological changes which have impacted on the role. These changes have been identified by nurses and others as a commissioned report on continuing educational needs of nurses for An Bord Altranais has shown (IPA, 1997). The data-gathering method used included workshops with nurses and interviews with health service managers (nursing, medical and administrative). The trends influencing role and practice of the nurse identified by this report included changes in hospital and community services, ethical and legal issues, technological changes, shifting role boundaries, educational changes and increasing specialisation. This section of the literature review is a general introduction to the literature addressing such trends amongst others. Some issues are addressed fully in this section. For others it is a brief introduction. As the trends apply to each branch of the discipline they are revisited and explored in greater detail if appropriate.

## 1.1 Nurses and Legislation

### Nurses and Professional Legislation

The profession of nursing is currently governed by The Nurses Act 1985 which repealed the previous Acts of 1950 and 1961. This Act defines a nurse as "a woman or man whose name is entered on the register and includes a midwife..." (The Nurses Act 1985, s2). It established An Bord Altranais as the statutory regulatory body for the Irish nursing profession. Its main functions have been identified as

> the maintenance of a register of nurses; the control of the education and training of student nurses and the post-registration training of nurses; the operation of fitness to practise procedures; and the ensuring of compliance with European Union directives on nursing and midwifery (An Bord Altranais, 1997a, px).

Membership of the Board is detailed in Section 9 of the Act. There are twenty nine members of whom the majority are nurses who are elected. There are also three medical practitioners appointed by the Minister of Health. This Act guarantees nurses the

authority to regulate their profession by increasing their majority membership (McCarthy, 1997).

O'Kelly and Ronan (1994) state that

> A number of professions have statutory powers which enable them to deal with the discipline of their members within the parameters of their own profession and to maintain the standards pursuant to their code of conduct (p 79).

This accountability is the essence of professionalism (McCarthy G., 1994). Part V of the Nurses Act 1985 deals with this accountability by establishing a Fitness to Practice Committee as a sub-committee of An Bord Altranais. This committee has powers of investigation. Its rulings may include removal from the register or such sanctions as suspension from the register, conditional register retention, and advice, admonishment or censure in relation to professional misconduct. An Bord Altranais (1985, 1988) has published a Code of Professional Conduct to direct its members. This has been described as "a very general document" (McCarthy G., 1994; p 6). Further direction has been issued following legal cases, for example the Supreme Court Ruling on the Ward of Court Case 1995 (An Bord Altranais, 1995). Guidance has also been given in relation to some issues, for example nurses with contagious/infectious diseases (An Bord Altranais, 1997b), the administration of medical preparations (An Bord Altranais, 1997c), guidelines for midwives (An Bord Altranais, 1994c). Calls for greater guidance have been tempered with the recognition that a prescriptive document may limit the development of critical competence. However a worrying finding in McCarthy's (McCarthy, G.,1994) study on a convenience sample of nurses (n = 127) showed how nurses perceived that their accountability was in the main to their employing authority, followed by the patient. Only 29% of nurses attending a course in a college and 5% of nurses attending a hospital based workshop perceived themselves to be accountable to the profession.

The Nurses Act 1985 also gave provision for the establishment of a "live" register which was subsequently created in 1987. Retention of a nurse's name on the register is by payment of an annual fee only. Calls to include mandatory post-registration education as part of "live" register retention have been examined by An Bord Altranais. However such a system was not deemed to be appropriate at present (An Bord Altranais, 1997a). The Irish nursing profession at the end of 1996 consisted of 53,641 registered nurses, 8,819 of whom were registered as inactive (An Bord Altranais, 1997a). This shows a rise from the 1993 position of 46,509 registered nurses with approximately (sic) 7,000 registered as not practising (An Bord Altranais, 1994a).

**Nurses and Workforce Legislation**

Whilst nurses perform their duties in a wide group of settings as employees they are subject to legislation governing their employment. O'Kelly and Ronan (1994) enumerate fifteen Acts which relate to conditions of employment of nurses. These include such Acts as the Unfair Dismissal Acts 1977 – 1993, Redundancy Payments Acts 1967 – 1984, and Payment of Wages Act 1991. Analysis of the total impact of labour legislation since 1980 on nursing has not been discussed in the literature. However explanations of single legislative Acts can be found, for example Mrkwicka's (1992) discussion on the Maternity Protection of Employees Act 1981.

The Irish nursing profession remains a predominantly female one with males accounting for only 6.5% of the total registered population (An Bord Altranais, 1991). It can

therefore be suggested that legislation dealing with the employment of women such as the Civil Service (Employment of Married Women) Act 1973; the Employment Equality Act 1977; the Maternity Protection of Employees Act 1981; and the Maternity Protection Act 1994 will have a large impact on the nursing profession. Since the bulk of responsibility for child rearing in Irish society falls to women, legislation with regard to part-time work such as the Worker Protection (Regular Part-Time Employees) Act 1991 and policies regarding job-sharing will also affect the profession. Job sharing in the health service became available in the mid-1980s. Circular S.204/1 from the Department of Health (1985) allowed managerial freedom in the granting of job-sharing status. Implementation then developed on an ad hoc basis. For example Mrkwicka is quoted in Horan (1995) as stating that up to 30% of nurses job-share in some hospitals. There is no national policy on job-sharing in nursing. Casey (1994) undertook a pilot study of the experiences of female job-sharing staff nurses. Within the limitations of the study the findings revealed that, as expected, family responsibilities were the prime reason for the choice of change in job status. However this change of status brought about some professional isolation and Casey warns of the possible development of a marginalised subgroup of nurses. The literature did not reveal related issues such as availability of childcare facilities even though this has been recommended (Callan and Farrell, 1991; Government of Ireland, 1993; Working Group on Childcare Facilities for Working Parents, 1994). The availability of job-sharing for male nurses or female nurses with reasons other than family commitments, such as further education, has not been addressed in the literature.

Social trends may also have an effect. The availability of contraception following the Health (Family Planning) Act 1979; the Health (Family Planning) (Amendment) Act 1985; and the Health (Family Planning)(Amendment) Act 1992 has allowed women more control over their fertility resulting in the trends identified by the Second Commission on Women (Government of Ireland, 1993) which impact on women's participation in the labour force and which include "lower fertility, fewer and later marriages, smaller completed family size, and earlier completed family age" (p.99). This all suggests there may be a change in the profile of nurses to that of a more experienced nurse at the bedside albeit one that is not there full-time. Reduced availability for full-time work, long periods of temporary employment, and the "disturbing shadow" of the marriage ban (Lynch I., 1993; p 57) all have implications for nurses' pension entitlements.

The Irish literature was very limited in its examination of career paths for nurses. One study was found but it was brought to proposal level only (O'Sullivan, 1988). A pattern of emigration is suggested as the main reason identified by nurses for joining the "inactive" file of the register is "working abroad" (An Bord Altranais, 1991) and approximately 1000 per year seeking validation of qualifications from An Bord Altranais (McCarthy, 1997). Turnover of nurses in one large general hospital was examined (McCarthy, 1993). The findings showed annual turnover rates varying between 22% and 52% and appeared to be related to temporary employment status. There was also the practice of employing newly qualified nurses on temporary contracts, ostensibly to allow experience to be gained, although there was a financial benefit to their employment. Reasons for leaving the hospital were given as contract expiring, emigration, new nursing posts and further education. Bouten and Versieck (1995) were unable to determine outflow from the Irish nursing profession and whether such outflow was of temporary or permanent nature. It was suggested that for the period 1987 – 1992 the main reason for loss of qualified nursing staff was due to rationalisation of the health service and the care of young families. Butler (1989) also outlines problems with staff recruitment and

retention at this time. Loss from the profession was examined in a small scale study by McMahon (1996). In this study fifty questionnaires were sent to a random sample of nurses aged less than 50 years whose names were contained on the An Bord Altranais inactive register (n=206). A response rate of 46% was achieved and the findings showed that overwork and understaffing on the ward, lack of job sharing opportunities, illness and family demands were factors influencing the decision to leave nursing.

For women who do leave the profession re-entry is not dependant on renewed authorisation (Bouten and Versieck, 1995). Whilst Back to Nursing and Midwifery courses are available they are not mandatory before resuming service. However, An Bord Altranais recommend that "nurses returning to practice undertake an appropriate education and practice course relevant to the area in which they propose to work" (An Bord Altranais, 1997a; pxiii). Bouten and Versieck (1995) in their analysis of available figures found participants with an increasing age distribution attending such courses.

Workplace safety is also governed by statute. The Safety, Health and Welfare at Work Act 1989 sets out employers and employees responsibility. This Act, in combination with increased awareness, is gradually changing nurse's practice with regard to occupational hazards. Literature examined showed concern for back (Buckley, 1993; Conway, 1992; Hayes, 1997; Roche 1994) and needlestick injuries (O'Reilly, 1994). Guidelines have also been issued from professional organisations (I.N.O, 1987). Litigation regarding injury to nurses at work has occurred, for example Allen v. O'Súilleabhain and the Mid Western Health Board (Medico-Legal Case Reports, 1997). In a European report on working conditions in hospitals, nurses have been identified as a main risk group by nine countries including Ireland. The risk factors to which they were exposed in their physical and organisational work environments included

> Musculo-skeletal loads (strenuous working postures and heavy lifting); deviant working hours (shift work, permanent night work); division of work and job content (jobs demanding high concentration, but also due to lack of control over how to perform the work); biological agents (hepatitis B via needle accidents) and chemical agents... (Verschuren et al., 1995, p 38).

The social work environment produces risk factors in relations with clients and the public. The same report stated that in Irish hospitals the average occurrence of occupational accidents with work interruption is 1%. The Health and Safety Authority's (HSA, 1995) Annual Report of 1995 reiterated the above risk factors and showed an increase in reported accidents and inspections for that year. A large study by Wynne et al (1993) examining stress in Irish nursing confirmed the occurrence of assault and verbal abuse, and concern over shift work amongst other stress inducing factors. Within the literature there is also evidence of small scale research conducted on the social and organisational work environment, for example, the effect of shift work on health (Wynne et al, 1984; 1985); nurses attitudes towards shiftwork and its effect on their health (Murray, 1989); assault on psychiatric nurses (Sheridan, 1990); violence in Accident and Emergency Departments (Tyrrell, 1993); bullying amongst nurses (Condell, 1995b); and burnout on psychiatric and general nurses (Dolan, 1987, McCarthy P., 1985). Guidelines have been produced by the statutory professional body, professional groups and trade unions with regard to the social work environment, for example on managing violent behaviour (An Bord Altranais, 1997d) and sexual harassment (I.N.O., 1993). Wynne et al (1993) found that student nurses experienced the highest level of stress and Marchant's (1997) work in a large training hospital on student stress concluded that there was a need for the provision of a professional counselling service as well as organisational changes such as improved

student supervision in the clinical area and changes in the attitude of registered nurses to students. The results of research into social and organisational work environments should be given full consideration, especially as the National Task Force on Suicide (Department of Health, 1996e) notes that nurses may be part of an occupational group with higher rates of suicide than others.

The right to join a trade union is protected by the Constitution although membership is not obligatory (O'Kelly and Ronan, 1994). Traditionally trade union membership amongst nurses varied with strong participation on the part of the psychiatric nurses and much less interest amongst other disciplines. Noel Browne suggests a lack of insight on the part of general nurses who aligned themselves with the medical profession to hold a "snobbish attitude to trade union activity" (Browne, 1986, p.145) and thereby ignoring the strong power base the medical profession already held through personal, social and political contacts. Changes have occurred in the last two decades though. McCarthy and Marchant (1993) outline the change of status in 1990 on the part of the Irish Nurses Organisation from being that of a professional body to that of a professional trade union affiliated to the Irish Congress of Trade Unions and thereby joining other trade unions with nurse memberships. Increasing membership of the Irish Nurses Organisation (O'Shea, 1997) and other unions has also occurred. An estimate of 80% trade union membership is given by Bouten and Versieck (1995). O'Shea (1997) concludes in a small study on a convenience sample of general nurses that participation in trade union activity is very low, despite high membership. She states that "protection of rights and legal security while at work and advice and council on industrial relations matters" (O'Shea, 1997, p. 12) were the main reasons nurses gave for joining a trade union. She also postulates that nurses oppositional attitude to industrial action has changed as illustrated by recent local and national disputes. Membership of a professional organisation allows Irish nurses access to international nursing organisations such as the International Council of Nurses and the European Forum of Nursing and Midwifery Associations and W.H.O. However the literature does not contain an analysis of how trade union membership may affect the professional role.

**Nurses and Litigation**

An incresingly litigious society means that many health care professionals are to the forefront as defendants in claims of negligence. An example can be found in the case report of Kathleen Murphy v South Eastern Health Board (Medico-Legal Case reports, 1995). However, for nurses vicarious liability applies whereby the hospital as an employer is responsible for the actions of its staff during the course of their employment (O'Kelly and Ronan, 1994). Hospital-based nurses work within a regulated environment with hospital policies and procedures guiding their actions and so the hospital undertakes responsibility for negligence. However if nurses do not follow acceptable professional standards, they may leave themselves open to claims of a breach of duty. O'Kelly and Ronan (1994) claim that there are few reported cases involving allegations of negligence against nurses in this jurisdiction. Kinlen (1995) advises however that all nurses should be aware of their position under the Nurses Act 1985 as all nursing decisions can be judicially examined. A further action might be in a report to the Fitness to Practice Committee of An Bord Altranais.

## 1.2 Nursing in a Changing Society

### Client Base

Ireland is a changing society in many ways. Some of the changes occurring will affect its health care system, and by extension, the role of the nurse. Whilst Ireland still has a large youth population it is entering a phase when the number of elderly will start to grow more rapidly than the total population (OECD, 1997). The impact of such a change may be modest, an OECD report claims (OECD, 1997), as costs may be offset by other demographic factors such as a falling birth rate and improved average health status. Life expectancy has been improving over the last forty years (Department of Health, 1995e) and in 1993 was 72.7 years for men and 78.2 years for women (OECD, 1997). Birth rates are changing and are discussed in this report in relation to their impact on midwifery (see section 2.5). There is also a fall in mortality rates. Provisional figures for 1993 show a mortality rate of 8.9[1] in comparison with the 1980 figure of 9.8 (Department of Health, 1995e). Almost 45% of the total number of deaths in 1993 were due to diseases of the circulatory system with cancers accounting for over 23% (Department of Health 1995e). However somewhat worryingly, Ireland has a higher mortality from cancer than the average for EU countries (Department of Health, 1996a) and regional disparities exist (Department of Health, 1996a; National Cancer Registry Ireland, 1997). One recently discovered disease which has impacted on health care is Acquired Immune Deficiency Syndrome (AIDS). Numbers remain small within the total Irish population with 443 cases of AIDS to 1994 and 224 deaths in the same period (Department of Health, 1995e).

Whilst these figures have focused on the biomedical model of disease patterns it should be remembered that there is also a social disease pattern. Health problems associated with unemployment, domestic violence, changing patterns in drug abuse (O'Higgins and Duff, 1997), increasing suicide incidence (Department of Health, 1996e) and child abuse impact on the health service. For example 34.6% of children in care at 31.12.91 were there for reasons of suspected or confirmed physical, sexual or emotional abuse or neglect (Department of Health, 1997e). A concentration of population on the eastern seaboard implicates the distribution of required services.

### Health Care Professionals

Demographic and social trends may also influence nurses and the people who choose nursing as a career. Nursing has been popular as a career with demand for places being higher than the number on offer (McCarthy, 1988; Bouten and Versieck, 1995). This was quantified by McCarthy and Marchant (1993) as six suitable applicants for each available place. That fact coupled with a higher educational entry requirement in Ireland set by An Bord Altranais meant candidates emigrated in order to undertake training (Bouten and Versieck, 1995). Entry numbers were set by the Department of Health due to the position of the student nurse as a service provider. McCarthy (1988) found that the majority of candidates for nursing were young, single women with an over representation from middle class and farming backgrounds. A rural background also featured in earlier work by a different researcher (Hanrahan, 1975). Candidates appear to be well motivated with 84% of McCarthy's (1988) sample stating that nursing was their first choice of career and 93% of a small study (Maher, 1993) sample considering nursing to be their career for life. Many

[1] This figure is based on the number of registered deaths as 31,656 which gives a crude death rate as 8.9. Mortality rates are quoted per 1,000 of the population.

appear to choose nursing as a career at an early age: 32.8% at 14 or younger (Maher, 1993), 61.9% between 15 and 17 years (McCarthy, 1988). Sheridan (1994) found that the family played a significant role in the influence of nursing as a career choice. The role of education in career selection for nursing was not found in the literature. However reference to differing ethos in girls schools *hints* that education may play some role in preparing girls for selecting a sex-stereotypical career such as nursing. Lynch (1989) studied the ethos of girls' schools and showed that

> even when formal curriculum provision has become relatively egalitarian (in gender terms) the extracurricular life and hidden curriculum of the schools may still be reproducing sex-stereotypes in very explicit ways (p. 13).

Lynch (1989) also found a much greater religious ethos in girls' schools; with girls having to attend more religious activities and exposed to more religious classes. It was found that girls were also subject to more regulations and rules with regard to demeanour and dress. McCarthy (1997) points out that changing social structures and a broadening of female occupational roles may imply an increased competition between nursing and other career choices for prospective candidates. This in conjunction with Wynne at al's (1993) study whereby

> The structures and institutions of nursing appear to be operating upon new entrants to the profession in such a way as to discourage many of them from remaining in the profession (p. 96).

Statistics appear to bear this out. Figures from An Bord Altranais (1991) show that 13% of students in 1987 failed to complete their training and/or register as nurses. This figure does not account for those who register but do not continue practising. Entry to the Diploma/Registration programme for nurses is through a National Applications Centre, which was established in 1995.

Other social trends include the increasing secularisation as a phenomenon within Irish society. Due to the historically large contribution of the religious to Irish nursing (McCarthy, 1986; Scanlan,1991) the fall-off in vocations since the late 1960s (Nic Ghiolla Phadraig, 1995) will reduce the influence of the church on nursing both at a macro and micro level. It might be suggested that the reducing role of the religious orders in education (Nic Ghiolla Phadraig, 1995) may also have some implications on traditional career selection patterns. The acceptance of alternative and complimentary therapies is also a social feature which has impacted on nursing. Irish nurses and midwives have written about such therapies (Boland, 1997; Brown, 1995; Cull, 1992; Skinner, 1987). Within the timeframe of this report it was not possible to quantify the verbal reports which claim that there has been an extension of the midwife's and nurse's role into this area. However from personal communication (Hayes, 1997) the author did verify that a nurse has recently been appointed co-ordinator of a Complementary and Supportive Therapies Department in a palliative care centre.

There has been a growth in the multidisciplinary approach within the health service. The literature examined did not address the issue of shifting role boundaries within health professional teams specifically. However there was some evidence to suggest that this phenomenon may be occurring. There has been a growth in availability of paramedical services including dietetics, occupational therapy, physiotherapy and psychology. For example, literature reviewed showed an average of 5% growth in membership of the Irish

Society of Chartered Physiotherapists (Schmidt, 1994), the non-statutory registration body for physiotherapists. Department of Health manpower statistics (Department of Health 1995e) also show increasing employment in the paramedical division. This growth may impinge on the role of the nurse resulting in role erosion. It is suggested that responsibilities for areas of patient care such as diet, mobilisation and counselling may now, in some instances, be the domain of other paramedical professionals and not nurses. Sheehan et al (1994) describes the establishment of a multidisciplinary pain clinic with input from physiotherapy, occupational therapy, social work and psychology but not nursing. Tensions and conflict may also occur within such multidisciplinary teams (Hendriks, 1983) especially where roles are not clearly defined. One study (Wagstaff, 1987) found cognitive dissonance amongst Irish physiotherapy students whereby they ranked nursing to be of higher importance in modern society than their own profession. It was suggested that nursing was accorded this higher status because of its close association with the hegemony of medicine (Wagstaff, 1987). Further work (Jackson et al, 1991) found a low ranking given by student physiotherapists to understanding other health professional roles. This may have implications for developing professional collaboration and understanding role boundaries. Role erosion may also occur with the introduction of a paranursing grade. Begley (1994) and Savage (1997 a,b) caution against the introduction of such a support worker without sufficient research and consideration of its full implications for the role of the nurse and the cost to the health service.

Historically role extension for the nurse has occurred with the offloading of medical tasks to nurses. This has been assisted by nurses valuing technical skills rather than the caring aspects of their role (Treacy, 1989). The situation continues to the present day, as a recent discussion document shows, whereby it is envisaged that appropriate medical duties would be transferred to nursing and other staff in order to solve medical manpower issues (Department of Health, Comhairle na n-Ospidéal, Postgraduate Medical and Dental Board, 1993). Undertaking such medical tasks is occurring with a background of an expansion in the number of non-consultant hospital doctors (OECD, 1997) and a slight increase in hospital consultants (Department of Health, 1995e) employed. An example of such role extension is the issue of intravenous drug administration (O'Sullivan, 1984; Department of Health, 1996b), with the inclusion of educational preparation for nurses for this role since 1984 (An Bord Altranais, 1983). Begley (1994) in writing on the subject of support workers in service provision offers the suggestion of "doctors' aides" rather than nurses "who would assist with erecting intravenous infusions, taking blood samples, cleaning trolleys, carrying charts, ordering supplies, tests etc..." (p.5). Flexibility in role boundaries may stem from a lack of a definition of nursing and is shown in Irish nurses having difficulty clarifying nursing and the nurse's role. (An Bord Altranais, 1994a). However the author also suggests that differences in the education of health care professionals and the context in which such education is delivered may perpetuate shifting role boundaries. Gender inequalities may also be part of the equation as a feminist analysis of Irish nursing shows (Condell, 1995a). In conclusion the parameters of nursing care may need to be clearly stated so that role boundaries are established and defined.

**Changing Usage in the Health Service**

In 1980 Ireland had one of the highest hospital admission rates amongst the OECD countries but this has since dropped significantly (OECD, 1997). The number of beds in publicly funded acute hospitals and district hospitals has dropped (Department of Health,

1995e). In contrast there has been a rise in day-care treatment (OECD, 1997) and outpatient attendance (Department of Health, 1995e). Hospital productivity has improved (OECD, 1997) as measured by bed occupancy and average length of stay. The 1993 figures showed bed occupancy at 83.6% and average length of stay at 6.7 days for the acute hospital sector (Department of Health, 1995e). However, waiting lists for surgery in the public system consisted of 40,000 cases in 1993 (OECD, 1997). Such patterns impact on the role of the nurse as

> A decrease in the average length of stay points to an intensifying of care per patient or per bed.... Moreover, patients are discharged from hospitals earlier after they have undergone surgical treatment. Both observations lead to the fact that: (1). the average condition of patients in general acute hospitals is more acute; (2). the necessary treatment and care is provided within a shorter period of time. Both quantitative indicators of workload (bed occupancy rates and average length of stay) point to a possible increase in nurses' workload in general hospitals (Bouten and Versieck, 1995, p. 57).

Changing usage of psychiatric services and mentally handicapped services will be discussed later in this report.

**Importing Consumerism into Health Care**

Since the late 1970s there has been a growth in self help groups for people with particular health problems. People have also organised around particular issues forming lobby or pressure groups such as the Irish Patients Association, and the Irish Association for Improvements in Maternity Services (I.A.I.M.S.). The desire to influence health services can be seen in the latter's publication of a consumer guide now in its second edition (I.A.I.M.S., 1995). The former has produced a report of the analysis of patient contacts (O'Connor S., 1996). This analysis was of approximately 70 contacts with the main problems being grouped under the headings of personal dignity and privacy; communications; and standards of medical and nursing care. Such "user" activities have occurred in tangent with a growth in health service consumer orientation which O'Donovan and Casey (1995) claim has been a stated objective in Irish health policy since the report Health the Wider Dimensions (Department of Health, 1986). O'Sullivan (1993) identifies the following as the four key benefits of such an approach:- increased awareness of patient's needs, improvements in the quality of service provision, unification of service providers' and service users' approach to health care and empowerment of service users to provide a counter-influence to the power of the professions and state. In 1992, the Department of Health published the Charter of Rights for Hospital Patients. A commitment to increasing consumer orientation is also found in Shaping a Healthier Future (Department of Health, 1994a) and the Department of Health Statement of Strategy (1997b). O'Donovan and Casey (1995) on analysis of their findings into the implementation of the Charter of Rights for Hospital Patients have suggested that the implementation of such a charter has more to do with "creating a semblance of closeness to the users of health services and counterbalancing medical authority" (p, 43) than to empowering the service users. Patients as consumers of health care has been addressed by medical (Johnson, 1987) and nursing researchers (Cowman, 1989b; McCarthy, 1992) in the Irish literature as well as other policy documents (Department of Health, 1995b, 1997a).

In conjunction with consumerism there has been a developing focus on quality of service. This is one of the key principles underpinning the Department of Health policy (1994a; 1997b). Some private health services have developed their own quality assurance evaluation systems (O'Connell, 1991). Irish nurses responded to this emerging health care issue with the publication of "Standards for Nursing Practice" (I.N.O., 1986) and the formation of the Quality Assurance in Nursing Association in 1989. The literature shows that nurses have continued to write about quality (Savage, 1996), explore methods of measuring quality (Carway, 1994), and plan and implement quality assurance schemes in general nursing (Buckley and Savage, 1995), psychiatric nursing (Gallagher, 1991; Gilheaney and Farrelly, 1993) and mental handicap nursing (Redmond, 1993). Irish nurses have also been fully involved in the clinical audit of palliative care (Hayes, 1993); have examined quality indicators in nurse education (Cowman,1996); and have applied quality assurance principles to infection control (Creamer and Smyth, 1993). The impact on the role of the nurse of these two managerial issues, consumerism and quality assurance, was not addressed in the literature examined.

**Focusing on Primary Health Care**

A reorientation of health service policy came into being in 1994 with the publication of Shaping a Healthier Future (Department of Health, 1994a). This document brought a strong commitment to the concepts of primary health care and health promotion. It followed two earlier documents advocating a similar approach (Department of Health, 1986b; Health Education Bureau, 1987) and was in response to World Health Organisation Strategy. Cowman (1990a) describes how a cross section of Irish nurses gave a positive and constructive response to this initial W.H.O. strategy of Health for All. The Department of Health have continued work in this policy area (Department of Health 1994b; 1995a; 1996a,c,d,f; Nutrition Advisory group 1995). An Bord Altranais (1994a) recommended that primary health care should become an essential feature of nursing curricula and that future programmes should provide nurses with knowledge and expertise in community nursing. McDonnell (1996) in a small study, examined nurses' attitude to and perception of primary health care. The results indicated that nurses have an awareness of primary health care and its relevance to their professional role. However variation between the two groups studied, hospital-based nurses and public health nurses, was seen in their rating of some of the concepts inherent in primary health care such as universal coverage, multisectorial involvement, primary health care as effective, affordable, manageable and culturally acceptable, and primary health care as promotion, prevention, curative and rehabilitative. Such variations were deemed to be the result of educational difference.

Notwithstanding the move from institutional to community care in the psychiatric and mental handicap service (see section 2.3 and 2.4) there are increasing numbers of nurses providing a primary health care service outside the public health nursing service (see section 2.6). These range from occupational health nurses and practice nurses to specialist nurses such as domiciliary palliative care nurses and special clinic nurses such as those providing for family planning, drug abusers, women working in prostitution (O'Connor, 1994), and the homeless (Leahy, 1989). Variations occur within some of these groups. For example the domicillary palliative care nurses have a range of employing agencies including the hospice movement, the Irish Cancer Society and the Health Boards (Department of Health, 1997d). There is evidence that some of these nurses are organising for education and professional development purposes. The Association of Family Planning

Nurses in Ireland was established in 1983 for on-going education for nurses who completed the Irish Family Planning Association's bi-annual course. The service offered by this and similar associations is valued as the centre of choice for family planning information by over a quarter of the female population (Wiley and Merriman, 1996).

The Irish Practice Nurses Association was formed in 1994 and there is also a Practice Nurse Section of the Irish Nurses Organisation. Murphy (1996) estimates that over 300 practice nurses are employed mainly as a result of the 1989 Department of Health, General Medical Services contract which gives a practice support subsidy; a figure of approximately 600 practice nurses is given in the Public Health Nursing Review (Department of Health, 1997d) however no definitive figure exists. These nurses are privately employed with no set terms and conditions. Harrington et al (1995) in a study examining the types of general practice employing practice nurses found that they were mostly single handed practices and in a town or rural setting. Another study (Harrington et al, 1994) found practice nurses undertaking basic treatment room tasks, practice organisation tasks and what was viewed as extended tasks such as counselling for obesity, cholesterol, smoking, psychological health and enuresis; women's health issues including cervical screening, breast examination, family planning and antenatal care; and management of asthma, diabetes and hypertension. Recognition that the expanding role of the practice nurse may cause role conflict was acknowledged by the authors (Harrington et al, 1994) as was the possible misuse of employing a practice nurse in lieu of a female general practitioner (Harrington et al, 1995). Role conflict may also be the root cause of an agreement between the health boards and the Irish College of General Practitioners forbidding domiciliary care by practice nurses (Department of Health, 1997d). There is the potential for other branches of nurses to be employed in the general practice setting as Butcher (1993) showed with a pilot study examining behaviour therapists in such a setting. Education for practice nurses is offered in the form of a short, An Bord Altranais approved, certificate course which commenced in 1991 and a one-year Diploma course from the Faculty of Nursing, RCSI which commenced in 1996. These provide a vocational training in primary health care to a group of nurses whose previous exposure to the concept is variable. However this post-registration education is arbitrary.

Another type of nurse providing primary health care is the occupational health nurse. An Bord Altranais provided an occupational health nursing course between 1976 and 1988 when it was incorporated into the multidisciplinary Diploma in Safety, Health and Welfare at Work (An Bord Altranais, 1994a). The literature did not reveal the extent of this nursing service. These nurses organise through an occupational health nurses section of the I.N.O.

Whilst the Public Health Nursing Review (1997d) recommended a nurse manager directing the community nursing service it is unclear where some of these diffuse and sometimes isolated community nursing groups would fit in, if at all, to the proposed structure. In the future, consideration may need to be given to the full evolution of a primary health care nursing service which could incorporate the present voluntary, private and statutory nursing services and perhaps from all branches of the discipline.

**Technology and Health Care**

Advances in technology are found throughout the Irish Health Service. These can be broadly grouped into two areas; the technology for patient or client treatments and therapies and information technology for enhancing the health professionals' knowledge

and service support. Most of the former group will be dealt with in Chapter 2. However it is noted that the stated policy of the Department of Health (1994a; 1997b) is to assess treatment technologies with regard to cost effectiveness and geographical distribution. With regard to the latter group the Commission on Health Funding (Government of Ireland, 1989) underlined the need for local information systems. One development is enhanced availability of the Hospital In-Patient Enquiry System (H.I.P.E.). Whilst in 1993, this system covered about 90% of discharges from publicly funded acute hospitals, maternity patients, district and private hospitals are excluded (Department of Health, 1995e). This system, in conjunction with figures such as from the Central Statistics Office (1997) and the National Cancer Registry Ireland (1997), will provide the necessary information for health service planning based on population needs (Department of Health, 1994a).

## 1.3 The Delivery of Care

### The Influence of Nursing Theories

Under the influence of emerging nursing theories and in common with nurses elsewhere in the world, Irish nurses have adopted the nursing process, nursing models and primary nursing. The Irish nursing literature displays evidence of all three developments.

The nursing process is a systematic approach to nursing care incorporating the four steps of assessment, planning, implementation and evaluation of care. Brophy (1988) explored the experience of nurse process implementation whilst Pierce (1997) describes the use of care planning as a means of documenting the nursing process. Crosbie (1994) examined the implications of the nursing process in caring for clients with mental handicap. McCarthy (M.,1994) in a study of change in general nursing examined the implementation of the nursing process as an example of such change. In the hospitals examined, nursing process implementation was at varying stages and there was considerable ambiguity in relation to one of the steps involved. On initial implementation workload increased and the change was made within existing resource allocations.

Nursing models focus on the four concepts of person, environment, health and nursing to describe or explain what is meant by nursing. There are numerous different models but the Irish literature examining models of nursing has focused almost exclusively on the Roper, Logan, Tierney Model both in patient care (Carney, 1986) and in curriculum planning (Boland, 1985; Boland 1987). The exception here was a general introduction to models by Chavasse (1986).

Primary nursing is a pattern of delivery of nursing care whereby one registered nurse assumes responsibility for the total care of a patient whilst hospitalised. The assistance of an associate nurse is required for direct patient care. Within the Irish nursing literature primary nursing has been described by McTague (1994). Its implementation in acute medical wards (O'Keefe, 1996; Ryan, 1992) and care of the elderly setting (Hayes M., 1996) has been the focus of a number of papers. Discussion on how these developments have impacted on the nurse's role was minimal. O'Keefe (1996) claims that roles and responsibilities are more clearly defined but does not elaborate. Hayes (1996) describes how primary nursing has enhanced the concept of partnership in care and research-based practice. Both Hayes (1996) and Ryan (1992) claim that primary nursing has improved nurses' effectiveness on multidisciplinary teams. Since 1990 the Irish Primary Nursing

Network has acted as a forum for discussion and dissemination of information on primary nursing. Another development that has been incorporated into Irish nursing is that of Nursing Development Units. A small number have been established in Ireland with two such units in Dublin and one in Tullamore. These are designated clinical areas, staffed by nurses who are committed to nursing practice development. Such a unit has been economically evaluated and found to be an effective use of healthcare resources (Flint 1995; Flint and Sinclair, 1996).

**The Specialist Nurse**

Another change which has occurred in the delivery of care is the establishment of the role of a specialist nurse. This was a development recommended by the Working Party Report (1980). The rationale for this recommendation was given as

> (i) to enhance the quality of nursing care (ii) to provide a specialist nursing service in certain nursing areas (iii) to provide a specialist nursing advice to other nurses in those nursing areas; and (iv) to enable more nurses to pursue a career in clinical nursing. (Working Party Report, 1980, p. 67).

Subsequent discussion in the Irish nursing literature (Healy, 1983; Ruddy, 1986) viewed the role as more multifaceted, adding an administrative and research component to that of clinician and educator. Thus there was an aspiration of the clinical specialist role enhancing the professionalisation of nursing (Healy, 1983). An analysis of whether this is an outcome, however, was not found. Many specialist nursing courses are now being offered at diploma or higher diploma level (An Bord Altranais, 1997a, appendix V).

As will be seen in Chapter 2 it was not possible from the literature to ascertain the total picture with regard to the types and numbers of specialist nurses in practice. It was also not possible to discover how many of these nurses developed because of a specified nursing need. It appeared that some specialist nurses may have evolved from the role of medical research assistant. Examples of nurses acting as medical research assistants are given by Mee (1992) and Ormiston (1996). Another nurse acting in such a capacity claims a specialist nursing role (Macken, 1997). This suggests that the role boundaries between nurses as medical research assistants and specialist nurses may not always be clear.

## 1.4 Nurse Education and Research

Perhaps some of the greatest impacts on nursing since 1980 are the advances that have been made with regard to education. The degree to which this development has been from grassroots demand and not policy driven merits consideration. Educational changes in programmes leading to registration are dealt with in Chapter 2 under the appropriate discipline branch. This introduction therefore deals with broad post-registration education of nurses with a focus on third level education.

Despite calls over the years to move basic nurse education into third level (Scanlan, 1991), it was post-registration education which was to break the mould. Following on the footsteps of the nurse tutor diploma in 1960, McCarthy (1986) outlines how a failed attempt in 1973 to establish a pre-registration degree course in University College Galway was followed by, in 1985, a three year post-registration diploma. A Faculty of Nursing was established in 1974 in the Royal College of Surgeons, Ireland. This facility offered post-registration diplomas and Primary and Final Fellowship courses (Carney, 1987) with the

first group being conferred with full Fellowships in 1982 (Burke, 1983). Regional centres of the Faculty were also established to assist in disseminating education. However, nurses wishing to attain university degrees in nursing still had to go outside the state. For example, Waterford Institute of Technology and the Regional Technical College, Letterkenny instigated institutional links with the University of Ulster, to provide a Professional Development Diploma (An Bord Altranais, 1997a). Alternatively, nurses undertook degrees from other domains of scholarship. From the literature examined it was not possible to quantify or qualify this statement. However, it is known from anecdotal accounts that nurses have undertaken degrees in sociology, arts and law amongst others.

A breakthrough came in 1984 when the two year, Nurse Tutor Diploma was extended to three years and awarded a Bachelor of Nursing Studies from University College Dublin. The graduate teacher resulted in an increasing demand from other nurses for degree programmes and subsequent developments led to post-registration undergraduate nurses being conferred in 1995 from University College Dublin. The establishment of Departments / Schools of Nursing in universities means that many registered nurses will now be able to undertake degree programmes in nursing and midwifery. Accessibility to such education is also being addressed by the development of distance learning packages from Dublin City University in co-operation with the University of Ulster (An Bord Altranais, 1997a) and the Irish Nurses Organisation in conjunction with the University of Limerick (Meagan, 1995).

The Health Strategy states that "... all staff need to be aware of the need for continuing education and training" (Department of Health, 1994a, p.41). Acknowledging the role of continuing education for nurses in advancing practice and preventing obsolescence (An Bord Altranais, 1994a), a report was undertaken to examine the current situation and recommend proposals for the future (An Bord Altranais, 1997a). This report makes several recommendations including a structure for continuing education, proposed professional pathways, and the role of An Bord Altranais in continuing education. The issue of mandatory continuing education however, was deemed to be currently inappropriate by this report. From the literature, Butcher (1996) displays the need for a continuing education policy within nursing and O'Connor (1996) describes the establishment of a continuing nurse education programme in the North Eastern Health Board, along the lines of that recommended by An Bord Altranais (1997a). Similar initiatives have also been established elsewhere (Eastern Health Board, 1997).

Continuing professional education for nurses was examined by Timoney (1997) in a small qualitative study. The findings suggested that engagement in such education increased the ability of nurses to deal with and implement change. A cautionary note was struck by the haphazard access to such education depending on an individual's status within an organisation and the employers' commitment to continuing professional education. Timoney (1997) welcomed the proposed An Bord Altranais (1997a) framework; the ability of concerned stakeholders to accept and act on it is previously mentioned in this review (Eastern Health Board, 1997; O'Connor, 1996).

In conjunction with education is the advancement of nursing knowledge through research. The literature has addressed some of the issues surrounding nursing research in Ireland (Cowman, 1990; Treacy 1985,1995). Points raised included the need for access to appropriate journals (Meehan et al, 1996) and computerised databases (Brazier and Begley, 1996; McGrath, 1990), although the latter has become more readily available in hospital libraries through a funding initiative from the Department of Health in recent years. Nurses have fostered nursing research through such organisations as the Irish

Nurses Research Interest Group which was established in 1976. Large one-off research projects have been undertaken as commissioned pieces for example Treacy (1990) and Wynne at al (1993). However the vast bulk of nursing research consists of small scale, pilot studies undertaken by individual nurses as a requirement for courses. This reveals a lack of a coherent policy on nursing research and a dearth of funding. Some funds have been established such as An Bord Altranais Research Scholarship Fund and the Nursing Research Unit in the Faculty of Nursing (Bartley, 1993) but such monies have been derived from nurses themselves in fund-raising activities or through their annual registration retention fee. The lack of commitment is shown not just in lack of funding but as Treacy (1995) outlines in the failure to fill the An Bord Altranais Research Officer post vacated in 1991 and to honour an early Ministerial commitment to investigate feasibility studies in nursing research. Whilst much has been achieved on limited resources a call is made for a centrally funded nursing research department in the Department of Health in order to develop a coherent and organised nursing research plan (Treacy, 1995).

## Summary

In this chapter a general discussion on the Irish demographic, societal and technological changes which have impacted on nursing and the role of the nurse was developed from the reviewed literature. The examined literature suggests that there is flexibility in role boundaries with role erosion and extension occurring. Hence the role is constantly developing and changing. Irish literature relating to trends in nursing practice including increasing specialisation and the development and application of nursing theory has been reviewed. The impact of professional and workplace legislation has been explored. The strategic direction of the Irish health services with greater consumerism and a move to primary health care have also been examined. The literature on Irish nursing research policy has been reviewed and there is a general introduction to nurse education. In the next chapter these issues will be revisited as appropriate and discussed in greater depth as they apply to each of the branches of the discipline of nursing.

CHAPTER 2

# THE BRANCHES OF THE DISCIPLINE OF NURSING AND MIDWIFERY

## Introduction

This section examines developments in each branch of the discipline of nursing. Until recently there were four basic registration programmes: those of general nursing, psychiatric nursing, mental handicap nursing and sick children's nursing. Whilst the latter no longer has direct entry since 1996 segmentation of nurses at basic programme level remains. After successful completion of one programme and registration, a further eighteen month programme could be undertaken in order to register in another of the four basic branches. However following EU Directive 89/595 EC which was implemented in 1992, hospitals offering such short programmes became limited. Programmes leading to other registrations such as nurse tutor may only be obtained after initial registration on one of these four registers. A midwifery registration programme may only be entered by nurses on the general register and public health nurses must also be registered midwives. An Bord Altranais holds a number of other registers, some of which are closed. They are orthopaedic, sanatorium, fever, advanced psychiatric, tuberculosis and infectious disease nurses and clinical nurse teachers. In 1996 they contained the names of 611 nurses (An Bord Altranais, 1997a). For the purpose of this report they will not be considered.

Under the Nurses Act 1985, the regulation of nurse education is vested in An Bord Altranais. The system operates through the Nurses Rules, 1988 with amendments in 1991 and 1994 (An Bord Altranais, 1994d); syllabi for the education and training of nurses in the general, sick children's, mentally handicapped and psychiatric branches; and Syllabus and Rules for the Education and Training of Student Midwives (An Bord Altranais, 1994b). An inspection of each school of nursing and midwifery is conducted by An Bord Altranais every five years, with subsequent monitoring of inspection report recommendations. In 1991, there were 44 schools of nursing and midwifery (An Bord Altranais, 1994a); 28 schools having closed since 1980 (An Bord Altranais, 1991).

## 2.1 General Nurses

For the majority of Irish nurses their first step into nursing was through the general nurse certificate programme. Registered general nurses remain the largest branch of the discipline with 43,869 names recorded on the live register (An Bord Altranais, 1997a), although not all of those registered have continued to work within the discipline. Those

that have can be found working in many diverse areas such as nursing homes (Horan and Culliton, 1996), the defence services (Anon., 1995), primary health care, palliative hospice care, as well as the acute hospital sector.

**General Nurse Education and Training**

Since 1980 there have been many changes to the general nurse training certificate programme. At that stage the student nurse was a salaried service provider and so occupied a dual role of learner and employee (An Bord Altranais, 1994a). The three year programme consisted of 28 weeks of theory, the delivery of which occurred in hospital-based Schools of Nursing. The remainder of the time was spent in clinical areas. This structure stemmed from the E.U. directives 77/452/EEC and 77/453/EEC which were implemented in 1979. The directives also meant that the specified areas of obstetrics, paediatrics, geriatrics, community care and psychiatric nursing were added to the clinical experience required in the general training programme. This had implications for hospital budgets as students had to be seconded for such clinical experience and replacement staff recruited to substitute when students were away from the service area. In most seconded clinical areas the student nurse was in addition to the staffing compliment and was treated as a learner/observer.

The need to provide service meant that there was two intakes of students for training per annum. The programme was described as an "apprenticeship" model of training (An Bord Altranais, 1994a) which produced nurses with highly developed practical skills. However, Treacy (1991) suggests that "the experiences of nurse training combine to promote adaptive rather than change oriented responses in student nurses" (p. 18). Research showed that this system also produced nurses that were unquestioning and submissive (Treacy, 1988; Coughlan, 1995). O'Connor (1991) found in a small study that a lack of assertiveness continued beyond the training period. The difficulties existing in nurse education at that time were "intrinsic to the whole social and traditional fabric of nursing in Ireland (Cowman, 1989a, p.26). The system

> neither challenged the other health care professions nor made demands on administration. It could only have existed in a world where women were prepared to be so self-denying, hard working and so amenable to discipline (McCarthy, 1997, p.178).

Two examinations were obligatory for registration. Part 1 registration occurred after 12 months of the programme and consisted of a written examination. The registration examination after 3 years consisted of written and oral examinations. Continuous assessment of clinical skills was undertaken throughout the three years using An Bord Altranais Proficiency Assessment Forms and a minimum of seven satisfactory forms from six week clinical placements were required for registration. A study which examined the use of such forms in one hospital found that the tool did not adequately test nursing skills and was subjective, unreliable, non-discriminatory and invalid (McSweeney, 1995). Subsequently an E.U.Directive, 89/595 EC, meant that an extra twelve weeks theoretical instruction was to be included bringing the total to 40 weeks of theory or one-third of the programme and clinical instruction to one-half of the minimum 4,600 hours required.

> This amendment became operative in Ireland in the Autumn of 1991. However, the statutory body, An Bord Altranais, did not notify the profession of the change until February of that year. Data in relation to the events which followed this notification from the statutory body has not been published. (McCarthy M., 1994, p. 4).

From the author's personal experience this included a manipulation of entry dates in the Autumn of 1991 to ensure that the new programme would not commence in Schools of Nursing until the Spring of 1992 which would allow the teaching staff time to prepare a curriculum to meet the new directive. At the same time the theoretical assessment procedure for registration changed. Part 1 registration examination was replaced with three knowledge assessments over the first 12 months. These were set by the individual Schools of Nursing and marked by the staff. The oral examinations in the registration examination were discontinued.

The EU Advisory Committee on Training in Nursing published guidelines III/D/5044/1/89-EN which focused on measures to reduce the theory practice gap in general nursing. Actions suggested included eliminating students as employees and granting them full student status, designing andragogical nurse programmes which incorporated self-directed components with the use of technology, and the use of continuing education and vocational up-dating. In September 1990 An Bord Altranais commenced a review of nurse training and education in accordance with section 36(2) of the Nurses Act 1985 and the results of which were published in 1994 (An Bord Altranais, 1994a). This review made the following recommendations amongst others: that Colleges of Nursing should be established with links to third level institutions; that student nurses should be granted supernumerary status; and that a common core eighteen month programme for students of the four basic branches should be established. The Working Party Report (1980) recommended a similar common core programme of two years duration. Some discussion and debate about the implications of this document did occur in the literature (Begley, 1994). However the review was quickly followed some months later by the commencement of a Diploma in General Nursing programme offered by Galway University Hospital School of Nursing in conjunction with University College Galway. Subsequently, under the direction of the Department of Health (1997e) other hospital schools followed a similar programme. It is planned that by 1998 all basic registration programmes would be accredited by associated third level institutions and universities.

Whilst the merits of the Diploma programme, such as full student status for students and formal support in the clinical area, have been recognised there has also been criticism. Issues raised and recognised as detrimental to the production of a "knowledgeable doer" include the university taught component of biological and social sciences being concentrated into the first year (Chavasse, 1996), and students remaining in schools of nursing for most of their education (McCarthy, 1997). Nor does it appear that this Diploma programme complies with An Bord Altranais (1994a) recommendations with regard to an eighteen month common core programme for all branches. A full evaluation of the programme in Galway is being undertaken, the first such systematic evaluation of a basic nurse training programme.[2]

**Continuing Education**

Changes have occurred in the area of continuing nursing education. For nurses wishing to work in a specialist area within the general branch of the discipline, clinical nursing courses are available. These specialist programmes are approved by An Bord Altranais but are not registerable. A move towards awarding such courses a third level diploma has

[2] The Oncology Nursing Development Project by Furlong (1993) did study nationally *one* aspect of the general and sick children's nursing programmes, that of cancer care.

occurred in the past two years and is on-going. Examples of courses include accident and emergency nursing, theatre and anaesthetic nursing (Flynn, 1997), ophthalmic nursing, and palliative care nursing. The programmes are of six months to one years duration. On completion of these programmes the nurse works as a generalist *within* the specialist area. There is evidence of nurses organising and forming networks for professional development and education focusing on these medically defined specialisms: the Irish Society of Endoscopy Nurses was formed in 1985, the Irish Association of Critical Care Nurses in 1986, the Association of Nurses in Radiology in 1989, the Irish Association of Nurses in AIDS Care in 1991, and the Irish Emergency Nurses Association in 1996. Some groups have produced position papers with regard to their specialist areas, for example the Operating Theatre Nurses Section of the Irish Nurses Organisation (Irish Nurses Organisation 1994, 1996a).

**Specialist Nurses**

A recommendation from the Working Party Report (1980) was the development of specialist nurses. It did not specify the areas for specialist nurses but did mention three such areas – Stoma Therapist, Infection Control and Oncology Nurse. The Irish nursing literature indicates that a greater number exists: triage nurse (Wall, 1988) and emergency nurse practitioner (Small, 1997), oncology nurse specialists (Redmond, 1997), breast care nurse (Shanahan, 1997), diabetes nurse (Boland, 1995) asthma nurse (Donaghy, 1995). The author perceives that this might still not depict the full extent of specialist nurses employed. The literature indicates that the specialist nurse in some cases undertook research (Creamer, 1986; Creamer et al, 1992). Whilst most of the Irish literature concerning specialist nurses outlined the clinical and educational function, one paper (Boland, 1995) addressed the stress caused by a lack of role clarity. Achieving recognition for the role it is suggested may be assisted by organisations such as the Irish Diabetes Nurse Specialist Association formed in the 1980s; the Irish Association of Nurses in Oncology founded in 1982; and the Irish Breast Care Nurses Association which was established in 1996. Role diversification might also develop from within the previously discussed specialist areas. An example is that of a nurse being appointed the national transplant co-ordinator from the area of renal nursing. This role has become a specialist one with the nurse providing education and research (Cunningham, 1993). Role diversification is also evidenced by nurses undertaking data collection for the Cancer Registry or being appointed cardio-pulmonary resuscitation trainers.

**Diseases, Treatments and Nursing Roles**

Advances in patient treatments have occurred. The Irish nursing literature revealed papers on lithotripsy (Belton, 1990; Leahy, 1988); percutaneous transluminal coronary angioplasty (Stockwell, 1987); low-density lipoprotein apharesis (Toibín, 1989); the pelvic pouch (Fahey, 1988); patient controlled analgesia (McAvinia and O'Flaherty, 1995; Thompson, 1994); blood glucose monitoring (Coleman, 1994); endoscopic minimal access surgery (Lowry, 1996); transplant surgery (Connolly, 1995; Farrell, 1995; Looby, 1995). Whilst all of the papers discussed the impact of such treatments for the patient, most did not address their impact on the nurses role. Some of these treatments allow for outpatient or day-care treatment only. Others such as endoscopic surgery lead to shorter hospitalisation and earlier resumption of normal activity (Kent et al, 1995; McDermott and Gorey, 1994). One paper addressing the impact of technology on the role of the nurse

(Farrell, 1992) examined the issue from the theatre nurse's perspective and discussed briefly how technology increases the complexity of nurses tasks, and requires enhanced knowledge and a clear policy in relation to responsibility for care and maintenance of equipment. A second paper addressed the impact of new technology in five intensive care units in Dublin (McCarthy E., 1989). The findings revealed that inexperienced qualified nurses in some cases learnt "on the job" with regard to new technology. A need for ongoing training was identified to reduce stress associated with the integration of such equipment into intensive care areas. With regard to information technology McCarthy (G., 1995) shows that definitions, classifications, coding and computerisation of Irish nursing data is at a very early stage and Brennan (1996) calls for full consultation with nurses with regard to design of any future development of systems.

Changing patterns of acute hospital usage impact on nursing as does changing morbidity trends. Within the literature from the branch of general nursing the disease trends can be seen. With diseases of the circulatory system being the main cause of mortality in Ireland it is not suprising to find that Irish nurses have written about and researched topics such as the information needs of patients with regard to pacemakers (Fealy, 1989); coronary artery bypass graft surgery (Joyce and Mulligan, 1994); and cardiac catherization (Dowling and O'Keffe, 1991); pain assessment in myocardial infarction (O'Connor L., 1995); cardiac life support (Ryan, 1992); cardiac rehabilitation (Elliott, 1989; Ingram et al , 1996a) and cardiovascular risk factors in hospital personnel (Ingram et al, 1996b).

The National Strategy for Cancer Services in Ireland recognises the role of nurses in delivering cancer services (Department of Health, 1996a). Issues surrounding cancer have been the focus of a number of Irish nursing papers and research projects. Hayes (1996a) describes the development of palliative care nurse education in Ireland and how this relates to palliative care as a speciality within nursing (Hayes, 1996b). Fennell-Flood (1988) and Wright (1996) both discuss the application of hospice principles in non-hospice settings and Staunton (1997) describes the development of a palliative care team in an acute hospital. Redmond (1996) outlines the advances in supportive care for cancer patients and Kelly (1994) investigated the link between patient characteristics and nausea and vomiting in patients undergoing chemotherapy treatment.

Delamere (1995) outlines the development of an AIDS course. This commenced in Ireland in 1992 and by 1995, 107 nurses had undertaken the programme. Other nurses have undertaken U.K. based courses as evidenced by McCarthy's (McCarthy N., 1989) paper on advances in supportive care for AIDS patients. This disease has brought about a heightened awareness of such blood borne infections and has implications for nursing practice in relation to infection control measures (Flynn, 1989).

**Ageing Population**

The literature in Section 1.2 showed the demographic changes and some disease trends within Irish society which impact on nursing. For general nurses an ageing population means an increase in work in non-acute care of the elderly hospitals and residential settings such as welfare, voluntary and private nursing homes. An annual survey of these settings was initiated by the Department of Health in 1980. The figures for 1990 (Department of Health, 1995e) show a 91.6% bed occupancy with approximately a 2:1 ratio of female to male residents. One study (I.N.O., 1995) highlighted the need to review the skill mix and staffing ratios in such settings. The Health (Nursing Homes) Act 1990 aims to ensure a high standard of care in residential settings. Section 6 of the Act

empowers the Minister to make regulations with regard to the service provided in such nursing homes (O'Kelly and Ronan, 1994). The Nursing Homes (Care and Welfare) Regulations 1993 and the Code of Practice for Nursing Homes (Department of Health, 1995d) impact on nursing practice in such institutions. There have been various publications from the National Council for the Elderly such as Kelleher's (1993) position paper on promoting health in the elderly. However the Working Party Report on Services for the Elderly (1988) perhaps has the greatest implications for nurses. This report recommended a home nursing service, greater training for all nurses in anticipatory care of the elderly and a district liaison nurse to co-ordinate services for the elderly. From the literature there was evidence of implementation of some of these recommendations. An Bord Altranais (1994a) in light of such demographic features recommended an enhanced level of nurse education and training in care of the elderly. Educational developments have occurred with the commencement in 1996 of a Masters Programme in Gerontological Nursing from the University of Dublin. This literature search revealed a paucity of articles but some small scale research by nurses addressing this nursing area as its primary focus (Brophy, 1991a,b; Doyle, 1996; Karungula, 1991; Knowles, 1993; McTaggart, 1996; Mpanda, 1989; and Owens, 1989).

**Trends in Nursing Practice**

Irish nurses have undertaken research to explore ways of reducing exposure with regard to blood in operating theatres (Maher, 1992), an example of research-based practice. Other research-based practice examples include a number of small pilot studies looking at recording temperatures (Ui Chiardha, 1990), assessment of venous leg ulcers (Bell, 1993) and non-pharmacological methods of pain control (Ryan, 1991). Follow-up studies were not found in the literature. One case study undertaken examined how nurses use the research findings on continence promotion (Kevelighan, 1997). Unfortunately the findings highlighted that research utilisation is very difficult in institutional settings where there is efficient, routinised care. This finding may not augur well for nursing practice which may still be largely based on routine and ritual.

General nurses have faced change with regard to the delivery of care and litigation. Consumerism and quality was also found in the literature from this branch of nursing. McCarthy's (1992) study shows how measuring patient satisfaction can stimulate the exploration of change in nursing practice. Quinn and Redmond (1993) measured patient satisfaction prior to standards setting in critical care areas and relatives' satisfaction has also been measured (Quinn et al, 1996). The refocussing of the health service towards primary health care has implications for hospital-based nurses. The Health Promotion Strategy (Department of Health, 1995a) has identified nurses as one professional grouping who, through their direct contact with the public, will make a significant contribution to health promotion. One model for such involvement is through the Health Promoting Hospitals. A cautionary note is struck however, on analysis of the research findings regarding nurse's health promotion role in acute hospitals. Maume (1996) in a small study on student nurses in one such setting found that the workplace ethos was not considered conducive to health promotion activities. A more comprehensive piece of research by Treacy et al (1996) also found that the organisational structures and the culture of nursing can mitigate against health promotion practice by nurses. This finding is similar to earlier work by Treacy (1988) which suggested that nurse training militated against nurses developing a patient centred approach to care which included health education. Treacy et

al (1996) found that hospital-based registered nurses lacked awareness of health promotion and ascribed it to patient education. They lacked the confidence to undertake such a function and preferred that role to be undertaken by clinical nurse specialists whom they perceived had the time, knowledge and patient contact for such a function. A prescriptive approach was used in the nurse's unplanned health promotion activities. The curative nature of their work in the hospital setting means that the study concludes that their potential health promoting role is unharnessed. However, there was evidence in the literature of health promotion activities by nurses in an acute setting outwith the auspices of formal nursing structures (Honan-Croke, 1995). It might be suggested from these findings that a role of health promotion nurse specialist might yet evolve.

**Conclusion**

In conclusion, this branch of the discipline of nursing has faced many changes in the years since the Working Party Report (1980). Fundamental changes in education for this branch have occurred with supernumerary status for students and academic credibility for the pre-registration programme. The reviewed literature suggests a growth in the development of specialist nurses within this branch of nursing. The disease trends of the population are clearly demonstrated by the literature concerning general nursing as are the technological advances and strategic trends in the health service. One of the difficulties in describing the changing role of the registered general nurse is the diffuse settings in which these nurses work leading to the conclusion that they are not an homogenous group.

## 2.2 Sick Children's Nurses

Sick children's nursing was another basic branch of the discipline of nursing at the time of the Working Party Report (1980). Then, there were three centres offering a three year certificate programme which led to registration in sick children's nursing. There was also a four year integrated certificate programme leading to dual qualification as a registered general and sick children's nurse. Whilst there has been no EU directive on sick children's nursing the educational programmes have changed. As and from 1996 there was no direct entry into this branch of the profession as all three or four year programmes had by this time ceased. Rather preparation for this branch of nursing has now become a post-registration qualification. The rationale for this change has not been documented in the literature. Links with two universities (Trinity College Dublin and University College Dublin) means that registration programmes are now being awarded higher diplomas. There is also a 6 month, hospital-based, paediatric intensive care nursing course available. In 1996 there were 3,407 registered sick children's nurses (An Bord Altranais, 1997a). There was no evidence of this group of nurses organising for professional development; a sick children's section of the Irish Nurses Organisation is at present inactive.

Limited literature is available which discusses this branch of nursing. However, since sick children's nursing is an acute service it mirrors general nursing with regard to affecting trends. For example with technology, paediatric nurses have written about the effects of computerisation on their practice (Connolly, 1988). The fact that children's hospitals offering intensive care facilities are based solely in Dublin means that sick children's nurses have examined the need for a specialised transportation service for critically ill children (Justin, 1996). Since 1980 the effects of a falling birth rate with a speculated reduction in service provision have been offset by advances in maternity and neonatal

care with a fall in perinatal and infant mortality rates (Central Statistics Office, 1997). As such, more children are surviving with chronic problems. McCarthy (McCarthy T., 1996) examined how demographic trends and technological advances have impacted on the case-mix of one paediatric hospital. Cardio-thoracic surgery and oncology were used as examples. In the former there was evidence that procedures increased not just in number, but also in complexity; the average length of ICU stay rose from 3.37 days in 1981 to 9.7 days in 1993. In the latter the example of the procedure of Broviac catheter insertion showed that 116 were performed in 1993, using an average of 2.5 hours of operating theatre time, in comparison with zero in 1981. The paper did not address the implications of such changes on the nurse's role. A metabolic screening service is available and over 53,000 specimens were examined in 1993 (Department of Health, 1995e). Improvement in diagnostics means that metabolic conditions are being treated at an earlier stage. One paediatric hospital has plans to offer a one week, An Bord Altranais approved course, on metabolic disorders in the autumn of 1997.

Specialist nurse roles have developed such as the paediatric oncology liaison nurse (Hunt 1995). Cronin (1995 a,b) outlines the important role that such nurses undertake in the care of a dying child and reports on relevant research findings. Other paediatric specialist nurses, such as the cystic fibrosis nurse, also undertake research (Leen, 1993). Whilst the literature revealed these two types of specialist nurses the author contends that more may be in existence, for example cardiac liaison nurse, HIV nurse, dermatology nurse. While it is known that specialist sick children's nurses perform home visits it was not possible to quantify the level. Recognition of the necessity for sick children's nursing research is suggested by the employment of a nurse researcher on a one year, contract basis by a paediatric hospital in 1990 (Brady, 1998). However there was no evidence of publication of such work in the literature examined.

Since the 1980s there has been an increased emphasis on family care (Cronin, 1995b) with the expectation that parents and siblings become fully involved in the care of the ill child or infant. This means a change in role for the sick children's nurse with far greater educational and counselling skills required. Evidence of consumerism is also available. The Association for the Welfare of Children in Hospital (Ireland) was formed in March 1970. They have campaigned for child-friendly organisations and have initiated research into non-medical services available for children and parents in hospitals (O'Hare, 1984).

In conclusion, many of the trends identified in Chapter 1 have impacted also on the role of the registered sick children's nurse. The lack of visibility of this branch of nursing is worrying especially in light of its educational changes.

## 2.3 Mental Handicap Nurses

Another basic branch of the discipline of nursing is that of the registered mental handicap nurse (RMHN). There are 3,231 nurses registered in this division (An Bord Altranais, 1997a). Recent research (Department of Health, 1997c) showed that approximately 2,020 of these nurses are employed in the mental handicap service. The figure quoted is a reflection rather than true rate of RMHN employed as this was from a survey with a response rate of 82%. These nurses work in 605 centres which include special residential centres, community residences, day care centres and workshop/occupational training centres (Department of Health, 1995e). Clients in these centres vary in their position on the lifespan and severity of handicap continua. Mild, moderate, severe and profound are the four recognised degrees of mental handicap.

There have been no EU Directives affecting this group of nurses. However there have been changes in the syllabus with revised versions introduced in 1978 and 1992. The latter revision meant that forty weeks of theory was included in the programme. The course remains a three year certificate programme offered in five schools. An eighteen month certificate programme is also available for nurses already registered in general, psychiatric nursing or sick children's nursing. As and from autumn 1997, two schools will offer a Diploma/Registration programme in conjunction with the University of Limerick and University College Cork.[3] It is planned that in 1998 all programmes will be offered at diploma level. There is a National Application Centre which processes the annual entry to the certificate programme. This has been in existence since 1990. A six month behaviour modification, An Bord Altranais approved, certificate course is available post-registration. The evaluation of a course in behaviour therapy is given by McEvoy et al (1990). Some RMHNs cross branches to undertake education in palliative or gerontological care; others cross disciplines into Montessori teaching or occupational therapy. For professional development purposes, in the second half of the 1980s there was an Organisation for Nurses of the Mentally Handicapped. This has since ceased to function. An Bord Altranais hold an annual seminar for nurses registered in this branch and the Nurse Teachers in Mental Handicap Group hold a yearly conference for practitioners.

The concepts of deinstitutionalisation, normalisation and quality of life have underpinned policy making with regard to mental handicap service provision since 1980. This change in emphasis has implications for the nurses role, not just in the settings in which such care is provided but in the enhancement of the educational and management aspects of that role.

> Nurses who work with people with a mental handicap have a diversity of roles, from intensive physical nursing in a grossly handicapped individual to supportive guidance in the management and habilitation of children, adolescents and adults (An Bord Altranais, 1993, p. 1).

There has been a move away from custodial care to primary health care. This can be seen in the upward trend of availability of community residences from 136 (Kelleher et al, 1990) to 342 (Department of Health, 1995e). The policy documents signifying this development include the Green Paper on Services for Disabled People (Department of Health, 1983), Report of the Review Group on Mental Handicap Services (Government of Ireland, 1990), Shaping a Healthier Future (Department of Health, 1994a), and the Report of the Commission on the Status of People with Disabilities (1996). The Green Paper on Mental Health (1992) highlighted the inappropriate placing of people with mental handicap in the psychiatric service. A proposal for relocation was made by the Review Group on Mental Handicap Services (Government of Ireland, 1990) and endorsed in later documents (Department of Health, 1994a). Whilst the RMHN works in community settings there is however no domiciliary mental handicap nursing service even though a 9 month pilot course was run by An Bord Altranais in mid 1980s.

Community-based living has been studied by researchers (Kelleher et al 1990; Leane and Powell, 1992a) with regard to quality of life. Within the nursing literature normalisation has been addressed through personal accounts of providing holidays for adults with mental handicap (Mulholland, 1991; 1992); and there has been a pilot study which researched decision making by adults in community based residences (O'Halloran, 1996). Other areas of social development such as relationships and sexuality were not

[3] Two training schools were closed in 1987, St.Raphael's, Co. Kildare and John Paul II Centre, Co. Galway.

identified in the published literature. Community care has also been studied by nurses from the carer's frame of reference (Moloney, 1989).

Demographic changes influencing this branch of nursing include the increasing age of the client group (Department of Health, 1997f) and the increasing trend in numbers in the categories of greatest severity. This has brought an increase in medicalisation because of special needs at either end of the lifespan. Accelerated ageing is also a phenomenon frequently found in those with mental handicap. Whilst traditionally there was gender segregation of services and therefore personnel, this has been changing since the mid-1980s.

In the literature examined there was little evidence of research-based practice and no evidence of the development of a specialist nurse in this branch of nursing. The aforementioned behaviour modification course undertaken by some RMHNs points towards some specialist development. Changes in practice have occurred through therapy development for activation. Examples include music therapy, sonas and snoozelean[4] but nurses involvement in developing such changes was not signalled in the Irish literature examined. Interdisciplinary care of clients may lead to the blurring of professional boundaries and the use of auxiliary staff, especially in long-term care may lead to role erosion for the RMHN (IPA, 1997). Other disciplines involved in the care of clients include physiotherapy, occupational therapy, social worker, psychologist and special teacher. Education for clients is explored in documents from Departments of Education and Health and Social Welfare (1983) and Department of Education (1992, 1993). For nursing, one paper (Courell, 1997) highlighted the difficulties posed by acute hospitalisation of ill clients because of the lack of skills displayed by general nurses in this area of care. The Federation for Voluntary Bodies in Mental Handicap and the National Association for the Mentally Handicapped of Ireland act as the main pressure groups although smaller service specific groups exist mainly for fund-raising purposes.

In conclusion, this branch of nursing has faced conceptual and organisational changes in the past twenty years. From a sociological perspective it is perhaps unique in comparison with the other branches of nursing in regard to its lack of medicalisation. An analysis of this implication on the role of the RMHN would be interesting.

## 2.4 Psychiatric Nurses

Psychiatric nursing is another branch of the discipline of nursing. There are 9,799 registered psychiatric nurses (RPN) (An Bord Altranais, 1997a). This is the third largest register held by An Bord Altranais and males account for approximately one third of the number of psychiatric nurses registered.

In 1986 there was a change in the training programme for psychiatric nurses with subsequent discussion in the nursing literature (O'Brien, 1987, 1990). This change provided an opportunity for psychiatric student nurses to gain knowledge and experience in acute, long stay and community services; the inclusion of models of nursing into the curriculum; and a modular approach to training to reduce the theory practice gap. In the Eastern Health Board this change coincided with the amalgamation of the three training schools in the public psychiatric service. A further revision in the training programme occurred in 1990. Similar to the mentally handicap and sick children's branches there has been no EU Directives affecting this branch of nursing but 40 weeks of theoretical instruction was incorporated into the programme in the early 1990s. The three year

[4] Such therapies explore colour, sound and texture as media for interaction with clients.

certificate programme has one annual intake. A Diploma/Registration programme commenced in 1995 between the Western Health Board and University College Galway. This development continues with other psychiatric schools of nursing in conjunction with other universities and third level institutions offering a similar programme. There are a number of An Bord Altranais approved specialist programmes specifically available for RPNs including a forensic psychiatric nursing course, behavioural therapy course, and a child and adolescent psychiatric nursing course. These are described as "hospital certificate courses" (An Bord Altranais, 1997a). An Bord Altranais organises an annual psychiatric nurses seminar.

The concepts of deinstitutionalisation, normalisation and quality of life have underpinned policy making with regard to psychiatric service provision since 1984. The documents underpinning this move include Planning for the Future (Department of Health, 1984), Green paper on Mental Health (Department of Health, 1992), Shaping a Healthier Future (Department of Health, 1994a), White Paper – A New Mental Health Act (Department of Health, 1995f). The latter White Paper was produced to bring mental health legislation in line with the European Convention on Human Rights. It has not been enacted. The current legislation governing the psychiatric services is the Mental Treatment Act 1945 and subsequent amendments. These policy and legislative documents have advocated a comprehensive community service across the needs and lifespan continua and with the necessary legislative backing and integration with other health services. Some discussion was generated initially in the nursing literature in response to this development (Ryan, 1985). Statistics (Department of Health, 1995e) show the decreasing trend in hospital in-patients with alcoholic disorders, schizophrenia, depressive disorders and mania being the main reasons for admission. There is a corresponding increase in the availability of day facilities and residences although there is a variation between health boards in providing these facilities. Unlike the mental handicapped service domiciliary psychiatric services are provided in the form of the community psychiatric nurse. Educational preparation for such community-based work has been questioned in a small study by Burke (1995) who raises the issue of a lack of systematic evaluation of basic training programmes as a preparation for community orientated care. Some post-registration education was made available in the 1980s by An Bord Altranais, and the Eastern and North Western Health Boards in response to this primary health care initiative but no evaluation of those programmes was published and the programmes were not continued.

Community-based living has been researched by nurses (Cusack, 1994) and non-nurses (Leane and Powell, 1992b) with regard to quality of life. A positive response with an increase in general life satisfaction was found by both studies. Social integration into the local community was not found in the former study (Cusack, 1994). The community psychiatric nurse service has also been an area for research. Tracey (1994) identified the need for such a service in geographical location previously without; Cunningham (undated) examined one such service in rural Ireland; O'Brien et al (1997) showed how the service of a home care psychiatric team reduced admissions and length of stay in the psychiatric hospital for that catchment area; and McTiernan and McGonagle (1988) describe the establishment of an outpatient Anxiety Management Programme.

In light of these changes and others, such as advances in medication and therapies, the role of the psychiatric nurse has evolved. A comprehensive study examining the role of the psychiatric nurse in clinical practice has recently been undertaken (Cowman et al, 1997). On the basis of Irish documents reviewed for that study Cowman et al (1997)

proposes that "the role of psychiatric nurse has moved from one of therapeutic assistant to one of central importance in the multi-disciplinary team" (p19). The study's findings highlighted the wide-ranging role and skills of the psychiatric nurse. Importantly, findings included how caring interactions are central to the psychiatric nurse's role and how such interactions are maximised by the constant presence of the RPN; how RPNs play a significant role in crises management; and how the RPN has a co-ordinating role in patient care. This study calls for appropriate legislation and professional guidelines to support the RPN in the light of changes in practice and patient care settings. Specialist areas of practice in psychiatric nursing include addiction and bereavement counselling; behaviour, cognitive and psychotherapy and family therapy. Evidence of the existence of some such specialist nurses is available in the Irish literature (Butcher, 1993; McGlynn, 1986). The educational profile in the appendix of Cowman et al's study (1997) suggests that, alongside these specialisms, complimentary therapies, such as aromatherapy, may also be extending into psychiatric nurse practice. The issue of role erosion was not addressed by the literature.

In common with other parts of the health service, voluntary support and pressure groups exist which focus on the psychiatric service. They include the Mental Health Association of Ireland (M.H.A.I.), the Schizophrenia Association of Ireland, AWARE and GROW. The literature did contain an example of the work of one such organisation in Casey and Glanville's (1986) description of the M.H.A.I.'s work in setting up a health promotion programme entitled "People under Stress". Other policy documents have implications for the service and by extension the psychiatric nurse. These include the National Task Force on Suicide (Department of Health, 1996e) and the National Alcohol Policy (Department of Health, 1996d).

In conclusion, this branch of the nursing discipline has faced conceptual changes over the past two decades with subsequent evolution in role.

## 2.5 Midwives

With the proud history of being the first country in Europe to provide institutionalised maternity care Irish midwifery has had to struggle to maintain its identity vis à vis obstetrics (Kiely, 1992). Midwifery strength in providing a domiciliary service has diminished greatly. This is particularly relevant when viewed in the context that, in 1993, 99.7% of births occurred in consultant-led units (Department of Health, 1996g). This is a statistic borne of policy recommendations (Comhairle na nOspidéal, 1976; Eastern Health Board, 1984) but which hides the midwives input. O'Dwyer and Mulhall (1997) claim that more than 75% of all deliveries are conducted by midwives. Whilst there are 14, 393 registered midwives (RM) in Ireland (An Bord Altranais, 1997a) not all of those who are registered are in practice. The requirement for a midwifery qualification for public health nursing and its employment enhancing value, especially with regard to some of the rural hospitals, meant that in the past many nurses undertook midwifery training for reasons other than to practice as a midwife. Since the 1985 Nurses Act "Notification to Practice as a Midwife" is no longer required for midwives working in maternity hospitals.

### Midwifery Education and Training

Changes have occurred in the education of midwives since 1980. Adoption of EU directives 80/154/EEC and 80/155/EEC (Ammended 89/594/EEC) which provided for mutual recognition of midwifery qualifications between member states resulted in the

extension of the training programme from 1 to 2 years duration and changes in clinical experience and syllabus. The directive 80/156/EEC set up an Advisory Committee on the Training of Midwives. This Committee has issued the recommendations III/D/1933/2/85-EN, III/F/5269/4/88-EN, and III/F/5122/4/90. An Bord Altranais as the statutory registration body ensures compliance with these recommendations. A further development occurred in 1995 when University College Dublin in conjunction with the National Maternity Hospital and the Coombe Women's Hospital commenced a Higher Diploma in Midwifery in concurrence with those hospitals' midwifery registration programmes. This has subsequently been followed by other schools making similar arrangements with associated universities/colleges. A Masters in Midwifery programme is to commence in the autumn of 1997 in the University of Dublin.

Organisation for professional and educational development can be seen in the activities of the midwifery section of the I.N.O., the establishment of the Midwives Association of Ireland and seminars organised by An Bord Altranais. The effects of education can be seen in the literature with midwives awareness of the need for research-based practice being evident. Work published includes midwifery research in the areas of episiotomy (Begley, 1986; Begley 1987); the third stage of labour (Begley,1989; Begley 1993); health education in relation to alcohol in pregnancy (Lynch G., 1993); breastfeeding (Begley, 1991; Clarke, 1996; Lynch C., 1993); abdominal palpation of the fetus (Millar, 1996) and antenatal preparation for epidural anaesthesia (Smith, 1987). Midwives also collaborate in obstetric research (e.g. Stronge et al (1996)) some of which examine routinised practices which are viewed as not being "woman-centred", such as rectal examinations to assess the progress of labour (Murphy et al, 1986).

**The Role of the Midwife**

The Working Party Report (1980) differentiates the midwife's role from that of other nurses because

> the midwife, in the vast majority of cases, cares for normal healthy women during a normal physiological function and, to a greater extent than any other professional nurse, she has a degree of clinical responsibility and independence of action (p.50).

The establishment of midwives clinics in some maternity hospitals underlines this independent role. For example the National Maternity Hospital's midwife clinic was established in 1984 and midwife clinics are also available in the Rotunda Hospital and St. Munchins Regional Maternity Hospital, Limerick. However one study (McCrea and Thompson, 1995) examining the midwife's role with regard to hospital in-patients, which included the women undergoing normal physiological processes, found that whilst midwives perceived themselves to have total responsibility for the tasks they undertake, the medical staff "claimed "ultimate" responsibility for all care" (p.501). The fact that technical tasks prescribed by doctors were perceived as part of the midwife's "normal role" led the authors to query whether the obstetric nurse concept was being accepted. Such a finding would illustrate the medicalisation of childbirth and the institutionalisation of maternity care. In response women as consumers of such services have demanded changes. This can be seen in the establishment of pressure groups such as the Irish Association for Improvements in Maternity Services in 1979, the Home Birth Centre in 1982, and Ciudiu – The Irish Childbirth Trust in 1984.

One such change is the issue of domiciliary births the case for which has been "forcibly made" (Department of Health, 1997a; p 31) and written about (O'Connor M., 1995). Lynch (1997) shows that there is an upward trend in home births. In 1992, 44 home births were recorded by the Central Statistics Office (0.16% of total) (Home Birth Centre, 1996). In 1993 this rose to 196 domiciliary births (0.4% of total) (Department of Health, 1995b)[5]. A more recent large survey (Wiley and Merriman, 1996) found that 14% of women who did not give birth at home would have liked to have done so. The legislation governing domiciliary midwifery is found in the Health Act 1970. Section 62 of this Act charges the health board with providing medical, surgical and midwifery services to women but its primary focus is to offer maternity services by general practitioners to women in the community. This is commonly known as the Maternity and Infant Care Scheme. In 1993, 26,683 women availed of antenatal care and 24,021 women availed of postnatal care under this scheme (Department of Health, 1997e). The results of a review of the scheme were recently made available (Department of Health, 1994c). Only one midwife is employed by a Health Board[6] to provide a service to women choosing domiciliary care. Other midwives are independent private practitioners with approximately 14 in practice (Lynch, 1997). The Review Report (Department of Health, 1994c) recommended that payments to these midwives should be examined as the health board's payment did not cover the midwife's fees and so could inhibit women from availing of the scheme. Lynch (1997) outlines this discrepancy. Independent midwives charge £500 to £1,000 per delivery according to the Home Birth Centre (1996). There is a range of payments available – £400 (Eastern and North Eastern Health Boards), £250 (South Eastern Health Board) to the Department of Health recommended fee of £26 (Western Health Board). The latter however is only applicable to salaried Health Board personnel who attend home births in addition to other duties. Criticism that An Bord Altranais (1994c) Guidelines for Midwives provide insufficient scope to monitor and deal with domiciliary midwifery is recognised (Department of Health, 1995a), although the basis for such criticism, under Section 57 (2) of the Nurses Act 1985, may rest with the lack of Ministerial regulations with regard to this matter. Lynch (1997) states that "regarding home births the role of the PHN as a practising midwife is not common except in rare occasions in rural parts of Ireland" (p. 35). The Department of Health (1997a) is committed to establishing pilot schemes "to test both the hospital-based and the community-based approaches to supporting women who choose to have their babies at home" as recommended by the Review group (Department of Health, 1994c; p. 32). The implications are that some midwives may combine practice in both hospital and community settings.

Currently in the post-natal period Public Health Nurses (PHNs) have a statutory obligation to visit the mother and baby. In one area this is supplemented with a postnatal home midwifery service. This service is offered by St.Munchin's Regional Maternity Hospital to women domiciled within a set radius of the hospital. A similar service was offered by the National Maternity Hospital until budgetary constraints forced its cessation in 1988. Midwifery care under EU directive 80/155/EEC includes care in the postnatal period. Women are discharged home two or three days post-delivery with the resultant deskilling of hospital-based midwives in post-natal care which is normally deemed to be six weeks. The Public Health Nursing Review (Department of Health, 1997d) outlines

[5] This figure differs from that in the Perinatal Statistics for 1993. On discussion with the Information Unit, Department of Health and Children it was felt that this figure (n = 196)was a provisional figure from the Central Statistics Office. A C.S.O. provisional figure of 206 domicillary home births for 1996 was given in that discussion.

[6] Western Health Board.

how a cumbersome birth notification process may delay the Public Health Nurse's visit by some days or weeks and so the handover of a mother and infant's care from one midwife (RM) to another (PHN) is variable. This critical time of adjustment has been the focus for some small scale research (Carroll 1991; Coleman, 1989; Kennedy, 1990). These studies varied in their methodology in relation to size and type of sample and their data gathering method. However they did identify that formal support services, either by RMs or PHNs, would benefit women at this time. The Department of Health (1997a) recognises this need but falls short of specifying home visits by professionals in stating

> expanding the support available for mothers of newly born children, some of whom experience great stress, through the home help service, support for mother and baby groups, community mothers programmes, information, advice and counselling (Department of Health 1997a, p. 33).

Voluntary groups do offer some support such as La Leche League, the Caesarean Support Group and the Post-Natal Distress Support Group (Kiely, 1992).

**Technology, Trends in Practice and Specialist Midwives**

Other changes have occurred which impact on the hospital midwife. Midwives have written about computers and midwifery (Kelly, 1988). In one maternity hospital, midwives as end-users, have been seconded from clinical areas to the Information Technology Department for designing and implementing information systems (Carroll et al, 1996; Lavin et al, 1997). Carroll et al (1996) claims that "the midwifery profession is well placed to produce Techno-Carers who will stand as equals with the knowledge workers of the future" (p.881). Other technological changes have occurred, for example cardiotocography, which have extended the role of the midwife. An increase in demand and availability of epidural analgesia as a means of pain relief in labour has impacted on the midwives practice and role. Epidural use has reduced the labouring woman's sensation and mobility with resultant potential problems requiring prevention. Maintenance of the epidural infusion, whilst remaining the responsibility of the doctor, is in fact undertaken by the midwife (An Bord Altranais, 1994c). Depending on individual hospital policies, midwives in the past twenty years may also have undertaken obstetric tasks such as artificial rupture of membranes, perineal suturing, and intubation of the newborn, thus extending their role. Advances in infertility treatments (Fawzy et al, 1996) has increased the rate of multiple births with sequelae of prematurity and other problems. Advances in technology and treatment have resulted in greater survival rates with viability occurring at earlier gestational age (Clarke, 1995). Neonatal intensive care is also required for other babies such as those of very low birth weight (Clarke, 1995). O'Shea (1991) outlines some potential problems that the technology itself can produce in these babies. Some midwives have changed the environment in which they practice to that of neonatal intensive care and have undertaken post-registration courses in order to enhance their education and practice in this area. Other specialist roles for the midwife have been developed. Lactation consultants, bereavement counsellors, and midwives performing ultrasonography are some examples of specialists working in Irish maternity care. The midwife's role in ultrasonography as part of the work of a Fetal Assessment Centre is detailed by McCarthy-Mannion (1994). No other literature on midwifery specialists from an Irish perspective was found.

## Litigation

Litigation is also a trend in maternity care which, in some cases, may change practice. An example is William Dunne v The National Maternity Hospital and Dr J. whereby the policy for fetal monitoring of labour in a multiple pregnancy has subsequently altered. In the course of the proceedings of this case Chief Justice Finlay laid down the principles of medical negligence. The institutionalisation of childbirth means that vicarious liability occurs. Hospital-based midwives work within a regulated environment. However domiciliary midwives do not and therefore leave themselves exposed to litigation proceedings. The Nurses Act 1985, Section 57 (2) places the onus on the Minister of Health to issue regulations for domiciliary midwifery by which the health board may supervise their actions but such regulations have not been made. Perhaps in response to increasing litigation as well as the influence of pressure groups consumer satisfaction with maternity services continues to be an area of research (Johnson, 1987; Bosio et al, 1996; Wiley and Merriman, 1996).

## Demography and Policy

Demographic changes have implications for maternity care and midwifery practice. Figures from the Central Statistics Office (1997) show that the fall in birth rate to 1994 has been arrested with 1995 and 1996 figures showing the start of an upward trend. The concept of the family is also changing. The average number of children per family is now 1.8; there are greater numbers (38%) of primigravid women i.e. first pregnancies resulting in a live birth; increasingly married women are postponing starting families (average age now 30 years at first birth); for single women this trend is reversed and 1996 saw 46 births to mothers of 15 or less years (C.S.O., 1997). Disease trends also impact for example heroin addiction and hepatitis. Many of these women and their babies require greater support, care and treatment. Nevertheless, within the period under review changes have occurred in maternal and infant mortality rates. Maternal mortality declined from 0.25 per 1,000 live births in 1971 to about 0.06 in 1985 and 0.04 in 1992. Infant mortality declined from 30.5 per 1,000 live births in 1961 to 8.9 in 1985 and 6.6 in 1992 (Government of Ireland, 1994). Changes have also occurred in the demography of the Irish midwifery profession itself. Mulhall (1995) states that five male midwives registered with An Bord Altranais between 1985 and 1995. This represents 0.02% of the total midwifery profession, although numbers of men practising as midwives may be less.

Policy reports from the Department of Health also influence changes. The Health Promotion Strategy (1995a), whilst acknowledging women as a priority population group, focused mainly on issues of maternal health; an area where midwives have a large health promotion role. The National Breastfeeding Policy (Department of Health, 1994b) outlines recommendations for the promotion of breastfeeding in hospitals and the training of health professionals. In response, a number of breastfeeding protocols have been developed by individual maternity hospitals (Department of Health, 1997a). The Women's Health Plan (Department of Health, 1997a) has implications for maternity services and, by extension, midwives. The family planning service of maternity hospitals/units, is to be evaluated (Department of Health, 1995c). This would seem to be important as an early study by Byrne (1989) carried out in one Community Care Area in Dublin found that 40% of women were not offered family planning information during their pregnancy and postpartum hospitalisation. The potential for the midwife in this area was identified.

**Conclusion**

The Department of Health (1995b) gives midwives the following recognition–

> Midwives, as the profession which is responsible for the care of women in normal labour and childbirth, have a particular responsibility to recognise the changing aspirations of women in relation to childbirth and to facilitate an appropriate response to that change (p. 35).

Such onerous responsibility should be viewed however in the light of a number of issues highlighted in this review. These include consumer perceptions and expectations, technology, specialist roles and responsibilities, litigation, demography and policy changes.

## 2.6 Public Health Nurses

The principle nurse providing primary health care in the community in Ireland is the public health nurse. This service has been described as complex and hidden (Chavasse 1995) although it is the single largest professional grouping in community care (NESC, 1987). Historically it has developed from an amalgam of community services (Scanlan, 1991; Mansfield, 1995) to offer a preventative and curative service across the lifespan. There are 1,853 registered public health nurses in Ireland (An Bord Altranais, 1997a), 1,222 of whom were employed in May 1996 (Department of Health, 1997d). At present these are all women as under the 1970 Health Act the Health Boards are responsible for providing a midwife for home births if demanded by an individual woman. A prerequisite to undertake the Public Health Nurses Course is registration as a midwife. Thus as a midwife, a public health nurse could attend such a confinement. Until recent times male nurses did not undertake midwifery training and by extension public health nurse training. Thus at present public health nursing is a female service. The Public Health Nurses are employees of the eight Health Boards and are divided into three grades. The Superintendent Public Health Nurse has an overall administrative role within a defined area. The Senior Public Health Nurse grade was created in 1981 and acts as a front line manager with a catchment sector of approximately 30,000 population. The Public Health Nurse acts as a field worker with a geographical area of between 3,500 and 5,500 people (Mansefield, 1995). From the literature Chavasse (1995) outlines some of the difficulties at the interface between the present structure and other primary health care services. For example eligibility for services is not always clear as Health Boards have discretionary powers about the provision of some services. The independent nature of the general practitioner services does not encourage the growth of multi-disciplinary teams. Mansefield (1995) states

> The introduction of the choice of doctor scheme in 1970 means that the patients the Public Health Nurse deals with in her geographical area could be attending a variety of general practitioners. This increases the workload of the Public Health Nurse as it requires her to liaise with so many doctors. Understandably, each doctor expects his patients to receive priority thus creating difficulties for the Public Health Nurse in balancing her responsibilities to all her clients. This situation is compounded by the priority the doctor puts on the curative mode of treatment whilst the nurse's primary function is prevention. A further tension is created by failure of the general practitioners to recognise the Public Health Nurse's responsibility to other groups such as vulnerable families, local community groups etc. The doctor/nurse link is the key relationship for patient centred care. However, the current structure of the general practitioner and Public Health Nursing Services mitigate against such co-operation (O'Sullivan, 1995).

## Public Health Nurse Education

Developments have occurred in the education of Public Health Nurses. In 1980 An Bord Altranais had responsibility for their education and training. However in 1987, University College Dublin commenced a one year Diploma in Public Health Nursing the development of which is described in the literature (Chavasse, 1991). An equivalent course has been available in University College Cork since 1994. There is also evidence of organising for professional and educational development with the formation of the Institute of Community Health Nursing in 1985 and its subsequent activities (ICHN, 1995). The effect of education can be seen in the literature which demonstrates PHN's awareness of the need for research-based practice. Examples of changes in practice found in the literature included the public's perceptions of immunisation (Breslin, 1987) and changing methods of treating leg ulcers (Diamond, 1990). Registered Public Health Nurses have also been to the forefront when initiating innovative health schemes for example the Early Childhood Development Project in 1981 (Martin, 1986); the Community Mothers Initiative in 1983 (Molloy, 1986; Lloyd, 1993); community involvement in setting up an elderly day-care centre in a rural area (O'Grady, 1996); a Womens' Self-development Course (McAuliffe et al., 1988); and needs assessment of informal carers (Syron, 1995).

## The Role of the Public Health Nurse

A Ministerial Circular (27/66) describes the duties of the PHN. This acts as a useful baseline measurement for future reports, documents and articles addressing the development of the PHN's role and functions (Burke, 1986; Department of Health 1975, 1986a; Hanafin, 1997; Institute of Community Health Nursing, 1992; O'Sullivan, 1995). The services provided by the PHNs are outlined in the recent Review document (Department of Health, 1997d). They include the following: antenatal and postnatal services, child health services, services to the elderly, to ill and dependent people, to the travelling community, and to people with disabilities. Thus the service is a generalist one with many distinct client groups. The service has also undergone further developments and extensions. For example extension of the twilight nursing service countrywide to people with disabilities and ensuring that the community nursing service has the capacity to provide for people with disabilities are two of the recommendations of the Review Group Report on services to people with physical and sensory disabilities (Department of Health, 1996f). Mansfield (1995) describes the reactive ad hoc development of a diffuse role. This is reflected in PHN's perceptions of a lack of clarity of role, unclear boundaries in caseload and problems with total community health service co-ordination (O'Sullivan, 1995). Lack of clarity of role can be found in a home visit analysis survey (Kelly, 1987) of one health board area which showed that PHNs are engaged in such activities as organisation of electricity and water mains connections for patients and arranging financial and social support for "at risk" clients. Perhaps this may be due to the lack of support services especially in rural areas as claimed by McCarthy (1997).

Legislation has impacted on the role of the PHN in the form of the Child Care Act 1991 and has been discussed at National Conference level (McCarthy K., 1995). The literature reflects that the PHN has a role in implementing such legislation as well as local guidelines (Molloy, 1988; Kelly, 1995; Department of Health, 1997d). One perceived difficulty is the dichotomy of implementing such functions in the social control aspect of child protection whilst preserving a traditional caring image and gaining access to client homes. This is felt to such an extent that one group of PHNs argued for social workers to

be responsible for the bulk of such work (Butler, 1996). However whilst Kelly (1995) called for an active embrace of the legislation by PHNs, she recognised other difficulties posed in its execution for PHNs including a lack of a defined caseload and clear policy statements on inter-professional management of such cases. The recent public health nursing Review document (Department of Health, 1997d) whilst acknowledging some of these concerns calls for a continued multidisciplinary approach with shared training of professionals in this area.

A recommendation in the Working Party Report (1980) and from the Commission on Health Funding (1989) was the employment of registered general nurses to provide a home nursing service thus allowing the PHN to concentrate on a preventative role. Fears of role diminution and recognition that this could fragment the holistic approach to client families that the PHN provides (Barron, 1991) meant that this development has not always been welcome. The preservation of the generalist role (O'Sullivan, 1995) with a smaller caseload (McDonald, 1993) would seem to be the preferred solution. However whilst the employment of registered general nurses has occurred it is only on an ad hoc and temporary basis. The Review document (Department of Health, 1997d) recommends integration of the RGN into the community nursing team structure under the management of the senior public health nurse. Role erosion occurring from paramedical sources appears not to have engendered a hostile response. The Review document suggests that the appointment of physiotherapists and occupational therapists has reduced the PHN's role with regard to equipment provision. Role extension may also be occurring with the early discharge of patients from acute services. Furthermore a recent document from the Department of Health (1996b) acknowledges and recommends development of the expanding role of the PHN in administering cytotoxic therapy for cancer treatment.

Chavasse (1995) outlines how the description of the generalist PHN role is at the micro level of the individual and that a policy shift (Department of Health, 1994a) towards increasing community participation has occurred. McDonald (1993), surveying a non-representative sample of public health nurses, reported that 60% of PHNs reported the experience of working with the "community as client" but saw size of caseload as one of the main barriers to working at the macro level. A published summary report of this work is given in McDonald and Chavasse (1997). Individual projects such as the Jobstown Integrated Development Project (JIDP., 1996), and the Pavee Point Initiative for the travelling community (Pavee Point and Eastern Health Board, 1995) are available as examples of this approach. According to Chavasse (1995) four developments are required for the policy of community participation to impact positively on public health nursing. They are

> smaller case loads, a management system which supports and empowers the nurses, in-service education for PHNs currently in practice, and an educational programme which, along with specific nursing abilities and knowledge, develops political skills and greatly enhanced self confidence (Chavasse, 1995, p. 7).

**Consumerism and Specialism**

Awareness of consumerism has been extended to public health nursing. Hickey's (1990) study examined the satisfaction of clients in relation to the child health service of the PHNs in one Health Board. This study found that almost half (47%) of the mothers surveyed were dissatisfied with the number of home visits received and that a majority (72%) indicated a need for more frequent visiting in the first three months following

their child's birth (See section 2.5, Registered Midwives). The trend towards increasing specialisation has also impacted on public health nursing. For example, specialist services such as a Continence Advisory Clinic (Lee, 1986) and an Enuresis Clinic (Hanafin, 1993) have been developed by PHN. Other specialist roles may result from policy decisions such as the recommendation that each Community Care Area should identify a PHN with expertise in breastfeeding to act as resource person and provide on-going support and in-service training to colleagues (Department of Health, 1994b). Some PHNs have diversified into other community health roles such as working with drug abusers (Stephens, 1992). Heath's (1996) study showed that PHN strongly favoured the move to develop specialists from within their own service rather than extending specialist services from the hospital. Factors given for this decision include problems with co-ordination of services, confusion for clients and professionals, hospital-based nurses' lack of community experience and erosion of the PHN's role. These challenges are already being faced as the discussion on primary health care in chapter one demonstrates.

### Conclusion

In conclusion, the PHN, providing a generalist service in the community, works in a system with load diversity and limited resources (McCarthy, 1997). Hanafin (1997) claims that the interdependency of the three functional areas of the public health nurse, that of manager, clinician and health promoter, enables a comprehensive service to be delivered. However, it appears that the generalist nature of the service is under threat from specialisation and expansionary pressures. The public health nurses' role merits consideration as to whether a generalist type role remains appropriate.

## 2.7 Nurse Tutors

The registered nurse tutors (RNTs) are the smallest branch of the nursing discipline. In 1996 there were 371 registered (An Bord Altranais, 1997a). This does not reflect the number in practice. McCarthy (1997) claims that the wastage of nurse tutors to nurse administration has been considerable and Garrigan (1995) in a study focusing on general nurse teaching only, found figures suggesting that nurse teachers who have qualified in the last ten years do not remain in hospital-based nurse education. From earlier figures (An Bord Altranais, 1991) it can be seen that the nurse teacher group is an ageing one with 34% over the age of 50 years. Within the time frame of the report it was not possible to obtain recent statistics with regard to this issue. Teachers are found in thirty-seven schools of nursing and seven schools of midwifery (An Bord Altranais, 1994a) and are increasingly found also in universities and other third level institutions. Males are over-represented in the general nurse teaching group. Garrigan (1995) shows how 13% of general nurse teachers are male in comparison with 4% in the total general nurse population and 6.5% of the total nurse population. This suggests that vertical gender segregation may be occurring in general nursing.

### Nurse Teacher Education

In 1980 nurse teaching was not a popular career choice for nurses due to economic and role issues (McGowan, 1979; Working Party Report, 1980). In common with other nurses, the nurse tutor was a generalist. There were two tiers of teachers. Until 1976 nurse and midwifery tutors were prepared for classroom teaching only and their small numbers

meant they did not teach in the clinical areas. The Working Party Report (1980) claimed a ratio of 1:40. A theory practice gap was evident. In response to this problem a second grade of teacher was introduced, the clinical nurse teacher (RCT), with specific responsibility for teaching in the clinical areas. However, with poor teacher:student ratios and increasing workload this grade was subsumed into skills teaching in the classroom. The Working Report Party (1980) recommended the abolition of the Registered Nurse Clinical Teacher grade and allowance for the nurse teacher to specialise within the syllabus. Whilst the former was achieved by the cancellation of the 6 month clinical teachers course, the latter has never been evaluated. Under the new Diploma programme formal support for pre-registration students in the clinical area is to be provided by the introduction of a Clinical Placement Co-ordinator (Department of Health, 1997e). Whilst the primary function of this grade of nurse is to maximise learning opportunities for students there are fears that the role may develop into that of the traditional clinical teacher. No such provision exists for similar student support in midwifery or sick children's training.

Other developments have occurred over the years in the education of nurse teachers. In 1984 the two year Nurse Tutor Diploma was extended to three years and awarded a Bachelor of Nursing Studies from University College Dublin. This was the first nursing degree in Ireland. The curriculum included supervised teaching and research and was designed to enable "experienced registered nurses and midwives to teach in the classroom and in clinical areas, and to manage nursing education" (Anon., 1990). In 1993 An Bord Altranais (1994a) surveyed the teachers in the approved training schools to assess the graduate status of the teaching population. At that stage, 86 were undertaking or held a Bachelors degree; a further 19 were undertaking or held a Masters degree. Whilst there is no quantitative analysis of the situation at present, in the author's personal experience these figures have continued to grow rapidly as in response to the changes occurring in nurse education many teachers recognise the need for higher degree level qualifications. Support from management, in the form of finance and study leave, is variable between and within institutions. Likewise the nature of the higher degrees taken by nurse tutors is unknown. The author knows of nurse tutors who are undertaking or have completed Masters programmes in nursing, education, management, management and training, organisational behaviour, women's studies, equality studies, and physiology. This is in contrast to the philosophy of An Bord Altranais (1997) where a possible professional pathway for nurse educators (as opposed to nurse tutors or teachers) is narrowly specified as through higher degrees in nursing only. However Masters in Nursing and Midwifery programmes have only recently become available. The nurse teachers have also organised for professional development purposes. There is an active branch of the Irish Nurses Organisation which comprises of nurse teachers from general nursing, sick children's nursing, mental handicap nursing and midwifery branches of the discipline. This group has published the Future Directions for Nurse Tutors Discussion Document (INO., 1996b). In 1980, the Association of Nurse Teachers was formed, with membership (RNT and RCT) open to all branches of the nursing discipline. There is also an active Mental Handicap Nurse Teachers Group.

**The Role of the Nurse Teacher**

Obviously the educational developments in nurse education of the 1980s and 1990s have impacted directly on the role of the nurse teacher. All branches have faced educational changes (see each section in chapter two) although literature discussing how these changes have impacted on the role of the nurse teacher is minimal. This dearth in literature may be partially explained by examining the case of general nurse tutors. Whilst An Bord Altranais recommends a student:tutor ratio of 1:15, the actual ratio for general nurse training was 1:28 in 1990 (An Bord Altranais, 1991). Likewise unqualified personnel were working as nurse tutors – 14% in general training in 1990 (An Bord Altranais, 1991). Against this background the EU directive 89/595 EC was to be implemented. With less than twelve months warning the general tutors were to prepare new curriculum documents, plan twelve weeks of new curriculum content and prepare for changes in the registration examination structure. McCarthy (1994) states how

> The nurse tutors reacted with tremendous anger and even threatened industrial action. On this occasion the tutors used their political muscle to implement change. Through professional representation they sought and obtained appropriate financial resources to implement the amendment. Funding was made available to prepare extra nurse tutors over a four-year period, and in many schools of nursing capital has been allocated toward the development of the physical resources (McCarthy M., 1994, p. 5).

It should be noted that the new programme was to be operational before extra personnel became available and Garrigan (1995) claims that the numbers of additional teachers "did not correspond in any reasonable way with the increased workload experienced by nurse teachers" (p.23). Likewise before completion of this new three year apprenticeship programme the links with third level education were initiated and yet another new programme was to be implemented. At the same time, nurse tutors became anxious to upgrade their level of qualifications as previously discussed. It is suggested therefore that nurse teachers' energy and commitment were used to deal with these changes.

In this time one study did address part of the nurse tutors multifaceted role and that is the work of Garrigan (1995) examining the clinical teaching aspect of the general nurse teacher's role. The findings show that at the time of the study, teacher:student ratios ranged from 1:12 to 1:36 in general nursing. There was a statistically significant association between the Schools of Nursing with ratios of 1:20 or less and the likelihood of nurse teachers achieving a clinical component as part of their role. Variable amounts of time were spent on this aspect of the role with factors such as classroom commitment, workload, class preparation and marking papers identified as barriers to spending more time on this aspect of their role. The author postulates that affiliation with third level institutions will also reduce time available to attend to clinical teaching. Almost 60% of Garrigan's (1995) respondents reported stress associated with the role; factors such as lack of time and credibility were cited as stress inducing. The latter may reflect the high number (73.9%) wishing to regularly update and maintain their clinical skills. In light of the findings, Garrigan (1995) recommends that alternative organisational models for Schools of Nursing should be explored. A smaller study in psychiatric nurse education had similar findings (O'Brien, 1994). The literature examined does not address other facets of the nurse teacher's role. However in reviewing the Irish literature there was evidence found of nurse teachers researching their own practice in the classroom (Cowman, 1995; Kearns, 1996);

nurse education in the clinical area (Flannagan, 1996; Landers, 1996); and exploring (Donlan and Ryan, 1986) and evaluating (Fealy, 1994) teaching/learning strategies in programme development. There was also evidence of nurse teachers assessing computer packages as learning tools (Creedon, 1997; Harvey, 1988) and syllabi (O'Connell and Redmond, 1988). Recognition that nurse teachers may have learning needs themselves was identified by Furlong (1994) as part of the Oncology Nursing Development Project.

Through the interpretation of An Bord Altranais Rules, 1988 (An Bord Altranais, 1994d), the Directors of Nursing or Midwifery maintain ultimate responsibility for student education. The Principle Tutor thus has a reporting relationship to the Director of Nursing or Midwifery. Calls and recommendations have been made to introduce a Director of Nurse Education post which would break this tradition and would be of complementary status (Working Party Report, 1980; I.N.O., 1996b). However, whilst in two schools the Director of Nurse Education or Principle Tutor reports directly to an Educational Board or Committee, in the vast majority of Schools this has not been achieved. In practice, research (Quinn, 1990) has found that the Principle Tutor was identified as both the actual and ideal decision-maker in Irish Schools of Nursing and Midwifery. Autonomy for nurse and midwifery education would give this situation formal recognition.

### Conclusion

McCarthy (1997) reviews some of the aforementioned developments and states

> There is a possibility that two types of teachers of nursing will now evolve. Firstly, those based in the schools of nursing and secondly those in academic departments, with different terms of employment and responsibility. Careful consideration needs to be given to developing joint appointments between the nursing and education services, and between hospital schools and university nursing departments. (p. 180).

The issue of the introduction of the clinical placement co-ordinator as another nurse educator is also threatening usurpation of the RNT role. In conclusion consideration is required to investigate whether a generalist role still exists or is appropriate for RNTs. Also the present relationships between RNTs and other nurse educationalists and nurse management merits examination with a view to directing the future development of the RNT role.

## Summary

Chapter two examined literature pertaining to each branch of the discipline of nursing. The review has shown that all divisions have undergone changes since 1980. The factors outlined in chapter one have impacted on the nurse's professional role throughout the period.

The move to academic education for public health nurses and nurse tutors in the mid to late 1980s was followed for all branches from 1994 onwards. This education gives diploma, higher diploma and degree recognition to nurse education programmes. The planned implementation of supernumerary status for student nurses on pre-registration programmes has given greater recognition to student's educational needs as opposed to the "apprenticeship" model where in practice, service needs were paramount. The apprenticeship model remains however in the post-basic registration programmes of midwifery and sick children's nursing.

The literature showed variable evidence of research activity in all branches of the profession. While some of this research was published, much of it remained in dissertations or thesis. There was no evidence of a strategic policy directing nursing research.

Evidence of increasing specialisation was seen in some branches of the discipline especially general, sick children's, psychiatric nursing and midwifery. The literature also showed evidence of nurses and midwives organising for professional development purposes especially within their own branches or specialist areas. Again, this was variable. For example there was no evidence of such activity within sick children's nursing at present.

Demographic trends impact on the role of all nurses and midwives. For example, increasing numbers of elderly people in the population require institutional nursing care and have greater demands on the primary health care nursing service. There are also increasing numbers of elderly people with mental handicap. Societal changes have led to mothers requiring greater support from midwives and public health nurses. Whilst such trends were noted in the literature discussion of their impact on professional roles was not explicit. Changes in disease trends and treatments and the increase in technology were reflected in the literature and merited discussion in relation to ensuing changes in practice and role. This appeared especially so from the general and sick children's nursing and midwifery literature.

Changes in health service policy with increasing consumerism and greater health promotion was reflected in the literature from all branches of nursing and midwifery. A move toward community care by psychiatric and mental handicap nursing services was evident. Discussion on legislation and litigation pertaining to a majority of branches was also available.

In summary the literature suggests that all branches of nursing and midwifery are evolving in response to change. However, greater clarity is required as to whether this response is reactive rather than proactive. For the latter approach to be taken the author suggests the need for greater politicisation and education of the profession.

# REPORT RECOMMENDATIONS AND CONCLUSIONS

In concluding this literature review on the role of the nurse in Ireland a number of recommendations can be suggested. Outlined in the introduction to the report are the difficulties encountered in the undertaking of such a review. The author suggests that consideration of the development of an Irish nursing research policy is required to assist the move from small scale, ad hoc studies to substantial research that can drive nursing practice and theory forward. Furthermore provision to establish an Irish nursing database and encouragement and opportunity for greater publication and dissemination of research findings should be made explicit.

From chapter one it is suggested that the Irish nursing profession may need to clearly state the parameters of nursing care so that role boundaries are established and defined. This will allow future clarity on the issues of role erosion and role extension. Discussion and debate by the profession on such issues is required as part of its future development and adaptation to change. The growth of specialist nurses and midwives is discussed in both chapter one and two. The literature reviewed did not quantify the types and numbers of such practitioners nor their evolution. The author suggests that this is an area for future work.

Whilst all branches of the profession merit close examination in their developing role and bearing in mind other work commissioned by the Commission on Nursing, from the literature examined for this review the author recommends that further work in two specific areas merits consideration. The first is that of primary health care nursing. Chapter one outlines how a diffuse community nursing service is developing with voluntary, private and statutory nursing services and representative of a number of branches of the discipline. Its future development and management requires attention. Furthermore from chapter two the generalist type role of the public health nurse as the principal nurse providing primary health care needs consideration as to its appropriateness.

The second area requiring further work is that of the role of the registered nurse tutor. Chapter two raises questions about the appropriateness of a generalist role for the RNT and outlines pressures from the expanding roles of other nurse educationalists. The remit of the Commission on Nursing in examining nurse education and training will obviously impact on nurse teachers and so further attention and work is required in this area.

The conclusion of this report is that many changes in the professional role of Irish nurses have occurred since 1980 due to social, demographic, legislative, educational and technological developments. The Final Report of the Commission on Nursing will itself become one of the future development forces that will issue in the new millennium for Irish nursing.

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