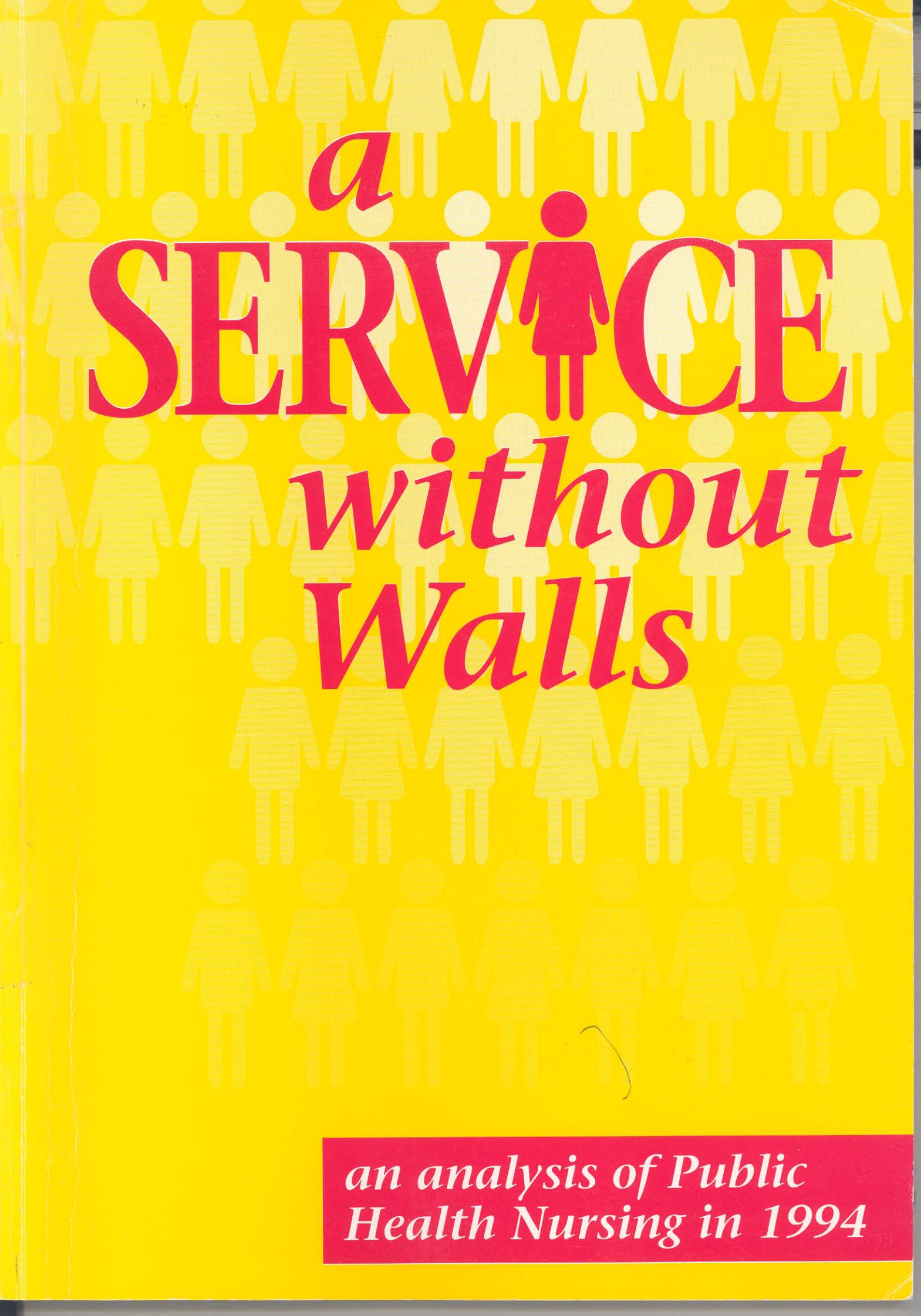
a
SERVICE
without
Walls
an analysis of Public
Health Nursing in 1994

FOREWORD

This report was commissioned by a national committee of public health nurses who came together in August 1993 to address matters of concern to the profession. The committee was representative of all grades within the public health nursing professon and all health board areas.

Two major reports had already issued on the Public Health Nursing Service, the *Survey Of The Workload Of Public Health Nurses* in 1975 and the Institute of Community Health Nursing Report in 1986.

It was considered that another report on public health nursing was opportune and that it should take account of the views of public health nurses and other key stakeholders in community service provision. The group of public health nurses acted as a steering committee during the preparation of the report.

The project was funded in total by public health nurses and it is our contribution to the current debate on the future of the community nursing services.

Mary McDermott (Supt. P.H.N. Co. Galway)

Chairman

National Public Health Nursing Committee
March 1995

CONTENTS

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Tim O'Sullivan,
Institute of Public Administration,
March 1995.

CHAPTER 1
INTRODUCTION

The public health nurse (PHN) has long been seen as a key professional in community care services and in the health services as a whole. She has traditionally worked as an "all-purpose" nurse with combined preventive and curative duties and with very close links to her local area.

The current change process in the health services encompasses significant changes in the organisation of hospital services and general practice and in services for key population groups such as children and the elderly. This process of change has also led to re-examination of the role of the public health nurse. Thus two studies of the workload of public health nurses were published in the 1970s and 1980s. A discussion document on public health nursing services in Ireland was circulated by the Department of Health in the mid-1980s. A conference on the future of community health nursing was organised by the Mid-Western Health Board at the end of 1992. Finally, a Department of Health working group is currently examining the public health nursing service.

This report seeks to contribute to this process of reassessment of the public health nursing service. It originated in a request from a national committee of public health nurses for a report on the service. It was agreed that the report would have the following major objectives:

- to present an overview of the public health nursing service in Ireland, its nature and scope;
- to examine the community and population needs to which public health nurses respond;
- to examine the current perceptions of public health nurses themselves and other key actors on the public health nursing service;
- to examine characteristics of workload in public health nursing;
- to report on the training and educational qualifications of public health nurses;
- to consider possible future trends in the development of the service.

The report, which is written by someone who is not a nurse, does not attempt to set out a prescriptive framework for the future organisation of public health nursing. The nursing profession itself has the primary responsibility for charting its own course. What the report does is to highlight key current issues in public health nursing.

The focus of this report is very specifically on the public health nursing service but that service is seen within the context of community care trends and developments generally. Links with the hospital service are also examined. A basic assumption here is that a presentation of the public health nursing service in the wider health service, and particularly community care, context is more likely to illuminate discussion of that service than any examination of public health nursing in isolation from other services.

An objective of the study was to examine the current perceptions of public health nurses themselves and other key actors on the nursing service. A large-scale survey covering several hundred respondents would produce very valuable data on the public health nursing service. Such a survey would have required, however, an input of time and resources which were not available in the context of this report. The research carried out here is smaller in scale and is therefore by definition of a more exploratory nature. Its aim was to explore the range of current perceptions on public health nursing rather than to seek to establish the prevalence of views about nursing among the relevant interests. This research however, which incorporated thirty-seven semi-structured interviews with health care personnel, produced very useful data, and is reported in chapter 5. Issues covered included the strengths and weaknesses of the public health nursing service, opportunities and threats facing the service, the current and possible future roles of the nurse and current and possible future links between the PHN and other professionals and services. Almost one half of those interviewed were area-level public health nurses. A full list of the questions used and of the repondents is given in Appendix 1.

While these discussions are not directly reported in the study, its author nevertheless benefited greatly from his participation, between January and September 1994, at several meetings of the steering group of the National Committee on Public Health Nursing.

The study looks first at the environment of public health nursing before examining the role of the nurse and her links with other services. It then reports on the results of the interviews which were carried out. It examines some relevant international trends in community health nursing before concluding.

CHAPTER 2
THE ENVIRONMENT OF PUBLIC HEALTH NURSING

2.1 Introduction

This chapter looks at the environment in which the public health nurse operates. It looks both at relevant demographic, economic and social trends and at policy and organisational trends in the health services which impinge on the public health nurse. As the elderly and children are two of the key groups with which nurses work, the chapter examines trends in both the elderly and younger age groups.

2.2 The Growth of the Elderly Population

The percentage of the population over 65 has grown nationally from 10.7 per cent in 1981 to 11.4 per cent in 1991. In absolute terms, the numbers grew from 369,000 to 402,000, an increase of around 9%. Within this population, the growth of the population over 75 should be noted. It grew from roughly 131,000 (3.8%) in 1981 to 144,000 (4.1%) in 1986. Table 1 sets out general trends in the elderly population.

Table 1: Trends in Elderly Population

	Total Population (Millions)	No. of Persons Aged 65 & over	As % of Population	No. of Persons Aged 75 & over	As % of Population
1971	2.98	331,000	11.2	119,000	4.0
1981	3.44	369,000	10.7	132,000	3.8
1988	3.54	384,000	10.9	144,000	4.1
1991	3.52	403,000	11.4	163,000	4.6

Source: Central Statistics Office data. *Figures relating to those over 65 and over 75 are rounded to the nearest thousand. The figures for 1991, based on estimated actual age, should be seen as provisional. Based on year of birth, there were 395,000 elderly persons in 1991 i.e. 11.2 per cent of the population.*

For various reasons, and particularly because of the traditionally high levels of emigration from there, the population of the elderly in the Western seaboard regions is particularly high. For example, in 1991, the percentage of the population aged 65 and over was 14.5 in both the North-Western and Western Health Boards. Table 2 gives the population distribution for each health board.

Table 2: Population Distribution for each Health Board, 1991
Percentage Aged

	0 - 14	15 - 64	65 +
Eastern	25.5	65.1	9.4
Midland	28.6	59.3	12.0
Mid-Western	27.2	61.0	11.8
North-Eastern	28.9	59.8	11.3
North-Western	27.7	57.8	14.5
South-Eastern	27.9	60.4	11.7
Southern	26.3	61.4	12.3
Western	27.1	58.4	14.5

Note: These are preliminary 1991 age group estimates which are subject to revision.

The scattered nature of the rural elderly population also places a particular responsibility on those responsible for service provision and particularly on the public health nursing service.

A variety of other social factors also make the elderly person more dependent on service provision. An important traditional model was one where a home-based married or unmarried daughter in a relatively large family would care for elderly parents, or even sometimes for elderly uncles or aunts, in their declining years. Various factors have made this model less customary. These include the following:

- Greater female participation in the labour force, which makes care of elderly relatives much more problematic. In 1989, for example, the percentage of married females participating in the workforce was 23.3. While this figure was low by European standards, the figure for younger women (42 per cent of those aged 20-24 and 39 per cent of those aged 25-34) was much higher than in the older age groups (22.9 per cent for those aged 35-44 and 19.8 per cent for those aged 45-54).

- The growth of marital breakdown and thus a decline in stable two-parent families which are better equipped to care for elderly relatives. While the rate of marital breakdown in Ireland is considerably less than in other European countries, it has nevertheless increased in recent years. In the 1986 census, 37,245 persons were classified as separated. In the 1991 census, the figure was 55,143 persons.

- The growth of births outside marriage can also be seen as increasing the number of single-parent households which are theoretically less well equipped to cater for elderly relatives. The number of live births outside marriage per 1000 live births grew from 26.5 in 1970 to 166 in 1990.

A rather more difficult change to quantify is that of change in attitude towards care of the elderly. It would appear that such care is now seen more often as the role of the State than was the case in the past. On the other hand, the cost of institutional care of the elderly may compel some middle-income families to care at home for elderly relatives.

2.3 Decline in Younger Age Groups

If the number of elderly persons has increased both proportionately and in absolute terms, the number of those in the younger age-groups (another key client group for the public health nurse) has declined.

The number of births in Ireland has dropped dramatically in the last couple of decades as the following table demonstrates.

Table 3: Births and Birth Rates

Year (of occurrence)	No. of Births	Annual Birth Rate per 1,000 population
1970	64,382	21.9
1975	67,718	21.2
1980	74,064	21.8
1985	62,388	17.6
1990	52,954	15.1
1991	52,690	15.0
1993	49,456	13.9

Note: *The 1990 figure relates to the year of registration.*
Source: Central Statistics Office, *Annual Reports on Vital Statistics.*

Table 4 indicates the drop in the total fertility rate between 1970 and 1990.

Table 4: Total Fertility Rate 1970 - 1990

Year	Rate
1970	3.87
1975	3.40
1980	3.23
1983	2.50
1990	2.17

Source: Eurostat, *Demographic Statistics.*

This drop in births has also led to a drop in the number of young children in the population, both in absolute terms and proportionately. Table 5 (below) documents this decline. While the number of children has dropped, the child care area has become more complex as a result of the increase in family breakdown and in child abuse.

Table 5: Trends in Number of Children Under 5

Year	Numbers	% of Population
1981	353,004	10.3
1986	324,078	9.2
1991	273,730	7.8

Source: Central Statistics Office, *Census of population 1991,1992*

2.4 New Social Problems

With social change, new social problems and issues have emerged which form part of the environment in which public health nursing operates and constitute some of the challenges which the nurse faces. These issues include:

- the growth of drug and substance abuse
- an increase in child abuse. Confirmed cases of child sexual abuse, for example, increased nationwide from 37 in 1983 to 599 in 1991.

- an increase in single-parent households. Statistics in this area were given above.

- a growth in unemployment. The number of those unemployed grew from 5.8 per cent of the civilian labour force in 1970 to 18.2 per cent in 1985. It decreased to 15.6 per cent in 1990.

- the return of large-scale emigration. Between 1986 and 1991, for example, there was an average net outflow of over 27,000. In more recent years, emigration has declined somewhat. There was net inward migration of 2,000 between April 1991 and April 1992.

It would clearly be wrong to give the impression that nurses in every part of Ireland operate in the same environment. There are clearly significant differences between urban and rural areas, the Eastern and Western seaboards etc. Problems such as drug abuse, child abuse, AIDS etc are more prevalent in urban areas and particularly in the Dublin area. Some recent reports have highlighted the specific problems of the Western region - for example, large-scale emigration, especially of young people, transport difficulties, a particularly high proportion of elderly people, and a scattered and, in many cases, declining population. Public health nurses also provide a very comprehensive service to the population in many of the islands off the West coast of Ireland.

2.5 Hospital Trends

Between 1980 and 1992, the number of hospital beds declined from 17,665 to 14,802. However, the number of hospital discharges dropped very little in the same period i.e. from 543,698 to 523,723. This was partly because the average duration of stay dropped significantly in this period i.e. from 8.6 to 7.1. The earlier discharge of patients has clearly increased demands for the services of those, including public health nurses, who deal with such patients in the community.

2.6 Community Care Trends

Community care in Ireland is in a process of recent or imminent reform which clearly impacts on the public health nursing service. Some of the key areas are looked at in turn below.

2.7 General Practice Reform

Considerable change has occurred in Irish general practice in recent years. In 1989, the fee-per-item method of payment was changed to a capitation-based system. In 1993, the GP units, which are intended to facilitate cooperation between GPs and health board services, were established. Significant investment in general practice has been made in recent years - for example, £4.2 million for secretarial/nursing allowances in 1991 and £8m in 1993 for various developments, including the establishment of the General Practice Units. This investment is intended to facilitate developments such as grouping of doctors, investment in practice premises, the employment of staff such as practice nurses or secretaries

and technological development among doctors. In 1992, GMS doctors employed just under 200 practice nurses and just under 900 secretaries.

The importance of general practice has also been emphasised by the National Health Strategy. This document which was launched in 1994, sets out a long-term strategy for health and care in Ireland and incorporates a four-year action plan, 1994-1997.

Another key development in general practice in recent years has been the development of continuing education among GPs, the establishment of GP training schemes and the promotion of research in general practice.

While continuing education among GPs has always existed, the Irish College of General Practitioners has put it on a structured and systematic basis. The College, which was only established in 1984, has also made a very major contribution to the vocational training schemes for GPs, which are an entirely new development in recent years. It has also put research into general practice on an entirely new basis and promoted, for example, a major national survey of workload in general practice.

These major changes and developments in general practice, a profession with close historical links to public health nursing, are clearly a very important part of the environment in which the nurse operates. The growth in the number of practice nurses, for example, has raised the question of how links will develop between these nurses and public health nurses. The greater focus on structured continuing education among doctors would seem to indicate a need for a similar focus within public health nursing.

2.8 Trends in Public Health Management

Public health nurses work in a overall service which is managed by a medically - qualified Director of Community Care. Public health nurses have also traditionally worked closely with public health doctors in areas such as immunisation. The preventative and promotional duties of nurses can be seen as an important part of the wider public health function.

In recent years, there has been a good deal of reflection on the organisation of public health management in Ireland. This process of reflection and any ultimate changes in organisation can be seen as an important part of the environment within which public health nurses operate.

It is possible to identify a few key activities which each health board must carry out in its mission of meeting the health needs of its population. These activities, in which public health nursing is involved at different levels, include the following:

- Reviewing regularly the health of the region's population and identifying areas for improvement.

- Defining objectives and setting targets to deal with these areas in the light of available resources.

- Relating decisions on resource distribution to the impact on the health of the population and to the objectives which have been defined.

- Monitoring and evaluating progress towards the stated policy aims and objectives, using appropriate performance indicators.

In April 1988, the Minister for Health established a Working Party to define the role of community medicine in the health services in the medium to long-term. The Working Party, which was chaired by Kieran Hickey, Chief Executive Officer, Eastern Health Board, published its report in April 1990.

A few of the key recommendations in the report, among many others, included the following:

- The term **public health medicine** should replace that of community medicine. The new title will help to emphasise the importance of communicable disease and environmental health control.

- Resources should be made available to develop health information systems.

- The preparation of an annual report on the health of the population should be resumed.

- An integrated approach to the preparation of health promotion and education programmes should be based on a good working relationship between the Health Promotion Unit at the centre and those who have closer contact with local problems and issues.

- The examinations of children, and the data collected in this area, should be standardised on a national basis.

- A new Department of Public Health Medicine in each health board should be headed by a Director of Public Health, who would be a member of the management team. There should also be a District Director of Public Health with responsibility for a population of 100,000 - 200,000 people. The existing Director of Community Care and Medical Officer of Health posts should be abolished.

In presenting the Report of the Working Party to the Minister, its chairman identified three key functions which should be identified in the public interest:

- **Surveillance** of the health of the population including control of environmental hazards on health and communicable diseases.

- The **prevention** of illness and health promotion through the encouragement of healthy lifestyles and health oriented public policies.

- Assessment of health service needs, determination of priorities and measurement of outcomes i.e. the **planning and evaluation** of health services in the light of available resources, including alternative forms of service.

Since the publication of the Hickey Report, discussions have been continuing about developing new structures for public health medicine but at the time of writing (December 1994), these discussions have not been finalised. However, the National Health Strategy gave a commitment to the establishment of a Regional Public Health Department in each region with a brief to provide a coordinated and integrated approach to epidemiology and to support the planning and evaluation of services.

2.9 General Community Care Policy Developments

In recent years, a range of important policy and service developments have taken place in community care, including significant legislative developments and a new emphasis on services to specific client groups.

Important new legislation with major implications for community care is a key development. One thinks here of the Child Care Act and of the Health (Nursing Homes) Act. Nurses are significantly involved in the implementation of both these pieces of legislation.

Resource constraints have over the years had serious implications for levels of service and staffing. These constraints can have a major implication at local level. On the other hand, funds have been released in recent years for certain areas, for example, general practice, child care and mental handicap.

At a local level, services have been increasingly organised by target or priority group, for example, the elderly, the handicapped, the mentally ill, or children at risk. This trend is very much in line with the policy recommendations of recent reports, for example **The Years Ahead** (1988).

Health board procedures and methods of operation have traditionally been quite centralised. In matters relating to financial management and control, for example, there has been relatively little delegation to community care area or sub-area or local district level. Nevertheless, there has recently been a move in some health boards to devolve budgets more from the centre. In some instances, Superintendent Public Health Nurses have been given their own budgets.

There is an increasing recognition of the importance of close links with voluntary organisations and community groups but these links are not always well structured.

There is general acceptance of the need for good cooperation with local community groups but not a strong emphasis on the active participation of such groups in service planning and provision. However, various health boards (for example, the Southern and Eastern Health Boards) have produced policy documents on links with voluntary organisations.

2.10 The Health Strategy

The launching, in April 1994, of the Health Strategy is clearly a crucial part of the environment within which the public health nursing service, along with other health services, operates.

This section first sets out some of the key points in the Strategy before turning to the implications for the public health nursing service.

Shaping a healthier future is described as a Strategy for the reorientation of our healthcare system – in other words, making the health and personal social services more effective by reshaping the way they are planned and delivered.

Three key principles underpin the entire strategy: equity, quality of service and accountability.

Equity

Equity includes greater uniformity in eligibility and charges, reduction of waiting times for public services, and special attention to disadvantaged groups. The establishment of health development sectors is an important part of the emphasis on equity. These sectors are areas or groups with low health status which will be given priority in the development of services. The health boards will be required to identify health development sectors in each region on the basis of indicators of health status and social problems.

Quality

The Strategy emphasises the importance of the pursuit of quality at all levels of the service, that is both technical quality (in terms of the outcome) and service quality (in terms of consumer satisfaction). Particular emphasis is placed on the development of information systems, on the evaluation of technology (a formal system of technology assessment will be introduced) and on the promotion of clinical audit. The Strategy also gives priority to the measurement of patient satisfaction through various methods such as consumer surveys.

Accountability

A second basic principle in the Strategy is accountability. This includes formal legal and financial accountability arrangements, which are in place and which are subject to ongoing development. It also includes the requirement on those providing services to take explicit responsibility for the achievement of agreed objectives. The Strategy also envisages mechanisms to ensure that those with decision-making powers are adequately accountable to consumers of the services.

In relation to managerial responsibility, the Strategy states that:

- Managers at all levels will have clearly defined responsibilities and will be fully accountable for achieving targets;
- The Department of Health will continue to work with the health authorities to introduce more efficient management practices;
- There will be a new emphasis on training and development of staff at all levels.

Health Gain and Social Gain

Two key concepts in the Strategy are health gain and social gain. According to the document, health services objectives have tended to focus on the provision of a level of service rather than on the achievement of a positive outcome. The Strategy gives prominence to the importance of health gain and social gain. These, it explains, are terms used to indicate that patients and clients of the health or personal social services should receive a clear benefit (or outcome) from their contact with the system. Health gain has to do with achieving improvements in health and social gain with adding to the quality of life.

2.11 Implications of Health Strategy for Public Health Nursing.

While the Strategy does not give a great deal of specific attention to the public health nursing service, it does make some specific references to the service. For example, the Strategy writes of strengthening the role of the public health nurse and of other professionals in supporting older people and their carers who live at home. The target will be to ensure that "not less than 90 per cent of these over 75 years of age continue to live at home". (p.67) Catherine Curry, president of the Institute of Community Health Nursing (ICHN), has stated that the Stategy "incorporates many of our Institute's aspirations" (ICHN News, no. 4, November 1994, page 1)

In general, some of the key approaches in the Strategy will have major implications for public health nursing. These include the identification of equity, accountability and quality as key principles, and the emphasis on health gain and social gain and therefore on outcomes. The Strategy's commitment to devolution of responsibility in the health services and to the clear definition of responsibilities for managers would seem to imply a greater devolution of responsibility to managers of the public health nursing service.

There is a strong emphasis on information, measurement and monitoring throughout the Strategy. The implications for public health nursing of this emphasis could include the allocation of greater priority and of additional resources to the information gathering and monitoring functions of the public health nurse. Such information gathering and monitoring will be a crucial part of local service planning. The development of information on, and of responsiveness to, the views

of service users is also an important theme of the Strategy. This will apply to users of public health nursing as much as of any other service.

The development of information will also facilitate the achievement of some of the Strategy's main objectives. In relation to equity, for example, the development of information by the nurse on particular geographical areas or population groups will facilitate the identification of health development sectors focused on those in greatest need: an important part of the Strategy's approach to equity.

Nurses are likely to be involved in developing methodologies of needs assessment as well as mechanisms for consumer consultation. The Strategy document suggests that varying approaches to improving the health status of the health development sectors should be adopted, through the setting up of pilot schemes. The findings of such schemes could be used for similar target groups elsewhere. Research work on nursing, for example in relation to child health services, has been sponsored in recent years by The Institute of Communty Health Nursing.

2.12 Conclusion

As this chapter has indicated, major change has taken place in recent years in the environment in which the public health nurse and indeed every health profession operates. However, it is worth highlighting the most significant changes affecting the environment of the nurse in particular. These include the ageing of the population, the greater dependence of the elderly person who needs care on service provision rather than on family care, the drop in the number of young children and the emergence of complex new social problems which are outlined above.
Many of these trends increase demand for the services of the public health nurse or for services of a similar nature.

This chapter has also given some details of the major reform process in the health services in recent years up to and including the current Health Strategy. Reforms in the area of community care were especially emphasised but the changes in hospital services, such as the drop in average length of stay, have also had a major impact. While the community care reform process has not touched public health nursing in a major direct way to date, it has led to considerable change in the environment of the nurse and in the patterns of care provided by other professionals with whom the nurse has key relationships.

CHAPTER 3
THE ROLE OF THE PUBLIC HEALTH NURSE

3.1 Introduction

This chapter looks first at the historical development of the public health nursing service, service objectives and trends, and trends in nurse numbers. It then looks at issues relating to specialisation and examines existing data on nursing workloads. It also briefly covers relevant educational trends.

3.2 Historical Development of the Service

The origins and development of the public health nursing service are clearly set out in the **Workload Survey** (1975) (pp1 ff). This report notes that present day public health nursing is an amalgam of three separate branches of community nursing services: midwifery, voluntary community nursing and public health nursing.

The **midwifery** service was set up under the Poor Relief (Ireland) Act 1851 at the same time as the dispensary medical system. Candidates for public health nurse training must still be registered midwives as well as registered general nurses but the Workload Survey of 1975 found that only 1.2% of the time of nurses on district duties was spent on maternity care. A survey of workload by Burke for the I.C.H.N. in 1986 did not include midwifery work as a separate category. Maternity aftercare continues, however, to be an important part of the nurse's role.

The **district home nursing service** was pioneered by voluntary organisations in the late 19th century. The names of these organisations are given in the 1975 Workload Survey. Some public health nursing is still carried out by nurses who are religious but voluntary district nursing services have now largely ceased.

The **public health nursing service** originated in the child welfare and school health services of the early twentieth century.

Over the years, these services merged into the modern state-run public health nursing service, which is sometimes also referred to as community nursing.

Department of Health Circular

In 1966, an important Department of Health circular on the 'District Nursing Service' (27/66) set out government thinking and policy on the services. The objectives outlined in the circular are given in the section below on 'service objectives and trends'. The aim, as the Workload Survey noted, was to make public health nursing available to families in each area throughout the country. A ratio of one nurse to every 4,000 population was adopted as a guide-line subject to local variation in relation to the size of area, difficult terrain or scattered population.

Senior Grade

The Circular also recommended that a Superintendent should be appointed where ten or more nurses were employed on district nursing duties. In 1982, following a recommendation of the **Working Party on General Nursing** (1980), an intermediate grade of **Senior Public Health Nurse** was introduced. While the Working Party recommended a Senior Nurse for every eight to ten nurses the ratio in 1991 was around 1:29.

The Working Party envisaged that the senior community nurse would be responsible:

> "(i) for the implementation of policy by the routine organisation and management of the nursing services within that part of the community area allocated to her and
>
> (ii) for the co-ordination of the practical training programme of all students in that area" (4.17.5).

In practice, the method of operation of the Senior post varies from board to board. In some boards, the number of seniors is relatively greater than in others. In some, the focus is on the specialist role of the Senior - for example, a senior might specialise in an area such as child care services or services for the elderly - and in others on her supporting role within the general nursing management function. Some nurses contacted in the course of this report argued that the senior's specialist duties hindered her involvement on the general management side.

British Experience

The Irish public health nurse has developed as an 'all-purpose nurse' with both preventive and curative responsibilities. The distinctiveness of the Irish experience can be better understood if we compare it with the position in Britain, where three separate categories of community nurse have traditionally existed. These are the **health visitor** with preventive and health educational responsibilities, the **district or home nurse** with nursing care responsibilities and the **midwife**. The first whole-time health visitors date from the 1890s. They are responsible for 'giving advice as to the care of young children, persons suffering from illness, and expectant and nursing mothers and as to the measures necessary to prevent the spread of infection' (Hicks, paragraph 498).

Health visiting in Britain expanded with the notification of births and maternity and child welfare legislation of the first two decades of the twentieth century. While similar or identical legislation was also passed in relation to Ireland, a separate health visitor type nurse did not develop here. One explanation suggested is that the British health visitor system had its roots in the voluntary work of local women rather than in nursing as such.

Views have varied on the usefulness of the British divisions in community nursing. Health visitors have generally held that it permitted a very worthwhile emphasis

on the preventive and educational aspects of nursing. Some GPs have held that the British divisions increased fragmentation in community services and led to difficulties, in particular, in the health visitor - GP relationship.

3.3 Service Objectives and the Nurse's Role

The aims of the public health nursing service were summarised as follows in Circular 27/66:

"Broadly, the aim should be to make public health nurses available to individuals and to families in each area throughout the country. More specifically, the object should be to provide such domiciliary midwifery services as may be necessary; general domiciliary nursing, particularly for the aged; and at least equally important, to attend to the public health care of children, from infancy to the end of the school-going period. The nurses should provide health education in the home, and assist local medical practitioners in the care of patients who need nursing care but who do not require treatment in an institution - whether for medical or social reasons. The aim should be to integrate the district nursing service with the general practitioner, hospital, in-patient and out-patient services, so that the nurse will be able to fulfil the important function of an essential member of the community health team and carry out her duties in association with the hospital staffs and other doctors in her district". (Para. 7). Other areas such as parentcraft education are also seen as very important.

The objectives of the community nursing services might more briefly be described as: to provide both a sick nursing and preventive nursing service, to facilitate early discharges from hospital and to maintain in the community patients who would otherwise be institutionalised. The focus is, therefore, on working within the community, helping both individual clients and distinct population groups to achieve a state of positive health. There is an emphasis on the early discovery of problems and on the prevention of avoidable problems.

As noted above, the nurse has an " all-purpose" role, encompassing both preventive and curative responsibilities. She is responsible for a particular area, is a professional who provides first-contract services to the public and has ready access to the homes and families in her areas. She has an important role in building links with other professionals and services.

A PHN interviewed for this study gave a striking description of the range of target groups for which the nurse is reponsible and her diversity of functions:

"In practice, we're coordinators of our areas and involved in many areas, for example, health education, health promotion, prevention, care of the terminally ill, child and maternal health, surveillance of the elderly, curative nursing, the facilitation of early hospital discharge, school medicals, screening work, setting quality standards, research. In practice, we're also involved in the psychiatric and mental handicap areas"

As the objectives of the public health nursing service are very broad, there are difficulties in defining very clearly the boundaries of the nurse's role An example is the issue of the boundaries between nurses and other professionals in relation to the care of children. (cf. Chapter 5) This lack of clarity, coupled with a similar lack of clarity about the precise parameters of the roles of other professionals, leads to difficulties of various kinds in inter-professional or inter-service linkages.

An area of growing importance for the public health nurse is that of the **training** of student nurses, both student general and public health nurses. Both sets of nurses spend time with PHNs in the community during their training. Such training placements have resource implications as the PHN must clearly spend time with the trainee. There is also an issue of the training or teaching skills of the PHN. In at least one board, PHNs have had the possibility of doing a Diploma in Teaching Methods. The training of care attendants and assistants is also likely to assume growing importance in the future.

3.4 Service Trends

According to Department of Health Statistics, the cost of "home nursing services" increased from £26.89m in 1991 to £28.61m in 1992.

Table 6: Trends in Numbers of Public Health Nurses

Date	Numbers	Nurse/Population Ratio
1964	509.0	1:5600
1974	797.0	1:3470
1980	1251.0	1:2700
1990	1358.2	1:2600
1992	1364.1	1:2580

Note: Figures include all grades of public health nurse. The 1990 figure is for whole-time equivalents, where the focus is on nursing time rather than on nurse numbers per se. Thus two nurses working half-days become one full-time nurse. The ratio figures are rounded.

While there has been a fairly steady countrywide increase in the number of nurses, the above figures conceal considerable regional variation. The Workload Survey for example (p. 70) reported a nurse-population ratio ranging from c. 1:2260 in Donegal to c 1:4870 in Dublin in the mid-1970's. The highest ratios, i.e. smallest number of nurses relative to population, were in Dublin, Cork, Wicklow and Limerick and the lowest in Donegal and Leitrim. Differences in population density could account only in part for the variation reported by the Workload Survey.

The Department of Health circular 27/66 established a nurse-population ratio of 1:4000 as a general guideline for the country. The Workload Survey subsequently suggested a somewhat tentative national guideline of 1152 nurses, equivalent at the time to 1 nurse per 2600 population.

1992 figures indicated that nurse population ratios varied from under 1:2000 in the North-West and the Midlands to almost the 1:2900 level in the East, and to 1:3100 in the South. Table 7 gives details of these figures. The number of nurses in management positions also varies considerably.

Table 7: Distribution of Public Health Nurses, 1990 and 1992

Health Board	Total Number of PHNs		Population Ratio	
	1990	1992	1990	1992
Eastern	429.33	430.34	1:2898	1:2891
Midland	94.40	103.56	1:2150	1:1960
Mid-Western	109.90	119.59	1:2830	1:2601
North-Eastern	118.60	122.70	1:2530	1:2445
North-Western	105.10	107.00	1:1979	1:1944
South-Eastern	144.50	146.05	1:2651	1:2622
Southern	182.05	171.59	1:2922	1:3100
Western	174.30	163.24	1:1968	1:2101
Total	**1358.20**	**1364.07**	**1:2594**	**1:2583**

Source: Department of Health
Note: *The ratios for both years are based on the Census figures in the 1991 population. Numbers are given in whole-time equivalents.*

Data on nurse numbers and workload (see below) give some indication of the **demand** for public health nursing services but they can also point to historical patterns of delivery as much as to patterns of demand per se. "Demand" in its turn can be distinguished from the concept of need, which seeks to provide an objective rather than subjective assessment of patient requirements.

The development of area and population profiles and thus of dependency patterns can be seen as one effort to establish need for nursing services in particular areas. However, there are significant difficulties in basing nursing establishments on dependency models. (cf. Chapter 6)

The President of the Institute of Community Health Nursing has called for more research to establish needs within the community and to assess the impact of nurses on health gain and social gain. She has also referred to the public health nurse's "increasing clinical and infirm elderly caseloads" and to "escalating demands in child health care" (ICHN NEWS no.4, November 1994, p.1)

There is little data in Ireland on public demand for public health nursing services but there is an undoubted need to develop survey - based information in this area, and particularly for information on the views of **users** or **"consumers".**

A small survey carried out by public health nurses among elderly persons in Drogheda in 1991 found that 89 per cent of those surveyed knew where and when to contact a PHN. On the other hand, 77 per cent of those surveyed felt that people did not have sufficient support to die at home and 51 per cent felt that more visits were required from the public health nurse if this were to happen. One suggestion coming from the elderly respondents was the need for a nurse to visit in the evening and to be on call 24 hours a day, especially when the person is dying.

Larger scale user surveys would clearly provide very useful data on the public health nursing service.

3.5 Specialisation Among Nurses

The development of specialisation among public health nurses is an important recent service trend. In relation to **services for the elderly**, the involvement of the nurse in this area is looked at in more detail in chapter 4. In areas such as the treatment of incontinence, school services, mental handicap counselling, general liaison work and care of the terminally ill, nurses have also developed strong specialities. Nurses have also been doing family development work and have organised community mothers programmes in a number of health boards.

An important traditional area of specialisation has been in **schools work.** Nurses in the schools service carry out a very wide range of activities, including screening tests in areas such as vision and hearing, liaison work with teachers and other health professionals, a wide variety of clinics and health educational work. The nurse may also attend at examinations being carried out by the area medical officer. She also does domiciliary visits on a follow-up basis where appropriate. Clinics in which the nurse is involved include child welfare and school clinics, developmental assessment, immunisation and other clinics.

In relation to psychiatry, a community services structure separate from public health nurses developed. **Planning for the Future** emphasised however (5.19) the importance of each sector team forming effective working links with public health nurses and other community care personnel.

Specialisation can be considered under a couple of dimensions. The first is **specialisation by some or all public health nurses.** Much of this specialisation would be in response to the increasingly complex needs of people in the community and particularly under the impact of an ageing population. The growth of specialisation among some nurses - for example in the treatment of incontinence or in the coordination of services for the elderly - can be seen in this context. Specialisation among public health nurses might also incorporate the delegation of

some less specialist roles to other staff, for example registered general nurses or secretaries. In theory, specialisation by a group of public health nurses might not affect the traditionally generalist role of the nurse. However, a general trend towards specialisation among public health nurses would, by definition, bring an end to the nurse's generalist, all-purpose role.

A second dimension of specialisation is **specialisation by other nurses in the community**. This might include the provision of specialist services by hospital nurses in the community (for example, in relation to the treatment of diabetes); the work of community psychiatric nurses; and the work of the hospice nurses with the terminally ill. Some regard this type of specialist development as a threat to the role of the public health nurse; others see specialist services of this type as valuable resources which the public health nurse can use.

The issue of specialisation is considered again in chapter 5, which reports the results of interviews with key actors on public health nursing. Issues relating to specialisation are also considered in the conclusion.

3.6 Nursing Workloads

Considerable information on nursing workload was provided in the Workload Survey of the 1970s.

This report found that two fifths of the nursing time of nurses on district duties was spent on home visiting, roughly a quarter on travel and a fifth on work in clinics, dispensaries and schools. Details are given in Table 8.

Table 8: Time Breakdown of Nursing Activities (Nurses on District Duties)

Activity Description	% of Actual Time
Home visiting (other than maternity)	40.9
Maternity care	1.2
Clinics, dispensaries, schools	19.8
Other activities (e.g. clerical duties, attendance at headquarters or at lectures)	10.3
Travel	24.6
Miscellaneous	3.1

Table 2 shows the allocation of time within one of these categories: home visiting. Within home visiting, the three major categories were technical nursing, preventive and educational nursing and basic nursing. Details are given in Table 9.

Table 9: Time Breakdown of Home Visiting

Activity Description	% of Time Spent
Technical nursing (e.g. injections, dressings	34.3
Preventive and educational nursing (e.g. immunisations, health advice)	26.9
Basic nursing (e.g. bed baths, prevention of bed sores)	24.9
Social Work	9.0
Home help activities	3.5
Unclassified	1.4

Nurses on district duties thus spent roughly a quarter of their home visiting on preventive and educational work.

Headquarters nurses (defined as nurses who worked "on preventive duties attached to local headquarters", (p.8) though in Dublin many of these nurses devoted "part of their time to duties ordinarily carried out by district nurses") for their part spent around 37% of their total time on clinics/dispensaries/schools work and 13% of their total time on preventive and educational nursing as part of home visiting.

Burke Report

A more recent workload survey was carried out by Burke for the ICHN in 1985 and published in 1986. It reported on a survey to which 732 nurses in seven health boards responded. It gave results both nationally and by health board. The categories chosen for this survey were somewhat different from those in the Workload Survey - for example, travel time was not included by Burke - so comparisons with the earlier survey are difficult. However, Tables 10 and 11 summarise some of the findings of the Burke Report.

Table 10: % of Total Nursing Time (Burke Report)

Category of Activity	% of Time Spent
Home Nursing	44.0
Child Welfare Visits	15.0
Ineffective Calls	0.6
Clinics	12.0
School Inspection	5.3
Team Consultation	3.0
Supportive Care	5.0
Clerical	15.0

Note: "Clinics" includes dispensary work. Most of the figures have been rounded to the nearest percentage point.

Table 11: Activities in Home Nursing: % of Time Spent

Activity Description	% of Time Spent
Care of Elderly Sick and Geriatric Surveillance	50.1
Leg Ulcers	14.0
Other Dressings	9.0
Physical Handicap	5.0
Acute nursing	6.8
Terminally Ill	5.7

Some interesting findings from this survey include the following:

- 44% of nursing time was spent on home nursing, though the values ranged from 39% in the east and mid-west to 54% in the north-east.
- Over 50% of the total time devoted to home nursing went to elderly people.
- Only 1.5% of child welfare visiting time was given to ante-natal visits. This finding seems in harmony with the earlier finding of the Workload Survey that only ten minutes per nurse per week was devoted to ante-natal care.
- Over half the time spent on clinic work was devoted to work with doctors in dispensaries or similar establishments.
- Only 2.6% of nursing time was devoted to consultation with others, a figure which, as Burke noted, was rather small.

Burke concluded that public health nurses could not provide an acceptable level of care and that in many areas because of a heavy workload, "they are not in a position to meet the demands made on them".

3.7 Professional Qualifications/Education

The contemporary public health nurse must have qualifications in general nursing (three years), midwifery (two years) and in public health nursing itself (one year). She must also have a minimum of two years experience in nursing. Midwifery was originally a one-year qualification but it has now increased to two years. The recent Bord Altranais report on **The Future of Nurse Education and Training in Ireland** recommended that registration as a midwife should no longer be needed for public health nursing and should be replaced by a maternity and child care module (4.19).

Apart from the midwifery recommendation cited above, the report of An Bord Altranais on **The Future of Nurse Education and Training in Ireland** had a number of recommendations or remarks of relevance to public health nursing. These included the following:

- The role of all nurses should be extended, in line with WHO recommendations, to encompass that of a health educator and facilitator (4.2).
- The WHO has underlined the need for the development of a nurse capable of working in both the hospital and the community (4.2)
- A greater level of nurse education is needed in the care of the elderly (4.17)

- Because of health policy developments, the health services will require an increased number of nurses working in community care (4.19)

- Primary health care and community nursing should be substantially enhanced in the proposed new nursing pre-registration programme (4.19)

- All nurses practising in the community should have an appropriate in-service training and orientation. (4.19)

This is a time of considerable change in nurse education. One thinks here, for example, of the movement towards a more academic syllabus in general nurse training. Broad issues and developments in general nurse training are largely beyond the scope of this report. However, there are some specific trends and recommendations which relate in a special way to community nursing.

In its report on community nursing, An Bord Altranais made a number of recommendations which had specific implications for community nursing. These included recommendations that:

- future patterns of nurse education and training should provide all student nurses and registered nurses with substantial knowledge and expertise in relation to community nursing; (no. 25)

- there should be greater integration of hospital and community nursing (and) the role of community nursing and the notion of primary care teams based around GP practices should be explored. (No. 26)

The UCD Diploma in Public Health Nursing sets out a number of objectives for the public health nurse and by implications for the diploma course. These objectives relate to areas such as inter-personal skills, needs assessment, the provision of direct care, health education, team work, evaluation, liaison with voluntary agencies etc. A diploma course for PHNs in UCC commenced in 1994.

3.8 Conclusion

This chapter has outlined the historical development of the public health nursing service and of the role of the nurse. A key feature of the role of the nurse in Ireland is that it has a dual purpose, both preventive and curative. This is in contrast to the division between preventive and curative nurses in Britain, for example.

Debate about the role of the nurse is closely linked to workload issues, that is, to the activities carried out by the nurse and the demands placed on her. The number of nurses has increased in the last thirty years but there is still considerable variation in nurse/population ratios.

Two major surveys of public health nursing workload in the 1970s and 1980s found that a significant proportion of nursing time went on home nursing. The first survey revealed that nurses on district duties spent around a quarter of their home visiting time on preventive and educational work and the second survey drew attention to the fact that 50% of home nursing time went on care of the elderly. It seems very doubtful that the preventive figure would be replicated in a current survey in view of the environmental changes which have increased the pressures for curative care. (cf. Chapter 2)

The chapter has referred to the growth of specialisation both by PHNs (e.g. in the management of incontinence) and by other nurses in the community, in areas such as psychiatry and terminal care. Schools and clinic nursing has traditionally been a strong speciality among PHNs. A key question facing the PHN services is what direction such specialisation should take in the future and whether the emphasis should be on specialisation by PHNs, or by other nurses. This issue is dealt with again in chapter 5.

CHAPTER 4
LINKS WITH OTHER SERVICES

4.1 Introduction

The last chapter discussed the role of the public health nurse. This chapter looks at links between the nurse and other services. These two issues are clearly connected. Links between the nurse and other professionals will depend both on how the role of the nurse and that of the other professionals are defined.

4.2 PHN-GP Relationships

Cooperation between the district medical officer and district nurse was undoubtedly much closer in the old dispensary service than it is at present between GPs and public health nurses. The introduction of the "choice of doctor" scheme in the early 1970s and the consequent greater mobility of patients between doctors led to increasing divergence between nursing areas and GP areas. This is particularly true in urban areas but even in rural areas, where GP-nurse relations may be closer, these relations are on an ad hoc rather than structured basis.

In view of the gaps between GPs and nurses, the McCormick Report suggested in 1975 that public health nurses should be attached to practices instead of being assigned to districts. In view, however, of the nurse's wider responsibilities to the community and of the importance of the preventive aspects of her work, this recommendation was not endorsed by the 1975 Workload Survey. That report argued that any attachment of public health nurses to a practice, even on an experimental basis, would be most useful in a situation where the group practice area approximated to the community for which the nurse was providing services.

The status quo - that is, attachment of nurses to areas rather than practices - was preserved in Ireland.

Perceptions of doctors and nurses on the GP - nursing relationship have obviously differed. Where the GP has traditionally assumed that general direction by him or her of the nurse's curative work is necessary for patient care, the nurse has generally been anxious to preserve her professional independence. On the GP side, a lack of nurse availability to his or her practice has often been criticised; on the nurse's side, there is criticism of medical failure to recognise her responsibilities for the wider community. On the other hand, one nurse interviewed for this study described the GP-nurse link as the key relationship for the nurse and many nurses saw it as crucial.

The different employment structures of the two professionals (that is, independent contractor on the one hand and health board employee on the other) have not perhaps facilitated cooperation. Until it was replaced by the capitation system in 1989, the fee-per-item method of payment was sometimes seen as discouraging

referral by the doctor to the nurse. Other important issues include the links between practice nurses and public health nurses and even whether there are possibilities of delegation from the nurse to the practice secretary.

4.3 Links Between the PHN and the Hospital

The PHN has in many ways a key role in the links between general hospital and community care services. This role has been formally recognised in many places through the nomination of PHNs as liaison nurses between the community services and the hospital services. The liaison nurse visits the hospital regularly, is informed about the particular needs of patients and liaises with her colleagues in the community about those needs in the context of future discharges from hospital and about the timing of discharges.

Links between the PHN and the hospital are particularly important in relation to areas such as maternity aftercare, the care of patients with very special needs (for example cystic fibrosis, diabetes, oncology) and the care of elderly patients.

Maternity aftercare has become more important as the length of stay after delivery drops and mothers go out into the community earlier. Thus more support is needed from the public health nurse. Nurses interviewed in a Dublin voluntary maternity hospital described a system where a liaison public health nurse came to the hospital once a week and visited every ward. Demand for home deliveries appears to be increasing but public health nurses have had little involvement in domiciliary midwifery in recent years. The report of An Bord Altranais on nurse education and training argued that the midwifery qualification of the public health nurse was no longer required. (cf. Chapter 3) Opinion within public health nursing appears to be divided on this recommendation but the key question to be dealt with is how the demand for home deliveries is to be met. In 1989, the maternity cover of the VHI was reduced and is currently worth £300 in maintenance costs, which covers around two post-natal days. The reduced stay of mothers in hospitals places additional pressures on the public health nursing service in the community.

The care of patients with special needs is also becoming more of a problem as sick patients are discharged earlier and as it becomes more possible, with support, to treat them in the community. Complex issues arise in this area: should specialist hospital nurses come out more to the community? Should at least some public health nurses specialise more in specific areas (for example, diabetes)? Should there be closer links between hospital specialist nurses and the public health nurse?

Care of the elderly patient is possibly the area where hospital - public health nurse links are most important. Many of the liaison arrangements which exist are geared particularly towards care of the elderly. The involvement of the public health nurse, under the Nursing Homes legislation, in the assessment of elderly patients for nursing home care adds another dimension to her work with the elderly.

The Years Ahead recommended that the function of coordinating services for the elderly in each district should be the responsibility of a district liaison nurse. The report envisaged that the district liaison nurse for the elderly would normally be a senior public health nurse (3.13). This nurse was to be supported by a district team for the elderly, representative of those with direct responsibility for providing services for the elderly. These district teams were to serve populations of 25-30,000.

In practice, implementation varies a lot from board to board. In the **north-east**, the matrons of geriatric hospitals are the district coordinators of services for the elderly.

In the **north-west**, the matron of a geriatric hospital is the district coordinator and there is also an area coordinator.

In the **east**, an area medical officer is coordinator of services for the elderly. In all community care areas, a senior public health nurse is team leader for the district care unit. A liaison public health nurse liaises with hospitals within her community care area. In Kildare, a geriatric liaison nurse deals exclusively with the geriatric services.

In the **midlands**, two experienced PHNs operate as liaison nurses for each county. Most of this work is in geriatrics. PHNs on the ground coordinate services at local level and an area medical officer is nominated as coordinator.

In the **mid-west**, senior public health nurses act as coordinators of services for the elderly.

In the **south**, a senior area medical officer is coordinator of services for the elderly. A senior public health nurse visits hospitals once or twice weekly (depending on the hospital size) to discuss patient discharges etc. She subsequently liaises with the area - level PHNs, who work with the families.

In the **south-east**, there are geriatric liaison nurses in each community care area and senior public health nurses who look after the management side of services for the elderly, for example assessments for nursing homes.

In the **west**, there is one liasion nurse in Roscommon and one in Mayo. In Mayo, a geriatric committee headed by a geriatrician controls all the beds. In the Galway community care area, there is a general liaison nurse and a geriatric liaison nurse.

There is need for preventive work by the nurse with the elderly as well as the provision of care. This preventive input is seen as an important part of the role of the PHN. In relation to the provision of care, PHNs today generally see themselves as responsible for the organisation of care. Such care may be either personal care or nursing care and may be provided by carers, home care assistants or RGNs. The

PHN has an important supervisory and coordinating role in this area. The organisation of services for the elderly at local level will be one of the major challenges of the coming years and there is a case for the development of pilot approaches which draw on the skills of a variety of personnel.

4.4 The PHN and the Psychiatric Services

Deinstitutionalisation and the development of community psychiatric services have been two of the major aspects of change in psychiatric services in the last decade or so. One consequence of these changes has been that many psychiatric nurses have moved into the community from the hospital. The development of links between the public health nurse and psychiatric nurses has been a new challenge for the public health nurse.

Some of those interviewed for this study described those links as poor and others saw them as extremely positive. There is frequently criticism in Ireland, however, of the development of a psychiatric service in the community in parallel with the existing community care service.

The deployment of specialist nurses such as community psychiatric nurses in the community would appear to undermine, at least in theory, the concept of the all-purpose community nurse and to lead to a certain reduction in the role of the PHN. Psychiatric care can be seen, however, as a very specialist area needing the involvement of specialist personnel. PHNs nevertheless continue to have some involvement in the care of psychiatric patients.

4.5 The PHN and Voluntary Organisations

The nurse's accessibility to the local community and her knowledge of local conditions makes her a valuable resource to the local community.

The PHN has a good deal of informal contact with a wide variety of voluntary organisations in her district. A Southern Health Board nurse contacted during this study gave some examples: Muintir na Tire, Catholic Marriage Advisory Council, Caring and Sharing Association, Meals on Wheels, Community Councils, the St Vincent de Paul, etc.

The PHN has been given a role in the assessment of individuals for nursing home services and thus has an important role in liaising with these private organisations. Care of the elderly is one important area where the nurse has a significant role in identifying the need for informal care and support and in arranging such care.

4.6 Conclusion

This chapter has sought to give an account, which is by no means comprehensive, of the services and professions with which the PHN interacts. The nurse's extensive network of relationships may be inferred from this account. Many of the links described in this chapter are quite informal. One exception is the liaison system with general hospitals, which operates on a more formal basis. The PHN

clearly liaises very effectively with a great variety of other professionals and services. Some of the problems in relationship to which this chapter has referred may indicate a need for more structured links in some areas.

CHAPTER 5
RESULTS OF RESEARCH

5.1 Introduction: Interview Methodology

This chapter reports on the interviews which were carried out for this report. Thirty-seven structured face-to-face interviews were carried out in the preparation of this report. Strong emphasis was placed in the report on interviewing area-level public health nurses and on including representatives from each health board. Fifteen such interviews were conducted with seventeen public health nurses. Thirteen nurses were interviewed individually and four in pairs of two. Six interviews were held with nurses in the Superintendent and Senior grades. Sixteen interviews were also held with those in management positions, with hospital-based nurses, with representatives of other professions and with personnel involved in the policy area. A full list of those interviewed is given in the Appendix.

The first part of each interview provided material for what is known as a "SWOT analysis" - that is, an analysis relating to the perceived *s*trengths, *w*eaknesses, *o*pportunities and *t*hreats of, or facing, the service. The term "SWOT" comes from the first letter of each of these dimensions. The second part of each interview included questions on the current role of the public health nurse and her desirable future role, current links with other professions and services and desirable future links. A full list of questions is given in the Appendix.

A "SWOT" series of questions invites respondents to reflect on negative as well as positive dimensions of their work. Clearly, the public health nurses who referred to what they saw as currently negative aspects of their work or service were making these comments in the context of a very strong professional commitment to their service. It should also be note that the comments, both positive and negative, about the public health nursing service which are reported in this chapter were made by a wide range of health services personnel and not just by public health nurses.

The public health nurses interviewed were generally selected on the basis of contacts established with the National Committee on Public Health Nursing. Some interviews were carried out in parallel with meetings of the committee. Given that relatively large numbers of face-to-face interviews had to be carried out, it proved convenient to interview several nurses in the same venue in this way. Some interviewees were selected on the basis of recommendations - for example, the two general practitioners, one of whom came from a rural area and the other from an urban area, were among a number recommended by the Irish College of General Practitioners. The two hospital matrons who were interviewed each nominated for interview a ward sister from their hospital.

Some of those interviewed were clearly crucial individuals at national level in the public health nursing field - for example, the nursing adviser in the Department of Health, the President of the Institute of Community Health Nursing and the director of the public health nursing programme in UCD.

While the views of interviewees were not known in advance, the lack of randomness in the selection of interviewees may seem to lessen somewhat the representativeness of the views reported. The views reported here are clearly not those of a random sample of public health nurses and other health care workers. Time and resources were not available to carry out a large-scale, nationally representative survey. On the other hand, as noted in the Introduction, the focus of this exploratory research was on the range of current perceptions rather than on their prevalence as such. The number and range of those interviewed, the nature and depth of the interviews (structured, face-to-face interviews generally lasting between thirty minutes and sixty minutes), and the range and diversity of the views reported provide a rich source of information about current thinking on public health nursing across the country. While some sharply divergent views are reported , the results of interviews tended in general to be mutually reinforcing and appeared in that sense to provide an authentic picture of current thinking on public health nursing. The sections which follow provide the results of the study under the different headings which have been indicated.

5.2 Strengths

The major strengths identified (in decreasing order of importance) came into categories such as the area-based nature of the nurse's work, her access to every home and family, her generalist role, her knowledge and value to the health services as a resource, the acceptability of her service, her role as a link person and various specific strengths.

* *Area - Based Nature of Work*

This covered the nurse's role in managing services in her area and what one respondent called her "continuous contact" with people, which can be seen as a fruit of the area-based nature of her work.

* *Access to Homes and Families*

Phrases such as "access to every home and family", the first point of contact for the family, a family-centred service and the public face of the health board on the ground were used. Points highlighted included the role of the PHN in primary prevention and the fact that PHNs had a mandate to visit the homes of people who are well.

* *Generalist Role*

Generalist in this context means in the first instance the curative and preventive dimensions of her role but also her responsibility for people for all ages and of every condition - an aspect which links the generalist point to the access point outlined above. Some comments highlighted her "holistic view of needs", the fact

that she deals with the whole person at all ages (or, as one respondent put it, has a "cradle to the grave" responsibility) and her "overall view" of the service.

**** Other Strengths***

Other strengths highlighted included the strong educational background of the nurse, the acceptability of her service and the link role of the PHN. This included her role in linking with other services, with GPs, with voluntary organisations and her work in the hospital-community liaison system. Knowledge of the role of other professionals was underlined by one respondent, who stated that "every professional will work at some stage with a nurse but not necessarily with every other professional".

More specific services or strengths which were mentioned included the pre-school child welfare service, geriatric surveillance, preventive work and immunisation, health promotion, flexibility, and the nurse's skill in contact tracing of people with infectious diseases. Reference was made to the maturity of PHNs, who tend to be somewhat older on average than registered general nurses (RGNs).

Other strengths identified included continence work, screening, group facilitation, counselling, the nurse's practical approach, confidentiality, the "relative independence" of the nurse and her place in the formal structure of responsibility in the health board. The knowledge of the nurse was also highlighted. This was seen as a resource for the health board - that is, both knowledge of the area, and knowledge of the health services.

5.3 Weaknesses

The second question which respondents were specifically asked related to the weaknesses which they perceived in the public health nursing service. The weaknesses identified have been grouped into a number of categories. The major categories relate to resource problems, isolation, confidence/appreciation issues and the generalist role.

**** Resource Problems***

The most commonly mentioned problems were resource problems. Some respondents said that there weren't enough public health nurses, or that there weren't enough nurses in primary care, or that populations in areas were too big, or that there was a lack of resources. Some respondents referred to the lack of an infrastructure or of back-up facilities of various kinds e.g. the lack of secretarial back-up or of RGNs in the community, of carers, of OT services or equipment. Some comments here related to a perceived lack of type for clerical work or to the perception that work could be organised better in a clinic. This latter comment can be seen as an organisational comment as much as a resource comment. The respondents who referred to duplication of form-filling can also be seen either as criticising an organisational defect or a resource problem of lack of clerical back-up or both. Reference was also made to the lack of money for research.

** Isolation*

A very specific problem mentioned by several respondents was that of isolation. In a few cases, the problem of isolation in a rural context was highlighted though one public health nurse respondent stressed that the urban PHN was also isolated. Another PHN respondent used the phrase "we don't support each other". A number of respondents in this category also referred to the problem of the isolation of the PHN from GPs or from the hospital.

** Confidence/Appreciation Issue*

The problem of isolation can be linked to that of a self-confidence/appreciation problem. Close to half of the respondents mentioned a problem of lack of confidence or of appreciation by others of the work of PHNs. Confidence is clearly affected by a perception of lack of appreciation by others. Words or phrases such as "stressful", "feel at the bottom of the pile", "our opinion doesn't matter", "PHNs don't value their work", "our role isn't understood", "we haven't sold ourselves" "others have a confused view of our work" were used. A couple of respondents saw the all-female nature of the PHN group as a problem - PHNs were seen as "not assertive", "not able to use power" or "not well organised". Some saw as a problem the fact that PHNs stayed so long in the same areas and changed area very rarely, or that PHNs were an older age group on average and slow to change. In one view, it was very difficult physically to work until the age of 65 but there was no potential to change the tasks of nurses over a certain age. Other responses saw PHNs as doing the work of others or work that others wouldn't do, for example, the care of psychiatric patients in certain circumstances or the treatment of incontinence. Two respondents, including a GP, saw it as a problem that other people controlled the work or decisions of PHNs. This could be reflected, for example, in externally imposed mileage restrictions or in very detailed requirements for record-keeping and form-filling by nurses. Nurses, in the view of one social worker respondent, "were trained to carry out the decisions of others". One Superintendent respondent felt that job satisfaction was poor and that service objectives were unclear.

** The Generalist Role*

As well as being seen as a major strength, the generalist role of the nurse was also seen by some respondents as a weakness, in that it made it difficult for the nurse to focus on specific areas. Critical comments here included the following: "jack-of-all-trades and master of none", "job description not defined nationally", "no parameters to role". Another view was that the generalist nurse could not keep up with current specialisation. Additional comments which were possibly related were that nurses were afraid of change or were not rewarded for change - change in this context might include a more specialist role. The argument was also made that PHNs were not using their skills, for example in the health education field.

The generalist role clearly includes both a preventative and curative dimension but some respondents felt that the curative dimension took precedence over the preventative and that this was a serious weakness. Expressions such as "reactive", "crisis intervention" and even "knee-jerk reactions" were used in this context.

*** *A Medical Model***

A comment from outside the Public Health Nursing Service was that the service followed a medical model rather than a primary health care model and that current practices were based on historical factors rather than on proven need. Another view here was that there is no common philosophy or mission in public health nursing and that as PHNs operated in quite an independent way, they had strong need of a common philosophy. In this view, the service was based on individual preferences rather than on objective measures and had developed differently in each area. A related comment from another respondent was that local needs were not taken into account in determining caseloads.

*** *Educational Problems***

Preventive work includes areas such as identifying and responding to need and is particularly dependent on educational and updating opportunities. The preventive problem may therefore be linked in this sense to the educational weakness which was identified by some respondents. These respondents highlighted the limited opportunities afforded for further education or even for staff meetings. The fact that costs for training courses are not now met by health boards was highlighted by some respondents. Reference was made to the lack of access to a library and to limited chances for promotion.

*** *Organisational or Co-ordinating Weakness***

Respondents here made comments such as "no structures for collaboration with GPs, social workers" and highlighted problems of coordination with GP and other services. Problems identified here included the perception that the work PHNs did in facilitating statistics gathering by other respondents was not recognised, problems of bureaucracy in management, and of mistrust between community and hospital nurses. A medical respondent felt that PHNs were inclined to engage in empire-building and to set up new services without consultation. One respondent argued that there were too many middle managers in nursing (i.e. too many senior nurses), that there was duplication of services, for example with the home care nursing of the hospice service, and that it was wrong to be moving PHNs around. This latter criticism incidentally was in direct contradiction with the earlier reported criticism that PHNs stayed too long in their areas and with the view expressed by one respondent that there were far too few senior nurses and that structures had not been developed. Another comment was that nurses were not involved in planning or decision-making or that there was a lack of planning and evaluation.

** Specific Weaknesses*

Some identified weaknesses related either to specific services or to specific problem areas. Five respondents in management positions in community care highlighted issues such as what was variously described as a lack of standards in record-keeping or in the approach to care; the "nine-to-five aspect" of the service; a "very patchy" child development service; "serious doubts about the value of school inspections"; and difficulties in evaluating the health promotion work of PHNs. Some responses identified the child development services as a problem area. "Who deals with disruptive children?" one asked. Several respondents identified problems in services for the elderly, including the lack of an accurate geriatric register, unclear lines of demarcation between the Coordinator of Services for the Elderly and the Superintendent, PHN and, in the view of one hospital nurse, a lack of commitment by some PHNs to elderly medical patients who required a lot of home care. Another comment here was that the increase in the number of elderly was increasing the pressures on nurses. Two respondents on the hospital side felt that PHNs were trained to manage rather than to give care.

5.4 Opportunities

An "opportunity" in this context means a development which increases demand for, or changes the scope of, the public health nursing service. The development in question may not be a positive one in itself - for example, increased unemployment or social deprivation are social evils which are greatly to be regretted but they do increase demand for services such as that provided by the PHN.

** Social and Demographic Changes*

Understood in this sense, social and demographic changes were seen by many respondents as an "opportunity" for the PHN. Several highlighted demographic changes such as the increase in the elderly population, the drop in the number of toddlers and in the number of carers at home. One comment cited an increase in cases of substance abuse and AIDS and in the number of single mothers. Another highlighted a need for a more structured type of counselling by PHNs, which "would be desirable and more cost effective in the long run". Greater public demand and higher public expectations, unemployment and social deprivation were also mentioned.

** Needs of the Elderly*

Some respondents highlighted the special needs of the elderly - whether for night sitting or night nursing services, for screening or anticipatory care, or for assessment. Others also cited the elderly in referring to the implications of the Nursing Homes Act but one (a PHN) argued that while the superintendent visited nursing homes for assessment, there was "no input" by the PHN.

** Opportunities and Strengths*

Some replies linked opportunities and the strengths of the PHN, which one respondent defined as "their access to homes, their flexibility and their presence as the 'eyes and ears' of the health board". One response saw the need for

coordination in the community as an opportunity - in this view, the nurse was well equipped to be a coordinator because of "her universal access to the population, her skill in assessing people and needs and her awareness of the role of other professionals".

** Opportunities Following on a Role Change*

Some respondents identified opportunities for the PHN if changes occurred in her role. These recommended changes included delegation, teaming up with GPs in a coordinated service, specialisation, and working as a manager or coordinator of care, including the management of the work of RGNs. A GP respondent felt that there was a need for the nurse to act in a more independent way and to develop linkages on the ground. It was argued that there was a need for more openness to teamwork among nurses. A GP respondent identified a move towards primary health care teams, especially in rural areas, as an opportunity. This respondent felt that there was an opportunity to have "a nursing unit in general practice including the PHN in a district and the practice nurse within a practice". This, he argued, would increase professional nursing contact. Another GP felt that the allocation of vaccinations to general practice would "make it easier to pursue the follow-up".

A Superintendent identified an opportunity for nurses if more discretion and looser structures were permitted to the Superintendent. A PHN respondent highlighted the need for definition of the role of the nurse if opportunities were to arise. Two PHN respondents highlighted the need to make people more responsible for their own health by showing families, for example, how to deal "with young people with disability or with elderly people". A hospital ward sister argued that PHNs should be more involved in respite care for the young chronic sick.

** Health Promotional Opportunities*

Reference was made to the importance of needs identification and the development of health profiles, and to the importance of the primary health care/Health for All model, which was seen as an opportunity for the PHN service. Other views were that there was a demand for health education and ante-natal cover but that there was a shortage of PHN personnel to carry out this work, and that targets in areas like immunisation would be an opportunity for the nurse.

** Service Changes*

Some respondents pointed to service changes as an opportunity for the nurse - for example, shorter lengths of stay in hospitals and earlier discharges, including earlier discharges for babies, more home delivery for babies, all of which were leading to greater need for care in the community. Some respondents saw the new Child Care Act as a potential opportunity for PHNs, though a few PHNs felt that the Act had not yet led to significantly increased resources for PHNs. One view was that the Health Strategy was an opportunity, "provided that we have the insight and ability to use it to our advantage".

** Miscellaneous Opportunities*

These included group work, further education and specialisation, an input into women's issues, the work of specialist hospital nurses in the community, and liaison with voluntary organisations.

Some respondents either felt it inappropriate to comment on opportunities facing the PHN service or could not identify any such opportunities.

5.5 Threats

** Role reduction*

Respondents were also invited to comment on the threats facing the public health nursing service. One of the major threats which was mentioned by the majority of respondents was that of possible role reduction. This threat was seen as coming from many sources - GPs doing screening, twilight nurses, community psychiatric nurses and social workers, OTs and physiotherapists, hospital-based midwives, AMOs moving into health education, and nurses who may do mother-and-child services. "Threats" which were mentioned frequently included those posed by RGNs in the community, (the most frequently mentioned "threat") specialist hospital nurses in the community, carers in the community and home helps.

Several respondents who did refer to possible "threats" in this sense added, however, that other personnel should be seen as a resource rather than a threat. Some PHN respondents argued that while some colleagues saw certain other personnel as a threat, they themselves saw these personnel as a potential resource.

In relation to RGNs in the community, one Senior PHN reported the PHN view that such nurses should report to the PHN rather than to the Superintendent. One view was that RGNs would be a threat "if there are not enough PHNs qualified and employed". Other replies expressed the fear that the PHN would be seen simply as an RGN. On the other hand, one respondent argued that even with RGNs in the community, there was still a need for "someone with an overview". Another view from public health nursing was that RGNs would only be "as much of a threat" as PHNs allowed them to be.

In relation to GP practice nurses, one respondent saw this GP/nurse relationship as a "controlling role". Another saw practice nurses as a threat, "especially if they go out to the community". The threat, in one perspective, was that practice nurses would be doing things the PHN was not - for example, ECGs or blood tests. It was argued that practice nurses would be a threat if they received a lot of training in the future. A PHN respondent argued that practice nurses were already receiving considerably more training than PHNs, but that these nurses should be seen as a complementary resource rather than as a threat. Those respondents who saw specialist nurses in the community as a possible threat all envisaged a role in this area for PHNs. One saw the work of specialist nurses as complementary to that of the PHN but noted that the specialist nurse was sometimes seen as the "expert". Another identified a possible threat from nurses interested in health promotion, an

area where, in this view, "PHNs don't do enough". It was also argued that specialisation in the community needed to be integrated with the hospital services.

* ***Isolation***

Isolation, it was argued, led to poor morale and to a lack of skills development. The stress of the job was also identified as a major threat - one PHN argued that "many nurses won't last till 65".

* ***Child Care Act***

The Child Care Act was seen as a threat by some respondents. It was argued that there could be a conflict between the health promotional role of the PHN and the task of identifying children at risk. In one view, the prospect of going more to court was a problem, while it was also suggested that PHNs had not been adequately informed about the implications of the Act.

* ***Tensions with Other Disciplines***

Some respondents made specific reference to problems in the GP-PHN relationship. In one view, the role of PHNs was not clearly understood by other disciplines: "We see ourselves as having a broad brief - they see us as bed-side, hands-on nurses like hospital nurses".

* ***Problems with Management***

Some respondents saw the Superintendents as a problem, either because they lacked consistency or were not supportive or were "dictatorial". There was criticism of the "rigidities" of management in the PHN service. Two respondents, one a senior and one an area-level nurse, had diametrically opposed views of a specific management issue. The senior argued that the failure of PHNs to move around was a threat while an area level nurse in another board saw the prospect of being moved around as a threat. Restrictions on mileage and the lack of involvement in planning were also seen as a threat. Two area-level nurses saw the new information system in the PHN service as a threat. Apart from the practical difficulties involved in completing its forms, these nurses considered that under this system they were "being monitored for every minute of their working day" and that this level of monitoring did not apply to other health professionals.

* ***Miscellaneous Threats***

These included the lack of promotional opportunities, an absence of communication about the implications of the Nursing Homes Act, the emigration of the young leaving the elderly on their own, early discharge from hospital, the threat of litigation in child abuse cases, the difficulty of finding time for research, the low priority given to the schools service, the problems posed by new age travellers, the separate operation of the community psychiatric service and the PHN service, and what one respondent described as the "lack of a good union". Other views were that safety issues had not been properly addressed and that change or the fear of change was a threat to nurses.

A number of respondents either did not reply to this question or in some cases did not consider it appropriate to do so because they came from outside the service.

5.6 Current Role of Nurse

There was a good deal of common ground in the perceptions of those interviewed on the role of the nurse. In principle, the nurse has both a curative and preventive role and both roles were explicitly mentioned by sixteen respondents. Other respondents would have taken it as understood that these two dimensions attached, in principle, to the nurse's role. A number of respondents also highlighted the nurse's responsibility for educational work, surveillance and advice, but it is possible to see these tasks as a sub-set of the preventive role.

* *Generalist Nature of Work*

The generalist nature of her work was emphasised by one Superintendent, who provided the following succinct definition of the nurse's role:
"She is a generalist, who deals with the whole person at all ages, is part of a team and knows when to refer".

* *Work with Specific Target Groups*

Her work with infants, with the elderly and with the terminally ill recurred again and again. One GP saw the nurse as the core professional in relation to the terminally ill. Her schools and immunisation work was also mentioned by several people. The GP respondent cited above also stated that statutory responsibility towards infants is "a primary part" of her duty.

* *Role Neglects Prevention*

Several respondents saw the role of the PHN as one which was mostly curative in practice or one in which prevention was neglected. In the view of one respondent, public health nursing followed a curative, medical model, focusing on certain cohorts of patients, rather than on what she called a primary health care model, "which focuses on the totality of the community". There was not a sense, this respondent stated, of "looking at local needs - urban, suburban and rural - and of looking at caseloads in the context of very varying needs". Another respondent in a management position felt that nurses were being "dragged away" from their preventive responsibilities by the sheer volume of their curative work. A Director of Community Care argued that PHNs were currently too busy to fulfil their important epidemiological role. Two respondents had a somewhat more upbeat view of the current preventive input of nurses: one manager described PHNs as "the unsung heroes" of primary prevention in children and adolescents. A PHN saw the nurse essentially as "a health promoter, looking at the entire family. She uses the opportunities offered by a case to raise other problems".

* *Range and Scale of Work*

The scale and range of the work was well captured by one Senior nurse who said of the role of the nurse that: "it encompasses a curative and preventive role, it is a family focused community nursing service, provides domiciliary home nursing,

wound care management, health education, ante-natal and post-natal care, child welfare services, and a supportive and advisory role in the care of the mentally and physically handicapped, the elderly and their carers".

A PHN in another region emphasised the differences among PHNs. Some were much more "hands-on" than others and involved in bed baths for example. Some delegated to care attendants and some did not.

5.7 Future Role of Nurse

In comment on the future role of the nurse, the major options envisaged were a role as an area manager and greater specialisation. A few respondents envisaged both options occurring together. One view was that the focus "should be more on the client than on ourselves - there is not enough objective assessment of need".

**** Area Management Option***

In relation to area management, the recommendation from one PHN interviewee was that the nurse should become nurse manager of an area, coordinating services and acting in an advisory capacity. What PHNs needed, this view held, "is more care attendants, and RGNs in the community in a support role". These developments would enable the PHN to do more health education work. This response also suggested that PHNs should specialise more, and focus on particular areas such as child welfare.

In principle, the two roles envisaged (that is, greater specialisation and local management of service delivery) seem quite divergent. A specialist role for the public health nurse seems quite different from that of a local care manager who could call on various other, more specialist services. Nevertheless, a nurse might take on a certain specialisation and also manage service delivery locally. One senior who envisaged some specialisation argued that specialists should be nurses on the ground, rather than seniors as at present. (However, a PHN in another health board felt that only seniors should specialise!). She also felt that such PHN specialists should be "covered where necessary". This respondent felt that some PHNs "are very good at general nursing and others at prevention. In future, nurses' preferences could be accommodated". A nurse in another health board area felt that the PHN area manager could specialise in areas such as child welfare. A view of how area management and specialisation might be combined was provided by one respondent who envisaged some specialisation by the PHN but who saw specialisation more as a direction for the RGN in the community: "The PHN should become a manager within her own area and delegate tasks as appropriate. She should supervise ongoing care and develop her primary role, which relates to the promotion of health and the prevention of ill-health. She should work with carers.

The nurse should remain as an all-purpose nurse. She needs all of the skills to be able to manage and delegate. It is important to have specialists within the nursing complement - not necessarily working as specialists but whose expertise can be

called upon. The expertise of the PHN is more to manage the service - specialist work could be done by an RGN. The PHN who had specialist training might do some specialist work, continue with her PHN work as well and provide ongoing education to other PHNs - for example, in the treatment of leg ulcers".

In the view of another respondent, specialisation involves "developing expertise, being a resource while maintaining a generic role. It is not about providing a specialist service to the client. There should be a core group of workers and a flexible budget to buy care thereafter. The PHN at local level should ultimately have her own budget".

* ***Specialisation Option***

Those who advocated specialisation did not always set out the type of specialisation which they had in mind. However, a considerable number of respondents did indicate appropriate areas. These included health education and promotion, epidemiological work including the identification of needs and surveillance work, ante-natal and post-natal support, and child care and child-oriented services. While few responses explicitly related to care of the elderly, other responses including continence work, cancer, terminal illness, respite care, and the planning of curative care can be seen as related areas. Other areas of specialisation mentioned included midwifery, the mentally and physically handicapped, assessment, cervical smear clinics, paediatrics, school nursing services, wound care, occupational health, AIDS treatment and women's health.

* ***Need for National Definition***

Some respondents emphasised the need to define nationally the role of the PHN or stated that there was a need for more nurses if the PHN were to do her job properly.

* ***Clinic Proposal***

A GP respondent argued that the PHN of the future should work more in health centres or clinics, where the nurse could draw more on other resources: "The nurse should organise her time in a more structured way - more time in clinics and less travelling". He also argued that there should be at least one ante-natal visit by the nurse during pregnancy and suggested that if a nurse were more clinic-based, a mother coming for an ante-natal visit to the GP could also visit the PHN.

5.8 Current Links

* ***Liaison System***

In relation to general hospital - PHN mechanisms, respondents identified as important the liaison nurse system, the presence of a PHN on a hospital's education committee for nursing and on its midwifery committee, and the visits of hospital student nurses to the community services.

Links between the public health nurse and the general hospital were an important area covered by respondents. Several respondents saw the liaison nurse system as

a very useful mechanism in the hospital - community relationship. Under the liaison system, a designated public health nurse visits the hospital for information about certain patients who are about to be discharged. In one view, the liaison system worked well because the liaison nurse was an exceptional person rather than because of the system per se. Another view was that while the liaison nurse was a useful mechanism, there were significant problems in the relationship between the general hospital and the PHN service.

**** Problems in Hospital - Public Health Nursing Relationship***

Problems identified here included the early discharge of patients, the existence of the hospital and community services as "two separate services", the lack of referrals in writing, the "haphazard" liaison nurse system, the lack of any formal communication between the matron and the superintendent, the deterioration of the liaison system and the absence of a full-time liaison nurse, and the fact that contacts between the hospital and the liaison nurse were only about certain patients - this respondent argued that the liaison system should apply to all patients. One PHN respondent maintained that the PHN herself could carry out liaison work and that there was no need for a specific liaison nurse.

A maternity hospital matron felt that the liaison system worked well and noted that the liaison PHN visited the hospital twice a week. The matron felt, however, that the nurse had only "limited" contact with hospital staff.

**** GPs and PHNs***

In relation to GP-PHN links, some respondents saw them as good and others saw them as poor. One respondent, a Superintendent, saw them as good in rural areas and difficult in urban areas. A PHN respondent saw them as good in one area but not in another, more urban area.

A senior PHN who had a very positive view of GP-PHN relations stated that this was "the most important link" for the nurse. She added that links were better in rural than in urban areas. A PHN in a different board working in a town stated that "a lot of trust" had been built up between GPs and PHNs. In the view of a Superintendent, the GP, the PHN and the home help were the key core workers and proximity was very important in building links, which tended to be "personality-driven".

Among those with a positive view of GP-PHN links, there were some qualifications. Some emphasised that links were good in rural but not in urban areas. Some stated that while they themselves had good links with GPs, other PHNs did not. One respondent specifically mentioned PHN-practice nurse problems. A PHN who was based in an urban area saw rural PHNs as very "isolated".

Among respondents who saw the GP-PHN relationship as a problem area, comments related to a perceived absence of structures for communication, a decline

in communication in recent years, the need for development of this relationship and a lack of contact between PHNs and practice nurses.

The view of a nurse involved in the policy area was that GPs didn't use nurses adequately or support them. In this view, communication with GPs could be "bad", even "destructive". One of the public health nurses interviewed saw nurse - GP links as a "disaster". Another felt that GPs hadn't updated their knowledge of the terminally ill.

One respondent, a Superintendent PHN, felt that while communications were good, consultation took place only when the PHN went to see the doctor.

On the GP side, an urban GP saw relations with GPs in urban areas as "not great" and indeed as very limited. Nor was there much contact between the nurses working in his practice and the local public health nurses. A rural GP saw nurse - GP links as poor and as informal rather than structured. There was no communication, for example, in relation to weekend resources. He argued that unless there were a shift to a "more structured" approach by nurses, with nurses based more in health centres, links with other professionals would not be built up.

** Social Workers and Public Health Nurses*

While a couple of respondents saw links with social workers as good, other saw links in this area as a problem. Comments made included the following: "no structures for collaboration", "poor communication from social workers about the work of the child care attendants", "no social worker cover at the weekends" etc. One PHN stated that she might have to talk to as many as four different social workers about a single case of child abuse.

A senior social worker who was interviewed argued that there were not "clear boundaries" about what is and what is not the role of the PHN. In her view, clear boundaries were needed, particularly in the area of services for children. Were nurses working with a medical model, focusing on immunisation and similar services, or was their focus more on the social, emotional and psychological needs of children? This "confusion", in her view, was illustrated by the "home makers" posts under the Child Care Act - in some boards, these posts are under the social work service, in others, under the PHN service.

** Other Links*

Other links which were mentioned in a positive vein included those with the mental handicap advisory nurse, community welfare officers, speech therapists, chiropodists, voluntary bodies, and the Garda.

Other liaison mechanisms which were cited included the geriatric liaison nurse, the presence of an area medical officer on the geriatric liaison team, the representation of the Superintendent at meetings about the GP unit, case conferences with social workers, the District Care Team, meetings between District Hospital personnel and

the PHNs and the fact that the Coordinator of Geriatric Services was a nurse.

A PHN involved in the schools service expressed regret that quarterly meetings on child health with child psychiatrists, psychologists, speech therapists etc, no longer took place. She also regretted that there had been much less contact with Area Medical Officers (AMOs) since 1992 because the AMOs were very involved with other issues, for example, services for AIDS patients.

Problem areas mentioned, apart from those already listed, included the home help services, the lack of a district geriatric liaison nurse, the dental services, the home care team, area medical officers and the lack of a clerical back-up.

Several respondents mentioned problems with the psychiatric services, including the lack of adequate arrangements for patients who were being discharged to the community, the absence of links with the PHN service and the lack of psychiatric service back-up.

General Comment on Links

Some respondents were quite wide-ranging in their comments on links with other services while others confined their remarks to one or two services or just made a few general points: this makes generalisation somewhat difficult. A strong theme from the interviews, however, was that links depended more on individuals than on formal structures and could vary a lot from area to area or from nurse to nurse. The clear implication here is that current structures do not facilitate effective links between the public health nursing services and other services.

5.9 Future Links

Most respondents advocated more structured links between PHNs and other professionals and services, including more structured links with GPs, more structured or more developed hospital - community links and some local structure of coordination such as a district care team. Many respondents made a case for one or more of these mechanisms.

Some respondents argued for a national policy defining the role of the nurse or the links between the nurse and other services. A few respondents felt that the nurse should operate as a coordinator or "patch manager". One respondent in a management position envisaged the coordination by a manager (not necessarily a nurse) of community services covering a population of 25-30,000. One PHN respondent argued for better communications by senior managers about changes in services or organisation.

In relation to hospital - public health nursing contacts, the mechanisms suggested included the following:

- closer collaboration between the Superintendent and the Matron;

- a system permitting PHNs to work for a time in the hospital and hospital nurses including ward sisters to work in the community;
- special training for PHNs to deal with complex post-hospital cases;
- a specialised liaison nurse for maternity services;
- the establishment of a named person in the hospital to do metabolic screening;
- a district-based liaison nurse;
- joint care plans between the PHN service and the hospital;
- discharge reports or written referrals from the hospital to the PHN service;
- community services serving hospital catchment areas;
- improved day hospital and day care services;
- community-based ante-natal services;
- a community midwife going out from the hospital;
- more collegiate and less bureaucratic relationships between hospital and community nurses.

In relation to links with GPs and social workers and other personnel, or to area team work at local level, the mechanisms suggested included the following:

- joint seminars for GPs, PHNs and social workers;
- more structured links with GPs, including regular meetings;
- structured area team contacts;
- a formal meeting of the primary health care team once a month;
- multi-disciplinary educational groups at local level;
- standard referral forms from nurses to other personnel and written feedback to the nurse following on such referral;
- the attachment of PHNs to individual GP practices;
- case conferences on problem families;

Some comments also referred to the need for more back-up from, or more structured links with, psychiatric services.

A couple of PHN respondents highlighted the need for PHNs themselves to work as a team. One of these nurses suggested that four nurses might work together in a team and that each nurse would specialise in a particular area. Each nurse would thus have access to specialists in other areas. The hospital OT could be invited to team meetings and the GP and other local professionals could be involved from time to time in the team.

Future Links and Current Links

Future links in the services can be seen as a development of comments on current links. For example, a nurse who highlighted a current absence of case conferences was also pointing out the need for more "group discussion" and case conferences as a way of building links between the professions. A Director of Community Care who saw nurses as encroaching sometimes on the work of other disciplines, also felt that if such "poaching" were to cease, links with other disciplines would improve considerably. By "poaching", this respondent meant, for example, the establishment of services by nurses which (in this view) infringed lines of demarcation with other disciplines.

The GP-nurse links provoked a lot of comment in the question on current links and also produced several suggestions in relation to future links. One suggestion was that nurse-GP contacts should be at several levels - that is, between the superintendent and the local branch of the ICGP, between the senior nurses and GPs and between the public health nurse and her local GPs. It was felt, however, that policy on GP-nurse links would have to come from the Minister. The view of one public health nurse was that informal meetings once a month with GPs would be useful and that referrals to and from GPs should be in writing. Another nursing view was that GPs should "come more to us" and that informal and regular links were appropriate for people working in a definable area. In the view of a Superintendent, the GP unit gave an opportunity for the first time to "get a handle" on GPs and to develop a mechanism for common policies between GPs and PHNs. There was, she said, a need to "foster links with the GP units and need for a plan to improve links. Common in-service education and seminars would help".

On the GP side, suggestions included attachment of nurses to individual practices, once or twice weekly meetings between GPs and nurses, a "more structured" approach to GP-nurse links and more delegation by nurses to secretaries - for example, the organisation of home helps could be done by a secretary following an initial assessment of need by a nurse. This would "free up" nursing time.

In relation to community-hospital links, one nurse recommended that nurses should receive a standard discharge form in relation to those under 5 or over 75; and that a comprehensive discharge report should be issued if nursing care were required for the person about to be discharged. A matron of a voluntary maternity hospital

suggested that a community midwife could go out from the hospital to the community.

Questions relating to the role of the nurse cannot be divorced entirely from the issue of links with other services. The nature of the nurse's role and perceptions of that role are bound to impinge on her links with other professionals or services. Thus a public health nurse felt that a greater effort nationally in defining the nurse's role would facilitate links with other professionals. Another view was that recruitment of nurses from mental handicap and psychiatric services would facilitate links with other services. One nurse advocated greater involvement in specialist services by the nurse and greater availability of back up secretarial services.

The view of one respondent involved in the policy area was that nurses needed to focus more on consumer links and on links with voluntary organisations. In relation to other specifically nursing issues, what was perceived as the bureaucratic nature of the public health nursing services was also criticised. A programme manager argued that multi-disciplinary links were more appropriate than "hierarchical models". A voluntary hospital matron advocated a more collegiate and professional relationship between hospital and public health nurses.

5.10 Conclusions

This chapter has reported on the views of a wide range of respondents about the PHN service under eight headings. A number of themes recurred under several of the headings:

- The nurse has a generalist and very wide-ranging role and there is considerable lack of clarity about its boundaries.

- The pressures of the job and service demands are obliging the nurse to focus on curative work at the expense of the preventive side of her work. Her preventive role is nevertheless seen as a crucial aspect of her work.

- Demographic and service trends such as an ageing population and shorter lengths of stay in hospital are increasing the pressures towards the "non-preventive" aspects of the work of the nurse.

- There are significant problems of coordination between public health nursing and other services and links between the public health nurse and other professionals and services frequently depend more on personalities than on structures. This is clearly a matter of concern. While individual dedication and commitment will always be at the heart of health services provision, effective service provision also depends on adequate structures.

- There is considerable anxiety among many public health nurses about an erosion of their role as other professionals, both nurses and others, move

into the community. There is also a significant body of opinion both within public health nursing and outside it which sees these other professionals as a resource rather than as a threat.

As a number of respondents suggested, this is clearly a crucial time for an examination of the role of the nurse and of links between the PHN service and other services. Interviewees tended sometimes to have clearer views on current problems than on the way ahead. Nevertheless, a number of possible avenues were suggested. Many suggestions for more structured links between the PHN and other services were reported in this chapter. A few respondents argued for a clear national policy both on the role of the nurse and on links with other services - for example, a national policy on discharges by the general hospital to the PHN service.

One avenue suggested by a number of nurses was for the nurse to become an "area manager" or coordinator managing services in her area and delegating, where appropriate, to RGNs, care attendants and other personnel. Some argued that the PHN was already an area manager, in fact, but that the role should be formally recognised and developed. The area management concept was also advocated by several respondents from outside nursing; one envisaged that an area manager need not necessarily be a nurse.

Another avenue suggested was that of specialisation. There was a certain divergence of views here. Some argued that the PHN herself should specialise while others felt that the PHN should call on other specialist personnel, including, for example, specialist RGNs. The concept of the PHN as area manager is certainly compatible with some degree of specialisation by the PHN and some such specialisation has already happened or seems desirable. Nevertheless, the area manager concept seems to fit more easily with a service where others, such as the RGN, specialise and where such specialist expertise is available to the area manager. This chapter has given many examples of the type of specialisation envisaged by survey respondents.

Another theme coming out of the responses was the need for nurses to foster a team approach, with other professions and services in the community, with nursing colleagues in the hospital services but also with PHN colleagues. An important theme of the responses was that many PHNs experience considerable isolation, particularly in rural areas but even to some degree in urban areas; on the other hand, links with GPs were seen as better in rural than in urban areas.

CHAPTER 6
LESSONS FROM OTHER COUNTRIES[1]

6.1 Introduction

The aim of this chapter is to look at the development of public health nursing in other countries, to see how services are organised, what issues are facing the public nursing service, and how these compare with the situation in Ireland. The focus is on European experience.

6.2 Historical Developments

The provision of a community nursing service by religious groups provided the background to the development of public health nursing in many European countries such as Germany and Belgium. In Scandinavia, however, public health nursing arose from the responsibilities of local government.

In its early stages, the focus of public health nursing tended to be on preventive care at the whole population level, with an emphasis on controlling and eliminating epidemic diseases. In all countries, there was a shift in the second half of the twentieth century towards more individually oriented care. The curative role of public health nurses has also grown in importance.

6.3 Organisation and Workload

In some countries there is a separation between child care and adult/elderly care, with different organisations providing services to each group. This is the case, for instance, in Belgium, Germany and parts of France. In other countries such as England, Finland, the Netherlands and Norway, however, childcare and adult/elderly care are provided by the same organisation.

Where both types of care are provided in the same organisation, is not necessarily the case that the same nurses give both types of care. In Finland, for example, in the rural areas and smaller towns each public health nurse aims to provide a comprehensive service to the whole population. However, in the larger towns public health nurses are likely to be allocated to specific patient populations such as child health care, the elderly, and school health care.

Links with other health and social services

In some countries non-nursing health services such as physiotherapy or chiropody are provided by the same organisation to which the public health nurses belong. This would be the case in Finland and Norway, for example. In other countries such services are run by separate organisations. However, it is possible for such non-nursing health services to be provided from the same location, as occurs in England in the district health authorities.

1. Some of the more general comparative comment in this chapter draws on Robert A. Verheij and Ada Kerkstra, *International Comparative Study of Community Nursing*, Avesbury, Aldershot, 1992.

In relation to contacts with other health service professionals, the main contact in most countries is with general practitioners. Usually, the nurse is dependent on the general practitioner for medical prescriptions. However, in England and the Netherlands nurse prescribing for a limited range of interventions is under scrutiny. Contact with general practitioners is usually on an ad hoc basis, in many cases of the order of 2–4 times a month (this would be typical in Finland and the Netherlands). The number of general practitioners a nurse may deal with varies in all countries, generally with lower numbers in rural areas and larger numbers in urban areas. According to Verheij and Kerkstra, attachment to a GP occurs only in England (where seventy per cent of district nurses have such an attachment) and to a lesser extent in Finland and the Netherlands. GPs in Finland work in specific areas, however, and the GP-attached nurses do so too, whereas in England the GPs have less strictly defined areas "and nurses who are GP-attached may have to travel a lot" (p.187).

In most countries, public health nurses work on a geographic areas basis.

Another key contact is with hospital personnel. The norm here is for ad hoc contacts, often based on personally developed relationships. In some countries however, such as England and increasingly in Norway, there are liaison nurses whose task it is to help coordinate services between hospitals and the community based nursing services. Sometimes these nurses are hospital based, sometimes they are based in the community.

In all countries, public health nurses spend most of their time on home visits. Estimates indicate that around sixty to ninety percent of nurses time is taken up by home visits. Administrative activities typically take up around a quarter of the time of public health nurses. These home visit and administrative percentages, which came from Verheij and Kerkstra, are considerably higher than the equivalent figures in the Irish Workload Surveys already cited but it is not clear that like is being compared with like.

6.4 Organisational trends and options in Britain

In Britain, community nurses are employed by the District Health Authority and may be district nurses, health visitors or midwives. Morley et al (1992) report an estimate that 70 per cent of district nurses and health vistors are attached to GP surgeries rather than allocated to a geographical area. Such attachment is less common in inner city areas where there can be a large number of small overlapping GP practices. Morley et al note that many inner London District Health Authorities, for example, have organised community nurses within a geographical area covering a number of practices with which they liaise.

A special report on community nursing carried out in 1986 (the Cumberlege Report) argued that there was scope for making better use of nursing skills and that the effectiveness of the primary health care team needed to be improved. Its main recommendation was that community nursing services be planned, organised and

delivered on a neighbourhood basis. Community nursing services in this context were those provided by district nurses, health visitors, school nurses, midwives and community psychiatric and mental handicap nurses. According to Cumberlege, services should be organised in units small enough to be sensitive to the needs of a population of between 10,000 and 25,000 but large enough to make best use of the staff concerned.

The British Goverment's White Paper on Primary Health Care (*Promoting Better Health*) endorsed the general thrust of the Cumberlege recommendations but did not accept the neighbourhood nursing approach as the single blueprint for service organisation (see par. 7.7). The Report also said (par. 7.9) that the goverment attached considerable importance to the strengthening of the primary health care team (PHCT).

In a circular issued at the same time, the DHSS suggested that neighbourhood nursing might be particularly appropriate in inner city areas: "If the pattern of general practitioner services in such areas is one of a large number of small overlapping practice areas, it may be unrealistic to expect comprehensive linkage with community nursing staff and for the time being working in primary health care teams may be no more than a long-term objective." It was clear, however, from the circular that the establishment of such teams was an important long-term objective.

Morley et al note that few of the proposals from the Cumberlege review have been implemented. "The DOH issued guidelines for locality-based nurse management but each district was left to develop its own policy. Nurses are now more likely to be grouped and managed on a locality basis but this development has been very uneven." (p.8)

A strong emphasis in community care in Britain today is on general practice and may be seen, for example, in the GP fundholding reforms. Taylor argues that morale amongst community nurses has been adversely affected by a fear that they may be marginalised as a result of the current major community care reforms in Britain. It is probably because of such anxieties, he adds, " that some community nurses appear hostile to recent increases in numbers of practice nurses. Between 1988 and the middle of 1990 the total of the latter employed by GPs rose from approaching 4,000 to some 7,500 WTEs (NHSME 1991). The total number of district nurses is currently in the order of 14,000." (p.35)

A report on community nursing produced by the NHS Management Executive outlined a number of possible options for the future organisation of community services. These were:

- that all community nurses could be managed by large independent community trusts; or

- under a locality management/neighbourhood nursing system; or
- that family health services authorities, which traditionally controlled GP services, could also assume responsibility for nursing services; or
- a hospital outreach system where teams from a hospital based management system provide nursing care to specified groups in the community, for example, to those needing mental health care or geriatric support services; or
- GP managed primary health care teams.

In a comment on these proposals, Salisbury (1991) saw the final option of primary health care teams as the most suitable, but argued that it should not be "GP managed." : " A better model would be one in which all staff, medical and non-medical, are accountable to a practice which is run by a multidisciplinary partnership. The nursing members of the practice would be accountable to a senior nurse, who would be a partner, along with the practice manager and the doctors" (p.398)

Salisbury's conclusion presented a stark choice in relation to doctor-nurse links in Britain : "The present inconsistent pattern of nursing should not continue. Doctors and nurses either have to propose structures that will put the primary health care team on a more sound managerial footing, or face an increasing division between themselves and a separately managed community nursing team" (p. 399)

6.5 Specialisation

In their study of international community nursing, Verheij and Kerkstra surveyed nine countries: Belgium, Canada, Finland, France, Germany before 1990, the Netherlands, Norway, England and the US. Of the countries surveyed, they state, the Netherlands is the only country where the same nurse takes care of child health care as well as elderly care. (This is also the situation in Ireland, of course.) In Finland, by way of contrast, specialist working has been the norm, but this is now under discussion. The concern is that the specialist approach causes fragmentation of care and decreases the nurse's commitment to the local community as a whole. Balanced against this is that the increasing complexity of care demands specialist knowledge.

In England, according to Verheij and Kerkstra, the existing division between preventive and curative care causes problems: "Care for healthy elderly is considered to be a task for health visitors and care for the sick elderly a task for district nurses. Some people question the efficiency of this division. Communication between the two types of nurses is often difficult because they work in separate teams." (pp.196-197)

Verheij and Kerkstra argue that the international division of services into separate nurses for preventive child care and curative elderly care works well. They also suggest, however, that there is a need for specialists within curative elderly care:

"In many countries, there is a limited number of specialist nurses whose main task is usually to advise colleagues" (p. 197)

Haste and Mc Donald (1992) have examined, in a British context, the relationship between specialist and district nurses. They attribute a growing interest in specialisation to a fear among district nurses of job erosion and of their job being de-skilled. The authors found in a London survey that most district nurses would have preferred to carry out specialist work themselves but saw this as impossible because of lack of time and heavy caseloads. According to Haste and Mc Donald, the majority of managers and nurses appeared to agree with recommendations in the Cumberlege Report that district nurses" should develop special responsibilities for particular patient groups to combine with district nursing duties" (p. 46)

Cartwright (1991) surveyed a group of English community nurses, hospital consultants and GPs, who had cared for a random sample of people who died, for their views on and experiences of specialist domiciliary terminal care services. In her study, GPs were " rather less enthuasiastic" than the other two professional groups about specialist medical or nursing domiciliary terminal care services. Seventy-nine per cent of community nurses who had some contact with specialist nurses in the care of the dying found them "very helpful", thirteen per cent "fairly helpful" and three per cent "not helpful".

Writing in an American context, Riportella-Muller (1991) et al argue that within the graduate specialty of community health nursing, specialty educational programmes are needed to provide community health nurses with skills specific to the needs of various population groups. Their survey of almost 600 community nursing leaders found that, in the view of respondents, the population groups most in need of graduate-prepared CHNs were:
the elderly, persons of low socio-economic status, the homeless, adolescents and the unemployed;
and that the health conditions most in need of CHN services are:
AIDS, pregnancy and prenatal problems, low birth weight and infant mortality, stress-related illness, and Alzheimer's and other chronic diseases of the elderly.

According to Riportella-Muller et al, these findings provide the direction and justification for developing specialty options within community health nursing that correspond to these identified and changing needs.

Two Finnish academics, Koponen and Pellinen (1993) argue, however, that "generalism" and "specialism" are complex concepts and can mean different things in different contexts - for example, generalism can be seen from the point of view of an individual nurse or a team.

6.6 Audit and Labour Force Issues

Balogh (1992) carried out a review of American and British literature on audits. Her review covered both quality of care and nursing labour force issues. On the basis of her findings, she argues that basing nursing establishments on workload/dependency models is problematic: she cites research which indicates that what nurses do depends more on the number of nurses available and hence on the time at their disposal than on the dependency of the individual patients. In her view, scientific methods (i.e. measuring dependancy or workload) can't remove the need for judgement in assessing nursing labour force needs.

Balogh identifies a number of key problems in developing systematic approaches to calculating labour force requirements:
"Firstly, it is unrealistic to expect timings for nursing activity to transfer from one local situation to another and from one specialty to another. Setting local timings, however, means a great deal of work; one way to resolve this problem is to acknowledge the role that judgement plays in this process and set them by professional consensus. However, it is often difficult to persuade non-nurses that this approach is not biased, because they do not have the professional expertise to corroborate for themselves the subjective element.

Secondly, it is clear that different nursing specialties require specific examination, especially with regard to the very complex area of psychosocial care.

Thirdly,...there is often some confusion concerning how systems are to be used...(There are) two kinds of objective: the setting of establishments and the short-term allocation of staff, and...while some systems have been set up with one of these in mind, they have often been used for the other...

Finally, there is the critical question of the quality of care actually received by patients...The evidence indicates that timings must be locally set, and they must therefore apply to nursing activities which deliver a locally acceptable standard of care. This raises the question of how to ensure that such a standard of care is being delivered" (pp124-125)

Balogh's article reviewed the extent to which the validity of audit instruments had been established. It showed the number of studies to be "small, almost exclusively in relation to American instruments and with inconclusive results." (p.119)

6.7 Funding issues

Generally, public health services are funded through taxation or insurance. Services are normally provided free of charge to users. However, in some countries such as the Netherlands and Belgium, the membership fee for the insurance scheme is used to contribute towards costs. Co-payment is also common in most countries with regard to prescribed drugs and medical services.

6.8 Conclusions

Perhaps the main conclusion from this brief review of European experience is that there is no one way of providing public health nursing or agreement on the role of the public health nurse. A diversity of approaches is evident. Even in relation to more technical aspects such as the calculation of labour force requirements, research does not point to the likely development of any internationally acceptable formulas.

Options for service delivery include services centred around the community as a whole, specific target groups or families. Verheij and Kerkstra refer to a study in Finland, which has experimented with three different models of service provision:

(a) comprehensive model (15 per cent of nurses in the study), where the community nurse delivers all the services needed by a small population.

(b) a semi-comprehensive model (35 per cent of nurses in the study), where the community nurse delivers 3-4 different kinds of service needed by the population - one nurse is responsible for maternity care, another for child care etc., in small groupings of areas.

(c) a specialised model (50 per cent of nurses in the study) where the community nurse delivers one service to the population, for example, maternity or childcare.

In some countries, child care and care for the elderly are provided by the same organisation, in others by different organisations. In some countries, the same nurse will provide services to the whole population, whilst in others there will be specialisation. Even within a single country such as Britain, there are major differences in the patterns of care provision by community nurses in different areas. In general, the specialist versus generalist issue is one which is continually being examined and discussed, with varying results. In both Britain and America, there are currently strong schools of thought which suggest that community nurses should develop special responsibilities for particular patient or population groups to combine with district nursing duties. Koponen and Pellinen stress, however, the complexity of the "generalist" and "specialist" terms and the fact that they can mean different things in different contexts. They also usefully emphasise the importance of clients and the community taking an active part in defining the ways in which nurses are assigned to target populations.

The British Model

British experience obviously has a special relevance to Ireland so the increased emphasis on general practice in Britain - for example, through the GP fundholding system - is also likely to be influential in Ireland. However, it is important that community nursing in Ireland takes account of trends in other countries and not just of those in Britain.

A key point which emerges from an examination of different countries is that there are many similarities in the problems faced by many European countries - for example, the problems faced by an ageing population and an increased demand for more intensive homecare. As Van Amelsvoort (1993) has noted in the Dutch context, (but the same trend can be found in many other countries), these challenges lead in turn to an examination of how closer links can be built between community nurses and other forms of home and family care.

CHAPTER 7
CONCLUSION

7.1 Introduction

This report has highlighted the crucial role of the public health nurse in the Irish health services. The report has pointed to her preventive and curative responsibilities, the range and scale of her work, her strong educational background and her close links with families and the general population in her area. The report has also referred to the increased pressures which the nurse faces in areas such as care of the elderly and child health care.

The problems facing the public health nursing service were very clearly set out in chapter 5, which reported on the results of the research carried out for this study. Some of the key points stressed by respondents included a lack of clarity about boundaries; a focus on the curative at the expense of the preventive; an anxiety about the erosion of the role of the PHN through the involvement of other professionals; and problems of coordination. Some recommended future directions for the PHN included the development of her role as an area manager of services, more structured links with other professionals and services and the need to foster a team approach among nurses themselves.

As noted in the introduction, this study has not set out to describe in a prescriptive way appropriate directions for the public health nursing service in the years ahead. These directions must be mapped out by the nursing profession itself in discussion with other interested parties. The aim of this study has rather been to identify key issues and options facing the public health nursing service.

Briefly put, the main issues highlighted by this study are those relating to:

- the role of the public health nurse;
- her links with other services and professions; and
- specialisation

7.2 Role of Nurse

A key issue, the importance of which was repeatedly emphasised throughout the study, was that of the role of the PHN. The need to clarify the role of the nurse was frequently emphasised. At present, though the nurse's job has a dual purpose (that is, both preventive and curative), many evidently find it difficult to give adequate attention to the preventive part of the role. The nurse's role is also so all-embracing that questions are increasingly asked about whether such a comprehensive brief is in fact realistic. There is certainly a growth in support for the concept of greater specialisation by the nurse.

A central issue is that of whether the nurse's preventive responsibilities should remain as a key part of her work. The consensus in chapter 5 appeared to be that they should. It does not seem, however, that a significant emphasis on prevention is compatible (particularly in the context of an ageing population) with a very significant allocation of time to the care of sick elderly patients. Both prevention and the care of sick elderly persons are crucial responsibilities but it is becoming more questionable whether the same person can do both.

The care of the sick elderly is a key task in community care and one which cannot be carried out on a five day week "office hours" basis. It is a task which demands continuous service cover. If the PHN is to be involved directly in such work, this will require a considerable commitment by the nurse at weekends. An alternative option and one which was more strongly favoured by those interviewed in the course of this study would be for such weekend and night work with the sick elderly to be done by RGNs under the general supervision of the PHN.

A key part of the nurse's role at present is to act as coordinator of services and to link, sometimes in an informal way, with other professionals and services. A strong theme coming out of the interviews, reported in chapter 5, is that a very appropriate future direction for the nurse would be one in which her coordinator's role was more formally recognised. This is a role in which the PHN would act as a local "area manager" - liaising with other professionals and services and delegating to certain categories of staff, for example RGNs and care workers after carrying out the initial assessment herself. The area manager concept would imply an expansion of such categories of staff in the community This role would require more emphasis than at present on the information - gathering aspect of the nurse's role and on the development of area profiles. The area manager concept would also imply close and structured links with other professionals in the community.

7.3 Links

Problems of coordination with other professions and services were emphasised in chapter 5, which also pointed to the need for structured links with the hospital and with other services in the community. Clarification of the role of the public health nurse will clearly facilitate links with other professionals and services. A key area where effective links are needed, as noted in chapter 4, is care of the elderly but structured links are also very important in areas such as child care. The significant recent emphasis on, and allocation of resources to, general practice and to education and training for GPs (described in chapter 2) would suggest that the GP-nurse relationship is a crucial relationship which needs to be examined and worked on. Issues here include referral procedures, arrangements for contact between the GP and the nurse and weekend arrangements.

It would clearly be wrong to give the impression that clarification of roles or of relationships with other professionals or services are straightforward processes or that even where such clarification is well conceived in theory, it must necessarily work well in practice. However, such clarification is a necessary first step for progress in this area.

7.4 Specialisation

The increased presence of other professions in the community - for example, palliative nurses, specialist nurses from the hospital, RGNs - raises the question of where precisely the boundaries lie with public health nursing and what, if any, overview function ought to be maintained by the PHN. The rise of these new specialisms also prompts examination of the issue of specialisation itself - in particular, should the PHN herself specialise and if so in what way? and what should her relationship be with the specialist nurses in the community?

Areas of specialisation highlighted by the respondents in chapter 5 include health education and promotion, ante-natal and post-natal support, child care and child-oriented services and care of the elderly. The area manager framework mentioned above does not exclude some degree of specialisation by the nurse. A good deal of specialisation already takes place within public health nursing in areas like mental handicap counselling, liaison work on services for the elderly, continence management etc. A Superintendent Public Health Nurse quoted in chapter 5 noted that it is possible both to have specialist skills within the public health nursing complement and to avail of the specialist work of RGNs. Nevertheless, specialisation up to now has had an ad hoc dimension. There is need for specialisation within public health nursing that is carefully planned and structured within an overall assessment of the needs of the population in a particular area. Greater clarity about the role of the PHN and the development of a more specialist role or of a greater range of specialisms within public health nursing should also contribute to an improvement in the morale problems of public health nurses which are highlighted in chapter 5.

As noted in chapter 6, international trends do not necessarily present any very clear models for the future organisation of public health nursing in Ireland or for specialisation. Even in more apparently "scientific" areas such as workload or dependency measurement, there are no simple formulas for the calculation of nurse labour force requirements. However, as the chapter noted, there are arguments in British and American literature that community health nurses should develop special responsibilities for particular patient or population groups. The frequent organisational distinction, where international community nursing is concerned, between child care and care of the elderly is also worthy of note. On the other hand, the current Irish system, where the nurse cares for both children and the elderly, has the advantage of variety and of a significant range of work.

7.5 A Climate of Change

Public health nurses have experienced significant change in recent years and an atmosphere of uncertainty. The environmental changes impinging on the public health nursing service, which were outlined in chapter 2, have in some cases increased significantly, at least in principle, the need for the services of the public health nurse. The uncertainty described by many nurses in this study relates to lack of clarity about the role of the nurse and about the nature of her links with other services in the community or in the hospital. This climate of change and uncertainty, while one of considerable difficulty, if not crisis, for many nurses, can also be seen as a moment of opportunity: the opportunity, in other words, to re-examine the public health nursing service and to map out directions for the service in the years ahead.

The organisation of public health nursing in the future must clearly take account of the wishes and aspirations and views of public health nurses. At a more fundamental level, the nursing service will progress only if it responds to, and is focused on, the needs of the population and of individual patients and clients. Closeness to the community indeed is one of the traditional strengths of public health nursing on which it can build. Responsiveness to the needs of the community also means that public health nursing should not be seen in isolation but rather in the context of the whole framework of health and social services within which it is a key element.

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APPENDIX 1

INTERVIEWS HELD ABOUT THE PUBLIC HEALTH NURSING SERVICE.

The following questions were asked of those interviewed as part of this study. The results of the interview were given in chapter 5.

- What do you see as the strengths, weaknesses, opportunities, and threats (of or facing) the public health nursing service?
- What is the current role of the public health nurse?
- How do you think that role should develop?
- How do you see the links at the moment between the public health nursing service and other community and hospital services?
- How do you think those links should develop?

THOSE INTERVIEWED

Those interviewed for this study were the following:

- Nursing Adviser, Department of Health;
- The Director of the Public Health Nursing Programme in University College Dublin;
- Three Superintendent Public Health Nurses from different health boards, one being the President of the Institute of Community Health Nursing and another being the Chairman of the National Committee on Public Health Nursing;
- Three Senior Public Health Nurses from different health boards;
- Seventeen area-level public health nurses including at least Two from each board and one involved in schools work;
- Two general practitioners from different health boards;
- Two hospital matrons, from a health board university teaching hospital and a voluntary maternity hospital;

- Two ward sisters, from a health board university teaching hospital and a voluntary maternity hospital;
- Two directors of community care, from different health boards;
- Two programme managers, community care from different health boards;
- A community psychiatric nurse;
- A senior social worker;
- A community care administrator; and
- An addiction counsellor and former public health nurse.

Appendix 2

STEERING COMMITTEE MEMBERS :-

Western Health Board

Mary McDermott
Community Care Offices
25 Newcastle Road
Galway
(Chairman)

Margaret McLoughlin
Community Care Offices
25 Newcastle Road
Galway
(Secretary)

Teresa Durkan
County Clinic
Castlebar
(Treasurer)

Eileen Kelly
Community Care Office
Roscommon

Helen Browne
Inisheer
Aran Island

Helen Duffy
County Clinic
Castlebar

Mary Byrne
Health Centre
Claremorris
Co Mayo

Celine Judge
Health Centre
Ballymun

North Western Health Board

Mary Whyte
Markievicz House
Sligo

Dorothy Meehan
Health Centre
Raphoe
Co Donegal

Margaret Hynes
Cloghan Health Centre
Cloghan
Co Donegal

Dympna O'Dea
Cliffoney Health Centre
Sligo

Pauline Diamond
Skreen
Co Sligo

Margaret Maguire
Health Centre
Blacklion
Co Cavan

North Eastern Health Board

Mary Brady
Loch Gowna
Health Centre
Co Cavan

Florence Greene
181 Brookville Park
Drogheda

Antoinette Doocey
Ballyboggan Health Centre
Parke
Kinnegad

Riona Laverty
Health Centre
Laytown
Co Meath

Eastern Health Board

Marion Green
Vergemount Hall
Clonskeagh
Dublin 6

Teresa O'Keeffe
Health Centre
Ballymun
Dublin 11

Margaret Burke
Community Care Offices
Poplar House
Naas

Midland Health Board

Eleanor Dowling
Health Centre
Dublin Road
Portlaoise

Catherine Leavey
County Clinic
Dublin Road
Portlaoise

Molly Buckley
Moylena
Clara Road
Tullamore

South Eastern Health Board

Mary Mahon
County Clinic
James Green
Kilkenny

Patricia O'Dwyer
Bansha
Co Tipperary

Southern Health Board

Elizabeth Mansfield
Health Centre
Hospital Grounds
Midleton
Co Cork

Shiela Cahalane
Grattan Street
Health Centre
Cork

Maureen Roche
Grattan Street
Health Centre
Cork

MID WESTERN HEALTH BOARD

Claire Healy,
O'Malley Park,
Health Centre,
South Hill,
Limerick.

The committee was established on 10 September, 1993.

The members of the committee wish to thank all the public health nurses who made submissions and who contributed to the cost of the report

FUNDING OF THE REPORT

These pages give a list of the public health nurses who contributed to the funding of the report.

WESTERN HEALTH BOARD

Co Galway

B O'Malley
M McDermott
J Deely
M O'Malley
B Blackwell
T Sheehan
M Coady
M Holian
D Greally
B Bolger
A Dooley
L Solan
R Caffrey
M Kelly
A Fahy
M Kelly
C Ni Ghiolla
M McLoughlin
A Moylotte
M O'Connor
M Regan
M Cooney
J Reynolds
E Coleman
M Syron
B Lohan
D O'Neill
M Bruton
T Minton
K Farrell
C Quinn
P Flannery
N McAleer
M Henry
M Kelleher-Durkan
I Carter
M Kane
J Finnamore
E O'Malley
E Clarke
J Ryan
C Walsh
M McClafferty
B Fitzpatrick
P Morris
M Day
F Lynch-Faherty
A Skelly
M Tummon
B Fahy
M Fitzpatrick
K Malee
M Coleman
C Stewart
M T Murphy
M Kinneavy
S Kelly
C Donnellan
A Joynt
Sr A Glennon
M Finlan
T Stankard
A Kenny
M Gorman
H Browne
Sr R Mollin
D O'Grady

Co Roscommon

F Keaney
M Hughes
B Greally
Mrs A Nolan
P Macklin
M Devine
A Nixon
M Queenan
C Higgins
B Kneasfey
E Naughton
M Keely
E Judge
M Winston
E Begley
M Casey
M Duffy
E Kelly
A Flanagan

Co Mayo

M Byrne
B McGovern
M C Davies
A O'Malley
E Collins
M McDonagh
M Hussey
B Sammin
B Reilly
E Gallagher
P Barrett
M Moran
E Hunt
G Campbell
M Collins
C Hughes
C Fitzgibbon
A Sammon
M Kenny
C Lavin
A Maguire
B Grogan
M Barret
M B Kelly
M Dunne
D Quinn
K Keaveney
M Prendergast
N O'Hora
H Duffy
T Durkan
A Boland
A Murphy
M Murphy
M Cawley
M McDonagh
V Lowery
C Needham
M Kelly
M McCormack
M Egan

K Morley
M Lyons
S McCarthy
T Melvin
M Kelly
M Gormley
C O'Malley
A Stewart

NORTH WESTERN HEALTH BOARD

Co Sligo

M Curran
M White
E Geraghty
S Golden
B McGarry
Sr F McDermott
A Mitchell
D O'Dea
M Bartley
M Tansey
A Ryan
M Rooney
C Conroy
J Mullaney
R Conlon
M McDonagh
C Brennan
P Diamond
S Hopper
U Duffy

Co Leitrim

P O'Hara
E Burke
P McCormack
I Freeman
M Reilly
U Brady
M Sharpley
B Boles
M Feely
R McGowan
D McNulty
M Maguire
M Gaffney

Co Donegal

M M Hynes
A Murphy
G D Gallagher
A Reilly
J Dolan
D Gallagher
M McHugh
D Meehan
M McLaughlin
P Hasson
R Doherty
M Farren
M Cunningham
A Kelly
A Madden
M Blair
A Henry
M Boyle
F Gallagher
T Connolly
B Brady
F McGloin
E O'Hanlon
B Jackson
A Anderson
R McNelis
M Strain
M Rodgers
G Love
P Kerr
T Leyden
S Stewart
M Hynes
T Leyden
P Scott

NORTH EASTERN HEALTH BOARD

Co Louth

F Greene
P McDonnell
K Kerley
A Prendegast
A Dorian
B Doherty
M Dooley
D McCourt
J Fitzgerald
K Gaynor
C Smyth
M Doyle
A Oakes
T McCormack
M Matthews
S Meehan
H Duffy
Sr K Gallagher
E Higgins
M Campbell
E Duffy
B Landy
M Farrell
B Guinness
K O'Sullivan
M McKevitt
M Irving
A Douglas Byrne
M Fagan

Co Meath

N Gilmartin
A Martin
C McHale
A Doocey
B Tarrant
M Tully-Hand
E Farrelly
M Joyce
M Lynam
A Parke
P Fannin
G Coogan
B O'Brien
E O'Connell
H Thornton
M Caffrey
A McDermott
L Brannigan

R Laverty
C Taffe
M Gilroy
M McGurn
P Crimmins
U Moore
P Brennan

Counties Cavan & Monaghan

M Gilroy
C O'Reilly
N Quigley
C McGoldrick
M Brady
B Smith
M Murphy
U Shannon
T Keogh
R Higgins
I Sorohan
A M Slowey
M McQuaid
M McCormack
B Jeffers
M Brady
S Donnelly
C Curry
R Brearty
K McBride
C Chamberlain

MIDLAND HEALTH BOARD

Co Westmeath

E Brady
F Monaghan
M Curran
C Fahy
C Leavy
R Gavin
F Fitzgerald
E Neville
R O'Connor

Co Longford

A Winter
T Hannon
M McCawley
K Quinn
M McCann
M Cush
M Henry
C Corrigan
B O'Byrne
M O'Connor
A Davis

Co Laois

B Carey
R Wall
B Mooney
A Dempsey
E O'Neill
E Gorey
B Lawlor Slattery
K Butler
B Davin
D Delaney
E Flanagan
B Hovendon
N Molumby
M Breslin
M O'Connell
E Dowling
K Foley
P Horan
M Dunne

Co Offaly

E Moran
C Smyth
N Hogan
T O'Connor
M Buckley
J Waldron
M O'Loughlin
M Quirke
A Ormond
S Igoe
M Coughlin

SOUTH EASTERN HEALTH BOARD

Counties Carlow & Kilkenny

M Mahon
A Sheehan
M Keogh
A Mullins
E Hennessy
B Brennan
A Gubbins
M Dooley
M Brennan
M Gaffney
P Cullinane
M Moran
B Conway
G Deering
M Tomkins
M O'Hallaron
E Lonney
T Drea
T Kennedy
A Dollard
M O'Toole
P Holohan
B Hardiman
C Reddy
H Nolan
M Lanigan
M Conlon
W O'Shea
E Coleman
B Magner
P Kavanagh

Co Waterford

A Twomey
S Dawson
M Ahern
E Coffey
M Walsh

Co Wexford

U Doherty
C Furlong
A O'Brien
B Kinsella
G Redmond
C Creedon

Co Tipperary

H Breen
M Maher
M Frawley
T Peters
P Delahunty
R Gardiner
P Kenny
M Murray
O Murphy
C Dwyer
D Mangan
N Lawrence
N Power
E Pyne
J Woodlock
J O'Meara
M Hannon
P O'Dwyer
N Greene
N Ryan
A Maher
B Farrell
M Fennell
M Considine
P McCall

SOUTHERN HEALTH BOARD

North Lee, Cork

D O'Donnell
E Mansfield
S Flynn
C Horgan
M Clancy
M O'Sullivan
M McCarthy
O Sheehy
M Hayes-O'Flynn
C Keleher
M O'Sullivan
M Ryan
J Morgan
S Cahalane
M Sheehan
M Collins
M Roche
A Morrisey
M Heffernan
Sr L Roche
Sr E Hennessy

South Lee

M Healy
V O'Donovan
M Cronin
L Kenny
M Lynch
P O'Regan
M Daly
R McCarthy
A Kelly
B Galvin
E Allen
T Lynch
E Harrington
J Murphy

West Cork

P Lynch
N McCarthy
G Harnedy
P Lovell
B O'Hea
B O Brien
M Dineen
M M O'Sullivan
M Callanan

North Cork

M Lane
Sr Gabriel
M O'Flynn
N Coffey
T Healy
N O'Sullivan
B Wilson
C Howard
N Gallagher-Sheehan
T Hickey O'Shean
P Aherne
J Taaffe
M Cahill
M Duggan
K Cashman
Sr Celesline
K Kelleher

Co Kerry

M Sheehan
M Ryan
J Murphy

MID - WESTERN HEALTH BOARD

Co Clare

M McNamara
P McMahon
T McMahon
H Flanagan
M Carey
M Moran
M Molloy
E Carey
M Considine

Co Limerick

E O'Connell
M Liston
D Coleman
B Ryan
B Keary
M Nash
A O'Donovan
K Gardiner
M Larkin
N Hinchy
M McEvoy
M Ryan
G Murphy
E O'Leary
C Bracken
A Neenan
M O'Donnell
M Bourke
P Kerr
U Dee
M Sheehy
S Graham
G Flannery
M Harty
M Hogan
A Wolfe
E Flaherty
C Richardson
M Hartnett
K Goulding
C Healy
M Barrett
P Murphy

Co Tipperary

J O'Grady
M Upton
M B Tierney
H Harris
M McDonnell
M Neilson
P Purcell
G Sexton,
O'Riordan
M Keely
S O'Reilly
M Egan
M Sheahan
D King
J Ryan
F Kelly
A Carroll
P Kennedy
B O'Brien
N Coffey

EASTERN HEALTH BOARD

Community Care Area 1

C Travers
H Young
I Elliott
A Staunton
P Donlon
M Quinn
M Sheeran
N Guerin
E Handy
M McGrath
M Costello
M Campbell
N Joyce
V Mee
M Looney
T Connell
J Whyte
Y O'Regan
M Russell
E Drum
V Lynch
C Drum
M Balmaine
T Hearty
C Barrett
M Fitzgerald
Sr Patricia Byrne
P Nolan
D Barry
E Cooney

Community Care Area 2

N Aherne
M Burke
M Cahill
J Cleary
Sr N Cleary
E Doherty
P Dolan
E Duffy
M Fallon
M Faughey
C Fenton
L Gaughran
A Gill
P Golden
M Kingston
M Greene
A Larkin
J Kavanagh
M Lennon
M Lochran
E McCormack
Majella Murphy
M Murphy
N Murphy
M McMullen
M O'Connor
F Palmer
A Pankhurst
J Power
E Prendergast
B Scott
S Smyth
M Stewart
M Thornton
D Wyer
M Kilmartin
M O'Donovan

Community Care Area 3

M McGovern
P Scanlon
S O'Reilly
M O'Brien
C Gibson
R Mansell
A Kenny
P Ross/M Ryan
A Flynn/Sr B Hudson
V Dowd/I Ward
A Igoe/M Davey
Boresen
K O'Leary

Community Care Area 4

A Rafter
F McHugh
M Sexton
K Lee
E Hanley
P O'Sullivan
M Regan
T Muldoon
H O'Connell
M O'Keefe
M Gleeson
M O'Neill
S Power
L Geary
J Stewart
K Gahn
I McMahon
C Hughes
V O'Kelly
M O'Brien

Community Care Area 5

M Corcoran
E Aspen
I McPeak

F Quinn
A Hession
S Cummins
S Power
M Argue
H Prendergast
E Power
M Hartford
S Cody
N Slevin

Community Care Area 6

M Fitzpatrick
S Fennell
T Farrell
E Maher
M Murray
A Nolan
T Keegan
C Smith
V Pye
B Grehan
F Donnelly
S Loughlin Stafford
D Kavanagh
E Hyland
K Cusack
G Lamb
S Jenkinson
M Grehan
C Murrin
M McKenna
K O'Donoghue
P McCluskey
K Craig
M Colgan
M Martin
T McGabhann
L Hendrick
M Quelly
M Macardle

Community Care Area 7

J Lynch
J O'Dogherty
T O'Keefe
A McCormack
M Mannion
M Lyons
Sr M Corry
M Brady
P Garry
M Lynch
R Gallen
M Gilboy
M Cronin
J Estall
E Harrington
M Veale Martin
V Brennan
I Kavanagh
D Cooke
C Farrell O'Sullivan
C Considine
S O'Connor
M Lonergan
B Sullivan
D Murray
C O'Connor
B Kilbride
B Rooney
B Molloy
Sr E Sheehan
H Broderick
S Crowley
B Harrington

Community Care Area 8

M Moloy
M Russell
A Rowan
S Armstrong
M McMahon
H Houlihan
M Ronghan
M Kavanagh
C Mitchell
H Sheehan
M Bolger
R Burke
M Sheridan
G Weston
G Gillanders
C Cullen
C Slattery
M Savage
C Judge
B Howard
M Patton
A Rohan
N P Brophy