Commission on Nursing Report

Professional Development

6.1 This chapter considers professional development issues in nursing and midwifery. The Commission is aware of the absolute importance of continuing education to the quality of services offered to patients and the development and growth of professional nursing and midwifery. Central to this is the development of a framework for continuing education and a clinical career pathway for nurses and midwives. The chapter is divided into four sections which deal with issues arising from the consultative process, continuing professional education, the development of a clinical career pathway for nurses and midwives and research in nursing and midwifery.

Issues Arising from the Consultative Process

6.2 Chapter four of the Commission on Nursing's interim report identified the important professional development issues facing nurses and midwives. The main issues have been outlined below.

6.3 Deficiencies in the ability of the profession to respond in an effective and proactive manner to the ever increasing pace of change and developments in the health services were highlighted in submissions made to the Commission. To address this issue, a comprehensive and coherent system of continuing professional education for nurses providing equity in access, availability of programmes and funding for courses was called for by nurses and midwives.

6.4 The Commission received submissions from approximately sixty groups and individual nurses who consider themselves to be "specialists" in particular areas of nursing and midwifery practice. Many of these nursing or midwifery specialities operate alongside medical specialities and seem to have developed in response to demands from medical professionals for more specialised nurses or midwives to support the medical field. A further group of areas which might also be regarded as nursing or midwifery specialities appears to have developed in response to the demands for changes in nursing and midwifery practice.

6.5 Many requests were made to the Commission for support in developing expanded/extended new roles for nurses and midwives. Heretofore, specialist and new expanded roles have largely developed in an informal, unstructured manner and have not been developed within a clinical career pathway.

6.6 It was submitted that the field of nursing and midwifery knowledge and its associated skills have become too vast and complex for any one nurse or midwife to master in full. The

Commission was asked to recognise that specialisation, developed within the framework of a clinical career pathway, is a necessity.

6.7 The proliferation of post-registration courses of varying length, content and academic award and the need for career guidance for nurses and midwives when selecting post-registration programmes was impressed on the Commission.

6.8 The interim report of the Commission identified the need for nursing and midwifery practice to be underpinned by research. There was a call for structures to be put in place which would encourage, support and develop nursing and midwifery research.

The Professional Development of Nurses and Midwives

6.9 This section sets out the proposed framework in relation to post-registration nursing and midwifery education, which deals with the establishment of a National Council for Professional Development in Nursing and Midwifery and a Nursing and Midwifery Planning and Development Unit for each health board area. The section also makes recommendations in relation to study leave.

6.10 The Commission, in considering a framework for post-registration/continuing nursing and midwifery education, gave particular consideration to the document produced by the Board, entitled Continuing Professional Education for Nurses in Ireland: A Framework, published in 1997 as well as the proposals contained in the submissions made to the Commission. Consideration was also given to the National Review of Specialist Nurse Education published by the Australian Government Publishing Service in 1997.

6.11 The Commission has adopted the following definition of continuing education which was embraced by the Board:

"Continuing education is a life long professional development process which takes place after the completion of the pre-registration nurse education programme. It consists of planned learning experiences which are designed to augment the knowledge, skills and attitudes of registered nurses for the enhancement of nursing practice, patient/client care, education, administration and research" (An Bord Altranais, 1994).

The Commission sees the need to develop and strengthen the availability of professional development for all nurses and midwives. The Commission suggests that it might be helpful to consider professional development under the following three broad headings:

- in-service training - which might, for example, consist of education on occupational health issues and work orientation programmes;
- continuing education - which might consist of education on developments in nursing and the treatment of patient groups; and
- specialist training - which would consist of dedicated educational programmes and experience, supporting a nurse seeking to practice at an advanced level.

The Commission recommends that the Minister for Health and Children (the Minister) make provision for the three main areas of professional development to be fostered and further developed.

6.12 The Commission is aware of the urgent need to give guidance and direction in relation to the development of specialist nursing and midwifery posts and post-registration educational programmes offered to nurses and midwives. The enormity of the task is acknowledged by the Commission and having considered the matter at some length, the view is that a special body (separate to the Board) should be formed to address this matter in a focused and expedient manner. To this end, the Commission recommends the Minister establish an independent statutory agency with responsibility for post-registration professional development of nursing and midwifery. The Commission recommends the independent statutory agency be called the National Council for the Professional Development of Nursing and Midwifery (the National Council).

6.13 The Commission envisages that the Board would concentrate on entry to nursing and midwifery, on-going monitoring of the registration/diploma course, the development of pre-registration nursing degree programmes, giving professional leadership and providing an ethical framework for the development of professional practice. The Board would fulfil the important role of setting the professional standards and defining scope of practice. The National Council would concentrate on giving guidance to the profession in relation to the development of specialist nursing and midwifery posts, in addition to accrediting post-registration courses which prepare nurses and midwives for specialist practice.

National Council for Professional Development in Nursing and Midwifery

6.14 As stated previously, the Commission recommends that the Minister establish the National Council as a statutory body, with its own officers. The Commission recommends the National Council be given the following functions:

To:

- monitor the on-going development of nursing and midwifery specialities, taking into account, changes in practice and service need;
- establish guidelines for the creation of specialist nursing and midwifery posts by health service providers;
- determine the appropriate level of qualification and experience for entry into specialist nursing and midwifery practice (interim and long-term requirements);
- accredit specialist nursing and midwifery courses (including those provided independently by universities and colleges) for the purpose of appointment as
- a clinical nurse or midwife specialist or advanced nurse or midwife practitioner, taking account of: standards of professional practice and conduct set by the
- Board; geographic spread and access by nurses and midwives; and, in particular, service need;
- support additional developments in continuing nurse education by health boards and voluntary organisations;
- assist health service providers by setting guidelines for the selection of nurses and midwives who might apply for financial support in seeking opportunities to pursue further education;
- accredit post-registration courses (other than those courses leading to registration as a midwife, public health nurse, sick children's nurse or nurse tutor) for the purpose of recording on the register maintained by the Board;
- liaise with bodies in other jurisdictions in relation to the professional development of nursing and midwifery; and
- publish an annual report on its activities, including the disbursement of monies by the Council.

6.15 It is envisaged that the National Council will approve courses to ensure accessibility, a geographic spread in the provision of specialist courses, as well as maximise the use of educational resources. The National Council would also develop a comprehensive database in relation to the provision of specialist post-registration nursing and midwifery education. It would also determine the appropriate level of qualification and experience for entry into speciality practice.

6.16 In its deliberations on a post-registration course, the National Council should engage in on-going consultations with the Board on the proposed practice outcomes of the course in relation to professional standards and scope of practice guidelines. In addition, the two members of the Board nominated as members of the National Council (see paragraph 6.19) should provide advice and guidance on issues

relating to professional standards. Finally, the National Council should notify the Board in writing of its intention to accredit a post-registration course, outlining the practice outcomes of the course. The National Council will accredit the course unless, within thirty days of the issuing of the notification from the Council, the Board informs the National Council in writing that in its view the practice outcomes of the course are not within the parameters of professional standards and scope of practice guidelines.

6.17 The Commission recommends that the National Council be funded through the Department of Health and Children to assist health service providers financially in the development of specialist training and continuing nurse education programmes. The National Council would support additional developments in continuing nurse education by health boards and voluntary organisations. The National Council could also retain some discretionary funding to contribute to the organisation of seminars on professional issues by other organisations.

6.18 The Commission recommends that:

- the National Council have a board of twenty members appointed by the Minister for a five year period;
- members be limited to serving two consecutive terms on the National Council; of the first National Council appointed by the Minister, half of the membership be limited to serving one term of office;
- on the first National Council appointed by the Minister, members limited to serving one term be selected by lottery on appointment;
- the Chair be appointed by the Minister and that subsequent Chairs be elected by the members of the board; and
- the Chair have a five year term of office.

6.19 The Commission recommends that the Minister provide for the following membership of the council:

- seven registered nurses, one from each of the following areas: general nursing, mental handicap nursing, psychiatric nursing, public health nursing, sick children's nursing, care of the elderly and a nurse tutor. The nurses appointed by the Minister from the various disciplines must be nurses of high professional standing with experience of advanced practice;
- a registered midwife of high professional standing with experience of advanced practice;
- two members of An Bord Altranais nominated by the Board;
- one member following consultation with the Office for

Health Management;
- one senior nurse manager following consultation with the appropriate professional bodies;
- two members following consultation with the Health Service Employers Agency;
- two officers of the Department of Health and Children, one of whom shall be the Chief Nursing Officer at the Department;
- one medical practitioner following consultation with the Royal College of Surgeons, the Royal College of Physicians, the Irish College of General Practitioners and the Royal College of Psychiatrists in Ireland; and
- three nurses or midwives following consultation with third-level institutes, one of whom shall be the Head of a Department of Nursing in a NUI University, one shall be the Head of a Department of Nursing in a non-NUI University and one shall be the Head of a Department of Nursing in an Institute of Technology or a Regional Technical College.

Nursing and Midwifery Planning and Development Units

6.20 In considering the management of the health services, the Commission recommends the establishment of a Nursing and Midwifery Planning and Development Unit at health board level (see chapter seven). It is envisaged that part of the role of the unit would include overseeing the provision of continuing nursing and midwifery education for the health board area.

These units would have the following general functions:

- strategic planning and quality assurance of nursing and midwifery services in a health
- board area;
- co-ordinating the delivery of nursing and midwifery services and improving co-operation between health board and voluntary bodies in the delivery of nursing and midwifery services;
- liaising with centres of nursing education in the provision of continuing education for nurses within the health board area;
- working in partnership with the Chief Nursing Officer in the Department of Health and Children in planning/policy development of nursing and midwifery issues; and
- assisting in improving internal communications with nurses and midwives in a health
- board area.

6.21 In relation to continuing education, the Commission recommends that the Nursing and Midwifery Planning and Development Units would have responsibility for overseeing

the detailed provision of continuing nursing and midwifery education within a health board area. Such provision could range from running day seminars within individual institutions, to supporting nurses and midwives to undertake specialist education on courses accredited by the National Council. These units would also have a role in fostering nursing and midwifery research at health board level.

6.22 The Nursing and Midwifery Policy and Development Units would submit development plans to the National Council when applying for additional development funding to support continuing nursing and midwifery education. These plans could be approved and funded by the National Council for up to three year periods. Fees, in respect of post-registration courses or bursaries to support students on post-registration courses, would be paid by the Nursing and Midwifery Planning and Development Units according to the guidelines laid down by the National Council.

Study Leave for Continuing Education

6.23 The Commission recommends the Minister provide that the contract of employment of every nurse and midwife, in the public service, should entitle them to release, by an employer, for a minimum of two days paid study leave each year for continuing professional education. With agreement from employers, such leave could be accumulated over three years. A nurse or midwife would be required by an employer to maintain a profile of professional development and show proof of attendance at seminars or conferences relevant to nursing or midwifery practice in utilising the two days paid study leave each year. The Commission recommends that the proprietors of nursing homes assist their nursing staff in updating practice by providing for two days paid study leave for continuing education each year. The Commission acknowledges that the implementation of this recommendation will have financial implications for health service providers.

Clinical Career Pathway

6.24 The consultative process identified the need for order and a coherent approach to the progression of specialisation and the development of a clinical career pathway for nursing and midwifery. This important function would form a large component of the work of the proposed National Council and the Nursing and Midwifery Planning and Development Unit in each health board area (referred to earlier in this chapter). The Commission is making recommendations for the development of a clinical career pathway from two perspectives; the long-term vision of the established clinical career path and the interim arrangements that will be required to reach this position.

6.25 The Commission has used the following information sources when considering the issue of a clinical career pathway: submissions made to the Commission; a review of the Irish and international literature; advice from the Board and Irish Nurse Managers and Educators; site visits in Australia to review the work of clinical nurse specialists (CNSs) and clinical nurse consultants (CNCs); advice of Australian nurse managers, nurse educators, The New South Wales Nurses Regulatory Body, The Australian College of Nurses and The Council of Deans of Nursing in Australia; the UKCC guidelines in relation to Post-registration Education and Practice (PREP) and advice from the Chair of the UKCC group reviewing the development of specialist and advanced practice in nursing in the UK.

6.26 The Commission is of the view that promotional opportunities should be open to nurses and midwives who wish to remain in clinical practice rather than following a management or education path. Currently, there is no career pathway for nurses wishing to advance their practice in clinical nursing and midwifery. The Commission recommends the establishment of a multi-stage pathway for clinical nursing and midwifery and in particular, recommends that the Minister provide for a three step clinical career path in nursing and midwifery. The Commission recommends the following clinical career pathway:

- registered nurse/midwife;
- clinical nurse or midwife specialist (CNS) - equivalent to ward sister level; and
- advanced nurse or midwife practitioner (ANP) - equivalent to middle nursing and midwifery management level.

The terms and conditions of employment should be determined through the normal channels.

6.27 It is not intended that there would be automatic progression through each step of the clinical career ladder. Seniority or years of clinical experience alone would not entitle a nurse or midwife to promotion. The Commission recommends that for progression along the clinical career ladder, nurses and midwives must meet the practice and education guidelines set by the National Council. Although not formally recognised today, there are several nurses and midwives operating in roles that could be described as those of clinical nurse or midwife specialists. The development of the position of advanced nurse or midwife practitioner is also currently emerging in Ireland; however, very few posts have yet been established. It is anticipated that in the future it would be a requirement for nurses or midwives appointed to the post of advanced nurse or midwife practitioner to have first held the post of a clinical specialist. Advanced nurse or

midwife practitioner posts should be developed to meet future service needs.

6.28 There is a difference between a nurse or midwife working within a speciality area and the work of a nurse or midwife specialist. This view has been emphasised by the UKCC, the International Council for Nurses (ICN) and the Board. It does not necessarily follow that nurses or midwives, with specialist post-registration qualifications working in specialist areas such as accident and emergency departments or neonatal intensive care, are clinical nurse or midwife specialists. The role envisaged for the clinical nurse or midwife specialists (CNSs) is very specific and differs largely from that of the registered nurse or midwife involved in the day-to-day delivery of services. A nurse or midwife working in a speciality area operating at the primary practice level is not a clinical nurse or midwife specialist.

6.29 The Commission recommends that to use either the title of "clinical nurse or midwife specialist" or "advanced nurse or midwife practitioner", a nurse or midwife must be appointed to a particular post. The recognition of CNS and ANP status must be matched with specified posts within the health services.

6.30 The Commission recommends that the Minister provide for a grade of clinical nurse or midwife specialist equivalent to ward sister level. The Commission recommends that the Minister also provide for a grade of advanced nurse or midwife practitioner equivalent to middle nursing and midwifery management level. The terms and conditions of employment should be determined through the normal channels.

6.31 Because of the variety of health care delivery models, (both in hospitals and in the community), it is not possible to be prescriptive in relation to the appropriate reporting relationships for CNSs and ANPs. The precise arrangements will vary from one organisation to another. The Commission recommends that the reporting relationships for each CNS and ANP be identified when the post is being established. The job description for each post should clearly state the particular reporting mechanism. It is anticipated, that where appropriate in large acute hospitals, CNSs might report to the unit nursing officer/services manager or assistant director of nursing for the particular area. However it is essential that close collaborative relationships are maintained between CNSs/ANPs and first line nurse managers (clinical nurse managers) at unit/ward level or in the community.

Guidelines for Clinical Nurse Specialist and Advanced Nurse Practitioner Roles

6.32 The Commission recommends that the National Council

takes a lead role in defining and differentiating between the role of the CNS and ANP. The Commission is aware of international difficulties encountered in this matter. To start the work, the Commission recommends the following guidelines for nurses wishing to take future posts as CNSs or ANPs. The guidelines outlined have been informed by international developments in the area, most notably in Australia, in the National Review of Specialist Nurse Education (1997) and the UKCC developments since the launch of the framework document Post-Registration Education and Practice (PREP) in 1994.

Clinical Nurse or Midwife Specialist

6.33 The literature reviews conducted on behalf of the Commission have been used to assist the Commission in formulating initial guidelines for the development of clinical nurse or midwife specialist (CNS) posts in Ireland; these are set out below:

- the CNS should be prepared beyond the level of a generalist;
- the CNS should have extensive experience and advanced expertise in the relevant specialist area of nursing or midwifery;
- the CNS should have undertaken a formally recognised relevant specialist post-registration course of study, at the minimum level of university/college diploma. This course should provide theoretical instruction and substantial clinical experience to ensure competency in the speciality practice (in the interim, certificate level or some other form of qualification or experience might be acceptable, if approved by the National Council);
- the CNS will work with medical colleagues and/or interdisciplinary team members within a specified area;
- the CNS may make variations in prescribed clinical options, within agreed protocols; and
- speciality practice of the clinical nurse or midwife specialist includes clinical practice, teaching, research implementation and advisory roles (adapted from ICN, 1992).

Advanced Nurse or Midwife Practitioner

6.34 The Commission is aware of the various and differing interpretations for the "practitioner". For this reason the Commission recommends the use of the title advanced nurse or midwife practitioner in the clinical career ladder. An outline of the role envisaged for the ANP is given below. The ANP:

- exercises higher levels of judgement, discretion and

decision making in the clinical area above that expected of the clinical nurse or midwife specialist;
- has extensive experience in the relevant area of nursing or midwifery;
- has undertaken advanced education in the relevant specialist area at masters degree level involving theoretical content and substantial clinical experience;
- receives clients with undifferentiated and undiagnosed problems and initiates treatments according to agreed protocols and within agreed parameters;
- practises an advanced expanded nursing or midwifery role, makes professionally autonomous decisions taking sole responsibility, within agreed protocols;
- works independently, but closely, with other professionals and respects professional
- boundaries; and
- monitors and improves standards of care and develops practice by active involvement in advanced clinical practice, carrying out audits, being involved in teaching patients and colleagues and conducting research.

6.35 From the guidelines outlined it is apparent that the distinguishing features between the CNS and the ANP are found in the level of educational preparation, independence in practice, autonomy in clinical treatments, level of research involvement and role in the education of future CNSs and ANPs.

Organisation of the Clinical Career Pathway

6.36 It is vitally important that the future clinical pathway for nursing is broad based. The clinical career pathway should include specialisation but must also equally apply to all disciplines and areas of nursing. Advanced practice nursing is as important in care of the elderly as it is in critical care nursing. This wider approach should minimise the concern that clinical career pathways might not develop in all nursing areas, a concern that was expressed by some nurses during the consultative process. Where the work envisaged for the CNS does not support a full-time post, the Commission recommends that the nurse or midwife be facilitated to work time as a CNS and time as a registered nurse or midwife, as appropriate.

6.37 The rapid development of new specialist and sub-specialist nursing roles within each discipline of nursing was identified in the submissions made to the Commission. There is a danger that the proliferation of such roles could lead to a fragmentation of the nursing service and difficulty in filling future specialist positions. There is also the risk of creating future career "cul de sacs" for nurses or midwives operating in very specialised areas. The Commission is aware of the importance of ensuring that the development of CNS and ANP posts is not confined to high technology areas or

domains where advanced nursing or midwifery education is already well established.

6.38 These issues were examined by the national review body for specialist nurse education in Australia (1997). Following extensive consultation, the group recommended that the career structure for nursing be guided by seven broad band nomenclatures with related sub-specialties. These are: maternal and child health nursing; high dependency nursing; mental health nursing; rehabilitation and habilitation nursing (quality of life issues); medical surgical nursing; community health nursing and functional nursing (management). The report envisaged that the broad band areas be used to give coherence to the development of specialist nursing posts and the direction of future post-registration educational programmes.

6.39 The Commission is suggesting that the Australian model be used as a guide and modified for the Irish nursing environment. The Commission recommends the Minister provide that the clinical career path be organised around seven broad bands of nursing and midwifery. The seven suggested broad band nomenclatures which might be used to group the relevant sub-specialist areas are set out below. The examples of sub-specialist areas given for each broad band area are only for illustrative purposes. The National Council will determine the range of sub-specialist areas within each broad band nomenclature.

- high dependency nursing, (this broad band might include areas such as coronary care, intensive therapy (psychiatry) and neonatal intensive care nursing);
- rehabilitation and habilitation nursing, (this broad band might include areas such as care of the elderly, spinal injuries and palliative care nursing);
- medical surgical nursing, (this broad band might include areas such as oncology, infection control, stoma care, neurosciences and anaesthesia nursing);
- maternal and child health nursing, (this broad band might include areas such as parent craft, ultrasonography, paediatric cardiology and paediatric oncology nursing);
- community health nursing, (this broad band might include areas such as health education and health promotion, family development and community psychiatry);
- mental health nursing, (this broad band might include areas such as addiction counselling and behaviour therapy); and
- disability nursing, (this broad band might include areas such as sensory stimulation and challenging behaviour).

6.40 The suggested broad band areas are not intended to replace or add to the existing disciplines of nursing which currently lead to registration with the Board (these would continue unchanged).

The intention is to give coherence and order to the multiple sub-specialist areas which have developed within each discipline. The broad band areas would fall under the recognised disciplines of nursing. At post-registration level high dependency nursing and the relevant sub-specialist areas could equally apply to general, sick children's, midwifery or psychiatric nursing. The strength of this framework is that it encompasses the needs of each of the disciplines of nursing (general, psychiatric, mental handicap, midwifery, sick children's and public health nursing).

6.41 The Commission is of the view that seven broad band nursing categories within the disciplines should offer greater flexibility to individual nurses and midwives when considering future career plans. The Commission envisages that the educational requirements would include common modules in the broad band area together with modules in the particular sub-specialty area. Nurses and midwives, working in very focused sub-specialist areas, will have the option of moving to related sub-specialist areas within their particular grouping. Having obtained the required educational qualification for one sub-specialist area within a particular broad band, the nurse or midwife could later be facilitated to move to another sub-specialist area by completing an additional module of education.

Education for Clinical Nurse Specialists and Advanced Nurse Practitioners

6.42 The National Review of Specialist Nurse Education (1997) reported that in Australia the proliferation of nursing specialities and the equally rapid development in educational provision has resulted in a lack of a unified scheme by which to determine requirements and qualifications for entry into particular areas of nursing speciality practice. This caused difficulties for employers when determining required qualifications for specialist staff, as well as for nurses and midwives in selecting their preferred career path. The Commission is aware of a similar proliferation of post-registration nursing courses in Ireland of varying length, content and academic award. Many of the Irish courses have an imbalance between theory and clinical practice. During the consultative process nurses expressed concern in relation to the availability and geographic accessibility of further education courses. There was a view that the "substantial" clinically-based specialist courses are only available in Dublin.

6.43 At present most specialist post-registration education

courses, are provided by health service providers and small numbers are provided by university departments of nursing in partnership with health service providers. These courses are generally awarded Category Two approval by the Board. During most post-registration courses, the cohort of nurses forms part of the workforce in the specialist area and are released for the theoretical component of the programme. Successful candidates of hospital programmes are awarded a hospital certificate and those from university programmes are awarded a higher diploma in the specialist area of nursing. The hospital programmes are generally organised and co-ordinated by a nurse with clinical expertise in the area of practice, usually called a course co-ordinator or course facilitator. A nurse tutor is assigned overall responsibility for the programme.

6.44 The Commission suggests that the seven broad bands be used to guide the future post-graduate nursing educational developments in Ireland. Education providers for nursing and midwifery should be encouraged to ensure that advanced programmes are available in the broad band areas with modules to cater for the sub-specialist areas. Each education programme should comprise theoretical instruction and a significant amount of clinical practice.

6.45 In developing courses, third-level institutes must maintain close contact with health service providers and respond to their identified need to prepare nurses for particular specialist nursing roles. A coherent framework is required for the development of such education programmes, which must meet academic standards.

6.46 The Commission recommends that the development of post-registration programmes will take place following collaboration between:

- the National Council for Professional Development in Nursing and Midwifery;
- universities/third-level colleges; and
- health service providers and the centres of nursing education.

6.47 It is envisaged that third-level institutes, in consultation with health service providers, would prepare curricula for university/college diplomas and masters degree programmes, which would prepare nurses for positions as CNSs or ANPs. The professional standards required by the Board and the guidelines of the National Council must be given careful attention when designing curricula for specialist programmes (see paragraph 6.16 of this chapter).

6.48 The Commission recommends that education providers submit their curricula to the National Council for

accreditation. The accreditation process will ensure that the requirements of the National Council for professional recognition as a CNS or ANP are met. The National Council will co-ordinate the equal distribution of courses throughout the country, taking into account the local service needs. Nurses who have completed specialist education programmes, accredited by the National Council, will be eligible to apply for CNS and ANP posts.

6.49 Support for fees in respect of post-registration courses or bursaries to support students on post-registration courses would be funded through the Nursing and Midwifery Planning and Development Units. The National Council has a role in providing guidelines for the selection of nurses and midwives who might apply for financial support in seeking opportunities to pursue further education.

6.50 The Commission recommends that programmes intending to prepare nurses and midwives for the role of CNS or ANP should have a large component of clinical practice (competency being assessed during the programme) and the programme should be accredited by the National Council.

6.51 The Commission, in considering the future direction of post-registration nursing education, was conscious of the need to develop simultaneously a coherent framework for the nurse educators currently involved in the delivery of post-registration programmes; these include nurse tutors, course co-ordinators and course facilitators. The Commission recommends the creation of joint clinical academic appointments to establish strong links between theory and specialist clinical practice.

6.52 The Commission recommends that when negotiating the move of post-registration programmes to third-level institutes, health service employers undertake a detailed consultation with the nurse educators currently involved in post-registration education programmes. Each nurse educator should be consulted in relation to her or his desired future career pathway, whether she or he wishes to move into the third-level sector, pursue other avenues in professional development within the health service or other career options in management or clinical practice. The Commission recommends that health service providers support post-registration nurse educators in upgrading their education or other qualifications to facilitate their transition to their desired career pathway.

6.53 As indicated in the guidelines given earlier in the document, the Commission recommends that clinical nurse or midwife specialists undertake a relevant specialist post-registration university/college diploma and have extensive experience in the particular field of nursing or midwifery. The Commission is conscious that there may be an initial practical

difficulty for some nurses, as the specialist university/college diploma courses may not yet be available for their area of practice. In the interim, certificate level or some other form of qualification or experience may be acceptable. However, this is a matter for the National Council to consider in greater detail. In the longer-term it is anticipated that graduate nurses, wishing to pursue a career as a CNS, will obtain post-graduate diploma level qualifications. The Commission recommends that advanced nurse or midwife practitioners, who will be expected to conduct research into clinical nursing or midwifery issues, be prepared to masters degree level.

6.54 The Commission does not consider it appropriate for nurses who have not attained the prescribed educational level to be automatically appointed to CNS or ANP posts. This recommendation is based on the advice and experiences of Australian nurse managers when introducing a clinical career structure for nursing in Australia in the late 1980's. Some of the nurses appointed to posts at that time did not have advanced educational preparation, nor did they achieve it once confirmed in post. While currently holding clinical nurse specialist posts, it appears that some nurses are not operating at the advanced level expected of clinical nurse specialists.

6.55 It is important that Irish nurses and midwives, who have pioneered and led the development of nursing and midwifery without the benefit of advanced education (as it was not available at the time), are appreciated. The Commission recommends that nurses and midwives with substantial specialist experience should be given accreditation for prior education

and experience when seeking entry to specialist educational programmes. They should be encouraged, supported and assisted (including financial assistance and study leave with replacement) by the health service to obtain the relevant educational qualification.

Establishing Clinical Nurse or Midwife Specialist and Advanced Nurse or Midwife Practitioner Posts

6.56 The consultative process clearly highlighted the urgent need to establish officially a clinical career path for nurses and midwives in Ireland. The first step in this process is to approve and set up, on a national basis, posts of clinical nurse or midwife specialists. A time scale for the establishment of the initial cohort of CNS and ANP positions must be agreed. This will involve reviewing existing posts (which heretofore have not been formally recognised as posts of CNS) and establishing new CNS posts in response to service needs. It is envisaged that a detailed analysis of both the local and national service needs will be required before the optimal numbers of CNS and ANP posts can be determined. The establishment of CNS and ANP posts should be based on the

needs of the particular organisation and the services provided for patients. It is thought that the final number and areas of work would be determined following consultation between:

- the Director of Nursing/Chief Nursing Officer/Superintendent Public Health Nurse;
- the Chief Executive Officer (CEO) for the organisation;
- the Nurse Planning and Development Unit for the health board area and health board CEO;
- the National Council for Professional Development in Nursing and Midwifery; and
- the Department of Health and Children.

6.57 Senior nurses and midwives with extensive clinical experience, currently in practice, must be valued and encouraged to seek posts as CNSs or ANPs. To achieve this, they should be strongly encouraged and assisted to obtain the educational qualifications set out in the guidelines for CNS or ANP positions. In the interim, specialist clinical experience accompanied by certificate level qualifications may be acceptable when appointing CNSs. However, the interim measure should only apply to specialist certificate programmes approved by the National Council.

6.58 The Commission is aware that there are currently a number of nurses working in roles similar to those envisaged for the CNS or ANP, who have not had the opportunity to pursue specialist post-registration programmes (either certificate or diploma) because appropriate programmes are not available in Ireland. Nurses working in such positions will need particular consideration when the clinical career ladder is being developed. The interim arrangements should apply to nurses currently in specialist positions when the first cohort of CNS posts are being created. Thereafter the practice and education guidelines set out in paragraphs 6.33 and 6.34 of this chapter should apply. To be eligible to apply for CNS or ANP posts the nurse or midwife must have completed the relevant education programme which is accredited by the National Council.

6.59 The Commission recommends the following process for creating CNS/ANP posts:

- the National Council would initially agree the guidelines - an interim set and long-term guidelines, for the recognition and establishment of the posts of clinical nurse or midwife specialist and advanced nurse or midwife practitioner;
- the Director of Nursing/Chief Nursing Officer/Superintendent Public Health Nurse, in consultation with nurse managers (first line and middle), would identify the need for developing a

number of CNS and possibly ANP posts for specified areas within their own organisation;
- a detailed job description would be devised outlining the requirements (experience and education) specified by be reviewed by the Nursing and Midwifery Planning and Development Unit in consultation with senior nursing and general management. This would ensure that a cohesive plan for the regional development of posts was put forward;
- the agreed plans would be submitted for approval to the Chief Executive of the hospital or health board, as appropriate; and
- the hospital or health board would submit the plan to the Department of Health and Children for approval.

6.60 The Commission recommends the following arrangements for appointing CNSs and ANPs:

- following approval for the creation of CNS and ANP posts, the responsibility for appointing suitably qualified nurses would rest with each health service provider;
- in the initial filling of posts, where the recognition and establishment of a post or posts have been identified, those nurses and midwives practising at a specialist level, who satisfy the criteria established by the Council (credit being given for prior education and experience) and are currently carrying out the duties of the approved post, should be appointed as clinical nurse or midwife specialists;
- where this situation does not arise, the posts should be advertised as soon as the approval of the Department is obtained and interviews should be conducted without delay; and
- pending the provision of the requisite graduate courses, all nurses or midwives who are appointed in the initial filling of vacant posts must agree, as a condition of their appointment, to obtain the proposed educational qualifications within an agreed time frame. This provision does not apply to nurses or midwives who are merely confirmed in specialist posts. Credit should be given for prior education and experience.

6.61 The Commission recommends that all concerned afford top priority to the creation of CNS and ANP posts. It is envisaged that the Department of Health and Children and the Nursing and Midwifery Planning and Development Unit in each health board area will take a proactive role in this matter.

6.62 The Nursing and Midwifery Planning and Development Unit would have the role of monitoring the development of CNS/ANP posts. This would include investigating failure to

develop posts within a health board, in all areas of nursing and midwifery (where a service need is apparent) and making representation accordingly.

Senior Staff Nurses and Midwives

6.63 The clinical career pathway, recommended by the Commission, will in time create a substantial range of increased career opportunities for nurses and midwives. However, the Commission is also conscious that many excellent nurses and midwives may not wish to specialise and seek promotion within the clinical, educational or management framework. Staff nurses and midwives will remain primarily responsible for the delivery of high quality care to patients and clients of the health service.

6.64 It was suggested that there needed to be increased recognition for those senior staff nurses and midwives who have provided many years of high quality public service within the health care sector. Using the Benner Model of skill progression, many senior nurses and midwives, on the basis of their extensive experience, are regarded by their colleagues as proficient/expert in their area of practice. There was a view expressed during the consultative process that senior staff nurses and midwives should have a further long service increment at some later stage in their career which would recognise their many years of contribution to the delivery of health services, without impacting on any differential. Similarly, there was a view that the annual leave entitlement of staff nurses and midwives should be on an incremental basis. It was argued that almost every other profession and occupation in the health services had a system of incremental annual leave according to the number of years service. It was stated that nursing and midwifery were physically arduous and emotionally stressful. The physical and stressful nature of nursing and midwifery, it was suggested, required a system of incremental annual leave to avoid "burn-out" amongst older nurses and midwives.

The Commission recommends that the question of additional recognition of long service for staff nurses be examined through the established structures.

Allowances

6.65 An issue raised during the consultative process by nurses and midwives in workshops, and in particular by the Nursing Alliance in a written submission, was the question of the dual qualified scale and the location-based and qualification allowances. The dual qualified scale applies to nurses who hold two of the following registerable qualifications; general, psychiatric or mental handicap nursing. It does not apply to an additional registerable qualification in midwifery or sick children's nursing. The dual qualified scale is referred to in

the Blue Book in the following terms:

"retention on a red-circled basis and personal to those nurses who are paid on the dual qualified scale on 1st October 1996, and for those in appropriate post-graduate training on that date only. The issue of dual qualified nurse is to be returned to as part of phase 2 under the 'services requirements' element."

6.66 There are also location-based or qualification allowances which are paid to all nurses or midwives working in certain areas such as care of the elderly and intensive care. The Blue Book refers to the finding by the Adjudication Board that: "the location-based and qualification allowances should continue to be paid to all nurses qualifying for same until revised arrangements are agreed between the parties on this issue". A case was also made during the consultative process for recognition of extra qualifications which are attained by nurses and midwives. It was argued that the additional qualifications have a beneficial impact on patient care and there should be recognition given to the nurse or midwife which reflects this benefit to service. Having considered the matter, the Commission was of the view that the forum in which these claims should be addressed is properly the Labour Court.

The Commission recommends that outstanding claims for allowances should be referred to the Labour Court for argument and determination as a matter of urgency.

Segmentation of the Grade

6.67 One of the terms of reference for the Commission was "segmentation of the grade". The Commission understands this to mean the division of a grade into different levels as has happened in the United Kingdom in the staff nurse grade. As detailed earlier in the chapter, the Commission has recommended the creation of two new posts in clinical nursing (CNS and ANP posts). These are new promotional opportunities for clinical nurses and midwives and should not be confused with segmentation of the grade. The Commission does not recommend segmentation of the grade of staff nurse.

Nursing and Midwifery Research

6.68 The literature reviews conducted on behalf of the Commission identified a dearth of published Irish nursing and midwifery research. The Commission attaches a particular importance to the development of nursing and midwifery research at every level; within each individual organisation (hospital or community), at health board level and within the Department of Health and Children.

6.69 In Continuing Professional Education: A Framework (An Bord Altranais,1997) it was suggested that nursing and midwifery research might form one of the four professional pathways for nursing and midwifery. However, the Commission is of the view that for nursing and midwifery practice to be evidence-based, research should form an integral part of all aspects of nursing and midwifery. For this reason, the Commission recommends that nurses and midwives wishing to develop careers in research be encouraged and supported to do so through the clinical, education or management pathway.

6.70 There is a need for nursing research to be promoted in clinical practice. Within organisations, the posts of practice development co-ordinators (described in Chapter Five) and advanced nurse practitioners (as outlined in 6.34 of this chapter) will make an important contribution, by instigating and leading research projects which examine clinical nursing and midwifery issues. The university sector, in collaboration with the health services, has an important role to play in the development of nursing and midwifery research. The Commission recommends the creation of joint clinical academic appointments to establish stronger research links between theory and practice and enhance the credibility of nursing and midwifery research.

6.71 The investigation of patient care issues involves formal research specifically related to nursing and midwifery practice. The role requires a practice climate of clinical inquiry, critical thinking, formal research investigation and the ability to interpret, evaluate and communicate the findings. The title "Nurse Researcher" should be reserved for nurses involved in researching nursing issues and not given to those involved in data collection for medical or other research.

6.72 The Commission recommends that the Minister provide for nursing and midwifery research to be funded through the Health Research Board (HRB) thus ensuring that nursing and midwifery research is seen in the context of the overall research activity of the health services and maintains a high level of quality. The Commission recommends that the Minister make funding available to the HRB specifically for nursing and midwifery research.

6.73 The Commission recommends that the Health Research Board establish a nursing and midwifery research advisory division which could assist and advise nurses and midwives on the presentation of projects for financial grants.

6.74 The Commission recommends that a comprehensive database of Irish nursing and midwifery research, funded by the State, be established. Proposals for the operation of the database should be submitted to The Department of Health

and Children.

6.75 The Commission attaches great importance to nursing and midwifery representation on the Health Research Board and recommends that the Minister appoint a registered nurse or midwife, with experience in research, to the HRB.

6.76 If nursing and midwifery research is to develop, it is important that efforts are made to ensure the education and development of nurse researchers, who will carry out research in nursing and midwifery which will stand up to rigorous academic analysis. A welcome development was made by the Board in September 1997 when they launched doctoral scholarships in nursing/midwifery, setting aside significant funding to support the scholarships. It is also noted from the annual report of the HRB for 1996, that eight advanced post doctoral research fellowships were awarded. The HRB, in conjunction with the Board, could in the future operate a scheme to support the development of nurses to Ph.D level, thus supporting the development of a cohort of high calibre nurse researchers.

6.77 To ensure a coherence in the development of nursing and midwifery research, it is the view of the Commission that the Nursing and Midwifery Policy Unit in the Department of Health and Children, in consultation with appropriate bodies, should draw up a national strategy for nursing and midwifery research. A strong recommendation on nursing research was made by the Committee of Ministers of Member States of the European Union in Document No R96(1). The Committee of Ministers, under Article 15.b of the Statute of the Council of Europe recommended that member states establish a strategy for the development of nursing research.

Summary

6.78 Central to the continued development of professional nursing is the enhancement of continuing professional education, the establishment of a clinical career pathway and the development of a strong body of skilled nurse researchers equipped to investigate clinical nursing issues. The provision of a minimum of two days paid study leave for every nurse and midwife is an important first step in ensuring equity and access to ongoing education. The establishment of the National Council for Professional Development in Nursing and Midwifery and the Nursing and Midwifery Planning and Development Unit in each health board are key to the development of a post-registration education framework and the establishment of the clinical career pathway. The Commission recommends that as the profession develops and the career pathway is firmly established the arrangements set out in this chapter be reviewed.

Summary of Recommendations in Chapter Six

The Commission recommends that the Minister for Health and Children (the Minister) make provision for the three main areas of professional development (in-service training, continuing education and specialist training) to be fostered and further developed. (6.11)

The Commission recommends the Minister establish an independent statutory agency with responsibility for post-registration professional development of nursing and midwifery. The Commission recommends the independent statutory agency be called the National Council

for the Professional Development of Nursing and Midwifery (the National Council). (6.12)

The Commission recommends the National Council be given the following functions:

To:

- monitor the on-going development of nursing and midwifery specialities, taking into account changes in practice and service need;
- establish guidelines for the creation of specialist nursing and midwifery posts by health service providers;
- determine the appropriate level of qualification and experience for entry into specialist nursing and midwifery practice (interim and long-term requirements);
- accredit specialist nursing and midwifery courses (including those provided independently by universities and colleges) for the purpose of appointment as a clinical nurse or midwife specialist or advanced nurse or midwife practitioner, taking account of: standards of professional practice and conduct set by the Board; geographic spread and access by nurses and midwives; and, in particular, service need;
- support additional developments in continuing nurse education by health boards and voluntary organisations;
- assist health service providers by setting guidelines for the selection of nurses and midwives who might apply for financial support in seeking opportunities to pursue further education;
- accredit post-registration courses (other than those courses leading to registration as a midwife, public health nurse, sick children's nurse or nurse tutor) for the purpose of recording on the register maintained by the Board;
- liaise with bodies in other jurisdictions in relation to the professional development of nursing and midwifery; and
- publish an annual report on its activities, including the

disbursement of monies by the
- Council. (6.14)

The Commission recommends that the National Council be funded through the Department of Health and Children. (6.17)

The Commission recommends that:

- the National Council have a board of twenty members appointed by the Minister for a five year period;
- members be limited to serving two consecutive terms on the National Council; of the first National Council appointed by the Minister, half of the membership be limited to serving one term of office;
- on the first National Council appointed by the Minister, members limited to serving one term be selected by lottery on appointment;
- the Chair be appointed by the Minister and that subsequent Chairs be elected by the members of the board; and
- the Chair have a five year term of office. (6.18)

The Commission recommends that the Minister provide for the following membership of the council:

- seven registered nurses, one from each of the following areas: general nursing, mental handicap nursing, psychiatric nursing, public health nursing, sick children's nursing, care of the elderly and a nurse tutor. The nurses appointed by the Minister from the various disciplines must be nurses of high professional standing with experience of advanced practice;
- a registered midwife of high professional standing with experience of advanced practice;
- two members of An Bord Altranais nominated by the Board;
- one member following consultation with the Office for Health Management;
- one senior nurse manager following consultation with the appropriate professional bodies;
- two members following consultation with the Health Service Employers Agency;
- two officers of the Department of Health and Children, one of whom shall be the Chief Nursing Officer at the Department;
- one medical practitioner following consultation with the Royal College of Surgeons, the Royal College of Physicians, the Irish College of General Practitioners and the Royal College of Psychiatrists in Ireland; and
- three nurses or midwives following consultation with third-level institutes, one of whom shall

- be the Head of a Department of Nursing in a NUI University, one shall be the Head of a Department of Nursing in a non-NUI University and one shall be the Head of a Department of Nursing in an Institute of Technology or a Regional Technical College. (6.19)

The Commission recommends the establishment of a Nursing and Midwifery Planning and Development Unit at health board level. (6.20)

The Commission recommends that the Nursing and Midwifery Planning and Development Units (recommended in chapter seven of the report) would have responsibility for overseeing the

detailed provision of continuing nursing and midwifery education within a health board area. (6.21)

The Commission recommends the Minister provide that the contract of employment of every nurse and midwife, in the public service, should entitle them to release, by an employer, for a minimum of two days paid study leave each year for continuing profey:

- registered nurse/midwife;
- clinical nurse or midwife specialist (CNS) - equivalent to ward sister level; and
- advanced nurse or midwife practitioner (ANP) - equivalent to middle nursing and midwifery management level.

The terms and conditions of employment should be determined through the normal channels. (6.26)

The Commission recommends that for progression along the clinical career ladder, nurses and midwives must meet the practice and education guidelines set by the National Council. (6.27)

The Commission recommends that to use either the title of "clinical nurse or midwife specialist"

or "advanced nurse or midwife practitioner", a nurse or midwife must be appointed to a particular post. The recognition of CNS and ANP status must be matched with specified posts within the health services. (6.29)

The Commission recommends that the Minister provide for a grade of clinical nurse or midwife specialist equivalent to ward sister level. The Commission recommends that the Minister also provide for a grade of advanced nurse or midwife practitioner equivalent to middle nursing and

midwifery management level. The terms and conditions of employment should be determined through the normal channels. (6.30)

The Commission recommends that the reporting relationships for each CNS and ANP be identified when the post is being established. (6.31)

The Commission recommends that the National Council takes a lead role in defining and differentiating between the role of the CNS and ANP. (6.32)

Where the work envisaged for the CNS does not support a full-time post, the Commission recommends that the nurse or midwife be facilitated to work time as a CNS and time as a registered nurse or midwife, as appropriate. (6.36)

The Commission recommends the Minister provide that the clinical career path be organised around seven broad bands of nursing and midwifery. The seven suggested broad band nomenclatures which might be used to group the relevant sub-specialist areas are set out below. The examples of sub-specialist areas given for each broad band area are only for illustrative purposes. The National Council will determine the range of sub-specialist areas within each broad band nomenclature.

- high dependency nursing, (this broad band might include areas such as coronary care, intensive therapy (psychiatry) and neonatal intensive care nursing);
- rehabilitation and habilitation nursing, (this broad band might include areas such as care of the elderly, spinal injuries and palliative care nursing);
- medical surgical nursing, (this broad band might include areas such as oncology, infection control, stoma care, neurosciences and anaesthesia nursing);
- maternal and child health nursing, (this broad band might include areas such as parent craft, ultrasonography, paediatric cardiology and paediatric oncology nursing);
- community health nursing, (this broad band might include areas such as health education and health promotion, family development and community psychiatry);
- mental health nursing, (this broad band might include areas such as addiction counselling and behaviour therapy); and
- disability nursing, (this broad band might include areas such as sensory stimulation and challenging behaviour). (6.39)

The Commission recommends that the development of post-registration programmes will take place following

collaboration between:

- the National Council for Professional Development in Nursing and Midwifery;
- universities/third-level colleges; and
- health service providers and the centres of nursing education. (6.46)

The Commission recommends that education providers submit their curricula to the National Council for accreditation. (6.48)

The Commission recommends that programmes intending to prepare nurses and midwives for the role of CNS or ANP should have a large component of clinical practice (competency being assessed during the programme) and the programme should be accredited by the National Council. (6.50)

The Commission recommends the creation of joint clinical academic appointments to establish strong links between theory and specialist clinical practice. (6.51)

The Commission recommends that when negotiating the move of post-registration programmes to third-level institutes, health service employers undertake a detailed consultation with the nurse educators currently involved in post-registration education programmes. Each nurse educator should be consulted in relation to her or his desired future career pathway whether she or he wishes to move into the third-level sector, pursue other avenues in professional development within the health service or other career options in management or clinical practice. The Commission recommends that health service providers support post-registration nurse educators in upgrading their education or other qualification to facilitate their transition to their desired career pathway. (6.52)

The Commission recommends that clinical nurse or midwife specialists undertake a relevant specialist post-registration university/college diploma and have extensive experience in the particular field of nursing or midwifery. (6.53)

The Commission recommends that advanced nurse or midwife practitioners, who will be expected to conduct research into clinical nursing or midwifery issues, be prepared to masters degree level. (6.53)

The Commission recommends that nurses and midwives with substantial specialist experience should be given accreditation for prior education and experience when seeking entry to specialist educational programmes. (6.55)

The Commission recommends the following process for creating CNS/ANP posts:

- the National Council would initially agree the guidelines - an interim set and long-term guidelines, for the recognition and establishment of the posts of clinical nurse or midwife specialist and advanced nurse or midwife practitioner;
- the Director of Nursing/Chief Nursing Officer/Superintendent Public Health Nurse, in consultation with nurse managers (first line and middle), would identify the need for developing a number of CNS and possibly ANP posts for specified areas within their own organisation;
- a detailed job description would be devised outlining the requirements (experience and education) specified by the National Council and the appropriate reporting relationship for the post holder;
- a plan for the development of such posts would be prepared (based on service needs and the criteria set down by the National Council and guidance from the Nursing and Midwifery Planning and Development Unit) for the health board area;
- the senior nurses and midwives for each organisation would submit their plans to the Nursing and Midwifery Planning and Development Unit;
- the plans and job specifications submitted would be reviewed by the Nursing and Midwifery Planning and Development Unit in consultation with senior nursing and midwifery and general management. This would ensure that a cohesive plan for the regional development of posts was put forward;
- the agreed plans would be submitted for approval to the Chief Executive of the hospital or health board, as appropriate; and
- the hospital or health board would submit the plan to the Department of Health and Children for approval. (6.59)

The Commission recommends the following arrangements for appointing CNSs and ANPs:

- following approval for the creation of CNS and ANP posts, the responsibility for appointing suitably qualified nurses would rest with each health service provider;
- in the initial filling of posts, where the recognition and establishment of a post or posts have been identified, those nurses and midwives practising at specialist level, who satisfy the criteria established by the Council (credit being given for prior education and experience) and are currently carrying out the duties of the

approved post, should be appointed as clinical nurse or midwife specialists;

- where this situation does not arise, the posts should be advertised as soon as the approval of the Department is obtained and interviews should be conducted without delay; and
- pending the provision of the requisite graduate courses, all nurses or midwives who are appointed in the initial filling of vacant posts must agree, as a condition of their appointment, to obtain the proposed educational qualifications within an agreed time frame. This provision does not apply to nurses or midwives who are merely confirmed in specialist posts. Credit should be given for prior education and experience. (6.60)

The Commission recommends that all concerned afford top priority to the creation of CNS and ANP posts. (6.61)

The Commission recommends that the question of additional recognition of long service for staff nurses be examined through the established structures. (6.64)

The Commission recommends that outstanding claims for allowances should be referred to the Labour Court for argument and determination as a matter of urgency. (6.66)

The Commission recommends that nurses and midwives wishing to develop careers in research be encouraged and supported to do so through the clinical, education or management pathway. (6.69)

The Commission recommends the creation of joint clinical academic appointments to establish stronger research links between theory and practice and enhance the credibility of nursing and midwifery research. (6.70)

The Commission recommends that the Minister provide for nursing and midwifery research to be funded through the Health Research Board (HRB). The Commission recommends that the Minister make funding available to the HRB specifically for nursing and midwifery research. (6.72)

The Commission recommends that the Health Research Board establish a nursing and midwifery research advisory division which could assist and advise nurses and midwives on the presentation of projects for financial grants. (6.73)

The Commission recommends that a comprehensive database of Irish nursing and midwifery research, funded by the State, be established. (6.74)

The Commission recommends that the Minister appoint a registered nurse or midwife with experience in research, to

the HRB. (6.75)

The Commission recommends that as the profession develops and the career pathway is firmly established the arrangements set out in this chapter be reviewed. (6.78)

Commission on Nursing Report

The Role of Nurses and Midwives in the Management of Services

7.1 This chapter outlines concerns identified during the consultative process in relation to the role of nurses and midwives in the management of the health services. These concerns related to a sense of exclusion from the strategic planning process, communication with nurses and midwives within organisations, the management of nursing and midwifery and the development of management potential within nursing and midwifery. The Commission recommends a framework for the greater inclusion of nursing and midwifery in the strategic planning process, the strengthening of nursing and midwifery management and the development of nurses and midwives for the management of nursing and midwifery within the wider health service. This chapter focuses on general issues in relation to the management of nursing and midwifery whilst making a number of recommendations specific to acute nursing and midwifery services. Chapter eight, Nursing in the Community, outlines the proposals of the Commission in relation to nursing management structures in the community, in particular, the development of the public health nursing management structure.

7.2 The role of nurses and midwives in the management of services must be seen in the context of increasing demands on the Irish health services in recent years. These demands have arisen from social and demographic changes in Irish society, the increasing consumer movement, the continuing rapid technological development in health care and the on-going need to account for the effective use of available resources. It is an environment where increasing demands for the provision and development of services must be placed within determined expenditure limits. Shaping a Healthier Future, published by the Department of Health in 1994, encapsulates the changes that have taken place in the Irish health services in recent years. This environment requires skillful management by all those with a management responsibility within the health services. As a consequence, the effective management of nursing and midwifery is particularly important because of the extent of the contact between patients/health service clients with nurses and midwives. The quality of care within the health service is primarily determined by the quality of the nursing and midwifery services. The effective management of the profession and the development of the nursing and midwifery management resource will have substantial benefits for the effective and efficient delivery of health care.

Issues Raised During the Consultative Process

7.3 A range of issues were identified during the consultative process in relation to the role of nurses and midwives in the management of services. These might be outlined as:

(i) the need for greater internal communication within organisations;

(ii) a perception that nurses/midwives and nursing/midwifery were not sufficiently involved in strategic planning or in policy development and strategy development;

(iii) the perception that there was a lack of partnership and consultation between general management and nursing/midwifery management and between nursing/midwifery management and nurses/midwives in the setting and attaining of corporate goals;

(iv) a concern that nursing and midwifery management was preoccupied with hierarchies and the detailed control of nurses and midwives rather than the management of the nursing and midwifery function;

(v) the need to examine the recruitment, selection and training of nurse/midwife managers in order to ensure that the profession had an effective cohort of leaders capable of responding to changing service needs; and

(vi) the need for the greater devolution of authority within the nursing and midwifery management structure.

Recent Initiatives

7.4 A range of initiatives has taken place recently in relation to the development of management skills within nursing and midwifery. These include a number of master classes organised by the Office for Health Management for directors of nursing and midwifery services of larger acute hospitals and superintendent public health nurses. A nurse management leadership development programme for nurses and midwives under thirty-five years of age is also being provided by the Office for Health Management with the development programme being delivered by a partnership led by the Centre for Nursing Policy and Practice, University of Leeds with the Institute of Public Administration and the Department of Nursing Studies, National University of Ireland - Cork. In addition, the Minister recently announced a major nurse management development programme developed by the Office for Health Management in partnership with the Irish Nurses Organisation and co-funded by the Department of Health and Children and the Irish Nurses Organisation. These programmes are:

- a managing and leading programme for nurse managers

from medium sized hospitals provided by the King's Fund;
- a programme for nurse managers from smaller hospitals provided by the University of Limerick;
- a pilot staff/management development programme for all the nursing staff in Longford-Westmeath General Hospital provided by the University of Leeds; and
- a public health nursing leadership programme focused on two neighbouring health boards provided by the Royal College of Nursing.

Internal Communications

7.5 As outlined above, a common concern expressed by nurses and midwives during the consultative process was that they were not informed of decisions or developments within the health service and were given little opportunity to express their views on developments. The communication process did not appear to be effective in conveying information from management to nurses and midwives and in turn conveying information from nurses and midwives to management. It was acknowledged that in some areas substantial efforts had been made in attempting to communicate with all staff in an organisation. Many organisations issue newsletters outlining developments and decisions on future direction. The Southern Health Board, for example, commenced a strategic change programme in 1993 with an increased emphasis on communication. The Commission also understands that a number of organisations have employed management consultants to assist them in developing a communication strategy.

7.6 An effective internal communication system within any organisation is difficult to develop and maintain. Health service providers have the difficulty of communicating with a twenty-four hour nursing and midwifery service. In the case of health boards, the nursing and midwifery service is located in a number of disparate sites. In addition, the different disciplines of nursing may have specific concerns and requirements and health boards must tailor a communication system to be responsive to these divergent needs.

7.7 Nurses and midwives represent a well educated and committed element of the health service.

It is essential that health service providers involve nurses and midwives in the development of corporate strategies through programmes of internal communication which build commitment and draw on the full capability of the nursing and midwifery personnel resource. The emphasis should be on a three way process of communication involving management, the nursing organisations and nurses and midwives. The objective should be to create a sense of unifying purpose amongst nurses and midwives and a sense

of belonging to an organisation.

7.8 There appears to be a culture in certain areas of the health service of retaining information. It appears that the retention of information is considered as underpinning a command and control model of management. In the absence of the disclosure of information, nurses and midwives will not be able to effectively contribute to the decision making process. There needs to be a culture within health service providers which encourages the full disclosure of information. Managers need to foster an open system of management where information, in relation to service developments and plans, is discussed openly and frankly with nurses and midwives involved in the delivery of services. It was suggested during the consultative process, for example, that many nurse and midwife managers were unaware of the full budget for in-service nurse and midwife training. This in turn lead to suspicions that such funds were diverted to other areas of the health service, which might not in fact have been the case. The greater dissemination of information and a culture within a health service provider which encourages and supports an open flow of information is essential to an effective communications system.

7.9 It is considered that in any communications strategy, the most important source of information to front line staff, is not senior management but their immediate supervisors. An effective communication system requires all levels of management to communicate with the personnel in an immediate reporting relationship. It will be necessary to train, encourage and support all levels of management in communications. It is not sufficient merely to designate a manager as being responsible for communication within an organisation. Effective communication is an essential component of every manager's job. Whilst an organisation can put in place paper and electronic communication systems, the primary and most effective means of communication will remain oral communication at all levels of an organisation. Managers should receive the necessary training to develop their oral communication skills.

7.10 A communication system is not merely about conveying the management perspective to staff but is also about being open to the receipt of information from staff. Management must not only have the capacity to convey information but must also show an equal willingness to listen to and seek the views of nurses and midwives involved in the delivery of services. In the absence of a culture where there is two-way communication (in both directions from management to employees and vice versa), any communication system will be seen merely as a means of conveying management "propaganda". The full utilisation of a well educated and committed workforce means that their views in the planning and delivery of services must be actively sought and

mechanisms must be in place to allow an effective input from nurses and midwives. An effective organisation is usually a "listening and learning" organisation.

7.11 An effective communications system also means having open communication with the nursing trade unions. The unions represent nurses and midwives across a wide spectrum of the health services. Management and unions can work in partnership to ensure an effective service which is delivered by an informed and committed workforce. However, an effective communication system with trade unions does not mean management can abrogate its responsibility to communicate directly with nurses and midwives.

7.12 The Commission recommends that all health service providers put in place mechanisms for ensuring an effective internal communications system with nurses and midwives. Such systems should be audited on an on-going basis to ensure their continuing effectiveness in conveying and receiving information.

Professional and Personal Career Planning

7.13 In any workforce and particularly in a professional workforce, there is a need for individuals to develop personal career plans which reflect their abilities and interests. Each nurse or midwife may have particular interests in either clinical practice, education or management and may wish to pursue particular career avenues. There is a need to develop systems which facilitate the desired personal career choices of individual nurses and midwives in the context of the needs of health service providers in meeting organisational and service goals. Developing a personal career plan which will involve identifying the skills, training and educational characteristics and needs of individuals is a challenging process. Such a process involves a real commitment from

both management and staff and also requires an understanding from both parties of the purpose and objectives of personal career planning and development. The purpose is to facilitate the development of individuals and is not related to either incremental pay or the disciplinary process. The process is a partnership between employers and staff in developing personal career plans within the context of organisational and service needs. The principles which might underpin personal development planning were recently outlined by Robin Douglas in an article for the Office for Health Management (Office for Health Management: Issue 3, May 1998).

These included:

- an acceptance of personal responsibility for one's own

learning;

- a recognition that self knowledge is crucial to effective development;
- an understanding of the many formal and informal opportunities that may be taken to improve knowledge and skills;
- a belief that action-based learning can provide the means to embed substantive knowledge and give the chance to apply ideas to practice;
- the understanding that the process of learning is not a simple change from incompetence to full capability, but contains many challenges in both intellect and emotion that must be met along the way. In other words, to learn, it is often important to unlearn, and for a period perhaps it is necessary to become less competent; and
- an acceptance that, although the responsibility for planning and implementing a personal development plan is likely to be an individual process, work with others will be crucial in achieving any development goals.

7.14 The Commission recommends that health service providers introduce systems to facilitate the development of personal career planning amongst nurses and midwives. Health service providers should provide training, resources, access to learning opportunities and funding or support for nurses and midwives to acquire new skills and capabilities. Training should be provided to managers and staff in the aims and objectives of personal career planning. Prior to the introduction of any system to facilitate the introduction of a professional and personal career planning system for nurses and midwives, there should be discussions between health service employers and nursing organisations.

The Strategic Planning of the Nursing and Midwifery Service

7.15 The consultative process identified a concern that nurses and midwives did not have an effective input in planning or in policy and strategy development. It was also suggested that there was a need to examine structures of ensuring the more effective development and planning of nursing and midwifery services at health board level. Nursing and midwifery are going through a period of rapid change impacting on the traditional career pathways of nurses and midwives, the parameters of nursing and midwifery practice and the organisation and delivery of nursing and midwifery services. The rapid development of nursing and midwifery, the increasing opportunities for nurses and midwives to focus and specialise in their practice, raises concerns in relation to the potential for increased fragmentation of the nursing and midwifery service. These developments will require the effective planning of the nursing and midwifery resource, particularly in identifying the educational and skills

requirement of nursing and midwifery within a health board area.

The Chief Nursing Officer at the Department of Health and Children

7.16 A Chief Nursing Officer was appointed in 1998 to the Department of Health and Children to strengthen its nursing and midwifery policy and planning function. This is a recent appointment and the function is still in the process of development. However, the Commission envisages that the Chief Nursing Officer and her office will have a crucial role in strengthening the central planning and strategic development of nursing and midwifery and in the implementation of the recommendations of this report. There is a need to strengthen the workforce planning, professional leadership and quality assurance functions in the Department of Health and Children. The Commission recommends the development of the post of Chief Nursing Officer at the Department of Health and Children. The post should be filled on a fixed-term contract basis. Given the crucial role of the post, the Commission recommends that the Chief Nursing Officer be supported by the recruitment of nurses and midwives from the health services. These nurses and midwives would provide additional professional expertise not readily available within the Department of Health and Children. Such staff should be recruited for up to two year periods from within the health service. Staff could then return to health service providers thus allowing any additional skills or perspectives acquired to be used to the benefit of health service providers whilst allowing a rotation of perspectives and skills into the Department of Health and Children.

A Nursing and Midwifery Planning and Development Unit

7.17 The Commission recommends the establishment of a Nursing and Midwifery Planning and Development Unit in each health board. These units would have a strategic planning and policy development role for nursing and midwifery services in a health board area. The Commission recommends the Nursing and Midwifery Planning and Development Unit have the following general functions:

- strategic planning and quality assurance of nursing and midwifery services in a health board area;
- co-ordinating the delivery of nursing and midwifery services and improving co-operation between health board and voluntary bodies in the delivery of nursing and midwifery services;
- working in partnership with the Chief Nursing Officer in the Department of Health and Children in planning and policy development on nursing and midwifery issues;

- overseeing the detailed provision of continuing nursing and midwifery education within a health board area;
- liaising with centres of nursing education of health service providers;
- developing, monitoring and reviewing the co-ordination and development of multi-disciplinary nursing services within a community care area;
- identifying inter-nursing disciplinary and inter-agency training needs and promoting the development of an inter-nursing disciplinary and inter-agency training strategy;
- reviewing significant issues in relation to inter-nursing disciplinary and inter-agency co-operation arising from the handling of selected cases; and
- assisting in improving internal communications with nurses and midwives in a health board area.

7.18 The Commission recommends that the Nursing and Midwifery Planning and Development Unit at health board level be headed by a senior nurse on a fixed-term contract - the Director of the Nursing and Midwifery Planning and Development Unit - who would report to the Chief Executive Officer of a health board. It is stressed that the Director of the Nursing and Midwifery Planning and Development Unit will not have a direct reporting responsibility for senior nurse and midwife managers in individual institutions but will operate at a strategic planning level in a manner similar to the Chief Nursing Officer at the Department of Health and Children. The post of Director of the Nursing and Midwifery Planning and Development Unit should be filled by interview following an open competition. The Nursing and Midwifery Planning and Development Units will require a range of other nursing and midwifery personnel in fulfilling its functions. The Commission recommends that the nursing and midwifery staff of the Nursing and Midwifery Planning and Development Units be recruited from nursing and midwifery staff within a health board area for periods of up to two years. This will allow for a greater exposure of nurses and midwives to the planning and policy development function within health boards and will also allow the Nursing and Midwifery Planning and Development Units make greater use of the nursing and midwifery personnel resource within a health board. The rotation of staff within the Nursing and Midwifery Planning and Development Unit should strengthen the operation of the unit and also assist in the development of the nursing and midwifery management function throughout a health board.

Senior Nursing and Midwifery Management

7.19 As previously outlined there was a view expressed that senior nursing and midwifery management concentrated on the individual management of nurses and midwives rather than the management of nursing and midwifery. It was

suggested that senior nursing and midwifery management focused on such issues as the rostering of nurses and midwives, sick leave and annual leave rather than the development of nursing and midwifery practice and policies for the more effective delivery of nursing and midwifery care. It was suggested that senior nursing and midwifery management operated on the basis of command and control rather than consultation and the delegation of responsibility.

7.20 The Commission considers that nursing and midwifery require strong professional leadership which can be provided by directors of nursing or chief nursing officers. The strategic planning and professional leadership of nursing and midwifery means that senior nursing and midwifery management cannot be involved in the minutiae of the day to day management of nurses and midwives (such as rostering). The involvement of senior nursing and midwifery management in detailed management issues would also undermine all levels of nursing and midwifery management. In such a scenario other levels of nursing and midwifery management will merely act as "gatekeepers" or "message carriers" for senior nursing and midwifery management. The Commission recommends that the responsibilities of senior nursing and midwifery management should include:

- providing strategic and clinical leadership and direction for nursing and midwifery and related services which results in the delivery of effective, efficient, quality assured and patient centred nursing and midwifery care;
- developing a shared sense of commitment and participation amongst staff in the management of change, the development of nursing and midwifery services and in responding to the changing health needs of patients;
- developing the concept of care planning in collaboration with other professionals;
- participating in the overall financial planning of the health service provided including the assessment of priorities in pay and non-pay expenditure;
- ensuring that appropriate in-service education programmes and on-going learning needs are met for all assigned staff; and
- ensuring that modern standards of clinical nursing and midwifery care are in operation and that regular monitoring of nursing and midwifery care is undertaken through audit.

7.21 It is essential that senior nursing and midwifery management empowers all levels of nursing and midwifery in the management and delivery of services. Senior nursing and midwifery management has a crucial role in providing professional leadership to nurses and midwives. This role will be particularly important where there is increased

specialisation and the potential for increased fragmentation in the nursing and midwifery service. Senior nursing and midwifery management must ensure continued coherence in the planning and development of nursing and midwifery services.

7.22 In recognition of the increased focus of senior nursing management on the strategic planning of nursing and midwifery services, the Commission recommends that in future all matrons in large acute hospitals and chief nursing officers in the psychiatric services should be entitled Directors of Nursing.

Nursing Management in Smaller Hospitals

7.23 The Commission recognises that matrons of smaller hospitals (bands three, four and five) need to combine a professional leadership role with detailed general management responsibilities. Their professional leadership role is just as important as in the larger hospitals, the difference being a matter of scale. They have a crucial role in overseeing the professional development of nurses in their hospitals. It was reported during the consultative process that many such matrons were not involved in the budgetary process. In order to discharge their general management functions more effectively, the Commission recommends that matrons of smaller hospitals (bands three, four and five) should be given more explicit input into the determination of the budget and greater control and responsibility over its utilisation. Where savings are achieved, they should be utilised to improve the standard of care or quality of life of the patients.

Middle Nursing and Midwifery Management

7.24 There are numerous titles ascribed to middle nurse and midwife managers in Irish hospitals as outlined in the literature review conducted by Maureen Flynn, on behalf of the Commission.

Examples of these include:

- Night Superintendent;
- Assistant Director of Nursing;
- Assistant Chief Nursing Officer;
- Unit/Divisional Nurse Manager;
- Directorate Nurse Manager;
- Superintendents; and
- Assistant Matrons.

7.25 The roles of nurses and midwives employed in these posts were identified as varying considerably and were described as being generally more administrative than

managerial. This has often resulted in confusion amongst staff in relation to those who have responsibility for decision making in areas such as; working arrangements, skill mix, educational requirements or career plans. It appears that in many cases, decisions on these matters are referred to the Director of Nursing or Chief Nursing Officer for decision, with middle nursing and midwifery management merely acting as conduits for information or "gatekeepers". Role conflict, ambiguity and incongruity, if allowed to continue, will undermine the rationale for the continued existence of a layer of middle nursing and midwifery management. There is a need when appointing nurses and midwives to such posts that they be furnished with realistic, explicit and detailed job descriptions and receive the requisite support from senior management. The introduction of new management structures in some services in recent years has meant in many cases that the middle nurse and midwife manager has a clear role and has direct managerial responsibility, authority and accountability for all nurses and midwives in her or his designated area.

7.26 It is essential that middle nursing and midwifery managers have a clearly defined management role, in structures within the health services. In the absence of any clearly defined role such posts may merely carry out a range of administrative duties which may bear little relationship to professional nursing or midwifery. In line with management developments in general, there are increasing calls to replace traditional hierarchical and bureaucratic models of management with flatter structures which empower those at the front line of service delivery. Middle nursing and midwifery management must have its management role clearly defined in the interests of the delivery of more effective, quality patient care.

7.27 The developments of clinical directorates and psychiatric care sectors within the Irish health service in recent years, have helped to provide middle nursing and midwifery management with more clearly defined management roles. Clinical directorates operate in a small number of hospitals as pilot sites at present. Directorates, headed by a clinical director, operate on a triumvirate system of management involving a medical consultant, nurse manager and a business manager. Overall responsibility for the budget and management of clinical services rests with the Clinical Director. Nursing and midwifery managers in this system have devolved authority in relation to the leadership and development of nursing and midwifery personnel within the directorate. In a directorate model, it is essential that nursing and midwifery retain a strong sense of identity and the nursing manager is responsible for ensuring this sense of identity and maintaining the highest standards of professional care for patients. To date, the Clinical Director in all cases is a medical consultant. The current contract for consultants

working in the Irish public health service provides that all clinical director posts within clinical directorates should be held by a medical consultant. The Commission has learned from contacts with the United Kingdom and on its visit to Australia that, on occasions, the clinical director post is held by a nurse or midwife in these countries. Such posts are held with the approval of all staff working within a directorate and appear to operate very successfully where a nurse or midwife has a combination of clinical awareness and management skills to manage a directorate effectively. Nurses and midwives may also be in a position to devote their full energies to this crucial function, whilst often medical consultants have little time to devote to their management responsibilities because of time demands in the treatment of public and private patients. In discussions with representatives of the Irish Hospital Consultants Association, it was stated that they would have no objection to a nurse or midwife being clinical director of a directorate where this was agreed with the clinical team. The Commission recommends that consideration should be given to the appointment of nurse or midwife managers as clinical directors, where appropriate.

7.28 In hospitals where clinical directorates have not been introduced, middle nursing and midwifery management has also worked effectively in taking on explicit functional roles or in the management of areas of care (such as surgical units of care). The functional roles have included bed management and practice development co-ordination. The Commission learned during its visit to Australia of middle nursing and midwifery management taking on roles in relation to the management of housekeeping and catering services, the co-ordination of nursing and midwifery services across a range of care areas and the nursing and midwifery research and continuing education function within a hospital.

7.29 The Commission recommends that middle nursing and midwifery management should:

- have a defined management role and not merely retain a "gatekeeping" administrative function;
- have defined management responsibility with explicit delegation of authority from directors of nursing and chief nursing officers;
- have definite functional roles either in managing units of care or in the management of functional responsibilities such as in bed management and practice development co-ordination; and
- have the authority to manage their area of responsibility without constant reference to more senior management. However, as in all management, there should be effective communication with front-line and senior management.

7.30 The Commission also considers that there should be a greater nursing and midwifery management input in areas which impact directly on the quality of care. These areas include catering, cleaning and laundry services. The Commission considers that nursing management should be involved in discussions on the award of contracts for such services.

First Line Nursing and Midwifery Management

7.31 The role of the ward sister and nursing officer (first line nursing managers) was widely acknowledged throughout the consultative fora and in written submissions as being crucial to the effective running of the hospital or service - ward sisters and nursing officers were often described as the "lynchpin". However, in the literature review undertaken by Maureen Flynn on behalf of the Commission it was found that there are large variances in the levels of autonomy and control given to first line managers across hospitals in Ireland.

7.32 Traditionally, staff nurses/midwives, in the absence of a clinical career pathway, have been promoted to ward sister and nursing officer on the basis of their competence and experience in the clinical field. However, good clinical nurses or midwives have not always made good nurse and midwife managers and this has been compounded by the fact that in many places ward sisters continue to be rostered in the staffing complement with a patient caseload, to the detriment of managing the ward. While clinical credibility is seen to be intrinsic to the role, the amount of time that a ward sister or nursing officer can devote to clinical practice varies considerably, depending on whether he or she is employed in a small district or a large tertiary health care facility.

7.33 Changes in the health services, such as much shorter lengths of stay in hospital, the increasingly acute nature of patients in hospital and the ever rapid rate of technological development have all impacted on the role of first line nursing and midwifery managers across the health service.

The management of care in nursing and midwifery increasingly calls for a range of well developed personnel and resource management skills in the ward sister and nursing officer. In many instances, first line nursing managers have not received appropriate management training or upskilling for their role as it has evolved in recent years. Many first line nursing and midwifery managers appear to have undertaken courses on their own initiative without acquiring management skills appropriate for the effective discharge of their duties.

7.34 First line nursing and midwifery managers need not only to develop management skills, but also retain the need to act as professional leaders amongst nurses and midwives

working on a ward or in a service area by maintaining clinical credibility. The key nature of the management and professional leadership role of first line nursing and midwifery managers was identified by Lewis in 1990 in a study which suggests that:

- first line nursing and midwifery managers exert such influence that they have the potential to effectively negate any changes in the professional function and therefore should be involved in all discussions in relation to change;
- in order to control the nursing and midwifery function effectively, first line nursing and midwifery managers should be expert in the three processes of the nursing and midwifery function; defining, managing and practising. First line nursing and midwifery managers must therefore have further education in theory relating to nursing and midwifery frameworks, management and practice; and
- as the maintenance of high professional standards is essential to the public interest, the clinical function of their role must not be sublimated to the managerial function.

7.35 In 1994, a review of twenty years of literature from both the USA and the UK regarding supportive supervision and the role of the nurse manager/ward sister was published. The research from both countries found that all nurses and midwives from student nurse to middle manager are seeking in their supervisor a person who will "enable them to give of their best while obtaining satisfaction from their work, rather than a controlling supervisor who attempts to mould them into a group of subservient drones" (Cameron Buccheri and Ogier, 1994). The authors suggest that the behaviour of supportive supervisors includes: demonstrating value for nurses and midwives as individuals; recognising their worth; allowing them to express their opinions and assisting them in decision making and problem solving by communicating adequate information. The authors offer four basic suggestions for supporting first line nurse and midwife managers in their role:

- they must be given adequate resources to develop their expertise as health resource managers;
- they should be given frequent feedback in relation to their own performance;
- too much emphasis should not be placed on the managerial functions of the first line nursing and midwifery manager at the expense of the clinical aspects of their role; and
- first line nursing and midwifery managers should have support from middle and senior management by sharing information with them, encouraging them to have an influence on their organisation and its policies

and by assisting them to receive recognition within the organisation.

7.36 The combination of managerial functions and clinical professional leadership required of first line nursing and midwifery managers calls for a significant level of managerial competence together with clinical credibility. The combination of both these functions needs to be carefully managed and supported by senior management. A ward sister or nursing officer should receive adequate support to ensure that both functions are effectively performed in the interest of the delivery of an efficient, effective and high quality health service. The Commission recommends that clerical and information technology support be made available to first line nursing and midwifery managers to support them in their managerial function, where appropriate.

7.37 In order to manage effectively the delivery of health care on a ward or in a service area and promote high standards of care, the control of resources should be delegated to the ward or unit of service delivery. The Audit Commission, in the United Kingdom, published a document entitled - Making Time for Patients - in 1992 which examined the role of ward sisters in the National Health Service. The report identified problems attaching to the split between responsibility for the ward and control over resources. Historically, responsibility for ward resources and the clinical activity on the ward has tended to be split between the managers above and outside the ward who control the resources and the ward sister who is responsible for patient care. The report advocates decentralised management structures that bring the two more closely together. A recent economic review of the Irish health services found that:

"the management of the hospital system seems to be unduly centralised and bureaucratic...

Moreover, in a hospital it is rare for budget responsibility to be devolved to operating units" (OECD, 1997)

7.38 The Commission supports the view that, in line with the Health Strategy - Shaping a Healthier Future - budgets should be devolved to the units of service delivery. It is recognised that the management information and support systems used by many health service providers will not support the effective devolution of budgetary responsibility. The Commission recommends investment in the management information and support systems used by health service providers to allow for greater devolution of budgetary responsibility which would result in significant improvements in the effective and efficient utilisation of resources.

7.39 The Commission recommends that first line nursing and midwifery management should be given greater budgetary

responsibility in relation to the utilisation of resources at units of service delivery. It is an essential ingredient of functional management to be involved in controlling, preparing and monitoring the budget. Front line nursing and midwifery management should have this responsibility and be supported in developing the necessary skills to perform this function effectively. It is essential that first line nursing and midwifery management receive training in analysing, constructing and monitoring budgets. It is acknowledged that currently many factors which will impinge on resource utilisation at the unit of service delivery may be outside the control of first line nursing and midwifery management; these factors include for example the ordering of excessive clinical tests by junior medical staff, the admission and discharge of patients and the requirement of one to one nursing ("specialling") ordered by a medical consultant. The effective management of resources at units of service delivery requires a partnership between all professionals involved in the delivery of services to clients and patients, particularly between nurses/midwives and medical professionals. The elements of the budget to be controlled by first line nursing and midwifery management should be agreed by all those involved in care teams, but should include at a minimum nursing/midwifery and ancillary staff pay costs and supplies. If savings are made, it should be clear to what extent such savings can be utilised within the ward.

7.40 The Commission recognises that these proposals involve a significant increase in the management responsibilities currently expected of many first line nursing and midwifery managers and must be balanced with maintaining effective clinical and professional leadership. Prior to the devolution of additional budgetary and management responsibilities, those who currently hold first line management positions must be supported in developing their skills. The Office for Health Management should identify the range of skills required by first line nursing and midwifery management to perform a clinical leadership and a resource and personnel management function. The Commission recommends that training programmes should be organised in partnership between health boards, voluntary agencies and the Office for Health Management to develop and support existing first line nursing and midwifery managers to enable them to take on additional management and budgetary responsibilities.

7.41 Front line nursing and midwifery managers have an enormous impact on the culture of care in a hospital or service with a resulting impact on the quality of patient care. It is essential that ward sisters and nursing officers are seen as a key management grade within the health service whilst at the same time retaining a clinical and professional leadership role. The Commission recommends the development of first line nursing and midwifery management to fulfil the following functions:

- professional clinical leadership;
- staffing and staff development;
- resource management; and
- facilitating communication.

The Commission also recommends that first line nursing and midwifery managers should have management training before taking up a post and be required and supported in continuing to develop management skills. The development of management skills should operate in tandem with maintaining clinical credibility by being aware of changes in clinical practice.

7.42 The title of ward sister may be regarded as an anachronism in the modern health service and it has been suggested that the function might be more appropriately titled "Clinical Nurse Manager" or "Clinical Midwife Manager". This title may more adequately reflect what the Commission envisages as the key functions of first line nursing and midwifery management; resource management, staffing and staff development, facilitating communication and professional clinical leadership. This title might also be considered by the psychiatric nursing services. The ward sister would be entitled Clinical Nurse Manager 2 or Clinical Midwife Manager 2.

7.43 The post of junior ward sister has been alternatively described as a useful preparation for nursing and midwifery management and as a "non-job" merely acting as an aid to a ward sister. The Commission is aware that the post of junior ward sister was used in some cases as an alternative to a ward sister post, which should not happen. The Commission having considered the matter was of the view that there was a need for an additional post in the management of a ward, where required by the activity and complexity of the nursing/midwifery service, below the ward sister or nursing officer. A person filling such a post should have a clearly defined role and responsibility and would normally take charge in the absence of a ward sister or nursing officer. The junior ward sister would in all cases report to the ward sister in her/his area. In the psychiatric services there is at least one deputy nursing officer in most units of care. The post of deputy nursing officer is similar but not identical to junior ward sister. This post would be entitled Clinical Nurse Manager 1 or Clinical Midwife Manager 1.

7.44 There is also the need for a level of first line nursing and midwifery management above that of ward sister and nursing officer in areas where it is justified by the complexity and level of activity. The Commission envisages that it will be extremely rare for all three levels of nursing and midwifery management to be in the same unit. However, in an area such as Accident and Emergency in a large tertiary acute hospital there may be a requirement for a number of ward sisters and

the Commission considers that one person should be designated as being in charge of the unit. It is in such a scenario that the Commission envisages a level of first line nursing and midwifery management above that of ward sister. The other ward sisters would report to this higher level of first line nursing and midwifery management. The post would be entitled Clinical Nurse Manager 3 or Clinical Midwife Manager 3.

7.45 In summary the Commission recommends that there should be three grades of first line nursing and midwifery management in the health service. All three grades would rarely be in place in a single unit and only one person would be designated as being in overall charge of a single unit of care or ward. The Commission recommends that the title used for first line nursing and midwifery management be "Clinical Nurse Manager" or "Clinical Midwife Manager". The three grades would be:

- Clinical Nurse Manager 1 or Clinical Midwife Manager 1 (reporting to a Clinical Nurse or Midwife Manger 2);
- Clinical Nurse Manager 2 or Clinical Midwife Manager 2 (in charge of a ward or unit of care); and
- Clinical Nurse Manager 3 or Clinical Midwife Manager 3 (in charge of a department).

The three first line nursing and midwifery management grades would reflect the three levels of first line nursing and midwifery management referred to in this section. The conditions of employment of these posts should be determined in the appropriate fora.

Promotion and Related Difficulties

7.46 It is important that the most suitable nurses are attracted into management. This will not happen if financial and other rewards are not in place. The issue of differentials between the staff nurse and ward sister/nursing officer grades has been the subject of concern and dispute since the early 1970's when premium pay was introduced in response to a request by nurses working unsocial hours. Since then, national wage agreements and grade increases have failed to resolve the problem which has been exacerbated by the last pay award to nurses.

7.47 The Commission considers that existing differentials constitute the main difficulty relating to promotion. Current pay structures seriously mitigate against encouraging nurses to avail of promotional opportunities. The loss of premium earnings frequently means that the ward sister/nursing officer in a promotional position earns less than a staff nurse. This makes it financially unattractive for nurses at present to seek promotion into the more senior nursing posts where premium payments do not apply. Many hospital agencies find it

difficult to encourage nurses to seek promotion.

7.48 The problems related to promotion are not just emphasised by nurses but are also recognised by the chief executive officers of the health boards and voluntary hospitals in their submissions.

7.49 Another factor which must be taken into account in relation to promotion is that unlike almost every other occupation in the health services, nursing does not have a system of incremental leave. A director of nursing gets the same number of annual days leave as a staff nurse.

7.50 The Commission recommends that differentials and incremental annual leave in promotional grades be examined as a matter of urgency, before the end of December 1998, through the established structures. To this examination should be added the effect of the enhanced role for ward sisters and higher grades which has been recommended by the Commission earlier in this chapter.

Nurses and Midwives in General Management

7.51 As stated previously nursing and midwifery provide a valuable personnel resource to the health services. Nurses and midwives have an in-depth knowledge of the health services and are particularly aware of the needs of patients and clients of the health services. Nurses and midwives possess a range of clinical skills and awareness which, if combined with management expertise, offer a potentially valuable management recruitment pool. The Commission was concerned that nurses and midwives in pursuing management roles in the health service appear to focus almost exclusively on roles within nursing and midwifery management. The Commission considers that nurses and midwives should seek opportunities in general management. The exposure of nurses and midwives to a wider range of management responsibilities would benefit both general management and nursing and midwifery. The nursing and midwifery perspective and awareness of clinical issues would be an invaluable attribute in a general management role. Similarly the exposure of nurses and midwives to wider general health service issues would benefit nursing and midwifery management should a nurse or midwife return to nursing and midwifery management at a later stage. The Commission recommends that health service providers encourage nurses and midwives to seek opportunities in general management and that nurses and midwives consider pursuing careers in general health service management.

Recruitment and Selection of Nurse and Midwife Managers

7.52 The recruitment and selection process for nurse and midwife managers was considered by the Commission. It was felt that when advertising for a nursing or midwifery management position, the job description should contain a requirement that applicants must have undergone a management course and have adequate experience relevant to the post. The Commission recommends that the Office for Health Management approve appropriate management courses for each particular level of nursing and midwifery management. The Commission also recommends that nurse and midwife managers at each level in the health service should have an appropriate management qualification and/or experience relevant to the post.

7.53 The Commission recommends that the Office for Health Management carry out a survey into the competencies required for nursing and midwifery management positions. These competencies should be drawn up in the light of the management responsibilities identified for each level of nursing and midwifery management by the Commission.

7.54 The issue of nurse or midwife managers' posts remaining vacant for long periods was raised during the consultative process. Nurse and midwife managers "acting-up" for long periods in management positions was not seen to be in the best interests of effective management but was disempowering and demoralising for all concerned. The Commission recommends that vacant management posts where nurses or midwives are "acting up" should be filled as soon as possible.

7.55 When the Commission met with directors of nursing of large acute hospitals in September 1997, they voiced their dissatisfaction in relation to their non-involvement in the recruitment and selection of middle nurse managers for their own hospital, competitions for which are handled by the Local Appointments Commission. They considered it very important that they would be involved in choosing someone who in their opinion would "fit in" with the ethos of the hospital and this would allow for better succession planning. The Commission considered that in the modern health service there may no longer be a requirement for the Local Appointments Commission to be involved in the selection and recruitment of middle nursing and midwifery managers. The selection and recruitment process could be organised by a health board or health service provider itself. Therefore, the Commission recommends that the Local Appointments Commission should no longer be involved in administering the selection and recruitment of middle nursing and midwifery managers.

Management Development

7.56 A number of management development programmes

have been provided for nurses and midwives by the Office for Health Management as identified in paragraph 7.4. These are welcome initiatives and reflect the need to develop current nursing and midwifery managers and future leaders. Nursing and midwifery, like other areas of the health service, will continue to need to develop and evolve rapidly in response to changing client needs and social circumstances. As outlined already, future nurse and midwife managers will require a range of resource management, communication and personnel skills to ensure the provision of an effective and efficient health service. These skills need to be developed and efforts need to be made to give nurses and midwives opportunities to develop these skills. In particular, nurses and midwives should be encouraged to participate in third-level post graduate management courses.

7.57 The increasing inter-disciplinary nature of the provision of health services requires co-ordination of professional and administrative services. In developing management skills it is important that all groups share ideas and perspectives. Therefore, the Commission recommends that, where appropriate, nursing and midwifery management development programmes should be run in conjunction with management programmes for other professional groups and general managers.

The Personnel Management of Nursing and Midwifery

7.58 The Commission in this chapter has recommended a revised management framework for nursing which refocuses the activities of senior nursing management on a strategic planning and quality assurance role. The management of staff, it is recommended, should be delegated to units of care. The effective management of nursing and midwifery staff is crucial to the delivery of high quality care within the health services. As identified in chapter two on the evolution of the nursing profession in Ireland, the traditional management of nurses and midwives reflected a rigid hierarchical culture derived from a semi-militaristic and religious service background. The consultative process identified a series of issues in relation to the management of nurses and midwives which should be addressed in the context of the revised nursing and midwifery management framework.

The Shortage of Nurses and Midwives

7.59 The Commission is aware that there is currently a shortage of nurses in certain areas of the country. There also appears to be a shortage of nurses for certain specialist areas such as theatre nursing. The shortage emerged during the life of the Commission and whilst not researched in great detail may be due to a variety of factors such as the change in status of nursing students from employee to supernumerary and the on-going well-being of the Irish economy in general which

means that there are increased opportunities outside of the health services for nurses. In addressing staff shortages, nursing management needs to be flexible and creative in the working opportunities offered to nurses. Opportunities should be created for those currently working outside of Ireland or not practising nursing to return to the workforce.

Flexible Working Arrangements

7.60 It was suggested during the consultative process that there was a need for greater flexibility in the hours worked by nurses and midwives at different levels. As a predominantly female profession, it was believed that increased access to and availability of job sharing or permanent part-time work ought to be encouraged to allow nurses and midwives combine satisfactorily their professional and family roles. Such flexibility in working arrangements was considered important in order to retain many highly qualified and competent nurses and midwives in the work force, instead of being employed in a temporary capacity.

7.61 Some nurses and midwives also raised the issue of obstacles to transferring either between hospitals in a health board area or between health boards, where a suitable vacancy existed. It was also stated that nurses were not able to move directly to a permanent post but had to take up temporary employment when moving between health boards or some hospitals within the same health board. A further complaint was that having reached a certain increment level whilst employed in one health board they had to revert to the bottom of the incremental scale on taking up temporary employment with another health board.

7.62 The Commission recommends that the Health Service Employers Agency and nursing unions develop an agreed framework for the provision of permanent part-time contracts of employment for nurses and midwives. The framework should provide for more flexible working opportunities for nurses and midwives and allow for a closer correlation between service need and the personal circumstances of individual nurses. Such permanent part-time contracts might require a nurse or midwife to work a certain number of hours per week or alternatively a specified number of weeks each year which could be concentrated in a period of maximum service need. These permanent part-time contracts should also provide for pension and other entitlements, such as sick leave and maternity leave. The Commission recommends that the Health Service Employers Agency and nursing unions examine the equity of current arrangements for nurses and midwives seeking to move from one health board to another or from one hospital to another within a health board.

The Effective Utilisation of the Professional Skills of Nurses and Midwives

7.63 The interim report of the Commission had identified the concerns of many nurses and midwives at the number of non-nursing or midwifery tasks which they were required to perform. It was suggested that the performance of such tasks did not make best use of the professional nursing and midwifery workforce. The Commission supports this view and recommends that health service providers, nursing and midwifery management and nursing organisations examine opportunities for the increased use of care assistants and other non-nursing personnel in the performance of non-nursing tasks. There is also a need to develop mechanisms which will assist in appropriately determining nursing and midwifery staffing levels. A number of such systems may be required, given the variable patient and client dependency, activity levels and the variety of settings in which nurses and midwives work. These mechanisms should also take account of the examination of opportunities for the increased use of care assistants and non-nursing personnel. The Commission recommends that the Department of Health and Children, health service providers and nursing organisations examine the development of appropriate systems to determine nursing staffing levels.

Hand-Over Time

7.64 Another issue identified by nurses and midwives was the fact that in some hospitals hand-over time between shifts was not rostered and the nurses and midwives involved were not paid for this extra time. In other hospitals hand-over time was rostered. The Commission recommends that staffing arrangements should be designed to ensure that nurses and midwives are not required to undertake hand-over duties in their own time.

The Selection and Recruitment of Nurses and Midwives

7.65 The view was expressed during the consultative process that systems for the selection and recruitment of nurses and midwives in certain areas of the health service were overly centralised and bureaucratic. The Commission recommends that the systems used for the selection and recruitment of nurses and midwives should be kept under review and should reflect current best practice.

Temporary Nurses and Midwives

7.66 The consultative process also identified concerns in relation to the number of long-term temporary nurses in the health services. The Commission is aware that health service employers and the nursing unions have agreed that the overall approach to temporary employment should be governed by the principle that the volume of temporary employment in the system should be reduced to the minimum level consistent with operational requirements. Agreement was also reached

that 2,000 nursing posts be converted from temporary to whole time permanent status by means of a confined competition. The Commission understands that this process is underway and that over 1,200 temporary nurses and midwives have been appointed to permanent positions since the commencement of the scheme. However, the Commission considers that there may be scope for the process to move at a quicker pace. The Commission is strongly of the view that the level of long-term temporary nurses in the health service, prior to the agreement between employers and unions, seriously impacted on the morale of the profession. This should not be allowed to recur. It is not in the best interests of the provision of a high quality health service that there are large numbers of long-term temporary nursing posts. The Commission strongly supports the agreement between employers and unions that the level of temporary employment in the service be kept to the minimum level consistent with operational requirements. The Commission recommends that vacant permanent posts should be filled without delay. A framework should be put in place, following discussions between the Health Service Employers Agency and nursing unions, to ensure the problem does not recur.

The Quality of the Working Environment

7.67 The issue of compassionate leave for nurses and midwives was also raised during the consultative process. Complaints were made that compassionate leave, which could be for periods of three to five days following bereavement, depending on the circumstances, did not take into account actual rostered time off occurring during the period. The Commission considers that cases should be dealt with on an individual basis. The Commission recommends that decisions on compassionate leave be delegated to local management so that there could be greater flexibility in granting additional compassionate leave, in appropriate cases.

7.68 The issue of the personal security of nurses in the workplace was raised during the consultative process. Many concerns were expressed at what was perceived as the lack of security afforded to nurses in particular situations, for example in the community, isolated hospital settings and emergency departments. Nurses and midwives reported being subjected to both verbal and even physical abuse from clients. Public health nurses reported being exposed to threatening situations either in very isolated areas or in inner-city areas with major socio-economic problems. It was stated that such nurses were very vulnerable as they were not equipped with mobile phones or personal alarms to enable them to call for help. It was submitted that nurses working in isolated settings felt particularly vulnerable at night. Some submissions from psychiatric nurses highlighted the increased exposure of nurses to violent behaviour. The relative isolation of some psychiatric units meant that sometimes there was no

immediate back-up in crisis situations.

7.69 The Safety, Health and Welfare at Work Act 1989 (the Health and Safety Act) places a duty of care on every employer to ensure, as far as is reasonably practicable, the safety, health and welfare at work of all employees within an organisation. Therefore there is an obligation on every employer to put in place appropriate safeguards to ensure that the safety of employees within the workplace is protected. Staff also have a role to play in being conscious of the potential abuse and violence in certain circumstances and in taking steps to defuse a potentially hazardous situation. Employers in meeting their obligations under the Health and Safety Act should make use of new technology such as mobile phones or personal alarms. There needs to be investment by employers and consultation with nursing organisations to ensure the personal security of nurses and midwives in the workplace.

7.70 Many health service providers have occupational health programmes providing occupational health support to nurses and midwives. However, such programmes are not uniformly available throughout the health service. The Commission recommends the on-going development of occupational health programmes where they are currently provided and their introduction in areas of the health service where they are not currently available.

7.71 The Sick Doctors Scheme was established primarily to assist doctors who have a substance abuse problem. Referrals are mainly from colleagues but may also come from employing authorities, nurses or occasionally a member of the public. On referral, doctors are assessed and advised on a particular course of treatment - those who require admission to a hospital or centre are liable for their own medical expenses. Financial assistance, by means of an interest free loan over five years, is provided to those who need it. Funding for the scheme is provided through the Irish Medical Organisation (IMO), Irish College of General Practitioners (ICGP), General Practitioner Wives Association and the General Practitioners Benevolent Fund. The scheme is administered by a committee comprising two representatives from each of the following organisations - Irish Medical Organisation and Irish College of General Practitioners. Others may be co-opted as necessary. Anonymity and confidentiality are seen as essential to the successful operation of the scheme.

An occupational health programme for doctors is currently being set-up under the auspices of the IMO and the ICGP. Among the services to be provided will be a help-line and counselling. 7.72 The Commission considers that a similar scheme would be beneficial for nurses and midwives. The Commission recommends that the nursing unions and other

relevant organisations establish a scheme to support nurses and midwives similar to the Sick Doctors Scheme.

7.73 The issue of a facility for the debriefing of nurses and midwives following critical incidents was also raised during the consultative process. Submissions to the Commission described situations where nurses having dealt with the consequences of a major accident were expected to continue with their work or go off duty without having had the opportunity of discussing the experience with anyone. The Commission is aware that many health service providers have a critical incident debriefing system for nurses and midwives. However, not all nurses and midwives avail of these facilities because of sensitivity that by using such a service there will be an impression that they cannot cope with the job. The culture which prevents nurses and midwives from seeking help when required needs to be addressed by nursing and midwifery management. The Commission recommends that where critical incident debriefing systems are not in place they should be developed as a matter of urgency.

7.74 Many nurses and midwives during the consultative process requested the provision of a professional confidential counselling service. It was suggested that such a service would allow nurses to receive counselling outside of their local environment and away from colleagues with whom they may be required to work subsequently. A number of health boards and voluntary agencies offer a confidential counselling system to their employees. The Commission considers the provision of a confidential counselling system as a vital support to nurses and midwives working in a daily stressful environment. The Commission recommends that all health service providers should ensure the availability of a professional confidential counselling system for nurses and midwives in their employment.

7.75 The question of sick leave for nurses and midwives was also raised during the consultative process. Some nurses and midwives suggested that sick leave incurred as a consequence of an injury at work should be treated as separate from the sick leave scheme. The Commission is of the view that the provision of sick leave is an issue for local nursing and midwifery management and personnel units. The Commission recommends that nursing and midwifery management should be enabled to use their discretion to a greater extent to allow for greater flexibility in the provision of sick leave in certain exceptional circumstances. The Commission has been informed that a scheme is in place which provides for the payment of an allowance (related to salary) to a nurse or midwife, employed by a health board or voluntary hospital, who is absent from work as a result of a serious physical assault incurred in the course of her or his duty. The scheme also covers medical expenses such as those relating to general practitioner or consultant visits or

prescription charges. The Commission understands that the scheme will shortly be extended to include nurses working for voluntary mental handicap agencies. The Commission recommends that details of the scheme be circulated generally.

7.76 The issue of rest facilities for nurses and midwives was also raised during the consultative process. It was suggested that in many health care facilities there were no, or barely adequate, changing and rest rooms for nurses and midwives. Modern employment practice suggests that staff should have adequate rest facilities on-site and this may be particularly the case in the physically demanding and stressful work environment of nursing and midwifery. The Commission recommends that health service providers ensure the provision of adequate rest and changing facilities for nurses and midwives.

7.77 The question was raised during the consultative process of the point of entry on the incremental pay scale of nurses and midwives who had spent a number of years working abroad. It was stated that nurses and midwives returning to Ireland to take up a permanent position in the health service took up employment on the first point of the incremental pay scale. There was a view that such nurses and midwives were a valuable asset to the Irish health service having gained experience and alternative perspectives on care whilst working abroad. The Commission considered the question of the point of entry on the incremental pay scale essentially a matter for local nursing and midwifery management. The Commission recommends that if a nurse or midwife has acquired skills and experience abroad which are of value to the service, then a nurse or midwife manager should have sufficient discretion within budget to allow her or him to determine the point of entry on the incremental pay scale according to local priorities and needs.

The Financing of Management Systems

7.78 It will be important to have services in place to support the nursing and midwifery management structures proposed by the Commission. The development of effective management systems and staff development needs to be underpinned by adequate resources. Staff development and management systems should not be seen as a "poor relation" in terms of priorities within the health services. Monies spent on the direct delivery of services will be more effectively utilised if the management structures and staff development programmes are supported by continuing adequate resources and not merely when there is some scope for extra expenditure in the system. The Commission recommends that there should be long-term financial commitment to developing communication, management information and support systems to allow for greater devolution of budgets

and staff development programmes. These programmes need to be underpinned by the allocation of adequate resources and a commitment to on-going funding.

Summary of Recommendations in Chapter Seven

The Commission recommends that all health service providers put in place mechanisms for ensuring an effective internal communications system with nurses and midwives. Such systems should be audited on an on-going basis to ensure their continuing effectiveness in conveying and receiving information. (7.12)

The Commission recommends that health service providers introduce systems to facilitate the development of personal career planning amongst nurses and midwives. (7.14)

The Commission recommends the development of the post of Chief Nursing Officer at the Department of Health and Children. The post should be filled on a fixed-term contract basis. (7.16)

The Commission recommends that the Chief Nursing Officer be supported by the recruitment of nurses and midwives from the health services. (7.16)

The Commission recommends the establishment of a Nursing and Midwifery Planning and Development Unit in each health board. The Commission recommends the Nursing and Midwifery Planning and Development Unit have the following general functions:

- strategic planning and quality assurance of nursing and midwifery services in a health board area;
- co-ordinating the delivery of nursing and midwifery services and improving co-operation between health board and voluntary bodies in the delivery of nursing and midwifery services;
- working in partnership with the Chief Nursing Officer in the Department of Health and Children in planning and policy development on nursing and midwifery issues;
- overseeing the detailed provision of continuing nursing and midwifery education within a health board area;
- liaising with centres of nursing education of health service providers;
- developing, monitoring and reviewing the co-ordination and development of multi-disciplinary nursing services within a community care area;
- identifying inter-nursing disciplinary and inter-agency training needs and promoting the development of an inter-nursing disciplinary and inter-agency training strategy;

- reviewing significant issues in relation to inter-nursing disciplinary and inter-agency co-operation arising from the handling of selected cases; and
- assisting in improving internal communications with nurses and midwives in a health board area. (7.17)

The Commission recommends that the Nursing and Midwifery Planning and Development Unit at health board level be headed by a senior nurse on a fixed-term contract - the Director of the Nursing and Midwifery Planning and Development Unit - who would report to the Chief Executive Officer of a health board. The post of Director of the Nursing and Midwifery Planning and Development Unit should be filled by interview following an open competition. (7.18)

The Commission recommends that the nursing and midwifery staff of the Nursing and Midwifery Planning and Development Units be recruited from nursing and midwifery staff within a health board area for periods of up to two years. (7.18)

The Commission recommends that the responsibilities of senior nursing and midwifery management should include:

- providing strategic and clinical leadership and direction for nursing and midwifery and related services which results in the delivery of effective, efficient, quality assured and patient centred nursing and midwifery care;
- developing a shared sense of commitment and participation amongst staff in the management of change, the development of nursing and midwifery services and in responding to the changing health needs of patients;
- developing the concept of care planning in collaboration with other professionals;
- participating in the overall financial planning of the health service provided including the assessment of priorities in pay and non-pay expenditure;
- ensuring that appropriate in-service education programmes and on-going learning needs are met for all assigned staff; and
- ensuring that modern standards of clinical nursing and midwifery care are in operation and that regular monitoring of nursing and midwifery care is undertaken through audit. (7.20)

The Commission recommends that in future all matrons in large acute hospitals and chief nursing officers in the psychiatric services should be entitled Directors of Nursing. (7.22)

In order to discharge their general management functions more effectively, the Commission recommends that matrons

of smaller hospitals (bands three, four and five) should be given more explicit input into the determination of the budget and greater control and responsibility over its utilisation. (7.23)

The Commission recommends that consideration should be given to the appointment of nurse or midwife managers as clinical directors, where appropriate. (7.27)

The Commission recommends that middle nursing and midwifery management should:

- have a defined management role and not merely retain a "gatekeeping" administrative function;
- have defined management responsibility with explicit delegation of authority from directors of nursing and chief nursing officers;
- have definite functional roles either in managing units of care or in the management of functional responsibilities such as in bed management and practice development co-ordination; and
- have the authority to manage their area of responsibility without constant reference to more senior management. However, as in all management, there should be effective communication with front-line and senior management. (7.29)

The Commission recommends that clerical and information technology support be made available to first line nursing and midwifery managers to support them in their managerial function, where appropriate. (7.36)

The Commission recommends investment in the management information and support systems used by health service providers to allow for greater devolution of budgetary responsibility, which would result in significant improvements in the effective and efficient utilisation of resources. (7.38)

The Commission recommends that first line nursing and midwifery management should be given greater budgetary responsibility in relation to the utilisation of resources at units of service delivery. (7.39)

The Commission recommends that training programmes should be organised in partnership between health boards, voluntary organisations and the Office for Health Management to develop and support existing first line nursing and midwifery managers to enable them to take on additional management and budgetary responsibilities. (7.40)

The Commission recommends the development of first line nursing and midwifery management to fulfil the following

functions:

- professional clinical leadership;
- staffing and staff development;
- resource management; and
- facilitating communication. (7.41)

The Commission recommends that first line nursing and midwifery managers should have management training before taking up a post and be required and supported in continuing to develop management skills. The development of management skills should operate in tandem with maintaining clinical credibility by being aware of changes in clinical practice. (7.41)

The Commission recommends that there should be three grades of first line nursing and midwifery management in the health service. The Commission recommends that the title used for first line nursing and midwifery management be "Clinical Nurse Manager" or "Clinical Midwife Manager".

The three grades would be:

- Clinical Nurse Manager 1 or Clinical Midwife Manager 1 (reporting to a Clinical Nurse or Midwife Manager 2);
- Clinical Nurse Manager 2 or Clinical Midwife Manager 2 (in charge of a ward or unit of care); and
- Clinical Nurse Manager 3 or Clinical Midwife Manager 3 (in charge of a department).
- The conditions of employment of these posts should be determined in the appropriate fora. (7.45)

The Commission recommends that differentials and incremental annual leave in promotional grades be examined as a matter of urgency, before the end of December 1998, through the established structures. To this examination should be added the effect of the enhanced role for ward sisters and higher grades which has been recommended by the Commission. (7.50)

The Commission recommends that health service providers encourage nurses and midwives to seek opportunities in general management and that nurses and midwives consider pursuing careers in general health service management. (7.51)

The Commission recommends that the Office for Health Management approve appropriate management courses for each particular level of nursing and midwifery management. The Commission also recommends that nurse and midwife managers at each level in the health service should have an appropriate management qualification and/or experience relevant to the post. (7.52)

The Commission recommends that the Office for Health Management carry out a survey into the competencies required for nursing and midwifery management positions. (7.53)

The Commission recommends that vacant management posts where nurses or midwives are "acting-up" should be filled as soon as possible. (7.54)

The Commission recommends that the Local Appointments Commission should no longer be involved in administering the selection and recruitment of middle nursing and midwifery managers. (7.55)

The Commission recommends that, where appropriate, nursing and midwifery management development programmes should be run in conjunction with management programmes for other professional groups and general managers. (7.57)

The Commission recommends that the Health Service Employers Agency and nursing unions develop an agreed framework for the provision of permanent part-time contracts of employment for nurses and midwives. (7.62)

The Commission recommends that the Health Service Employers Agency and nursing unions examine the equity of current arrangements for nurses and midwives seeking to move from one health board to another or from one hospital to another within a health board. (7.62)

The Commission recommends that health service providers, nursing and midwifery management and nursing organisations examine opportunities for the increased use of care assistants and other non-nursing personnel in the performance of non-nursing tasks. (7.63)

The Commission recommends that the Department of Health and Children, health service providers and nursing organisations examine the development of appropriate systems to determine nursing staffing levels. (7.63)

The Commission recommends that staffing arrangements should be designed to ensure that nurses and midwives are not required to undertake hand-over duties in their own time. (7.64)

The Commission recommends that the systems used for the selection and recruitment of nurses and midwives should be kept under review and should reflect current best practice. (7.65)

The Commission recommends that vacant permanent posts

should be filled without delay. A framework should be put in place, following discussions between the Health Service Employers Agency and nursing unions, to ensure the problem (the number of long-term temporary nurses in the health services) does not recur. (7.66)

The Commission recommends that decisions on compassionate leave be delegated to local management so that there could be greater flexibility in granting additional compassionate leave, in appropriate cases. (7.67)

The Commission recommends the on-going development of occupational health programmes where they are currently provided and their introduction in areas of the health service where they are not currently available. (7.70)

The Commission recommends that the nursing unions and other relevant organisations establish a scheme to support nurses and midwives similar to the Sick Doctors Scheme. (7.72)

The Commission recommends that where critical incident debriefing systems are not in place they should be developed as a matter of urgency. (7.73)

The Commission recommends that all health service providers should ensure the availability of a professional confidential counselling system for nurses and midwives in their employment. (7.74)

The Commission recommends that nursing and midwifery management should be enabled to use their discretion to a greater extent to allow for greater flexibility in the provision of sick leave in certain exceptional circumstances. (7.75)

The Commission recommends that details of the scheme (for payment of an allowance and medical expenses to nurses or midwives assaulted during the course of work) be circulated generally. (7.75)

The Commission recommends that health service providers ensure the provision of adequate rest and changing facilities for nurses and midwives. (7.76)

The Commission recommends that if a nurse or midwife has acquired skills and experience abroad which are of value to the service, then a nurse or midwife manager should have sufficient discretion within budget to allow her or him to determine the point of entry on the incremental pay scale according to local priorities and needs. (7.77)

The Commission recommends that there should be long-term financial commitment to developing communication,

management information and support systems to allow for greater devolution of budgets and staff development programmes. These programmes need to be underpinned by the allocation of adequate resources and a commitment to on-going funding. (7.78)

Commission on Nursing Report

Nursing in the Community

8.1 This chapter outlines concerns in relation to the organisation and delivery of nursing services in the community. The consultative process undertaken by the Commission had identified a number of concerns in relation to the integration of nursing services in the community. There were also concerns in relation to the current and future role of public health nurses and community psychiatric nurses. The Commission makes recommendations in relation to the better integration of nursing services in the community, the organisation of nursing services and the role of nurses in the community. Midwifery services in the community are dealt with in chapter ten of the report.

8.2 The interim report of the Commission on Nursing identified a range of concerns in relation to the future direction of nursing in the community. Community psychiatric nurses and public health nurses have been working in the community since the 1960's. However, increasingly in recent years, a number of other nursing groups have started to work in the community, these include general, palliative care, psychiatric (other than community psychiatric nurses) mental handicap, practice nurses and other nurses. There was concern in relation to the level of integration of the increasingly diverse range of nursing services available in the community. Public health nurses were concerned in relation to their future direction with the increasing number of nursing groups providing services in the community. It was argued there was a need to examine the role of the Public Health Nurse (PHN) and to retain and develop the particular "community" skills which they had developed over the years and to examine the need for "specialist" skills in the community nursing service.

8.3 The Commission received from the Department of Health and Children a copy of the working party report on public health nursing, entitled Public Health Nursing: A Review (1997), which it considered in its deliberations on the issues identified in the interim report.

8.4 The Commission also requested Patricia Leahy-Warren, to undertake a literature review with the following terms of reference:

to conduct a review of the literature on community nursing - service models, care delivery, management of, education for and financing with particular reference to literature from the United Kingdom, United States of America, Australia, Canada and Europe, especially Finland.

8.5 The Commission requested Jean Clarke, Co-ordinator Higher Diploma in Nursing Studies (Public Health Nursing), Department of Nursing Studies, National University of Ireland - Dublin, Catherine McTiernan, Assistant Chief Nursing Officer, Mental Health Services, Eastern Health Board and Netta Williams, Royal College of Surgeons in Ireland, Department of General Practice to submit discussion documents outlining their views on a framework for the future development of nursing in the community.

An Outline of the Current Range of Nursing Services in the CommunityPublic Health Nursing

8.6 The current Public Health Nurse (PHN) service is based on a Department of Health circular in 1966 on the "District Nursing Service". The circular outlined the objectives of a community-based nursing service which were summarised as follows:

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 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 staff and others in her district.

8.7 The concept outlined in the circular was of a public health nursing role encompassing a broad range of preventive and caring functions. However, the role of the PHN has evolved in the thirty years since the circular of 1966. PHNs carry out a diverse range of nursing services responding to the needs of individuals, families and the community. The range of community services provided by PHNs includes:

- support and advice to a parent or parents following the birth of a child, such a service may be provided from shortly after the birth of the child and, if required, continues until the child is of school going age;
- the delivery of school health services;
- providing personalised nursing care to patients who have been discharged to the home from hospital;
- providing a range of nursing services to the elderly and support for carers in the home; and
- providing nursing services and support in the home for

persons with a disability.

Health promotion remains an integral part of the role of the PHN. An example of the development of the role of PHN in recent years, which was cited in Public Health Nursing: A Review (1997), was the "Primary Health Care for Travellers Project" piloted by Pavee Point and the Eastern Health Board. The four aims of the project are to establish a model of traveller participation in the promotion of health; to liaise and assist in creating dialogue between travellers and health service providers in the area; and to highlight gaps in health service delivery to travellers and work towards reducing inequalities that exist in established services. Two co-ordinators, one a PHN and one a community worker, were appointed and eight traveller women were trained as community health workers. Such developments offer new opportunities for PHNs in meeting the particular health care needs of marginalised groups in the community.

8.8 The number of PHNs employed on 31 May, 1996 was 1,222 (Public Health Nursing: A Review). PHNs are required to have a higher diploma in public health nursing provided by National University of Ireland - Dublin or National University of Ireland - Cork. Those applying to enter these programmes must be registered general nurses and midwives and also have at least two years work experience.

8.9 Whilst there is some variation between health boards, registered general nurses (RGNs) are employed to support the public health nursing service. In this capacity, they may cover weekend duties, twilight shifts or work as part of the community care team. They are also employed for periods of PHN absence. These RGNs are employed within the public health nursing system in a temporary capacity.

Mental Handicap Nursing

8.10 A substantial proportion of the mental handicap services are delivered by voluntary agencies serving catchment areas. Traditionally funding for these voluntary agencies was provided directly by the Department of Health. However, in line with Shaping a Healthier Future (1994), the Department of Health and Children published Enhancing the Partnership (1997) which provides for a new framework for the funding of voluntary mental handicap agencies. In future all voluntary mental handicap agencies will be funded through the health board in which they are based.

8.11 The emphasis of care in the mental handicap services is helping each client attain her or his potential as outlined in the report Needs and Abilities (1991). Nurses in this discipline have a diversity of roles, on a continuum ranging from intensive physical nursing of persons with a severe degree of handicap, to supportive guidance in the

management of children, adults and the elderly. Client centred nursing services are provided in many settings including developmental day units, respite care, special education development, vocational training, adult special care units, long-term training units, residential services, including community-based group homes and community support services. Mental handicap nurses wish to see an expansion of the range of community services they provide with greater emphasis on the delivery of specialist mental handicap nursing care in the family home.

Psychiatric Nursing

8.12 Psychiatric nursing services are provided across a range of settings from acute hospitals to high support hostels to the community. This section is intended merely to outline the organisation of psychiatric services in the community which is just one element of the service. Psychiatric services are organised around catchment areas which in turn are divided into sectors to encompass a population of approximately 25,000. Inter-disciplinary teams were established to provide a range of services within each sector. Within this context there is no division between the hospital and community service, rather the hospital, health centre, day hospital and high support hostels are seen as options of care for clients within the catchment area. Psychiatric nurses can be based in any of these facilities. They manage a case load and provide a wide range of nursing services including rehabilitation, social skills training, individual counselling, group work, psycho-education, family support, liaison work and mental health education.

The Grade of Community Psychiatric Nurse

8.13 Community psychiatric nursing emerged as a feature of the Irish health services in the 1960's. During this period the development of new drugs for the treatment of certain conditions allowed for the discharge to the community of patients from mental health institutions. However, a number of such patients had to be readmitted to the institutions following the re-emergence of psychotic symptoms. The most significant reason for the return of such symptoms was identified as non-compliance with the new medication, together with poor preparation of the families to accept the recovered patient back home from the institution. In response to these and other needs the establishment of a new grade of Community Psychiatric Nurse (CPN) was deemed necessary to enable the smooth transition of patients from institutions into the community.

Practice Nurses

8.14 Practice nurses are a fairly recent development in the Irish health services. They are nurses attached to general

practitioner practices and deliver a broad range of nursing services such as immunisations, women's health issues, ante natal care, wound care, counselling and asthma care. Practice nurses do not visit clients in their home. The scheme was set up by the Department of Health in 1989 to support general practitioners in their practice and there are now approximately 500 nurses attached to general practitioner practices. A subsidy towards the cost of employing a practice nurse is available to general practitioners participating in the General Medical Service (GMS) scheme with a patient panel size of at least 100. The amount of subsidy increases in bands of 100 with the maximum subsidy of £14,742 applicable to a GMS patient panel size of 1,200. This subsidy applies to practice nurses employed on a full-time basis and employment contracts of shorter duration are subsidised on a pro rata basis.

Palliative Care Nurses

8.15 Palliative care nurses provide nursing care to chronically ill patients. The care provided by these nurses includes alleviation of pain, symptom control and enhancing quality of life. Palliative care nurses providing such a service may be based in the community. In recent years, hospice home care teams have been set up to provide a call-out and advisory service to enable families to care for a terminally ill family member at home.

Other Nurses

8.16 In addition to the nurses outlined above and the independent domiciliary midwives (referred to in chapter ten), other nursing groups have also recently begun to provide services in the community. Some are health board employees and some are employed by voluntary organisations or in the private sector.

A Framework for Improved Integration of Nursing Services in the Community

8.17 The increasingly diverse range of nursing services being provided in the community has resulted in calls for improved communication and integration between the range of nursing services in the community. The need for improved integration and co-operation in the delivery of nursing services in the community was identified as an issue during the consultative process undertaken by the Commission. It has also been stated that there is a need to improve communication between acute care and community care services. In the absence of improved integration and communication between those providing nursing services in the community, there is a danger that the delivery of nursing care will become increasingly fragmented which is not in the best interests of health service clients or the efficient utilisation of resources.

8.18 The Commission recommends that the Nursing and Midwifery Planning and Development Unit in each health board (see chapter seven of the report) should develop strategies to improve communication and integration between nursing services in community care areas. The systems developed by the Nursing and Midwifery Planning and Development Unit should recognise the particular social, demographic and geographic characteristics of each area. The functions of the Nursing and Midwifery Planning and Development Unit with reference to the community would include:

- developing, monitoring and reviewing the co-ordination and development of multi-disciplinary nursing services within a community care area;
- identifying inter-nursing disciplinary and inter-agency training needs and promoting the development of an inter-nursing disciplinary and inter-agency training strategy; and
- reviewing significant issues in relation to inter-nursing disciplinary and inter-agency co-operation arising from the handling of selected cases.

8.19 This monitoring role should ensure that on-going liaison and co-operation between the different services in the community are kept under constant review and will assist in the coming years in the fundamental reappraisal of nursing services in the community as outlined at the end of this chapter.

Issues Arising from the Consultative Process in Relation to Public Health Nursing

8.20 The Commission received numerous submissions from individual PHNs and from groups of PHNs expressing concern in relation to their role in the delivery of community health services during the consultative process. A number of issues were identified during the consultative process as being of concern to PHNs. These included:

- an increasing workload and an increasingly complex range of social and health issues related to substance abuse and child care protection; and
- concerns in relation to role reduction following the increasing emergence in the community of "specialist" nurses such as palliative care nurses and the increasing employment of practice nurses by general practitioners to provide nursing services attached to their practice.

8.21 Many of the issues identified in the consultative process have arisen as a result of substantial changes in the organisation and delivery of services since the Department of Health issued the circular establishing the current public health nursing system in 1966. The circular predates the

establishment of the eight regional health boards under the Health Act 1970. Community nursing and general practitioner services had been closely aligned under the old dispensary scheme. The introduction of the choice of general practitioner scheme allowed patients in the General Medical Services system to choose their own doctor within the scheme. This has resulted in greater consumer choice. However, general practitioners are patient-based and work mainly in their surgeries, whereas PHNs are area-based and work mainly in the family home. This has resulted in increasing difficulty in aligning public health nursing services with general practitioner services in an area. There have also been further recent changes in the management of community services with the creation of general manager posts with responsibility for community care areas. Technological, social and epidemiological changes have also impacted on the role of the PHN.

8.22 The requirement that nurses applying for public health nursing have a midwifery qualification was also raised as an issue during the consultative process. It was felt by some that such a qualification may no longer be required because of the changed service demands currently facing PHNs. It was also seen as discouraging male nurses from becoming PHNs because of the very few who would have a midwifery qualification. It was suggested that an education module on maternity/child care might be incorporated in the public health nurse higher diploma programme as an alternative.

The Future Direction of Public Health Nursing

8.23 In considering the future direction of public health nursing, the Commission examined other international models for the delivery of nursing services in the community. However, the literature review undertaken by Patricia Leahy-Warren suggested that international trends do not offer any clear models or trends in the organisation and delivery of nursing in the community.

8.24 It appears that the public health nursing system is still essentially based on the Department of Health Circular of 1966. This circular is still seen by many as the core strategy statement in relation to the role of public health nursing in the community. The organisation and delivery of health services have changed radically since 1966 and there is a need to provide a revised strategy statement for public health nursing which has evolved substantially in the intervening thirty years as have other nursing and health services in the community. The Commission recommends that the Department of Health and Children issue a revised strategy statement on the role of public health nursing. The report Public Health Nursing: A Review (1997) should inform the deliberations on a revised strategy statement.

8.25 As stated previously the core concept of the public health nursing system is that of a nurse providing a wide range of nursing services to a district or area. The advantage of such a service was suggested as being the coherence of the nursing service provided to a diverse range of patients and clients in the community. In such a system an individual nurse can provide a range of services to a patient or family. It was suggested that a number of nurses responding to specific needs in a narrowly focused manner (such as would occur by a proliferation of specialists) brings with it the danger of increased fragmentation of the nursing service. Such fragmentation would cause particular problems in the community where distance and isolation from a health centre may already cause difficulties for patients and clients.

8.26 The Commission considers that the PHN should remain at the core of nursing services being delivered in the community. The PHN should remain focused on a district or area meeting the curative and preventive nursing needs of the population within the area. The Commission envisages the PHN continuing to be responsible for people of all ages and of every condition. However, the PHN will also act as a co-ordinator in the delivery of a range of services in the community. This co-ordination might also involve home nursing services provided by registered general nurses (the role of the registered general nurse in the community is discussed at paragraph 8.37). Consideration should be given to allowing the direct referral of clients to "specialist" services such as speech therapy, where such direct referral does not presently take place. There is also a need for public health nurses to develop to a greater extent their health promotion role. In order to fulfil the functions envisaged by the Commission, PHNs need to have their professional autonomy supported by the public health nursing management system. PHNs should also receive greater support in their role through the provision of new technology and, where appropriate, clerical support.

8.27 The Commission recommends the continuation of the present area-based model of public health nursing. However, the PHN should be allowed focus to a greater extent on a health promotion and disease prevention role in the community. The Commission recommends that PHNs should receive greater support in their role through the provision of new technology and, where appropriate, clerical support.

8.28 There is a need for improved links between the public health nursing system and other services in the community. In particular, there is a need for improved liaison and communication between public health nursing and general practitioners. A number of organisational factors appear to impact on good liaison between the two services. General practitioners are not health board employees and are patient based, whilst PHNs are health board employees and are area-

based. These factors may make communication more difficult in urban areas in particular, where patients may have a greater choice of general practitioner. However, these organisational differences are not of themselves barriers to good communication and liaison. On a practical level health boards should give regular formal notification of the names of public health nurses to general practitioners in an area. PHNs should develop informal contacts and liaison with local general practitioners and practice nurses. The greater use of information technology would greatly assist communication, making it easier for both PHNs and general practitioners to contact each other. Good communication will require an active effort by both services to ensure the delivery of an optimal health service to their mutual patients.

8.29 Chapter six of the report has outlined a clinical career pathway in nursing involving clinical nurse specialists and advanced practitioners. The Commission considers that PHNs already operate at the level of clinical nurse specialist. The Commission considers that there is scope for the development of advanced practitioner roles in public health nursing.

8.30 As outlined previously the issue of the mandatory requirement of a midwifery qualification for entry to public health nursing was raised in the consultative process. The Board, in the publication The Future of Nurse Education and Training in Ireland (1994), having reviewed the evolving community care needs, recommended that the requirement of registration as a midwife should not be a prerequisite for entry to public health nursing. It recommended that it be replaced by a maternity and child care module. Public Health Nursing: A Review (1997) also recommended that the mandatory requirement of midwifery be discontinued (a minority of the Review Committee dissented). The Commission supports these views and recommends that, in light of the range of services offered by public health nurses and the on-going development of nursing and midwifery services in the community, registration as a midwife should no longer be a mandatory requirement for entry to the higher diploma in public health nursing or registration as a public health nurse. An alternative education programme relating more closely to the core generic maternal and child care service requirements of public health nursing should replace the mandatory midwifery requirement. The Commission recommends that the Board establish a working party composed of PHNs, health service providers and nurse educators to determine the content and duration of a course in maternal and child health as an alternative to the mandatory midwifery qualification.

The Public Health Nursing Management Structure

8.31 There is a two tier management structure for public health nursing. The two management grades in public health

nursing are Superintendent Public Health Nurse and Senior Public Health Nurse.

Superintendent Public Health Nurses

8.32 It was suggested during the consultative process that superintendent public health nurses, in common with other areas of nursing management, were excessively concerned with the detailed management of individual nurses rather than managing the function of nursing. This management of individual nurses may reflect the job description for superintendent public health nurses issued by the Department of Health and Children which describes their responsibilities as including the direction, supervision and co-ordination of public health nurses and other such staff as may be designated by the Chief Executive Officer. The Commission considers that superintendent public health nurses, in line with proposals in relation to senior nursing management, as outlined in chapter seven, need to provide strong professional leadership. There is a need for an increased focus on the strategic planning, quality assurance and professional development roles of the superintendent public health nurse. The Commission recommends that the future role of the superintendent public health nurse should be concentrated on issues such as:

- providing strategic and clinical leadership and direction for nursing and related services which results in the delivery of effective, efficient, quality assured and patient centred nursing care;
- developing a shared sense of commitment and participation amongst staff in the management of change, the development of nursing services and in responding to the changing health needs of patients;
- developing the concept of care planning in collaboration with other professionals;
- participating in the overall financial planning of the health service provided including the assessment of priorities in pay and non-pay expenditure;
- ensuring that appropriate in-service education programmes and on-going learning needs are met for all assigned staff; and
- ensuring that modern standards of clinical nursing care are in operation and that regular monitoring of nursing care is undertaken through audit.

8.33 The Commission considers that in the modern health service environment the title Superintendent Public Health Nurse is slightly anachronistic. Therefore, the Commission recommends that the title of Superintendent Public Health Nurse be changed to Director of Public Health Nursing and that the job description reflect the changing role.

Senior Public Health Nurses

8.34 The grade of Senior Public Health Nurse was introduced following a recommendation in the report of the Working Party on General Nursing in 1980. The working party envisaged that the senior public health nurse would be responsible for:

(i) 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) the co-ordination of the practical training programme of all students in that area.

However, it appears that the actual role of senior public health nurses may vary from area to area.

A number of seniors specialise in areas such as child care or services for the elderly whilst others occupy a supporting management function within the public health nursing structure. There was much criticism of the management role of the senior public health nurse. It was suggested that many senior public health nurses performed no "real" management function and acted merely as conduits of information from public health nurses to superintendent public health nurses. There was even a suggestion given the type of administrative, "gatekeeping", non-decision making role assigned to many senior public health nurses that there was no longer any need to maintain the grade.

8.35 The Commission, in light of the re-focusing of the role of superintendent public health nurses, considers that there is an important management function to be fulfilled by senior public health nurses. In line with the original recommendation of the report of the Working Party on General Nursing (1980) and the report Public Health Nursing:A Review (1997), the routine management function of public health nursing should be assigned to senior public health nurses. There should be clear delegation of management responsibility and decision making in relation to specific geographic areas or specified functional roles to senior public health nurses. The Commission recommends that senior public health nurses should:

- have a defined management role and not merely retain a "gatekeeping" administrative function;
- have defined management responsibility with explicit delegation of authority;
- have definite functional roles in managing areas for the delivery of public health nursing services; and
- have the authority to manage their area of responsibility without constant reference to more senior management but, as in all management, there should
- be effective communication with public health nurses and senior management.

8.36 The Commission considers that in the modern health service environment that the title Senior Public Health Nurse is slightly anachronistic. Therefore, the Commission recommends that the title of Senior Public Health Nurse be changed to Assistant Director of Public Health Nursing.

Registered General Nurses working in the Community

8.37 The consultative process undertaken by the Commission had identified concerns amongst registered general nurses employed in the community at the lack of opportunities for permanent employment. Registered general nurses are currently employed in a temporary capacity when delivering nursing services in the community. The permanent employment of registered general nurses in the community nursing service has been recommended by a number of studies, including The Working Party on General Nursing (1980) and Public Health Nursing: A Review (1997). The principle is also supported in The Interim Report of the Dublin Hospital Initiative Group (1990) and The Future of Nurse Education and Training in Ireland (1994). Public Health Nursing: A Review states that "the introduction of the general nurse will serve to improve the responsiveness of the service to patient/client need."

8.38 The Commission recommends that where registered general nurses are employed in the community it should be in a permanent capacity in line with service need. Such nurses should be employed in support of the public health nursing service as part of the community nursing team. Flexible permanent part-time employment opportunities could be provided to registered general nurses working in the community which would more effectively align service needs with the personal circumstances of such nurses.

The focus of the registered general nurse could be on home nursing services provided in accordance with a care plan developed with the PHN. Prior to commencing work in the community, registered general nurses should be provided with in-service orientation training in community nursing.

Mental Handicap Nursing Services in the Community

8.39 As outlined previously, mental handicap nursing services are delivered primarily by voluntary agencies to a catchment area. There is a continuum of care from residential centres to high support hostels to day centres to support in the home of a client. The Commission envisages mental handicap services in the home of a client continuing to be provided under the aegis of a mental handicap service provider. Services radiate out from a residential centre and meet the entire range of mental handicap service needs, from institutional care to support in the home, as appropriate.

8.40 However, it appears from the consultative process that there is a need to further develop mental handicap nursing services to support clients in their home. The organisation and management of an enhanced community mental handicap nursing service should be encompassed within the existing management structures for the mental handicap services. There is a need to enhance the community service; the development of the clinical nurse specialist role within mental handicap will offer opportunities for the enhancement of community mental handicap services. Working titles for clinical nurse specialist in mental handicap nursing can be agreed between the National Council and health service providers when the posts are created.

8.41 There is a need to develop educational programmes to underpin the role of clinical nurse specialists in mental handicap services. Mental handicap will have a distinct identity within third-level institutes following the transition to the degree programme. Third-level institutes working in close collaboration with health service providers and the National Council should develop courses to underpin the enhancement of mental handicap services in the community.

8.42 The Commission also sees the potential for the development of advanced nurse practitioners in mental handicap nursing which will greatly enhance the delivery of services in the community and in residential care. These advanced practitioners would be educated to masters degree level, would practice an expanded nursing role, making professionally autonomous decisions and taking sole responsibility within agreed protocols.

8.43 The Commission recommends that health service providers and the National Council examine the development of clinical specialisms with consequential posts which would enhance the delivery of mental handicap nursing services in the community.

Psychiatric Nursing Services in the Community

8.44 As stated previously, psychiatric services are organised on a catchment area basis which are divided into sectors providing mental health services to population groups of 25,000. This allows the provision of a seamless service to the patient or client from the community to the hospital.

A chief nursing officer is responsible for the management of psychiatric nursing services within the catchment area. In many sectors an assistant chief nursing officer is assigned to manage nursing services in the community.

8.45 The publication of Planning for the Future (1984) resulted in a reorientation of mental health services in this

country with an even greater emphasis on community services. It was stated that increased numbers of psychiatric nurses were now working in the community and many CPNs in submissions to the Commission requested the continuance and review of the grade and their role.

8.46 The Commission supports the concept of a seamless psychiatric service covering acute centres, day hospitals, high support hostels and community services. The Commission envisages all psychiatric nurses being enabled to provide mental health services across the range of locations, including the community.

8.47 However, the Commission also recognises that there is a need for specialist community psychiatric nursing to further enhance the psychiatric nursing service provided in the community. There is an increasing need for an enhanced role for psychiatric nursing teams in the promotion of mental health and in areas such as suicide prevention. The psychiatric nursing service needs to extend its area of activity beyond responding to the needs of diagnosed patients and clients and towards enhancing the mental health of a population group within a geographic area. Community psychiatric nurse specialists should, in addition to holding a client group, focus on mental health promotion in the community. There is also a need to ensure the delivery of a high quality specialist nursing service to patients in the community who may have serious underlying mental illness. Such a service might include, for example, visiting schools in an area and providing advice and assistance to potentially vulnerable groups.

8.48 The Commission recommends the development of community psychiatric clinical nurse specialists. Such community psychiatric clinical nurse specialists have the same characteristics as clinical nurse specialists as outlined in chapter six. A specific grade for community psychiatric clinical nurse specialists should be developed and they should be designated "community mental health nurses".

8.49 The Commission envisages such community mental health nurses operating in a community psychiatric nurse team with registered psychiatric nurses. Such a team would meet the mental health needs of a community in a manner similar to a general nursing community care team composed of public health nurses and registered general nurses. The Commission considers the community mental health nurses as developing the role of the CPN and psychiatric nursing services in the community. CPNs who do not wish to convert to community mental health nurses would remain in their current position and on the same salary scale. However, for those CPNs who wish to seek an appointment as community mental health nurses, the Commission recommends that the interim procedures for the appointment of clinical nurse

specialists, outlined in chapter six, would also apply to community mental health nurses.

8.50 The increasing prevalence and diversity of mental health needs in the community will also require the development of a role of advanced nurse practitioner in community psychiatric services. Advanced practitioners would be prepared to masters degree level and would see patients with undifferentiated and undiagnosed problems and initiate treatment within agreed parameters according to agreed protocols. This area should be examined by the National Council at an early stage. The Commission envisages that the development of such a service will greatly enhance the capacity of the psychiatric nursing services to respond flexibly and promptly to the growing mental health needs in the community. Career opportunities for psychiatric nurses in the community psychiatric services will also be available in management as outlined in chapter seven.

8.51 Educational programmes to underpin the role of the community mental health nurses and advanced nurse practitioner should be developed in a collaborative process involving third-level institutes, health service providers and the National Council as outlined in chapter six.

8.52 The Commission recommends that an enhanced community psychiatric nursing

service should provide for the development of clinical nurse specialists and advanced practitioners within the community in each catchment area throughout the country, according to service need.

Professional Support for Practice Nurses

8.53 Practice nurses in submissions to the Commission have requested a closer relationship with health boards to provide support for their professional development. The private contractual relationship between independent general practitioners and practice nurses is a unique relationship in nursing which offers numerous advantages to nursing. In addition to the support and assistance offered by general practitioners, the Commission considers that there is a need for improved support and assistance for practice nurses from health boards. The Commission recommends that the Nursing and Midwifery Planning and Development Unit in planning the continuing professional development needs of nurses within a health board area should also assist practice nurses in their professional development. The Commission also recommends that a practice nurse be attached on a sessional basis to the General Practice Unit within the health board to assist in identifying and supporting the development needs of practice nurses. The Commission recognises that the Irish College of General Practitioners has assisted practice nurses

in their professional development and hopes that it will continue in this role.

The Future Direction of Nursing in the Community

8.54 The recommendations of the Commission, in relation to a future framework for public health nursing, mental handicap nursing, practice nursing and psychiatric nursing in the community, reflect the realities of the current state of development of nursing in the community in Ireland. However, the Commission considers that there is a need for a fundamental reappraisal of nursing services in the community as these services develop in the coming years. The demographic, social and health care changes which have impacted on nursing services in the community in the past thirty years will continue to alter the delivery and nature of nursing services in the community. The pace of change in the health services will mean that increasing numbers of patients and clients will need and seek nursing care in the community.

8.55 The Commission is conscious that the organisation and delivery of health services in the community is a complex and difficult task. The community presents a range of disparate needs which may vary substantially according to the demographic and socio-economic characteristics of a particular area. The community represents the environment in which nursing services are delivered but the service demands, priorities and difficulties will vary according to the particular local characteristics of the population.

8.56 The Commission is of the view that in the longer-term, consideration should be given to the development or a more coherent and integrated structure for the delivery of nursing services in the community. In particular, consideration should be given to the development of a more integrated management structure for nursing in the community. This more integrated management structure should encompass the range of nursing services provided in the community and allow for the creation of a post of "Director of Community Nursing". The holder of such a post would be responsible for the strategic planning and delivery of all nursing services in the community.

8.57 In addition to a more integrated management structure, a community nursing education programme could develop the community skills of each nursing discipline. Such a programme could provide a common core module on care and nursing within the framework of the broad band specialist community category, outlined in chapter six. Nurses might then progress by specialising in the care of particular client groups in the community. A common core community nursing programme would provide a common underpinning to all disciplines of nursing, practising in the community. Such a programme would provide nurses from each discipline

with the necessary skills to function effectively in the community whilst being part of an inter-disciplinary community care team.

8.58 The outline framework for the greater integration of the management of and education for nursing in the community will require discussion in the profession. There is little consensus in the profession and amongst health service providers on the future direction of nursing in the community. There is a need for the profession to develop a coherent vision for the future direction of nursing in the community which reflects the nursing needs of the community rather than the status of individual groups within the profession.

Summary of Recommendations in Chapter Eight

The Commission recommends that the Nursing and Midwifery Planning and Development Unit in each health board (see chapter seven of the report) should develop strategies to improve communication and integration between nursing services in community care areas. (8.18)

The Commission recommends that the Department of Health and Children issue a revised strategy statement on the role of public health nursing. The report Public Health Nursing: A Review (1997) should inform the deliberations on a revised strategy statement. (8.24)

The Commission recommends the continuation of the present area based model of public health nursing. However, the public health nurse (PHN) should be allowed focus to a greater extent on a health promotion and disease prevention role in the community. The Commission recommends that PHNs should receive greater support in their role through the provision of new technology and where appropriate, clerical support. (8.27)

The Commission recommends that, in light of the range of services offered by PHNs and the on-going development of nursing and midwifery in the community, registration as a midwife should no longer be a mandatory requirement for entry to the higher diploma in public health nursing or registration as a public health nurse. An alternative education programme relating more closely to the core generic maternal and child care service requirements of public health nursing should replace the mandatory midwifery requirement. The Commission recommends that the Board establish a working party composed of PHNs, health service providers and nurse educators to determine the content and duration of a course in maternal and child health as an alternative to the mandatory midwifery qualification. (8.30)

The Commission recommends that the future role of the

superintendent public health nurse should be concentrated on issues such as:

- providing strategic and clinical leadership and direction for nursing and related services which results in the delivery of effective, efficient, quality assured and patient centred nursing care;
- developing a shared sense of commitment and participation amongst staff in the management of change, the development of nursing services and in responding to the changing health needs of patients;
- developing the concept of care planning in collaboration with other professionals;
- participating in the overall financial planning of the health service provided including the assessment of priorities in pay and non-pay expenditure;
- ensuring that appropriate in-service education programmes and on-going learning needs are met for all assigned staff; and
- ensuring that modern standards of clinical nursing care are in operation and that regular monitoring of nursing care is undertaken through audit. (8.32)

The Commission recommends that the title of Superintendent Public Health Nurse be changed to Director of Public Health Nursing and that the job description reflect the changing role. (8.33) The Commission recommends that senior public health nurses should:

- have a defined management role and not merely retain a "gatekeeping" administrative function;
- have defined management responsibility with explicit delegation of authority;
- have definite functional roles in managing areas for the delivery of public health nursing services; and
- have the authority to manage their area of responsibility without constant reference to more senior management, but as in all management, there should be effective communication with public health nurses and senior management. (8.35)

The Commission recommends that the title of Senior Public Health Nurse be changed to Assistant Director of Public Health Nursing. (8.36)

The Commission recommends that where registered general nurses are employed in the community it should be in a permanent capacity in line with service need. Such nurses should be employed in support of the public health nursing service as part of the community nursing team. Flexible permanent part-time employment opportunities could be provided to registered general nurses working in the community which would more effectively align service needs with the personal circumstances of such nurses. (8.38)

The Commission recommends that health service providers and the National Council examine the development of clinical nurse specialisms which would enhance the delivery of mental handicap nursing services in the community. (8.43)

The Commission recommends that an enhanced community psychiatric nursing service should provide for the development of clinical nurse specialists and advanced practitioners within the community in each catchment area throughout the country, according to service need. (8.52)

The Commission recommends that the Nursing and Midwifery Planning and Development Unit in planning the continuing professional development needs of nurses within a health board area should also assist practice nurses in their professional development. (8.53)

The Commission recommends that a practice nurse be attached on a sessional basis to the General Practice Unit within the health board to assist in identifying and supporting the development needs of practice nurses. (8.53)

Commission on Nursing Report

Nursing in Care of the Elderly

9.1 Care of the elderly is not a nursing discipline but crosses most disciplines in nursing and is becoming an increasingly important component of the nursing service. Concern was expressed at the regional seminars, organised by the Commission following the publication of the interim report, that there had not been a section in the report on care of the elderly. The changing demographics of the Irish population mean that Ireland has an increasingly ageing profile. It was suggested that there was a need to emphasise the importance of this area of nursing. There was a concern that nursing in care of the elderly was viewed in some quarters as a "Cinderella" service. There was also concern about conditions and staffing levels in some care of the elderly settings which were adversely impacting on the quality of nursing care.

9.2 The Commission considers that care of the elderly offers substantial opportunities for nurse led services. Health boards and voluntary health service providers should examine to a greater extent the opportunity of developing nurse led services in care of the elderly. There is a need to promote care of the elderly as a career in nursing in order to continue to attract high calibre nurses into the service.

9.3 Care of the elderly facilities are located throughout the country and the Commission was conscious that in developing a clinical career pathway these services should provide further clinical career opportunities for nurses. The recommendation of the Commission on a clinical career pathway in nursing, outlined in chapter six, will provide clinical career opportunities in care of the elderly and not just in the highly technical, high patient turnover areas of nursing.

9.4 The Commission is concerned at the anecdotal information supplied to it in relation to conditions and staffing levels in care of the elderly and recommends that the Department of Health and Children examine, as a matter of urgency, conditions and staffing levels in care of the elderly services. Apart from the effect on the standards of care, staffing levels impact on the ability of staff to attend educational courses. The Commission recommends that the Department of Health and Children review services for the elderly in each health board at the earliest opportunity.

9.5 The setting up of post-registration nurse education programmes in care of the elderly is a welcome development. These courses vary in their academic award up to masters in gerontological nursing. The advancement of post-registration education to this level is important in relation to the development of clinical career pathways of clinical nurse

specialist and advanced nurse practitioner in care of the elderly. Unfortunately, both the number of courses and their participants are small when compared with the number and educational needs of nurses working in care of the elderly. The Commission recommends that centres of nursing education, in conjunction with third-level institutes, develop nurse education programmes to meet the needs of nurses working in care of the elderly, which would facilitate greater integration among the disciplines of nursing.

9.6 Private nursing home bed provision has increased significantly according to a survey by the Department of Health in 1995. Nursing homes are covered in the Health (Nursing Homes) Act 1990, which allows for tighter quality controls through compulsory registration of nursing homes.

In view of the significant increase in private nursing homes, the Commission considers that nurses working in these care of the elderly settings should be encouraged and facilitated to update their skills and knowledge. The Commission recommends that application for or renewal of registration of nursing homes should indicate the opportunities for educational update provided for nursing staff.

9.7 Care of the elderly nursing services are both hospital and community-based and span several disciplines of nursing. This diversity of service is identified in the substantial review by the National Council on Ageing and Older People in 1997 of the implementation of recommendations made in the Years Ahead Report (1988). The Commission was informed of the development of one such recommendation relating to the setting up of a psychiatry of old age service. This specialist development has encouraged a tailor made service for older people with functional mental illness and dementia, provided by a team involving community psychiatric nurses and psychiatric nurses in an integrated service. This service is seen as a valuable resource to all those collaborating in the delivery of care of the elderly services.

9.8 The 1997 review of the Years Ahead Report acknowledges the unique role of the PHN, in conjunction with the general practitioner, in the provision of care of the elderly at home. This role entails that PHNs, in their visits to the elderly, place emphasis on anticipatory care of the elderly, health promotion and care planning in collaboration with other community care services. To enable them in the provision of this role, PHNs need other supports such as RGNs, care assistants, home helps and other support services. The Commission recommends that PHNs should receive greater support in their role in care of the elderly, through the provision of support staff and other services, where appropriate.

9.9 As already identified, care of the elderly spans several

nursing disciplines, based in the community and hospital services. This diversity requires a concerted effort to integrate and co-ordinate a comprehensive service for the elderly. The Commission considers that the Nursing and Midwifery Planning and Development Unit at health board level, in addition to creating specific posts within the service, will facilitate a further means of integrating and co-ordinating the diverse service for care of the elderly.

Summary of Recommendations in Chapter Nine

The Commission recommends that the Department of Health and Children examine, as a matter of urgency, conditions and staffing levels in care of the elderly services. (9.4)

The Commission recommends that the Department of Health and Children review services for the elderly in each health board at the earliest opportunity. (9.4)

The Commission recommends that centres of nursing education, in conjunction with third-level institutes, develop nurse education programmes to meet the needs of nurses working in care of the elderly, which would facilitate greater integration among the disciplines of nursing. (9.5)

The Commission recommends that application for or renewal of registration of nursing homes should indicate the opportunities for educational update provided for nursing staff. (9.6)

The Commission recommends that PHNs should receive greater support in their role in care of the elderly, through the provision of support staff and other services, where appropriate. (9.8)

Commission on Nursing Report

Certain Issues Relating to Mental Handicap Nursing

Midwifery and Sick Children's Nursing

10.1 This chapter considers particular issues relating to mental handicap nursing, midwifery and sick children's nursing. The substantive issues relating to the clinical disciplines of general and psychiatric nursing are addressed throughout the report. Recommendations made throughout the report are also relevant to mental handicap nursing, midwifery and sick children's nursing. However, there are a number of issues relating to mental handicap nursing, midwifery and sick children's nursing which are particular to each of the disciplines. Mental handicap and sick children's nursing are viewed by some as low profile disciplines that require particular promotion. Midwifery has an identity distinct from nursing and there are a number of issues in relation to the preparation for and practice of midwifery. Issues in relation to the regulation of midwifery have been addressed in chapter four. This chapter seeks to provide a framework in relation to the future direction of mental handicap nursing, midwifery and sick children's nursing.

Mental Handicap Nursing

10.2 Services for people with a mental handicap (also referred to as intellectual disability) have evolved in recent years with a greater emphasis on integration at school, work and in the community. The mental handicap nurse works with all age ranges and all levels of handicap including persons with mild, moderate, severe, profound and multiple handicaps. The age range includes an increasing population of senior citizens. A wide range of services, are provided, such as:

- day care including assessments, early intervention services, pre-school, special education development;
- residential and respite care, which is inclusive of community group houses and local centres; and
- vocational training, sheltered and supported employment.

10.3 A number of submissions suggested that the role of the mental handicap nurse needed to be clearly defined in an increasingly diverse and complex service for those with such a handicap. There was a need to respond to changes taking place within the service such as the increasing age profile and increasingly complex range of disabilities of those with a mental handicap. Submissions referred to the need for nurses

to be at the centre of the service, responding to these changing needs and suggested that the skills of the mental handicap nurse needed to be retained and developed to ensure the on-going development of a quality and responsive service. Some mental handicap nurses expressed concern in relation to a lack of appreciation of their specialist skills with the increasing employment of general nurses, teachers and non-nursing personnel in these services.

10.4 The Commission received a copy of the Report of the Working Group on the Role of the Mental Handicap Nurse from the Department of Health and Children. The Commission also visited Stewarts Hospital, Palmerstown and St. Joseph's Hospital, Clonsilla to meet with mental handicap nurses.

10.5 The Commission, having reflected on the service needs in the mental handicap services, in particular as identified in the Annual Report of the National Intellectual Disability Database Committee (1996) considered that there was a need to stress the crucial importance of mental handicap nurses to the service. Nurses from this discipline provide a range of services across a wide variety of locations to meet the particular, complex and difficult needs of their clients. Meeting these needs requires a high level of intuitive and perceptual skills which can only be acquired through experience and a dedicated education programme. The quality of the service provided to this most vulnerable group of clients, who will remain in need of support and care from infancy to late adulthood, is primarily determined by the quality of the nursing care. The Commission recognises that mental handicap nurses require particular skills and personal qualities distinct from those in other disciplines of nursing. The Commission has already recommended that mental handicap nursing remain a direct entry discipline with a four year third-level institute-based degree programme in chapter five.

The Commission considers that there is a need to promote the distinct identity and unique working environment of mental handicap nursing and recommends that the Board develop a strategy, in consultation with nurse educators, mental handicap nurses and service providers, to promote mental handicap nursing as a career.

10.6 It was submitted to the Commission that nurses have been employed as houseparents in the mental handicap services and have carried out duties which could be characterised as nursing duties. They have later discovered that their service was not recognised as nursing service. The Commission considers that the question of their professional status should be reviewed by the parties concerned.

10.7 The issue of the increasing use of non-nursing personnel

in the mental handicap services was also raised during the consultative process. There was a view that the increasing use of non-nursing personnel combined with a shortage of mental handicap nurses was contributing towards an increasing "de-professionalisation" of the service. The better promotion of mental handicap nursing combined with the move to a degree qualification on registration should assist in improving the profile and attractiveness of mental handicap nursing in the longer-term. However, the Commission also considers that there is a need for the Department of Health and Children to examine the policies and practices of mental handicap service providers in relation to non-nursing personnel.

Midwifery

10.8 It was argued by some midwives during the consultative process that the Nurses Act 1985, which governs the regulation of the nursing profession, fails to recognise the separate and unique role of midwives by defining a nurse as also including a midwife. It was argued that midwives had a distinct role in the delivery of care to women during the course of pregnancy and following birth. Many European countries offer direct entry into midwifery and midwifery students are not registered general nurses in those countries. Midwifery training and practice are dealt with under a separate EU Directive, 80/155/EEC.

10.9 The definition of a midwife adopted by the International Confederation of Midwives (ICM) and the International Federation of Gynaecologists and Obstetricians (FIGO), in 1972 and 1973 respectively and later adopted by the World Health Organisation (WHO) was given in a number of submissions to the Commission. The definition was amended by the ICM in 1990 and the amendment ratified by the FIGO and the WHO in 1991 and 1992 respectively and now reads:

"A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care.

She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service."

10.10 Many midwives during the consultative process expressed the view that midwifery practice had become increasingly constrained in recent years and that midwives were becoming de-skilled in the provision of maternity services. Many midwives suggested that the increasing "medicalisation" of normal pregnancies had turned midwives into obstetric nurses rather than the independent practitioners allowed by their education. It was suggested that midwifery provided substantial scope for the development of a woman centred care service before, during and after pregnancy. In order for midwifery to develop its potential for the delivery of women centred care, it was suggested that the regulatory framework for nursing practice needed to recognise the distinct identity of midwives. In addition, there were concerns in relation to the current education programme for the preparation of midwives. The current programme is of two years duration, with thirteen weeks theoretical instruction. Students are part of the midwifery workforce during the two year period. Concern was also expressed during the consultative process in relation to the provision and supervision of a domiciliary midwifery service.

10.11 The Commission recognises that midwifery has an identity distinct from nursing. Midwives respond to the needs of pregnant women, many of whom are increasingly aware of the birth options available to them. Midwifery offers practitioners a unique opportunity for autonomous practice in the provision of health services to women. The Commission has outlined in chapter four its recommendations in relation to a revised regulatory framework for midwifery and has recommended that future amending legislation recognise the distinct identity of midwives.

The Education of Midwives

10.12 The two year programme for the education of midwives commenced in 1983 and there are increasing concerns that it may no longer adequately prepare midwives to meet the service needs of the next century. In particular, there are concerns that midwives are being trained as "obstetric" nurses and do not have the preparation necessary to develop as autonomous practitioners. There is an increasing international demand for intervention free maternity services. The Commission, during a visit to Australia, visited a midwife led birth centre attached to a maternity hospital in the Central Sydney Area Health Services (there is no similar service attached to a maternity hospital in Ireland). If midwives were to offer similar intervention free maternity services in Ireland, it has been suggested that there would need to be an improved educational programme for entry to midwifery. It has been

argued that the thirteen weeks of theoretical instruction provided to student midwives is inadequate. The Commission recommends that the Board review the current midwifery education programme as a matter of urgency. The review should, in particular, examine the length of the programme and the level of theoretical instruction provided to student midwives and compare such theoretical instruction with that required under a third-level post graduate higher diploma programme. In addition, the Commission recommends that a direct entry midwifery course be piloted by the Board in a maternity hospital. Such a programme should initially be provided at diploma level but should move to a degree programme in 2002.

Domiciliary Midwifery

10.13 A number of midwives have set up independent private practice around the country to provide a midwifery service for those wishing to have a homebirth. These midwives contract directly with the woman wishing to have a homebirth. The fee may range from £600 to £900. There are fourteen independent domiciliary midwives in Ireland.

10.14 Concern was expressed during the consultative process in relation to the current supervisory arrangements for domiciliary midwives providing for homebirths. Health boards are obliged, under the Health Act 1970, to provide domiciliary midwifery care for women who wish to give birth at home. It was reported that in 1996, there were 50,390 births in Ireland, of which 206 were home births (CSO, 1996). Section 57(1) of the 1985 Act provides that if a midwife intends to practise in a health board area, she must notify the health board of her intention to practise if she is not an employee of the health board. Section 57(2) of the 1985 Act imposes a duty on health boards to exercise general supervision and control over independent midwives practising in a health board area. The person designated by health boards to exercise this supervision and control is a superintendent public health nurse. There was concern expressed by superintendent public health nurses and midwives in relation to this arrangement.

10.15 The Commission considers that the determination of the suitability of midwives to provide an independent domiciliary service and the professional parameters of their practice are matters for the Board. The Commission recommends that the statutory midwives committee within the Board, proposed in the revised regulatory framework, develop a scope of practice framework covering the activities of independent midwives in the community. Such a scope of practice should cover the professional requirements of a midwife practising

in the community and address issues in relation to their on-

going practice and clinical audit. The Commission recommends the deletion of section 57(2) of the 1985 Act.

Sick Children's Nursing

10.16 Sick children's nursing appears to have a particularly low profile as a separate discipline within the nursing profession. The Commission did not receive a large number of submissions from nurses practising in this area and had difficulty sourcing material in relation to the historical background to the discipline.

10.17 It was suggested by registered sick children's nurses during the consultative process, that nursing children differs from nursing adults because of children's special health care needs. It was submitted that children were physically and emotionally different from adults and needed constant care and support from their parents. Children, therefore, required care from specially skilled staff. Because of the age range of patients, sick children's nurses required an in-depth understanding of the physical, psychological, social development and maturation processes from infancy to early adulthood. Sick children's nurses needed acute skills of observation and communication as frequently their patients were not capable of telling them what was wrong with them and might be totally dependent on them. It was submitted that in promoting the concept of family centred care, the sick children's nurse required special skills in teaching and support by entering into partnership with families in the provision of care. There have been social changes in the nature of the family in Ireland in recent years which have challenged traditional concepts of family life and impacted on the nursing care provided to children. Some parents of children in hospital could themselves be considered children, being under eighteen years of age.

10.18 The care of children suffering from medical problems requires nurses who have the training and education to respond to their particular emotional and physical requirements. Sick children's nursing is at the core of the paediatric services. The Commission has recommended an increase in the number of sick children's nurses on the Board to start the process of raising the profile of the discipline. However, there is a need for directors of nursing from the paediatric hospitals, sick children's nurse educators and nurses in the paediatric services to develop a coherent vision for the future development of the discipline.

The Education of Sick Children's Nurses

10.19 The education of sick children's nurses recently became a post-registration education qualification.

It is an eighteen month course open to nurses who are already on the register with the Board. Previously there had been direct entry courses in sick children's nursing and it seems that a key factor in the move to a post-registration qualification was the increasing difficulty in recruiting students. Many nurses, with only a sick children's nursing qualification, had found it difficult to get employment outside the major Dublin paediatric hospitals. Developments in medical diagnoses and therapeutics meant that acutely ill children, who might not previously have survived, were now being cared for by sick children's nurses. It was also suggested that the nature of sick children's nursing and the changing nature of the family, with an increasing number of single teenage parents, required a greater maturity in the practice of sick children's nursing. It was suggested that with the development of degree programmes for direct entry nursing disciplines there may be duplication between the current sick children's nursing programme and the pre-registration degree programmes. It was suggested that the sick children's nursing programme could be shortened to twelve months.

10.20 The Commission recommends that the qualification of sick children's nursing remain a post-registration qualification. However, prior to the transition of direct entry nursing disciplines to a degree programme, directors of nursing from the paediatric hospitals, sick children's nurse educators and the Board should review the content, duration and academic award of the sick children's nursing course, in light of the proposed degree course curricula.

10.21 It was suggested that the title Sick Children's Nurse was slightly anachronistic in the modern health service. The Commission accepted this view and recommends that the title Sick Children's Nurse be changed to Child Health Nurse.

Summary of Recommendations in Chapter Ten

The Commission considers that there is a need to promote the distinct identity and unique working environment of mental handicap nursing and recommends that the Board develop a strategy, in consultation with nurse educators, mental handicap nurses and service providers, to promote mental handicap nursing as a career. (10.5)

The Commission recommends that the Board review the current midwifery education programme as a matter of urgency. The review should, in particular, examine the length of the programme and the level of theoretical instruction provided to student midwives and compare such theoretical instruction with that required under a third-level post graduate higher diploma programme. In addition, the Commission recommends that a direct entry midwifery course be piloted by the Board in a maternity hospital. Such a

programme should initially be provided at diploma level but should move to a degree programme in 2002. (10.12)

The Commission recommends that the statutory midwives committee within the Board, proposed in the revised regulatory framework, develop a scope of practice framework covering the activities of independent midwives in the community. Such a scope of practice should cover the professional requirements of a midwife practising in the community and address issues in relation to their on-going practice and clinical audit. (10.15)

The Commission recommends the deletion of section 57(2) of the 1985 Act, (which places a duty on health boards to exercise general supervision and control over independent midwives practising in a health board area). (10.15)

The Commission recommends that the qualification of sick children's nursing remain a post-registration qualification. However, prior to the transition of direct entry nursing disciplines to a degree programme, directors of nursing from the paediatric hospitals, sick children's nurse educators and the Board should review the content, duration and academic award of the sick children's nursing course, in light of the proposed degree course curricula. (10.20)

The Commission recommends that the title Sick Children's Nurse be changed to Child Health Nurse. (10.21)