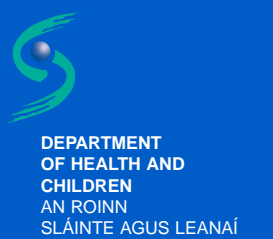




REPORT OF THE NATIONAL TASK FORCE ON MEDICAL STAFFING 2003

THE CHALLENGE FOR NURSING AND MIDWIFERY

A DISCUSSION PAPER NOVEMBER 2003



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PREFACE

As we move forward into the twenty first century there is no doubt that the contribution made by nurses and midwives in the provision of services will continue to be of paramount importance to the delivery of an effective health service. This is a time of significant potential for nurses and midwives in Ireland.

The European Working Time Directive has significant implications for all nurses and midwives as they are pivotal to the organisational and structural changes outlined in the Report of the National Task Force on Medical Staffing (2003) (Hanly Report). A reconfiguration of services will enable nursing and midwifery to develop to its maximum potential in tandem with the evolving service needs. This document identifies a range of possible developments for nursing and midwifery elicited from nurses and midwives in acute, psychiatric and midwifery settings.

The views of these disciplines within nursing were targeted specifically as the Hanly Report focuses on the delivery of acute hospital care. While the potential for developing the scope of practice in any nursing or midwifery discipline is not dependent on the Hanly Report, the report may assist the drive to increase and recognise the nursing and midwifery contribution to care in a range of settings. This document also identifies the supports nursing and midwifery will need in order to develop new services and promote interdisciplinary working.

In this discussion document, the Department of Health and Children identifies key development issues facing nursing and midwifery in the future. This is in order to establish a strong platform for the formulation of a strategic response to these issues. The document contains an insightful analysis of the challenges ahead and identifies a range of possible responses. It is anticipated that following the launch of the Hanly Report an implementation plan which includes nursing and midwifery will be developed and agreed.

Over the past nine months, the Steering Group has recognised the range of opportunities and challenges that face nursing and midwifery. Partnership between all stakeholders is a key requisite to ensure that nursing and midwifery can flourish and respond appropriately to the range of issues facing the Irish health system.

I would formally like to thank everyone involved, the Steering Group for their contribution to the nursing section of the Hanly Report, the Project Officers from the pilot sites, and in particular all the nurses and midwives who by contributing to this report have engaged in mapping their own future. Now more than ever the health system is dependent on the resourcefulness of nursing and midwifery. It is clear we have nurses and midwives who are competent to provide the innovative practice that will underpin healthcare provision.

I would also wish to record my appreciation of the significant work undertaken by the Steering Group and the Project Officer Aileen Lynch for leading the project.

Mary McCarthy
Chief Nursing Officer

EXECUTIVE SUMMARY

Key Success Factors

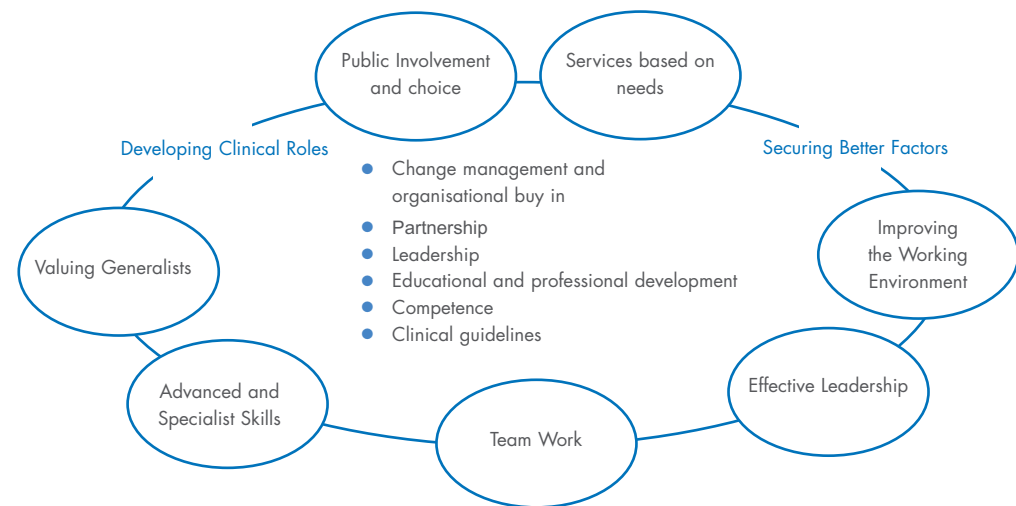
The overall attitude of the nurses and midwives involved is one of willingness to develop and expand practice. There is general recognition that important changes will take place in the health service, in patient and public expectations and in patients’ health care needs. The population is ageing, chronic illness is increasing, and the role of the nurse and midwife is expected to change significantly. To support these changes it is necessary for nurses and midwives to have improved access to clinical supervision, continuing professional development and education, skill mix, good information technology support and the knowledge and skills they need to provide high quality patient care which is based on sound contemporary evidence.

When developing roles it is essential for managers to network with key stakeholders, be clear about objectives in terms of patient care, “find your champion”, and provide education and support. Evidence from the UK and Northern Ireland indicates that the time involved in making a change to roles takes approximately six to nine months. It is important to set realistic goals, develop protocols and outline the service to be provided. Audit needs to be built into the system from the beginning to demonstrate effectiveness, patient safety and value for money. The key success factors identified by the pilot sites were:

- Change management and organisational buy in
- Partnership
- Leadership
- Educational and professional development
- Competence
- Clinical guidelines

Planning services in a new way

The following diagram identifies key factors to be addressed when planning new services



Effective leadership is vital if nurses and midwives are to take on new roles, work differently and develop new services for patients and their families. This requires greater understanding of team development and the management capability to use human and financial resources creatively and effectively.

Communication is essential if changes are to occur. It is important to meet staff regularly and communicate with colleagues to raise awareness about new initiatives. By updating staff regularly and offering them the opportunity to develop professionally, staff will feel empowered and develop ownership of their new role/service.

Partnership has been recognised as essential to the development of many government initiatives. Collaboration can have the effect of fostering commitment from staff, help reduce fears that individuals may have about the impact of changes on them and also identify individual’s skills and knowledge.

Nurses and midwives will play a key part in delivering patient focused services that are accessible, responsive and appropriate to the needs of patients as individuals, their families and carers. The professions of nursing and midwifery are central in the delivery of an effective health service. The fundamental aim of nursing and midwifery practice is to promote people’s health and provide excellent and sensitive care to individuals and families.

Public health care systems worldwide are facing unprecedented challenges. Expectations are rising and changing demographics and lifestyles are creating diverse needs. The challenge facing everyone is to create health and social gain in a comprehensive and equitable manner by responding to the evidence presented from social, economic, environmental factors and also illness patterns. As science, technology and public demand for healthcare become increasingly complex it is vital to ensure that healthcare is delivered to the highest possible standard and that public resources are effectively used. The Health Strategy Quality and Fairness, A Health System for You (DOHC, 2001), provides a framework to achieve this goal. The four principles guiding the Health Strategy - Equity, People Centeredness, Quality and Accountability – give a solid base from which to work and is a blue print to guide policy makers and service providers in achieving the vision of a future health system.

Public services are at the top of the political agenda and none more so than health services. Patients, the public, politicians and staff all want to see investment and reform. The Irish Health Service spends almost 9 billion euros annually and demographic changes will further increase demands on the health service. Nursing and midwifery staff are the largest occupational group in the Irish health service comprising almost 36% of the healthcare workforce. Nurses and midwives are often the first point of contact for patients coming into the health system, and nursing care is provided over a 24 hour period seven days a week. There is considerable potential for nurses and midwives to further enhance the development of quality patient care and positive outcomes. It is vital for nurses and midwives to be involved in shaping and influencing the planning process to achieve a patient centred health system. The role of the nurse and midwife has never been more important in either developing new roles or responsibilities, or in leading the transformation of services and organisations.

The Report of the Forum on Medical Manpower (DOHC, 2001) suggests that greater consideration should be given to the concept of team working in all specialties. Consideration should also be given to the configuration and/or re-designation of existing services. A reconfiguration of services within hospitals should be pursued through a reengineering of roles within the multidisciplinary team.

Consultant Delivered Service

The Report of the National Task Force on Medical Staffing, (Hanly, 2003), states that reorganising hospital services must be implemented in tandem with redefined roles for both consultants and non-consultant hospital doctors (NCHD's). It states that a consultant – provided service should be defined as, “A service delivered by consultants working in teams, where the consultants have a substantial and direct involvement in the diagnosis, delivery of care and overall management of patients” (Hanly, 2003, Section 3.3.3).

Advantages for consumers and patients will be improved access to acute care services, particularly out-of-hours. Professionals involved in the consultant provided teams will have improved access to other team members, direct access to diagnostic facilities, infrastructural and information technology supports. The introduction of suitably resourced teams with appropriate skill mix will ensure that many health professionals will have more time to engage in preventive activities and continuous personal and professional development.

Nursing and Midwifery Opportunities

Within the context of enhancing the quality of patient care and within the framework of the multidisciplinary team it is essential that nurses and midwives embrace the opportunities that these changes will bring.

An examination and redefinition of nursing and midwifery roles and the services they provide has never been timelier. The publication of the Review of Scope of Practice for Nursing and Midwifery (An Bord Altranais, 2000a), the implications of nurse prescribing, the development of the clinical career pathways of Clinical Nurse Specialists (CNS) and Advanced Nurse Practitioners (ANP) and the training of Health Care Assistants (HCA) will present nursing and midwifery with opportunities to become autonomous practitioners and manage a caseload with admission, discharge and prescribing privileges.

These new roles and responsibilities bring the opportunities to liberate the potential for experienced, competent nurses and midwives to help the whole healthcare team to concentrate on what matters – ensuring patients receive quality care.

Section 1

INTRODUCTION AND BACKGROUND

Context

The National Task Force on Medical Staffing was established in February 2002 by the Minister for Health and Children. Its purpose was to devise an implementation plan for substantially reducing the average working hours of Non Consultant Hospital Doctors (NCHDs) to meet the requirements of the European Working Time Directive (EWTD); to plan for the implementation of a consultant-provided service; and to address the medical education and training needs associated with the EWTD and the move to a consultant-provided service. The Task Force's terms of reference charged it with “devising, costing and promoting implementation of a new model of hospital service delivery based on appropriately trained doctors providing patients with the highest quality service, using available resources as equitably, efficiently and effectively as possible” (Hanley, 2003, Section 1.1).

The EWTD requires that, by the 1st August 2004, NCHDs must no longer work more than an average of 58 hours per week on the hospital site. By this date they cannot be required to work for more than 13 hours per day on-site, and certain other rules regarding minimum rest and break periods must be in place. By the 1st August 2007, NCHDs cannot be required to work more than an average of 56 hours per week on-site. This limit must reduce to an average of 48 hours by the 1st August 2009.

At present, there are over 3,900 NCHDs in Ireland, delivering frontline services in more than 40 public acute hospitals and numerous other health agencies. They work an average of 75 hours per week on-site, often for continuous periods of more than 30 hours, with minimal rest. From 1st August 2004, these working arrangements will no longer be legally permissible. As the phased working limits of 58, 56 and 48 hours take effect, the ability of NCHDs to provide medical cover for long periods of time will diminish significantly. The Task Force had regard to two previous reports during its work; The Report of the Forum on Medical Manpower (DoHC, 2001), and the Report of the National Joint Steering Group on the working hours of non-consultant hospital doctors (DoHC, 2001).

Establishment of Steering Group

In the context of the above, Ms. Mary McCarthy, Chief Nursing Officer, DoHC, establishing a Steering Group derived from the Task Force to examine the implications of the reduced working hours of the NCHDs for nurses and midwives. The Steering Group was established in October 2002. The terms of reference were as follows:

Terms of Reference

1. To examine the opportunities that the deliberations of the National Task Force on Medical Staffing will present to nursing and midwifery in the pilot sites.
2. To assess the impact on quality outcomes of patient care that any reconfiguration will have.
3. To examine the resource implications that a reconfiguration of services will have to enable nursing and midwifery to develop to its maximum potential in tandem with the evolving service needs.
4. To examine the supports that nursing and midwifery will need in order to develop new services.

Meetings were scheduled on a monthly basis in the Department of Health and Children and chaired by Ms Mary McCarthy, Chief Nursing Officer.

Membership of the Steering Group

- Chair: Mary McCarthy, Chief Nursing Officer, Department of Health and Children
- Project Officer: Aileen Lynch, Department of Health and Children
- Eilish Hardiman, Director of Nursing, St. James’s Hospital, Dublin
- Geraldine Regan, President, Irish Association of Directors on Nursing and Midwifery
- Nora O Rourke, Director, Nursing and Midwifery Planning and Development Unit, Mid-Western Health Board
- Lorna Peelo – Kilroe, Project Officer Nursing and Midwifery Planning and Development Unit, Mid-Western Health Board
- Nora Fitzpatrick, Director of Nursing, Limerick Regional Hospital, Mid-Western Health Board
- Pauline Doyle, Director of Nursing, St. Vincent’s University Hospital, Dublin
- Raphel McMullin, Nursing Practice Development Co-ordinator, St. Vincent’s University Hospital, Dublin
- Liz Roche, Assistant Director, Nursing and Midwifery Planning and Development Unit, Eastern Regional Health Authority
- Catherine McTiernan, Assistant Director of Nursing, Northern Area Health Board, PNA
- Mary Durkin, CNM 2, Sligo General Hospital, SIPTU
- Mary Fogarty, Industrial Relations Officer., I.N.O.
- Kevin Callinan, National Secretary, Health Division, IMPACT
- Martin McDonald, Assistant Chief Executive Officer, Health Services Employers Agency
- Thomas Kearns, Education Officer, An Bord Altranais
- Kathleen MacLellan, Head of Professional Education and Continuing Education, National Council for the Professional Development of Nursing and Midwifery
- Michelle Butler, Lecturer, School of Nursing and Midwifery, University College Dublin
- Jackie Crinon, Management Organisation Development Specialist, Office for Health Management
- Julie Ling, Nurse Advisor, Care of the Older Person/Palliative Care, Nursing Policy Division, Department of Health and Children
- Tracy O’ Beirne, General Nurse Advisor, Nursing Policy Division, Department of Health and Children
- Siobhan O’ Halloran, Health Strategy Implementation Team, Department of Health and Children
- Susan Reilly Assistant Principle, Nursing Policy Division, Department of Health and Children
- Fergal Lynch, Project Director, National Task Force on Medical Staffing, Department of Health and Children
- Anne Pardy, Medical Manpower Manager, Mid-Western Health Board
- Mary Halpin, Director of Human Resources, Midland Health Board

Project Staff

A Project Officer with a nursing background was appointed on a full time basis in December 2002 and was based in the Nursing Policy Division. The Project Officer worked closely with the Task Force Secretariat, the Steering Group and pilot sites.

A project plan was drawn up by the Project Officer and agreed by all members of the Steering Group.

PROJECT GOALS

- Clarification of services covered according to priority, initially starting with the acute services.
- Information to be shared between pilot sites, a collaborative approach to be adopted.
- Key stakeholders identified, Nursing and Midwifery Planning and Development Units to act as conduits of information.
- Networking and benchmarking with other organisations who have implemented similar strategies, such as information gathering on the role of the nurse/midwife, educational and professional development requirements, skill mix requirements.

Section 2

METHODOLOGY

Pilot Sites

The National Task Force on Medical Staffing selected two regional pilot sites - the Mid – Western Health Board (MWHB) and the East Coast Area Health Board (ECAHB), to explore the proposed reconfiguration of services.

The purpose of the regional pilot sites was:

- To gain a full understanding of the delivery of the present health system,
- To explore alternative models of delivery, with particular emphasis on the work patterns of medical and other staff,
- To estimate the likely cost of adopting a specific model.

The Task Force recommended that it was important to examine services in a regional context rather than considering individual hospitals in isolation. The links between hospital and other health services in the region, particular primary care and community mental health, were of particular importance.

Criteria for Selecting Pilot Sites

- One region should have hospitals that were primarily under health board management while the other would have at least one major voluntary hospital in its area
- The regions would serve a population of between 300,000 and 350,000, bearing in mind the need for the study to be carried out reasonably quickly
- No individual hospital in the selected regions would have more than 500 – 600 beds, for the purpose of a detailed study within the timeframe of the Task Force
- The hospitals involved would have shared governance or other close working relationships with the smaller hospitals in their catchment area
- The hospitals would have a number of joint departments in their catchment area

A number of health boards met the above criteria, and after detailed consideration, the Task Force chose the East Coast Area Health Board and the Mid-Western Health Board.

The consultation process which informed this discussion paper took place between December 2002 to July 2003 in the selected pilot sites involving locally organised focus groups. The focus groups provided a forum for nurses and midwives to discuss the opportunities for professional enhancement in the context of the EWTD.

Focus Group Methodology

The aim of the focus groups was to gather information from nurses and midwives to guide the Steering Group to:

- Reach a consensus on the future role of the nurse/midwife.
- Identify educational and professional development requirements.
- Identify supports needed to develop new services, which will enhance the future role of the nurse/midwife.

A Project Officer Ms. Lorna Peelo-Kilroe was recruited in the MWHB in January 2003 to coordinate the focus groups. In the East Coast Area Health Board (ECAHB) the focus groups were coordinated by the Nurse Practice Development Co-ordinator Ms. Raphael McMullin in St Vincent's Hospital, and Assistant Director of Nursing, Ms. Liz Roche in the Nursing and Midwifery Planning and Development Unit (NMPDU) in the Eastern Regional Health Authority (ERHA).

The Mid-Western Region included:

Croom Orthopaedic Hospital
Ennis General Hospital
Limerick Regional Hospital
St John's Hospital Limerick
Nenagh General Hospital
Regional Maternity Hospital
Ennis Acute Mental Health Unit
Clare Acute Mental Health Unit
Dept. of Psychiatry, Unit 5B, (MWHB)
Limerick Acute Community Mental Health Unit
North Tipperary Acute Community Mental Health Unit

The East Coast Region included:

Loughlinstown Hospital
St. Michael's Hospital, Dun Laoghaire
St. Vincent's University Hospital, Dublin
The National Maternity Hospital, Holles Street

Pilot Sites and Focus Groups

An extensive consultation process was conducted in the two pilot regions. Over 50 focus groups were held with over 300 nursing staff, including registered nurses, midwives, clinical nurse managers, night superintendents, assistant directors of nursing, deputy directors of nursing and directors of nursing. All clinical areas and different shifts were represented.

Formation of Regional Sub Groups in both Pilot Sites

- Regional sub groups were established in March 2003 in the MWHB, and in April 2003 in the ECAHB pilot site.
- Terms of reference and membership of the local sub groups were adopted from the Medical Manpower Nursing and Midwifery Steering Group. The partnership model was embraced by all groups.
- In each of the pilot sites different approaches were engaged to ensure that there was a fair representation of registered nurses and midwives.
- These meetings are ongoing and scheduled on a regular basis.

Other methods used by the Project Officer to gather information included networking and benchmarking with other organisations that have implemented the EWTD. This involved the Project Officer attending a conference in London on Friday January 17th 2003 on "Changing roles in acute and intermediate care".

A site visit was organised to the Mater Hospital Trust in Belfast to observe the implementation of the EWTD and the role of nursing as a result of these changes. This visit took place on May 19th and 20th 2003.

Part of the networking process also involved establishing links and consultation with key stakeholders, including An Bord Altranais, the National Council for Professional Development for Nursing and Midwifery, The Office for Health Management, Nursing and Midwifery Planning and Development Units and the Mater Hospital Trust in Belfast.

Acknowledgements

The Nursing and Midwifery Medical Manpower Steering Group sought and received extensive written information and reports from nursing personnel in both pilot sites on an ongoing basis.

Literature Review and Previous Reports

The Project Officer conducted an extensive literature review. The international literature on the relevant issues was taken into account by the Nursing and Midwifery Medical Manpower Steering Group. Key documents that were used by the Steering Group and distributed to the relevant personnel in the pilot sites were:

- Department of Health and Children, (2001) *The Report of The National Joint Steering Group on the working hours of non consultant hospital doctors*. Dublin: Stationery Office.
- Department of Health and Children, (2001) *Report of the Forum on Medical Manpower*. Dublin: Stationery Office.
- Dublin Academic Teaching Hospitals, (2001) *Skill Mix Group Report*.
- Department of Health, UK, (2002) *"Developing key roles for nurses and midwives, a guide for Managers"*.
- Department of Health UK, (2002) *"Liberating the talents". Helping Primary Care Trust and nurses to deliver The NHS Plan*.
- Wiles, R. Postle, K. Striner, A. and Walsh, B. (2003) Nurse-led intermediate care: patients' perceptions. *International Journal of Nursing Studies* 40 (2003) 61 – 71.
- Richardson, A. L, and Cunliffe, L. (2003) New horizons: the motives, diversity and future of "nurse led care". *Journal of Nursing Management*, 2003, 11, 80- 84.

Section 3

ROLE DEVELOPMENT

Registered Nurse and Midwife

The nursing and midwifery profession plays a central role in the delivery of an effective health service. There is considerable potential for nurses and midwives, who comprise almost 36% of the health care workforce to further enhance the development of quality patient centred care and positive patient care outcomes. The scope of nursing and midwifery practice has evolved over time in Ireland in response to many imperatives and most importantly, patients' health needs.

Both nationally and internationally, the profession of nursing and midwifery has sought to avoid fragmentation of nursing roles and to develop through expansion of role rather than taking on "tasks", with subsequent certification of competence. Expansion of practice involves a broader holistic process in relation to both the patient's needs and the individual nurse. Many aspects of healthcare systems across Europe are undergoing profound change. As a result of these changes, the role of the nurse has never been more important in either developing new roles or responsibilities. When defining the role of nurses and midwives and expanding the scope of practice, it is the registered nurse/midwife who is responsible for the delivery of care. The appropriate delegation to the non-professional healthcare worker should be based on the complexity of the patient's healthcare needs.

Most people in their life span experience nursing at some time. Nursing care is delivered by millions of nurses across the world. It is part of the social mandate of a profession to make clear to the public the nature of the service it offers, and to ensure the quality of its service through mechanisms such as professional regulation. This is the basis of the relationship of trust between the profession and the public it serves and between the individual professional and the patient to whom the profession owes a "duty of care". In specifying the service it offers, the profession must be sensitive and responsive to the needs of those it serves. Governments and providers of healthcare must ensure that the most effective mix of staff delivers care in the most cost-effective way, and that the nursing/midwifery resource is used efficiently and effectively. With the recently launched Health Strategy Quality and Fairness, A Health System for You, (DoHC, 2001) and a tightening fiscal policy, there is a requirement for more innovative use of the existing resources dedicated to healthcare in Ireland. It has been previously identified that nurses and midwives will play a critical role in developing the "new" health system. An Irish study of nurses' and midwives' understanding of empowerment, highlights that empowerment is a key requirement to encourage innovative practice that will underpin healthcare provision. Any nurse may become an innovator and make a discovery through observation or research that advances nursing practice. These nurses do not by virtue of their discovery become CNSs or ANPs. (See Appendix III). Advanced nursing practice remains a distinct sphere of nursing in its own right.

The World Health Organisation (WHO) defines nursing in the following terms "The mission of nursing in society is to help individuals, families and groups to determine and achieve their physical, mental and social potential, and to do so within the challenging context of the environment in which they live and work. This requires nurses to develop and perform functions that relate to the promotion and maintenance of health as well as to the prevention of ill health. Nursing also includes the planning and implementation of care during illness and rehabilitation, and encompasses the physical, mental and social aspects of life as they affect health, illness, disability and dying. Nursing is the provision of care for individuals, families and groups throughout the entire life span from conception to death. Nursing is both an art and a science that requires the understanding and application of the knowledge and skills specific to the discipline. It also draws on knowledge and techniques derived by the humanities and the physical, social, medical and biological sciences". (WHO, 1991). A more recent definition from the Royal College of Nursing defines nursing as "the use of clinical judgement and the provision of care to enable people to promote, improve, maintain, or recover health or, when death is inevitable, to die peacefully" (RCN, 2002: 1).

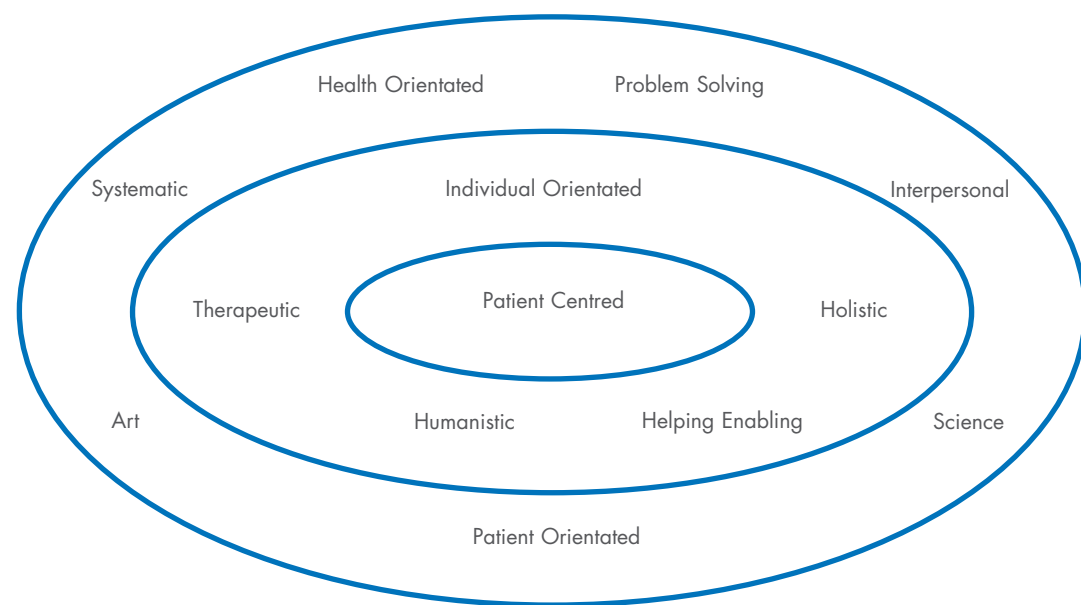


Figure 1. Key attributes of nursing derived from theoretical definitions.
Descriptions of Nursing (Savage, 1998)

Scope of Nursing Practice

The scope of nursing and midwifery practice in Ireland is the range of roles, functions, responsibilities and activities, which a registered nurse/midwife is educated, competent, and has the authority to perform (An Bord Altranais, 2000a). Scope of practice for nurses and midwives in Ireland is determined by legislation, EU directives, international developments, social policy, national and local guidelines, education and individual levels of competence. In determining his/her scope of practice, the nurse or midwife must make a judgement as to whether he/she is competent to carry out a particular role or function. To be competent, it is not enough to be able to fulfil a specific role or function or even to be able to practice at a specific level of skill. A competent professional nurse or midwife possesses many attributes. These include practical and technical skills, communication and interpersonal skills, organisational and managerial skills, the ability to perform as part of a multidisciplinary team yet demonstrating a professional attitude, accepting responsibility and being accountable for one's practice (Eraut, 1994, Sharp et al, 1995 and Fraser et al, 1996).

Code of Professional Conduct

Nursing and midwifery frameworks and models provide the principles, values and goals for practice required by the nursing and midwifery profession. These principles guide the expanding role of the nurse and midwife. The Code of Professional Conduct for each Nurse and Midwife (An Bord Altranais, 2000b) provides "the framework to assist the nurse and midwife to make professional decisions to carry out his/her responsibilities and to promote high standards of professional practice".

Focus Group Feedback

Acute Nursing Services

The findings of the focus groups from acute services are outlined in the following section. Participants had no difficulty in articulating how they envisaged their roles would develop and expand. The recurrent themes among all the focus groups included caring, advocacy, patient trust, liaison and linkage.

"Caring" was the word most frequently used to define the philosophy of nursing, sometimes qualified to holistic patient care, which was described in terms of looking after the emotional, spiritual, psychological and medical needs of patients.

"Advocacy" surfaced as the second most frequently cited tenet of the philosophy of nursing with nurses and midwives seeing themselves as the individual who verbalises the patient's needs and feelings to the rest of the multidisciplinary team.

Closely aligned to the concept of advocacy was the issue of "patient trust" in nursing and its importance. Other nurses and midwives described themselves as the staff member whose duty it is to ensure that patients get the best available nursing care.

The fourth most frequently cited word used to describe the philosophy of nursing and midwifery both in hospitals and the community was "liaison and linkage". Nurses and midwives saw this aspect of nursing as key, gleaned valuable and critical information from patients in a caring and congruent fashion and passing it on to the appropriate staff, such as consultants or medical social workers.

Participants in the focus groups identified gaps in the current health service in meeting the twenty-four hour needs of the patient and opportunities available to improve patient care. Participants emphasised that they did not endorse nurses "taking on what doctors want to drop", but appreciated the need to work in partnership with patients, their relatives and other carers in collaboration with others as members of the multi-disciplinary team.

Nurses and midwives suggested that the sole responsibility for improving service delivery does not rest with the nursing profession alone, but that it must encompass all stakeholders and service providers within the health service. Nurses and midwives were reluctant to discuss lists of tasks in relation to practice development as they felt that they had much more to offer patients. Participants also identified duties that doctors may wish to relinquish could be transferred to other healthcare workers other than the nursing profession.

Participants identified a number of key areas in their practice which could be expanded. These include the following:

Pre-Assessment Clinics

Registered General Nurses have a role in assessing patients not requiring a general anaesthetic. ANPs have a key role in pre-assessment of patients undergoing elective procedures. This service assists with efficient and effective use of resources such as enhanced bed management, decreased length of hospital stay, decreased waiting lists and demonstrates value for money.

Respiratory Clinics

Respiratory clinics have been demonstrated as an area for the development of CNS roles in the management of “at risk” patients with chronic respiratory illnesses. The CNS works as part of the multidisciplinary team and provides a service based on best practice to co-ordinate the medical and nursing management of patients with chronic respiratory illnesses. The CNS also liaises with primary care when the discharge plan for the patient has commenced and continues to do so until the patient's condition stabilises. This area is also an opportunity for the development of ANP roles.

Minor Injury Clinics

Minor injury clinics are led by ANPs who assess, diagnose and treat patients in accordance with agreed protocols, and refer or discharge patients. They ensure that the patient receives the correct intervention from the appropriate person at the right time. They ensure collaboration with and appropriate referral to other members of the multidisciplinary team. Patient satisfaction with the care provided by nurses in minor injury clinics is reported to be high. Dale and Dolan (1994) reported that patients choose appropriately between attending minor injuries units and an accident and emergency department.

All of the participants agreed that the value and contribution of specialist nursing roles to patient care should not be underestimated. Specialist nurses are ideally positioned to provide specialist direct care services to patients and their families. Specialist nurses are in a position to proactively respond to patient needs and to identify current and future service requirements.

Nurses and Midwives in all of the focus groups identified a number of areas in which nurses’ and midwives’ roles could be further expanded. The most frequently cited examples were administration of first dose intravenous medications, administration and collaborative prescribing of medicinal products, referral to other members of the multidisciplinary team, requesting of routine blood tests and x-rays, microbiological swabs, male catheterisation and increased participation in discharge planning.

The standard of practice for the expanded role involving prescribing of medicinal products needs regulatory control by An Bord Altranais to ensure protection of the public and standards of education achieved to support the nurse to embrace this expanded role. Legislation both within and outside of nursing will need review to support some elements of the expanded roles.

Psychiatric Nursing

The primary objectives of psychiatric nursing are to facilitate the maximum development of the mental health of the individual who has psychiatric problems and to promote mental health (An Bord Altranais, 2000c). Integral to this role is the establishment of therapeutic relationships with patients and their families. The intention of all interventions by psychiatric nurses is to support people with mental health problems to live in the community or support those already residing in the community setting.

The shift from institutional care to community care is a national policy goal and psychiatric nurses work as part of a much larger multidisciplinary team. The scope of services provided by psychiatric nurses includes rehabilitation, social skills training, medication management, individual counselling, group work, psycho-education, family support, liaison work and mental health education. Psychiatric nurses have developed professional skills and knowledge but many are currently prevented from using these skills because they have to undertake inappropriate non-nursing duties. The ECAHB continue to coordinate focus groups with mental health nurses working in the community.

Nurse-led Admission and Discharge Protocols

Nurse-led (See Appendix I) services with a triage system in place, would facilitate the opportunity to develop the roles of the CNS and ANP in the development of nurse-led clinics. This development would improve patients outcomes and reduce readmission rates. Many participants indicated that due to the very high relapse and readmission rates, many patients are well known to them. Psychiatric nurses who participated claimed to have established strong rapport and understanding of individual patients and their social circumstances. As such they are familiar with the individual’s progress and development and feel competent to use their clinical skills and judgement to admit and discharge this group of patients. They argued that nurse-led admission and discharge protocols would reduce the numbers of readmissions and reduce the length of stay in hospital.

In one admission unit, 20% of bed capacity was taken up with long stay patients. In another unit, it was indicated that the lack of juvenile facilities results in beds being blocked for unacceptable lengths of time. The shortage of step-down facilities results in the inappropriate early discharge of some patients, to facilitate urgent admission of others thus contributing to the cycle of admission and readmission. Expanding the role of the psychiatric nurse, especially in areas of adolescent and patients with enduring mental illnesses could ensure that this patient group are managed more effectively.

Role of the CNS in Mental Health Services

The continued development of CNS roles regionally will enhance the quality and uniformity of mental health services offered to patients. The development of new roles, both CNS and ANP, should take place in relation to patient need, health policy and the core values of psychiatric nursing. Easier and direct access to psychiatric nursing services is required to advance service quality and improve ease of access for the public.

Approved CNS roles are in the areas of addiction, eating disorders, autism, behaviour therapy, substance misuse, community psychiatry of old age, deliberate self harm and community mental health nursing. The continued development of CNS posts and the scope for the development of ANP positions are currently being explored.

The overall attitude of participants in the mental health sector is one of willingness to develop and expand practice. There is general recognition that the mental health services requires change and that nursing practice should develop in tandem to meet the service needs. The focus of the mental health services is shifting from a medical model to a psychosocial model. This model acknowledges the expertise of all disciplines involved in care delivery and psychiatric nurses feel that they have a considerable contribution to make to this service. The main emphasis of the mental health services at present is on the secondary and tertiary care. The opportunity for nursing in the mental health services to become more involved in primary prevention is clear.

Midwifery

Midwives described their role as woman-centred, caring and educating. The caring, autonomous nature of the profession was stressed alongside the developmental and educational aspect of the role of the midwife both in acute and community settings.

The philosophy embodied in midwifery care promotes the right for women to access information and make decisions about their own care and care of babies. Midwifery-led care has been acknowledged by the World Health Organisation (WHO, 1996) as “the most appropriate and cost effective type of health care provider to be assigned to the care of women in normal pregnancy and birth, including the risk assessment and recognition of complications”. The increasing medical intervention of maternity services has reduced the autonomy and potential of the role of the midwife in the delivery of maternal child health.

A major issue discussed by the participants was whether the development of specialist posts in midwifery was appropriate. Clinical midwifery specialities already exist in one of the pilot sites for scanning, diabetes, and lactation. Much has been written in the literature about the theory and practice of specialist nursing and midwifery roles. The participants acknowledged that there is a danger of deskilling and fragmentation of care occurring if the specialist nurse/midwife makes all the decisions regarding a specific area of patient care. McGee et al, (1996) suggest that if CNSs become too focused on a particular speciality, they may lose their generic nursing skills and become professionally isolated. Castledine (1997) argues that they may find themselves in a professional “cul-de-sac” that is, ostracised from the mainstream of nursing with a consequent impact on career development and progression. There was also the opinion offered that many midwives and nurses did wish to pursue a career pathway, such as management or clinical pathways, while others in the profession wish to remain providers of bedside care.

Out-Patient Clinics

Almost 95% of the out patient service is currently delivered by midwives in one of the pilot sites, which was seen as a very positive development. There was a sense that there was huge potential for midwifery-led clinics. Midwives were clear that they delivered a very specific package of care and suggested the establishment of more midwifery-led clinics would provide best value for money for service provision while offering women holistic and continuous care.

Shared Care

Shared care was another service discussed and midwives saw a role for themselves in sharing care with GPs. All women could visit midwife clinics and parent craft classes in their local health centres and GP surgeries. This would offer greater convenience for pregnant women without the need to travel distances to visit the hospital.

Management of Women in Labour

The Labour Unit at one of the pilot sites is midwifery-led, which was acknowledged by pilot site participants as unique in Ireland. As midwives are already providing an autonomous service the impending changes with regard to NCHD working hours was considered not to have much impact on their practice. It was noted that midwives already deliver full care to the mother and baby during labour and delivery and they also rupture membranes, suture, cannulate, administer medications intravenously in the delivery ward.

At the other pilot site the midwives stated that their training provides them with the expertise to offer professional assistance to mothers during labour. They have the knowledge to monitor the condition of the foetus in utero by appropriate clinical and technical means, and conduct spontaneous deliveries including episiotomies when necessary, and in urgent cases a breech delivery. The participants suggest the role of the midwife is restricted in many areas due to local policy. Many acknowledge that their training provides them with the knowledge and skills to be more active and innovative for the mother and baby during labour. For example, midwives identified that they could be more involved in conducting newborn examinations, administration of prostaglandin gel, interpreting and taking appropriate action on CTG traces in accordance with agreed guidelines, and also refer to senior obstetrician when deviation from the norm is identified, for suturing, phlebotomy and cannulation.

Neonatal Care

Neonatal nurses in the pilot sites describe themselves as specialised and experienced professionals who have chosen neonatal nursing after having acquired midwifery and/or paediatric nurse training. The neonatal nursing staff were clear that they wished to continue their focus on spending quality bedside time with parents and babies and provide quality holistic nursing. In the unit midwives already cannulate, administer first and second dose antibiotics, take routine blood samples and tube feed babies. Neonatal nurses also felt that the discharge planning process could be improved upon and that the introduction of an ANP (Neonatal Nursing) would lead to a more effective service, which would benefit the organisation as a whole.

Post Natal Care

A role for a Lactation Consultant was discussed at one of the pilot sites and the consensus was that this role would make a valuable contribution to the service by giving mothers with feeding difficulties greater access to expert knowledge and advice.

Midwifery collaborative prescribing and standing orders were seen as vital in the post natal clinical setting as it would reduce delays in medication administration and reduce the stress experienced by women. One of the pilot sites is currently participating in the midwife-prescribing project, which began in 2001. The feedback received to date is viewed positively.

Midwives also see a greater role for midwives in the admission and discharge process, as this would enhance the woman-centeredness of maternity care. Policies and guidelines could be developed to put this service in place.

Community Midwives

There is a post natal district midwife service and a Domino service in operation at the two pilot sites. Both of these pilot schemes are good examples of best practice and provide further scope for the development of practice. Midwives have identified further areas for development, towards a more efficient and effective service. For example introduction of early transfer schemes (24- hour post delivery discharge), antenatal visits in the community and direct referrals to GPs, which would lead to a decrease in hospital admissions. Midwives suggested that with a quality community midwife service available to women and their babies, early discharges from the hospital could be safely managed in the community resulting in improved use of scarce resources, such as, beds in the acute hospital system.

Public Health Nursing

The ECAHB are continuing to co-ordinate focus groups in August and September 2003 to examine the implications of the reduced working hours of the NCHD's to public health nursing. The results from these focus groups will be available from the NMPDU in the ERHA.

Paediatric Nursing

There is no feedback from paediatric nurses included in the discussion document as there was no paediatric hospital within the selected pilot sites. It has been acknowledged by the Nursing and Midwifery Medical Manpower Steering Group that there are opportunities for role development within paediatric nursing.

Section 4

SKILL MIX

Introduction

This section presents the views of nurses and midwives throughout the pilot regions on the opportunities presented to them in light of the forthcoming introduction of the EWTD. The majority of nurses and midwives stated that they are willing to embrace opportunities to expand their practice towards improving the quality of nursing and midwifery care delivered to patients, thereby supporting the delivery of seamless care in the Irish health service. Nevertheless, the majority of nurses and midwives felt that issues such as skill mix, education and support structures were vital and needed to be addressed before implementation of the EWTD.

Skill Mix and Nursing Workload

Skill mix has been defined as "the balance between trained and untrained, qualified and unqualified, supervisory and operative staff within a service area as well as between different staff groups. Optimum skill mix is achieved when the desired standard of service is provided, at the minimum cost, which is consistent with the efficient deployment of personnel and the maximisation of contributions from all staff members. It will ensure the best possible use of scarce professional skills to maximise the service to clients" (Nessling, 1990)

There are benefits of skill mix changes to all stakeholders – staff, patients and organisation, such as:

- Reduction in some mundane aspects of work providing the staff member time to undertake complex tasks,
- Speeding treatment and access to treatment,
- Method of responding to staff shortages (Dyson, 1991).

Planning the nursing and midwife resource and skill mix is a complex process, which requires understanding of nursing workload measurement systems. According to Thibault et al (1990), there are four components to nursing workload.

- Direct nursing clinical activities, such as direct care to patient,
- Indirect nursing clinical activities, such as care planning,
- Non-nursing tasks which are not related to the nurses expertise,
- Invisible work, such as cognitive and emotional work which is discrete.

Several developments during the past decade have increased the need to develop a more explicit description of services a nurse or midwife can offer, and to differentiate the particular contribution of nursing within the framework of the multidisciplinary healthcare team. This concept in Ireland is under development.

The distinction may be encapsulated as follows:

- The knowledge that is the basis of the assessment of need and the determination of action to meet the need.
- The clinical judgment inherent in the processes of assessment, diagnosis, prescription and evaluation.
- The personal accountability for all decisions and actions, including the decision to delegate to others.
- The structured relationship between nurse and patient, which incorporates professional regulation and a code of ethics within a statutory framework.

Role of Health Care Assistants

The Report of the Commission on Nursing (DoHC, 1998) made recommendations in paragraphs 4.55 and 7.63 regarding the scope for increased use of care assistants and other non-nursing personnel in the performance of non-nursing tasks, and on the need to agree standard criteria in relation to entry requirements, educational qualifications and training for these grades. Specifically, paragraph 7.63 recommended that a group be established to “examine opportunities for the increased use of care assistants and other non- nursing personnel in the performance of other non- nursing tasks”.

A Working Group was established to examine the “effective utilization of the professional skills of the nurses and midwives”, which reported in May 2001. The Working Group recommended that the grade of HCA/ Maternity HCA be introduced as a member of the healthcare team to assist and support the nursing and midwifery function. It also recommended that a Further Education and Training Awards Council (FETAC)/National Council for Vocational Awards (NCVA) Level 2 qualification be the preparation required for employment as a HCA. This programme is available nationwide from September 2003.The Working Group’s Report has since been published and is available on the website of the Department of Health and Children at <http://www.doh.ie/publications/eupsnm.html>.

As the nursing team expands their role, nurses and midwives will require input from support services, such as clerical, information technology, portering and pharmacy services.

Almost without exception, nurses and midwives from all the focus groups in both pilot sites acknowledged that access to education and professional development opportunities, the development of guidelines and protocols, were crucial if their roles were to expand.

Changes in Organisational Structure

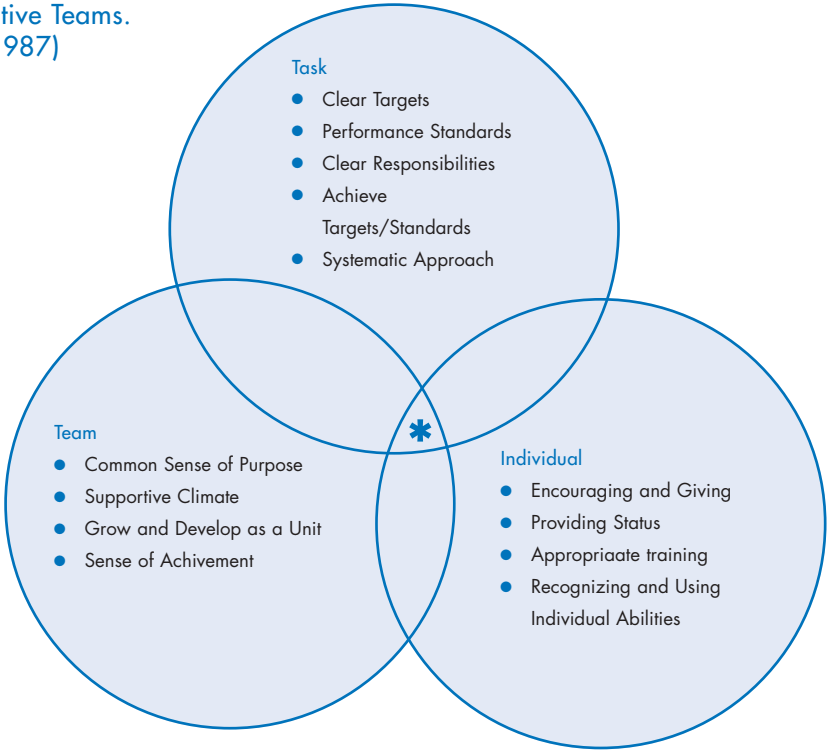
The belief amongst many focus group participants is that there needs to be a cultural change at all levels so that other healthcare professionals and departments co-operate with the evolving role of the nurse/midwife. Communication between professionals will need to develop with a multidisciplinary approach to care being the main focus for all. Re-engineering must become a core competence in organisations; the hallmark of the truly successful organisation will be its ongoing ability to respond to change, and redesign of organisational processes to achieve improvements in critical measures of performance such as quality issues and illustration of value for money.

Collaborative Team-working

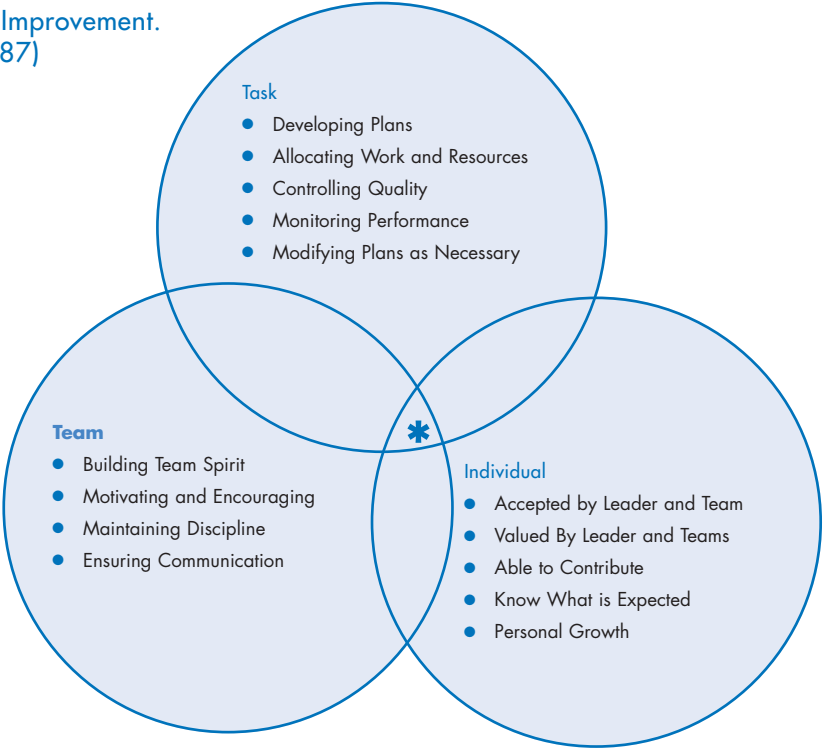
Team-working is the pillar that supports quality service delivery. Senge (1992) states that high performing successful teams have one thing in common: they all have a clear vision and purpose. He suggests that when a team has a “shared vision” they then start to talk about our team and “our organisation” rather than “the organisation”. The commitment to the partnership approach adopted by the Health Service National Partnership Forum is an explicit recognition of the fact that people need to have a sense of ownership and belonging to events that impact on their professional lives. It is also recognition of the fact that people who deliver the service are in the premium position to influence positive changes.

The following models identify approaches that may be used within organisations when developing/reengineering teams and approaches to quality improvement.

Developing Effective Teams.
Adair’s Model (1987)



Teams for Quality Improvement.
Adair’s Model (1987)



Section 5

CRITICAL SUCCESS FACTORS

Nursing and Midwifery: Critical Success Factors for Development

The impetus for expansion of practice must be in the best interests of patients and within the context of nursing as a profession. Competence and the acceptance of individual accountability are key to role expansion. Adequate supports will be needed in order for nurses and midwives to expand their scope of practice. Key success factors will include:

- Management of Change
- Partnership
- Leadership
- Education and Professional Development
- Competence
- Clinical Guidelines

Management of Change

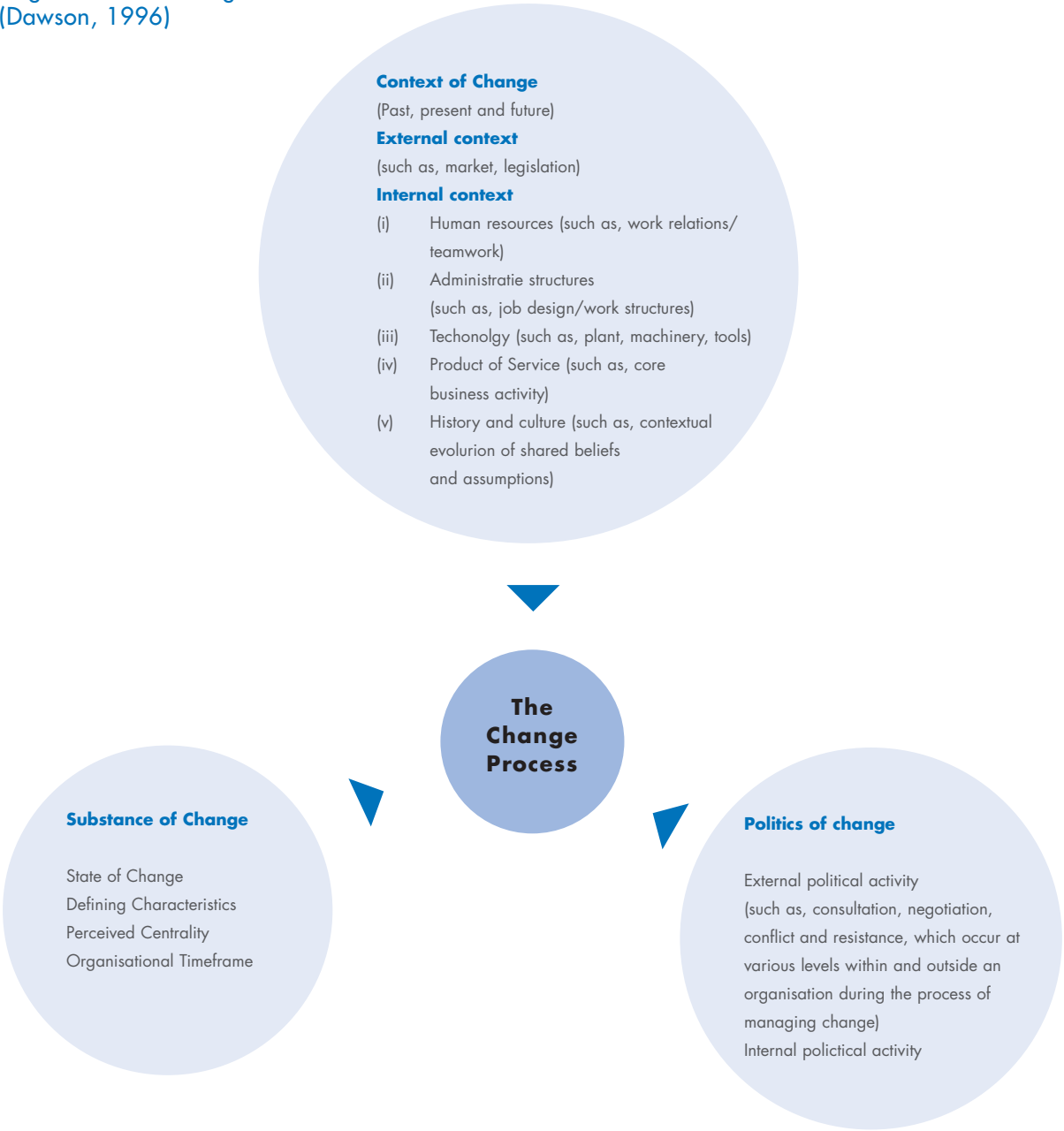
The impact of change cannot be underestimated. Building and enhancing management capacity will be central to the ability of the healthcare system to deliver the kind of organisational change required. A more enlightened and participative style of management, with an emphasis on delegation and empowerment of staff, needs to be fostered and supported. Managers need to be clear about their own managerial purpose and how this contributes to the overall goals of the organisation. They need to motivate and develop staff by involving them in planning and decision making and by providing them with opportunities to undertake more challenging work in line with their knowledge, skills and experience. Support must be given to staff in the form of clinical supervision, time for development and education, and by communicating and involving all the major stakeholders.

It will require an atmosphere of mutual trust, substantial flexibility, innovation and a willingness to change on the part of all the stakeholders; patients, health professionals, management, unions, education and training bodies, regulatory bodies, government and the wider political system. Partnership is deemed the most appropriate vehicle for the implementation of change and can play an important role in the implementation of the Hanly Report (DoHC, 2003).

Implementing the proposals of the Hanly Report (DoHC, 2003) will be challenging for all healthcare personnel. The experience of the pilot sites demonstrated that resource allocations differed between individual organisations and that the requirements of a particular organisation are best addressed at local level. Therefore, the Steering Group agreed that its third term of reference was beyond their scope and will be addressed during the implementation phase of the Hanly Report (DoHC, 2003).

The following diagram emphasises the context, substance and process of change and highlights the role of internal and external politics when implementing change.

Organisational Change
(Dawson, 1996)



Partnership

There are over 95,000 staff working in the Irish healthcare system who are involved in the partnership process. It confers a sense of ownership – an extremely valuable commodity. Through partnership, staff views are taken on board and valued and facilitates employee’s participation in making decisions that directly affect working lives. Partnership is now demonstrating that in the future it can go on to assist in providing the quality of healthcare to which we aspire.

Leadership

Leadership is a critical determinant of organisational effectiveness. Leadership in healthcare carries with it responsibility for the delivery of effective, dignified and timely care for patients and their families and carers. Effective leadership involves people management, creating a sense of direction and communicating the vision with staff to promote provision of a quality service. This requires all our health services is to give priority to the development of a new breed of nursing leaders able to thrive in complex environments. New organisational reform will demand rapid and innovative responses from those responsible for shaping training and curricular design for the next generation of nursing leaders. Such educational change requires leadership to provide learning experiences, which produce not only the clinical leaders of our future but also the educational leaders able to maintain our academic and research base.

Education and Professional Development

Nurses must always comply with the Code of Professional Conduct (An Bord Altranais, 2000b) and recognise their own accountability for their practice. Feedback given from both pilot sites emphasises that the training and development of the HCA is vital and needs to take place in tandem with the education and professional development of registered nurses and midwives.

Institutions that proposed to expand nursing roles must ensure that arrangements for education and professional development are fully thought through. Education training and development should be primarily focused on and integrated with improved service provision and enhanced patient care. Programmes should evolve in response to an identified health service need as identified by health service policy, workforce needs, service plans, demographic trends, epidemiological profiles and other related factors.

In the spirit of partnership, all key stakeholders should be engaged in programme development and design. Development of programmes should be based on the findings of programme evaluation and quality improvements. Evaluation and audit procedures should take account of the full range of stakeholders’ perspectives and be developed along with feedback from service providers and service users satisfaction with the new developments.

Competence

Competence brings a more focused approach to the key qualities and behaviours required for effective performance and as such can contribute to improved management through applications across a range of processes.

Competence is defined as the ability of the registered nurse/midwife to practice safely and effectively, fulfilling his/her professional responsibility within his/her scope of practice. (An Bord Altranais, 2000a). Safe and effective practice requires a sound underpinning of theoretical knowledge that informs practice and is in turn informed by that practice. Within the complex of changing healthcare environments it is essential that practice is informed by the best available evidence. A team and partnership approach should be applied when assessing competence.

Clinical Guidelines

Proposed new guidelines must comply with policy in the early stages of development and have clear aims and objectives. These should be defined in terms of patient care, patient outcomes, protocols, and clinical supervision. Continuous clinical audit should be developed and implemented into the process from the beginning to ensure patient safety and protection.

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Appendices

APPENDIX I

Definition of Nurse/Midwife-led Care

Nurse/Midwife-led Care

Nurse/midwife-led care provided by nurses responsible for case management which includes comprehensive patient/client assessment, clinical leadership, and decision to admit or discharge. Patients/clients will be referred to nurse/midwife-led services by nurse, midwives or other health care professionals, in accordance with collaboratively agreed protocols.

(Nurse/midwife-led is distinct from nurse/midwife coordinated, or nurse managed services).

(National Council for the Professional Development of Nursing and Midwifery, 2003)

APPENDIX II

Focus Group Questions

St Vincent's University Hospital

1. How can we free nurses to spend more time with patients?
2. What structures/ procedures organisational changes could we implement that would make the patients care more seamless?
3. What supports are needed for nurses in order to improve patient care?

Mid – Western Health Board

1. What are the gaps in the service provision at present?
2. What skills and knowledge are required to fill these gaps?
3. Who are the appropriate people to do this?
4. What educational and support needs will be required?
5. What areas of your practice would you like to see expanded?

East Coast Area Health Board

1. Three words to describe the essence and philosophy of nursing
2. What are the key principles of any nurse's role?
3. In light of the EWTD how do you see your role changing (specific examples were asked for) what will this mean for you?
4. How would you like to see your role developing?
5. How do you think your role will change?
6. Define patient care, what it means to you in your role, will this continue to be a central part of your role? If not what would your role actually entail – how to balance hands on care elements of nursing and other newly identified duties.
7. What aspects of your job will change, disappear? What new duties do you see yourself talking on?
8. How will these changes impact on your work load, staffing structures in your environment?
9. Do you think there will be opportunities to feed into the formulation and implementation of the hospitals strategic management decision making- ideas how this could be facilitated?
10. With regard to role changes what would need to change to help you undertake your new role (IT, data storage, sharing, management, how knowledge is shared, how could these systems be improved?)
11. Looking at the changes what core competencies do you think are needed to fulfil this role?
12. What training, support, if any would help or be needed to carry out these changes in your nursing role?
13. Do you feel that you can influence your working environment, are you empowered to make autonomous decisions?
14. How do you think you could influence your working environment?

Organisation of focus groups:

Each group was allocated a designated facilitator and a designated writer. The focus groups lasted approximately one and a half hours. A series of questions were asked by the facilitator during the workshop. These questions were developed from the terms of reference for the project and were designed to assist the facilitator in focusing the discussion of the workshops. The writer took notes on the main points discussed. The last half – hour of the focus group was used to sum up what had been discussed using the writer's notes as a guide

Introduction to focus group:

The project officers gave a welcoming address and some background information to the project.

Facilitators:

Facilitators were chosen locally by the Directors from the Nursing and Midwifery Planning and Development Units from the Pilot Sites. In order to prepare them, facilitators' workshops were organized. These workshops gave a background to the project, outlined the focus group process and prepared the facilitator for the focus group.

The facilitator was asked to:

- Focus the discussions around the questions, but not to direct the participants to respond in a particular way
- Provide clarification of the questions for the participants
- Ensure that each participant had an opportunity to participate
- Create an atmosphere in which participants felt comfortable contributing

Purpose of discussion paper

The primary aim of this paper is to generate discussion and inform nurses and midwives about both the challenges and opportunities presented to them in the near future. The paper describes how the pilot sites organised the focus groups locally and obtained the views of the participants.

This information assisted the National Sub Group Committee to reach a consensus on:

- The future roles for nurses and midwives
- Educational and professional development requirements
- Supports and skill mix

APPENDIX III

Specialist Nurses

Nurses have a major role to play in delivering health care. They are already making a substantial contribution, for example, taking on new roles such as becoming CNSs, ANPs and in the near future taking on other roles, such as prescribing. With the advent of these new roles and responsibilities comes the opportunity to unleash the potential for experienced, competent nurses and midwives to help the whole health care team to concentrate on what matters – ensuring patients receive quality patient care. The concerns around specialisation include fragmentation of care and loss of holism and that this approach is following a medical model rather than nurses using its own conceptual framework. Advanced clinical nursing practice and expanded role function should be guided by a nursing model. It should not be directed or dictated by physicians or a medical model.

Many nurses and midwives fear that a medical orientation will impact on their role particularly with the impending EWTD. We must be careful that such pressures do not compromise its development and implementations within a nursing framework.

Clinical Nurse Specialists:

The CNS has a clinical case load which involves assessment, planning, delivery and evaluation of care. (National Council, 2001). He/she has the authority to make alterations in prescribed clinical options and acts as a consultant to his/her nursing multidisciplinary team colleagues.

Advanced Nurse/ Midwife Practitioners

The ANP is expected to exercise higher levels of judgement, discretion and decision making in the clinical area above that expected of the nurse working at primary practice level and CNS. This means that the ANP may conduct comprehensive health assessment and demonstrate expert skill in the diagnosis of acute/or chronic illness from within a collaboratively agreed scope of practice framework and demonstrate expert skill in the diagnosis of acute and/or chronic illness from within a collaboratively agreed scope of practice framework alongside other healthcare professionals. The crucial factor in determining advanced nursing practice is the level of decision making and responsibility rather than the nature or difficulty of the tasks undertaken (National Council, 2001).

There is a lead in time to new role expansion, which includes skills acquisition, and in the case of the CNS, the acquisition of a higher diploma, ANPs/AMPs require a Masters degree for the role.

Current education programmes require further development and increased accessibility particularly for nurses/ midwives working in rural areas. Nurses/midwives expanding their roles need time to become confident in these roles and hospital systems also need to adapt to embrace such role change.