NURSE EDUCATION AND TRAINING

CONSULTATIVE DOCUMENT

INTERIM REPORT OF THE REVIEW COMMITTEE

OCTOBER, 1991
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# CONTENTS

**PREFACE**

**TERMS AND ABBREVIATIONS USED IN THIS REPORT**

**MEMBERSHIP OF THE COMMITTEE**

**TERMS OF REFERENCE**

**CONSULTATION PAPER THEMES**

**SECTION 1: HISTORICAL DEVELOPMENTS**
- The Development of Nursing in Ireland
- The Legislative Framework
- Reports on Nursing
- Health Service Reports
- Summary
- References

**SECTION 2: THE SYSTEM OF NURSE EDUCATION AND TRAINING**
- Schools of Nursing
- Features of Nurse Education and Training
- International Trends
- The European Community
- Post-registration Nurse Education and Training
- Summary
- References

**SECTION 3: RECRUITMENT, LABOUR FORCE AND MANPOWER ISSUES IN NURSING**
- The Role of Women In Society
- Entry Requirements
- Student Nurse Recruitment
- Student Nurse Attrition Rates
- Profile of the Profession
- Nursing Manpower Issues
- Biographical Details
- Summary
- References

**SECTION 4: A CHANGING SOCIETY AND HEALTH SERVICE REQUIREMENT**
- Child and Adolescent Health Care
- Health Care for Adults
- The Elderly
- The Role of Nursing in a Changing Health Service Requirement
- Summary
- References

**SECTION 5: PERSPECTIVES FOR THE FUTURE**
- The Role of the Nurse
- Evaluating Nurse Education
- A Framework for Education
- The Case for Change

**KEY ISSUES FOR DISCUSSION**
PREFACE

The Nurses Act, 1985, empowered An Bord Altranais to "provide for the registration, control and education of nurses". It stated "the Board may engage in research into the education and training of nurses, including the formulation of experimental curricula and the evaluation of existing programmes and examination and assessment procedures" (Part IV, Section 36(2)).

The establishment of the present Review of Education and Training can be traced back to February 1989 when An Bord Altranais decided that a review of pre- and post-registration nurse education should be undertaken.

A committee to undertake the review was established in September 1990. This committee consists of twelve members of An Bord Altranais; two nominations each from the Department of Health, Chief Executive Officer Group in Health Boards and the Voluntary Hospitals; one representative each from the Higher Education Authority and National Council for Educational Awards and one representative appointed to represent hospitals with Boards established under the Health (Corporate Bodies) Act, 1961.

The Review Committee believes that it is of fundamental importance that the review process incorporates a working formula of consultation and communication with the profession at large. The intention is to provide opportunities for comment and debate to individual nurses, employers and groups representing nurses and nursing.

This paper represents the first formal stage in the consultative process and it, along with further discussion papers and seminars, will provide a substantial basis for comment and an invitation to the various groups representing nursing and nurses to submit views.
TERMS AND ABBREVIATIONS USED IN THIS REPORT

1. PRE-REGISTRATION NURSE EDUCATION

Educational programmes designed to prepare students for entry to a division of the register maintained by An Bord Altranais.

It includes programmes leading to a first entry on the register and programmes which prepare students already on one division of the register for entry to another division of the register.

2. POST-REGISTRATION NURSE EDUCATION

Educational programmes and courses developed for registered nurses and embodies terms such as in-service training, specialist courses and refresher courses.

3. CONTINUING EDUCATION

A life-long learning 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, education, administration and research.

4. STUDENT NURSE

A person who is undertaking a pre-registration nurse education programme and whose name has been entered on the candidate register of An Bord Altranais.

5. THE REGISTER

The register of nurses established under Section 27 of the Nurses Act, 1985.

6. NURSE

A woman or a man whose name is entered on the register and includes a midwife.

7. MIDWIFE

A person whose name is entered in the midwives division of the register.

8. INACTIVE

A system of classifying nurses whose names are entered on the register and who have made a declaration to An Bord Altranais that they are not practising nursing in Ireland at present and will not be practising in the immediate future.

9. ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>RGN</td>
<td>Registered General Nurse</td>
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<tr>
<td>RPN</td>
<td>Registered Psychiatric Nurse</td>
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<td>RSCN</td>
<td>Registered Sick Children's Nurse</td>
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<td>RMHN</td>
<td>Registered Mental Handicap Nurse</td>
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<tr>
<td>RM</td>
<td>Registered Midwife</td>
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<td>RNT</td>
<td>Registered Nurse Tutor</td>
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<td>RCT</td>
<td>Registered Clinical Teacher</td>
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<td>RPHN</td>
<td>Registered Public Health Nurse</td>
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<tr>
<td>EHB</td>
<td>Eastern Health Board</td>
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<td>SEHB</td>
<td>South Eastern Health Board</td>
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<td>SHB</td>
<td>Southern Health Board</td>
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<td>MWHB</td>
<td>Mid-Western Health Board</td>
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<td>MidHB</td>
<td>Midland Health Board</td>
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<td>NEHB</td>
<td>North Eastern Health Board</td>
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<td>NWHB</td>
<td>North Western Health Board</td>
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<td>WHB</td>
<td>Western Health Board</td>
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<tr>
<td>UKCC</td>
<td>The United Kingdom Central Council for Nursing, Midwifery and Health Visiting.</td>
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NB The female gender is used regularly in the text and, where appropriate, should be read as also implying the male gender.

**MEMBERSHIP OF THE COMMITTEE**

<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>Sr Columba McNamara</td>
<td>President of An Bord Altranais and Chairperson</td>
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<tr>
<td>Mr M. O'Connor</td>
<td>Vice President of An Bord Altranais</td>
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<tr>
<td>Ms M. Breslin</td>
<td>Member of An Bord Altranais</td>
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<tr>
<td>Prof J. Coakley</td>
<td>Member of An Bord Altranais</td>
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<td>Ms C. Collins</td>
<td>Member of An Bord Altranais</td>
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<td>Mr J. Griffin</td>
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<td>Sr Triona Harvey</td>
<td>Member of An Bord Altranais</td>
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<td>Board Member and Department of Health</td>
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<td>Ms A. Halpin</td>
<td>National Council for Educational Awards</td>
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<td>Prof M. Mulcahy</td>
<td>Higher Education Authority</td>
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<td>Mr P. McLoughlin</td>
<td>Representing Health Board</td>
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<td>Mr P. J. Fitzpatrick</td>
<td>Representing Health Board</td>
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<td>Ms A. Carrigy</td>
<td>Representing Voluntary Hospitals</td>
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<td>Ms F. Tyndall</td>
<td>Representing Voluntary Hospitals</td>
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<tr>
<td>Mr M. McLoone</td>
<td>Representing hospitals with boards established under the Health (Corporate Bodies), Act. 1961</td>
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TERMS OF REFERENCE

1. To analyse the strengths and weaknesses of the present system of training, educating and examining student nurses.
2. To make proposals in regard to the training, education and examination processes.
3. To analyse the current post-registration education and training of nurses.
4. To make proposals in relation to the adequacy and suitability of post-registration education and training of nurses.
5. To make recommendations and to outline the professional, service and financial implications of implementing the stated proposals.
6. To publish the findings.

CONSULTATION PAPER THEMES

This first consultation paper:

1. Reviews the historical development of nursing and nurse education.
2. Describes nurse education as it is today.
3. Outlines key features of the nursing profession in relation to labour force and recruitment.
4. Provides a general description of demographic and epidemiological patterns in the context of future health care needs and health service delivery.
5. Presents key aspects of the debate on future patterns of nurse education and training.
HISTORICAL DEVELOPMENTS

The long established tradition of caring for the sick in Ireland can be traced back to before the advent of Christianity. The earliest form of care was given by relatives of people suffering from diseases of natural cause (burns, hypothermia). The evolution of nursing can be traced from the arrival of the Celts and the Brehon Laws, to the contribution to the care of the sick offered by the Christians and deacons. Early records of the ancient Brehon Law indicate that those who tended to the mentally ill were given special standing in the community, or even exempted from the law's attentions. The religious orders provided care and refuge on a charitable basis up until the suppression of religious houses in the 16th century. During this time, the overall plight of the sick poor and the mentally ill was identified and the period was judged to be particularly disorganised and chaotic in regard to caring for sick people.

THE DEVELOPMENT OF NURSING IN IRELAND

1.1 In Ireland the Poor Law Act, 1838, established a system which divided the country into a number of Unions, each under the control of a Board of Guardians. These institutions provided care for those poor who were unable to provide for themselves. Eventually, infirmaries were established to look after the sick poor, including the mentally ill.

1.2 The Public Health Service has its roots in the late 18th century when the voluntary hospital system gradually emerged, some under the control of religious orders and others incorporated by charter or statute and administered by boards of governors.

1.3 In the earliest days, there was no formal training for any personnel who provided care. Knowledge was handed down by word of mouth. Hippocrates (460 BC) was the first to suggest the need for training in care of the sick. The title "nurse" was applied to anyone who looked after the sick. However, the title gradually took on a more formal interpretation as applying to professional women whose skilled service extended over a wide area of help for the sick, not just in institutions but also in the home and community.

1.4 The earliest home nursing service was provided by midwives and the system of public health nursing has its origins in the dispensary medical system established under the Poor Relief Act, 1851. The earliest form of community nursing was through voluntary district nursing services. A training school for district nurses was formed in 1876. The Queen's Institute, founded in 1887, and Lady Dudley Nursing Scheme, founded in 1903, provided maternity and home nursing service up until 1967 and 1974 respectively.

1.5 The earliest attempt to co-ordinate and provide institutional care for the mentally ill was through Dean Swift, who bequeathed a sum of money which contributed to the founding of St. Patrick's Hospital, Dublin, in 1745.

The religious orders in Ireland, from the early nineteenth century onwards, had a profound impact on the development of standards of care through the Irish Sisters of Charity, the Sisters of Mercy and the Brothers of the Order of St. John of God.

1.6 Under the Registration of Births (Extension) Act, 1915, provision was made for the employment of nurses to visit mothers with children less than five years of age. In 1924 nurses were employed by local authorities for school health examinations. The report on the Relief of the Sick Poor,
1927, recorded that 657 midwives had been appointed, of whom only five had qualifications in general nursing.

1.7 Plans for instruction in nursing were outlined as early as 1817 and there are records of some nurse training taking place in Dublin from about 1835, but training was relatively unsystematic, with no overall pattern. Towards the end of the nineteenth century, Florence Nightingale, through her feats in the Crimean war, had gained respectability for nursing and her influence had resulted in the establishment of a more formal system of nurse training.

1.8 This system consisted of classroom instruction and practical training, predominantly in a hospital setting. The arrangement for student nurse training consisted of a student working on the ward and attending lectures in off-duty time. The system, then and as it is today, is mainly characterised by a hospital based training pattern, where the student is a hospital employee. From an educational perspective, the system has been described as apprenticeship in nature. The system of nurse training commenced by Nightingale was exclusively for females. In the early years, the system was strictly divided to accommodate the upper class (lady’s) and the lower class (poor law nurses).

It was the Royal Medico-Psychological Association which, towards the end of the 19th century, co-ordinated the training of psychiatric nurses and the awarding of certificates.

THE LEGISLATIVE FRAMEWORK

1.9 In Ireland, as the provision of health care increased, there was a need for a greater regulation of nursing services, with a consequent need for legislative control. The first regulatory recognition given to any aspect of nurse training in Ireland was under the Midwives Act, 1902, which, although only applying to England and Wales, recognised Midwives training certificates from the Royal College of Physicians of Ireland, Coombe Lying-in Hospital and the Rotunda Hospital for the Relief of the Poor Lying-in Women of Dublin.

1.10 The first piece of legislation directly concerned with nursing in Ireland was the Midwives Act, 1918, which established the Central Midwives Board. The Midwives Act, 1944, made further and better provision for the enrolment, certification, control and training of midwives.

1.11 The Nurses Registration Act, 1919, established the General Nursing Council for Ireland which had “a duty to form and keep a register of nurses for the sick”. The Act specified that the register should consist of the following parts “a) General Part ...” supplementary parts containing “b) the names of male nurses... c) the names of nurses trained in nursing and care of persons suffering from mental diseases... d) the names of nurses trained in nursing sick children... e) any other prescribed part” (Chapter 94, Section 2).

1.12 An Bord Altranais was established under the Nurses Act, 1950, which repealed previous Acts and Sections of the Midwives Act, 1944. Under this Act, a statutory committee of An Bord Altranais was established and was known as the Midwives Committee. Under the rules of this Act, five new parts were added to the register: Nurses caring for the Mentally Handicapped, 1958; Nurse Tutors, 1964; Public Health Nurses, 1966; Clinical Teachers and Diploma in Advanced Psychiatric Nursing, 1973.

1.13 The Nurses Act, 1950, was later amended and extended by the Nurses Act, 1961. The 1961 Act also repealed Section 44 of the Midwives Act, 1944.

1.14 The present governing legislation is the Nurses Act, 1985, which repealed the Midwives Act, 1944, and the Nurses Acts of 1950 and 1961. The Nurses Act, 1985, does not make provision for specific registers nor does it dissolve existing registers but empowers An Bord Altranais to
“maintain a register of nurses ...which shall be divided into divisions specified in such rules and such divisions shall include a division applicable to midwives” (Nurses Act, 1985, Part III, Section 27).

1.15 The rules, in accordance with the Nurses Act, 1985, provide for divisions of the register where the names of nurses who are qualified as competent to practice are entered. The seven divisions of the register are:

- General nurses
- Psychiatric nurses
- Sick children’s nurses
- Mental handicap nurses
- Midwives
- Public health nurses
- Nurse tutors

(Nurses Rules, 1988, Part 3.2)

1.16 Certain divisions and supplementary divisions of the register have been discontinued with the passage of time. Formerly divisions and supplementary divisions existed for the registration of:

- Male nurses
- Infectious disease nurses
- Sanatorium nurses
- Orthopaedic nurses
- Tuberculosis nurses
- Diploma in advanced psychiatric nursing
- Clinical teachers

1.17 The Nurses Rules, 1988, no longer include such divisions of the register. They do, however, make provision for the continued use of such titles by holders of those qualifications. Establishing such divisions was essential at that earlier time as it served to place emphasis on a particular medical or nursing practice or health concern.

1.18 The nursing service, as a part of the multi-disciplinary health service, was very much influenced by the general administration of health services.

Traditionally the responsibility for health services was vested in local government. Under the provisions of the Health Act, 1970, and the creation of Health Boards, a new system of administration emerged. Under this system, the role and development of health service administration, including nursing services, have not been subjected to any evaluation since its introduction in 1970.

REPORTS ON NURSING

1.19 The United Kingdom’s structures for nurse education appear more closely aligned to Ireland’s structures than any other of our European partners. However, the nursing profession in Ireland has not been studied as extensively as in the United Kingdom, nor is there such a range of reports on nursing. Reports on nursing in the United Kingdom, including the Lancet Commission (1932)(2), Athlone (1938)(3), the Wood Report (1947)(4), Nuffield (1953)(5), Platt (1964)(6) and Briggs (1972)(7), point out a variety of problems and solutions concerned with nursing and nurse education.

1.20 In the United Kingdom, it was through the recommendations of the 1986 report, Project 2000(8), that significant changes in nurse education occurred. Project 2000 sets out a strategy for nurse
education and training "which will provide for the professional practice of nursing, midwifery and health visiting for the 1990s and beyond". This new preparation for practice, through forming links with third level education systems, resulted in radical change to the traditional systems of nurse education and training.

1.21 Reports on nursing in Ireland have their origins in 1970. The Matrons Association commissioned a study to investigate the reasons for the shortage of staff nurses in the Irish general hospital system. The survey, which was undertaken by University College Dublin, included 345 student nurse respondents and reported on the training and career aspirations of final year student nurses. It was found that approximately 60% of the respondents expressed a favourable attitude to linking training schools to university departments in the near future. The provision of ward based clinical experience was perceived to be of fundamental importance to the nurse training programme. The report highlighted that, amongst respondents, emigration was linked to lack of educational and career opportunities at home, coupled with poor prospects of promotion and unsatisfactory remuneration.

1.22 A Working Party on Psychiatric Nursing Services of Health Boards reported in 1972 and outlined a strategy for a new direction and approach in relation to role, student nurse training, organisational structure and systems of promotion.

The 1972 report stated that "the closest possible integration in training and registration should be aimed at for general and psychiatric nursing" (Para. 9(7)). The report recommended that "consideration should be given to a common basic nurse training course to be followed by further training and specialisation in the different fields of nursing" (Para. 9(8)). It was suggested that Regional Technical Centres would best facilitate the common basic training approach. An improved co-ordination and intensification of post-registration education and staff development was recommended.

1.23 A Working Group on the work load of public health nurses reported in 1974. Amongst its many and wide ranging proposals were recommendations for refresher courses and ongoing education for public health nurses.

1.24 In 1980 the Working Party on General Nursing published its findings and made recommendations on many aspects concerning the control, functioning and provision of nursing services. The report called for the introduction of a two year common basic training programme with a further year of intensive training in the discipline in which the student chose to register (Para. 7.9.1).

Recommendations were made for a comprehensive approach to continuing education (Para. 7.12.1). The report also stated that "priority be given to the development of a degree course for registered nurses" (Para. 7.16.3).

Other recommendations of the 1980 Working Party are reflected in the current legislation, the Nurses Act, 1985, and are concerned with the membership of the Board (Para. 6.8), a live register (Para. 6.3), entry requirements for nursing (Para. 5.4), a central applications bureau (Para. 5.3) and fitness to practise (Para. 6.5.2).

1.25 In 1979, the Institute of Public Administration reported on a survey of attitudes of Irish nurses to career development and working conditions. In relation to education, it concluded that there was a need for a flexible system of training which would offer the opportunity to pursue a university course to some nurses. The majority of nurses felt that the basic training course prepared them adequately for work as a nurse, however, almost half of those surveyed felt that they had further duties for which they had been inadequately trained. In this regard, the need for periodic educational updating and continuing education were raised.
The period 1980 to 1990 can be regarded as a time of change in health services, with changing public attitudes resulting in an increased accountability amongst health care staff. It was also a period when the nursing profession and employers of nurses recognised the need to enhance or redirect nurse training. From 1980 to 1990 five submissions on pre-registration nurse education programmes were made to An Bord Altranais\(^{[14a-c]}\), each profiling an alternative to the existing method of training and education for nurses. In 1984 An Bord Altranais established its own third level education committee, which reported in 1986 on a new programme of third level education for nurses\(^{[14d]}\).

Many groups, both formal and informal, who reported on nurses and nursing have contributed to the development and shape of nursing as it is today. The Matrons Association, having been formed in 1904, adopted the development of a uniform system of education and training as a key objective. The Irish Nurses Union (later to become the Irish Nurses Organisation) was formed in 1919 and, along with many trade unions who formed professional branches, was concerned with improving all aspects of nurse education and training.

In 1960 a diploma course for nurse tutors commenced at University College Dublin and marked the first involvement of universities in nursing. The Faculty of Nursing in the Royal College of Surgeons in Ireland was founded in 1974 and concerned itself chiefly with the development of post-registration nurse education. The Association of Nurse Teachers, which was founded in 1980, was primarily concerned with the promotion of pre- and post-registration nurse education.

Alongside the various representative associations, a number of groups representing speciality areas of nursing were formed. The formation of such groups serves to emphasise the intense specialisation of nursing and makes a forceful statement in relation to future patterns of pre- and post-registration nurse education.

**HEALTH SERVICE REPORTS**

Other reports from the wider health services, not chiefly concerned with nursing, made recommendations to the nursing profession.

The Health Act, 1947, established the Department of Health, with members of the nursing profession as nurse advisors to the department. Among the many functions of the Department of Health, as defined in 1947, was one specifically concerned with the regulation and control of the training and registration of persons for health services\(^{[15]}\).

A number of reports concerned with the delivery of health services have recognised the influential role of nursing and have gone on to identify the desired changes in nursing structures and nurse education.

The 1965 report of the Commission of Inquiry on Mental Handicap\(^{[16]}\) called for the strengthening of mental handicap nurse training "by placing greater emphasis on the social services, both theoretical and practical aspects, and the educational aspects in the care of the mentally handicapped" (Para. 159).

The report identified a need for "common basic training for nurses followed by further courses of training for specialisation in particular fields such as mental handicap ...may be the ultimate future pattern for Ireland" (Para. 161). The report called for an experimental scheme of joint nurse training between mental handicap and psychiatric nursing (Para. 161). It also recommended regular refresher courses for nurses (Para. 160).

A report of the Working Party on the Education and Training of Severely and Profoundly Mentally Handicapped Children, 1983\(^{[17]}\), outlined the need for an expanded role for trained
teachers of the mentally handicapped. It indicated that "many of the staff of care units have limited orientation towards education and training" (Para. 6.10(c)). In its recommendations it stated "where trainee nurses are engaged in education and training programmes, and, where their own training demands that they be absent from the team for certain periods, they be employed as additional to the basic staff complement" (Para. 7.16).

1.33 In 1990 the report of the Review Group on Mental Handicap Services(18) identified the need for a reform of services, with the development of specialist services and integrated models of care. The report, in outlining alternatives, called for a change of terminology by altering the term mentally handicapped to intellectually disabled.

1.34 The Health Act, 1953, paved the way for a comprehensive public health nursing service. The services envisaged included home nursing and midwifery. However certain deficiencies, including a lack of training for public health nursing, hindered developments. A white paper in 1966 outlined the aims and directions for the future development of district nursing services and the development of training facilities for public health nurses.

1.35 As recently as 1989, the Report of the Commission on Health Funding(19) discussed home nursing services and recommended "an urgent review of its role and work load" (Para. 14.66). The report favoured the extension of home nursing services and discussed "the redeployment of general nurses, given appropriate training, to augment the home nursing service" (Para. 14.67). An extension of "the Domiciliary Maternity Scheme" (Para. 11.58) was perceived to be a more comprehensive way of providing ante-natal and post-natal care.

1.36 In psychiatry the Mental Treatment Act, 1945, clearly provided for an alternative to the traditional custodial care approach for the mentally ill. This particular legislative advance was seen as heralding a new era in care of the mentally ill and introduced the concept of community care.

1.37 The case for community care was raised again by the Commission of Inquiry on Mental Illness, 1966(20). Its report recommended "a common basic training for all nursing grades" (Para. 161) and it was considered desirable that psychiatric and general nurse training should be more integrated. The development of library facilities and refresher courses for nurses (Para. 165 and 166) was considered fundamental to the development of the psychiatric services.

1.38 The report Planning for The Future, 1984(21), very clearly characterised the desired shape of future psychiatric care as a community based service. It recommended that psychiatric nurses "should be actively involved in planning, implementing and monitoring various rehabilitation programmes at ward level" (Para. 10.13); "the current training syllabus for psychiatric nurses should be revised and training in rehabilitation and therapeutic techniques should be expanded and developed" (Para. 10.27(7)). It also recommended the avoidance of "having separate hospital nurses and community nurses" (Para. 14.15(4)) and that "programmes of training and education for nurses in rehabilitation and in community work should be organised in all parts of the country" (Para. 14.15(5)).

1.39 Health, the Wider Dimensions, 1986(22), a consultative document from the Department of Health on health policy, conveyed the message that the future approach to health should rely to a greater extent on prevention. Traditionally the main thrust of health service planning has been towards curative services in high technology hospitals, as a consequence, health professionals have become accustomed to a hospital centred system. The report called for profound changes in attitude and practice in health professionals (Para. 2.7).
SUMMARY

In reviewing the historical developments, it is clear that the co-ordination and delivery of nursing services demonstrates a developmental path. The various reports from the middle of the 1960s onward have expressed reservations and made recommendations on nurse education at both pre- and post-registration levels.

The common theme emerging from the reports is support for greater emphasis on community care and integration of both hospital and community health services.

The general tone of most of the reports is one of a gradual shift of emphasis from curative to preventive strategies across the health sector. Irish nurses were consulted in 1988 in relation to the WHO strategy Targets for Health for All by the Year 2000(23), which had a philosophy of preventive health care services. The Irish nurses’ response was one which was positively directed towards adopting the aims expressed in the WHO strategy. The restructuring of nurse education and the affirmation of the necessity of continuing education for nurses were raised in the context of the report and debate(24).

In essence the desired pattern of nurse education, as set-out in the various reports reviewed, appears to be one of common basic training and a move away from specialisation at too early a stage. A common basic training approach, coupled with a structured system of post-registration education for nurses, is seen as the best system for facilitating the continued development of both nurses and health services.

The need for enhanced academic recognition for nurse education and training programmes has been an integral part of many of the reports reviewed.
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3 Athlone Report (1938), Interdepartmental Committee on Nursing Services, HMSO, London.
5 Nuffield Report (1953), Work of Nurses in Hospital Wards, Nuffield Provincial Hospital Trust, London.
14a University College Galway (1980), Proposal for a Degree in Nursing – Bachelor of Nursing, Unpublished.
23 World Health Organisation (1985), Targets for Health for All by the Year 2000, Copenhagen Regional Office.
THE SYSTEM OF NURSE EDUCATION AND TRAINING

An Bord Altranais, under the current legislation, the Nurses Act, 1985, is charged with the responsibility for the control of nurse education. The system operates and is controlled through the Nurses Rules, 1988, and Criteria for the Implementation of the Syllabi of Training\(^{(1)}\). An Bord Altranais’ criteria provide guidance to schools of nursing on the implementation of their programmes of nurse education and training.

The criteria established by An Bord Altranais must fulfil the European Directives on general nursing and midwifery, as stipulated by the Commission of the European Communities. There are currently no European Community Directives on sick children’s, mental handicap and psychiatric nursing, although discussions are at an advanced stage on the publication of directives for psychiatric and sick children’s nursing.

Individual schools of nursing are monitored through the inspection system of An Bord Altranais. A report and recommendations on such schools of nursing are made at least once every five years. There is also an ongoing informal relationship through which schools of nursing are advised and directed.

The examination and assessment system consists of continuous assessment of clinical skills through a proficiency assessment format and a final written registration examination conducted by An Bord Altranais.

SCHOOLS OF NURSING

2.1 There are thirty-seven schools of nursing and seven schools of midwifery presently approved by An Bord Altranais for the education and training of student nurses and student midwives (Table 1).

NUMBER OF NURSE TRAINING SCHOOLS, 1991

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</tr>
</thead>
<tbody>
<tr>
<td>Health Boards</td>
<td>[b]</td>
<td>[b]</td>
<td>[b]</td>
<td>[b]</td>
<td>[b]</td>
<td></td>
</tr>
<tr>
<td>EHB</td>
<td>8(7*)</td>
<td>4(3*)</td>
<td>203</td>
<td>3*</td>
<td>257</td>
<td>3*</td>
</tr>
<tr>
<td>SEHB</td>
<td>1</td>
<td>126</td>
<td>1</td>
<td>44</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHB</td>
<td>3(2*)</td>
<td>584</td>
<td>1</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MWHB</td>
<td>1</td>
<td>207</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MidHB</td>
<td></td>
<td></td>
<td>7</td>
<td>70</td>
<td>6</td>
<td>708</td>
</tr>
<tr>
<td>NEHB</td>
<td>1*</td>
<td>136</td>
<td>1</td>
<td></td>
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<tr>
<td>NWMB</td>
<td>2</td>
<td>168</td>
<td>1</td>
<td>10</td>
<td></td>
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<tr>
<td>WHB</td>
<td>2(1*)</td>
<td>364</td>
<td>1</td>
<td></td>
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<td></td>
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<tr>
<td>Total</td>
<td>18</td>
<td>3135</td>
<td>9</td>
<td>271</td>
<td>7</td>
<td>367</td>
</tr>
</tbody>
</table>

\(a = \text{No. of Schools})

\(b = \text{No. of Students})

\(\ast \text{Number of nursing schools independent of Health Board management.})

TABLE 1
2.2 A considerable process of rationalisation of schools has occurred between 1980 and 1991 (Table 2). The number of schools has been reduced from 72 in 1980, to 44 in 1991. The Working Party on General Nursing, 1980\(^2\), recommended that there should be "a total of fifteen schools with at least one in each Health Board area" (Para. 7.3.4).

**NUMBER OF SCHOOLS OF NURSING/MIDWIFERY BY DISCIPLINE, 1980 AND 1991**

<table>
<thead>
<tr>
<th>Schools of Nursing</th>
<th>1980</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>29</td>
<td>18</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>22</td>
<td>9</td>
</tr>
<tr>
<td>Sick Children's</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Mental Handicap</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Midwifery</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>72</strong></td>
<td><strong>44</strong></td>
</tr>
</tbody>
</table>

**TABLE 2**

2.3 The rationalisation of hospital services in recent years has led to the creation of larger schools and the pooling of resources. Despite such rationalisation, considerable variation still remains in the size of schools. The annual student nurse intake may vary from less than twenty in some schools, to over one hundred in other schools.

2.4 Recruitment to nurse training programmes operates on a student labour basis, with a well defined constant replacement system; as one group of student nurses completes their training, another takes their place in the hospital setting.

2.5 The control and supervision of nurse education and training are vested in An Bord Altranais. The Nurses Act, 1985, (Part IV) states "The Board shall, from time to time as occasion may require but, in any event, not less than once in every five years, satisfy itself as to..." (Section 36(1)) "The suitability of the education and training for nurses provided by any hospital or institution approved of by the Board..." (Section 36(1)(a)), "The standards of theoretical and practical knowledge required for examinations..." (Section 36(1)(b)), "The clinical training and experience provided in any training programme organised by a hospital or institution approved of by the Board" (Section 36(1)(c)).

2.6 In accordance with the Nurses Rules, 1988, An Bord Altranais conducts a formal inspection of schools of nursing at least once every five years, or more often if required. There are follow-up inspections to monitor and ensure the implementation of the recommendations of An Bord Altranais.

2.7 The recommendations of An Bord Altranais are, in most cases, both wide ranging and specific. Over the years, An Bord Altranais has observed and documented the many developments as they occur in schools of nursing. Whilst the overall standards remain high there are, nevertheless, key areas to be addressed in accordance with the continuing evolution of nursing. To this effect, there are common problem areas which are shared by all divisions of the register. The following recommendations were the most frequently raised in relation to the schools of nursing/midwifery inspections (1985 to 1990).
SUMMARY OF MAIN RECOMMENDATIONS MADE DURING SCHOOLS OF NURSING/ MIDWIFERY INSPECTIONS, 1985 TO 1990

(i) The need for improvement in the ratio of tutors to students (Table 3 and Table 4). An Bord Altranais recommends a ratio of one tutor to fifteen students.

RATIO OF REGISTERED NURSE TUTORS/CLINICAL TEACHERS TO STUDENT NURSES/STUDENT MIDWIVES, MARCH 1990

Teacher ratio to student nurse of:

<table>
<thead>
<tr>
<th></th>
<th>RGN</th>
<th>RPN</th>
<th>RSCN</th>
<th>RMHN</th>
<th>RM</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNTs</td>
<td>1:31</td>
<td>1:14.5</td>
<td>1:31</td>
<td>1:41</td>
<td>1:34.5</td>
</tr>
<tr>
<td>RCTs*</td>
<td>1:236</td>
<td>1:58</td>
<td>1:52</td>
<td>1:91</td>
<td>1:45.1</td>
</tr>
<tr>
<td>RNTs &amp; RCTs (combined)</td>
<td>1:28</td>
<td>1:11.5</td>
<td>1:19</td>
<td>1:28</td>
<td>1:32</td>
</tr>
</tbody>
</table>

TABLE 3

ACTUAL NUMBER OF REGISTERED TUTORS, REGISTERED CLINICAL TEACHERS AND UNQUALIFIED TEACHERS IN POST, MARCH 1990

<table>
<thead>
<tr>
<th></th>
<th>RGN</th>
<th>RPN</th>
<th>RSCN</th>
<th>RMHN</th>
<th>RM</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNTs</td>
<td>98</td>
<td>12</td>
<td>8.5</td>
<td>9</td>
<td>13</td>
<td>140.5</td>
</tr>
<tr>
<td>RCTs*</td>
<td>13</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>26</td>
</tr>
<tr>
<td>Unqualified</td>
<td>17.5</td>
<td>2.5</td>
<td>1</td>
<td>7</td>
<td>6</td>
<td>34</td>
</tr>
</tbody>
</table>

*The Clinical Teachers Register has been closed since 1988.

TABLE 4

(ii) The need to enhance clinical teaching and to form greater educational links between the staff of the schools of nursing and the staff of clinical areas.

(iii) The need for improvements in conducting proficiency assessments of student nurses and student midwives.

(iv) The need for improvements in certain areas of the curriculum, with greater emphasis on development in areas such as learning objectives, internal examinations, school records and to reduce the over-reliance on the lecture method of teaching. The lack of student nurse representation on education committees was identified as a shortcoming in many inspection reports.

(v) The need to increase the ratio of registered nursing staff to students.

(vi) The need for increased provision of continuing education and in-service training for registered nursing staff.

(vii) The need to improve nursing library services.

(viii) The need for increased secretarial services in schools of nursing.

(ix) The need to monitor factors related to non-nursing and non-midwifery duties being undertaken by student nurses/midwives in some training hospitals.
The need to establish policy and procedure in certain areas such as dispensing of medicines, medicine administration and infection control.

FEATURES OF NURSE EDUCATION AND TRAINING

2.8 The present model of nurse education and training (Fig. 1), which allows for seven different professional entries to the register (Section 1.15 of this report), is characterised by the building of one training on top of another. Following a first entry to the register as a RGN, RSCN, RPN, or RMHN, a nurse can undertake a shortened programme of eighteen months to have his/her name entered on another part of the register. For example, a nurse may become dual qualified as RGN and RPN in four and a half years. It is argued that some duplication of knowledge may occur in this process of building one training on top of another.

It takes a minimum of six years of professional education to be registered as a public health nurse.

![Diagram of Nurse Education and Training](image)

2.9 Pre-registration nurse education in Ireland has always been aligned with specialties of medicine, including psychiatry, paediatrics, obstetrics, mental handicap and medicine/surgery. Accordingly, divisions of the nurses register have been established for psychiatric, sick children's, midwifery, mental handicap and general nursing. In tandem with this, hospitals developed training programmes which encapsulated their specialties and associated clinical experiences, with the emphasis strongly placed on hospital based nurse training programmes.

The present Criteria for the Implementation of the Syllabi of Training for nurses\(^1\) stipulate a requirement of home nursing/community experience for student nurses over a three year programme as follows:

- General nursing: 1 week
- Sick children's nursing: 1 week
- Mental handicap nursing: 4 weeks
- Psychiatric nursing: 14 weeks
2.10 The system of pre-registration nurse education has been described as an apprenticeship, where the student nurse occupies a dual role as learner and employee.

2.11 Nurse training in its apprenticeship form has had its critics. It is within the framework and expressions of this model that many of the current disagreements and inconsistencies related to nurse education and training are centred. There is an abundance of nursing research evidence, spanning two decades, which expresses many concerns about the apprenticeship system of nurse education and training; Bendall (1973), Fretwell (1978), Orton (1980) and Reid (1985).

As early as 1977, McFarlane argued that the nursing profession required a rational theoretical basis, derived from empirical observation and further, that the difficulty this would pose for traditional nurse education and training programmes would become increasingly apparent.

2.12 The emergence of the need for research based theory linked to nursing practice has increased calls for a reform of the apprenticeship type educational programme. Florence Nightingale, who pioneered nurse training in its apprenticeship form, was very committed to the process and utilisation of research. There is evidence that Miss Nightingale envisaged the nursing school developing along similar lines to the medical school, with separate funding derived from student fees and the hospital providing the arena for supervised practice.

INTERNATIONAL TRENDS

2.13 In recognising that the nurse remains the only member of the health care team not currently receiving a professional education outside of the workplace, many countries have examined and introduced alternative methods to the apprenticeship nurse education programme. In recent years, New South Wales, Australia, Canada, Spain and the United Kingdom, amongst others, have redirected their programmes of preparation for nursing practice through a third level education based model.

2.14 The United Kingdom, in 1986 through Project 2000 and in 1990 through the Post-Registration Education and Practice Project (PREPP), provided a blueprint for nurse education at pre- and post-registration levels (Fig. 2). Project 2000 has now been implemented and it is significant that Northern Ireland has located its nurse education programmes in third level education. Specifically, Project 2000 nurse training comprises 4,600 curricular hours of which half is designated to learning within practice settings. Normally one-third, that is six months or no more than 20% of the course, is designated as rostered contribution to nursing services. This service contribution is educationally directed and normally takes place in the third year of the programme.

2.15 There are certain characteristics common to current third level nurse education programmes as developed, including:

(i) a common core programme for all entrants to nursing for a period of one to two years;

(ii) student nurses are supernumerary to staffing requirements for set periods of time;

(iii) student nurses receive training grants/bursaries (these grants may be under the control of the Department of Health or the Department of Education);

(iv) joint professional and academic validation, with academic recognition for professional qualifications;
(v) the preparation of a registered nurse practitioner competent to function in institutional and non-institutional settings;

(vi) the development of a coherent, comprehensive and cost effective framework for nurse education beyond registration;

(vii) the creation of a position of helper/care worker directly supervised and monitored by a registered nurse practitioner.

THE EUROPEAN COMMUNITY

2.16 A major development in European nursing has been brought about by the adoption of directives for general nursing and midwifery. The directives for general nursing which became operative in Ireland in 1979 were concerned with "The mutual recognition of diplomas, certificates and other evidence of the formal qualifications of nurses responsible for general care, including measures to facilitate the effective exercise of the right of establishment and freedom to provide

The directives for midwifery became operative in Ireland in 1983. These directives defined certain “activities which the midwife is entitled to take up and pursue” (Council Directive 80/155/EEC).

2.17 In 1989 a directive from the Council of European Communities (89/595/EEC) amended directives 77/452/EEC and 77/453/EEC. More specifically, Article 1(4) of directive 77/453/EEC was amended in such a way as to set out the length of the theoretical instruction to be at least one-third, and that of clinical instruction at least one-half, of the minimum length of training, which is 4,600 hours. In effect, this meant an increase in the amount of theoretical instruction given to student nurses undertaking general nurse training.

2.18 The advisory committee on training in nursing in the European Community in 1990 produced “guidelines on reducing the gap between theory and practice in programmes leading to qualification as a nurse responsible for general care.” The guidelines focused on a range of very specific relevant issues including:

- a shortage of nurses with the appropriate preparation in teaching;
- deficiencies in the design of programmes of preparation;
- the status of students as employees;
- the lack of continuing education.

POST-REGISTRATION NURSE EDUCATION AND TRAINING

2.19 The Nurses Act, 1985, states “The Board shall, from time to time as occasion may require but, in any event, not less than once in every five years, satisfy itself as to ... the adequacy and suitability of post-registration training courses for nurses provided by bodies recognised by the Board for that purpose” (Part IV, Section 36(1)(d)).

2.20 One outstanding feature of the present model of nurse education in Ireland (Fig. 1) is that it is primarily concerned with pre-registration nurse education, consequently, there is no structured educational mechanism for the professional development of nurses beyond registration.

2.21 The Working Party Report on General Nursing, 1980, (Para. 7.12.2) identified five areas where it considered that planned, formal, continuous programmes should be organised:

- courses in specialist nursing;
- courses in management and administration;
- refresher courses;
- in-service training;
- university based or faculty courses.

In recent years, a number of specialist nursing courses have received approval from An Bord Altranais. The development of specialist courses has, in the main, resulted from increased medical specialisation. In relation to specialist nursing courses there remains, however, an uneven distribution, both in the variety and the geographical location of courses.

2.22 It is argued that competence can only be maintained through continuing education and professional development. All registered nurses should therefore be helped to take every reasonable opportunity to improve their performance, through acquiring greater knowledge and understanding by participation in educational courses beyond registration.
2.23 The growth of new and highly specialised forms of patient care demands a flexible framework for continuing education in nursing. The continuing specialisation of services requires nurses to have a new range of skills to provide care and treatment in a situation of changing relationships with the client/patient as a consumer of health services.

2.24 In recent years the changed relationship between nurse and patient/client is epitomised by an increased accountability and an environment where litigation is becoming increasingly prevalent.

2.25 In developing a framework for post-registration education, every attempt must be made to relate the provision of education to the role and working responsibilities of individual nurses.

A post-registration education system should ensure that practitioners and managers of nursing services would avail of educational courses directly related to developing and enhancing their roles in the broader health services. In such a scenario, post-registration nurse education would be directly related to maintaining and increasing standards in all areas of nursing practice, research and management, thus providing greater public protection.

2.26 The principle of continuing education and the growing awareness of its significance is clearly highlighted in the report of the Commission on Adult Education, 1983(11). In relating the concept of "learning as a life long process", the report provides a comprehensive perspective on the importance of access to educational opportunity. The report identified a wide range of educational options as means of providing continuing education, including open and distance learning.

When deciding on programmes for post-registration nurse education, distance and open learning have many merits. These would facilitate individual nurses in studying at their own pace, at a time convenient to them and at a reasonable cost.

2.27 Professional accreditation and academic validation would be vital components of an enhanced post-registration nurse education system. With such a system in place, registered nurses would have an opportunity to accumulate points towards the completion of a recognised award, as is the case in the development of post-registration education in the United Kingdom (Fig. 2).

The principles of access, progression, relevance and flexibility should provide the foundations for post-registration nurse education.
SUMMARY

The system of nurse education and training as described, exists in an environment where constant change is required. However, problems exist which are intrinsic to the apprenticeship model of nurse education, with a conflict between the educational needs and the service requirements.

There is a clear need for defined policy in relation to the number and size of schools. Manpower policy and planning need to be evaluated so as to estimate the number and skill mix of registered nurses required for health services.

There is an urgent need to examine teaching and learning strategies in nurse education. Reviewing the extending base of nursing knowledge leads to fundamental questions being raised about nursing values and where the educational focus should lie within the nursing curriculum.

In identifying the need for continuing education, it is very evident that a formal structure in post-registration education is required. The complexity of health services and the resulting demand for greater technical and managerial expertise, coupled with a changing knowledge base, are key factors in determining the need for continuing education.

Many countries of the world have redirected their nurse education programmes, forming links with third level education, with many characteristic effects (Section 2.15). The Commission of the European Communities stipulated the requirement for greater theoretical input in nurse training programmes.

Ireland, therefore, in its national criteria, must take cognizance of the wider dimensions and trends in nurse education.
REFERENCES

RECRUITMENT, LABOUR FORCE AND MANPOWER ISSUES IN NURSING

The changing demographics of Europe are beginning to make an impact on the available labour force. Many countries, including the United Kingdom, are affected by the decline in the number of school leavers available for recruitment to nursing. Although Ireland is unique in having the highest birth rate in Europe, the indications that this population growth has ceased must be of concern in the context of future recruitment to nursing.

The changing composition of the labour force is made more complex by the changing role of women in the labour force. In 1974 the “Marriage Bar”, which extended to nurses, was removed for women working in the public services. The Employment Equality Act, 1977, provided for "equal treatment as between men and women and between single and married persons in access to employment, training and working conditions". The impact of this legislation has been gradual and is reflected in the changed composition of the labour force.

THE ROLE OF WOMEN IN SOCIETY

3.1 In 1987 women made up 49.5% of the population of working age (15 to 64 years). By contrast, they made up 30.9% of the labour force and 32.4% of those in employment (Table 5).

3.2 The trend in Ireland towards later marriages and towards lower marriage rates is also seen in Europe and seems to reflect wider social change and an increasing level of participation by married women in the labour force.

In Ireland the average age of women at first marriage was 24 in 1979 and since then has steadily increased reaching 25.5 in 1987. The absolute number of marriages has fallen from 21,800 in 1980 to 18,100 in 1987(1).

3.3 Since 1984 there has been a sharp fall in labour force participation rates among women and men aged 15 to 19. Blackwell, 1989(1), indicates that this is reflected by a rise in participation rates in education.

3.4 A significant feature is that in the period 1984 to 1987, a marked rise in labour force participation rates for women aged 25 to 34 occurred. There were also rises among women aged 35 to 54.

3.5 This distinctive pattern of labour force participation rates by women may be identified in nursing by the continuous increase in the number of older women who are attending “Back to Nursing” courses for general nurses and midwives, some of whom may be planning to re-enter the labour force following a break in their nursing career. Back to Nursing and Midwifery courses are organised and co-ordinated by An Bord Altranais. The courses are provided on the following basis:

- refresher courses;
- preparation for entry to the nurses register.

By far the greatest interest in “Back to Nursing” courses was in the age group 40 to 49 (Fig. 3).

Thousands (except where percentage is stated)

<table>
<thead>
<tr>
<th></th>
<th>1971</th>
<th>1981</th>
<th>1987</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population aged 15–64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1,717.3</td>
<td>2,030.7</td>
<td>2,142.3</td>
</tr>
<tr>
<td>Women</td>
<td>847.9</td>
<td>1,002.0</td>
<td>1,061.4</td>
</tr>
<tr>
<td>% of women to total</td>
<td>49.4</td>
<td>49.3</td>
<td>49.5</td>
</tr>
<tr>
<td>Labour force</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1,125.4</td>
<td>1,272.0</td>
<td>1,319.2</td>
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<tr>
<td>% of women to total</td>
<td>25.7</td>
<td>29.1</td>
<td>30.9</td>
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<tr>
<td>Married women in the labour force*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>39.2</td>
<td>112.0</td>
<td>161.6</td>
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<tr>
<td>% of female labour force</td>
<td>13.6</td>
<td>30.2</td>
<td>39.6</td>
</tr>
<tr>
<td>Employed labour force</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1,049.5</td>
<td>1,146.0</td>
<td>1,087.6</td>
</tr>
<tr>
<td>Women</td>
<td>275.6</td>
<td>337.0</td>
<td>352.5</td>
</tr>
<tr>
<td>% of women to total</td>
<td>26.3</td>
<td>29.4</td>
<td>32.4</td>
</tr>
<tr>
<td>Unemployed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>75.9</td>
<td>126.0</td>
<td>231.6</td>
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<tr>
<td>Women</td>
<td>13.8</td>
<td>33.0</td>
<td>55.2</td>
</tr>
<tr>
<td>% of women to total</td>
<td>18.2</td>
<td>26.5</td>
<td>23.8</td>
</tr>
</tbody>
</table>

*In order to ensure comparability over time, the data include separated and divorced women.

Notes: The labour force consists of those who are employed together with the unemployed. The unemployed include those who are looking for a first regular job. The data for 1981 are from the Census of Population which are recast in order to make them comparable with Labour Force Survey concepts.


TABLE 5

“BACK TO NURSING”
COURSE NUMBERS BY AGE GROUP

FIGURE 3
3.6 On examining population projections for the years 1991 to 2021, it is clear that a marked decline in numbers will occur in the 19 to 24 age group (Fig. 4).

As recruitment to nurse training programmes almost exclusively focuses on school leavers, the reduced labour force participation rates among the 15 to 19 age group must be considered in the context of future recruitment to nursing strategies.

3.7 The reduced numbers in the 19 to 24 age group (Fig. 4) and the broadening of the female occupational role, will mean that future recruitment to nursing policies will have to be more flexible and be capable of attracting and retaining the mature entrant. Therefore, it is likely that in the future educational institutions and employing authorities will have to facilitate and make further provision for married women.

3.8 This factor was identified in a study of career patterns of Scotland’s qualified nurses(3). Entry to nurse training and returning to work amongst nurses was greatly influenced by finding hours to suit their domestic situations. Career breaks were also very much on the increase and the findings of the study revealed that, amongst the sample of 8,865 nurses, 50% had taken a career break of at least six months at some point in their career, some of whom never returned to work.

The Scottish study stressed the need for continued improvement in the provision of facilities and conditions which help match domestic commitments with working life. Such improvements
were seen to reduce wastage in nursing by improving retention of staff, enhancing ability to return to work and allowing mature entrants to nursing.

3.9 A study of nurse recruitment and retention in the National Health Services in the United Kingdom in 1988(4) undertaken by Price Waterhouse, identified the fact that nursing offered many opportunities for personal job satisfaction. The study highlighted the importance of maintaining and building on the strengths of nursing as a career. The survey detailed many areas of dissatisfaction which consistently had an adverse effect on retention and recruitment. In particular, respondents felt they did not get the right training at the right time to further their career.

3.10 Arising out of most studies, recruitment policies aimed at attracting and recruiting more males to nursing are also seen as a realistic aim for the future, given the present low number of males entering nursing.

ENTRY REQUIREMENTS

3.11 In accordance with the Nurses Act, 1985, Part IV, Section 35(1), the minimum educational requirements for entry to nursing are determined by An Bord Altranais and are based on the post-primary leaving certificate. Other equivalent educational attainments, as adjudicated by the Higher Education Authority, may also be considered acceptable.

Candidates who are twenty-four years or over on the 15th of October of the year of application must satisfy the approved training school or institution of their suitability for nurse training.

STUDENT NURSE RECRUITMENT

3.12 The Nurses Act, 1985, states “The Board may, if it so determines, establish a central applications bureau to process applications from persons wishing to undertake training as a nurse”(Part IV Section 35(2)). The current system of application for admission to nurse training involves a significant degree of multiple applications by individuals to different schools.

Consequently, there is some difficulty in identifying the number of applicants to nursing, since a number of applications are made by each individual. The Working Party on General Nursing in 1980 identified 32,407 applications completed by 11,943 individuals, which amounted to approximately three applications per individual.

3.13 An examination of issues and trends in the recruitment of student nurses to general nursing for the South Eastern Health Board(5) identified that in 1989, out of 419 applicants, 62% had applied to four schools or more, with only 7% applying to one school only.

3.14 The policies for interviewing for student nurse training in the various hospitals and Health Boards are at variance. Generally, Health Board policy is to invite all eligible candidates for preliminary interview with a short listing for final interview, following which places are offered to candidates. Voluntary hospitals usually invite a selected number of candidates for one interview, following which places are offered to candidates.

3.15 For the purposes of the review of nurse education and training, a five year retrospective analysis of recruitment to nurse training was conducted for the years 1986 to 1990 inclusive, for general, psychiatric, mental handicap, sick children’s nursing and midwifery.

The exercise was somewhat limited by the lack of substantial records kept by some hospitals for the years 1986 to 1987. However, accurate records were obtained for 1990 (Table 6).
RECRUITMENT TO NURSE/MIDWIFERY TRAINING PROGRAMMES, 1990

<table>
<thead>
<tr>
<th>Total Number</th>
<th>RGN</th>
<th>RPN</th>
<th>RSCN</th>
<th>RMHN</th>
<th>RM</th>
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<td>Applications Eligible</td>
<td>12300</td>
<td>1973</td>
<td>706</td>
<td>253</td>
<td>866</td>
</tr>
<tr>
<td>Applications Ineligible</td>
<td>3560</td>
<td>552</td>
<td>226</td>
<td>138</td>
<td>362</td>
</tr>
<tr>
<td>Invited for Interview</td>
<td>6676</td>
<td>1971</td>
<td>548</td>
<td>253</td>
<td>398</td>
</tr>
<tr>
<td>Attended Interview</td>
<td>4632</td>
<td>1248</td>
<td>306</td>
<td>186</td>
<td>320</td>
</tr>
<tr>
<td>Places Available(i)</td>
<td>1065</td>
<td>132</td>
<td>108</td>
<td>*133</td>
<td>222</td>
</tr>
<tr>
<td>Places Offered(ii)</td>
<td>1390</td>
<td>311</td>
<td>155</td>
<td>156</td>
<td>266</td>
</tr>
<tr>
<td>Declined Offer</td>
<td>325</td>
<td>179</td>
<td>47</td>
<td>32</td>
<td>44</td>
</tr>
</tbody>
</table>

Ineligible: Candidates who fail to fulfil An Bord Altranais' minimum educational entry requirements. In midwifery, certain health boards have a policy of recruiting and selecting internally within the board area, almost exclusively in some instances and partially within others. Therefore applications from outside the health board may be rendered ineligible.

(i) Quota of students officially sanctioned by the Department of Health.
(ii) Number of places offered by Health Boards/hospitals to fill quota.
No figures are available for one midwifery school which would normally recruit approximately 40 students.
*Mental handicap nursing had a shortfall of nine students and failed to fill the quota of students sanctioned.

TABLE 6

3.16 On the basis of information gathered, it would appear that the system of recruitment to nurse training is inefficient and expensive, with a considerable amount of wastage.

3.17 The number of applications to nursing has remained constant for the years 1986 to 1990. However, there is a decline in the number of applications since 1980. The Working Party on General Nursing in 1980 identified a total of 32,407 applications, compared with 15,860 applications for general nursing in 1990. However, it must be noted that the Leaving Certificate educational requirements for entry to nursing were increased in 1985.

Based on numbers applying, it is clear that general nursing is the most popular choice for applicants, with a declining interest in mental handicap and psychiatric nurse training, for the years surveyed.

3.18 In 1990, based on the total number of applications to nursing/midwifery, over 23% were judged ineligible. Of the eligible candidates, 39% were not invited for interview. This pattern is reflected in recruitment to training for all divisions of the nurses register (Table 6). However, it is reflected to a lesser extent in psychiatric, sick children's and mental handicap nursing where there were less applications. It is significant that in general nursing, 46% of applications holding minimum educational requirements were not invited for interview in 1990.

3.19 At the point of interviewing there is a further source of wastage. In 1990, 33% of candidates who were invited for interview for nurse training (excluding midwifery) failed to turn up; approximately 44% failed to turn up for a selection interview for sick children's nurse training. For all divisions, the numbers not attending on being invited for interview has increased steadily throughout the years 1986 to 1990 inclusive. A pattern of refusing places offered or not being available has emerged among candidates successful at interview for the years 1986 to 1990. When midwifery is excluded, total rejections as a percentage of total places offered for nurse training was 29% in 1990. It is significant that approximately 30% of places offered for sick children's nurse training and 58% of places offered for psychiatric nurse training were refused (Table 6).
The problems of recruitment to nurse training in the discipline of mental handicap nursing led to the establishment of a National Applications Centre in 1990. However, there still remained a shortfall in recruitment of nine student nurses in 1990.

Recruitment of student nurses to training programmes is an expensive process. The total cost of recruiting 1,660 student nurses/midwives in 1990 was £245,935 (Table 7).

COST OF RECRUITMENT TO NURSE TRAINING PROGRAMMES, 1990

<table>
<thead>
<tr>
<th>Division of Register</th>
<th>Advertising</th>
<th>Staff/Secretarial</th>
<th>Interviews</th>
<th>Stationery Information Phone Calls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>£7,889</td>
<td>£76,412</td>
<td>£51,803</td>
<td>£20,738</td>
<td>£156,842</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>£4,509</td>
<td>£9,645</td>
<td>£11,038</td>
<td>£1,987</td>
<td>£27,179</td>
</tr>
<tr>
<td>Sick Children’s</td>
<td>£2,000</td>
<td>£11,825</td>
<td>£4,316</td>
<td>£611</td>
<td>£16,752</td>
</tr>
<tr>
<td>Mental Handicap*</td>
<td>£40</td>
<td>£24,219</td>
<td>£3,800</td>
<td>£456</td>
<td>£30,475</td>
</tr>
<tr>
<td>Midwifery**</td>
<td>£11,825</td>
<td>£4,316</td>
<td>£611</td>
<td>£30,475</td>
<td>£45,687</td>
</tr>
<tr>
<td>Total</td>
<td>£14,438</td>
<td>£130,312</td>
<td>£75,849</td>
<td>£25,336</td>
<td>£245,935</td>
</tr>
</tbody>
</table>

*Extra costs were incurred due to establishing a National Applications Centre
**Figures not available for one Maternity Hospital
(Figures for costings supplied through personnel officers of Health Boards and matrons/directors of nursing and secretary/managers of voluntary hospitals.)

TABLE 7

STUDENT NURSE ATTRITION RATES

The number of student nurses/midwives entering training remained fairly constant for the years 1986 to 1990, with a notable decrease in numbers during 1987 (Table 8).

STUDENT NURSES/MIDWIVES ENTERING TRAINING, 1986 TO 1990

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RGN</td>
<td>1253</td>
<td>830</td>
<td>1115</td>
<td>1141</td>
<td>1065</td>
</tr>
<tr>
<td>RPN</td>
<td>192</td>
<td>75</td>
<td>35</td>
<td>107</td>
<td>132</td>
</tr>
<tr>
<td>RSCN</td>
<td>144</td>
<td>75</td>
<td>87</td>
<td>90</td>
<td>108</td>
</tr>
<tr>
<td>RMHN</td>
<td>106</td>
<td>106</td>
<td>105</td>
<td>117</td>
<td>133</td>
</tr>
<tr>
<td>RM</td>
<td>260</td>
<td>106</td>
<td>254</td>
<td>226</td>
<td>222</td>
</tr>
<tr>
<td>Total</td>
<td>1955</td>
<td>1192</td>
<td>1596</td>
<td>1681</td>
<td>1660</td>
</tr>
</tbody>
</table>

TABLE 8

It is noted that for the years 1986 to 1990 inclusive, the total number of student midwives entering training exceeded the number of student nurses entering either psychiatric, mental handicap or sick children’s nursing.

Based on the number of student nurses/midwives entering training, it is clear that for one reason or another a proportion of students never complete the nurse training programmes or register as nurses. For the year 1986, approximately 8.5% and for the year 1987, approximately 13% of the total numbers entering training never registered as nurses/midwives.
A number of student nurses/midwives who successfully completed the final registration examination did not register their qualification. This is particularly evident amongst student midwives and also student nurses who completed a first training and pursued a shortened second registration programme (Table 9).

### NUMBER OF STUDENTS WHO PASSED EXAMINATIONS AND DID NOT APPLY FOR REGISTRATION AS A NURSE/MIDWIFE

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RGN</td>
<td>5(4*)</td>
<td>3(3*)</td>
<td>6(3*)</td>
<td>10(2*)</td>
<td>23(8*)</td>
<td>7(6*)</td>
<td>54</td>
</tr>
<tr>
<td>RPN</td>
<td>4(3*)</td>
<td>2(1*)</td>
<td>1(1*)</td>
<td>2(2*)</td>
<td>2</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>RSCN</td>
<td>1</td>
<td>0</td>
<td>2(2*)</td>
<td>1(1*)</td>
<td>0</td>
<td>2(2*)</td>
<td>6</td>
</tr>
<tr>
<td>RMHN</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1(1*)</td>
<td>4</td>
</tr>
<tr>
<td>RGN/RSCN</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>RGN/RPN</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>RM</td>
<td>5</td>
<td>5</td>
<td>12</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>52</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>16</td>
<td>12</td>
<td>24</td>
<td>25</td>
<td>36</td>
<td>20</td>
<td>133</td>
</tr>
</tbody>
</table>

* Number of nurses whose names were already entered on another division of the register.

### TABLE 9

**PROFILE OF THE PROFESSION**

The number of nurses registered by An Bord Altranais during the years 1986 to 1990 has decreased. A total of 2709 nurses were registered in 1986 compared to 2548 in 1990 (Table 10). Notable patterns of registration within the disciplines of nursing are a decline in the number of psychiatric, mental handicap and sick children’s nurses. The number of nurse tutors registered has increased by 90% between 1986 and 1990, although the numbers are relatively small. Males currently account for 6.5% of the population of registered nurses in Ireland. In the United Kingdom males account for 8.5% of registered nurses.

### NUMBERS OF NURSES REGISTERED EACH YEAR, 1986 TO 1990

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RGN</td>
<td>1594(2%)</td>
<td>1551(3%)</td>
<td>1440(3%)</td>
<td>1443(4%)</td>
<td>1596(4%)</td>
</tr>
<tr>
<td>RPN</td>
<td>274(35%)</td>
<td>302(26%)</td>
<td>187(22%)</td>
<td>115(21%)</td>
<td>209(25%)</td>
</tr>
<tr>
<td>RSCN</td>
<td>163</td>
<td>184</td>
<td>144</td>
<td>144</td>
<td>156</td>
</tr>
<tr>
<td>RMHN</td>
<td>181(10%)</td>
<td>121(4%)</td>
<td>168(11%)</td>
<td>152(11%)</td>
<td>154(12%)</td>
</tr>
<tr>
<td>RM</td>
<td>442</td>
<td>504</td>
<td>416</td>
<td>350</td>
<td>371</td>
</tr>
<tr>
<td>RNT</td>
<td>10(50%)</td>
<td>18(22%)</td>
<td>6(17%)</td>
<td>15</td>
<td>19(11%)</td>
</tr>
<tr>
<td>RCT</td>
<td>4(25%)</td>
<td>6</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RPHN</td>
<td>41</td>
<td>58</td>
<td>18</td>
<td>32</td>
<td>43</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2709</td>
<td>2744</td>
<td>2383</td>
<td>2251</td>
<td>2548</td>
</tr>
</tbody>
</table>

(%) Percentage males.
Two males were registered in the midwifery division between 1986 and 1990.

### TABLE 10

The overall number of qualifications from EC countries registered in Ireland has increased by 90% between 1985 and 1990. Registrations of foreign qualifications, other than EC, although relatively small in number, demonstrate an overall increase from 2 in 1985 to 14 in 1990, with a total number of 47 qualifications being registered between 1985 and 1990.

Therefore, the overall number of overseas qualifications registered, including EC and those other than EC, has increased by 93% between 1985 and 1990 (Table 11).
3.28 The number of certificates and verification documents issued by the UKCC to nurses and midwives intending to work in Ireland reached its highest point in 1989/90, having fallen considerably in 1987/88 (Table 12).

### NUMBER OF CERTIFICATES AND VERIFICATIONS ISSUED TO AN BORD ALTRANAIS BY THE UKCC

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984/85</td>
<td>340</td>
</tr>
<tr>
<td>1985/86</td>
<td>381</td>
</tr>
<tr>
<td>1986/87</td>
<td>355</td>
</tr>
<tr>
<td>1987/88</td>
<td>200</td>
</tr>
<tr>
<td>1988/89</td>
<td>293</td>
</tr>
<tr>
<td>1989/90</td>
<td>511</td>
</tr>
</tbody>
</table>

### NURSING MANPOWER ISSUES

3.29 In March 1991 there were 39,595 nurses on the register maintained by An Bord Altranais; 93.5% were female and 6.5% were male. The total number of qualifications registered by the 39,595 nurses was 58,534 (Table 13).

### TOTAL QUALIFICATIONS REGISTERED, MARCH 1991

<table>
<thead>
<tr>
<th>Qualifications</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>32295</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>7556</td>
</tr>
<tr>
<td>Sick Children's</td>
<td>2520</td>
</tr>
<tr>
<td>Mental Handicap</td>
<td>2175</td>
</tr>
<tr>
<td>Midwifery</td>
<td>11651</td>
</tr>
<tr>
<td>Nurse Tutors</td>
<td>233</td>
</tr>
<tr>
<td>Clinical Teachers</td>
<td>123</td>
</tr>
<tr>
<td>Public Health</td>
<td>1528</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>106</td>
</tr>
<tr>
<td>Sanatorium, Fever, Advanced Psychiatric Tuberculosis and Infectious Disease</td>
<td>347</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>58534</strong></td>
</tr>
</tbody>
</table>

**TABLE 13**
DIVISION OF THE REGISTER IN WHICH THE NAMES OF NURSES WITH ONE QUALIFICATION IS ENTERED

<table>
<thead>
<tr>
<th>Qualifications</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>16427</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>4996</td>
</tr>
<tr>
<td>Sick Children's</td>
<td>293</td>
</tr>
<tr>
<td>Mental Handicap</td>
<td>1736</td>
</tr>
<tr>
<td>Midwifery</td>
<td>70</td>
</tr>
<tr>
<td>Nurse Tutors</td>
<td>4</td>
</tr>
<tr>
<td>Public Health</td>
<td>6</td>
</tr>
<tr>
<td>Sanatorium, Fever, Tuberculosis and Infectious Diseases</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23552</strong></td>
</tr>
</tbody>
</table>

**TABLE 14**

3.30 The register of nurses shows that 59% of nurses are registered in one division only, 34% registered in two divisions, 6% registered in three divisions, 0.6% in four divisions and 0.03% in five divisions.

3.31 In the case of the total number of nurses registered in one division only, 70% of nurses names were entered in the general division (Table 14). Based on the total number of qualifications registered in the mental handicap division, 80% are registered as single qualifications and in the psychiatric division, 66% are registered as single qualifications.

NUMBER OF NURSES CLASSIFIED AS INACTIVE BY REASON

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working Abroad</td>
<td>1988</td>
</tr>
<tr>
<td>Other</td>
<td>557</td>
</tr>
<tr>
<td>Retired</td>
<td>548</td>
</tr>
<tr>
<td>Unemployed</td>
<td>428</td>
</tr>
<tr>
<td>Career Break/Leave</td>
<td>389</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3910</strong></td>
</tr>
</tbody>
</table>

**TABLE 15**

COUNTRIES IN WHICH NURSES CLASSIFIED AS WORKING ABROAD MAY BE LOCATED

<table>
<thead>
<tr>
<th>Country</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom</td>
<td>1050</td>
</tr>
<tr>
<td>Australia</td>
<td>339</td>
</tr>
<tr>
<td>United States</td>
<td>282</td>
</tr>
<tr>
<td>Africa</td>
<td>74</td>
</tr>
<tr>
<td>Canada</td>
<td>60</td>
</tr>
<tr>
<td>Middle East</td>
<td>56</td>
</tr>
<tr>
<td>Germany</td>
<td>20</td>
</tr>
<tr>
<td>Switzerland</td>
<td>14</td>
</tr>
<tr>
<td>Italy</td>
<td>11</td>
</tr>
<tr>
<td>France</td>
<td>10</td>
</tr>
<tr>
<td>Netherlands</td>
<td>8</td>
</tr>
<tr>
<td>Other Countries</td>
<td>32</td>
</tr>
<tr>
<td>Travelling</td>
<td>32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1988</strong></td>
</tr>
</tbody>
</table>

**TABLE 16**
3.32 Based on the total 39,595 nurses registered with An Bord Altranais, 10% of nurses were classified as inactive. The number of nurses classified as inactive has gradually increased in recent years. The main reason identified for inactivity is "working abroad" with a majority working in the United Kingdom (Table 15 and Table 16).

3.33 In noting the movement of nurses to and from overseas and the increasing numbers of nurses on the inactive register who are working abroad, it is clear that manpower in nursing is becoming increasingly mobile. Consequently, factors such as conditions of service and educational opportunities, as identified in the Price Waterhouse study on nurse retention and recruitment, are fundamentally important in the context of future nurse manpower planning.

**BIOGRAPHICAL DETAILS**

3.34 With regard to the age groups of registered nurses, 37% of nurses are in the age group 40 and over and 63% are in the age group 21 to 40 (Table 17).

3.36 On examining selected age groups of registered nurses, 89% of nurses holding mental handicap qualifications and 81% of nurses holding sick children's qualifications are in the age group 21 to 40. It should also be noted that 34% of nurses with a nurse tutor qualification and 30% of nurses with a public health nurse qualification are in the over 50 age group (Table 18).

### NUMBER OF NURSES BY AGE GROUPS

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown</td>
<td>336</td>
</tr>
<tr>
<td>21-30</td>
<td>11616</td>
</tr>
<tr>
<td>31-40</td>
<td>13157</td>
</tr>
<tr>
<td>41-50</td>
<td>8011</td>
</tr>
<tr>
<td>51-60</td>
<td>4721</td>
</tr>
<tr>
<td>61-65</td>
<td>1159</td>
</tr>
<tr>
<td>Over 65</td>
<td>595</td>
</tr>
</tbody>
</table>

**TABLE 17**

**NUMBER OF QUALIFICATIONS REGISTERED BY AGE GROUP**

<table>
<thead>
<tr>
<th>Qualifications</th>
<th>Unknown</th>
<th>21-30</th>
<th>31-40</th>
<th>41-50</th>
<th>51-60</th>
<th>61-65</th>
<th>Over 65</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>266</td>
<td>9483</td>
<td>10538</td>
<td>6519</td>
<td>3969</td>
<td>991</td>
<td>529</td>
<td>32295</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>82</td>
<td>1547</td>
<td>2972</td>
<td>1790</td>
<td>905</td>
<td>191</td>
<td>69</td>
<td>7556</td>
</tr>
<tr>
<td>Sick Children's</td>
<td>19</td>
<td>1039</td>
<td>994</td>
<td>347</td>
<td>91</td>
<td>13</td>
<td>17</td>
<td>2520</td>
</tr>
<tr>
<td>Mental Handicap</td>
<td>13</td>
<td>1053</td>
<td>886</td>
<td>163</td>
<td>48</td>
<td>7</td>
<td>5</td>
<td>2175</td>
</tr>
<tr>
<td>Midwifery</td>
<td>104</td>
<td>1400</td>
<td>5221</td>
<td>2833</td>
<td>1520</td>
<td>383</td>
<td>190</td>
<td>11651</td>
</tr>
<tr>
<td>Nurse Tutors</td>
<td>4</td>
<td>2</td>
<td>67</td>
<td>82</td>
<td>58</td>
<td>12</td>
<td>8</td>
<td>233</td>
</tr>
<tr>
<td>Clinical Teachers</td>
<td>4</td>
<td>0</td>
<td>33</td>
<td>64</td>
<td>15</td>
<td>6</td>
<td>1</td>
<td>123</td>
</tr>
<tr>
<td>Public Health</td>
<td>28</td>
<td>18</td>
<td>452</td>
<td>587</td>
<td>339</td>
<td>64</td>
<td>40</td>
<td>1528</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>0</td>
<td>2</td>
<td>62</td>
<td>27</td>
<td>9</td>
<td>3</td>
<td>3</td>
<td>106</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>64</td>
<td>60</td>
<td>21</td>
<td>148</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>2</td>
<td>0</td>
<td>13</td>
<td>59</td>
<td>38</td>
<td>24</td>
<td>25</td>
<td>161</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>522</td>
<td>14544</td>
<td>21240</td>
<td>12472</td>
<td>7056</td>
<td>1754</td>
<td>908</td>
<td>58496</td>
</tr>
</tbody>
</table>

(A total of 38 qualifications are excluded from above; Sanatorium, Fever, and Advanced Psychiatric Nursing.)

**TABLE 18**

28
SUMMARY

As nursing is predominantly a female profession, the changing role of women in society and the labour force generally must be acknowledged in the context of nursing.

In reviewing aspects related to the labour force in Ireland, the most notable change in recent years has occurred in relation to the increased participation by married women in the labour force. Such changed patterns are also reflected in nursing with increasing numbers of women returning to the labour force following a career break.

It is also clear that the demographic factor will work through and shape the age structure in relation to recruitment to nurse education and training programmes. The broadened female occupational role will mean that nursing will have to compete with many unconventional occupations in its recruitment strategies.

In future, therefore, there may be an older and more diverse work force in nursing, signifying a possible collapse of the conventional career in nursing (6).

Recruitment and applications to nurse training programmes are a unique and complex process. The system is characterised by its inefficient and expensive nature, with a large degree of wastage.

The nursing work force is also becoming increasingly mobile, with an increased movement of nurses to and from overseas.

The patterns of registration demonstrate a wide range of qualifications for nursing practice. However, it must be noted that 60% of nurses have one qualification only, thus restricting their choice of work settings and practices.

On the basis of the trends and patterns identified, strategies and policies for pre- and post-registration nurse education and training in the future must be capable of facilitating a wider and more diverse group of people.
REFERENCES


3 Institute of Manpower Studies (1990), *Career Patterns of Scotland's Qualified Nurses*, a report for the Scottish Home & Health Department.


A CHANGING SOCIETY AND HEALTH SERVICE REQUIREMENT

The development of the health service, including the provision of specialist care and improved diagnostic and therapeutic facilities, has greatly influenced the provision of health care in Ireland today. Patterns of mortality and morbidity demonstrate marked changes in the health profiles of the population.

In contrast to other European countries, Ireland has an unusual demographic profile. The total population has increased from 3 million in 1971 to 3.5 million in 1986, whereas it has been relatively static or declining in other European countries. However, demographic projections for Ireland suggest that population growth has ceased(1).

When the age distribution of the projected population is considered, it is clear that patterns of health service usage will change over the next twenty-five years(2).

This will require fundamental changes in the nursing profession so as to ensure that nurses fulfil their roles and that the provision of nursing services continues to be closely aligned with health service needs.

CHILD AND ADOLESCENT HEALTH CARE

4.1 Although the birth rate in Ireland has declined from 21.8 per 1,000 population in 1970, to 14.7 in 1989 (Fig. 5), this birth rate still represents the highest in the European community.

ANNUAL BIRTH RATE PER 1,000 POPULATION

Source: Dept. of Health, Vital Statistics, 1st Quarter 1990

FIGURE 5
BIRTHS OUTSIDE MARRIAGE AS A PERCENTAGE OF TOTAL BIRTHS, 1976 TO 1990

In recent years there has been a marked increase in the number of births outside marriage (Fig. 6), making Ireland the fifth highest ranking country in the European Community in this respect.

4.2 The number of maternity units throughout Ireland have been reduced and births are taking place in larger units (Fig. 7).

There is also an emerging pattern of new born infants being exposed to changing feeding practices; the number of mothers breast feeding is relatively low at 32%, when compared with other European countries(3)(4).

4.3 The infant mortality rate has declined rapidly from 19.2 in 1970, to 7.5 in 1989 and is one of the lowest in the European Community. Perinatal and neonatal mortality rates are in the middle or upper levels of the rates for European countries (Fig. 8). These figures may be accounted for by the trend in some European countries for early diagnosis of congenital abnormalities and resulting termination of pregnancy. Based on this practice, it is expected that differences between Ireland and other countries in neonatal and perinatal morbidity rates, resulting from neural tube defects and Down’s syndrome, will be more marked in the future(5).

4.4 The numbers of children in care has remained relatively static. There were 2,446 in 1982 and 2,614 in 1988. Recent years have seen an increased demand on child care services, with an associated increase in the number of families experiencing difficulties. The relationships between children and parents are changing with accompanying life-style concerns such as drugs, alcohol, violence, accidents and suicide. The principal reasons for admission to care in 1988 were “parents unable to cope” and “neglect” (Fig. 9).

There is also an increased recognition of the need for greater emphasis on child and adolescent psychiatric services(6) which, by nature, will necessitate a close working relationship between families and care providers, with close liaison between hospital out-patient and community care services.
PERCENTAGE DISTRIBUTION OF BIRTHS BY SIZE OF MATERNITY UNIT
1966 AND 1987

1966

1,000 to 1,999
2,000 & Over
500 to 999
Domiciliary
1 to 499

1989

2,000 & Over
1 to 499
500 to 999
1,000 to 1,999

Source: Perinatal Reporting System, Department of Health.
Cited: Health Statistics, 1989

FIGURE 7

4.5 In the context of the changing need for child and adolescent health care services, the application of nursing and midwifery services must be evaluated. The centralisation of maternity units and the creation of larger units will require the development of domiciliary midwifery services to ensure a geographical spread of maternity services.
INFANT, NEONATAL AND PERINATAL MORTALITY RATES FOR EC COUNTRIES, 1987

INFANT

NEO-NATAL & PERINATAL

Infant and neo-natal mortality rates per 1,000 live births. Perinatal mortality rates per 1,000 live and still births.

DEFINITIONS:
INFANT DEATHS refers to liveborn infants surviving less than one year
NEO-NATAL DEATHS refers to liveborn infants surviving less than four weeks
PERINATAL DEATHS refers to late fetal death plus deaths of liveborn infants aged under one week

* Source: Central Statistics Office
Source: Demographic Statistics, Eurostat 1989: (a) 1988, (b) 1986, (c) 1984, (d) 1983, (e) Provisional
Cited: Health Statistics, 1989

FIGURE 8
CHILDREN IN CARE AT 31 DECEMBER, 1988 BY PRIMARY REASON FOR CURRENT ADMISSION

- Child awaiting adoption
- Other family crisis
- Parental illness
- Child abandoned/neglected
- Child out of control
- Parental disharmony
- Parent(s) unable to cope
- Neglect
- Emotional abuse
- Sexual abuse
- Physical abuse

Total Number in Care: 2,614
Source: Health Statistics 1989

FIGURE 9

HEALTH CARE FOR ADULTS

4.6 Over the last two decades there has been a marked decrease in overall adult mortality rates in Ireland. This is reflected in the fall in death rates from 11.5 to 8.8 per 1,000 of population from 1970 to 1989 (Fig. 10).

ANNUAL DEATH RATE PER 1,000 POPULATION

Source: Dept. of Health Vital Statistics, 1st Quarter 1990

FIGURE 10
On examining the principal causes of death (Fig. 11), it becomes clear that many of the deaths occurring before old age are preventable ones. Coronary artery disease, lung cancer, injury, poisoning and some respiratory disorders are preventable. It should be noted that the death rate from lung cancer and the standardised ratio for ischemic heart disease amongst Irish women is one of the highest in Europe\(^{(7)}\).

In 1985 there were 33,222 deaths in Ireland; 17,321 of these deaths were due to smoking-related diseases. Approximately 5,000 of these deaths were estimated to be directly attributable to smoking\(^{(1)}\).

The number of persons availing under the long-term illness scheme shows a steady increase for the years 1979 to 1988. Based on medical condition, the chief groups of people availing of this benefit are persons with diabetes mellitus, epilepsy and mental handicap (Table 19).

### LONG TERM ILLNESS SCHEME, NUMBER OF PERSONS AVAILING, 1979 AND 1988

<table>
<thead>
<tr>
<th>Condition</th>
<th>1979</th>
<th>1988</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>14,082</td>
<td>21,494</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>8,253</td>
<td>13,876</td>
</tr>
<tr>
<td>Mental Handicap</td>
<td>1,914</td>
<td>2,809</td>
</tr>
<tr>
<td>Parkinsonism</td>
<td>807</td>
<td>1,594</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>579</td>
<td>1,172</td>
</tr>
<tr>
<td>Spina Bifida/Hydrocephalus</td>
<td>1,004</td>
<td>1,116</td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td>576</td>
<td>993</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td>523</td>
<td>898</td>
</tr>
<tr>
<td>Acute Leukaemia</td>
<td>175</td>
<td>460</td>
</tr>
<tr>
<td>Phenylketonuria (PKU)</td>
<td>187</td>
<td>341</td>
</tr>
<tr>
<td>Muscular Dystrophics</td>
<td>134</td>
<td>271</td>
</tr>
<tr>
<td>Haemophilia</td>
<td>146</td>
<td>199</td>
</tr>
<tr>
<td>Mental Illness (under 16 years only)</td>
<td>120</td>
<td>156</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>28,500</strong></td>
<td><strong>45,379</strong></td>
</tr>
</tbody>
</table>

Source: Statistical Information Relevant to Health Services, 1982, Health Statistics, 1989
4.9 General hospital services care statistics display a decrease in the length of time patients spend in hospitals (Fig. 12). It should be noted that the greatest reduction in the average length of stay in hospital is in the 75 years and over age group.

4.10 The Acquired Immune Deficiency Syndrome (AIDS) and Human Immuno-deficiency Virus (HIV) pandemic is also well established in Ireland, with a marked increase in new cases and deaths from AIDS (Fig. 13). AIDS, as the greatest perceived problem facing health services in Europe has far reaching consequences for health care services and will require creative alternative approaches to care including preventive, hospice, respite and combinations of home and institutional care.

### FIGURE 12

**AVERAGE LENGTH OF STAY IN HOSPITAL BY AGE, 1987 AND 1988**


### FIGURE 13

**CASES OF, AND DEATHS FROM, AIDS, 1982 TO 1989**

Source: Health Statistics, 1989
4.11 The trend in the psychiatric services is for a continuing decline in the number of in-patients (Fig. 14), with a corresponding increase in the provision of community facilities. There were 32 day centres and day hospitals with approximately 800 places established at the end of 1984, by the end of 1989 the number had increased to 94, providing places for approximately 2,300 people. In 1984 there were 121 hostels with over 900 places, this had more than doubled by 1989 with 285 hostels and approximately 1,900 places (figures supplied by Department of Health).

4.12 The rate of admission to public psychiatric hospitals has declined slightly in the period 1982 to 1988 from 8.5 to 6.8 per 1,000 population. Admissions to psychiatric hospitals and units by diagnosis and sex for the year 1987 (Fig. 15) highlights that in males, alcohol abuse and in females, depressive illness were the main reasons for admission to hospital.
SPECIAL RESIDENTIAL CENTRES FOR THE MENTALLY HANDICAPPED, NUMBERS CATERED FOR ON 31 DECEMBER, 1985

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Number of Residential Places</th>
<th>Number of Persons Attending:</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Day Care</td>
<td>Workshop</td>
</tr>
<tr>
<td>Eastern</td>
<td>2,220</td>
<td>218</td>
<td>405</td>
</tr>
<tr>
<td>Midland</td>
<td>213</td>
<td>5</td>
<td>31</td>
</tr>
<tr>
<td>Mid-Western</td>
<td>498</td>
<td>19</td>
<td>9</td>
</tr>
<tr>
<td>North-Eastern</td>
<td>296</td>
<td>52</td>
<td>59</td>
</tr>
<tr>
<td>North-Western</td>
<td>345</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>South-Eastern</td>
<td>443</td>
<td>9</td>
<td>48</td>
</tr>
<tr>
<td>Southern</td>
<td>886</td>
<td>43</td>
<td>929</td>
</tr>
<tr>
<td>Western</td>
<td>285</td>
<td>21</td>
<td>106</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,186</strong></td>
<td><strong>336</strong></td>
<td><strong>706</strong></td>
</tr>
</tbody>
</table>

Source: Health Statistics, 1989

### TABLE 20

4.13 The emerging picture is of a psychiatric service in which the psychiatric hospital still plays a major role, but a role that is diminishing and changing.

4.14 The provision of special residential centres for the mentally handicapped by health board area, including services provided by voluntary bodies, is outlined in Table 20. The 1981 psychiatric census identified 2,170 mentally handicapped persons resident in psychiatric hospitals, by 1989 this was reduced to approximately 1,550, of whom 1,090 were in mental handicap only accommodation, with a further 282 in dedesignated units (figures supplied by Department of Health).

4.15 The admission rate of mentally handicapped persons to psychiatric hospitals by sex and selected age groups for 1987 is displayed in Table 21. There was a reduced admission rate from 23 per 100,000 in 1977, to 11.9 per 100,000 population in 1987.

### MENTAL HANDICAP ADMISSIONS TO PSYCHIATRIC HOSPITALS AND UNITS, RATE PER 100,000 POPULATION, 1987

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>111</td>
<td></td>
</tr>
<tr>
<td>25-44</td>
<td>187</td>
<td></td>
</tr>
<tr>
<td>45-64</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>65 &amp; Over</td>
<td>32</td>
<td></td>
</tr>
</tbody>
</table>


### TABLE 21

4.16 It is clear that the world population is becoming an increasingly aged one and that the numbers of persons who are very old and very frail will be proportionately larger by the turn of the century. The increase in the elderly population is also seen in the annual death rate of persons aged 65 and over per 1,000 corresponding population, which has decreased from 72.9 in 1970, to 61.3 in 1989. A projection of the numbers aged 65 years and over as a percentage of the total population for selected countries, including Ireland, shows a gradual increase in the population of persons in this age group (Fig. 16).
POPULATION AGED 65 AND OVER AS A PERCENTAGE OF THE TOTAL POPULATION


FIGURE 16

4.17 It was identified in the 1986 Irish Census that, of the total population, 10.8% were 65 years or over and 4.1% were 75 years or over. It should be noted that approximately 50% of people hospitalised in psychiatric hospitals for one year or more are over 65 years old. It is significant that over 16% of persons admitted to psychiatric hospitals for the first time in 1988 were 65 years or over, over 40% of these patients were admitted with depressive disorders (figures supplied by Department of Health).

4.18 The provision of appropriate care facilities and supervision for persons suffering with dementia and confusion is presenting a challenge to those who provide services for the elderly.

RESIDENTS OF LONG STAY GERIATRIC UNITS BY MEDICO-SOCIAL STATUS


FIGURE 17
4.19 The medico-social status of residents in long-stay geriatric units is shown in Figure 17. Whereas the number of residents with chronic illness has declined, residents with social reasons for admission increased between the years 1980 and 1988.

4.20 In the future, there will be an increase in the number of people reaching advanced old age, who will require health services. The question is whether an extension of the present services and the current pattern of the provision of residential services (Fig. 18) is desired, or whether nursing services must be geared to an alternative perspective as aimed for in the report, The Years Ahead – A Policy for the Elderly, 1988(8). In its outline of a policy for the elderly, it identified a desired interdisciplinary approach in education and practices and recommended “that greater attention be paid in the training of nurses generally and public health nurses in particular, to anticipatory care of the elderly” (Para. 6.31). It identified the need for the provision of intensive home nursing services, particularly to discharged hospital patients and to patients whose admission to hospital could be avoided. The report recommended “that the function of co-ordinating services for the elderly in each district should be the responsibility of a district liaison nurse” (Para. 3.13).

**DISTRIBUTION OF PERSONS IN LONG-STAY GERIATRIC HOMES BY TYPE OF HOME, 1988**

![Pie chart showing distribution of persons in long-stay geriatric homes by type of home, 1988](chart.png)

**FIGURE 18**

**THE ROLE OF NURSING IN A CHANGING HEALTH SERVICE REQUIREMENT**

4.21 Changes in health services will need to be maintained in response to changing demographic and epidemiological patterns. To enhance the effectiveness of a change in the underlying philosophy of health care, there is need for a comprehensive strategy for developing new attitudes and services in nursing.

In compliance with a shift towards a model of primary health care, nursing services must be developed on the basis of a greater integration of hospital and community nursing services in all sectors of health care.

4.22 Designing a framework for increased home nursing services will require alternative approaches in the delivery of nursing services. The role and function of home nursing services, as currently applied through public health nursing structures, must be evaluated.

Medical general practitioner services, through contracting practice nurses and the advent of twilight nursing services, represent a move towards the provision of a more comprehensive
community based nursing service. Establishing a desired skill mix is fundamentally important in designing comprehensive home nursing services.

4.23 The demographic changes will mean that health care will have to be increasingly directed towards an ageing population. The number of preventable deaths, the increased numbers registered under the long term illness scheme and the levels of chronic illness require the promotion of positive health behaviour at every opportunity, in both the community and hospital.

4.24 To maximise initiatives in health promotion and disease prevention, there must be multi-disciplinary and multi-sectoral co-operation.

Nurses, by virtue of their numbers, high level of patient/client contact and opportunities presented during the course of daily activities, have the potential to play a pivotal role.

4.25 Hospital based nursing practice must be evaluated in a climate of changing levels of hospital activity. Changing and advancing medical and therapeutic interventions will require an extension of the traditional nursing role and higher competency levels.
SUMMARY

The demographic and epidemiological patterns as outlined, reveal a trend of continuous change which has fundamental implications for nursing and health care delivery in the future. To date, certain of these changing patterns have triggered the commissioning of a number of new reports and the formulation of health policy in elements of the health service.

The nature and structure of society is also undergoing change, with a declining birth rate and a projected increase in the number of people reaching advanced age. As elderly people make disproportionately high use of health services, the need for expansion of these services, or perhaps the creation of new, alternative health care provisions for elderly people, will present a challenge to health care planners.

The increased awareness of social inequalities has resulted in a sharp focus of attention on the health related effects of unemployment, homelessness and poverty. Concern has been expressed about the profound health disadvantages both in levels of health and in access to services associated with some areas of rural and inner-city life. The social impact and the life-style and resulting health profile of the travelling people has been increasingly highlighted.

The reliance on acute hospital care as the preferred solution to illness has been questioned. The patterns of hospital usage in acute general services and psychiatric services over recent years demonstrate marked changes. A higher proportion of hospitalised patients are acutely ill and require more sophisticated care, with increased technology and intense specialisation.

A new concept of primary health care has emerged which focuses on the community, with hospitals and other facilities as back-up to the community. The acknowledgement that health is multifaceted and linked to aspects of life-style may signal new initiatives in health care, involving a major emphasis on health promotion and preventive health care.

It would appear that nurses who can deliver care across a broader spectrum of need, both in hospital and community, will be required. Equally, more technically skilled and highly specialised nurses will be required in response to specialised diagnostic care and treatment facilities.

The role of support workers and untrained carers will need to be scrutinised in the context of health care provision. Ultimately and as a consequence of changing health care patterns, the role of nursing in health services must be clearly defined. To this end, future strategies for nurse education have a pivotal role to play.
REFERENCES


7 Department of Health (1986), *Health, the Wider Dimensions, a Consultative Statement on Health Policy*.


THE ROLE OF THE NURSE

5.1 The nursing profession has a responsibility to look to the future to ensure that its potential continues to be realised in the context of health services.

Rapid social, technological and medical changes have, in the later part of this century, presented the nursing profession with many challenges requiring nurses to be flexible and adaptable.

5.2 Patterns of health and disease have changed considerably over the years demanding concomitant changes in the health care services. Successive reports on health services have outlined many alternative strategies for health care which, if realised in the future, may generate new paradigms in health care. Such paradigms will represent a distinct change in the hospital as the exclusive source, custodian and provider of health care, thus creating new and broader definitions of health care. Changing health care practices are currently reflected in altered patterns of hospital usage with increased use of day care and out-patient facilities.

5.3 The trend towards community care and the pattern of shorter duration of hospital stay will require a move from the historical predominance of hospital based nursing practice.

5.4 The orientation towards community care will, however, mean the reorientation of many traditions in nursing including educational preparation and the role and function of hospital nurses, community nurses and public health nurses.

5.5 To ensure cost effectiveness and efficiency, the role of the nurse must be clearly determined and the specific aspects which constitute nursing function clarified. Nursing audits and measures aimed at quality assurance will be central to determining skill mix in nursing services. The extension of health care delivery settings, as part of the new orientation in health services, will mean that nurses will relate to a greater variety of non-nursing staff in their work. A range of helpers and health care assistants will be required for services and they will need to be supervised and directed by nurses.

5.6 The artificial barriers which separate hospital nursing from community nursing will have to be examined. The skills of the individual nurse will be extended into areas of counselling, facilitating self care and training people to appropriate life-styles; the nurse will, therefore, need a self-directed and autonomous approach to nursing practice.

5.7 "With the changing emphasis in care the hospital services will cater for the very sick and will require fewer in number but more highly skilled nurses. Simultaneously, the high technology services will develop and the concept of intensive care with highly specialist approaches will not be limited to acute general medical units but will include various psychiatric and geriatric services as well..."*

*(Ben Dov, N., 1988, Megatrends Affecting the Reorientation of Nursing in Europe, paper presented to WHO, European Conference on Nursing, Vienna, 21-24 June)*
EVALUATING NURSE EDUCATION

5.8 Preparation for nursing, midwifery and public health nursing stresses the importance of assessing and providing care in response to a wide range of health needs through a holistic approach. However, structures for student nurse education compartmentalise nurse education by division of the register and do not espouse a holistic approach. Consequently, a conceptual shift may be required in nursing towards a more open, critical and experimental approach in both education and practice. There are areas common to the present educational preparations for divisions of the nurses register and there are questions about the possibility of an unnecessary and wasteful overlap between different preparations. Could they be brought together, rationalised or reduced?

5.9 The present system of nurse education and training which has been maintained for over one hundred years has, as one of its characteristics, a strong base of clinical experience for student nurses.

5.10 The facilitation of clinical experiences for student nurses across a wide range of patient and client medical conditions and circumstances, provides a sound practical base as a preparation for nursing practice in a hospital setting. This has been regarded as one of the strengths of the current system.

This factor, combined with the high reputation of Irish Nurses both at home and abroad, would dissuade the general public from believing that there is anything very much wrong with nurse education. The lay person will ask the question “If the system of nurse education is so very wrong why are Irish nurses in such demand?”

However there are many problems inherent to the apprenticeship system of nurse education and training with volumes of research spanning two decades as outlined earlier (Section 2.11). Many countries, including Spain and the United Kingdom, have developed blueprints and instituted change in nurse education. Ireland remains one of the few European countries not to have developed alternatives to the present system of nurse education, or formed links with third level educational institutions for pre-registration nurse education.

5.11 Advances in health services have meant that student nurses are presented with increased amounts of knowledge to be gained and increased work responsibilities in hospitals. Consequently, the disentanglement of the education of student nurses from the requirement to provide nursing services is necessary. Paradoxically, student nurses need to do a great deal of their learning and develop their skills in a clinical setting.

5.12 Fundamental to such debate is the extent to which student nurses should be supernumerary to nurse staffing establishments.

5.13 In the context of any discussions on future patterns of nurse education, the terms generalist and specialist preparation for nursing practice must be focused on. With the current emphasis on a specialist approach, the registration education and training programme is structured to prepare nurses for general, psychiatric, mental handicap and sick children’s nursing in a hospital setting. Public health nursing, nurse teaching or midwifery courses may be undertaken at post-registration level.

5.14 Specialisation at registration, as it currently exists, has several different bases. Some specialise by client group, others specialise more by medical condition of the client group, while others specialise by care setting.
5.15 An alternative model of nurse education as preparation for registration is the generalist approach. In a generalist approach, pre-registration students enter a common programme and study common elements up to the point of registration as a generalist nurse. The student is given a preparation so that once registered, she is able to practice to a specified level of competence across a very wide range of areas and care settings. The nurse can, at a later date, undertake education and training at a more advanced level, if she so chooses.

A FRAMEWORK FOR EDUCATION

5.16 On the basis of specialist and generalist nurse education programmes, the following diagrammatic representations may provide for greater clarity.

MODEL 1

Model 1 is representative of the current specialist type preparation for registration in Ireland. The main thrust of this model is that from the point of entry, students undertake specialist preparation up to the point of registration, with the exceptions of midwifery, which is taken following registration as an RGN, and public health nursing, which is taken following registration as RGN, RM.

![Diagram of Model 1](image1)

MODEL 2

In model 2 all students commence on a common core programme and follow it for a specified time. For a further specified time they undertake a specialist programme up to the point of registration.

![Diagram of Model 2](image2)
MODEL 3

Model 3, the generalist model, consists of a common core programme right up to registration, at which point the nurse can work in any of the health care settings. Further education is provided in the specialist areas beyond the point of registration.

PRE-REGISTRATION PROGRAMME

COMMON CORE PROGRAMME

REGISTRATION

POST-REGISTRATION

EDUCATIONAL ADVANCEMENT THROUGH SPECIALIST AREAS

GENERAL NURSING
PSYCHIATRIC NURSING
SICK CHILDREN'S NURSING
MENTAL HANDICAP NURSING
MIDWIFERY
GERIATRIC
OTHER

FIGURE 21

Models 2 and 3 might be implemented in a variety of educational establishments, with a possible educational award at diploma or degree level.

5.17 The present system of recruitment to nurse training programmes is cumbersome and expensive, both for the recruitment agency and the prospective student nurse, as shown in Section 3.21. Consequently, there is a need to rationalise the recruitment process and make it more cost effective.

5.18 On examining population projections and trends, it becomes clear that demographic factors will shape the age structure in relation to entry to nurse training programmes, with a resulting need for flexibility in recruitment strategies.

5.19 To ensure a more economic model of nurse education and training, a balance will need to be established between the number of nurses being prepared for registration and nursing manpower needs and skill mix.

5.20 In the context of this report and for the purposes of evaluating present or alternative models of nurse education, the fundamental questions are:

1) Does the model of nurse education at pre- and post-registration level develop and support nursing services in accordance with current and future health needs?

2) Is the model of nurse education attractive for student and staff recruitment and retention purposes?

3) Is the model of nurse education efficient and cost effective?

4) Is the model of nurse education acceptable in an educational context?
5) How will the framework for nurse education influence, or be influenced by, the current legislation, the Nurses Act, 1985?

6) Will any alternative to the present model of nurse education be acceptable to, and supported by, the nursing profession, employers and other interested parties?

THE CASE FOR CHANGE

The Review Committee, through this consultation paper, identifies key factors prompting a need for reform in nurse education.

1) The various reports and policies which detail a shift towards the provision of health care in the community and an increased emphasis on health promotion and the prevention of illness.

2) The significant changes and trends in demographic and epidemiological patterns.

3) That nursing services must continue to be cost effective and efficient in the context of changing definitions of health care.

4) The need to rationalise and strengthen the process of nurse education in accordance with European and International developments.

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KEY ISSUES FOR DISCUSSION

1. Forming structures to support centralised applications through a central applications system.

2. A common core programme for all entrants to nursing.

3. Establishing a process of academic recognition for nursing qualifications.

4. Creating structures for nurse education beyond the registration programme.

5. Establishing the status of future students of nursing.

1. FORMING STRUCTURES TO SUPPORT CENTRALISED APPLICATIONS THROUGH A CENTRAL APPLICATIONS SYSTEM

Rationale

i) To co-ordinate, standardise and simplify the dissemination of information and career guidance in nursing.

ii) To eliminate the present level of multiple applications.

iii) To make the process of recruitment more cost effective and efficient.

iv) To reduce the disparity in recruitment procedures.
v) To provide a data base to allow monitoring and profiling of the profession and to provide a basis for manpower planning.

2. A COMMON CORE PROGRAMME FOR ALL ENTRANTS TO NURSING

Rationale
i) To provide a preparatory foundation aimed at educating nurses to deliver care across a broader spectrum of need, both in the hospital and community setting.

ii) To provide nurses with a common and broader perspective on health care issues directly and indirectly concerned with nursing.

iii) To establish a greater understanding and a common professional identity between nurses from the various divisions of the nurses register.

iv) To make optimum use of personnel, teaching resources, recruitment and selection procedures and thus provide a more cost effective model of nurse education.

3. ESTABLISHING A PROCESS OF ACADEMIC RECOGNITION FOR NURSING QUALIFICATIONS

Rationale
i) To improve the academic credibility of nursing with positive implications for the enhancement of the profession.

ii) To augment and expand the paradigms of knowledge in nursing in order to equip nurses for a more diverse, flexible and changing role in health services.

iii) To allow appraisal and authentication of nursing knowledge as it has existed for over 100 years, extend it, develop research mindedness and sensitise the profession to the need for the continuous evaluation of nursing practice.

iv) To provide nurses with a greater opportunity for independent learning, interpersonal development and the development of problem solving skills, through an enhanced academic base.

v) To ensure comparability between Ireland and other European countries.

4. CREATING STRUCTURES FOR NURSE EDUCATION BEYOND THE REGISTRATION PROGRAMME

Rationale
i) To establish a system of professional accreditation and academic validation for current and future courses beyond registration.

ii) To examine the merits of mandatory or statutory continuing education in the profession.

iii) To ensure that educational initiatives for continuing education are cost effective and related to the specific manpower needs of the existing and emerging health services.
5. **ESTABLISHING THE STATUS OF FUTURE STUDENTS OF NURSING**

Any change of status for student nurses requires discussion on:

i) whether student nurses should be supernumerary and, if so, whether they should be supernumerary:
   - in all clinical settings all of the time;
   - in some clinical settings all of the time;
   - in all clinical settings some of the time;

ii) whether they should acquire supervised service responsibilities in the latter period of training;

iii) whether students should be paid grants, bursaries or training allowances;

iv) whether students should be attached to, or be based in, universities or colleges of third level education;

v) given supernumerary status to whatever level, the replacement cost to the health service if the present service contribution of student nurses is reduced;

vi) the practicalities and professional implications of establishing health care support workers as assistants to nursing services in part replacement of the loss of student employment;

vii) the effect on recruitment of changing the status of nurse education.