

National Council for the Professional  
Development of Nursing and Midwifery

# Agenda for the Future Professional Development of Nursing and Midwifery

May 2003



*National Council for the  
Professional Development  
of Nursing and Midwifery*

*An Chomhairle Náisiúnta d'Fhorbairt  
Ghairmiúil an Altranais agus  
an Chnámhseachais*

## Mission Statement of the National Council

The Council exists to promote and develop the professional role of nurses and midwives in order to ensure the delivery of quality nursing and midwifery care to patients/clients in a changing healthcare environment.

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# Foreword

The National Council is pleased to publish this report, which aims to review the implications of health policy and stimulate debate regarding the future professional development of nursing and midwifery.

Major change and reform are planned for the Irish health services. The current *Health Strategy* is centred on a whole-system approach to tackling health in Ireland. It involves every person and institution with an influence or role to play in the health of individuals, groups, communities and society at large. In order to achieve the objectives of the *Health Strategy* it is likely that there will be a need for significant structural reform. These issues are to be addressed in the forthcoming *Prospectus Report* commissioned by the Department of Health & Children. The financing of the health services is also the subject of a root and branch review, the outcome of which will be published in the *Brennan Report* commissioned by the Minister for Finance.

The *Health Strategy* is particularly relevant to the development of nursing and midwifery services, which comprise the largest group of staff in the health services. Nurses and midwives are the first point of contact for many to the health system, and care is provided over a 24-hour period, 7 days per week.

The integration of services is key to a strong health system and there is a need for greater interdisciplinary working.

The *Report of the Commission on Nursing*, published in 1998, put forward a framework for the further development of nursing and midwifery, emphasising that nursing and midwifery were among the cornerstones of the modern Irish health service. Significant change has already been implemented, and the National Council recognises the need for continued strategic direction for the future, so that nurses and midwives can contribute significantly to positive health for the nation.

To this end, the National Council has prepared this report, which is intended to benchmark progress to date and set the agenda for a debate on options, direction and action for the future. An evaluation of the role of the CNS/CMS and the introduction of the role of the ANP/AMP will be undertaken later this year.

The preparation of this report has been made possible as a result of the generous and committed participation of nurses, midwives and stakeholders throughout the country. The National Council is very appreciative of their inputs. In addition, I wish to record particular thanks to my colleagues, Kathleen MacLellan, Head of Professional Development; Professional Development Officers, Christine Hughes, Mary Farrelly, Georgina Farren and Jenny Hogan; and Project Officers, Ruth Maher and Sheila Doyle.

Yvonne O'Shea  
Chief Executive Officer



# Introduction & Methodology

This report on the professional development of nursing and midwifery reviews general, sick children's, psychiatric, mental handicap and gerontological nursing and midwifery. Developments in public health nursing are being considered by the forthcoming *Strategy for Nursing and Midwifery in the Community*, which is being developed by the Nursing Policy Division of the Department of Health and Children (DoHC) and therefore only a brief overview of the role of the public health nurse is provided.

Our aim is to stimulate debate, building on the achievements of nurses and midwives, in a way that gives tangible support to the objectives for a quality health service as outlined in the *Health Strategy* (DoHC 2001a).

Ireland faces major health challenges. The mortality rate in Ireland is higher than the EU average. Circulatory diseases, respiratory diseases, cancer, mental health problems and accidents continue to be the principal causes. Population growth is set to continue and the demographic profile is of an increasingly ageing population. There are social inequalities including significantly higher mortality rates for people from lower socio-economic groups.

Important changes are taking place in the public's expectations of the health services. In addition, patients/clients are discharged from hospitals early, and responsibility for continued care is shifting towards the community.

These and other issues outlined in this report form the changing environment within which nursing and midwifery moves forward, both professionally and in terms of individual career development. There is enormous opportunity for nurses and midwives to enhance their contribution. It is a time for assessment, evaluation and informed debate about the future.

In preparing this report, a comprehensive and representative consultation process was carried out nationally by the National Council. This took place from March 2002 to March 2003. Workshops were held with Directors of Nursing and Midwifery, Directors of the Nursing and Midwifery Planning and Development Units, and nurses and midwives from all divisions of the register. Submissions were called for and 105 were received (Appendix 1).

The National Council is grateful for the time spent by many individuals and groups, who provided valuable information in relation to the development of the professions. Staff of the National Council conducted extensive literature reviews to provide a picture of the evidence and experience of nurses and midwives.

## Submissions

Submissions were called for via the National Council's Newsletter and Website, communication with all Directors of Nursing and Midwifery, Directors of the Nursing and Midwifery Planning and Development Units and key stakeholders.

## Workshops

Twenty-two workshops were held, with 843 nurses and midwives attending. Participants were asked to consider:

- Current issues
- Future developments in nursing and midwifery
- Structures and supports necessary
- New roles for nursing and midwifery

## Meetings

Twenty meetings were held with key stakeholders to consider future developments in nursing and midwifery.

## Health Policy

Current health policy reports were considered in light of their implications for nursing and midwifery. An index of the major policy reports is provided in Appendix 2.

## Structure of the Paper

The Executive Summary identifies the major themes emerging from the report in relation to continuing professional development, education for practice and research, and gives a synopsis of discussion points that provide the agenda for future development.

The paper comprises seven sections:

- **Section 1 - General Nursing**
- **Section 2 - Midwifery**
- **Section 3 - Psychiatric Nursing**
- **Section 4 - Sick Children's Nursing**

- **Section 5 - Mental Handicap Nursing**
- **Section 6 - Gerontological Nursing**
- **Section 7 - Public Health Nursing**

Each section contains a brief history, an overview of demographic and epidemiological issues and a review of current developments and key issues. An agenda for future development specific to each area of practice is included at the end of each section.

# Executive Summary

# Agenda for Future Development

The important issues raised in this report set the agenda for the consideration and careful strategic planning of future developments in nursing and midwifery. Nursing and midwifery leaders must provide the framework for the future at national, regional and local levels.

Nurses and midwives face the challenge of embracing new methods of care delivery that will provide a quality service that is truly people-centred – an approach that underpins the current *Health Strategy*.

Key policy reports are shaping the health services. Currently the *Health Strategy*, the *Primary Care Strategy* and the forthcoming *Report of the National Task Force on Medical Staffing* are among the most important.

## Continuing Professional Development

Continuing professional development (CPD) is a lifelong process, which includes both structured and informal activities that may include formal education programmes, participation in journal clubs, case-conferencing, clinical supervision, learning sets, preceptorship, mentorship, workshops, distance learning programmes and reflection on practice. CPD encompasses processes, activities and experiences that contribute towards the development of a nurse or midwife, both personally and professionally.

CPD emerges as the predominant issue in this paper. Since the publication of the *Report of the Commission on Nursing* in 1998, there has been considerable progress in providing CPD for nurses and midwives in Ireland.

The third-level education sector has established higher diploma/postgraduate programmes in specialist areas of nursing and midwifery practice, and more nurses and midwives are undertaking degree-level study. Healthcare organisations have linked with the education sector to provide higher diploma/postgraduate programmes, and have expanded their in-house education. The initial development of the centres for nurse education has occurred.

The DoHC has provided funding for undergraduate and postgraduate programmes. The National Council has contributed to CPD for nurses and midwives by funding a wide range of initiatives. The focus now is on how CPD resources can best enhance roles in order to support quality health services.

## Participation in CPD

Nursing and midwifery practice involves a team effort, in which everyone makes an active and effective contribution. It follows from this that, if CPD represents an investment in

the quality of care delivery, then it needs to be directed at all nurses and midwives.

This report shows that there are often barriers to participation. Among the obstacles to involvement in CPD activities are: distance from centres providing education programmes, limited opportunities to leave the workplace because of staff shortages, working part-time or on permanent night-duty, lack of encouragement from managers and lack of available places.

In the consultation process, nurses and midwives described staff being sent to study days and in-service training events on an *ad hoc* basis, rather than through professional development needs analysis.

Costs, and particularly replacement costs, were cited as a significant barrier to obtaining study leave. Distance problems were frequently mentioned, as well as the importance of local support on return to a clinical area following participation in CPD. Provision of education for specific disciplines of nursing is restricted. The diverse settings for clinical practice also affect the provision of CPD.

These kinds of obstacles have prompted more flexible approaches, such as primary degrees in nursing through distance learning, and the e-learning programme on the assessment of nursing students' competencies, developed by An Bord Altranais. The education programme associated with the review of nurses and midwives in the prescribing and administration of medical products project contains some elements of distance learning.

A number of higher diploma/postgraduate distance learning initiatives are planned. The provision of flexible learning needs to continue, with a greater range of open learning packages. CPD needs to adapt to the working arrangements of nurses and midwives with, for example, weekend or evening teaching, on-site teaching in practice settings and interagency co-operation to provide shared programmes.

## Intra- and Inter-disciplinary CPD

The *Health Strategy* emphasises the need for integrated healthcare provision and for initiatives that promote relationships between healthcare professionals. This report indicates that there is an extent to which nurses and midwives, registered in different divisions of the register,

share the same needs for CPD. This is widely recognised and many educational programmes, from in-service to higher/postgraduate diploma level, involve mixed participation by nurses and midwives. Some undertake educational programmes alongside professionals from other healthcare disciplines such as medicine, occupational therapy and physiotherapy.

Intra- and inter-disciplinary education programmes are mainly provided in the third-level education sector, on subjects such as healthcare management, health promotion, primary healthcare and psychotherapy. There is also an increased level of in-service interdisciplinary CPD, for example in basic and advanced cardiac life support, electro cardiograph interpretation, counselling skills and stress management.

There will be additional opportunities for intra- and inter-disciplinary and education as departments of nursing and midwifery become more established in the third-level education sector, and the centres of nurse education are further developed.

### Needs Assessment for CPD

In an environment that promotes cost effectiveness, the provision of CPD must be driven both by the learning needs of nurses and midwives and by health service and patient/client needs. Effective assessments of need in relation to CPD for nurses and midwives should take account of the following issues.

Patients/clients, service managers, other professionals and educators have viewpoints on the needs that CPD should address. This suggests that CPD needs should be prioritised on the basis of consensus between a range of participants, with nurses and midwives taking account of the services within which they work.

A systematic approach to needs assessment for CPD could form part of a process of quality assurance. CPD would be an aspect of an integrated response to rectifying deficits in the quality of service. In particular consideration should be given to the cultural diversity of the workforce and the users of the service.

### Impact of CPD

The benefits of CPD tend to be described in terms of personal development – working through problems related to work, and improving the knowledge base of staff, and thereby improving the quality of nursing and midwifery care.

There is a dearth of evidence that demonstrates the positive impact of CPD on nursing and midwifery care. This indicates a need to move beyond traditional evaluations and take a more rigorous approach to evaluating the outcomes of nurses and midwives CPD in terms of patient/client care so that CPD programmes are developed which will have a positive impact on patient/client care.

### Harnessing the Potential of CPD

This report indicates that the effectiveness of CPD is heavily influenced by the extent to which participants' learning is

reinforced within practice settings. But some nurses and midwives have had mixed experiences regarding the extent to which their acquisition of knowledge and skills is valued by their colleagues and managers.

Attention needs to be given to how the knowledge and skills acquired by nurses and midwives through CPD, can be harnessed within their healthcare organisations. This concept was well supported in the consultation process.

Part of the answer is to involve managers, nurses and midwives in a collaborative approach to the planning of CPD. For example, managers can negotiate with staff regarding learning outcomes that are relevant to the needs of the practice setting. Other approaches, such as clinical supervision, may also help to maximise the impact of CPD on the organisation.

The desire to establish formal performance review systems was a recurring theme throughout the consultation process, and was linked with career development and progression, as well as competence development. CPD should, therefore, be viewed as a partnership process between all stakeholders.

The personal development needs of individual nurses and midwives are important, but CPD is more likely to be effective if it is consistent with, and informed by, the direction of care delivery within the practice setting.

### Education for Practice

This report highlights the need for appropriate nursing and midwifery skill mix in all areas of practice. Caregivers must have the skills and competencies necessary for practice. The consultation process highlighted some of the difficulties in relation to such competencies from the current organisation of programmes for registration.

There are three programmes with direct entry leading to registration: general, psychiatry and mental handicap nursing. In order to register as a sick children's nurse, it is necessary to be a registered general, psychiatric or mental handicap nurse. Only upon registration in any of these disciplines, can a nurse undertake a post-registration education programme in paediatrics. Currently, prior registration in general nursing is necessary to pursue midwifery. There is a three-year direct entry pilot midwifery education programme in process that is scheduled to conclude on 31st May 2003. A psychiatric nurse who wishes to pursue general nursing must undertake the four-year degree programme in general nursing, and vice versa. These issues may deter nurses and midwives taking further study to gain entry to other divisions of the register. There is merit in some areas of practice for dual-qualified nurses. For example, a nurse registered in both psychiatry and general nursing may have the appropriate skills for dealing with patients/clients with a mental illness in the emergency department. Similar issues in relation to mental handicap nursing were described in the consultation process.

Post-registration education provision should be flexible, and developed in modular frameworks where possible, to facilitate transferability, transparency and credit accumulation.

The difficulty in gaining accreditation for prior learning was mentioned frequently in the consultation process.

While there are difficulties for third level institutions in accrediting prior learning, consideration must be given to supporting those nurses and midwives who wish to continue their CPD.

Education for advanced practice presents unique difficulties given the diversity of domains, with small numbers likely to emerge. The challenge is how to encourage and support an equitable geographic spread of courses and access to courses.

## Research

For nurses and midwives, professional guidelines from An Bord Altranais state that the best available evidence underpins care. This means that nurses and midwives must engage with research evidence on a number of levels. For the vast majority of nurses and midwives, this engagement will consist of interpreting and implementing, where appropriate, the research conducted by others. To this end, a supportive framework is being developed under the guidance of the *Research Strategy for Nursing and Midwifery in Ireland*. However, some nurses and midwives will need to undertake research to further develop the knowledge base for practice in Ireland. For example, this is explicit for the Advanced Nurse Practitioner/Advanced Midwife Practitioner (ANP/AMP) role and will provide an evidence base for further development of that role. For those practising in roles other than ANP/AMP, and wishing to participate in the generation of knowledge for practice, the Strategy specifically recommends the development of a flexible career pathway incorporating research on a full-time, part-time or joint appointment basis.

Cognisance should be taken that nurses and midwives integrate and interface with other health professionals and service providers. They, too, must engage with research, so that decision-making and planning will be underpinned by evidence, as the *Health Strategy* envisages. Nursing and midwifery must be involved with multidisciplinary research, and act as the collaborative partners in the research process, if the quality of service is to be enhanced.

## General Nursing

The changes in population, and the health needs of the nation have all challenged general nursing. The population of Ireland continues to increase, the birth rate is rising, life expectancy increasing, older people will form a larger portion of the total population and migration trends are rapidly reversing.

Epidemiological and globalisation trends are major influences on the profile of health service users. General nurses should have a higher awareness of, and exposure to, information on health trends in the population, including demographic and epidemiological trends.

The role of nurse managers and Nursing Practice Development Co-ordinators (NPDCs) are key roles within service development, and continued investment in their CPD is needed. General nursing should be more proactive and more directly involved in policy development.

Team working is the pillar that supports quality service delivery. Investment in team working should take the form of

intra- and inter-disciplinary CPD and local facilitation.

In relation to the clinical career pathway, there should be generalists, specialists and advanced practitioners practising across all areas of general nursing, where there is an identified health service need.

There should be a competency-based approach to the professional development of generalist nurses, which allows for the development and enhancement of roles, within which the generalist is supported. There is a need for education programmes at higher diploma/postgraduate level, which support medical and surgical nurses.

The role of the Clinical Nurse Specialist (CNS) should be developed in a way that supports the role of the generalist. Improved career guidance for general nurses is needed and approaches towards supporting role transition need to be developed. Examples of potential CNS roles and nurse-led services include minor injuries, pre-surgical assessment, and chest pain assessment.

Role expansion, not extension, needs to occur to support holistic approaches to care management.

Increased involvement in research is needed, and methods for the implementation of audit of practice need to be developed.

## Midwifery

Demographic changes have implications for maternity care and midwifery practice. Statistical trends indicate that there is an increase in the core childbearing age group and an increase in the number of births. Therefore more women are potential users of the maternity services. Midwives need to recognise and overcome the barriers to providing women with alternatives to medicalised care, i.e., lack of acknowledgement of the role of the midwife within private insurance schemes, maternity services policies not informed by evidence-based research or by bodies such as the World Health Organisation (WHO), lack of collaboration among professionals in the maternity services and failure to recognise midwives as professionals capable of and responsible for the safe and effective care of healthy pregnant women.

In order to sustain and build on the existing models and potential of maternity care, midwives must work in partnership with women, and with other relevant professionals, to help ensure a quality service and a wider choice of care options for women and their families throughout the country. Maternity services should demonstrate in their policies and practices the underpinning philosophy that pregnancy is a normal physiological process. Development of midwife-led care, and team midwifery in hospitals are important for maternity care and for the profession. The community role of the midwife needs to be enhanced and more midwife-led antenatal clinics developed. Midwives should also be involved in policy formulation service review and planning.

There are issues within specialist and advanced midwifery practice, that require further examination and debate, and this will help to ensure that, ultimately, these roles will improve the quality of midwifery practice and the care received by childbearing women.

## Psychiatric Nursing

It is estimated that, at some point in their lives, one in four adults will suffer from mental illness and that 25% of families are likely to have at least one member suffering from a mental illness.

Much development of structures has taken place within the mental health services and psychiatric nurses have been key personnel in implementing the changes.

In maximising the psychiatric nursing contribution to mental healthcare, a number of key issues emerge.

Psychiatric nursing intervention skills require continued development, particularly in relation to chronic and enduring mental illness, and outcome evaluation is an important component of this development.

The continued development of CNS roles regionally will enhance the quality and uniformity of service offered to patients/clients. The development of new roles, both CNS and ANP, should take place in relation to patient/client need, health policy and the core values of psychiatric nursing.

Easier and direct access to psychiatric nursing services is required to improve service quality and ease of access for the public.

There is much room for development in post-registration psychiatric nursing education. Flexible frameworks are required that allow for curriculum development in line with service need and ease of access for participants.

The main emphasis of the mental health services at present is on secondary and tertiary care. The need for the mental health services to become more involved in primary prevention is clear and psychiatric nurses have a major role to play in this area.

## Sick Children's Nursing

Ireland has the highest proportion of children in the birth to fourteen-year age group in the EU. Given the current causes of morbidity and mortality for children in Ireland, paediatric nurses need to embrace health promotion, including healthy lifestyles, and disease prevention at all levels of care.

The outcome on the discussions on the future of a direct entry paediatric education programme is still awaited.

The development of the *Strategy for Nursing and Midwifery in the Community* will be welcomed, and it is anticipated that it will result in the integration of paediatric nursing services in the community.

Practice development in paediatrics will be important to support developments in care both at primary, secondary and tertiary level.

There is a need to increase the number of CNS roles in response to identified health service needs outside the major centres. Suggested CNS posts include: pain management, neonatology, breastfeeding, community, adolescent care and health promotion. However, while suggesting these areas for CNS posts, there is also a need to fully assess service need.

Promotion of healthy lifestyles, particularly in relation to diet, physical activity, smoking, alcohol and substance abuse falls

within the scope of paediatric nursing practice, and is being further developed in paediatric nurse education programmes for the future.

Potential areas for ANP development are: primary care, accident and emergency (A&E), dermatology, respiratory medicine, community paediatrics, cardiology, pain management, gastroenterology, human immuno virus (HIV), haematology/oncology, hepatology, endocrinology and diabetes management.

## Mental Handicap Nursing

The overall prevalence of mental handicap internationally is between 1% and 3% of the population. In April 2000 there were 26,760 people registered on the National Intellectual Disability Database (NIDD), with a prevalence of 7.38 per 1,000 of the total population. There is a changing age profile, with fewer children and more adults availing of, or in need of, mental handicap services. Mental handicap nursing practice and role development should be driven by client-need.

A key issue is the need for greater integration of mental handicap nursing into the main body of the nursing profession, while at the same time retaining its distinct identity. The benefits of integration include the potential to draw upon the resources available to nurses in terms of clinical practice, research and other evidence, and access to supports for ongoing professional development.

The Registered Mental Handicap Nurse (RMHN) should continue to deliver direct specialised nursing care in a changing healthcare environment. At the same time, RMHNs need to respond to the lack of role clarity, especially where they do not work in settings with traditional hierarchical structures. There is a need for more evidence and research to demonstrate the outcomes of mental handicap nursing, which may help to clarify roles and underline the value of the generalist mental handicap nurse in intellectual disability (ID) services and service provision.

There is a need for more equitable access to continuing education within the third-level sector, and a need for flexible programmes that address the needs of RMHNs and people with ID. There is also a need for appropriate and responsive in-service education.

More detailed information is needed in relation to where RMHNs are employed in order to assist in workforce planning, take a strategic approach to providing opportunities for CPD, and facilitate realistic individual career planning.

Strategies need to be developed for raising the profile of RMHNs among, and collaborating with, other nurses in mainstream services, such as Public Health Nurses (PHNs), practice nurses, other community-based nurses, and health and social care professionals.

Development of specialist and advanced mental handicap nursing practice should be based on an approach that is evidence-based and best suited to the needs of the client population. Development of the CNS role in mental handicap nursing offers opportunities for enhancement of community ID services.

## Gerontological Nursing

The demographic and health profile of older people poses many challenges in terms of planning for appropriate services. The population is ageing and, after the year 2006, the number of older people is expected to increase more rapidly.

Older people are major users of the health and social services. Regardless of the varied care settings in which gerontological nursing is practised, the central focus of care should be older people and their families, with an emphasis on health promotion and prevention of illness.

There is a need for a refocus on the health promotion and primary prevention aspects of the nursing role. One of the major challenges to gerontological nursing is a perceived lack of prestige attached to caring for older people. The multidisciplinary nature of care provision for older people is important.

There is a need to develop both CNS and ANP posts in gerontological nursing in response to health service need. In addition, older people are cared for across all care settings and additional skills and expertise are required to ensure effective care. Care of older people offers opportunities for nurse-led services.

The importance of the nurse in all settings, understanding age-related issues, especially in smaller community and district hospitals, should be acknowledged and a competency-based approach to professional development introduced.



# Glossary

A&E	accident and emergency	NHS	National Health Service (UK)
AIDS	acquired immuno deficiency syndrome	NIDD	National Intellectual Disability Database
AIMS	Association for Improvements in the Maternity Services	NMPDU	Nursing and Midwifery Planning and Development Unit
AMP	Advanced Midwife Practitioner	NPDC	Nursing Practice Development Co-ordinator
ANP	Advanced Nurse Practitioner	NWHB	North Western Health Board
BUPA	British United Providence Association	NUI	National University of Ireland
CCU	coronary care unit	OHM	Office for Health Management
CHF	chronic heart failure	PHN	Public Health Nurse
CNE	Clinical Nurse Educator	RMHN	Registered Mental Handicap Nurse
CNM	Clinical Nurse Manager	RCN	Royal College of Nursing (London)
CMM	Clinical Midwife Manager	RGN	Registered General Nurse
CMS	Clinical Midwife Specialist	RPN	Registered Psychiatric Nurse
CNS	Clinical Nurse Specialist	RSCN	Registered Sick Children's Nurse
CPD	continuing professional development	SARS	severe acute respiratory syndrome
CPR	cardio-pulmonary resuscitation	UK	United Kingdom
CSO	Central Statistics Office	UKCC	United Kingdom Central Council for Nurses, Midwives and Health Visitors
DATHs	Dublin Academic Teaching Hospitals	UN	United Nations
DPT	diphtheria, pertussis and tetanus	USA	United States of America
DoH	Department of Health	VHI	Voluntary Health Insurance Board
DoHC	Department of Health and Children	WHO	World Health Organisation
DOMINO	Domiciliary Care In and Out of Hospital		
DSIDC	Dementia Services Information and Development Centre		
ECG	electrocardiogram		
EEC	European Economic Community (now the European Union)		
ENT	ear, nose and throat		
ESRI	Economic and Social Research Institute		
EU	European Union		
FIGO	International Federation of Obstetrics and Gynaecologists		
FRASE	Fall Risk Assessment Scale for the Elderly		
GP	General Practitioner		
HIB	haemophilus influenzae type B		
HIV	human immuno virus		
HSEA	Health Services Employers Agency		
ICM	International Confederation of Midwives		
ICP	integrated care pathway		
ICU	intensive care unit		
ID	intellectual disability		
MMR	measles, mumps and rubella		
NCNM	National Council for the Professional Development of Nursing and Midwifery		
NEHB	North Eastern Health Board		
NFVB	National Federation of Voluntary Bodies (Providing Services to People with Mental Handicap)		



# General Nursing

## 1.1 Introduction

This section gives an overview of current developments in general nursing in Ireland. To provide context, the history, major national health and nursing strategies, policies and current issues in Irish nursing relevant to general nursing are reviewed. These provide the backdrop to a review of further developments in general nursing and subsequent professional development needs. This section describes progress to date and reviews opportunities for further development, particularly career opportunities for those working in general medical and surgical wards.

## 1.2 History

The first legislation to govern nursing in Ireland, *The Nurses Registration Act 1919*, established a register of general nurses. *The Nurses Acts 1950, 1961, and 1985* retained this register, and these acts formalised the authority under which general nurses could practice. Over fifty thousand nurses (50,088) have registered general qualifications on the live register (An Bord Altranais 2003a). A new Nurses Act is being prepared, which will take account of the recommendations of the *Report of the Commission on Nursing* (Government of Ireland 1998). With the establishment of the National Council for the Professional Development of Nursing and Midwifery in 1999, the clinical career pathway for the general nurse (from staff nurse to Clinical Nurse Specialist to Advanced Nurse Practitioner) was formalised.

General nurse training has seen much development and increasing academic recognition, and pre-registration education for entry to the register is now at degree level. There has also been progress in continuing education (Condell 1998). For those wishing to work in a specialist area within general nursing, post-registration courses are available (DoHC 2002a).

### 1.2.1. Policy Context

The role of the general nurse in the health service has been determined by the development of social policy, the health of the nation, new technologies and public health laws and regulations. Given that general nurses comprise the largest proportion of all nurses, their role and functions are varying and diverse. General nursing extends across a broad range of care settings, including critical care, emergency, medicine, surgery, oncology, palliative care, endocrinology, gastroenterology and genito-urinary medicine. General nursing care is provided across acute hospitals, the community, long stay areas and day care. This has led to the development of diverse competencies and it has also presented major challenges in providing post-registration education and developing a career path for general nurses.

The *Report of the Commission on Nursing* (Government of Ireland 1998) provided a framework for the development of general nursing in the context of changes in the health services, their organisation and delivery. A significant number of its recommendations have already been implemented, such as the commencement of the pre-registration degree programme with full integration into third level education, the initial development of the centres for nurse education and the processes for the clinical career pathway.

As a result of recommendations made by the Commission, a number of new bodies have been set up, including the National Council for the Professional Development of Nursing and Midwifery, the Nursing Policy Division in the Department of Health and Children and the Nursing and Midwifery Planning and Development Units. These, in partnership with the relevant stakeholders, are providing strategic and professional guidance to steer the profession through future policy developments that will have a direct influence on how general nurses will deliver their service.

The *Health Strategy* (DoHC 2001a) marks a decisive move away from a short term and therefore limited approach to planning healthcare provision. Major reform is planned in primary care, acute hospital care and continuing care services. National treatment protocols are expected to ensure uniform, high quality care and planning, and mechanisms for the funding and delivery of health services are expected to be more transparent. The *Health Strategy* (DoHC 2001a) forms the context within which nursing development will occur.

The forthcoming *Report of the National Task Force on Medical Staffing* will devise an implementation plan for reducing the average working hours of non-consultant hospital doctors to meet the requirements of the European working time directive. The Chief Nurse in the Department of Health and Children has convened a Nursing and Midwifery Steering Group to review the Report's implications.

**Relevant Policy Development:** The *Cardiovascular Strategy* (DoHC 1999a) specifically cites nurses as having an

opportunity to be more proactive in health promotion and cardiac rehabilitation. The *Health Promotion Strategy* (DoHC 2000a) recommendations refer to practice nurses in the management of cardiovascular disease, nurses as health promoters and the importance of sexual health programmes. The *Report of the National Advisory Committee on Palliative Care* (DoHC 2001b) refers to specialised nursing care for patients/clients and access to palliative care for people with non-malignant disease. The *National Drugs Strategy* (Department of Tourism, Sport & Recreation 2001) provides a plan for the improvement of the health and well being of drug misusers.

The forthcoming *Strategy for Nursing and Midwifery in the Community*, in conjunction with the *Primary Care Strategy* (DoHC 2001c), will provide a new direction for delivering nursing and midwifery care in the community.

The Nursing and Midwifery Prescribing Project is reviewing the role of nurses and midwives in the prescription and administration of medicinal products and will provide future direction in relation to medicines management for general nurses. This is a three-year joint project of the National Council and An Bord Altranais, which commenced in September 2001.

**Recruitment and Retention of Nurses:** There have been some difficulties filling nursing posts within the general nursing services in Ireland, which reflects a worldwide shortage of nurses. The mean annual turnover rate of nurses in Ireland in 1999 and 2000 was 12%, and 10% in 2001 (DoHC 2002a). Nine factors have been identified which affect turnover (McCarthy *et al* 2002a). These are:

- Job satisfaction
- Decision-making
- Communication and participation
- Justice and promotion
- Promotional opportunities
- Facilitation of CPD
- Variety/routine/repetition
- Quality of working life and
- Perceived status.

A number of recruitment and retention initiatives have been recommended including CPD, induction programmes, return to practice programmes, increasing permanent contracts, flexible working hours, crèches, and participation in committee work (DATHs 2000). The implementation of the recommendations of *Towards Workforce Planning* (DoHC 2002a) will be critical in ensuring that such initiatives continue.

**Healthcare Assistants:** The *Report of the Working Group on the Effective Utilisation of the Professional Skills of Nurses and Midwives* (DoHC 2001d) provides for the training of healthcare assistants, which is intended to contribute toward the maximisation of the professional skills of nurses and allow nurses to spend more time in direct patient/client care.

**The Scope of Nursing and Midwifery Practice Framework:** The scope of nursing practice is defined as "the range of roles, functions, responsibilities and activities which a registered nurse is educated, competent and has authority to perform." (An Bord Altranais 2000a). The framework was developed following consideration of national and international developments in nursing practice and its aim is to support nurses in the expansion of their scope of practice.

**Accreditation:** The Accreditation Scheme, under the auspices of the Irish Health Services Accreditation Board, provides Irish health agencies with a mechanism to objectively assess and measure their performance against an agreed set of standards. These standards will apply to all areas of a hospital, from theatres and laboratories to staff facilities. Eleven of the largest hospitals have joined the scheme to date.

### 1.3 Demographic and Epidemiological Issues

The population of Ireland has been increasing steadily since the early 1990s, and is currently 3,917,336 (CSO 2003a). This increase is expected to continue. The birth rate is rising, life expectancy has increased, older people will form a larger portion of the total population and migration trends are rapidly reversing. It is expected that in the future, 10,000 – 11,000 people will seek asylum annually.

The greatest causes of mortality in Ireland are circulatory disease (45%), malignant neoplasms (24%), respiratory diseases (15%), and injuries and poisonings (4%) (Institute of Public Health in Ireland 2001).

The Economic and Social Research Institute's Report (2002) on activity in acute public hospitals in Ireland (1990–1999), states that 800,000 discharges were treated in 1999, an increase of over 40% since 1990. Much of this may be attributed to reductions in the length of patient/client stays and in the increased number of day beds in hospitals, which has resulted in increased use of day services. In 1999, one-third of all discharges were treated on a day basis, compared with just one in ten discharges in 1990.

Global trade and travel, global warming and migration trends mean that new infectious diseases/syndromes such as Severe Acute Respiratory Syndrome (SARS) will emerge; others, such as tuberculosis will re-emerge. New commuter towns, and the subsequent loss of community support have a detrimental effect on both the upbringing of young children and on support for the elderly (DoHC 2001e).

The *National Health and Lifestyle Surveys* (Friel *et al* 1999) reported that 32% of adults were overweight, that exercise was likely to decrease with age and that most adults consumed alcohol, with approximately one in four exceeding the recommended weekly limits for sensible drinking. Lower socio-economic groups tended to have less healthy lifestyles. The survey was repeated in 2002, and reported that rates of obesity had increased by 3%. Although the percentage engaging in physical exercise had improved in some age groups, there was a strong inverse trend according to educational status at all ages and that there were only modest drops in rates of smoking (Kelleher *et al* 2003).

Collecting relevant demographic and epidemiological data

can help shape service needs. This is demonstrated in initiatives such as *People Living in Tallaght and Their Health Report* (Long *et al* 2002). The Adelaide Hospital Society conducted a cross-sectional survey among people living in Tallaght concerning their health needs. The report proposes a model for how local health needs assessment might be adopted throughout the health services to address the *Health Strategy's* requirement to base decisions on the best available evidence (DoHC 2001a). For example, it highlighted that non-nationals occupy 6% of households, which showed a need for confidential translation facilities in the health service.

In order to provide a solid basis for evidence-based policy and decision-making, there is a need for the ongoing and systematic collection of reliable data on demographic trends such as mortality rates, morbidity rates and population figures, all of which have a direct impact on the general nursing environment. The nursing profession needs to examine skill mix, measure levels of dependency and review clinical skills and competencies in order to respond to the changing demographic and epidemiological picture. In the past, this has been reactive: today, the profession can be proactive, armed with the relevant data and be more confident in addressing patient/client needs in tandem with its own professional developmental needs.

## 1.4 Current Developments

Those who participated in the consultative process saw a need for a standardised coherent approach to the progression of specialisation and the continued development of a clinical career pathway for general nursing. In relation to consolidation of the career pathway, a recurring theme was the need for action in developing, supporting and valuing the role of the generalist nurse and a need to give particular attention to medical and surgical nurses.

### 1.4.1. Clinical Career Pathway

Consolidation of the clinical career pathway was welcomed. There were concerns about the roles of the CNS and ANP and their relationship with generalist nurses. Some referred to 'over-medicalisation' of general nursing roles and the need to ensure that recent developments value basic or fundamental nursing care. That said, expansion of the generalist nurse role and the introduction of CNS and ANP roles were welcomed by general nurses. A more coherent approach to the development of intra-professional relationships was seen as needed to ensure effective teamwork among nurses.

Savage (1998) states that failure to recognise and acknowledge clinical nurses' skills and expertise may result in de-skilling and this could occur across the career pathway with the introduction of new roles such as CNSs and healthcare assistants. General nurses were concerned about de-skilling and wanted clarification about the nature of the relationship between the generalist and CNS.

On de-skilling, Marshall (1998) states that part of the problem manifests itself as conflict, where the specialist is perceived to be, or acts as, a judge of the care that ward staff are giving. Conflict also arises when the specialist makes all the decisions regarding a specific area of patient/client care, is

autocratic and keeps the knowledge to him/herself, resulting in the abdication of care by the generalist. Marshall suggests that specialist nurses (or ANPs) need to collaborate and demonstrate the efficacy of the contributions that they can make to the quality of patient/client care, as well as to the professional development of the generalist nurse, without taking over the care, and emphasises the importance of change management and interpersonal skills.

The National Council regards education, training and consultancy as core concepts of both the CNS and ANP role (National Council 2001a, 2001b). It is evident from the consultations that, while these concepts have been embraced, and work well in some areas, further development is needed.

### 1.4.2. Generalist Practice

Role ambiguity was described across the career pathway. There are clear definitions in relation to CNSs and ANPs (National Council 2001a, 2001b). However, definition of the terms 'general' or 'generalist' nursing requires clarification and debate. Castledine (1996) goes so far as to suggest that this debate is the key to the future role of the nurse. The terms 'general' and 'generalist' are used interchangeably in the literature and there is little published literature focusing on the term 'generalist' (Marshall 1998).

Various interpretations of 'generalist' practice are described in the literature and from the consultative process. It was suggested that generalist practice in general nursing is that which occurs in medical and surgical wards, as opposed to areas traditionally considered specialist, e.g., ICU, A&E, and operating theatres. Alternatively, it was proposed that nurses can enter an area of specialisation (such as medicine, surgery and ICU) but enter it as a generalist. Generalist practice is described as distinct from 'specialist' and 'advanced' practice and is seen as the foundation upon which a career pathway towards specialist and advanced practice will be sought. Dowding *et al* (in press) describes significant differences between the practice of medical nurses and the practice of surgical nurses, which demonstrates the effect that context has on the role of the nurse, albeit in areas both considered traditionally 'generalist'.

Working in a speciality does not render one a specialist (Government of Ireland 1998) or, as Castledine (2002) puts it, working in a speciality does not equate with higher-level practice.

This raises questions about the appropriate use of the terms 'generalist' and 'general'. What is the actual career pathway for a generalist and is it possible to be a generalist practising in a speciality? There is a sense that the term 'general nursing' is too limited. Similar conclusions have been made in the United Kingdom, where terminology includes 'Adult Nursing', 'Acute Adult Nursing', and 'Acute Secondary Care Nursing'. However, none convey the breadth and diversity of general nursing in Ireland.

Castledine (1998) is emphatic in his belief that it is from the generalist domain that all nursing practice evolves, making it the fundamental basis of all nursing care. This could be interpreted in the Irish context that, for general nurses, generalist practice forms the basis of care. This equates to

comments made in the consultation process about ‘the pivotal role’ of the generalist and the need for ‘up-to-date clinically competent staff in all areas’. This does not in any way detract from the value and importance of CNS and ANP roles, but simply underlines the need to invest in the generalist nurse and clarify and define the role and the future of the role.

Due to the increased complexity in healthcare, changing health needs and health policy, structural changes and new technologies, new specialities are emerging, such as ambulatory care, medical assessment and stroke care (Wood 2000). Thus, the boundaries of traditional specialities are now blurred.

This may be true of the continued perceptions of what are traditionally considered the location for generalist practice, e.g. medical and surgical units. There has been a rapid sub-specialisation in medical and surgical practice. In addition, the much publicised effects of bed shortages in acute hospitals suggests that a more diverse group of patients/clients are being admitted outside their specialities, and that this clearly has an effect on the way in which these patients/clients are nursed and by whom.

The location of the delivery of nursing care is, in itself, increasingly complex. It is likely that there could be generalists, specialists and advanced practitioners practising across all areas of general nursing. Consideration of the development of specialist and advanced practice in this way may help move from the perceived ‘over-medicalisation’ of roles, and link general nursing developments with service need, whilst operating within a nursing framework. The debate should, therefore, begin around making the transition from one role to another. This may help differentiate the levels of practice, and thus explicate subsequent supports and CPD associated with roles.

### 1.4.3 Specialist and Advanced Practice

Many nurses have been operating at different levels of practice in the past. Nurse specialists have been practising in the Irish context for many years. Historically, they have been operating in the absence of a framework for development, have had a diversity of role titles and have been at a variety of grades from staff nurse to Clinical Nurse Manager 2 (CNM 2). There is now a clear definition of CNS (National Council 2001a). The immediate pathway for CNSs confirmed 796 general CNSs in post. New posts are currently being developed and approved under the intermediate pathway. In total, 864 CNSs are currently approved in general nursing.

### Titles of Approved CNS Posts in General Nursing. Source: National Council CNS/CMS Database May 2003

- AIDS
- Anaesthetic Support
- Asthma
- Asylum Seeker Health Assessment
- Autotransfusion
- Behaviour Management
- Bone Bank Co-ordinator
- Bone Marrow Registry Co-ordination
- Bone Tumour
- Breast Care
- Cancer Co-ordinator
- Cardiac Disease Management
- Cardiac Rehabilitation
- Cardiology
- Cardio-Pulmonary Resuscitation
- Chemotherapy
- Chest Pain
- Coloproctology
- Colorectal
- Colposcopy
- Community Rehabilitation of the Older Person
- Complementary Therapy
- Continence Promotion
- Counselling
- Creative, Diversional & Recreational Activation
- Cystic Fibrosis
- Dementia
- Dermatology
- Diabetes
- Diversional Therapy
- Dyspnoea
- Elderly Assessment
- Elderly Care
- Emergency Practice
- Endocrine
- ENT
- Epilepsy
- Falls/Osteoporosis
- Gastroenterology
- General Practice
- Gerontological Assessment
- Gerontological Rehabilitation
- Haematology
- Haemophilia
- Haemovigilance
- Head & Neck Oncology
- Health & Well Being
- Health Advice
- Health Promotion & Intervention
- Heart Failure
- Hepatitis C
- Hepatology
- Home Therapy Immunology
- Ilizarov Method
- Infection Control
- Interventional Radiology
- Invasive Cardiology
- Joint Replacement
- Laser Therapy
- Lithotripsy
- Liver Recipient Co-ordinator
- Lung Cancer
- Lung Transplant Co-ordinator
- Lymphoedema
- Male Genito-Urinary Cancer
- Mammography
- Migraine/Headache
- Minor Injuries
- Motor Neurone Disease Liaison
- Multiple Sclerosis
- Nephrology
- Neurology
- Occupational Health
- Older People
- Oncology
- Ophthalmology
- Orthopaedic Casting & Splinting
- Osteoporosis
- Pain Management
- Palliative Care
- Parkinson's Disease/Aspen
- Peri-Anaesthesia
- Rehabilitation Care of the Older Person
- Renal
- Reproductive Health Care
- Respiratory
- Rheumatology
- Sexual Health
- Smoking Cessation
- Spinal Cord Injury - Liaison Nursing Service
- Stomatherapy
- Stroke Care
- Surgical Liaison
- Therapeutic Apheresis
- Therapeutic Programmes
- Tissue Viability
- Transfusion Surveillance
- Transplant Liaison
- Trauma and Minor Injuries
- Urodynamics
- Urology

There is a diversity of titles for CNSs, and these do not always reflect the domain of practice. Titles and domains have emerged in response to service need and reflect the innovation and commitment of many organisations and individuals. A brief analysis of titles of the roles indicates that some roles relate to symptoms (lymphoedema, dyspnoea), diseases (diabetes, multiple sclerosis), treatments (chemotherapy), health promotion (health advice, health and well-being), and assessments (colproctology, elderly assessment), and other roles relate to what could be considered particular areas of care (stoma care).

There has been some preliminary review of roles and titles. For example, the CNSs in stoma care and their managers have indicated that the title is too narrow and does not reflect what they actually do. They suggest that Colorectal Nurse Specialist is more appropriate. These issues will form part of the National Council's current research project on the role of the CNS/CMS, which will report in September 2003.

As the CNS pathway develops, and new domains of practice emerge, consideration must be given to emerging roles and their support for patient/client care within a nursing framework.

In advanced practice, four ANP posts in emergency and one in sexual health have been approved to date.

## 1.5 Key Issues

For general nursing to develop, strong management and leadership are required. Specific attention has been focused recently in Ireland on the development of management roles in nursing, with various publications, guidance and review from the Office for Health Management (OHM). There has been a huge boost in the provision of education and development activities for nurse managers and it is critical that this continues.

In March 2000, the Empowerment of Nurses and Midwives Steering Group – An Agenda for Change, was established, for the purpose of developing systems that will enable nurses and midwives to have a meaningful input into the management of their units and organisations. The OHM has published guidelines to reflect the competencies for first and middle level nurse managers (OHM 2000) and to ensure consistency and uniformity in commissioning nurse management development programmes (OHM 2002).

The role of the Nursing Practice Development Co-ordinator (NPDC) in providing leadership, supporting practice development and promoting quality assurance was introduced, in tandem with the diploma in nursing registration programme in training hospitals (McCarthy *et al* 2002b). The NPDC heads a nursing practice development unit, the aims of which are to evaluate, develop, implement and monitor nursing practice in the relevant services.

Practice development is described as: "a continuous process of improvement towards increased effectiveness in patient centred care. This is brought about by helping healthcare teams to develop their knowledge and skills and to transform the culture and context of care. It is enabled and supported by facilitators committed to systematic, rigorous continuous

processes of emancipatory change that reflect the perspectives of service users" (Garbett & McCormack 2002).

### 1.5.1. Career Progression for the General Nurse

In the consultation process, nurses said that there was a lack of practice-based post-registration education relevant to general medical and surgical nursing practice. They said that in order to pursue post-registration education relevant to clinical practice, they had to leave the area of generalist practice and move to more specialised areas such as ICU, CCU or A&E. The alternative was to undertake a generic nursing degree programme, which was perceived as preparation for management rather than further development of clinical expertise.

Higher/postgraduate diplomas in medical and surgical nursing should be considered to support expert practice and to stop the drain of skilled practitioners. There are many courses in particular areas, such as wound care, that lead to academic or professional awards, and these could become specialist modules on medical and surgical higher/postgraduate diplomas. Consideration and work has already begun on such higher/postgraduate diplomas in some third level institutions. The challenge is to provide such higher/postgraduate diplomas with a strong practice base and in a cost effective manner. This should occur within a planned postgraduate framework, which supports access to masters' degree programmes (National Council 2002).

Many general nurses said that they did not necessarily wish to pursue formal post-registration education, but wanted CPD which enhanced their clinical skills. They described their difficulties in gaining clinical skills, given that, in some wards, the most senior nurse had only two years' post-registration experience, and they asked for more support at ward level. Clinical support roles have emerged in some areas to address these skills deficits. The function of the role varies, but involves staff orientation, skills development, skills maintenance and CPD. Post titles include clinical support nurse, staff development facilitator and clinical skills facilitator. These roles are outside of any defined career pathway and there has been little evaluation of them. One submission alluded to the temporary nature of such roles, noting that these roles were dispensable once the current "poor skill mix improved." It is important, therefore, that these roles are reviewed at a national level.

McCormack and Slater have published *An Evaluation of the Role of Clinical Education Facilitator in Northern Ireland* (2002). This role is at clinical directorate level and has been operational for approximately twelve months. The evaluation indicates that practising nurses valued the role and that all nurses were assured access to CPD, but that to-date there was little evidence to show if these posts had impacted on the quality of clinical education within the directorates.

During the consultation process a competency-based approach to the professional development of generalist nurses was proposed, which would allow for the development and enhancement of roles within the generalist domain. A framework such as Benner's (1984) *Novice to Expert* was suggested. This would facilitate the demonstration of progression through different levels of practice and go some

way to explicating expertise in generalist practice. Castledine (1998) suggests that without the generalist who is at expert level, patients/clients will receive fragmented and disjointed care.

King and Clark's (2002) study, which explored the clinical expertise of nurses in the surgical ward and intensive care, differentiated four incremental levels in nurses' knowledge and skill across a continuum of nursing expertise. They found that intuitive and analytical elements were apparent in nurses' clinical decision-making from advanced beginner to expert level. Expert nurses had the greatest ability to recognise rapidly changing relevant clinical signs, identify actions needed and their possible outcomes and to organise effective interdisciplinary involvement in the patients/clients care.

Logan and Boss (1993) also explored the learning patterns of staff nurses in a surgical ward and identified levels of practice from advanced beginner to competent, proficient and expert level. The study indicated that nurses need to move from the novice to expert stage of skill acquisition before they can focus on acquiring skills in their relationships with patients, doctors and other nurses.

The identification of a set of core competencies for each clinical area has begun in Australia, where orientation to an area involves the development of these competencies by use of mentorship, portfolios, booklets, in-service and specialist roles over a specified time period. Mentorship, preceptorship, portfolios and competency development were frequently mentioned during the consultation process. In addition, it was suggested that CPD for generalist nurses should include management development training.

On career progression, participants in the consultation process said that they would benefit from career advice and coaching. They suggested that this needed to be a dedicated role and could potentially become a new role in general nursing.

### 1.5.2 Specialist and Advanced Practice

The concept of specialist and advanced practice across all areas of general nursing was mentioned by nurses. There are a number of clinical areas where, to date, no CNS roles have developed, such as surgical wards, medical wards and ICUs. Access by nurses and patients/clients to consultation, education and specialist or advanced expertise is limited and the clinical career pathway of nurses is restricted. This suggests a need to develop CNS and ANP roles in all areas of general nursing practice, where there is an identified health service need.

A CNS role on a surgical or a medical ward to enhance generalist practice was suggested. This CNS could provide a consultative role, lead and undertake audit, be an educator and carry his or her own caseload. There would be opportunity for the CNS to operate at a higher level of practice, making decisions at specialist practice level and, where appropriate to develop nurse-led services.

A CNS in surgical nursing could help reshape a surgical ward and the way in which surgical care is provided. For example, the CNS could run a nurse-led pre-admission clinic, provide in-patient care and support a nurse-led follow-up outpatient

clinic. Links could be made directly from the surgical ward to the community and telephone support provided for the patient/client. With careful planning, such a role could increase continuity of care, provide specialist support for the surgical ward and ensure a clinical career pathway for the surgical nurse.

CNS and ANP roles for critical care are already under consideration. Suggested roles and functions for an ANP in critical care include expanding location of practice to include care, assessment and support to high dependency patients/clients in ward areas. For example, the ANP could assess all patients/clients recently discharged from the critical care unit, intervene if more intensive care is needed, and, in critical cases, have the authority to readmit patients/clients to the critical care unit. The ANP would be both educator and consultant to the ward nurses.

In the community, the role of practice nurse has, in many instances, evolved to CNS status. Nurse-led clinics have emerged, for example, in the provision of breast and cervical screening within general practices, which support the objectives of the *Health Strategy* (DoHC 2001a). Also in the community, home care palliative care nurses carry and manage their own caseloads.

The *Health Strategy* (DoHC 2001a) specifically highlights the role of the ANP in emergency care. CNS roles in emergency care are already developing (e.g. respiratory, chest pain assessment etc). Nursing roles in managing patients/clients with chest pain may include initial assessment, commencement of treatment, follow-up in dedicated cardiac wards, and outpatient care.

*Diabetes Care - Securing the Future* states that all persons with diabetes should have access to specialist diabetes care as required, and recommends that 4 diabetes nurse specialists be employed per 80,000 to 100,000 population (Clarke 2002). The role of the ANP in diabetes care is currently being developed.

The Association of Coloproctology of Great Britain and Ireland (2001) states that there is a need for nurses to provide continuity of care in the cancer patient's/client's pathway from diagnosis to surgical, adjuvant and palliative treatments, and to liaise between the patient/client, primary care doctor and the hospital services. Colorectal nurse specialists have improved the quality of care and the role of nurse endoscopists is identified. The Association states that there should be 4 full-time equivalent stoma care nurses per 500,000 population.

In rural Ireland, many CNS posts in palliative care have their posts funded by voluntary bodies. Whilst this has been born out of necessity problems can arise with management issues and development of services. The issue of a clinical career pathway for those nurses wishing to remain working in an in-patient setting in palliative care, given that many home care posts are confirmed as CNS posts, was raised in the consultation process. To date, the opportunity for in-patient CNS posts has been in areas such as lymphoedema. Consultation participants had mixed views as to whether there is a need for CNSs in in-patient units, given that palliative care units are generally very small or whether it

would be more beneficial for ward nurses to have access to CNSs in areas such as tissue viability, infection control and lymphoedema. There was support for the role of ANP in palliative care.

In relation to cancer nursing, the forthcoming *National Cancer Strategy 2003-2010* will provide direction for the future, and this will have implications for nursing. In addition, roles in areas such as oncology, haematology and breast care are being developed at advanced practice level nationally.

### 1.5.3. Role Progression

There is merit in the development of generalist, specialist and advanced practice roles in all practice settings where there is a health service need. Such roles can cross boundaries and, by doing so, enhance the continuity of care for the patient/client. Nurse-led clinics and services were mentioned in the consultation process as potential areas for development. Nurse-led is distinct from nurse co-ordinated or nurse-managed services. Wiles *et al* (2002), when describing nurse-led intermediate care, indicated that nurse-led care requires nurses to be responsible for assessment, care management, clinical leadership and discharge. Nurse-led care can thus be defined as care provided by nurses responsible for case-management which includes comprehensive patient/client assessment, developing implementing and managing a plan of care, clinical leadership and decision to admit or discharge. Patients/clients will be referred to nurse-led services by nurses, midwives or other healthcare professionals, in accordance with collaboratively agreed protocols. Such care requires increased skills and knowledge and the nurse will need preparation in both the clinical and management aspects of the role. Such nurses will be practising at an advanced level and may be working in specialist or advanced practice roles.

There are many examples of expanded general nursing practice across all healthcare specialties and of general nurses taking lead roles in developing services to enhance patient/client care. Several examples are:

- Nurse-led minor injury services
- Nurse-led outpatient clinics
- Nurse-led pre-admission clinics
- Nurse-led emergency chest pain assessment
- Telephone triage
- Drop-in clinics and telephone support
- Health promotion
- ANP (Ophthalmology)
- ANP (Primary Healthcare).

Expansion of the nurse's role through scope of practice, whether at generalist, specialist or advanced practice level, appears to work best where role development is gradual, operates within a nursing framework and where there is considered implementation, with CPD available (Read & Graves 1994).

Consultation with CNSs indicated a natural progression eventually to ANP, but that not all CNSs would want this.

In the experience of the National Council, much preparation is needed in order for a CNS role to progress to an ANP role or, indeed, for a staff nurse to progress to a CNS role. Both the general nurse and the employer need to go through a reforming process which involves 'letting go' previously held tasks in order to fulfil new role requirements. The transition from CNS to ANP requires the employer to consider service need, and whether the role of CNS will continue when an ANP role is developing. Woods (1998) states that nurses in transition to ANP are likely to place priority on gaining competence in clinical skills, as opposed to broader 'professional' skills – thus skills in audit, research and supervision are likely to suffer.

Greater attention needs to be focused on role transition and the concept of role construction, so that the extent of the preparation required for new roles can be made explicit. Guest *et al* (2001) emphasise the need for further research into the way in which nursing roles evolve, whilst evaluating their impact on patient/client care and their contribution to change within the modern healthcare environment.

Generalist nurses should be supported to develop skills and gain experience, so that they can progress from novice to expert in their area of practice, and have opportunities for CNS and ANP role transition. It is critical that research into this issue is undertaken.

### 1.5.4. Medical Staffing

The forthcoming *Report of the National Task Force on Medical Staffing* is expected to make proposals in relation to the re-organisation and grouping of hospital services. In reviewing the role of general nursing in such a re-organised service, it will be important to ensure that the fundamental aspects of general nursing care are retained and that fragmentation of nursing roles is avoided. Practice development should happen through expansion of role rather than just taking on tasks. Expansion of practice involves a broader holistic process, both in relation to patient/client needs and the individual nurse. This concept is supported in the *Scope of Practice Framework* (An Bord Altranais 2000a).

The crucial factor in determining developments in nursing practice is the level of decision-making and responsibility, rather than the nature or difficulty of the task undertaken.

There are opportunities within general nursing for roles to develop, for non-nursing duties to be shed and for crossing traditional primary and secondary care boundaries. Expansion of new roles, however, requires a lead-in period, during which skills are acquired or enhanced and higher/postgraduate diploma and masters' degree programmes for CNSs and ANPs respectively are undertaken.

Current post-registration education programmes require further development and improved accessibility, particularly for nurses working in rural areas. Nurses expanding their roles need time to become confident in these roles, and hospital systems need to adapt and embrace such role changes.

Competence, and the acceptance of individual accountability, is key to role expansion. Supports are needed for the nurse to expand his/her scope of practice. Opportunities for CPD to

support skills acquisition are needed and the availability of support staff such as clerical, portering and care assistants needs to increase. Legislative and policy changes are needed in the short term to support nurse prescribing, requesting of x-rays and laboratory investigations, referral authority and integrated information technology systems. Developments in general nursing need to occur at each level of the career pathway, from staff nurse to CNS to ANP.

It is critical that such expansion should take place within a framework of nursing, and following an assessment of need, to ensure that the fundamental aspects of nursing are retained and that appropriate training, education and supports are in place.

### 1.5.5. Care Management

The *Health Strategy* (DoHC 2001a) places an integrated approach to care planning for individuals high on the agenda, and it has proposed training initiatives to promote interdisciplinary working. In the consultation process, it was suggested that there would need to be flexibility in care giving and a blurring of both role and organisational boundaries. Team working was cited as critical, and support and facilitation were needed across all areas of general nursing and across the interdisciplinary team.

Consideration must be given as to how such care planning can assist in interdisciplinary team working and audit of practice. Participants in the consultant process raised questions as to how much of the current care planning process was effective, and suggested that it was seen at times to be a paper exercise rather than a planned method of care delivery.

The importance of being able to define nursing and what nurses do in terms of nursing theory is supported in the literature (Draper 1990, Barnum 1994). There is, however, a lack of empirical information on nursing theories and their application (Mc Kenna 1997). Mason (1999) supports a reinvention of traditional nursing care, without the constraint of a nursing model as a necessary foundation.

Given the national policy direction, and the support for team work that was expressed by consultation participants, consideration must be given as to how best general nurses can assess, plan, implement and evaluate general nursing care. There will need to be an integrated approach with the care provided by the interdisciplinary team, while being able to maintain the unique contribution of the general nurse.

Local protocols and integrated care pathways (ICPs) were cited as key methods of promoting team working in order to enhance quality patient/client care. An ICP is an organised, goal-defined, and time-managed plan that has the potential for facilitating timely interdisciplinary co-ordination, improving discharge planning, and reducing length of hospital stay (Sulch *et al* 2000). Benefits ascribed to ICPs include improved communication, a reduction in reoperation, improved clinical outcomes, a multidisciplinary review of practice, and less duplication of care, resulting in reduced cost and length of stay (Middleton & Roberts 2000). Nurses must ensure the development of such approaches includes nursing care as a key element.

## 1.6. Agenda for Future Development

The changes in population, and the health needs of the nation have all challenged general nursing. The population of Ireland continues to increase: the birth rate is rising; life expectancy is increasing; older people will form a larger portion of the total population and migration trends are rapidly reversing.

Epidemiological and globalisation trends are major influences on the profile of health service users. General nurses should have a greater awareness of, and more exposure to, information on health trends in the population, including demographic and epidemiological trends.

The role of nurse managers and NPDCs are key roles within service development, and continued investment in their CPD is needed. General nursing should be more proactive and more directly involved in policy development.

Team working is the pillar that supports quality service delivery. Investment in team working should take the form of intra- and inter-disciplinary CPD and local facilitation.

In relation to the clinical career pathway, there should be generalists, specialists and advanced practitioners practising across all areas of general nursing, where there is an identified health service need.

There should be a competency-based approach to the professional development of generalist nurses, which allows for the development and enhancement of roles, within which the generalist is supported. There is a need for education programmes at higher diploma/postgraduate level, which support medical and surgical nurses.

The role of the CNS should be developed in a way that supports the role of the generalist. Improved career guidance for general nurses is needed and approaches towards supporting role transition need to be developed. Examples of potential CNS roles and nurse-led services include minor injuries, pre-surgical assessment, and chest pain assessment.

Role expansion, not extension, needs to occur to support holistic approaches to care management.

Increased involvement in research is needed, and methods for the implementation of audit of practice need to be developed.

# Midwifery

## 2.1. Introduction

This section outlines the current drivers and opportunities affecting the role of the midwife and the future professional development of midwifery in Ireland.

The international definition of the midwife adopted by the International Confederation of Midwives (ICM), the International Federation of Obstetricians and Gynaecologists (FIGO) & World Health Organisation (WHO) (1992) is as follows:

*“A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.*

*She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.”*

This definition is endorsed by An Bord Altranais (An Bord Altranais 2000a).

The philosophy of midwifery practice is that having a baby is a normal healthy event for most women. Pregnancy and childbirth are not only clinical events but social and psychological transitions of tremendous significance for women and their families. The unique and specific needs of women are best provided by the midwife during pregnancy, labour and postnatally. Midwifery care emphasises the concept of partnership between the woman and the midwife based on support and collaboration, which facilitates informed choice and decision-making (An Bord Altranais 2001).

## 2.2. History

Up until the early 1950s, hospital births were infrequent in Ireland, and most births were domiciliary. The *Maternity and Infant Scheme* which was introduced under the *Health Act, 1970*, provided for a full maternity service for all women. The result was increased hospitalisation of childbirth and the decline of domiciliary births (Kennedy 2002). As the number of home births declined, the numbers of domiciliary midwives were also reduced. In 1976, the discussion report *Development of Hospital Maternity Services* (Comhairle na n-Oispeideal 1976) recommended that all births should take place in an obstetric-staffed maternity unit. This was reiterated in *Developing a Policy for Women’s Health* (DoH 1995).

Ireland was the first country in Europe to provide institutionalised maternity care, and Irish midwifery has experienced difficulty in maintaining its identity (Kennedy 2002). Midwives are required to follow obstetric rather than midwifery policies. Direct midwifery-led care is rare, despite being within the remit of midwives. The role of the midwife as internationally defined is not being fulfilled by many midwives in Ireland, leading to dissatisfaction within the profession (Government of Ireland 1998). Although the *Report of the Commission on Nursing* identified the midwifery profession as distinct from nursing, with exclusive skills in relation to maternity care, many midwives feel confined by obstetric practices (Government of Ireland 1998). Midwifery-led care has long been an aspiration of midwives and women in Ireland (DoH 1997a). The *Report of the Maternity Review Group* in the North Eastern Health Board (NEHB) proposed the setting up of a unit that would provide midwifery-led care (NEHB 2001). To this end, a taskforce has been established and plans are underway to develop the service in 2003.

There have been many debates amongst stakeholders regarding choice for women in the models of care available in childbirth. In recent years, women have requested more choices in maternity care, such as flexibility in accessing services, natural birth, midwifery-led care and the development of community services (DoH 1997a, DoHC 2001a). Maternity care consumer groups such as Irish Childbirth Trust, Home Birth Association, the Association for Improvements in the Maternity Services (AIMS), Midwifery Birth Alliance, La Leche League of Ireland and

Baby Milk Action Ireland have raised awareness about choice and control in pregnancy and childbirth.

Many midwives have stated that they are now actively seeking opportunities to practise midwifery within settings that provide autonomy and alternative choices in childbirth (Government of Ireland 1998, An Bord Altranais 2001). However, the Mother and Infant Care Scheme, which entitles women to shared care only between the GP and hospital obstetrician, remains the only template for combined care in the present organisation of maternity services, and midwives are not recognised as service providers in maternity care. Although some units offer midwives' clinics for antenatal care, there are no opportunities for midwives to provide continuity of care to women throughout childbirth and the postpartum period.

There are examples of innovative community practice taking place at present, such as the service provided by the Southern Health Board (SHB), which employs independent midwives to provide domiciliary maternity services. The evaluation of the pilot scheme DOMINO (Domiciliary Care In and Out of Hospital) in the National Maternity Hospital showed that it was extremely successful and viable and, given sufficient funding, was sustainable in the long term (Community Midwifery Service, National Maternity Hospital 2001). The evaluation made a strong case for the development of similar schemes in other Dublin maternity hospitals and other units around the country. Similar projects are already taking place in Galway, Cork and Waterford and, during the consultative process, midwives said that these models could be extended for the benefit of all women regardless of their geographical location.

Midwives already involved in developing these services have gained valuable experience, which can contribute to and inform the future expansion and development of the role of the midwife within the community.

Each health board has a legal obligation to provide a domiciliary midwifery service (Government of Ireland 1970). Independent midwives provide community maternity services, but there are only 14 practising around the country (Home Birth Assoc. of Ireland 2003), so choice for women is restricted and inequitable.

### 2.2.1. Policy Context

A number of recent reports refer to the future development of midwifery in Ireland. The *Report of the Commission on Nursing* stated that midwifery has an identity distinct from nursing, offering practitioners a unique opportunity for autonomous practice in the care of women during pregnancy and following birth (Government of Ireland 1998). It recommended that the title of the *Nurses Act, 1985* should be amended to the *Nurses and Midwives Act* to provide for the restoration of a separate statutory midwives' committee. A new Midwifery Committee has recently been set up by An Bord Altranais. Its role will be to provide expert advice and to make recommendations to An Bord Altranais with regard to the education, registration and professional practice of midwives in Ireland (An Bord Altranais 2003b).

The *Scope of Nursing and Midwifery Practice Framework* (An Bord Altranais 2000a) and the *Guidelines for Midwives* (An Bord Altranais 2001) provide midwives with a framework to develop their role, with considerable scope for flexibility in the interpretation and focus of that role. These guidelines serve to empower midwives but their scope of practice is already outlined within the definition of a midwife and within the EEC Council Directive 80/155/EEC of 1980 (Council of European Communities 1980).

The *Health Strategy* (DoHC 2001a) places great emphasis on primary care and reinforces the need for an holistic view of healthcare, which provides continuity, and choice for women. It has recommended the establishment of a working party to provide a plan for high-quality maternity care.

During the consultations with midwives, a restructuring of maternity care was recommended, which included more midwifery involvement and less medicalisation in the delivery of the maternity services. The *Health Strategy* (DoHC 2001a) may pave the way for this, as it recommends the increased involvement of midwives in the management and delivery of maternity services. The development of healthcare centres could provide a focal point in which to develop an integrated community service including community midwives. Midwives proposed that the current DOMINO pilot scheme, and community services already provided by some maternity hospitals, would need to be expanded and enhanced.

The forthcoming *Nursing and Midwifery in the Community Strategy* will provide a new direction for how midwifery care in the community will be delivered. The strategy is underpinned by a vision of "a sustainable community nursing and midwifery service that will effectively meet the health needs of the population of Ireland within a primary care setting." Midwives stated that this strategy could reduce the centralisation of maternity services and that smaller units should be maintained with the development of midwifery-led units, if medical personnel resources cannot be sustained. They suggested that specialised neonatal care and neonatal transport systems should be developed to complement midwifery services.

The *Primary Care Strategy* (DoHC 2001c) identifies the midwife as one of the core members of the primary care team in the community. Midwifery services in the community have been developed in many countries with differing models of maternity service delivery. Midwives already make a substantial contribution to public health, and the distinct role of midwives within primary care needs to be researched further, and appropriate education and support structures put in place.

The *Report of the Maternity Services Review Group* (NEHB 2001) has recommended the setting up of two midwife-led units attached to conventional maternity units in the NEHB. It is anticipated that three further stand-alone midwifery units will be established on a phased basis.

Midwives will require development programmes in order to adapt to these changes. This could be facilitated through a practice development approach, together with support systems, such as clinical supervision.

### 2.3. Demographic and Epidemiological Issues

From 1971 to 2000 there was an increase of 366,800 women in the core childbearing age group of 15-49 years (Kennedy 2002). There has been a steady increase in the number of births in Ireland since 1995 with a total of 57,882 births registered in 2002 (CSO 2002). This has implications for the provision of maternity care.

Following the publication of the discussion report *Development of Hospital Maternity Services* (Comhairle na nOspideal 1976), which recommended that all births should take place in an obstetric staffed maternity unit, a number of smaller maternity units have been closed down. This has resulted in a significant increase in the number of births in larger maternity hospitals, and many women are now required to travel long distances, both for their antenatal care and to give birth in urban centres (NEHB 2001).

Additional pressures have been placed on the limited resources of maternity hospitals by large numbers of refugee and asylum-seeking women. The Commissioner of the Office of Refugee Applications recently stated that "between 45-50 per cent of female asylum seekers were visibly pregnant at the time of application" (Quinlan 2002). During the consultative process, it was suggested that in this increasingly multicultural environment, education and training is required in transcultural care, including priorities such as language and communication needs. It was also proposed that educational programmes on health and maternity issues be developed for refugees and asylum seekers.

### 2.4 Current Developments

In Ireland, where a medicalised approach to childbirth predominates, the service is increasingly technologically driven. Intervention rates tend to be high and midwives have a diminished role (Kennedy 2002). The caesarean rate in Ireland is now 20.6%, an increase of 13.1% from 1988 (Rynne 2003a). The World Health Organisation (WHO) recommends that caesarean sections should not be necessary for greater than 10% of women (WHO 1999a). Midwives in Ireland have a role to play in maintaining the normality of pregnancy and birth and promoting this philosophy.

From the consultative process, it was evident that many midwives thought that the current model of pregnancy and childbirth was inappropriate and alternative models such as the social model, which promotes the concept of birth as a normal physiological process, needs to be promoted. Others proposed that both models of care could co-exist, with co-operation and mutual respect between obstetricians and midwives, organised in a flexible way to meet the individualised needs of all women. The midwifery model of care, to which many midwives aspired, is community-based and incorporates the principles of continuity of care, informed consumer choice, choice of birth setting, collaborative care, accountability and evidence-based practice.

Women attending the maternity services, and their representative groups, should be consulted on a regular basis regarding their wishes for maternity care, and women's satisfaction with the service needs to be measured. During the

consultations, it was suggested that there should be more public information on the role of midwives as principal caregivers in the maternity services. The public needs to be aware of the role of the midwife, the advantages of midwifery care and that it is as safe or safer than the care provided by doctors (McDorman & Singh 1998).

#### 2.4.1. Staffing Shortages

There are 13,565 midwives on the active register (An Bord Altranais 2003a). However, despite on-going problems of retention and recruitment, there are no accurate statistics on midwifery employment (McCarthy *et al* 2002a). In 2000, the staff turnover rate within the major maternity hospitals ranged between 19% and 31% (DoHC 2002a).

A recent study indicated that staffing shortages and overcrowding in maternity hospitals was a major problem, which contributed to poor quality care (Ring 2002). Many midwives said that they were continuously 'fire-fighting' in practice. They said that women were treated as though they were on a conveyer belt, because bed shortages meant that midwives had to get as much work done and have discharges completed as quickly as possible. In many instances, there was no time to get to know the women and their families as a lot of their time was taken up on non-midwifery duties. Whilst working in these conditions many midwives said that they got no job satisfaction and that this was one of the main reasons they were leaving or would leave the midwifery profession. The literature supports the fact that job satisfaction is important in staff retention (Irvine & Evans 1995, Tovey & Adams 1999).

Recent UK research into the reasons why midwives leave the profession found that a major cause was widespread dissatisfaction with midwifery, because practitioners could exercise only limited control over their practice (Ball *et al* 2002). During the consultation process, midwives said that to reverse the trend in midwifery staffing, services must ensure that midwives receive effective support and that they are able to work in an environment that allows them to practise midwifery.

Midwives also said that the current model of postnatal care, following discharge from hospital, was inadequate and did not facilitate successful transition to motherhood and parenthood. Enkin *et al* (2000) refer to the postnatal period as a time in which the new mother requires both emotional support and practical help. Postnatal care and support are very important for all mothers but especially first-time mothers. Given that 41% of the 57,900 births registered in Ireland in 2001 were to first-time mothers, this is a cause for concern.

At present there is no statutory provision of midwifery postnatal care and the service for women varies throughout the country. Under the Maternity and Infant Care Scheme, women and their babies are entitled to free medical care for up to six weeks following childbirth. Many midwives emphasised the need for more community-based postnatal care. Benefits to women of community midwifery care include an increase in breastfeeding rates and the identification of postnatal depression.

### 2.4.2. Litigation

Litigation has been a major force in the increased medicalisation of birth and in a more active intervention policy (Rynne 2003b). Many midwives said that they base their provision of midwifery care on avoiding litigation, generally through defensive practice and early intervention. They said that in order to move forward from defensive practice, evidence-based practice in midwifery was essential. Chalmers *et al* (1990) identify continuity of care from a qualified midwife as best practice for the majority of healthy women, as research indicates that one-to-one midwifery care reduces intervention rates, and that continuity of midwifery care is effective in lowering morbidity and mortality rates in pregnancy and childbirth. The development of national standards and protocols for quality care, patient safety and risk management would also help define accepted practice and allay fears of litigation.

### 2.4.3. Private Healthcare

The nature of private maternity care is the single biggest influence on the model of maternity care provision (NHS Scottish Executive 2002). Many pregnant women in Ireland opt for private care by obstetricians influenced by the fact that private obstetric care includes private hospital accommodation. Private insurance companies regard obstetricians as the lead professionals responsible for maternity care with the insurance covering only a short postnatal stay. Consequently many midwives do not fulfil their midwifery role and function primarily as obstetric nurses.

In the consultative process, midwives said that they should be the primary care-givers for pregnant women and their families, taking cognisance of women's right to choose the primary carer. Support for the midwife's role in normal pregnancy and childbirth is gradually increasing. Both VHI and BUPA give substantial grants to subscribers who wish to avail of a home birth.

## 2.5. Key Issues

### 2.5.1 Specialist and Advanced Practice

The *Report of the Commission on Nursing* (Government of Ireland 1998) noted the importance of clinical career pathways that involved specialist and advanced practice. These pathways are linked with specific educational requirements (NCNM 2001a, 2001b). The core concepts of a Clinical Midwife Specialist (CMS) include clinical focus, patient advocate, education and training, audit and research and consultant. Currently, the National Council has approved 31 CMS posts. CMS titles include diabetic care, drugs liaison, ultrasound and foetal assessment, urodynamics, neonatal, bereavement counselling, and infection control.

During the consultation process many midwives expressed the view that the term CMS was inappropriate in the context of midwifery and that a preferred term was *Enhanced Midwife Practitioner*. Others said that 'specialist' does not fit with the holistic concept of midwifery practice and that the introduction of midwife specialists could lead to fragmentation of what they see as an already 'piecemeal'

midwifery service in Ireland. It was suggested that creating sub-specialities in midwifery in order to provide promotional opportunities was detrimental to the professional development of midwifery. However, it was acknowledged that midwives remaining in practice required a career pathway but that 'specialities' should aim to integrate the role of the midwife. Midwives suggested that ultimately it was desirable for them to fulfil rather than extend their role.

According to the midwives who participated in the consultation process, development of further CMS posts requires careful consideration to ensure that they are adequately supported and managed by service providers, and such posts should provide added value to the maternity service, and to women. Development of CMS posts should be service-led. Further areas suggested for midwifery specialism included pregnancy in adolescence and for refugees and asylum seekers.

Some midwives said that, although there was a need for specialist midwives in some areas, specialisation should not be regarded as more valuable than essential midwifery. It was suggested that opportunities should be provided for midwives to fulfil the holistic midwifery role rather than fragmenting into specialist practice, otherwise expertise will be lost with consequent deskilling of midwives. One such opportunity is midwifery-led care, which is at present being established in the NEHB, subsequent to the publication of the *Report of the Maternity Services Review Group* (NEHB 2001). This report recommended the implementation and evaluation of the pilot provision of a midwifery-led service. Other development opportunities include team midwifery within the hospital setting, midwife-led antenatal clinics, and providing pregnant women with the combined care of their general practitioner and a hospital-based midwife.

The core concepts of Advanced Midwife Practitioner (AMP) include autonomy in clinical practice, pioneering professional and clinical leadership, expert practitioner and researcher (NCNM 2001b). At present, there are no AMPs, but site preparation for such a post is currently in process. Some midwives view the establishment of AMP posts as crucial to the development of the profession and have stated that the development would strengthen clinical leadership within midwifery services through role modelling, clinical practice at an advanced level and through involvement with service review and planning. The AMP role was seen as central to providing new midwifery knowledge because of the requirement for the post-holder to be actively involved in research. A number of midwives felt that the role of AMPs could have a positive impact on key relationships within the maternity services, i.e., between midwives, obstetricians, managers and educationalists.

### 2.5.2. Practice Development

Professional and practice development of midwifery requires effective management and leadership. The roles and responsibilities of midwives and midwife managers need to be clarified and levels of authority established. Participants said that further support for the introduction and implementation of leadership programmes was required to drive forward the midwifery agenda. Recognised models of best midwifery-led

practice need to be implemented in many areas, and the creation of practice development posts was seen as essential, particularly in the context of preparing midwifery-led services.

The ICM believes that midwives have a responsibility to advance midwifery knowledge to achieve an improvement in the health of childbearing women and their families. It is suggested that midwives should be involved in all aspects of research into midwifery practice in order to contribute to the professional body of midwifery knowledge, both nationally and internationally. Appropriate training programmes to support this may need to be further developed. The recent *Research Strategy for Nursing and Midwifery in Ireland* (DoHC 2003a) will be instrumental in the advancement of midwifery research in Ireland.

Midwives said that explicit career planning structures, together with appropriate support and education programmes, were needed to support and coach them in making decisions about their future careers. Further midwifery education programmes should be accessible to all midwives. Primary and masters' degree programmes in midwifery education should be provided outside the eastern region, in order that midwives have equitable access to relevant education. Midwives said that they should not have to undertake further studies in nursing in order to advance their education, which is often the case at present.

Participants suggested that midwifery services should have systems in place to review individuals in relation to their work performance, and that each member of staff should have a personal development plan. Structures for the development of clinical supervision of midwives should be developed where they do not exist.

### 2.5.3. Midwifery Education

The *Report of the Commission on Nursing* (Government of Ireland 1998) stated the need for an improved educational programme for student midwives, increasing the thirteen weeks of theoretical instruction, which was deemed inadequate, to twenty-six weeks. Following the Commission's recommendation, a diploma in midwifery (direct entry) was established in a tripartite arrangement between Trinity College, Dublin, the Rotunda Hospital, Dublin, and Our Lady of Lourdes Hospital, Drogheda. The programme is due to be completed on 31st May 2003. Participants in the consultation process regarded it as successful and a re-confirmation of the midwifery profession as distinct and separate from nursing. Trinity College, Dublin, will commence a degree programme in midwifery in September 2003.

A number of the submissions noted that the gap between what is taught in the classroom and what is experienced in practice is extreme, and that students have difficulty relating theory to practice. The greatest influence on student learning is the clinical area and unless student midwives have the opportunity to participate in midwife-led care, they will not be able to fulfil their role. They will be midwives with an excellent theoretical foundation but limited clinical experience, an issue which was highlighted during the consultation process.

Participants in the consultation process saw an urgent need for a midwifery programme, within which student midwives would be exposed to midwife-led care and community midwifery from the onset of their educational programme. They should be supported and precepted by competent autonomous midwifery practitioners. Some midwives said that they did not observe, and so could not emulate, a non-interventionist approach to childbirth in labour wards and, therefore, they were not sufficiently skilled in normal midwifery practice.

In recent years, a significant number of midwives who have practised as community midwives in other countries have returned to Ireland. Their expertise should be utilised to educate and support both student and qualified midwives who have not been exposed to the community setting and autonomous practice.

## 2.6. Agenda for Future Development

Demographic changes have implications for maternity care and midwifery practice. Statistical trends indicate that there is an increase in the core childbearing age group and an increase in the number of births. Therefore more women are potential users of the maternity services. Midwives need to recognise and overcome the barriers to providing women with alternatives to medicalised care. The barriers include lack of acknowledgement of the role of the midwife within private insurance schemes, maternity services policies not informed by evidence-based research or by bodies such as the WHO, lack of collaboration among professionals in the maternity services and failure to recognise midwives as professionals capable of and responsible for safe and effective care of healthy pregnant women.

In order to sustain and build on the existing models and potential of maternity care, midwives must work in partnership with women, and with relevant professionals, to help ensure a quality service for women and a wider choice of care options for women and their families throughout the country. Maternity services should demonstrate in their policies and practices the underpinning philosophy that pregnancy is a normal physiological process. Development of midwife-led care, and team midwifery in hospitals are important for maternity care and for the profession. The community role of the midwife needs to be enhanced and more midwife-led antenatal clinics developed. Midwives should also be involved in policy formulation service review and planning.

There are issues within specialist and advanced midwifery practice, that require further examination and debate, and this will help to ensure that, ultimately, these roles will improve the quality of midwifery practice and the care received by childbearing women.



# Psychiatric Nursing

## 3.1. Introduction

Psychiatric nurses practice in all settings in which mental healthcare is delivered in Ireland and are instrumental in the implementation of change and the modernisation of mental health services. Thus, they have a major role to play in the continued development of the mental health services in Ireland. This section looks at developments that have taken place within the profession and mental healthcare, and discusses future directions and developments in the context of current policy and service requirements.

## 3.2. History

The first major move towards the professionalisation of psychiatric nursing in Ireland came towards the end of the 19th century when the Medico-Psychological Association began to co-ordinate the training of psychiatric nurses. In 1919, under the *Nurses Registration Act*, a supplementary part of the General Nursing Council register was established for mental nurses and the first entry was made to this register in 1921.

The discovery of the phenothiazines as a treatment for psychosis in the 1950s, together with more enlightened views in society about the nature of mental illness, paved the way for the rehabilitation of the mentally ill and provided an opportunity for a more therapeutic role for psychiatric nurses than in the past.

The publication of the policy report, *Planning for the Future* (DoH 1984), set out the blueprint for development of a community mental health service in Ireland. This report outlined major changes in the mental health services, notably moving the delivery of in-patient services from large psychiatric hospitals to units in general hospitals. There was greater emphasis on rehabilitation of the mentally ill and a relocation of services into mainstream medical care and especially the community. This shift in policy represented a major change in the role of psychiatric nurses and provided a unique opportunity for development of skills and roles (Sheridan 2000).

Psychiatric nursing is a division of An Bord Altranais' register, through rules made in accordance with the *Nurses Act, 1985*. In 1986, the training programme was revised to reflect mental health trends of the time, and this included a larger proportion of clinical practice experience in the community (An Bord Altranais 1994). In 1994, a diploma in nursing programme was set up in the Western Health Board, in conjunction with the National University of Ireland, Galway, and was extended to all schools of nursing, including psychiatry in the following four years. In 2002, along with general and mental handicap nursing, the first pre-registration

degree programme commenced in psychiatric nursing. There were twelve courses throughout the country, giving a total of 343 places for psychiatric nursing students (An Bord Altranais 2003a).

### 3.2.1. Policy Context

Mental healthcare is provided within a framework of legislation and health and social policy that directs service development and has implications for those who provide the services. The *Mental Treatment Act, 1945* provides for the prevention and treatment of mental disorders and the care of persons suffering from such disorders. Although considered inadequate to guide present day mental healthcare, the 1945 Act was revolutionary for its time, providing, as it did, for the treatment of patients/clients on a voluntary basis in hospitals. Until commencement orders are issued for enactment of the *Mental Treatment Act 2001*, care continues to be governed by the 1945 Act.

The *Mental Treatment Act, 2001* repeals, in the main, all other acts and brings the law in Ireland into conformity with the *European Convention for the Protection of Human Rights and Fundamental Freedoms* (Council of Europe 1950). The main vehicle for implementing the provisions of this new legislation is the Mental Health Commission, whose principal functions are to promote and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services, and to take all reasonable steps to protect the interests of persons detained.

The implications for psychiatric nurses of this change in legislation need to be carefully considered in the development of roles and skills. Issues such as power of detention, and the exclusion of alcoholism and personality disorder as a reason for detention, will require significant reflection for service providers.

The major policy report influencing the mental health services and psychiatric nurses has been *Planning for the Future* (DoH 1984). It is now recognised that this framework needs to be revisited and the DoHC have committed to the development of a national policy framework for the further

modernisation of the mental health services (DoHC 2001a). In addition to this, the *Health Strategy* (DoHC 2001a), and the *Primary Care Strategy* (DoHC 2001c) contain a number of actions that will have a considerable impact on the services and implications for psychiatric nurses.

The main areas of priority for mental health outlined in the *Health Strategy* (DoHC 2001a) are:

- Development of a national policy framework for the further modernisation of the mental health services, updating *Planning for the Future* (1984)
- Establishment of the Mental Health Commission
- Investment in community care services
- Provision of additional community residences where community places per head is lower than average
- Expansion of mental health services for children and adolescents
- Further development of services aimed at specific groups including older people and those who would benefit alcohol treatment programmes
- Preparation of a report on services for people with eating disorders by the Working Group on Child and Adolescent Services
- Introduction of a programme to promote positive attitudes to mental health
- Encouraging and resourcing independent patient advocacy services
- Intensification of suicide prevention programmes
- Introduction of legislation on entitlement to defined core services free of charge, including mental health and substance abuse services.

Although the in-patient population has decreased due to the policy of de-institutionalisation and the development of community care, there has been an increase in the up-take of services and it is expected that this will continue as a result of the modernisation of services, a decrease in stigma, the ageing population, family breakdown and drug abuse (DoHC 2001a).

The development of day hospitals, day centres and community residences to equivalent levels throughout the country will influence the role development and skill requirements of psychiatric nursing, as will the proposed developments in psychiatry of old age and child and adolescent psychiatric services.

The introduction of a new model of primary care (DoHC 2001c) means the development of an interdisciplinary team-based approach to primary care. It is anticipated that the nursing contribution to the primary care teams would match the needs of the community, and mental healthcare has been identified in the *Primary Care Strategy* (DoHC 2001c) as one of the nursing functions of the primary care team. Some mental health services have already developed initiatives, in co-operation with the GP services, the psychiatric services and with nurses working across boundaries, to provide a

streamlined, readily accessible service to patients/clients. The provision of focused therapeutic interventions in primary care has been shown to reduce suicide rates, in-patient admissions and sick leave due to mental health problems (Rutz *et al* 1989).

The *National Health Promotion Strategy* (DoHC 2000a) outlines the importance of mental health promotion. It particularly mentions older people, children and young people, women, men, travellers, people with a mental handicap, the gay and lesbian community, the homeless, refugees and asylum seekers as groups requiring particular attention. Its main objectives are:

- To initiate research into models of best practice in mental health promotion,
- To initiate research into the development of a national positive mental health strategy and
- To work in partnership to support the recommendations of the *Report of the National Task Force on Suicide* (DoHC 1998a).

The 1997 strategy, *A Plan for Women's Health* (DoH 1997a), highlighted the medical orientation of the services and called for more access to counselling services in non-medical environments, in crisis management and stress management initiatives. Earlier and easier access to mental health services was also highlighted as important in the *Report of the National Task Force on Suicide* (DoHC 1998a). The *National Drugs Strategy* (Department of Tourism, Sport and Recreation 2001) stressed the importance of prevention and the provision of appropriate treatment services for those dependent on drugs, by providing professional assessment and counselling, treatment and rehabilitation.

The *Report of the Commission on Nursing* (Government of Ireland 1998) supported the concept of a seamless psychiatric service covering acute centres, day hospitals, high support hostels and community services and it envisaged all psychiatric nurses being able to provide services across a range of locations, including the community. The Commission expressed concerns about the level of integration of the range of nursing services offered in the community. A recognition of the need for specialist community psychiatric nursing resulted in the transition of the role of Community Psychiatric Nurse to that of the Community Mental Health Nurse (CMHN), or Clinical Nurse Specialist (Community Mental Health). The Commission envisaged the CMHN operating in a community psychiatric nurse team with Registered Psychiatric Nurses (RPNs) meeting the mental health needs of a community, in a manner similar to that of the general nursing community team.

### 3.3. Demographic and Epidemiological Issues

It is estimated that, at some point in their adult lives, one person in four will suffer from mental illness and that 25% of families are likely to have at least one member suffering from a mental illness. The incidence of depression in Ireland is estimated at 10% and schizophrenia at 1% (DoHC 2001a).

The number of in-patients/clients in psychiatric hospitals has been steadily decreasing over the past number of years. At the

end of 2001 there were 4,256 in-patients/clients in psychiatric hospitals and units, compared with over 19,000 in 1963. In 2001, there were 24,446 admissions, 7,301 of which were first admissions. Depressive disorders accounted for 31% of admissions, followed by schizophrenia (20%) and alcoholic disorders (18%). However, of those resident in psychiatric hospitals and units at the end of 2001, the largest proportion (37%) had a diagnosis of schizophrenia, with depression second (18%) and mental handicap third (14%) (Daly & Walsh 2003). These figures support international statistics from the World Bank indicating that depression, bipolar disorder and schizophrenia constitute 9.5% of the total burden of disease and disability in Europe (WHO 1999b).

Suicide has been shown to be strongly related to depression. The number of deaths from suicide and self-inflicted injury have seen a steady increase in Ireland from 346 in 1991 to 486 in 2000 (CSO 2000). Numbers reached a peak in 1998 (514), but have declined slightly since then, which is in line with worldwide trends (WHO 1999b).

The number of day facilities, out patient-clinic attendances and community residences has increased over the past decade, reflecting the community orientation of the services. In 2001, there were 254 outpatient clinics, with a total of 237,667 attendances, 63 day hospitals with 1,145 places, 104 day centres with 2,498 places and 404 high, medium and low support community residences with 3,077 places (Daly & Walsh 2003).

It is clear that the main focus of care in the mental health services is now in the community, with the focus of in-patient care being only for short term acute episodes or for chronically disturbed patients/clients who cannot function in lower support environments. This means that the psychiatric staff nurse requires skills to care for people in a variety of environments. This has implications for role development, postgraduate education and for the planning of CPD.

### 3.4. Current Developments

The mental health services have expanded and developed since the publication of *Planning for the Future* in 1984 (DoH). While some areas are still lacking certain structures, such as the required number of day hospitals, community residences, etc., nevertheless a framework is in place that provides a direction for development.

Psychiatric nurses have expanded and changed their roles in response to changing healthcare needs and mental health and social policy. They have been required to work in a wide variety of settings, including in-patient settings such as acute, rehabilitation, long stay, care of the elderly mentally ill and psychiatry of old age, and community settings including outpatient clinics, day hospitals, day centres, home care teams, outreach teams and hostels.

Some psychiatric nurses work across in-patient and community settings, providing specialist care in areas such as behaviour therapy, addiction and family therapy, bereavement etc., and some are working across services providing liaison and linkage between primary care, acute services and the mental health services, in areas such as deliberate self-harm and affective disorders, for example.

The role of the community mental health nurse is that of a clinical nurse specialist. It has expanded and developed and is pivotal to the multidisciplinary team. The development of such services and roles has required development of skills and knowledge by psychiatric nurses and this continues to take place as new services are created.

#### 3.4.1 The Registered Psychiatric Nurse

Psychiatric nurses make up the third largest group on the nursing register. There are 9,603 nurses in Ireland registered in the psychiatric division of the live register (An Bord Altranais 2003a). In 2001, there were approximately 5,372 nurses working in designated psychiatric services in Ireland (DoHC 2002a). These nurses are the largest group providing mental healthcare in the country.

The largest proportion of psychiatric nurses delivering care to patients/clients is at primary practice level. Psychiatric nurses are prepared at registration to care for people with mental health problems through therapeutic interventions in a variety of settings (An Bord Altranais 2000b). The unique contact that psychiatric nurses have with people with mental health problems makes them an important group in service delivery and development. Through their constant presence, they have the potential to maximise opportunities to interact with patients and therefore use therapeutic skills that are timely and appropriate to the patient's level of receptivity (Cowman *et al* 1997).

Given that the bulk of services are now provided in the community, the development of psychiatric nursing needs to continue to take place in this context, as recommended by the *Report of the Commission on Nursing* (Government of Ireland 1998). Roles have continued to develop for RPNs in the community. The development of pre-registration education programmes have facilitated this and the continued development of competencies for RPNs requires post-registration education frameworks and in-service education that are relevant to patient/client requirements.

Due to the development of services, many areas are becoming more specialised. The same issues emerge in psychiatric nursing as for general nursing, i.e., working in a specialised area does not necessarily equate with operating at an advanced or specialist level of practice. Services require psychiatric nurses with a broad range of skills to provide care in an holistic manner to people with mental health problems in a variety of settings. Throughout the consultation process, psychiatric nurses expressed concern that care could become fragmented if services become too specialised.

#### 3.4.2. Specialisation

In the 1960s and 1970s, specialisation began to emerge in psychiatric nursing in areas such as addiction, family therapy, child and adolescent psychiatry and behavioural psychotherapy (Sheridan 2000). Some of this, but by no means all, was initiated by medical specialisation of the time. The increasing recognition of the benefit of family therapy, for example, and the subsequent development of psychiatric nurses' skills in this area, were guided by an acceptance of social theories of mental illness and the necessity highlighted by the de-institutionalisation of people with mental health problems.

To some extent, the major specialisation of the services has developed through a life cycle framework, with child and adolescent, adult and old age being the main major specialities. Other specialisation has followed a disease-or condition-oriented approach, addiction or eating disorders for example. Approaches to psychotherapy have driven the development of other specialities, such as behaviour therapy and family therapy, among others. Some specialities have developed around settings – community mental health, for example.

### 3.4.3 Clinical Nurse Specialist Roles

The *Report of the Commission on Nursing* (Government of Ireland 1998) clearly differentiated between nurses working in specialist areas and clinical nurse specialist roles, noting the difference between a nurse working at a generalist level in a specialised area and a nurse working to a higher level of practice as a clinical nurse specialist fulfilling all aspects of the role. The development of the clinical career pathways has provided a framework for development of specialist and advanced practice in psychiatric nursing and has addressed the previous lack of standardisation and uniformity in CNS posts. The existence of a database of CNSs provides information that previously was not available nationally, and which can be used as a basis for development of services and roles.

At present, there are 401 clinical nurse specialists practising in psychiatry in Ireland. The specialist areas in which they are practising are outlined below:

#### Titles of Approved CNS Posts Psychiatric Nursing.

Source: National Council CNS/CMS Database May 2003

- |   |   |
|---|---|
| • Addiction                                 | • Family and marital therapy            |
| • Affective disorders                       | • Eating disorders                      |
| • Attention deficit hyperactive disorder    | • Family therapy                        |
| • Autism                                    | • Home based treatment acute psychiatry |
| • Behaviour therapy                         | • Integrative counselling               |
| • Cognitive behaviour therapy               | • Liaison psychiatry                    |
| • Community child and adolescent psychiatry | • Mental health education/promotion     |
| • Community mental health                   | • Psychotherapy                         |
| • Community psychiatry of old age           | • Stress management/biofeedback         |
| • Counselling                               | • Substance misuse                      |
| • Deliberate self harm                      | • Therapeutic programmes                |
| • Drug court liaison                        | • Vocational rehabilitation             |

It is clear that there has been much innovation and reflexivity in the development of services and roles. Many of the major mental health problems are reflected in the specialities that have emerged. The majority of these roles have been developed over a number of years and were approved under the immediate pathway. While roles have been emerging under the intermediate pathway, there is still much potential for development. Many of the roles listed above are present only in small numbers and in only some health boards.

Participants in the consultation process saw the need to develop these nursing services across the health boards. The Nursing and Midwifery Planning and Development Units are playing a proactive role, together with psychiatric

nurse managers, in identifying opportunities for development.

In addition to the development of existing roles, participants suggested the following areas for development:

- Rehabilitation
- Schizophrenia and severe mental illness
- Postnatal illness
- Crisis intervention
- Forensic nursing
- Psychiatric intensive care nursing
- Mental health and mental handicap (dual diagnosis)
- Mental health and addiction (dual diagnosis)
- Anxiety management
- Challenging behaviour
- Homeopathic interventions
- Bereavement counselling
- GP liaison
- Child sexual abuse
- Dementia
- Anger management

These areas reflect health policy and respond to consumer need. Such development would need to take place alongside integrated service development and interdisciplinary team working, so that quality of care can be maximised.

### 3.4.4. Advanced Psychiatric Nursing Practice

At present, there are no advanced nurse practitioner posts approved in psychiatric nursing in Ireland. Several services are in the process of site preparation for such roles, and much work is being done to ensure that these roles will meet patient/client need and enhance service delivery. Currently under consideration in a number of services are advanced psychiatric nursing practice roles in areas such as bereavement, community mental health, behaviour therapy, addiction, child and adolescent psychiatry, health promotion and family interventions.

The scope for the development of advanced practice roles is wide, given the range and diversity of service need. Throughout the consultation process, there was concern that roles should not necessarily develop along a disease-oriented model, but would enhance holistic care and truly represent advanced psychiatric nursing practice. There is much potential for improvement in services through advanced psychiatric nursing practice. Careful consideration of service need and skills development will help to ensure this.

## 3.5. Key issues

### 3.5.1. Psychiatric Nursing Skills

Psychiatric nurses highlighted, during the consultation process, the need to focus on development of skills. There is anecdotal evidence to suggest that psychiatric nurses contribute greatly to the mental healthcare of patients/clients generally, but there has been little research in Ireland to indicate their levels of effectiveness. It is opportune to focus on the appropriateness of interventions with a view to improving outcomes.

The experience of the UK is important, given that Ireland is in the process of developing primary healthcare structures. In the 1980s in the UK, many community psychiatric nurses began to work in primary healthcare settings with patients/clients who had mainly neurotic disorders, leading to a situation whereby this accounted for 40% of their work (White 1990). The development of community mental health nursing services around what could be termed the less severe mental health problems (neurotic conditions), without a corresponding response to severe mental illness and disability, has been recognised worldwide (Gournay 2000). The UK Department of Health, (1994a) has asserted that the primary focus of the work of the mental health nurse should be for people with serious and enduring mental health problems.

A growing body of evidence supports psychosocial interventions in the management of serious and enduring mental illness. The Thorn Initiative, developed in the UK in 1992, is an educational skills-based initiative, that was aimed originally at developing the skills of community mental health nurses working with people who have schizophrenia and their families. The programme focuses on three core modules, assertive community outreach, centering on the organisation of care into small caseloads with frequent personal contacts, and family interventions and psychological interventions. Outcome evaluation indicates that patients/clients managed by Thorn students show significant improvement in clinical and social functioning (Lancashire *et al* 1997). The programme is now offered in some centres to the wider multidisciplinary team.

In addition to such developments, specialities such as cognitive behaviour therapy continue to develop in the UK. The *National Service Framework for Mental Health* emphasises this form of therapy as the central, evidence-based, non-pharmacological intervention for mental health problems (DoH UK 1999). While behaviour therapy and cognitive behaviour therapy have traditionally been used in the treatment of neurotic disorders and social skill deficits with the long-term mentally ill, there is growing evidence of its efficacy for psychosis (Cormac *et al* 2003). This evidence could be more fully incorporated into the practice of psychiatric nurses at primary practice level in meeting the needs of those with enduring mental illness. Given the predominance of people with psychotic disorders receiving mental healthcare in Ireland, this type of skills development is appropriate and vital. In the consultation process, nurses spoke of the need for skills development in this area.

It is clear from the recommendations of health and social policy and epidemiological data that mental healthcare at primary, secondary and tertiary level requires development. Psychiatric nurses with their knowledge, skills and experience have the capacity to be a central part of the multidisciplinary team. Their response to the mental health needs of the population needs to be carefully considered, taking into account areas of greatest need, empirical evidence of efficacy, professional development and education and interdisciplinary working.

### 3.5.2. Psychiatric Nursing Care Delivery

New and innovative models of mental healthcare delivery are

emerging. There is increasing evidence to support home-based treatment for people with acute mental health problems (Muijen *et al* 1992, Audini *et al* 1994), and assertive outreach for those with severe and enduring mental health problems (Hemming *et al* 1999). Some services in Ireland have developed care along these models and this has provided opportunities for psychiatric nurses to develop their role further within the multidisciplinary team. Innovations such as this present a challenge to the profession to critically examine the way in which care is delivered to patients/clients and develop services that best match needs.

The Department of Health and Children (1998b) recommends that patients/clients in psychiatric hospital settings should be allocated a primary nurse who is responsible for their care. It is evident that there is now more emphasis being given to continuity of patient care by systems of work allocation, such as primary nursing and team nursing, but this is not universal (DoHC 2002a). As part of the inspection of psychiatric services, the Inspector of Mental Hospitals and his assistants incorporate consumer feedback by talking to patients/clients about their views of the services. Generally, patients/clients report satisfaction with elements of the service. However, they also report consistently poor knowledge of their illness, treatment plan and rights, lack of continuity of nursing staff, not knowing who their key or primary nurse is and wanting more therapeutic time with the nursing staff. These are issues that challenge psychiatric nurses in practice, education and management to address in the best interests of patient/client care.

It is evident from the consultation process that much effort is being made to implement systems that maximise nurse-patient interaction. The area where this proves most difficult is with in-patients, and sometimes other residential facilities, where psychiatric nurses frequently find that routine non-nursing tasks reduce the time available for interaction with patients/clients. Some mental health services already employ alternative grades of staff to perform tasks that are not within the professional role of the psychiatric nurse.

The recent report on the *Effective Utilisation of the Professional Skills of Nursing and Midwifery* (DoHC 2001d), provides a framework for the introduction of healthcare assistants. The potential of this resource can be utilised by psychiatric nurses in maximising their therapeutic potential with patients/clients.

### 3.5.3. Interdisciplinary Working

Mental healthcare is delivered within the context of a multidisciplinary team. In areas such as mental healthcare, where the interpersonal process is a central medium of care, it is inevitable that there is some overlap of roles within the team. In other countries, case management systems of care delivery have developed to match skills to patient/client needs and maximise continuity of care. To date, there has been little movement in this direction in Ireland.

The development of the mental health services in Ireland has resulted in the medical model being predominant in mental healthcare delivery. This centrality is reinforced in legislation and service structures, and has implications for expansion of services and psychiatric nursing roles.

Counselling, stress management, psychotherapies and other such services are increasingly provided by psychiatric nurses but, in many cases, referral systems and existing service structures preclude ease of access. Direct access to psychiatric nursing interventions also requires consideration when advanced practice roles are being considered, as autonomy is central to the concept of advanced practice. According to nurses participating in the consultation process, the development of innovative roles and services to meet patient/client needs has occurred, in the main, in services where medical support has been present.

#### 3.5.4. Mental Health Promotion

Mental health promotion is a central issue for the mental health services. The SLAN survey, which provided data in relation to perceived requirements for better health, found that the majority of respondents, both men (34%) and women (39%), regarded 'less stress' as their requirement for better health (Kelleher *et al* 2003). This was consistent across social class and age groups.

In consultations undertaken by the Department of Health and Children to inform the *Health Strategy*, the needs of people with mental health problems received more attention from participants than other conditions. The need to integrate mental health promotion into the work of all members of the multidisciplinary team, including nurses, was stressed, nurses being mentioned as particularly well placed to respond to this need. The *Health Promotion Strategy* (DoHC 2000a) particularly mentions depression, suicide, alcohol and drug misuse as targets for action and recommends the development of a national strategy for mental health promotion.

Mental health promotion has become a more central concern for mental health professionals. However, opportunities to develop services in this area have in the past been limited. While mental health promotion is part of the role of every psychiatric nurse, the organisation of services is focused on those with a diagnosis of mental illness, and therefore the full range of mental health promotion activities cannot readily be engaged in, in particular primary prevention.

#### 3.5.5. Aggression and Violence

Dealing with aggression and violence is receiving increasing attention in nursing generally, and psychiatric nursing in particular. Much work has been done in Ireland to train staff in prevention, de-escalation and management strategies. There is considerable variance in the use of seclusion among services. Some of this may be explained by differing levels of acuity and violent behaviour, and to some extent staffing or skill mix levels, or availability of facilities. But the issue continues to present a challenge to psychiatric nurses to deal with people in the most safe and therapeutic manner possible. The development of forensic nursing services in prisons, regional secure units and intensive therapy units provides opportunities for psychiatric nurses to develop expertise in this area. Concern was expressed by psychiatric nurses regarding the quality of education and training for dealing with aggression and violence, and the development of standardisation in this area was seen as vital.

#### 3.5.6. Education for Practice

Since the introduction of the diploma in psychiatric nursing, undergraduate pre-registration is now the only route to registration as a psychiatric nurse in Ireland. Although there has been a large increase over the past number of years in the number of places available in psychiatric nurse training (from 70 in 1994 to 343 in 2003) (An Bord Altranais 2003a), the registration route has implications for recruitment into the area and for the skill mix of the workforce, given the diverse settings and complexity of problems that patients/clients have. For example, in 2001, 14% of in-patients/clients in psychiatric hospitals were diagnosed with mental handicap (DoHC 2002b). Notwithstanding the imperative to move patients/clients with mental handicap to specialised care suited to their needs, there are some who have a dual diagnosis and would benefit from a range of knowledge and skills from both psychiatry and mental handicap nursing. In the past, nurses with qualifications in both disciplines would have the competencies to care for people with this form of dual diagnosis. The profession needs to examine the requirements for service and develop educational frameworks that will prepare nurses accordingly.

While psychiatric nurses can avail of generic postgraduate programmes, such as primary degrees, higher/postgraduate diplomas and masters' degrees in nursing, post-registration educational opportunities for psychiatric nurses in areas of mental healthcare require further development. At present, there are courses at various levels, up to and including masters' degrees, in behaviour therapy, cognitive behaviour therapy, counselling, mental health of older people, acute mental health, community mental health, addiction, child and adolescent mental health, and psychoanalytic studies, among others. However, these courses are not available throughout the country, and many are located in the Dublin region. Many of these courses are not specific to nurses.

The range of courses provided also requires development. Courses have tended to follow existing specialities and, while this is appropriate to some extent, frameworks need to be sufficiently flexible to incorporate new areas of practice. A number of areas not perceived as being sufficiently provided for were mentioned in the consultation process. These included challenging behaviour/dealing with violence and aggression, eating disorders, rehabilitation and severe and enduring mental illness. Postgraduate education frameworks for psychiatric nursing in third level institutions is central to the development of practice.

#### 3.6. Supports for Development

In the dialogue surrounding the development of psychiatric nursing roles, the importance of CPD could not be overstated. The issues common to other divisions of nursing and midwifery are referred to in the Executive Summary. Clinical supervision was particularly mentioned as being important in providing support, encouragement and skills for psychiatric nurses in developing their psychotherapeutic interventions with patients/clients.

A number of psychiatric nurses currently engage in clinical supervision, due to their involvement in psychotherapies, but

this tends to be outside the course of their normal work. The evidence relating to clinical supervision suggests that positive outcomes for staff can be achieved (Butterworth *et al* 1997, Bishop 1998), but there is little research carried out on benefits to patients/clients. There are some developments in integrating clinical supervision and reflection on practice into psychiatric nursing practice, which, when evaluated, will provide valuable information on frameworks for the future.

Clinical nurse managers are central to the culture and orientation of care areas, and the degree to which innovation and development can take place. In the consultation process, openness, facilitation, leadership and flexibility were qualities that were highly valued in clinical nurse managers by psychiatric nurses. The extent to which clinical nurse managers are developed and supported for their central role needs consideration.

### 3.7. Agenda for Future Development

It is estimated that at some point in their adult lives, one person in four will suffer from mental illness, and 25% of families are likely to have at least one member suffering from a mental illness.

Much development of structures has taken place within the mental health services, and psychiatric nurses have been key personnel in implementing the changes.

In maximising the psychiatric nursing contribution to mental healthcare, a number of key issues emerge.

Psychiatric nursing intervention skills require continued development, particularly in relation to chronic and enduring mental illness, and outcome evaluation is an important component of this.

The continued development of CNS roles regionally will enhance the quality and uniformity of services offered to patients/clients. The development of new roles, both CNS and ANP should take place in relation to patient/client need, health policy and the core values of psychiatric nursing.

Easier and direct access to psychiatric nursing services is required to improve service quality and ease of access for the public.

There is much room for development in post registration psychiatric nursing education. Flexible frameworks are required that allow for curriculum development in line with service needs and those of participants.

The main emphasis of the mental health services at present is on secondary and tertiary care. The need for the mental health services to become more involved in primary prevention is clear and psychiatric nurses have a major role to play in this area.



# Sick Children's Nursing

## 4.1. Introduction

This section explores the role of Registered Sick Children's Nurses (RSCNs) in Ireland now and in the future, in line with changing service needs. It reviews paediatric nurse education and clinical nurse specialist and advanced nurse practitioner roles. The term *paediatric nurse* is used throughout this section to encompass all nurses holding a registerable qualification in the care of the child (i.e., RSCNs).

## 4.2. History

The need for specialist hospitals for the care of sick infants and children has been inherent in Irish healthcare for well over a century, and this is evident in the founding of what became known as The National Children's Hospital in 1821, followed by the founding of The Children's Hospital, Temple Street in 1872. Then, to serve the needs of the paediatric population of south and west Dublin, a third children's hospital, Our Lady's Hospital for Sick Children, was founded in 1956, in Crumlin (Kelleher & Musgrave 2000).

Healthcare provision at this time centred on the acutely ill child being admitted to hospital. Children had limited contact with their families, visiting was kept to a minimum and admissions to hospital tended to be prolonged, with little time for children to play or continue their education (Kelleher & Musgrave 2000).

The first schools of paediatric nurse education were set up in The National Children's Hospital and Temple Street Hospital in 1884 and 1883 respectively. The School of Nursing in Our Lady's Hospital Sick Children was established in 1957 (Kelleher & Musgrave 2000). The model of nurse education provided was the traditional apprenticeship model, and the first registerable qualifications in sick children's nursing were recorded with An Bord Altranais in 1922. The duration of these courses varied in length and the documentary evidence available reflects the changing structure of these courses from the early 1950s to the present day.

During the early 1950s, there was a three-year programme leading to registration as a RSCN, and this was followed in the early 1970s by the commencement of a four-year programme, leading to combined registration in both the sick children's and general divisions of the register. Both programmes were phased out. Rationales cited for phasing out the three-year programme included problems encountered by singly qualified paediatric nurses in finding employment outside the greater Dublin region, and outside Ireland and the UK (Kelleher & Musgrave 2000, DoHC 2000b). The four-year programme was phased out in the late 1980s and early 1990s, due to a reduction in the number of applicants, and also due to the success of the post-registration

programme, which over the years has developed and is now a higher diploma of eighteen months' duration. Many paediatric nurses currently working in centres outside Dublin are required to hold an additional registerable qualification, usually in general nursing.

### 4.2.1. Policy Context

The need for nurses trained and skilled in the care of sick children and their families has been well reported in the literature over the years. A number of policy reports identify what those needs are, and how paediatric nurses play a key role in caring and being an advocate for children from birth to adulthood. The focus of RSCNs is to meet the physical, emotional, social, spiritual and developmental needs of each child within the context of the family and community in order to maximise health. RSCNs assist the child and their family/primary caregivers in the promotion and improvement of health, management/recovery from illness and support in dying and death.

Fundamental to the practice of paediatric nursing are the complexities of caring for children from birth to adulthood. The Child Care Act, 1991 defines a child as "any person up to the age of 18 years (other than a married person)." This definition presents paediatric nurses with many challenges in their practice, from caring for the infant, to the child, to the young parent, and to the complexities of advocacy and consent to treatment.

As early as 1959, the *Platt Report* in the UK identified the needs, and expressed concerns, about the welfare of children in hospital (Ministry of Health UK 1959). The UK produced guidance for all those working with sick children, in relation to child health, nursing services, service provision and the minimum standards acceptable for caring for children in hospital. Examples of such reports include *The Welfare of Children and Young People in Hospital* (DoH UK 1991) and *Bridging the Gaps* (Thornes 1993).

In more recent times, the Allitt and the Bristol Royal Infirmary Inquiries have helped to focus health service providers' minds on the complex issues associated with caring for sick children, and the minimum accepted standards in caring for them, and recognition of the skills and training

required to meet their needs (DoH UK 1994b, RCN 1994, Bristol Royal Infirmary Inquiry 2001, UKCC 2001).

The Allitt Inquiry was an independent inquiry set up to inquire into the deaths and injuries on the Children's Ward at Grantham and Kesteven General Hospital from February to April 1991. The findings of the report highlighted many inadequacies in the system for recruiting paediatric nurses, and monitoring of sick leave. The report made 13 recommendations. The problems encountered in Grantham and Kesteven could potentially have occurred anywhere, and, for that reason, strict guidelines were issued in light of the findings reported by many groups, including the Royal College of Nursing (RCN), which recommended a minimum of two registered paediatric nurses per shift (DoH UK 1994b, RCN 1994).

The Bristol Royal Infirmary Inquiry was set up to inquire into the management and care of children receiving complex cardiac surgical services in the Bristol Royal Infirmary between 1984 and 1995. This inquiry led to 198 recommendations being made in relation to the future care of children; culture of the NHS; respect and honesty; a health service which is well led; competent healthcare professionals, and safety of care (Bristol Royal Infirmary Inquiry 2001).

The *Health Strategy* (DoHC 2001a) recognises that social, economic and environmental conditions all have an impact on child health and management, and that an integrated approach is required. It outlines a commitment to undertake a review of paediatric services. The *Primary Care Strategy* (DoHC 2001c) outlines a framework for healthcare in the community between primary, secondary and tertiary healthcare providers.

The *National Children's Strategy* (Government of Ireland 2000a) encompasses all aspects of children's needs and particularly on the changing pattern of disease, the need to tackle the social causes of disease, the impact of advances in medicine and surgery and the participation of children in damaging behaviours. The strategy has 14 objectives, subdivided into three main national goals: all children will have a basic range of needs; some children have additional needs; and all children need the support of family and community. The Strategy states that "Children deserve to be highly valued for the unique contribution they make through just being children". Their best interests should always be the primary concern.

*Children First*, produced by the DoHC, contains national guidelines for the protection and welfare of children (DoHC 1999b), which help focus all healthcare providers on their duty to protect children. It provides guidance on different types of abuse, how to report suspected incidents, and treat and care for vulnerable children. The issue of child abuse is a complex area, and is one that is very much in the public domain at the moment. It is an area of child health that needs to be addressed in more depth and needs to be incorporated into paediatric nurse education and CPD across all sectors of primary, secondary and tertiary care.

In 2000, the DoHC published the *Report of the Paediatric Nurse Education Review Group* (DoHC 2000b). This report was the result of work undertaken in light of the *Report of the*

*Commission on Nursing*, which recommended that the content, duration and academic award for Sick Children's Nursing be reviewed (Government of Ireland 1998). The report made twelve recommendations, including that there should be educational options for those wishing to obtain registration as a RSCN (DoHC 2000b). It proposed that the option of an integrated programme leading to a dual qualification should be explored within the context of a direct entry programme, and an accelerated post-registration route to registration as a RSCN. It also recommended that paediatric nurse education should be available outside the Dublin region. The DoHC has funded a post to explore the feasibility of developing a post-registration course outside Dublin. The report highlights that children's healthcare and subsequent nursing needs are fundamentally different to adults. Kennedy suggests that these unique and specific needs of both children and their families are best provided by a distinctive and competent nursing workforce who hold a recognised qualification in caring for children (Bristol Royal Infirmary Enquiry 2001).

One of the key policy developments following the *Report of the Commission on Nursing* (Government of Ireland 1998) has been the appointment of a Nursing Advisor for Paediatric Nursing to the Nursing Policy Division in the DoHC. Since the commencement of this post, there have been a number of initiatives and groups brought together to highlight and progress the needs of paediatric services on a nationwide basis.

One such group is the Paediatric Nursing Advisory Forum, which has representatives from clinical, managerial and educational sectors in different settings across the country. The group provides a forum where issues may be discussed and debated at both a national and local level.

The *Report of the Commission on Nursing* also recommended the change in the registerable qualification from that of *Registered Sick Children's Nurse* to *Child Health Nurse* (Government of Ireland 1998). However, no decision has been made on the title change. Debate continues on the preferred title to be used, and is currently being reviewed by the Paediatric Nursing Advisory Forum.

The introduction of the *Scope of Nursing and Midwifery Practice Framework* (An Bord Altranais 2000a), has enabled nurses to enhance the care of children and to identify future needs for both the profession and the service. It has enabled paediatric nurses to expand their knowledge, question practice and develop many roles, which previously may not have been possible.

The report *Investing in Parenthood to Achieve Best Health for Children* (Best Health for Children 2002) called for universal and targeted supports for parents, multi-agency and cross-departmental working, people-centred and community development approaches and promotion of children's rights.

The report *Children Being Cared for in Adult Wards* (Children in Hospital Ireland 1999) recommended that all children in hospital should be cared for in appropriately staffed and supervised children's units, whether medical or surgical. This also applied to children attending A&E units that do not have the facilities to care for children.

Given the current difficulties with skill mix, it has not always been possible to have a RSCN on duty 24 hours a day in adult A&E units. The RCN, however, recommends that where a separate department cannot be provided, separate waiting areas, play facilities and examination, treatment and recovery rooms should be available (RCN 1994).

The *Charter for Children in Hospital* (Children in Hospital Ireland 2002) details care required for children in hospital. This encompasses hospital care versus care at home; parental involvement; information sharing; reducing anxiety and/or treatments. The charter states that children should be cared for in children's wards and not cared for with adults; play, recreation and education should continue while in hospital; children should be cared for by staff who are trained and skilled in meeting their physical, emotional and developmental needs; continuity of care and privacy should be respected at all times.

The *Report on the Implementation of the United Nations' (UN) Convention on the Rights of the Child* clearly identifies the lack of a cohesive service between primary, secondary and tertiary care in Ireland, which, in turn, hinders the care being provided to children (Department of Foreign Affairs 1996).

In the late 1990s, at the request of the Minister for Health and Children, the Council for Children's Hospital Care was established between the three Dublin paediatric hospitals to assist, co-ordinate and facilitate the development of a co-ordinated approach to paediatric services among the three hospitals.

The *Nursing Recruitment & Retention Group Report* (DATHs 2000) was published as a result of a review of nursing vacancy rates in November 1999 by the Dublin Academic Teaching Hospitals, including one of the three children's hospitals. The report outlines some of the causes for vacancies, including lack of promotional opportunities; pay; low staffing levels; dissatisfaction with nursing management; lack of recognition and poor working conditions. Although not all the paediatric hospitals were included in this review, the findings of the report and the action plans identified could be applied to paediatric settings, especially in light of the decreasing numbers of students undertaking the post registration course. Initiatives such as preceptorship programmes, back-to-nursing courses, CPD and better working conditions are critical in ensuring that paediatric services are maintained.

### 4.3. Demographic and Epidemiological Issues

Ireland has the highest proportionate population of children in the EU: almost 24%, compared to a mean proportion for the rest of the EU of 17.4% (DoHC 2002c). However, there has been a steady decline in this age group in recent years, as the population of the country continues to age.

Injuries and poisoning remain a major cause of death in the under 14 year olds (Best Health for Children 2002). Table 1 details the causes of infant/child deaths ages 0-18 years during 2001 (CSO 2001). It should be noted that statistical analysis does not allow for recording of the 15-18 year age group, this group are therefore represented in the 15-24 year old age group.

With a decreased level of infant mortality, and an increase in the numbers of immigrant children presenting with diseases not frequently seen in Ireland, together with changing expectations, the health service is currently encountering inequalities in its service provision for children (DoHC 2002c). The infant mortality rate in Ireland is similar to the EU average. However, the infant mortality rate for Travellers is 2.5 times that of the average population (Best Health for Children 2002).

There have been huge improvements in the health status of our children and a reduction in infant mortality. There is however evidence to suggest that this improvement has not been as large, or as sustained, as the health status of children from other European countries (DoHC 1999c, DoHC 2002c).

Accidents are a significant cause of morbidity and mortality. Psychological and psychiatric conditions are also a significant healthcare issue in childhood and adolescence. A large proportion of health service resources are spent treating accident victims. There is a need to increase public awareness of childhood disability, and this includes an awareness of the prevention of some of these disabilities (DoHC 2002c).

The pattern of disease is changing: rising rates of adolescent suicide, substance abuse, sexually transmitted diseases and asthma, together with an increase in child obesity and other eating disorders are further challenges for paediatric nurses.

In relation to immunisations for children, the uptake for primary immunisation averages 86% for DPT/HIB/Polio vaccinations, and 75% for MMR. The Government's aim is for a 95% uptake rate, which is necessary to eradicate measles in Ireland by 2007 (DoHC 2000a, 2002c)

There are significant deficits in relation to data collection and how this data is stored. All ten health boards collect birth notifications, marital status of the mother and data regarding uptake of primary immunisation. Apart from this, different health boards collect a wide range of data. Six boards record breast-feeding initiation rates, but only four record maintenance at three months. This is computerised in only one area (Best Health for Children, 2000). The *National Breast Feeding Policy for Ireland* (DoH 1994a) recommends that rates of breastfeeding should be recorded at discharge and four months. Accident data for ages 0-15 are recorded by only one board, as is the update of the six-week developmental check. The National Conjoint Child Health Committee recommended that a core data set needs to be nationally agreed before child health indicators can be developed (Best Health for Children 2000).

The Irish family, which traditionally comprised two married parents and a support network of relations, has changed in recent decades, resulting in changes to informal family support structures (McKeown 2001, Molloy 2002). There is a responsibility on society to address child poverty, develop quality services for all and reduce family conflict (McKeown 2001, McKeown & Sweeney 2001). These factors impact on paediatric nurses, as their role encompasses child health promotion and parentcraft and they will need further education of the implications of the social circumstances of the children in their care.

Table 1 Deaths Registered during 2001, Classified by Cause and Age Group. Source: CSO 2001

	UNDER 1 YEAR	1-4 YEARS	5-14 YEARS	15 – 24 YEARS
<b>Total number of Deaths</b>	337	69	83	410
Infectious & Parasitic Diseases – Total	9	3	4	7
Whooping cough	1			
Meningococcal infection	6		4	3
Septicaemia	1	1		1
Other infectious & parasitic diseases	1	2		3
Malignant Neoplasms - Total	1	8	10	38
of stomach				2
Leukaemia		3	3	7
Other malignant neoplasms	1	5	7	29
Diabetes Mellitus				1
Anaemias	1			
Meningitis	1	1	1	
Diseases of the Circulatory System - Total	7	4	3	11
Ischaemic Heart Disease	2			1
of which Acute Myocardial Infarction	2			1
Atherosclerosis	1			
Other diseases of Circulatory System	4	4	3	10
Pneumonia	3	6	2	5
Bronchitis, emphysema & asthma		1		4
Ulcer of stomach & duodenum				1
Nephritis, nephrotic syndrome & nephrosis		1	1	
Congenital Anomalies	114	11	4	14
Certain conditions pertaining to the perinatal period	130	2		
Birth trauma	4			
Signs, symptoms & ill-defined conditions	49	5	1	3
Injury & Poisoning	2	19	37	275
Fractures		2	4	30
Intracranial and internal injuries, including nerves		8	15	113
Burns		1	2	3
Poisoning and toxic effects		3	2	21
Other injuries and poisonings	2	5	14	108
All other diseases	20	8	20	51
<b>EXTERNAL CAUSES</b>				
Accidents & adverse effects	1	19	35	186
Motor vehicle traffic accidents		8	17	119
Accidental falls			4	12
Suicide			2	97
Homicide	1	1	2	9
All other external causes				7

Ireland has a growing culturally diverse population, with increased numbers of asylum seekers and refugees with complex needs and differing cultural traditions (NWHB Public Health Department 2001). Cultural diversity education should be incorporated into all aspects of paediatric training.

The *National Health and Lifestyle Surveys* (Friel *et al* 1999) noted the worrying percentage of children smoking (as young as 9), drinking alcohol, having poor diet patterns and a lack of regular exercise. Less healthy lifestyles are associated with lower socio-economic groups. This has implications for

paediatric nursing practice and education, such as the necessity to consider the role of health promotion and illness prevention for all paediatric nurses.

The second *National Health and Lifestyle Surveys* (Kelleher *et al* 2003) states that there has been a 2% drop since 1998 in the percentage of school-age children smoking, particularly in the 12-14 year age group. In relation to alcohol consumption, the report found that there had been an increase of 9% in the numbers of school age children who had never consumed an alcoholic drink, being most marked in 10-11 year olds. The aim of the *National Health Promotion Strategy* (DoHC 2000a)

is to delay the onset of alcohol consumption in children and adolescents, and the above figures seem to indicate a move in that direction.

Poverty has a negative effect on health, for example rural location and isolation are barriers in accessing health services (DoHC 2000a, 2002c). These factors, together with other influences, such as homelessness and poverty, need to be tackled (DoHC 2002c). *Best Health for Children* (2001) aims to achieve equity for children, ensuring that they have access to a universal standardised child health service through an holistic health promotion approach.

#### 4.4. Current Developments

There is a paucity of published information in relation to paediatric nursing in Ireland and Condell (1998) highlights the lack of visibility of this discipline of nursing.

There are 388 beds in the three Dublin paediatric hospitals. In the rest of the country, there are 560 beds for paediatric patients. These beds are based in designated paediatric wards and units, or in adult services, in a variety of hospitals (DoHC 2000b). However, analysis of these bed numbers does not allow for the recording of these figures by the Department of Health and Children as speciality paediatric beds. Therefore, it is difficult to clearly identify the location of paediatric beds throughout the country, because some children are seen in adult clinics and treated in general hospitals, and their episodes of care are recorded under the adult specialities, as opposed to distinct paediatric specialities (Children in Hospital Ireland 1999).

The *National Review of Acute Hospital Bed Capacity Report* indicates that the projected bed days used for the 0-14 yr old age group will increase, and that an additional 125 beds will be required by 2011 (DoHC 2002d). This has implications for paediatric nurses and services, as fewer paediatric nurses are being trained.

Current data indicates that children from different health board areas experience significantly different levels of health service provision (NWHB 2001, *Best Health for Children* 2001, DoHC 2002b). Examples include the lack of availability of paediatric A&E departments and expert paediatric care from paediatric CNSs outside the eastern region. There are only four paediatric CNSs based outside the eastern region, which necessitates children travelling long distances from home to receive such specialist care. However, it is also recognised that, due to the location of the majority of the paediatric CNSs in the eastern region, a number of them provide a service whereby they will visit children in their own homes throughout the country.

The concept of shared care has developed, particularly in paediatric oncology, as a means of providing expert care to children without the necessity for them to be based in Dublin for long periods of time during their treatment. Shared care enables expert care to be provided in the acute tertiary centre, with the child returning nearer home, to a hospital in their community, to receive the continuing care required to treat their condition (Patel *et al* 1997).

An example of the increasing complexity of care in the home

was highlighted by a recent study undertaken in Our Lady's Hospital for Sick Children, *A Review of the Needs of Children Dependent on Long-term Ventilation* (O'Callaghan 2003). In the past, children on long-term ventilation may not have survived their initial disease process, but due to the advancement of medical and nursing knowledge and practice, their life expectancy has increased, and there is an expectation, from both the children's families and also healthcare providers, that they will be cared for at home.

This means that there is a need to develop services to care for these children at or near home. For the most part, expert practitioners in the acute hospital setting care for such children. In some cases, due to the complexity of the condition, the needs of the child may not be fully met in their local hospital, and, for this reason, a number of children are required to stay for prolonged periods in one of the three Children's Hospitals in Dublin.

Improved hospital care and facilities are needed for adolescents (*Best Health for Children* 2000) and separate designated hospital facilities, together with appropriately trained paediatric nurses, are priorities.

Traditionally, children were admitted to hospital, treated, and, after some time, were discharged home to the care of their parents. Now, however, hospital stays are shorter, children with complex needs are being cared for at home, and, in a number of cases, with minimal professional intervention. The expectations of children and their parents/carers are greater, and higher standards of care and services are required. However, in accepting this 'partnership' in providing for these children, healthcare providers must ensure that the service is there to support these children and families at home.

##### 4.4.1. Specialist Practice

Nurse specialists have worked within paediatric nursing in Ireland for some time, their roles and skills developing in the absence of a planned framework. There is, however, little published literature in relation to specialist paediatric practice. Lloyd's study of paediatric nurse specialist practice in Ireland (Lloyd 2000) outlined recommendations in relation to role development, management support, nursing policy and educational requirements for CNS roles, and mentions the need to examine career and professional development within the CNS role to reflect the novice to expert nature of the role.

Cronin (2000) highlights the value of specialist nursing practice for the dying child. King (1999) suggests that paediatric nurses are well placed to detect and monitor dysfunctional families and have a valuable role to play in the management of children who are victims of abuse. Bastian-Lee (2002) described the role of the paediatric respiratory nurse specialist and notes the autonomy and recognition that these roles have brought to paediatric nurses.

In their research study in 1997, Bamford and Gibson described the development of the CNS role in two acute hospitals in the UK (Great Ormond Street Hospital and University College London Hospital, NHS Trust) and outlined the future development, educational needs and

career pathways for nurses in these posts, and the necessity for these roles to develop alongside service development.

#### 4.5. Key Issues

The *Health Strategy* outlines levels of care for children and the health system (DoHC 2001a). These levels relate to family and self-care, primary care, acute hospitals/specialist services and tertiary care. There are many possibilities for future development of paediatric nursing within these levels of care.

##### 4.5.1. Generalist, Specialist and Advanced Practice

Participants in the consultative process discussed the concept of generalists, specialists and advanced practitioners across all areas of general nursing. Some said that this was relevant for paediatric nursing, given the complexity of paediatric care. A competency-based approach, which allows for the development and enhancement of roles within the generalist domain, would be useful, utilising a framework such as Benner's (1984) *Novice to Expert*. This would help demonstrate progression through different levels of practice and would go some way to explicating expertise in practice. Participants said that specialist modules, based on clinical expertise, should be provided for those who do not wish to pursue CNS or ANP roles, i.e., stay in generalist roles, but who wish to enhance practice and engage in CPD.

Participants mentioned the lack of specialised courses in clinical specialities. There are three paediatric specific-modules on courses in one third level institution: the paediatric accident and emergency, intensive care and oncology courses.

Participants said that other specialist courses were needed, either as modular, distance learning, full or part time programmes. Courses suggested were community nursing, orthopaedics, ENT, non-oncology haematology, pain management, palliative care, cardiac, child development, challenging behaviour, neurology and neonatal care (care of the sick as opposed to the premature neonate).

Since the development of the CNS framework by the National Council, there have been 57 paediatric CNSs approved in Ireland. Only four are located outside the Dublin region, although a significant number of paediatric beds are located outside the region. The following outlines titles of approved CNS paediatric posts.

##### Titles of Approved CNS Posts Paediatric Nursing. Source: National Council CNS/CMS Database May 2003

- |                          |                         |                       |
|--------------------------|-------------------------|-----------------------|
| • Airways/tracheostomy   | • Epidermolysis Bullosa | • Occupational Health |
| • Asthma                 | • Gastroenterology      | • Oncology            |
| • Bone Marrow Transplant | • Haemodialysis         | • Ophthalmology       |
| • Cardiac                | • Haemovigilance        | • Orthopaedic         |
| • Child Psychiatry       | • Haematology           | • Paediatric Liason   |
| • Continence             | • Hepatology            | • Pain                |
| • Cystic Fibrosis        | • HIV                   | • Parent Educator     |
| • Dermatology            | • Infection Control     | • Oncology            |
| • Diabetes               | • Metabolic Disorder    | • Renal               |
| • Endocrine              | • Neurology             | • Resuscitation       |
| • ENT                    | • Nutrition             | • Urology             |

A review of the needs in other areas of the country should be undertaken, as some of the existing roles could be developed in other locations. Other CNS roles suggested for future development were:

- Colorectal nursing
- Breastfeeding
- Neonatal care
- Adolescent care
- Anaesthesia
- Community paediatrics
- Challenging behaviour
- Health promotion
- Laser
- Psychiatry
- Child development
- Learning disabilities
- Transitional care co-ordinator
- Childhood obesity
- Sexual health and
- Adolescent suicide.

In developing these roles, consideration must also be given to the educational programmes available, or required, in order to enable the CNSs to reach their full potential.

At present there are no ANPs in paediatrics in Ireland. However a number of centres are exploring the possibility of developing ANP roles. Possible roles put forward by participants included:

- Primary care
- A&E
- Dermatology
- Respiratory medicine
- Community paediatrics
- Cardiology
- Pain management
- Gastroenterology
- HIV
- Haematology/oncology
- Hepatology
- Endocrinology and
- Diabetes management.

##### 4.5.2. Nursing Leadership

Participants in the consultation process said that it was important to have a paediatric nurse at health board executive level to ensure recognition of the need for paediatric nurses and paediatric services. There is a critical need for the

integration of child health services and collaboration with members of the multidisciplinary team in primary, secondary and tertiary care to support best practice and provide a co-ordinated, seamless service. A key concept identified in the development of paediatric nurse leaders was the provision of relevant educational programmes to develop staff.

#### 4.5.3 Nurse Education

Currently, the only route available to train as a paediatric nurse is to undertake a post registration education programme. Nurses who hold a qualification in another discipline of the register may apply to undertake the Higher Diploma in Nursing (Sick Children's Nursing) in any of the three children's hospitals, in association with the third level institutions to which they are affiliated.

Participants in the consultation process were of the view that the length of study for a nurse who is registered in another discipline of nursing to complete a higher diploma in sick children's nursing may militate against entry to paediatric training. Currently, it will take a minimum of four years to obtain a primary degree, followed by a period of clinical placement, and then an 18-month higher diploma, before a person can obtain a RSCN qualification.

It should be noted that, in the last three years, the numbers of registered nurses commencing training in paediatric nursing has dropped from 133 in 1999, to 126 in 2000 to 107 in 2001. Currently there are 3,774 Registered Sick Children's Nurses on the active register (An Bord Altranais 2003a).

In 2002, University College Dublin appointed a paediatric nurse tutor to develop the curriculum programme for the proposed four-and-a-half year degree programme, leading to the dual qualification of RSCN and RGN. The decision with regard to progressing the dual qualification programme has yet to be made.

Participants said that clinical nurse educators were a useful model in supporting and developing complex and specialist skills training at ward level. These roles have developed in a number of sectors, including the acute paediatric centres. The post holders are employed in a specific ward and/or division and are responsible for the education of trained staff, from induction and orientation, through preceptorship, to expert practitioner in their specialist area. This is achieved through formal and informal teaching including working alongside nurses in the clinical setting. The role of the nurse educator needs to be further explored.

The consultation process identified a considerable lack of paediatric nursing research, and this is evident in the dearth of Irish literature.

#### 4.5.4. Community Paediatric Nursing

Today, it is acknowledged by healthcare providers that families play an important role in the care of their child, and in modern healthcare it is envisaged that parents/carers, together with other family members, will be fully involved in the child's care, with hospital stays kept to a minimum.

Participants said that there was a need to develop the community paediatric nursing services nationwide. Following

the transfer of children to their homes, they and their families can be left with minimal support from healthcare providers. However, at the moment, this support/care is currently being met by combined efforts from CNSs appointed to liaise with the community, PHNs, and CNSs from the eastern region providing an outreach service. Although the PHN is recognised as playing a significant and valuable role in supporting these families, the community paediatric nurse also has a role, and therefore the development of community paediatric posts should complement the role of the PHN in the community setting. Community paediatric nurses could be considered at both generalist and specialist practice level.

Currently the Nursing Policy Division in the DoHC is developing a *Strategy for Nursing and Midwifery in the Community*, for which submissions were called from all disciplines of nursing, including paediatrics. The forthcoming Strategy is expected to suggest that community paediatric nurses are best placed to provide nursing care for children, and the best location for this care is in the child's home.

Each year, children present who have specialist healthcare needs, and these should be addressed in conjunction with specialist nurses in secondary care settings, liaising with primary care teams, tertiary centres, and shared care providers. Currently, two nurse specialist roles have developed in relation to community paediatric nursing. This initiative could be used as a model for developing similar posts elsewhere in the country.

#### 4.5.5. Health Promotion

The report of the Chief Medical Officer, *The Health of our Children* (DoHC 2002c), comments on the need for the development of health services for children, and in particular health promotion. Irish children, compared to their European counterparts, have a higher usage of illicit drugs and alcohol usage, and, between 1995 and 1999, there was a marked increase in alcohol, tobacco and drug usage, particularly alcohol, in the 15-16 year age group.

There is a need for greater emphasis on the promotion of healthy lifestyles, protective measures (e.g. immunisation), prevention of accidents, appropriate management of disability including rehabilitation (DoHC 2002c), and improvements in dietary habits (DoHC 2000a). Promotion of healthy lifestyles, particularly in relation to diet, physical activity, smoking, alcohol and substance abuse falls within the scope of nursing practice. All paediatric nurses will need to embrace the principles of the promotion of healthy lifestyles. The current paediatric nurse education programmes encompass health promotion (An Bord Altranais 2000b), but the emphasis needs to change from that of the sick child to the importance of health promotion in providing optimum healthy life styles, across all sectors and in collaboration with all healthcare workers.

#### 4.5.6. Practice Development

Paediatric nursing practice needs to be developed across the primary, secondary and tertiary sectors of the health service, and needs to encompass not only the development of practice guidelines but also the development of research projects, audit, quality and risk management initiatives. The role of

the Nursing Practice Development Co-ordinator is to provide professional nursing leadership, and the development, implementation and evaluation of clinical policies, procedures and protocols, the establishment of nursing development units and leading quality assurance programmes. The post is relatively new and, currently, there is only one such post in paediatrics in Ireland.

Participants in the consultation process argued that there was a need for evidence-based guidelines and protocols at national level to assist paediatric nurses in providing optimum care to children and their families. A number called for a central database, which would be available to all paediatric nurses, and nurses working in paediatric units, to which they could contribute and avail of the shared knowledge and experiences. However, even with the development of guidelines, there should be clear programmes for implementation, dissemination and evaluation, in order to ensure that performance improves (Royal College of Paediatrics and Child Health 2001).

#### 4.5.7. Clinical Placement Co-ordinators

The need for CPCs to support students in the three paediatric training hospitals was mentioned by participants. Currently there are no CPCs in post, as these posts were originally developed to meet the needs of pre-registration students. However, with the move of nurse education to third level, the increasing numbers of seconded students, and the complexities of paediatric nursing, the need for further support for both pre- and post-registration students is widely recognised.

#### 4.5.8. National Retrieval and Transport Teams

Participants said that there was a need to set up retrieval and transport teams to enable the safe and timely transport of acutely sick children throughout the country. Paediatric intensive care is a relatively new speciality in paediatric healthcare (NHS Executive 1997). All of the paediatric intensive care units are based in the children's hospitals in Dublin, and it is necessary for children to be transferred to Dublin for intensive care. Participants stated that it is on occasions, difficult for some of the smaller general paediatric units to secure the safe transfer of a patient from their units to one of the Dublin hospitals (Justin 1996). It was felt that the development of a retrieval team for the safe transfer of the acutely ill child, similar to the service provided by the three Dublin Maternity Hospitals for the safe transfer of the acutely ill neonate, would enhance the service for these children. This is not a problem that is unique to Ireland, it has been reported in the UK in recent years (NHS Executive 1997). Participants suggested that all paediatric nurses should undertake a paediatric advanced life support course. This would ensure adequate training to care for children in emergency situations, especially for those nurses working outside Dublin, who will be involved in the transfer of these children to other centres at some stage, and who may be caring for them in an adult environment.

In the reports of the Committee on Neonatal Care Services, (1988a, 1988b) Comhairle na n-Ospideal acknowledged the role of the nurse in the provision of special/intensive care for neonates. They stressed that encouragement, and the necessary arrangements by health boards, should be given to

nursing staff to acquire formal training in the area.

#### 4.5.9. Information Technology/Communication

Throughout the consultation phase, the issue of poor information technology infrastructures and poor communication across primary, secondary and tertiary services were discussed. Participants felt that the service could be improved with an investment in this infrastructure, together with appropriate training and support. The needs of children and families could be met more efficiently, and thus healthcare provision could be improved.

#### 4.6. Agenda for Future Development

Ireland has the highest proportion of children in the birth to fourteen-year age group in the EU. Given the current causes of morbidity and mortality for children in Ireland, paediatric nurses need to embrace health promotion, including healthy lifestyles, and disease prevention at all levels of care.

The outcome on the discussions on the future of a direct entry paediatric education programme are still awaited.

The development of the *Strategy for Nursing and Midwifery in the Community* will be welcomed, and it is anticipated that it will result in the integration of paediatric nursing services in the community.

Practice development in paediatrics will be important to support developments in care both at primary, secondary and tertiary level.

There is a need to increase the number of CNS roles in response to identified health service needs outside the major centres. Suggested CNS posts could include: pain management, neonatology, breastfeeding, community, adolescent care and health promotion. However, while suggesting these areas for CNS posts, there is also a need to fully assess service need.

Promotion of healthy lifestyles, particularly in relation to diet, physical activity, smoking, alcohol and substance abuse falls within the scope of paediatric nursing practice, and is being further developed in paediatric nurse education programmes for the future.

Potential areas for ANP development are: primary care, A&E, dermatology, respiratory medicine, community paediatrics, cardiology, pain management, gastroenterology, HIV, haematology/oncology, hepatology, and endocrinology and diabetes management.

# Mental Handicap Nursing

## 5.1. Introduction

This section reviews mental handicap nursing, the most recently established discipline of nursing in Ireland. Registered Mental Handicap Nurses (RMHNs) provide a range of services across a wide variety of locations, addressing the particular and complex needs of their clients, and requiring particular skills and personal qualities distinct from those in other disciplines of nursing. An overview is given of the history of the discipline and current issues affecting its development in recent years and in the immediate future.

The World Health Organisation (WHO 2000) defines intellectual disability (ID) as:

*"...A condition of arrested or incomplete development of the mind characterized by impairment of skills and overall intelligence in areas such as cognition, language, and motor and social abilities. Also referred to as intellectual disability or handicap, mental retardation can occur with or without any other physical, [sensory,] or mental disorders."*

The term ID encompasses any set of conditions, resulting from genetic, neurological, nutritional, social, traumatic or other factors occurring prior to birth, at birth, or during childhood, up to the age of brain maturity, that affect intellectual development.

In this report, the title *Registered Mental Handicap Nurse* is used, as described in the *Nurses Act, 1985* as this is the current legal title, and *mental handicap nursing* will be used to refer to the relevant nursing activities. The term *intellectual disability* or *ID* is used to refer to services (except where texts are quoted directly).

## 5.2. History and Context

### 5.2.1 Development of Mental Handicap Nursing in Ireland

Until the late 1950s there was relatively little provision of special services for people with mental handicap. In 1955 the DoH requested An Bord Altranais to consider the need for a three-year course in ID nursing (Robins 2000). The register for RMHNs was established and the first training schools offering a three-year course in mental handicap nursing opened in 1959 (Government of Ireland 1998). Mental handicap nursing in the early 1960s focused on the treatment and care of the severely disabled of all ages, the treatment, care and training of the lower ranges of moderately disabled children and moderately and mildly disabled adults and of others with ID (DoH 1965).

More schools of mental handicap nursing were established

from that time until 2002, and the syllabus of training has been revised on several occasions to reflect trends in care and service provision (Chavasse 2000).

### 5.2.2 Philosophical and Other Influences on Services for People with Intellectual Disability

The main initiative for the provision of services for people with ID has come from voluntary organisations, including religious orders and parents' and friends' organisations. The philosophy of services, including nursing services, for people with ID has been influenced by shifting paradigms. From the 1970s through to the 1990s normalisation (Wolfensberger 1972) was the guiding philosophy for ID service providers. Residential and support services gradually developed to reflect the principles of normalisation, social and community integration, social role valorisation, inclusion, person-centred planning and quality of life.

## 5.3. Demographic and Epidemiological Issues

In April 2000 there were 26,760 people registered on the National Intellectual Disability Database (NIDD) of the Health Research Board, with a prevalence of 7.38 per 1,000 of the total population. The prevalence rate for mild ID is 2.99 per 1,000 and the prevalence rate for moderate, severe and profound ID is 4.06 per 1,000 (Mulvany 2001).

The NIDD has reported the following trends in the population with ID (Mulvany 2000, 2001):

- An increase in the number of individuals registered on the NIDD since 1996, but a decrease since 1999
- A larger number of individuals with mild ID up to the age of 19, which reflects the number of children in special education who receive support services from the ID sector, many of whom do not transfer to the ID services after leaving school
- An increase in the number of individuals more severely affected from 11,256 in 1974 to 14,713 in 1999 (an increase of 31%) and in the prevalence (3.80 per 1000 to 4.06 per 1000 over the same period)

- A changing age profile over the period from 1974 to 1999, with fewer children and more adults needing, or availing of, ID services
- Falling prevalence rates of moderate, severe and profound ID in the younger age groups, with, however, an increase in the 0-4 age group since 1981, possibly due to better and earlier identification of ID, or to a real increase in prevalence
- An increase in the average maternal age from 28.3 years in 1978 to 29.6 years in 1998, with the associated increased risk of offspring with ID
- Increased survival prospects of babies at risk of severe ID, because of recent advances in neonatal care, possibly resulting in an increase in prevalence
- Increased longevity among people with ID and
- A clear relationship between level of disability, age and utilisation of services, with a tendency for day services to be accessed by younger individuals of higher ability, while residential services are utilised primarily by older people with moderate, severe and profound levels of ID.

In addition, there is international evidence that medical advances have enabled increasing numbers of pre-term infants and infants with congenital impairments to survive, leading to the emergence of a group of children with continuing medical and nursing needs, some of whom remain dependent on medical technology (Tommet *et al* 1993, Kirk 1999). Accompanying these medical advances has been a move to care for such children at home rather than in hospital, and nurses in other disciplines have developed the skills to care for such children, including those with ID, in their homes.

#### 5.4. Current Developments

Government policy on the provision of services to people with disabilities emphasises mainstreaming, i.e., that specific services for people with disabilities should be the responsibility of those government departments and state agencies who deal with the general public (DoHC 2001a). The *Health Strategy* proposes a number of actions that relate specifically to people with ID, namely:

- Investment to expand day places, training, residential and respite care and other support services
- A programme to transfer people with an ID currently in psychiatric hospitals to appropriate accommodation as soon as possible, and not later than 2006
- Investment to provide support services for people with autism and
- An information system to provide accurate data on the numbers of persons with autism and their service needs.

There are still unmet needs in the overall range of support services required by people with ID. There are also concerns about access to services, including the adequacy of provision in some geographical areas and the varying criteria for access to day, residential and respite care. Despite advances in medical care and community support services, a significant number of people with ID require long-term care. Of the

27,149 people with ID identified in 1999, 24,095 (89%) were in receipt of services in 1999. These included day services, five-day or seven-day residential services, residential care in psychiatric hospitals, and residential support services only. The population with moderate, severe or profound ID, and aged 35 and over, is increasing, leading to a greater demand for residential services (Mulvany 2000).

While the NIDD has facilitated the planning of ID service provision, and policy has indicated the general priorities, for the first time, national standards for services for people with disabilities have been set. The *Draft National Standards for Disability Services* (National Disability Authority 2003) have been designed to ensure that services are provided to an agreed level of quality that is consistent on a national basis. These standards will impact upon nursing roles and activities.

##### 5.4.1. Employment of RMHNs in Intellectual Disability Services

RMHNs comprise less than 4.5% (3,749) of nurses on the active file of the register (An Bord Altranais 2003a). They have been found to work in the following settings and areas:

- Assessment and early intervention services
- Pre-schools
- Special education
- Developmental day units
- Respite care
- Vocational training
- Adult special care units
- Long-term training centres
- Residential services, including community-based group homes and
- Community support services.

(DoH 1997b, Government of Ireland 1998).

While they might expect from their broad pre-registration education/training programme to work in the various settings identified by the *Report of the Commission on Nursing* (Government of Ireland 1998) and in various policy reports, most RMHNs work in residential centres, and therefore deliver care to a small proportion of people with ID (DoH 1997b).

Despite the small number of RMHNs, there has been some difficulty in establishing exactly how many work in these services and the capacity in which they are employed (i.e., as nurses or with other titles). The National Federation of Voluntary Bodies (NFVB) is currently conducting a survey, which should show where nurses are employed, the division in which they are registered and the grade at which they are employed. This information will contribute to the achievement of a more accurate picture of the employment of RMHNs and other nurses in the ID services. Using information supplied by the Health Services Employers Agency (HSEA) the survey will include almost all ID services, but will identify only those nurses who are employed in nursing roles (NFVB 2003).

More detailed information is needed in relation to where RMHNs are employed (i.e., types of ID service provider, setting), the type of shift systems used (which would indicate the proportion of RMHNs working on night-duty), where nurses other than RMHNs are employed in ID services, if they (and other nurses) are employed as nurses (and if not, in what capacity), and the specific client groups they work with (e.g., people with challenging behaviour or multiple needs). This information would assist in workforce planning and understanding trends in turnover rates (DoHC 2002a). Together with NIDD information, it would also assist the higher/third-level education institutions, centres of nurse education and directors of the NMPDUs to anticipate and respond to trends in the demand for specialist (and generic) education relating to care of people with ID. This information could help organisations and service providers to identify where specialist/advanced practice posts are required, and to create career pathways within both management and clinical practice. It might also enable RMHNs to make realistic career plans.

During the consultation process, managers and front-line staff said that they were concerned about the shortage of RMHNs working in ID services, particularly in those services offering clinical placements to student nurses. They were also concerned about the effects of skill mix on the role of RMHNs working directly with people with ID, with skill mix referring to the mix of RMHNs and other nurses, care assistants, and other professional and non-professional staff.

#### 5.4.2. Implications for Mental Handicap Nursing

With people with ID expected to make greater use of mainstream health and social services, it should be noted that their healthcare needs may not be met due to their inexperience in dealing with mainstream services and poor communication skills, and those of their families and carers in dealing with health and social services (Minihan & Dean 1990, DoH UK 1995, Stanley 1998). Other factors may include a lack of awareness of their needs by healthcare professionals (including nurses and midwives), along with healthcare professionals' lack of skills, duplication of services by different organisations and minimal co-operation between professional groups and between service providers (Matthews 1996, Mental Health Foundation 1996, Barr 1997, Lawrenson *et al* 1997, Malin *et al* 2000, Davies & Northway 2001, While 2001, Gill & Brown 2002, Cope 2003). In the UK, the need for Registered Learning Disability Nurses to support people with ID and their families/carers as they access mainstream health and social services is well reported, as is the potential and actual role development in this area (Parrish & Birchenall 1997, Turnbull 1997, Parrish 1998, Sines 1998).

While there are differences in the ways in which Irish and British ID services are structured, distinct similarities are:

- The constantly changing context of policy and provision in health and social services
- The wide dispersal of ID services
- The range of service providers
- The need for nurses to be in contact with a wide range of

people who are significant to their work

- The developmental and continuing education needs of nurses and
- The increasing level of information and research available to the public and professionals on health and disability issues.

In the UK, acknowledgement of these factors has led to the recognition of the need for nurses in ID services to network with each other primarily, and on an intra- and inter-disciplinary basis, with the crucial aims of sharing good practice, and seeking support when taking forward personal initiatives or service developments (Association of Practitioners in Learning Disability *et al* 2000). In Ireland the NMPDUs can provide opportunities for nurses at different levels to network at regional level. Fora such as the National Intellectual Disability Nurse Advisory Forum, led by the Nursing Policy Division, DoHC, can provide similar opportunities at national level.

## 5.5. Key Issues

### 5.5.1. Role Development

Mental handicap nursing is part of the nursing profession, yet is specialised and different from other forms of nursing. RMHNs have expanded and changed their roles in response to the evolving needs of and social policy on people with ID. The parameters of care involved in the mental handicap nursing role are *physical, emotional, intellectual, social, and spiritual* (Baldwin & Birchenall 1993). These parameters may help to clarify the role of mental handicap nurses in the provision of comprehensive and quality healthcare. The role components of these parameters of care, which can be drawn from nurses' work and skill base, are identified as clinician, helper/counsellor, advocate/advisor, manager, teacher/educator and therapist. These components are operationalised in:

- The primary domain (the hands-on giver of care, equating with the primary nurse),
- The secondary domain (the nurse working and co-ordinating care at a practical level through others, whether formal or informal carers), and
- The tertiary domain (the nurse's role at a societal level in planning services and promoting positive images of people with ID) (Baldwin & Birchenall 1993).

During the consultation process, participants considered that current mental handicap nursing role components were: practitioner, management, training and education of clients, assessment and supervision of student nurses and care staff, and liaison with clients' families and/or significant others. The strength of mental handicap nursing is its flexibility and responsiveness to the practical implications of philosophical considerations, policy on people with disabilities and the views of those others with a stake in the services (i.e., clients themselves, families, healthcare and other professionals, advocacy groups, and various agencies). However, in order to ascertain the valuable contribution made by RMHNs to people with ID and ID services, their roles and the outcomes of their contribution require further study in line with best practice and in order to promote evidence-based practice.

The *Report of the Commission on Nursing* noted that nurses other than Public Health Nurses (PHNs) and Community Psychiatric Nurses/Clinical Nurse Specialists (Community Mental Health), including mental handicap nurses, have started to work in the community (Government of Ireland 1998). The Commission was concerned about the level of integration of the increasingly diverse range of nursing services in the community. In order to promote a seamless system of service provision, mental handicap nurses in the community may need to consider strategies for collaborating with other nursing colleagues such as PHNs, community-based general and psychiatric nurses, and practice nurses, as well as with health and social care professionals within the community and within the local ID service provider. However, the *Primary Care Strategy* identifies mental handicap nurses as part of the primary healthcare team (DoHC 2001c). Further discussion of community mental handicap nursing can be found in subsection 5.5.6.

Although the *Health Strategy* and *Primary Care Strategy* reflect the trend toward primary care, it was found six years ago that most RMHNs worked in adult residential services and in services providing care for people with moderate and severe ID (DoH 1997b). If the majority of RMHNs are still employed in long-term adult services, ways must be found to value their contribution to the care and support of people with ID. In some services, this may include developing CNS and ANP posts in response to client need, or providing familiar, as well as innovative, activities of and opportunities for CPD. Nevertheless, it is a truism that generalist nursing practice is the basis from which all other levels of practice emanate. That said, greater clarity is required about what is meant by generalist mental handicap nursing (see subsections 1.4.2 and 1.5.1 concerning generalist practice and career progression).

Guidance for nursing role development in mental handicap nursing is perhaps less clear than for other disciplines, given the tensions between medical, social and rights-based models of ID service provision. Strong management and leadership are required from nurse managers and from non-nurse managers who have an appreciation of developments and trends in ID and nursing generally and also in mental handicap nursing specifically. Where such posts exist in ID services, NPDCs can monitor role developments for generalist and other nurses, especially in relation to practice outcomes.

### 5.5.2. Education

#### *Pre-registration Education and Training*

The contents of the various pre-registration training and education syllabi show a trend away from lists of tasks, to a more holistic approach to care, based on the needs of people (and their families) in a changing society and at different stages of their development. The syllabi were also influenced by trends in therapeutic methods and interventions, in mainstream nursing and nursing education, and the place of the RMHN in service delivery and social structures (An Bord Altranais 1984, 1986, 1993, 1994, 1999 & 2000b, WHO 1999b, Government of Ireland 2000b).

The aim of the current syllabus is to enable newly qualified

nurses to work with people with ID in "a diversity of roles, from intensive physical nursing of profoundly handicapped individuals to supportive guidance in the management of habilitation of children, adolescents and adults" (An Bord Altranais 2000b). The number of places available on pre-registration education programmes has increased in recent years, but during the consultation process, concerns were expressed about the number of vacant places on the mental handicap nursing degree programme that commenced in 2002.

#### *Post-registration Education and Continuing Professional Development*

Providing professional education for nurses who work with people with ID is inherently complex (Birchenall *et al* 1993), and there has been little development in Ireland of post-registration education in mental handicap nursing (DoHC 2002a). Submissions received by the National Council from RMHNs during consultation raised issues around the lack of appropriate post-registration programmes. The lack of opportunities for CPD was perceived as inhibiting role development.

The majority of higher/postgraduate diploma and higher degree programmes offered by schools or departments of nursing studies are concerned with specialist areas of general nursing and/or are restricted to applications from nurses holding a general nursing qualification, with or without a specified period of post-registration experience in general nursing. Other courses of relevance to mental handicap nurses, such as behaviour management, are offered by non-nursing departments within third level institutions and in other facilities. Some RMHNs, who have undertaken generic post-registration nursing courses, comment on the lack of explicit relevance to mental handicap nursing and care of people with ID.

Post-registration nursing courses available to nurses, who are registered in mental handicap nursing, include generic nursing degrees, generic nursing management degrees, and, more recently, higher/graduate diploma-level courses in challenging behaviour, community nursing and care of the older person with ID.

RMHNs participating in the consultation process stated that there was a need for more regionally-based programmes in order to facilitate equity of access, and that programmes should be developed in response to client/service user needs. Implications for service providers and managers such as staff replacement need consideration. The perceived inconsistencies in the distribution of funding available to nurses for continuing education programmes requires some deliberation, so that the continued availability and development of courses and thus specialist/advanced practice can be sustained.

Topics suggested by RMHNs for in-service education included community care, challenging behaviours, person-centred planning, individualised care approaches, sensory development, care of the person with complex needs, health promotion, assessment, documentation of care and intervention, dual disability, care of the older person with ID, communication, case management, reflective practice,

evidence-based practice and research, care of the child with ID, and health and safety issues in client care.

Some areas of transdisciplinary skills development were also suggested, such as mainstream education, physiotherapy, speech and language therapy and occupational therapy, in order to complement the role of those other healthcare professionals and to promote equality between professionals. It was proposed that in-service education should incorporate the needs of nurses registered in different divisions in order to operationalise the notion of integrated workforce planning.

### 5.5.3. Practice

The Review Group on Mental Handicap Services (1990) noted that a diversity of professional outlooks and backgrounds had proved to be a creative force in the development and operation of ID services. It recommended a multidisciplinary approach in the employment of personnel, both at the frontline and in the support services, and the promotion of disciplinary diversity in residential services. The *Report of the Working Group on the Role of the Mental Handicap Nurse* stated that the RMHN was an "essential and integral element" of the multidisciplinary team required to deliver services required by people with ID (DoH 1997b), and references to multi-/inter-disciplinary working are interspersed throughout the *Health Strategy* and *Primary Care Strategy* (DoHC 2001a, 2001b). This kind of working is a reality of service provision and is seen as both an opportunity for, and a threat to, RMHNs, whose concerns about their employment as houseparents, while carrying out nursing duties and the increasing use of non-nursing personnel contributing to the 'de-professionalising' of the service, were noted by the *Report of the Commission on Nursing* (Government of Ireland 1998).

The pre-registration training syllabus has been revised several times to mirror the expanding roles of RMHNs (Chavasse 2000), which include leading developments in behaviour management and therapy, computer-assisted learning, multi-sensorial and therapeutic activities, developmental education, and recreational activation. The current syllabus for pre-registration mental handicap nursing programmes includes nursing and professional development, evidence-based practice, organisational management, life-long learning, person-centred care, disability and society, and policy (An Bord Altranais 2000b). This wide-ranging syllabus prepares RMHNs to carry out the role components in the domains identified by Baldwin & Birchenall (1993). However, the Working Group on the Role of the RMHN concluded that most RMHNs are working in residential centres, and, in the absence of clear published evidence of what RMHNs do in the primary domain of care, it is likely to be the demographic trends among people with ID that will primarily impact on their practice.

### 5.5.4. Specialised and Specialist Practice

The *Report of the Commission on Nursing* recognised the need for a structured approach to the development of specialist and sub-specialist roles within each discipline of nursing, but also noted that a proliferation of such roles could lead to a fragmentation of the nursing service and difficulty in filling future specialist positions (Government of Ireland 1998). It

could also create a career *cul de sac* by operating in very specialised areas, and hinder the development of CNS and ANP posts outside high technology areas or domains, where advanced nursing or midwifery education is already well established. Further reservations were expressed in the literature and during the National Council's consultation process about the appropriateness of clinical specialist roles, on the basis that such roles are incongruent with holism. The concerns relating to the de-skilling of generalist nurses, the actual contribution of CNSs and the relationship between generalist nurses and CNSs (Marshall 1998, Savage 1998) are discussed in subsection 1.4.1.

Specialist practice in mental handicap nursing has been promoted in the UK for over ten years (Bollard & Jukes 1999). Examples of clinical specialisation are community care, multiple disabilities, challenging behaviour and forensic needs. Clinical specialist roles for RMHNs suggested by the *Report of the Commission on Nursing* were sensory stimulation, challenging behaviour and community nursing (Government of Ireland 1998). Another suggested area for developing practice is in the rehabilitative care of people with severe head injuries (Richardson 1994). Some role changes have ranged from health and social care responsibilities of the nurse, that may include non-direct client contact and a care management role, to purely direct client contact specifically for health gain role concerns, and from health service-led provision responsibility to the local authority-led role for people with ID.

Prior to the establishment of the National Council, the Nursing Policy Division initiated a consultative process with mental handicap nurses to determine both the specialist and advanced nursing roles and the educational framework required to support such roles. The *Proposed Framework for the Development of Clinical Specialism and Advanced Practice in Mental Handicap Nursing* (DoHC 2002e) cites evidence from the NIDD of the increased longevity of people with ID, a decrease in the number of children with more severe ID, and the increasing prevalence of management difficulties associated with medical fragility and pervasive developmental disorders. It reiterates the NIDD's statements concerning an increased demand for residential placements, therapeutic support services for people who continue to live with their families, more intensive services (i.e., assessment and respite, developmental education centres, behavioural support, and mental health), and services designed specifically to meet the needs of the older person with ID. RMHNs can respond to these demands by developing and expanding their practice in the community, promoting and developing facility-independent community mental handicap nursing teams, developing and enhancing the skills required for more intensive services, and responding to the needs of older people with ID.

The Nursing Policy Division's research was undertaken with focus groups around the country. The researchers identified numerous issues that were distilled into fifteen themes or potential areas of specialist practice, in order to provide a more holistic approach to the development of specialisms (see over). The *Proposed Framework* recommends that the clinical specialisms be developed in accordance with a combination of

client need, stage in the client's lifespan and negotiation between stakeholders, and that generic postgraduate/higher diploma programmes in mental handicap nursing be developed, based on a model comprising core and specialist elective modules designed to support specialist practice.

### Themes for the Basis of Initial Specialist Practice and Modular Development (DoHC 2002)

1. Sensory development
2. Management of behaviour
3. Multiple and complex disabilities
4. Assistive technology
5. Health promotion
6. Respite care, crisis intervention and assessment
7. Training and employment
8. Community nursing
9. Palliative care
10. Advocacy and activation
11. Mental health and mental handicap (dual diagnosis)
12. Communication, speech and language
13. Developmental education and play therapy
14. Interpersonal relationships and counselling
15. Care of the older person

Some submissions received by the National Council endorsed these areas, with some additional areas suggested, and amendments to, and elaboration of, others proposed in order to make their implementation 'more meaningful.' One submission suggested condensing the potential specialisms, for example, linking community care with respite assessment and intervention. Given the size of the client population, it may be appropriate to create posts at a regional level, and in response to the needs of the population being served (DoHC 2002e). There are currently 105 CNS posts in mental handicap nursing recorded on the National Council's database, with titles or areas of specialist practice approximating those proposed by the Nursing Policy Division.

### Titles of Approved CNS Posts Mental Handicap Nursing. Source: National Council CNS/CMS Database May 2003

- Alternative and augmentative communication
- Assistive technology
- Autistic spectrum disorders
- Behaviour management/therapy
- Care of the elderly
- Complementary therapies
- Community mental handicap
- Continence promotion
- Creative, diversional and recreational activation
- Epilepsy and health promotion
- Early intervention
- Health promotion and intervention
- Infection control
- Mental health promotion and intervention
- Mobility and therapeutic programmes
- Nutrition
- Palliative care
- Personal development programmes
- Physical disability
- School children with special needs
- Sensory integration and therapeutic programmes
- Social and vocational rehabilitation
- Supported living
- Vocational rehabilitation

These posts cover a broad range of specialisation within a small discipline of the profession, but the only currently available post-registration courses concerned with specialised mental handicap nursing practice are the higher/graduate diploma programmes in challenging behaviour, community mental handicap nursing and care of the older person with ID.

Third level providers may need to consider more flexible ways of facilitating the clinical career pathway of RMHNs, such as enabling them to access programmes or modules focusing on the complex physical health needs of children who are technology-dependent, and of dependent older adults. At a regional level, the NMPDUs and centres of nurse education might also examine the demographics of the population with ID and ID service provision, in order to provide other forms of continuing education in specialist practice.

A review of the job descriptions and profiles submitted by the employing agencies shows that posts with similar titles may vary in terms of client case-load, age range, setting and primary activities of the nurses. These variations may even occur within a single agency, which supports the notion that guidelines for the posts and educational preparation for the posts cannot be prescriptive, lest the workforce becomes inflexible and responsive service provision is stifled (DoHC 2002a).

Concerns expressed about the clinical career pathway during the National Council's consultation process centred on the perceived lack of opportunities to gain specialist experience in

those ID services where traditional nursing hierarchical structures are not in place. This was seen as a barrier to obtaining the relevant clinical specialist experience and progression to advanced nursing practice.

It was suggested that more opportunities for specialisation could occur if CNS posts were shared by two or more service providers, or established on a regional basis.

### 5.5.5. Advanced Nursing Practice Roles in Mental Handicap

Little has been written about advanced mental handicap nursing practice. The tertiary domain/dimension of mental handicap nursing (i.e., the nurse's role at a societal level) is related to the acquisition and maintenance of high order skills through a continuing process of study, reflection and practice (Birchenall *et al* 1993). The ANP in mental handicap is concerned with adjusting the boundaries for the development of future practice, pioneering and developing new roles responsive to changing needs. He/she also undertakes research and education to enrich professional practice as a whole, contributes to health policy and management through a disciplined examination of the processes, skills and frameworks that contribute to nursing practice, and looks towards the further development and provision of existing and future services (Jukes 1996). Six aspects of the advanced practitioner role in mental handicap nursing are health and nursing assessment skills, psychotherapeutics, research, community nursing, service development and quality service measurement. Barriers to the establishment of advanced practice roles include traditional perceptions of nursing by the nursing profession itself and healthcare services, and the need for the value of such roles to be demonstrated to nurses, other healthcare professionals and service managers. (Jukes 1996)

In the UK to date, there are twelve nurse consultant posts in mental handicap nursing (Crouch 2003). Eleven of these posts are based in primary care, while one is in secondary/tertiary care. Six of these nurses are concerned with challenging behaviour, forensics, mental health/dual diagnosis, health promotion and promoting access to primary care. The age range of their clients is unspecified.

In the Irish context, the *Proposed Framework* (DoHC 2002e) proposes that lifespan stages be considered as one model for the development of advanced mental handicap nursing practice, i.e., the child, the adolescent, the adult and the older adult. One submission received by the National Council supported advanced practice in relation to the child and older adult with ID, but argued that the needs of adolescents and adults with ID were too broad. Another submission proposed consolidating the identified areas of clinical specialism into three or four categories, which would facilitate the development of relevant postgraduate degree programmes. The *Proposed Framework* also recommends the development of a generic master's degree programme in mental handicap nursing, based on a model comprising core and specialist elective modules, to support advanced mental handicap nursing practice. Emphasis would be placed on academic progression from higher diploma level, and career progression, insofar as possible, from specialist to advanced

practice, in order to develop a body of knowledge and to inform practice development.

### 5.5.6. Mental Handicap Nursing in the Community

Mental handicap nursing services are delivered primarily by voluntary agencies to a catchment area. There is a continuum of care, from residential centres, to high support hostels, to day centres, to support in the home. The *Report of the Commission on Nursing* envisaged that ID services in the home of a client would continue to be provided under the aegis of an ID service provider, but noted that there was a need to develop ID services further to support clients in their home (Government of Ireland 1998). It also suggested that the development of the CNS role in mental handicap nursing would offer opportunities for enhancement of community ID services. A further suggestion was that the third level institutes, working in close collaboration with health service providers and the National Council, should develop courses to enhance ID services in the community.

The *Primary Care Strategy* states that the primary care team will liaise with specialist teams in the community, and with the specialist institutional services, to improve integration of care (DoHC 2001c). PHNs have acknowledged the need to work more closely with community-based nurses, including community-based mental handicap nurses (Hanafin *et al* 2002), but the forthcoming *Strategy for Nursing and Midwifery in the Community* is expected to provide a plan for the integration of nursing and midwifery services that builds on the existing diversity of nursing competencies.

The vision for ID services in the twenty-first century is firmly based in the community. Collaboration with other healthcare professionals in primary healthcare is essential to the development of mutual understanding of roles. This vision encompasses a domiciliary nursing service, catering for the needs of people with ID and their families in their own homes. Until now RMHNs have figured primarily in secondary and tertiary service provision, but the National Council has approved Clinical Nurse Specialist posts in Community Mental Handicap, many of which are facility-independent. As proposed by Bollard & Jukes (1999), RMHNs can function as autonomous practitioners, with responsibility for the healthcare needs of a caseload comprising people with ID. The possibilities for RMHNs' role development within primary care teams and/or liaison with PHNs, practice nurses and other community nurses need to be flagged to other nurses and midwives at all levels within the health service, as, more importantly, do the inclusion of people with ID within the primary care caseload, and awareness of their more complex healthcare needs.

## 5.6 Agenda for Future Development

The overall prevalence of mental handicap internationally is between 1% and 3% of the population. In April 2000 there were 26,760 people registered on the NIDD, with a prevalence of 7.38 per 1,000 of the total population. There is a changing age profile, with fewer children and more adults availing of, or in need of, mental handicap services. Mental handicap nursing practice and role development should be driven by client-need.

A key issue is the need for greater integration of mental handicap nursing into the main body of the nursing profession, while at the same time retaining its distinct identity. The benefits of integration include the potential to draw upon the resources available to nurses in terms of clinical practice, research and other evidence, and access to supports for ongoing professional development.

The RMHN should continue to deliver direct specialised nursing care in a changing healthcare environment. At the same time, RMHNs need to respond to the lack of role clarity, especially where they do not work in settings with traditional hierarchical structures. There is a need for more evidence and research to demonstrate the outcomes of mental handicap nursing, which may help to clarify roles and underline the value of the generalist mental handicap nurse in ID services and service provision.

There is a need for more equitable access to continuing education within the third-level sector, and a need for flexible programmes that address the needs of RMHNs and people with ID. There is also a need for appropriate and responsive in-service education.

More detailed information is needed in relation to where RMHNs are employed in order to assist in workforce planning, take a strategic approach to providing opportunities for continuing professional development and facilitate realistic individual career planning.

Strategies need to be developed for raising the profile of RMHNs among, and collaborating with, other nurses in mainstream services, such as PHNs, practice nurses, other community-based nurses, and health and social care professionals.

Development of specialist and advanced mental handicap nursing practice should be based on an approach that is evidence-based and best suits the needs of the client population. Development of the CNS role in mental handicap nursing offers opportunities for enhancement of community ID services.

# Gerontological Nursing

## 6.1. Introduction

Gerontology is the branch of science that deals with ageing and the problems of ageing people. It is multidisciplinary in nature and is a specialised area within various disciplines, such as nursing, psychology, social work and occupational therapy. This section provides a review of the literature and the issues that emerged in the consultation process regarding gerontological nursing in Ireland. History and context are provided. Demographic trends are referred to and current and future developments, including service developments, are reviewed.

## 6.2. History

Demographic changes have had significant implications for society in general, the healthcare service and the nursing profession. Most people in Ireland today can expect to live into old age. This is in striking contrast to the situation at the beginning of the century, where life expectancy was around 50 years. Life expectancy is currently 78.7 years for females and is expected to increase to 84 years by 2031. The corresponding figures for males are 73 and 77.8 years (CSO 2003b). This dramatic change has come about largely due to changes in living standards and to a lesser extent in healthcare. It presents the challenge of providing appropriate facilities and staff to cope with an increasing number of sick and disabled older people. These trends have led to the acceptance of gerontological nursing and geriatric medicine as important parts of the nursing and medical professions. So, while nurses have always cared for older people, gerontological nursing has only recently 'come of age' as a speciality.

The 1960s saw an increasing awareness of the numbers of older people, and their need to share in the rising living standards in the country. Several schemes were introduced, such as free travel and free electricity. Government policy was heavily influenced by the *Report of an Inter-Departmental Government Committee* in 1968, chaired by J J Darby, which recommended radical changes in the aims of services provided for older people.

It recommended that older people should continue to live in their own homes or, if they could not, in similar accommodation. If these options were not possible, substitutes for normal homes should be provided. Hospital services would be provided where none of the other options were available.

The Report stressed the importance of the development of community services, with improvements in nursing and medical services, saying that it was better, and probably much cheaper, to help older people live in the community than to provide for them in hospitals or other institutions.

It advocated the establishment of geriatric assessment units within general hospitals and the development of day hospitals. Welfare Homes for frail older people were recommended. The Report proposed the establishment of a National Council for the Aged, to promote in every possible way the general welfare of the elderly, and co-ordinate the efforts of voluntary and public services at national level.

### 6.2.1. Policy Context

Services for older people are provided in a variety of settings including hospital, community, residential and nursing homes. Participants in the consultation process said that older people are cared for in ICU, A&E, medical and surgical wards, healthcare centres, day wards, and specialist areas, in addition to Departments of Medicine for the Elderly.

The *Health Strategy* (DoHC 2001a) recognised the need to develop a comprehensive approach to meeting the needs of older people. The strategy noted service provision gaps in community-support services (health promotion, home help and day care), acute hospitals (shortage in assessment, rehabilitation beds and day hospital facilities) and long-stay places (need for additional community units). It stated that there was inadequate co-ordination of services for older people, both within services for older people and the interface between these services and acute hospitals and other specialised services such as mental health.

*The Years Ahead, A Policy for the Elderly* was published by the Department of Health in 1988 and has had considerable influence on the development of services for older people. It set objectives and made proposals for the management of services for older people and set out national norms for the provision of these services. In relation to general hospitals, it recommended that a policy on the admission and discharge of older people be developed in consultation with the co-ordinators of services for older people in the catchment area of the hospital.

It recommended that geriatric departments should be provided as a matter of urgency, and that a norm of 2.5 beds

per 1,000 older people in geriatric departments in general hospitals, and a norm of 3 beds per 1,000 older people for rehabilitation beds be adopted. Every hospital with, or associated with, a specialist department should provide a day hospital to facilitate diagnosis, treatment and rehabilitation of older people.

The Report recommended that a district liaison nurse should have responsibility for co-ordination of services and that health boards should appoint a co-ordinator of services, who would be assigned to a community physician. The liaison nurse should maintain a register of older people, and each community care area should have at least one Public Health Nurse (PHN) with special interest in the management of incontinence. The promotion of health for older people was a primary concern of the Report. There were also recommendations in relation to community hospitals and that an independent inspectorate of extended care facilities for older people be established within the Department of Health and Children.

The *Health Strategy, Shaping a Healthier Future*, was launched in 1994 (DoH 1994b). It was a four-year action plan, with priorities for the elderly based on many of the recommendations of *The Years Ahead* (DoH 1988), and aimed to give a clearer sense of direction to the health services.

However, a review of the implementation of *The Years Ahead* was critical of the slow pace of these developments (Ruddle *et al* 1997). The review emphasised the need to plan, to include consumers' views in planning and decision-making and promote healthy ageing and mental health. It stated that, at local level, health education with older people was usually carried out by a PHN and tended to operate on an opportunistic basis, usually once contact was made with the health services. As a result, health education was rarely carried out with healthier older people and one of the best opportunities for illness prevention was being lost. The review concluded that a major difficulty was the lack of guidance on the content of health education services.

The Department of Health and Children established the Dementia Services Information and Development Centre (DSIDC) in 1998 to promote excellence in all aspects of dementia care in Ireland. The Centre's remit is for professionals, service providers, planners, and health administrators, and encompasses education and training, research and a consultancy and information service. The DSIDC's *Action Plan for Dementia* (O'Shea & O'Reilly 1999) made 33 recommendations of which six related to the need for staff involved in all aspects of dementia care to have education and training in dementia care.

The DSIDC Action Plan stated that skilled dementia nurses were required throughout the range of service areas where care was provided, not only in services for older people but also in the mental health and learning disability services.

The central focus of recent health policy in Ireland and in the EU has been towards primary care in the community. The model of service delivery is "centred on the needs of individuals and groups and will match their needs with the competencies required to meet them" (DoHC 2001a). This

proposed model will feature integrated interdisciplinary primary care teams, which will include nurses in a range of roles, i.e., public health, generalist roles, clinical nurse specialists and advanced nurse practitioners. The process will begin with an emphasis on health promotion and prevention of illness.

The *Report of the Commission on Nursing* (Government of Ireland 1998) considered that gerontological nursing offered substantial opportunities for nurse-led services, and the *Scope of Nursing and Midwifery Practice Framework* provides nurses with the framework for this determination, review and expansion of practice (An Bord Altranais 2000a). The exploration of new developments in nursing care for older people entails an examination of possible innovative and non-traditional roles, and an exploration of roles that take responsibility for aspects of care previously undertaken by another group of health professionals (Read *et al* 1999).

During the consultation process, participants said that one of the major challenges to gerontological nursing was the perceived lack of prestige attached to caring for older people. The central philosophy and caring ethos attached to this type of nursing and care was not valued by nurses or by the public.

### 6.3. Demographic and Epidemiological Issues

There are approximately 453,200 people over the age of 65 living in Ireland (CSO 2003a). There is remarkable stability in the relative size of the elderly population between 1961 and projections for 2006. Older people are projected to comprise 11.8% of the population in 2006, compared with 11.2% in 1961. After 2006, however, a more rapid increase in the number of older people is expected and the prediction is for an increase to 17% by 2026. The increase among the 65-69 age group will be around 60%, but for those over 85, the increase will be 120%.

At age 60, life expectancy for both men and women in the Republic of Ireland is lower than other EU countries (WHO 2001a). Older Irish people are, on average, in poorer physical health than their European counterparts, with the principal causes of premature morbidity and mortality being cardiovascular, cancer and respiratory disease – all of which are inextricably linked with lifestyles and health related behaviours (DoHC 2001a).

The *Final Inquiry Report: Life, Work and Livelihood in the Third Age* (Carnegie UK Trust 1993) found that the process of ageing could be greatly influenced by lifestyle and environment at later as well as younger ages. The *Health Strategy* (DoHC 2001a), notes that cancer is more common in older people.

The *National Health and Lifestyle Surveys* (Friel *et al* 1999) reported that approximately 41% of older people adhered to the recommended servings of healthy eating guidelines and that exercise was likely to decrease with age. The survey was repeated in 2002 and reported that over 55s were under the national target of non smokers, that older people were less likely to report that their health was well and that, while the percentage engaging in physical exercise had improved, in some age groups there was a strong inverse trend according to

educational status at all ages, which was widest in the older group (Kelleher *et al* 2003).

These findings underline the importance of health promotion programmes for older people. In exploring the future role of the nurse in providing services and care to older people, one of the primary focuses must be the development of health promotion and primary prevention aspects of the nursing role. This will require a fundamental shift away from emphasis on the disease model and curative interventions to one of promotion and prevention.

## 6.4. Current Developments

Care of older people has tended to be organised around the speciality areas of medical practice, with physical health issues being dealt with within the acute care system and psychological and mental issues by psychiatric services. As with all other healthcare services, the emphasis on providing care for older people has been on dealing with illness rather than on promoting and maintaining health. Little attention has been paid to the area of appropriate rehabilitation of older people once illness has been diagnosed.

In the UK, the National Health Service (NHS) has created a plan to support long term care for the elderly, which is based around extending access to services, ensuring co-ordinated care, assuring standards of care and providing strong support for primary care. The plan includes investment in intermediate care and related services to promote active independence through acute recovery and rehabilitation services (NHS 2000).

Evidence of the effectiveness of gerontological nurses caring for older people is well reported. In the USA and Canada, where the role of gerontological nurse specialists and gerontological nurse practitioners is well developed, evidence shows a reduction in re-admission rates and costs (Naylor *et al* 1994) and cost-effective improved quality care in nursing homes (Small 1994).

Schofield (1999) identifies the slow development of the gerontological nurse specialist in the UK. A pilot study conducted in an A&E department in the UK, following the employment of a CNS for older people, showed reduced waiting times, prevention of unnecessary hospital admissions and a greater awareness by staff of the needs of older people (Bridges *et al* 2000).

Skilled and specialist nursing are described as central to any evolving system providing care for older people (Johnson 1998). This is an opportunity for nurses to develop key roles in caring for this patient/client group. Katz *et al* (1995) maintain that potential benefits may accrue from gerontological nursing being affiliated to an academic institution, which is likely to offer a synergy between education, research and clinical care.

During the consultation process, participants said that important areas in ensuring continuity of expert practice included:

- The ability to reflect on the effectiveness of practice
- Having authority in, and accountability for, practice

- Therapeutic interpersonal relationships with team members and older people/carers
- A practice environment that enables a person-centred approach to the organisation of care services and
- The appropriate nurse-to-patient ratio.

### 6.4.1. The Generalist Nurse

Participants in the consultation process emphasised that it was important for the generalist nurse in all healthcare settings to develop a good working knowledge of age related issues and presentation of illness which impact on the outcomes of nursing care. Although initial general nurse preparation includes a specific module on caring for the older adult, CPD relevant to the practitioners needs should be provided, in order to respond and adapt to changing work environments and the needs of older people.

Many of the issues for general nurses (see Section 1) are common to nurses working with older people. Participants suggested a competency-based approach to the professional development of gerontological nurses, which would allow for the development and enhancement of roles within the generalist domain. Frameworks such as Benner's (1984) *From Novice to Expert* were suggested. This would facilitate the demonstration of progression through different levels of practice and go some way to explicating expertise in practice.

Participants, particularly those from the smaller community and district hospitals, spoke of the need for CPD. Programmes such as the higher/postgraduate diplomas and masters' degrees in gerontological nursing help to address education needs, but there should be short programmes which are interdisciplinary and that include care staff. Participants said that there was a lack of appropriate in-house training. It was suggested that 'train the trainers' type of programmes, to promote local self-sufficiency, would be of use in areas such as intravenous cannulation and cardio pulmonary resuscitation (CPR).

Participants said that training in the detection of elder abuse should be a core component in training for care of older person nursing. There should be clear and sufficient protocols in place for the detection, assessment and management of elder abuse. These should cover all areas of contact with the older person, including the community, general nurses, A&E nurses and nurses in long term care institutions. The recently published report, *Protecting Our Future* (DoHC 2002f), has emphasised the need for further education and research in this area.

Participants referred to the lack of a definite career structure for nurses who have completed postgraduate courses. They said that many of these nurses have returned to their workplace to carry on as before, with no measurable improvements in patient/client outcomes. Some of this was attributed to the hierarchal structures still adhered to in many care of older people settings. They emphasised the need for national minimum standards of care, staffing levels and appropriate skill mix ratio for care of the older person.

There was support for the idea of generalist, specialist and advanced practice in gerontological nursing, given the

complexity of this type of care. Participants said that those nurses who work in areas not specifically dedicated to care of older people, such as ICU, would need CPD relevant to this area of care.

#### 6.4.2. Specialist and Advanced Practice

Gerontological nurses have been operating at different levels of practice in the past. However, although nurse specialists have been practising in the Irish context for many years, the development of specific CNS posts in gerontological nursing has been slow. This has been attributed to the lack of funding and lack of provision for education. To date, the National Council has approved 13 CNS posts specific to care of the older person. There are other approved CNS posts, particularly in acute care, which provide a service but are not dedicated to older people. Titles of approved CNS posts are outlined below

**Titles of Approved CNS Posts Gerontological Nursing.**  
Source: National Council CNS/CMS Database May 2003

- Community Rehabilitation
- Continence Management
- Diversional & Recreational Activation
- Elderly Assessment
- Elderly Care
- Gerontological Assessment
- Gerontological Rehabilitation
- Older People
- Older Person Learning Disabilities

A great deal of further consideration is required to improve the number of CNS posts in this area of practice, in order to ensure that patients/clients have access to specialist care.

The RCN (1998) states that older people need nurses who have a broad repertoire of skills and knowledge. The RCN lists the key attributes of the gerontological nurse specialist as:

- Holistic knowledge and practice, incorporating an in-depth understanding of all aspects of ageing
- The ability to see the most pertinent issues in a situation and respond appropriately
- Knowledge of the patient
- Respect for dignity and rights, whilst promoting positive attitudes and empowerment through comprehensive risk assessment
- Skilled know-how, in the form of highly proficient expert practice that promotes holistic rather than linear approaches, based on tacit knowledge.

While there has been no development of an ANP post in gerontological nursing to date in Ireland, participants in the consultation process stated that they saw great potential for advanced practice in older people care. They suggested that because many areas operated with minimal medical support, they were well placed to introduce nurse-led care.

## 6.5. Key Issues

### 6.5.1. Care and Case Management

Participants in the consultative process said that there was a need for a seamless service when dealing with older people, and that the perceived divide between hospital and community had to be overcome. Intra- and inter-disciplinary co-operation was a means of achieving this. Equally, a single assessment process for older people in relation to care management could minimise the need for duplication of work by the various service providers, in addition to promoting equity for service users.

Since 1992, the National Council on Ageing and Older People has recommended greater co-ordination in care planning and delivery in Ireland.

The Report, *Care and Case Management for Older People in Ireland* (Delaney *et al* 2001) concluded that a care or case manager, or, in the context of the *Health Strategy* (DoHC 2001a), a key worker, would need to possess certain core skills and competencies to ensure that resources were optimised and health and social gain achieved by older people. Two core skills are organisational and interpersonal. These two broad categories include negotiation and conflict resolution, counselling skills, communication skills, health and welfare assessment skills, political skills, and the ability to understand work and organisational sensitivities and the ability to understand and work with the local community. Acquiring these skills requires specialist education and training.

Participants in the consultative process said that the nursing profession is well placed for the adoption of the role of case manager, as nurses are often the first point of contact with regard to health and social services for the older person. The *Report of the Commission on Nursing* (Government of Ireland 1998) recommended that centres of nurse education, in conjunction with third level institutions, should meet the needs of nurses working with older people. The National Council for Ageing and Older people endorses this recommendation and proposes that training courses in care and case management should be an integral part of any nurse education programme established (Delaney *et al* 2001).

Research into gerontological nursing in order to support evidence-based practice is necessary.

### 6.5.2. Clinical Nurse Specialists and Advanced Nurse Practitioners

Participants in the consultation process discussed whether CNSs for older people should be generic specialists or specialists in aspects of older people care. They saw a danger of care fragmentation, owing to the multipathologies of old age. Schofield (1999) states that CNSs for diabetes care, continence, tissue viability and Macmillan nurses are all likely to see a sizable proportion of older people, with the emphasis being on the physical dimensions of care, rather than on an holistic approach to care of older people.

Possible posts suggested by participants included:

- Stroke management

- Genito-urinary health
- Dementia care
- Mental health
- Diabetes
- Tissue viability and
- Falls assessment.

In addition CNS roles with an overall title in gerontological care were suggested.

Participants in the consultation process said that there was a need for ANPs in gerontological nursing. This role has developed in primary care in the USA, and Schofield (1999) describes the ANP as having responsibility for maintenance of health and function through health promotion, chronic disease management or acute illness. The practitioner sees older people in a surgery or outreach clinics, care homes and through domiciliary visits. Participants in the consultation process stated that an ANP in gerontological nursing would need substantive knowledge of relevant pathophysiology of ageing, age-related issues and implications, clinical presentation, diagnostic procedures and management of care. The practitioner would then have the ability to deliver evidence-based responses to problems associated with co-existing clinical conditions, using drug and/or complementary therapies, patient/client education, lifestyle modifications, referral, consultation and follow-up.

The ANP could be dedicated to health promotion and maintenance, disease prevention, facilitation of self-care, assessment management and maintenance of older people in situations and circumstances that support the highest standards of clinical practice, and environments dedicated to quality of life. This would require an extensive knowledge base and a high level of autonomy and credibility. The post of ANP in dementia care was proposed for both community and hospital settings.

### 6.5.3. Day Hospital Developments

A rapid ambulatory assessment and diagnostic facility/day hospital is an integral part of any quality service (DoH 1988). Apart from the general medical and functional assessment, certain specialist activities could usefully be located on such a site to streamline appropriate care for older people, and to facilitate exposure of the patients/clients to appropriate expertise within the geriatric team, including specialist nursing input. The following describes some of these specialist clinics:

**Falls/Syncope Clinics:** Falls account for up to 20% of admissions into acute medical wards each year, with an average hospital stay of between 11 and 15 days (Sattin *et al* 1990). Falls account for almost one-third of deaths from all accidents. Older people are at particular risk, with a much higher mortality rate from falls occurring among older people (CSO 2000). Thorough and effective assessment requires a unit with expert staffing and equipment. A recent UK randomised control trial demonstrated that the introduction of an integrated approach to falls management significantly reduced the risk of falling, the risk of recurrent falls and the

odds of admission to hospital. In addition, a 50% reduction in fracture rate was seen (Close *et al* 1999).

The Irish Society of Physicians in Geriatric Medicine stresses the urgency for the provision of such clinics in Ireland. Work has already begun in this area. Several hospitals are using the Fall Risk Assessment Scale for the Elderly (FRASE). Falls prevention programmes are being developed in some health boards under the guidance of clinical risk managers. Auditing of these initiatives has still to be carried out. Evidence suggests that preventing falls and their sequelae may delay or reduce admissions to nursing homes (Tinetti & Williams 1997).

**Osteoporosis Treatment and Fracture Prevention Clinic:** Osteoporosis is particularly prominent in the elderly. Up to 25% of the over 70 age group are thought to have osteoporosis, and a further 50% to have osteopaenia. The mortality rate associated with osteoporotic hip fractures is 33%. A further one-third require continuing institutionalised care, and a significant number never regain full independence (Gullberg *et al* 1997). Participants said that prevention of a first osteoporotic fracture was a major clinical goal, and that prevention strategies fell within the scope of practice of nurses, and included lifestyle modifications, pain relief and reduction in risk.

**Memory Clinic:** The *Action Plan for Dementia* has emphasised the critical importance of early and accurate diagnosis of dementia (O'Shea & O'Reilly 1999). There are just over 31,000 people in Ireland with dementia. 22,000 reside in the community. Data is not available to allow for a comparison of prevalence rates in Ireland over time. The *Action Plan* forecasts increases of the incidence of dementia of approximately 5,000 per year between 2001 and 2011. Sufferers of this condition have a reduced life expectancy, with greater usage of medical services and greater requirement for institutionalised care. Many patients/clients present with a treatable pathology. In addition, patients/clients and carers can be given advice about planning for the future, 'enduring power of attorney', the making of wills and the services available. Recent studies suggest that, in addition to these benefits, memory clinics can reduce carer stress (O'Shea & O'Reilly 1999).

**Parkinson's Disease Clinic:** In the EU the overall prevalence of the disease is estimated to be 1.6 per 100 in persons over 65 years of age (WHO 2001b). Parkinson's disease affects about 2% of people over 75 years of age. Irish figures for the prevalence of Parkinson's disease are unreliable, but are estimated at 5-6,000. Problems experienced by older patients with Parkinson's disease include recurrent falls, dizziness, urinary and faecal incontinence, swallowing problems and a high incidence of dementia. These problems require the input of a multidisciplinary team, including a CNS. In the UK, there has been a rapid growth in the provision of specific Parkinson's disease clinics and of specialist Parkinson's nurses. Participants in the consultation process supported this approach.

**Stroke Prevention Clinic:** Mortality rates from stroke are decreasing in the 65-74 year age group, with the current mortality rate at approximately 200/100,000 population (DoHC 2003b). A stroke prevention clinic aims to assess

patients/clients considered at high risk of stroke by their G.P. or consultant. The clinic would provide fast track assessment, followed by prompt commencement of preventative treatment and follow up. All of these preventative interventions have a firm evidence base and are highly cost effective (Hankey & Warlow 1999). Many of these interventions, including health promotion strategies, lifestyle changes and smoking cessation groups, are within the scope of practice of specialist nurses.

**Chronic Heart Failure (CHF):** is a highly prevalent disorder in old age. The prevalence of heart failure is between 3 and 20 per 1000 population. However, this may exceed 100 per 1000 in those over the age of 65 years. It has been estimated that 1% to 2% of total healthcare resources are consumed in the management of this condition (McGowan 2000). With the steady rise in the proportion of elderly people, the prevalence of CHF is likely to rise. Major advances in the early detection and treatment of CHF have proven health gains for patients. One such advance is improved patient/client follow up and support in the community, interfacing with hospital services through a Heart Failure Clinic and CHF CNS (Erhardt & Cline 1998). This role has already been established as a CNS in Ireland.

## 6.6 Agenda for Future Development

The demographic and health profile of older people poses many challenges in terms of planning for appropriate services. The population is ageing and, after the year 2006, the number of older people is expected to increase more rapidly.

Older people are major users of the health and social services. Regardless of the varied care settings in which gerontological nursing is practised, the central focus of care should be older people and their families, with an emphasis on health promotion and prevention of illness.

There is a need for a refocus on health promotion and primary prevention aspects of the nursing role. One of the major challenges to gerontological nursing is a perceived lack of prestige attached to caring for older people. The multidisciplinary nature of care provision for older people is important.

There is a need to develop both CNS and ANP posts in gerontological nursing in response to health service need. In addition, older people are cared for across all care settings and additional skills and expertise are required to ensure effective care. Care of older people offers opportunities for nurse-led services.

The importance of the nurse in all settings understanding age related issues, especially in smaller community and district hospitals should be acknowledged and a competency-based approach to professional development introduced.

# Public Health Nursing

This section provides a brief overview of the role of the Public Health Nurse. A *Strategy for Nursing and Midwifery in the Community* is currently being developed by the Nursing Policy Division in the Department of Health and Children. Following publication of this strategy, which will provide a framework for future care in the community, the National Council will review the implications for professional development of public health nursing.

Public health has been described as organised social and political effort and health promotion for the benefit of populations, families and individuals. The Public Health Nurse (PHN) practises as part of a multidisciplinary team to deliver domiciliary care (DHSSPS DoHC 2003). There are 1,552 PHNs on the active register which makes them the largest group of professionals working in the community (An Bord Altranais 2003a). PHNs have a wide remit encompassing primary, secondary and tertiary care at three levels including individual, family and community (Hanafin *et al* 2002). They have responsibility for the provision of a nursing service in the community to multiple client groups with any type of condition and public health nursing is an amalgamation of services incorporating midwifery, public health and home nursing.

The role is threefold, combining that of manager, clinician and health promoter (Hanafin 1997). Their wide range of abilities and responsibilities are reflected in the educational and experiential preparation required to register as a PHN. This takes a minimum of eight years as the PHN must be a registered general nurse, a registered midwife, have achieved a Higher Diploma in Public Health Nursing and in addition have a minimum of two years in clinical practice. Their commitment and the contribution they have made to community nursing is widely acknowledged and there is general agreement that public health nursing has a well deserved reputation for quality and excellence (DoH 1997c, Commission on the Family 1998).

The *Report of the Commission on Nursing* (Government of Ireland 1998) re-examined the public health nursing service in Ireland in terms of its organisation, delivery and focus. Recommendations included the need to develop a coherent vision for the future direction of nursing and midwifery in the community, which reflects the needs of the community. To this end, the Nursing Policy Division in the DoHC are developing a *Strategy for Nursing and Midwifery in the Community*. Following publication of this strategy, which will provide a framework for future care in the community, the National Council, will review the implications for the professional development of public health nursing.



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# Appendix 1 – List of Submissions

1. Ms Marie Keane, Beaumont Hospital, Dublin
2. Ms Sinead Quill, National Council on Ageing and Older People, Dublin
3. Ms Gertrude Cole, Hospital of the Assumption, Thurles
4. Ms Gertrude Cole, Ms Irene O'Connor & Ms Noreen Spillane, Nurse Managers, Elderly Care Services, Mid-Western Health Board
5. Ms Niamh Maher, MedEL, St James's Hospital, Dublin
6. Ms Anne Quinn, Ms Mary B Ryan & Ms Breda Sweeney, St Patrick's Hospital, Tipperary
7. Ms Phyl Saunders, Lifford District Hospital, Co Donegal
8. Ms Regina Boyle, Portiuncula Hospital, Ballinasloe, Co Galway
9. Ms Mary Courtney, Director Nursing & Midwifery Planning & Development Unit, Western Health Board
10. Mr Jim Brown, Director Nursing & Midwifery Planning & Development Unit, North Western Health Board
11. Mr Colum Bracken, Director Nursing & Midwifery Planning & Development Unit, North Eastern Health Board
12. Mr Patrick Glackin, Director Nursing & Midwifery Planning & Development Unit, Midland Health Board
13. Ms Joan Phelan, Director Nursing & Midwifery Planning & Development Unit, South Eastern Health Board
14. Ms Catherine Killilea, Director Nursing & Midwifery Planning & Development Unit, Southern Health Board
15. Ms Sheila O'Malley, Director Nursing & Midwifery Planning & Development Unit, Eastern Regional Health Authority
16. Ms Nora O'Rourke, Director Nursing & Midwifery Planning & Development Unit, Mid-Western Health Board
17. Ms Ruth Lernihan, South Infirmary - Victoria Hospital Ltd, Cork
18. Ms Sibeal Carolan, The Adelaide & Meath Hospital incorporating the National Children's Hospital, Dublin
19. Ms Margaret McCarthy, School of Nursing & Midwifery Studies, University of Dublin, Trinity College
20. Prof Geraldine McCarthy, Department of Nursing Studies, University College Cork
21. Ms Margaret Landers, Mr Mark Tyrell, Ms Mary O'Donoghue & Ms Mairin O'Mahoney, Department of Nursing Studies, University College Cork
22. Mr Harry Gijbels, Department of Nursing Studies, University College Cork
23. Ms Eileen Savage & Ms Patricia O'Dwyer, Department of Nursing Studies, University College Cork
24. Ms Alice Coffey, Department of Nursing Studies, University College Cork
25. Mr John Sweeney, Department of Nursing Studies, University College Cork
26. Ms Rhona O'Connell, Department of Nursing Studies, University College Cork
27. Prof Seamus Cowman, Royal College of Surgeons in Ireland, Dublin
28. Ms Mary Carway, Nurse Education Committee (and Sub-committee), Sligo General Hospital
29. Ms Joan Phelan, Director Nursing & Midwifery Planning & Development Unit, South Eastern Health Board (on behalf of Directors of Nursing & Midwifery, South Eastern Health Board)
30. Ms Vivienne Fay, Northern Area Health Board, Drugs/Aids Service, Dublin
31. Ms Anne O'Mahony, Listowel Community Hospital, Co Kerry
32. Mr Eddie Byrne, Cavan / Monaghan Hospital Group
33. Ms Marie Grimes, Clinical Nurse Specialists Group, Cork University Hospital

34. Ms Mary Walsh, Sligo General Hospital
35. Ms Catherine Deegan, St James's Hospital, Dublin
36. Ms Mary Brosnan, National Maternity Hospital, Dublin
37. Sr Marian Harte, Ms Theresa O'Loughlin, Ms Mary Reynolds & Ms Breda Noonan, Daughters of Charity of St Vincent de Paul, Dublin
38. Ms Paula Mullery, Ms Frances Reynolds, Mr Maurice Healy & Ms Marion Keane, John Paul Services, Galway
39. Ms Mary O'Connor, Brothers of Charity, Roscommon
40. Nursing staff of Sisters of Bon Sauveur Services, Co Waterford
41. Ms Mary Drury, St James's Hospital, Dementia Services Information & Development Centre, Dublin
42. Mr Martin Crowe, Mr Martin Burke, Mrs Maeve Dwan, Ms Eileen Carr & Ms Linda Mulvihill, Lucena Clinics, Co. Dublin and Co. Wicklow
43. Ms Bridgid Coohill & Mr Andrew Callinan, West Galway Mental Health Services, University College Hospital, Galway
44. Mr Bill Frewen, Mr Terry Hayes, Mr John Murray & Ms Audrey Hennebry, Waterford Mental Health Services
45. Mr John McCardle, St Conal's /Letterkenny General Hospital, Donegal Mental Health Services
46. Mr Martin Farrell & Mr Jim Maguire, Dublin NW (Area 6) Community Mental Health Services, Dublin
47. Ms Kay Downey Ennis, Board of Management, Daughters of Charity Service for Intellectual Disabilities, Dublin
48. Ms Veronica O'Reilly, St Ciaran's Day Centre, Co Leitrim
49. Ms Mairead Vaughan, Ms Debbie O'Toole, Ms Caroline McGuire, Ms Colette McDonnell, Ms Karen O'Connell & Ms Marie Carroll, Rosedale School & Burrenview Child Development Centre
50. Ms Patricia Connolly, Mr Rory Douglas, Ms Mary McConnell & Ms Carmel Smyth, Kilcornan Centre, Co Galway
51. Ms Mary McHugh, University College Hospital, Galway
52. Ms Eithne Cusack, Nursing & Midwifery Planning & Development Unit, Eastern Regional Health Authority
53. Ms Liz Roche, Nursing & Midwifery Planning & Development Unit, Eastern Regional Health Authority
54. Mr Bernard McCarthy, Western Health Board, Galway
55. Mr John Pepper, Hospitaller Order of St John of God, Intellectual Disability & Mental Health Services, Dublin (on behalf of nurses in Dublin, Kildare and Wicklow services)
56. Ms Eilis Geraghty, Entrust, Irish Clinical Nurse Managers Association
57. Sr Maureen McDonnell, St Joseph's Hospital, Ballina
58. Ms Mary Mahon, Association of Irish Nurse Managers
59. Ms B A Howley, Galway Regional Hospitals
60. Ms Susan Carton, Sisters of La Sagesse Services, Cregg House, Sligo
61. Ms Phil McKenna, South Infirmary -Victoria Hospital, Old Blackrock Road, Cork
62. Mr Michael Shannon, Letterkenny General Hospital, Letterkenny
63. Ms Nora Fitzpatrick, Regional General Hospital, Dooradoyle, Limerick
64. Ms Patricia Tobin O'Dwyer, Our Lady's Co. Surgical Hospital, Cashel
65. Mr Robert Quinn, St. Josephs County, St. Josephs Medical and Maternity Hospital, Clonmel
66. Ms Eithne Cusack & Ms Eithne Ni Dhomhnaill, Eastern Regional Health Authority
67. Ms Anne O'Mahoney, Listowel Community Hospital, Co Kerry
68. Ms Mary Flanagan, Our Lady's Hospice, Dublin
69. Ms Patricia Russell, Portiuncula Hospital, Ballinasloe, Galway
70. Ms Maura Connolly, The Adelaide & Meath Hospital, incorporating The National Children's Hospital, Dublin
71. Ms Patricia Larkin, National Midwifery Advisory Forum, Department of Health & Children

72. Mr Declan Devane, Dr Cecily Begley, Ms Margaret Carroll & Ms Deirdre Daly, School of Nursing & Midwifery Studies, University of Dublin, Trinity College
73. Ms Joan G Lalor, Ms Christine McDermott & Ms Edna Woolhead, Rotunda Hospital, Dublin
74. Ms Mary Higgins, Co Cork
75. Ms Colette McCann, Our Lady of Lourdes Hospital, Drogheda
76. Ms Nora Mansell-Quirke, Unified Maternity Services Midwives, Cork
77. Dr Michelle Butler & Ms Maria Healy, School of Nursing & Midwifery, National University of Ireland, Dublin
78. Ms Eleanor Doyle, St Joseph's County Medical & Maternity Hospital, Co Tipperary
79. Ms Sheila Sugrue, Coombe Women's Hospital, Dublin
80. Ms Annette Keating, College of Midwifery, St Finbarr's Hospital, Cork
81. Midwifery Tutors, Regional School of Midwifery, Our Lady of Lourdes Hospital, Drogheda
82. Ms Christina Pasley, Ms Maura Porter & Ms Linda Murphy, Fairlands Child Development Services, Galway
83. Mr Sean Abbott, Cope Foundation, Cork
84. Sr Anne Lynch, Sisters of Charity of Jesus & Mary, Moore Abbey, Monasterevin, Co Kildare
85. Behaviour Management Team, Brothers of Charity Services, Limerick
86. Mr Liam Power, Peamount Hospital, Co Dublin
87. Mr Richard Redmond, School of Nursing & Midwifery Studies, University of Dublin, Trinity College (on behalf of the working group on specialist clinical nurse practice areas)
88. Ms Lisa Cullen, Ms Anne White, Ms Audrey Fennell & Ms Sinead Farrell, St Vincent's University Hospital, Dublin
89. Ms Geraldine Murray, Mayo General Hospital
90. National Paediatric Nursing Advisory Forum, Department of Health & Children
91. Ms Honor Nicholl, School of Nursing & Midwifery Studies, University of Dublin, Trinity College
92. Ms Mary Hughes, Staff of 5th Floor Infants, Our Lady of Lourdes Hospital, Drogheda
93. Ms Judith Foley, The Children's University Hospital, Temple Street, Dublin
94. Ms Mary Mullins, Midland Regional Hospital, Tullamore
95. Ms Eleanor Carpenter, Neonatal Unit, Waterford Regional Hospital
96. Ms Linda Ennis, Neonatal Intensive Care & Paediatric Services, Waterford Regional Hospital
97. Ms Catriona Irwin, Paediatric Ward, Letterkenny General Hospital
98. Ms Marie Mc Sweeney & Ms Mary O'Sullivan, Paediatric Unit, St Mary's Orthopaedic Hospital, Cork
99. Ms Mairead Kenny & Ms Ann-Marie Staunton, Office of Women's Health & Children, Mayo General Hospital
100. Mr Damien O'Dowd, St. John of God Adult Mental Health Services, Dublin
101. Ms Eileen O'Leary & Ms Geraldine Tracey, Irish Association for Palliative Care
102. Ms Geraldine Regan, Our Lady's Hospital for Sick Children, Crumlin, Dublin
103. Ms Julie Ling, Nurse Advisor, Nursing Policy Division, Department of Health and Children, Dublin
104. Ms Margaret Buckley, Nursing & Midwifery Planning & Development Unit, Southern Health Board
105. Nurse Teachers' Group (Mental Handicap), c/o Cregg House, Sligo



# Appendix 2

## Index of Official Publications

### **Report of the Commission on Nursing, A blueprint for the future (Government of Ireland 1998)**

The Commission on Nursing was established following a recommendation of the Labour Court (Recommendation No. LCR15450) in March 1997. The agreed terms of reference were:

- The evolving role of nurses, reflecting their professional development and their role in the overall management of the services
- Promotional opportunities and related difficulties
- Structural and work changes appropriate for the effective and efficient discharge of that role
- The requirements placed on nursing, both in training and the delivery of the services
- Segmentation of the grade and
- Training and education requirements.

An Interim Report was published in October 1997 and a final report 1998. The final report was titled *Report of the Commission on Nursing, A blueprint for the future*. Recommendations were made within this report in relation to: regulation of the profession, preparation for the profession, professional development, role of nurses and midwives in the management of services, nursing in the community, nursing in care of the elderly, mental handicap nursing, midwifery and sick children's nursing.

### **Building Healthier Hearts: Report of the Cardiovascular Health Strategy Group (DoHC 1999a)**

The Cardiovascular Health Strategy Group's terms of reference required consideration of initiatives to improve cardiovascular health, the further development of cardiac care and rehabilitation at primary, secondary and tertiary care levels and the co-ordination of services for patients. The following four key areas for action on cardiovascular disease were recommended: to standardise care in the pre-hospital and hospital settings across health board regions, to establish a protocol for appropriate primary care, to ensure an effective surveillance system and to expand or put in place settings-based health promotion programmes.

### **Scope of Nursing and Midwifery Practice Framework (An Bord Altranais 2000)**

This framework was developed following a recommendation of the Commission on Nursing (1998). The framework provides principles, which should be used to review, outline and expand the parameters of practice for nurses and midwives. The framework aims to support and promote best practice for all nurses and midwives, which will ensure the protection of the public and the timely delivery of quality health care in Ireland.

### **The National Health Promotion Strategy 2000-2005 (DoHC 2000a)**

This Health Promotion Strategy sets out a broad policy framework within which action can be carried out to advance strategic aims and objectives. The strategy aims to promote a holistic approach to health in Ireland, for example by focusing on the link between health promotion and the determinants of health and emphasising the role of inter-sectoral and multi-disciplinary approaches in the planning, implementation and evaluation of health promotion initiatives including the involvement of the consumer.

### **Quality and Fairness – A Health System for You (DoHC 2001a)**

This *Health Strategy* was published in 2001 and is a blueprint to guide policy makers and service providers over the next 7-10 years. It builds on the planned and strategic approach of the previous health strategy (*Shaping a Healthier Future 1994*) and upon the publication and implementation of other health-related strategies. The Health Strategy outlines a programme of investment and reform of the health system to be implemented over the next decade. It sets clear priorities but also involves all elements of the system. What distinguishes the strategy is the unique level of consultation with individuals, professional groups, disciplines, voluntary organisations and state agencies on which it was based.

### **Primary Care: A New Direction (DoHC 2001c)**

*Primary Care: A New Direction* provides strategic direction for primary care over the next 10 years. It proposes changes which aim to improve access for all to primary care services, enhance links between both primary and secondary care and emphasise the importance of prevention of disease and health promotion. An inter-disciplinary team based approach is proposed.

### **Effective Utilisation of the Professional Skills of Nurses and Midwives (DoHC 2001d)**

The working group of the *Effective Utilisation of the Professional Skills of Nurses and Midwives* recommended that the grade of healthcare assistant be introduced as a member of the healthcare team to assist and support the nursing and midwifery function. A national 6 month training programme was completed June 2002.

### **The Nursing and Midwifery Resource: Final Report of the Steering Group. Towards Workforce Planning (DoHC 2002a)**

The principal aims of the study were to analyse the current position with regard to workforce, to advise on methodologies for the projection of future needs and to recommend how these needs can be met through future planning. An interim report was published in September 2000 and a final report 2002. A comprehensive approach to workforce planning for nursing and midwifery is described.

### **Proposed Framework for the Development of Clinical Specialism and Advanced Practice in Mental Handicap Nursing (DoHC 2002c)**

This report outlines a project undertaken by the Nursing Policy Division of the Department of Health and Children, which aimed to initiate discussion on the future development of clinical specialism, advanced practice and supporting educational programmes for mental handicap nurses in Ireland.

### **A Research Strategy for Nursing and Midwifery in Ireland, Final Report (DoHC 2003a)**

This strategy was developed following a recommendation that the Nursing Policy Division in the Department of Health and Children draw up a national strategy for nursing and midwifery research. A series of recommendations outlining national, institutional and individual commitment for the development and growth of nursing and midwifery research in Ireland is provided.

# Appendix 3

## Working Definitions

### **Extended Role**

The *extended role* is defined as one that involves tasks borrowed from other professions; these tasks are used by the nurse at the discretion and convenience of others and may involve training, supervision and certification by other professions.

### **Holistic Care**

*Holistic care* is the treating of the whole person including mental and social factors rather than the symptoms of a disease.

### **Nurse-led Care**

*Nurse-led care* is distinct from *nurse co-ordinated* or *nurse-managed* services. Nurse-led care is care provided by nurses responsible for case management, which includes comprehensive patient/client assessment, developing, implementing and managing a plan of care, clinical leadership and decision to admit or discharge. Patients/clients will be referred to nurse-led services by nurses, midwives or other healthcare professionals, in accordance with collaboratively agreed protocols. Such care requires increased skills and knowledge and the nurse will need preparation in both the clinical and management aspects of the role. Such nurses will be practising at an advanced level and may be working in specialist or advanced practice roles.

### **Role Expansion**

*Role expansion* involves becoming more competent, reflective, autonomous practitioners and developing expertise and skills to meet patients'/clients' nursing needs (An Bord Altranais 1999a).











*National Council for the*  
**Professional Development**  
*of Nursing and Midwifery*

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*An Chomhairle Náisiúnta d'Fhorbairt*  
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