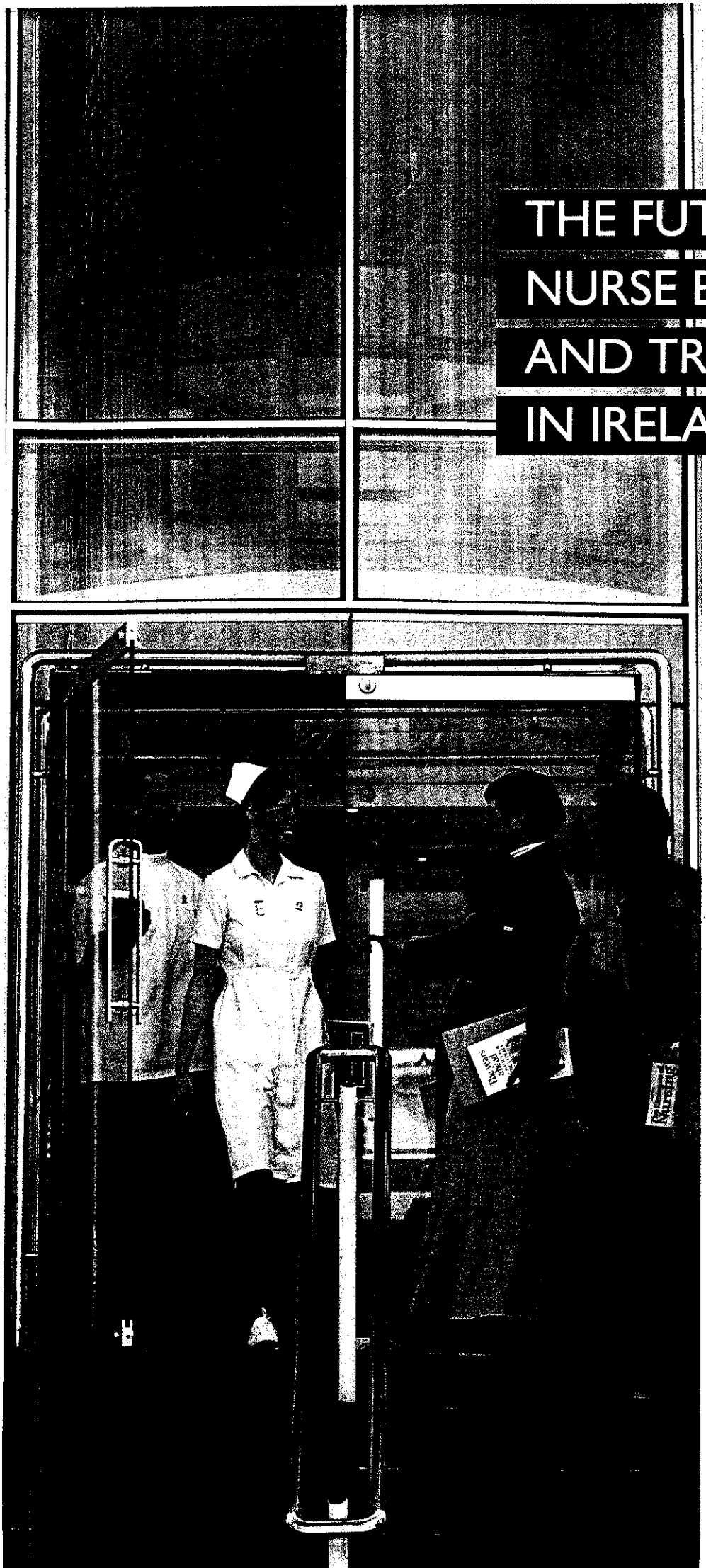

THE FUTURE OF NURSE EDUCATION AND TRAINING IN IRELAND

An Bord Altranais

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An Bord Altranais

(The Nursing Board)

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THE FUTURE OF NURSE EDUCATION AND TRAINING IN IRELAND

CONTENTS

FOREWORD

It gives me great pleasure to present the report, *The Future of Nurse Education and Training in Ireland.* The culmination of extensive research and consultation, it is the consensus view of a widely representative and expert group.

An Bord Altranais presents twenty-eight recommendations which relate to organisational, educational, training and economic issues surrounding the future preparation of nurses. The recommendations when implemented will ensure the continued development of the profession and enable it to meet the expectations of the profession itself and of the health services.

An Bord Altranais is aware of the fundamental changes required to implement its recommendations. An Bord will make available to the Minister for Health a separate accompanying report costing the implications of their implementation. This work was undertaken by an independent consultancy group commissioned by An Bord.

An Bord Altranais is confident that a future developed on the basis of its recommendations is the best option to ensure the availability to the health services of a highly educated and trained nursing profession prepared to meet the needs of the health services up to and beyond the year 2000.

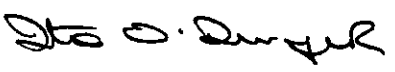
The Minister for Health has already referred to the need for a major overhaul of nurse training in the recently published strategy document, *Shaping a Healthier Future –a Strategy for Effective Healthcare in the 1990s.* This acknowledgement of the need for change and the broad framework for development in nurse education and training set out in the strategy document are welcomed by An Bord Altranais.

While the Department of Health has indicated reservations on some aspects of the recommendations set out in this report, I am confident that any differences of view can be addressed both in the debate concerning implementation of the report and in experimenting with new models of nurse education and training.

Over the past hundred years, Irish nursing has developed and maintained a high reputation for standards in nursing care at home and worldwide. An Bord looks to a future which will build on the excellence of the past and ensure that professionalism in clinical practice will continue to merit public confidence and international acclaim.

An Bord appreciates the work done by the members of the advisory review committee on nurse education and training, the individuals, groups and organisations who made written and oral submissions and the nurses who attended regional consultative seminars. The work spanned the term of office of the membership of two boards in its three years of deliberation.

An Bord acknowledges the support of the executive staff: Eugene Donoghue, Chief Executive Officer; Kathleen Keane, Chief Education Officer; other officers who supported the work of committees and Seamus Cowman, Education Officer, who supported the work of the advisory review committee.



Ita O'Dwyer
President of An Bord Altranais

AN BORD ALTRANAIS (THE NURSING BOARD)

An Bord Altranais is the statutory regulatory body for the nursing profession in Ireland. Its main functions relate to:

- the maintenance of a register of nurses
- the control of the education and training of student nurses and the post-registration training of nurses
- the operation of fitness to practise procedures
- the ensuring of compliance with European Union Directives on nursing and midwifery.

The present board was established under the Nurses Act, 1985. It consists of twenty-nine members, seventeen of whom are nurses elected by the nursing profession and the remainder drawn from the medical profession, the management of the health services, educational interests and the general public, appointed by the Minister for Health.

THE NURSING PROFESSION IN IRELAND

At the end of 1993, the nursing profession in Ireland consisted of 46,509 registered nurses who between them had registered 68,192 qualifications as follows:

● General nurse	37,281
● Midwife	13,191
● Psychiatric nurse	8,884
● Sick children's nurse	2,962
● Mental handicap nurse	2,645
● Public health nurse	1,664
● Nurse tutor	256
● Other*	597

An Bord maintains an inactive file for nurses who are not practising nursing in Ireland and approximately 7,000 of the above nurses are listed on this file.

Approximately 2,000 new nurses register annually.

* *Including orthopaedic, sanatorium, fever, advanced psychiatric, tuberculosis, infectious disease nurses and clinical teachers.*

ESTABLISHMENT OF ADVISORY REVIEW COMMITTEE

An Bord Altranais has a specific responsibility [section 36(2) of the Nurses Act, 1985] to review and evaluate existing programmes of nurse education and training.

In accordance with that responsibility An Bord established a committee in September 1990 to assist it in carrying out a review. The committee consisted of a group of members of An Bord together with a number of persons co-opted to it to represent certain relevant interests (see Appendix 1).

The terms of reference of the committee were:

- to analyse the strengths and weaknesses of the present system of training, educating and examining student nurses
- to make proposals in regard to the training, education and examination process
- to analyse the current post-registration education and training of nurses
- to make proposals in relation to the adequacy and suitability of post-registration education and training of nurses
- to make recommendations to outline the professional, service and financial implications of implementing the proposals
- to publish the findings.

This report, based on the work of the review committee, represents the views of An Bord Altranais on the subject of nurse education and training in Ireland.

PROCEDURE

An interim report, prepared by the review committee, was presented to the Minister for Health and published in October 1991. It was intended to be a consultative document to initiate a process of consultation with the profession, employers and groups representing nurses. The contents of that document included:

- a review of the historical development of nursing and nurse education
- a description of nurse education as it is today
- an outline of key features of the nursing profession in relation to labour force and recruitment
- a general description of demographic and epidemiological patterns in the context of future healthcare needs and health service delivery
- key aspects of the debate on future patterns of nurse education and training.

Following publication of the consultative document, An Bord Altranais engaged in a series of regional consultative seminars with nurses. Eighteen workshops were conducted, at least two within each health board area. A total of 819 nurses participated. The participants included representatives from all grades of nursing and from all divisions of the register of nurses. Formal submissions on the consultative document were invited from individual nurses, employers of nurses, groups representing nurses and other external health agencies.

The services of consultants were employed in November 1993 to undertake a study of costings in nurse education and to provide costing estimates on current and new models of nurse education.

In December 1993, prior to preparation of this final report, the draft recommendations were circulated to the profession and to other interested parties and their views were invited on the draft proposals. A wide range of submissions was received in response to this document (Appendix 6).

An Bord Altranais, having considered the findings of the review committee and analysed the range of views obtained through the consultative process, and having reviewed health service policy, nursing literature, national and international trends in nurse education, now presents its final recommendations for the future development of nurse education and training in Ireland.

GLOSSARY OF ABBREVIATIONS AND TERMS

ABBREVIATIONS

RGN	Registered General Nurse
RPN	Registered Psychiatric Nurse
RSCN	Registered Sick Children's Nurse
RMHN	Registered Mental Handicap Nurse
RM	Registered Midwife
RNT	Registered Nurse Tutor
RCT	Registered Clinical Teacher
RPHN	Registered Public Health Nurse

COMMON CORE PROGRAMME

The common core programme will introduce the student nurse to the principles of nursing and related knowledge. The programme will also provide each student nurse with an appreciation of general, psychiatric, mental handicap and sick children's nursing.

CONTINUING EDUCATION

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

INACTIVE FILE

The inactive file is a system of classifying nurses whose names are entered on the register and who have made a declaration to An Bord Altranais that they are not practising nursing in Ireland at present and will not be practising in the immediate future. They are not required to pay the annual retention fee.

MIDWIFE

The term midwife indicates a person whose name is entered in the midwives' division of the register.

NURSE

The term nurse indicates a woman or a man whose name is entered on the register and includes a midwife.

PRE-REGISTRATION NURSE EDUCATION AND TRAINING

Pre-registration nurse education and training includes educational programmes that are designed to prepare students for entry to divisions of the register of nurses maintained by An Bord Altranais.

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

POST-REGISTRATION NURSE EDUCATION AND TRAINING

Post-registration nurse education and training includes educational programmes and courses that are developed for registered nurses and embody terms such as in-service training, specialist courses and refresher courses.

THE REGISTER

The register refers to the register of nurses which is established and maintained under Section 27 of the Nurses Act, 1985. The divisions of the register include general, psychiatric, mental handicap, sick children's, midwifery, nurse tutor and public health nursing.

SCHEDULED CLINICAL PLACEMENTS

Scheduled clinical placements are distinguished from other clinical placements inasmuch as the student nurse is rostered for duty.

SPECIALIST COMPONENT OF THE PROGRAMME

The specialist component of the programme is the part of the programme which student nurses, on successful completion of an eighteen-month common core programme, follow for registration in one of four specialist divisions of the register for general, psychiatric, sick children's or mental handicap.

STUDENT NURSE

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

VALIDATION

This is the process by which courses are assessed by the appropriate authorities, for their academic and professional credibility.

NB: The female gender is used regularly in the text and, where appropriate, should be read as also implying the male gender.

SUMMARY OF MAIN RECOMMENDATIONS

Pre-Registration (Section 2)

- A Central Applications System for entry to nursing should be established (par. 2.6).

- The number of students entering nurse education and training leading to registration should primarily be determined on the basis of national policy in relation to health service needs (par. 2.8).

- The student nurse should have the status of student throughout the course of education and training leading to registration and should not be an employee of a service (par. 2.8).

- Colleges of nursing and midwifery should be established with links to third level institutions. A college of nursing and midwifery should embrace a group of hospitals and institutions including general, psychiatric, sick children's, mental handicap, midwifery and facilities for community nursing services. The college of nursing shall be under the direction of a registered nurse tutor or midwife teacher (par. 2.20, 2.21).

- A comprehensive national framework should be established by An Bord Altranais for links between the colleges of nursing and midwifery and higher education institutions (Appendix 7) for the purpose of accreditation of courses (par. 2.21).

- The student nurse should have a simultaneous registration as a student with An Bord Altranais and a higher education institution (par. 2.21).

- A common core programme of eighteen months for all student nurses should be established followed by a further eighteen months of specialisation leading to registration in a particular part of the register for general, psychiatric, sick children's and mental handicap nursing (par. 2.12, 2.13, 2.14, 2.20).

- Educational preparation for clinical teaching responsibilities should be provided for nurses in clinical areas approved by An Bord Altranais for the education and training of student nurses (par. 2.14).

- Clinical experience should be under the guidance of a registered nurse tutor with the support of a preceptor in each clinical setting. An appropriate educational preparation for preceptors should be provided (par. 2.26).

- An Bord Altranais should establish a national curriculum development unit to monitor and advise on aspects of the nursing curriculum. Curriculum design should follow a modular approach and should include continuous assessment procedures. A period of scheduled clinical placements should be included in the later stages of the programme (par. 2.18).

- The role and preparation of the nurse tutor should be developed in a context of future educational change (par. 2.23, 2.24).

- The Department of Health should continue its financial support for student nurses through the provision of funds for students on courses leading to registration (par. 2.22).

Post-Registration (Section 3)

- A national framework for post-registration nurse education and training including mandatory nurse education and training should be developed by An Bord Altranais in conjunction with employers, providers of education and training, accrediting authorities and should receive adequate funding (par. 3.3, 3.4).

- Structures for post-registration nurse education and training should facilitate the preparation of nurses for clinical nursing roles, management and research (par. 3.4, 3.5).

- Structures for post-registration education and training should include a credit accumulation and transfer system (CATS) and must be flexible enough to recognise a nurse's/midwife's previous experience and learning (par. 3.2, 3.7).

- A nurse or midwife on successful completion of a course professionally validated by An Bord Altranais should have the course recorded with her individual registration (par. 3.6).

- A nurse returning to practice after a five year or greater period of absence from practice or a nurse transferring from one discipline to another must undertake a refresher course validated by An Bord Altranais (par. 3.5).

Community Nursing (Section 4)

- Primary health care should be an essential feature of the nursing curriculum (par. 4.3, 4.5).

- Future programmes of nurse education and training should provide all student nurses and registered nurses with substantial knowledge and expertise in relation to community nursing (par. 2.18, 4.19).

- The provision of a satisfactory learning environment in the community care setting for student nurses should be developed in the interest of student nurse learning (par. 4.19).

- An enhanced level of nurse education and training should be provided in care of the elderly (par. 4.17).

- Midwifery registration should no longer be required for entry to public health nursing and should be replaced by a maternity and child care module (par. 4.19).

Midwifery (Section 5)

- Article 2 of the EU Midwives Directive, 80/154/EEC, should be used to provide flexibility in the approval and validation by An Bord Altranais of programmes of midwifery education and training (par.5.12).

- Midwifery education and training programmes should have academic accreditation (par. 5.12).

- A new curriculum should be developed for the midwifery registration programme (par. 5.12).

- Programmes of midwifery education and training should be located in colleges of nursing and midwifery and should be under the direction of a qualified midwife teacher (par. 5.12).

- The EU recommendation (111/D/5159/2/89) on continuing education of midwives should be implemented (par. 5.10).

- The EU recommendation (111/F/5122/4/90) on midwives and research should be implemented (par. 5.10).

SECTION I

NURSING IN THE FUTURE – THE CHALLENGES

1.1 Constant Change in the Professional Environment

Nursing operates in a professional environment where constant change is taking place. The Consultative Document (1991)[1] outlined a range of change occurring in society and healthcare. In examining perspectives for the future, the Consultative Document stated that 'the nursing profession has a responsibility to look to the future to ensure that its potential continues to be realised in the context of changing health services' (par. 5.1). Nurses in future years will look critically at decisions made now by leaders of the profession in the development of nursing. *If the profession of nursing and midwifery takes a long-term view now rather than introduce short-term solutions, the interests of the profession and those it serves will benefit to a greater extent.*

1.2 Complex Influences

The healthcare systems in which nurses operate today are complex ones. Healthcare issues involving new and different demands from informed consumers, the economics of healthcare, health service resourcing and issues related to accountability and legality are all influencing and transforming the role of the nurse.

Many changes in the latter half of this century brought about by social, technological and medical change have presented the nursing profession with challenges requiring that nurses be flexible and adaptable. New structures for nurse education which have been introduced in other countries such as the United Kingdom and Australia have demonstrated that the effective performance of professional nursing practice can be based on a body of knowledge specific to the profession of nursing.

1.3 Demographic and Epidemiological Factors

In recent years developments in the provision of healthcare have been greatly influenced by demographic and epidemiological factors. These developments include changes in specialist care and improved diagnostic and therapeutic facilities. The next decade is expected to be a time of rapid global change owing to:

(i) the continuing shift in demographic patterns
(ii) the increased mobility of the population
(iii) the use of information technology
(iv) the availability of complex technology.

It is clear that technology and scientific advances will change the environment for nursing. Sophistication in investigative techniques involving non-invasive procedures will lead to the detection of disease at an earlier and more curable stage. Advances in anaesthesia and surgical repair will result in a higher survival rate and an improved quality of life.

1.4 Information Technology

The future will bring advances in the information technologies used in databases to accommodate knowledge related to clinical, epidemiological and environmental factors. Artificial intelligence will lead to sophisticated systems for clinical and

administrative decision making. In the context of such developments, it is incumbent on nurses to become computer literate and to develop creative ways to use computers in order to streamline the nursing assessment of patients, the nursing care of patients, patient education and nurse education. It is recognised that Irish nurses have already made a considerable amount of progress in the area of computerisation.

1.5 Biomedical and Psychosocial Knowledge

The advance of biomedical and psychosocial knowledge in recent decades has created much broader horizons for all healthcare professionals including nurses. Sophisticated knowledge, clinical reasoning, problem solving and decision making will be crucial in arriving at clinical nursing judgements. *Nurses can no longer approach their practice from a task-orientated perspective; they need to be educated and prepared to adapt to changing healthcare environments.*

1.6 Influences for Change in Education

An Bord Altranais in its Consultative Document (p. 49), stated the case for change in nurse education and identified influential factors as including:

- the various reports and policies which detail a shift towards the provision of healthcare in the community and an emphasis on health promotion and the prevention of illness
- the significant changes and trends in demographic and epidemiological patterns
- the requirement that nursing services continue to be cost effective and efficient in the context of changing definitions of healthcare
- the need to rationalise and strengthen the process of nurse education in accordance with European and international developments.

1.7 Changing Role of Nursing

In relation to the role of the nurse, Akinsanya (1990)[2] states, 'A misunderstanding of the nursing profession has been perpetuated by a lack of definition of nursing.' The respondents who participated in the workshops conducted to discuss the Consultative Document expressed difficulty in defining nursing and in describing the current role of the nurse. They did, however, perceive the nurse's role to be changing in relation to the health services. Besides increased levels of clinical expertise, new and enhanced roles were envisaged in areas related to health promotion, innovation, research and management.

The respondents' perceptions of the changing role of Irish nurses echo the views expressed by the World Health Organisation (1991).[3] The WHO related the mission of nursing in society and stated that 'nurses will be required to develop and perform functions that relate to the promotion and maintenance of health as well as the prevention of disease. Nursing includes the planning and delivery of care during illness and rehabilitation. The physical, psychological, social and spiritual aspects of life as they affect health, illness, disability and dying are encompassed in that care.' (pp 8,9).

1.8 Irish Nurses' Views on Change

In relation to the WHO's aim of Health for All, Irish nurses were consulted in 1988 through the Department of Health and An Bord Altranais and a response was prepared on their behalf.[4] In relation to the required changes in the present system of nursing, the Irish nurses' recommendations included the following:

- all nursing curricula should have greater emphasis on health education and the identification of positive healthy behaviour
- there is a need for systematic nursing care based on the holistic model
- nurses should act as change agents in achieving the shift in emphasis to primary health care
- nursing practice should be research based
- continuing education is essential in facilitating nurses to respond to changing patient/client needs
- nurses should have greater involvement in decision making at all levels of the healthcare system.

1.9 Factors Supporting the Need for Change

Nursing is a practice discipline and theory and practice are intrinsically related. Nursing theory is intimately related to practice and theory grows out of practice. An Bord's recommendation for new strategies in nurse education reflects such an educational philosophy. In making recommendations for educational change and in determining the main features of such change, An Bord perceives the principal factors supporting the need for change as follows:

- the various nursing and health service reports of the past two decades on psychiatric and mental handicap services which recommend a desired common core/generic programme for nurses
- the wider healthcare and societal trends (Section 4, Consultative Document) which identify the need for a greater integration of hospital and community services
- the necessity to prepare nurses to deliver care across a broader spectrum of need in both the hospital and community setting
- the submissions[5] to An Bord Altranais in the 1980s/90s for nurse training which incorporate a common core or generic programme
- the findings of the workshop consultations and the submissions received by the review committee which support changing from direct entry to a specialist programme of nurse training as currently exists
- the recognition that there is a substantial knowledge base common to educational preparations for students undertaking study for all the divisions of the register of nurses and the recognition of the overlap that exists in the syllabi for the four pre-registration nursing programmes (Appendix 2)
- the emerging need for a more cost-effective model of nurse education
- the benefits of providing a greater professional identity, understanding and equity amongst all nurses with regard to education and practice issues
- the need to maintain standards in education and training which are consistent with international trends

- the need to provide all nurses with a deeper knowledge and a broader perspective on healthcare issues directly and indirectly concerned with nursing
- the need for specific educational objectives which will ensure the development of abilities and skills related to research, innovation, self direction and problem solving
- the expansive range of policy documents and EU directives concerned with nursing/midwifery practice and education. Such documentation refers to oncology, primary health care, integration of theory and practice, continuing education and research.[6]

SECTION 2

PRE-REGISTRATION – A MODEL FOR NURSE EDUCATION AND TRAINING

2.1 Introduction

Nurse education has a role to play in ensuring that nursing practice is sensitive, relevant and capable of responding to the wide range of health and social needs of society. Nurse education must also ensure that nurses have the capacity to adjust where and when appropriate to changing circumstances. The diversity and complexity of nursing in today's healthcare services makes it necessary to prepare nurses who are innovators, who can think critically and creatively and who have a substantial education in nursing-related sciences and the humanities. The nurse must also possess the motivation for life-long learning and the ability to transfer new knowledge and skills into healthcare for individuals, families, groups and communities in all settings in which healthcare services are needed.

In relation to strategies for nurse education and training this section of the report examines the present and alternative models of nurse education including the professional, educational and service implications.

2.2 General Nursing

The present system of general nursing is rooted in a long-established tradition of caring for the physically sick in hospital. Plans for instruction in general nursing were outlined as early as 1817 and there are records of some training having taken place in Dublin from about 1835. However, training was relatively unsystematic with no overall pattern. As the provision of healthcare increased a greater regulation of nursing services was introduced through the Nurses Registration Act, 1919. The first nurse's name was entered on the general register in 1921.

The current division of the register for general nurses was established through rules made in accordance with the Nurses Act, 1985. There is a total of 37,966 persons with general nurse qualifications entered on the register maintained by An Bord Altranais. There are three educational routes of entry to the general nurse register (Table 1).

Table 1 Different Routes to Training and Numbers of Student Nurses on Candidate Register for General Nursing (November 1993)

Registration Programme	No. of Students
Three years	3,160
Eighteen months (following registration as RPN, RSCN, RMHN)	140
Four years (integrated RGN/RSCN)	18
Total	3,318

The historical developments in general nursing are paralleled by changing healthcare patterns and health service activity. In recent years, general nurses within the clinical setting have had to respond to technological change and advances in medical and surgical techniques. Changes such as these have brought about the need for specialisation in nursing. A greater number of hospitalised patients are acutely ill and require more sophisticated care with increased technology and intense nursing specialisation.

Such specialisation has resulted in the need for some nurses to acquire levels of competency beyond that provided in the pre-registration programme. Nursing specialisation has developed the nurse's role in many areas of intensive care including coronary care, renal care and neurology. Nurses have acquired new responsibilities and have developed independent specialist roles both in hospital and community care areas.

2.3 Psychiatric Nursing

The recognition of the need for special care and treatment of those who are mentally ill dates back to the thirteenth and fourteenth centuries. The first special institution for the care of the mentally ill in Ireland, St Patrick's Hospital, Dublin, was established by Dean Swift in 1745. The state established a system of district lunatic asylums during the nineteenth century.

Toward the end of that century, the Medico-Psychological Association co-ordinated the training of psychiatric nurses and awarded certificates. This particular initiative represented the beginning of a systematic approach to the education and training of psychiatric nurses. Under the Nurses Registration Act, 1919 a supplementary part of the register was established for 'mental nurses'. The first entry to the register was made in 1921.

The current division of the register for psychiatric nurses was established through rules made in accordance with the Nurses Act, 1985. There is a total of 8,884 persons with psychiatric nurse qualifications entered on the register. There are two educational routes of entry to the psychiatric nurse register (Table 2).

Table 2. Different Routes to Training and Numbers of Student Nurses on Candidate Register for Psychiatric Nursing (November 1993)

Registration Programme	No. of Students
Three years	301
Eighteen months (following registration as RGN, RSCN, RMHN)	43
Total	344

The revised training programme for psychiatric nurses (1986) introduced a new philosophy for the training of psychiatric nurses including the provision of a longer

duration of community nursing experience for student nurses.

In recent years, psychiatric nursing specialist courses have been developed in areas related to alcoholism, behaviour therapy, child and adolescent psychiatric nursing and forensic psychiatric nursing.

2.4 Nursing of Persons with Mental Handicap

The earliest forms of care for persons with a mental handicap were provided by families and the community, generally on a voluntary basis. Stewart's Hospital, Dublin, opened in 1869 specially for persons with a mental handicap. The Daughters of Charity and St John of God Brothers developed further residential services in the early part of this century. Until 1950 services were based almost entirely on residential centres (the number of such residential places is shown in Table 3).

Table 3. The Number of Mental Handicap Residential Places

Year	No. of Places
1922	125
1932	500
1942	900
1952	1,300
1964	3,130
1985	5,186
1988	4,633
1990	4,548

Source: Earlier figures (1922-1952) cited in the *Commission of Inquiry on Mental Handicap* 1965 p.34. Later figures drawn from Health Statistic Reports for various years (*Department of Health*).

The development of services, including the formation of a group of nurses specially trained to care for persons with a mental handicap, has been of comparatively recent origin. In accordance with the Nurses Act, 1950 a new part of the register for nurses caring for the mentally handicapped was established in 1958. The first entry to the register was made in 1960.

The current division of the register for nurses of the mentally handicapped was established through rules made in accordance with the Nurses Act, 1985. There is a total of 2,645 persons with mental handicap nurse qualifications entered on the register maintained by An Bord Altranais. There are two educational routes of entry to the mental handicap nurse register (Table 4).

Table 4. Different Routes to Training and Numbers of Student Nurses on Candidate Register for Mental Handicap Nursing (November 1993)

Registration Programme	No. of Students
Three years	412
Eighteen months (following registration as RGN, RPN, RSCN)	44
Total	456

More recently, further nursing specialisation has occurred with a specialist educational course established in behaviour modification. A revised syllabus for the education and training of student nurses in mental handicap nursing was introduced in 1992.

2.5 Sick Children's Nursing

Sick children's nursing has a long tradition in health services. Under the Nurses Registration Act, 1919 a supplementary part of the register was established where the names of nurses trained in nursing sick children were entered. The first nurse's name was entered on the sick children's part of the register in 1922. The location of the earliest training programme was The Children's Hospital, Temple Street, Dublin and from 1924 onwards nurses were applying for registration following examination.

The current division of the register for sick children's nurses was established through rules made in accordance with the Nurses Act, 1985. There is a total of 2,962 persons with sick children's nurse qualifications entered on the register maintained by An Bord Altranais. There are three educational routes of entry to the sick children's nurse register (Table 5).

Table 5. Different Routes to Training and Number of Student Nurses on Candidate Register for Sick Children's Nursing (November 1993)

Registration Programme	No. of Students
Three years	229
Eighteen months (following registration as RGN, RPN, RMHN)	84
Four years (integrated RGN/RSCN)	18
Total	331

Sick children's nursing has also become intensely specialised through advancement in medical/surgical techniques and procedures. The nature of the relationship between the child, the nurse and the parents is now well accepted in a therapeutic sense. New nursing roles have evolved in many areas including roles in the management of cystic fibrosis, diabetes mellitus, asthma, operating theatre nursing, oncology, AIDS and intensive care. Post-registration specialist nursing courses have been developed in some of these areas.

2.6 Securing Entry to Nursing

Entrants to nursing are still required to make separate applications to each individual hospital and to undergo multiple interviews before securing a place in a programme leading to registration. An Bord regrets that the attempt made to establish a Central Applications System during the mid 1980s was unsuccessful. Such a system requiring only a single application to a central application office would have provided a simpler, more economic and fairer method of selection. It should be borne in mind that the great majority of school leavers seeking entry to education for a professional

career now enter through a centralised system of selection. An Bord cannot find a reason why there should not be a similar approach in relation to entry to nursing. The strongest arguments for doing so are based on equity and fairness regarding the criteria for selection as well as the convenience involved and the likely financial savings for applicants and employers. The Interim Consultative Document (1991) set out a strong case for such a system. An Bord has noted the overwhelming reaction in its favour among those consulted. The recommendation aimed at giving the status of student to the student nurse should help the development of a central system of application and we strongly recommend its introduction. *The system should evolve in consultation with the new colleges of nursing and midwifery and the Central Applications Office currently operating in the higher education sector.*

'It should be borne in mind that the great majority of school leavers seeking entry to education for a professional career now enter through a centralised system of selection. An Bord cannot find a reason why there should not be a similar approach in relation to entry to nursing.'

2.7 A Description of the Existing Programmes

The present model of training (three years) allows for direct entry to four specialist parts of the register including: general, psychiatric, sick children's and mental handicap. Following a first entry to a division of the nurses' register, a nurse can undertake a shortened training (eighteen months) for entry to another part of the register. Further programmes are available for entry to parts of the register for nurse tutors, public health nurses and midwives. Individual hospitals and health boards provide training programmes and curricula in accordance with An Bord's *Rules and Criteria for the Education and Training of Student Nurses* (1991).[1] The Rules and Criteria for the implementation of syllabi of training stipulate the criteria related to theoretical instruction and clinical instruction (Appendix 2). Assessment and final examination procedures are also laid down. Assessment of clinical nursing skills is carried out through a proficiency assessment format undertaken during a student's clinical practice. The final certificate of proficiency in clinical nursing skills for the registration examination is based on a minimum of four satisfactory proficiency assessments during the period of training following the award of an intermediate certificate.

An Bord proposes that, in the future, continuous assessment systems should be introduced as a means of reflecting a student's clinical and theoretical achievements during the total programme. Under such schemes, successfully completed assessments would be taken into account for the purposes of credit in the Registration Examination.

Theoretical instruction of forty weeks is provided either through a block or modular system arranged over the three-year period.

The theoretical requirements and the range of clinical experiences required during a student nurse's training programme have expanded. As a result students often have

to be seconded from their employing hospital to other hospitals and healthcare agencies for particular experiences. Accommodating such an event involves a fine balancing of the off-duty nursing roster to maintain manpower levels. Frequently the student nurses from general nursing have to be seconded from the parent hospital to gain experience in areas of mental health and psychiatry, child care and paediatrics, care of the old and geriatrics, home nursing and maternity care.

More recently the lines of demarcation with regard to classifying medical or surgical wards have been unclear as clinical areas have been subjected to changing circumstances. This has occasionally created a problem in some training programmes in the identification of a medical or surgical experience. Similarly in psychiatry the introduction of new policies has reduced labelling and designation of particular wards in a traditional clinical psychiatric sense. Therefore for student nurse training the provision of experience is influenced by the specialist orientation and range of clinical activities of a particular healthcare institution. The recent development of day care services and short-term care facilities must also be examined in the context of providing students with particular learning experiences.

Each school of nursing is afforded a level of flexibility in the allocation of clinical experiences beyond those specified in the Rules and Criteria (1991). Student nurses having completed the designated clinical and theoretical time as specified must be allocated for the unspecified clinical placements by the school of nursing for the following amounts of time, expressed here in weeks and overall percentage time: general nursing, 44 weeks (28.2%); sick children's nursing, 47 weeks (30.2%); psychiatric nursing, 25 weeks (16.1%); mental handicap nursing, 30 weeks (19.3%); general/sick children's integrated, 39 weeks (18.8%); midwifery, 35 weeks (33.7%) (Appendix 3).

Following a first entry to the register as RGN, RSCN, RPN, RMHN, a nurse can undertake a programme of eighteen months' duration to have his/her name entered on another part of the register. For example a nurse may become dually qualified as RGN and RPN in four and a half years.

2.8 The 'Apprenticeship' System

The present model of nurse education and training has been described as 'apprenticeship' in nature, with the student nurse occupying a dual role as learner and employee. Student nurses form a large part of the work force and provide a very substantial service contribution.

'There is a need for student nurse training numbers to be incorporated into a process of manpower planning in nursing.'

Student nurse education and training patterns at present operate on the basis of a constant labour replacement system. As one group of student nurses completes a particular clinical experience another group takes its place in that particular area. Recruitment to student nurse training programmes is therefore based on the requirement for student labour during the period of training. There is no direct link between the number of student nurses trained and the number

of registered nurses required in health services. This arrangement has, in recent times, been exacerbated by a general contraction in nurse employment both at home and abroad. There is a need for student nurse training numbers to be incorporated into a process of manpower planning in nursing.

The role of student nurses as employees is well documented:

- 'A hospital benefits by employing student labour in its nursing services; this is so well recognised that even hospitals which are not approved as training schools by the General Nursing Council (UK) enlist the services of probationers' (Lancet Report 1932, par. 104) [2]
- It is within the framework and expressions of the 'apprenticeship' model that many of the current disagreements and inconsistencies related to nurse education and training are centred. Treacy (1987)[3] in a Republic of Ireland study, concluded that the student nurse often learns only that which is necessary to function as a service worker within the hospital. The author also found that learning needs were often subordinated to the needs of the service
- Reid (1985)[4] in a Northern Ireland study, drew attention to the small amount of teaching that student nurses received on wards, the inattention to learning objectives and the disillusionment of the learners themselves
- There is an abundance of nursing literature spanning two decades which expresses concern about the 'apprenticeship' system of nurse education and training (Bendall 1985,[5] Fretwell 1982,[6] Gott 1984,[7] Reid 1985, Treacy 1987). The findings of such studies indicate a lack of control over student nurse clinical learning environments, and an increasing demand on student nurses for learning and the delivery of services
- The *Working Party on General Nursing* (1980)[8] expressed its concern about the apparent division between the theory and practice of nursing and stated, 'the theoretical training of the nurse is frequently isolated from the actual practice of nursing at ward level and this is not helped by the system of nurse education which has developed. Nurse tutors concentrate mainly on theory and practice of skills in the classroom setting, spending little time in wards, while nurses in the clinical areas have difficulty reconciling the student nurses' learning needs with the need to deliver patient care' (par. 4.18.1)
- In the context of the 'apprenticeship' model of nurse education and training in the United Kingdom prior to Project 2000 Melia (1983)[9] reported that learners spent most of their time working with nursing auxiliaries and other students with the result that learning may have been limited to an intuitive experience. The English National Board (1985)[10] in their review of 'apprenticeship' training suggested that it was increasingly difficult, given the worker status of nurse students, for educational programmes to become a reality
- Burnard and Chapman (1990)[11] suggested that student nurses, through 'apprenticeship' nurse education and training, will constantly interact with different individuals and will learn to 'pick up' nursing skills. In questioning such an assumption, the authors stated, 'its inefficiencies are obvious; trial and error learning is painful, is inefficient in time and unreliable in outcome' (p.10)

- It is also argued that in relation to the acquisition of clinical skills there is a level of repetition in relation to student learning within the clinical area. Able-Smith (1975)[12] in noting this point states, 'over the past seventy years there has been an immense expansion of the technical procedures and technical knowledge which can be taught to nurses. If the three years of training was needed in 1890 the period of training (still three years) must now be too short. If three years are adequate now, three years was too long sixty years ago'

During the regional workshop consultations in 1992, nurses debated many aspects of the current system of nurse training. They identified 'apprenticeship' training as being a good 'hands on' experience. However, in the context of today's health services, they also identified many areas of weakness in the system which mitigate against a beneficial experience for the student nurse. Some of these included a lack of student nurses' preparedness for certain duties, a lack of clinical teaching, an emphasis on work rather than learning, and an involvement in non-nursing duties. These are compounded by a more complex clinical environment and patient turnover.

'An Bord Altranais recommends that future students be given full student status throughout the period of preparation for registration and that their current dual status of employee and student should be discontinued.'

The proposed changes in nurse education are aimed at removing the reliance by managers on student nurses in providing a service contribution. During the programme the student nurse's involvement in clinical areas should be provided solely in the interest of the student gaining clinical experience in a controlled learning environment. An Bord Altranais recommends that future students be given full student status throughout the period of preparation for registration and that their current dual status of employee and student should be discontinued. This recommendation is consistent with decisions taken in other countries where changes have been implemented in student nurse training and education.

2.9 Issues Raised During An Bord's Inspections

In accordance with the Nurses Act, 1985, An Bord Altranais conducts formal inspections of schools of nursing at least once every five years. Inspections are carried out more often if required. The recommendations arising from inspections of An Bord Altranais are in most cases wide-ranging and specific. Over the years, An Bord Altranais has observed and documented the many developments as they have occurred in schools of nursing. Whilst the overall standards remain satisfactory there are nevertheless key areas to be addressed in accordance with the continuing evolution of nursing. Arising from the most recent inspections, schools need to:

- improve the ratio of tutors to students
- improve clinical teaching and the formation of greater educational links between the staff of the schools of nursing and the staff of clinical areas
- improve the conducting of proficiency assessments of student nurses and student midwives
- improve certain areas of the curriculum, placing greater emphasis on developments

in areas such as learning objectives, internal examinations and school records
- increase student nurse representation on education committees
- increase the ratio of registered nursing staff to students
- increase the provision of continuing education and training for registered nursing staff
- improve nursing library services
- increase the provision of secretarial services in schools of nursing
- monitor factors relating to non-nursing and non-midwifery duties being undertaken by student nurses/midwives in some training hospitals
- establish policy and procedure in areas such as dispensing of medicines, medicine administration and infection control.

To enable An Bord Altranais to continue to satisfy itself as to the suitability of learning environments, new approaches will be considered. Such approaches under the guidance of An Bord Altranais will aim to empower the college of nursing (as referred to in par. 2.20 of this report) to have greater control over the maintenance of standards through learning audits conducted in approved clinical learning areas.

2.10 Developments Elsewhere

In other countries, new paradigms in nurse education have reorientated the curriculum to enable nurses to acquire greater knowledge and skills related to:

- community health issues
- preventive healthcare, including patient/client education
- problem-solving abilities and independent practice
- interpersonal skills
- management and accountability
- research awareness as applied to nursing practice.

There are certain characteristics common to pre-registration nurse education as it has evolved in other countries, e.g. the United Kingdom and Australia:

- there is a common core programme for a specified period of the nurse training programme, or a generic programme
- the student nurses are supernumerary to staffing requirements during clinical placements
- the student nurses are in receipt of training grants/bursaries. These grants are provided either by the Ministry of Education or the Ministry of Health
- there is conjoint professional and academic validation and accreditation with educational recognition for nursing qualifications.

It is on the basis of such criteria and incorporating professional, educational and service perspectives that An Bord Altranais debated a future model of nurse education and training.

2.11 Defining Nursing

It is important to place nurse education and training in context by defining nursing.

Henderson's (1960)[13] definition of nursing has gained international acceptance. However, nursing continues to be redefined in a context of health service change. Wolff *et al* (1983)[14] characterised modern nursing in the following terms:

- nursing is grounded in caring
- nursing involves close personal contact with the recipient of care
- nursing is concerned with services that take humans into account as physiological, psychological and sociological beings
- nursing is committed to personalised services for all persons without regard to colour, creed, social or economic status
- nursing is committed to promoting individual, family, community and national health goals in the best possible manner
- nursing is committed to involvement in ethical, legal and political issues in the delivery of healthcare.

Such characteristics suggest that the essence of nursing continues to be related to ensuring high standards of care to people in need.

2.12 Proposed Model for Future Change

The Consultative Document 1991 presented three models of nurse education and training for consultation with the profession and other interested parties. The models included were:

Model 1 The present model of *apprenticeship* nurse education with specialisation from the beginning of the nurse training programme.

Model 2 A *common core programme* for all student nurses for a specific period of time. For a further specified period of time students should undertake a *specialist programme* up to the point of registration as a general, psychiatric, sick children's or mental handicap nurse.

'Having consulted with the profession and considered a wide range of literature, An Bord Altranais recommends that pre-registration nurse education and training should comprise a common core programme for a period of eighteen months which should be followed by an eighteen-month programme of specialisation in the discipline chosen by the student preparing for registration in one of the divisions of the register: general, psychiatric, sick children's or mental handicap.'

Model 3 A *generic model* of nurse education. Such an educational programme would prepare a nurse for registration in a single division of the register entitled Registered Nurse (RN).

Having consulted with the profession and considered a wide range of literature, An Bord Altranais recommends that pre-registration nurse education and training should comprise a common core programme for a period of eighteen months which should be followed by an eighteen-month programme of specialisation in the discipline chosen by the student preparing for registration in one of the divisions of the register: general, psychiatric, sick children's or mental handicap.

The Department of Health has expressed a reservation regarding this recommendation and does not support its introduction at this time. The Department accepts that a degree of commonality of knowledge applies across all divisions of nursing, but they do not accept that the same commonality applies to the same extent to clinical experience. This reservation is expressed here following an official communication regarding the recommendation from the Department of Health.

2.13 A Common Core Programme (CCP)

The following considerations inform the above recommendation of An Bord Altranais: a common core programme period in the nurse training programme will provide all student nurses with a greater range of experiences in a variety of care settings; it will facilitate a greater transfer of learned skills and will therefore provide a practical and theoretical basis for a greater understanding of holistic care; the student nurse will be afforded the opportunity to develop the knowledge and skills required to nurse patients or clients in areas varying from hospital to community settings. The common core programme will ensure the development of a broader cognitive perspective and will aim to:

- provide a preparatory foundation aimed at educating nurses to deliver care across a broader spectrum of need, in both the hospital and community setting
- provide nurses with a common and broader perspective on healthcare issues directly and indirectly concerned with nursing
- establish a greater understanding and a common professional identity between nurses from the various divisions of the register of nurses
- make optimum use of personnel, teaching resources, recruitment and selection procedures and thus provide a more cost-effective model of nurse education.

A new programme embedded in health rather than illness should introduce the student nurse to wider concepts in health, healing, selfcare, health promotion and community care. The programme should aim to develop a wider cognitive perspective and a broader skills base by exposing the student to a variety of care settings. Also, it should aim to provide the student with an introduction to the principles of nursing, and the associated knowledge and skills, as a foundation for nursing practice. The completion of a common core programme should not carry with it any recognition and would only mark a stage on the way to registration in a particular division of the register following a further eighteen-month specialist programme.

'A new programme embedded in health rather than illness should introduce the student nurse to wider concepts in health, healing, selfcare, health promotion and community care.'

The concept of a common core programme as applied in the United Kingdom through Project 2000[15] includes a common foundation programme of eighteen months followed by an eighteen-month branch programme of specialisation in adult (general), mental health (psychiatric), sick children's or learning disabilities (mental handicap) nursing.

The common core programme as a conceptual basis for pre-registration nurse education and training in Ireland is not new. In 1965 and 1966 the *Commission of Inquiry on Mental Handicap*[16] and the *Commission of Inquiry on Mental Illness*[17] favoured a common basic training, followed by further courses of training for specialisation. The Working Party Report *Psychiatric Nursing Services of Health Boards* (1972)[18] on considering the desirability of training general and psychiatric nurses separately went on to state:

> the working party would like to see the early evolvement of a common basic training course for a truly general trained nurse, one whose basic training equips her/him for a post-basic career in general medicine or psychiatry with, of course, further training and qualification in the field of nursing in which the nurse decides to specialise. A scheme for a common basic training could possibly be best based in the regional technological centres with student nurses circulating through the general medical and psychiatric hospitals for their practical training. (par. 57).

Following extensive consultation and research the *Working Party on General Nursing* (1980) was satisfied that considerable argument favoured 'the adoption of a common basic training with a common portal of entry.'

Nurses and their employers recognise the need to move away from the traditional approach of direct entry to nurse education and training programmes. Between 1980 and 1992 six submissions on new programmes of nurse education and training were made to An Bord Altranais.[19] Common core and generic education approaches were features central to the submissions.

An Bord Altranais, having examined the various syllabi and training programmes for general, psychiatric, sick children's and mental handicap nursing, agrees that there is a level of common knowledge and experiences reflected in the programmes of preparation for these individual parts of the register.

2.14 The Specialist Component of the Programme

Following successful completion of the CCP the student should progress to a specialist programme for registration either in general, psychiatric, sick children's or mental handicap nursing. The student should indicate her particular choice at the commencement of the three-year programme.

'During the specialist programme, the student nurse is provided with some scheduled clinical placements in a controlled learning environment.'

The aim of the specialist component of the programme is to expand and consolidate themes commenced in the CCP and apply them in a specific context of general, psychiatric, sick children's and mental handicap nursing. This stage of the programme introduces the student to a philosophy of nursing for the chosen specialist programme. During the specialist programme, the student nurse is provided with some scheduled clinical placements in a controlled learning

environment. The aim of the experience is to consolidate specific clinical nursing procedures and to provide a greater insight into nursing practice. An Bord Altranais emphasises the educational intent of such an experience as it provides a basis for reflective consideration on aspects of nursing practice. The application of scheduled clinical placements also enables the student to apply the knowledge and develop the competency required for registration in a particular part of the register.

An Bord recommends that every student nurse should have a period of scheduled clinical placements in a variety of approved settings. Each student should have nursing experience for a period of time and this experience should require a student to observe defined periods of experience in day and night duty, and undertake responsibilities in clinical areas under the guidance of registered nurses. This requirement will ensure that students registering in the future will have an adequate level of competency consistent with the traditional system.

2.15 Pre-Registration Programme: a Second Registration

The current provisions whereby a student can obtain a second registration in another division of the register through a shortened programme of seventy-eight weeks' duration will continue in the new proposed model.

The nurse seeking a second registration will be required to undertake the specialist component of the appropriate programme.

2.16 An Integrated Approach to Nurse Education and Training

The recommendations of An Bord for a new model of nurse education provide for an integrated approach to nurse education and training which is not only rational but economic as well. The programme will provide the student nurse with a greater breadth and depth of knowledge and with exposure to a greater range of clinical learning experiences. In support of the notion of broad-based learning experiences, Yeun (1986)[20] identified that traditional nursing has distinguished its practice according to setting, i.e. psychiatric, mental handicap, general hospital, children's hospital, community. It is argued that this distinction has promoted a divided image of nursing. The development of an integrated approach to nurse education suggests that there is a generalised entity called nursing that can be taught independent of the setting in which it takes place. Problem solving, interpersonal skills, management and caring are basic to the practice of nursing in all healthcare settings. By providing a greater breadth and depth of knowledge and experience in pre-registration programmes, the interest of the employer and the patient/client would be advanced. *The general nurse would have a greater knowledge and awareness of the needs of the mentally handicapped person and the mentally ill person. The psychiatric nurse would have a greater knowledge and awareness of the needs of the mentally handicapped person and the physically ill person. The sick children's nurse would have a greater knowledge and awareness of the needs of children with a mental handicap and children with mental illness. The nurse caring for the mentally handicapped would have a greater knowledge and awareness of the needs of the physically sick child/adult and the person suffering from mental illness. All nurses would have a greater understanding and awareness of community care.*

2.17 Structure of Proposed New Programme

An Bord Altranais proposes that clinical experience and knowledge be applied in accordance with the following criteria. The proposed programme will be three years (156 weeks) (Appendix 4), structured as follows:

- common core programme 72 weeks
- specialist programme 72 weeks
- annual leave 12 weeks.

The minimum requirement for theoretical instruction will be twenty-four weeks in the common core programme and twenty-four weeks in the specialist programme and should amount to one third of the programme. The common core programme should include theory and experience in different practice areas related to general, psychiatric, sick children's and mental handicap nursing and the specialist programme should include a specific focus in either general, psychiatric, sick children's or mental handicap nursing in preparation for registration.

2.18 Developing a New Curriculum

The major goal of nurse education and training is to help students develop the competencies necessary for effective practice. The WHO (1991)[21] indicated that the first step in designing a re-oriented curriculum is to decide upon competencies as expected outcomes of the programme. The WHO indicated that a number of lists of competencies or outcomes now exist in international nursing. An example of such a list of competencies to be achieved as outcomes of the nurse education programme is outlined by the WHO (1991). These include the following:

- to select information to enable nursing care for individuals, families, groups or communities to be assessed, planned, delivered and evaluated
- to apply pertinent research to nursing practice
- to apply a problem-solving approach to care, making specific interventions as appropriate
- to contribute to the organisation and deployment of care
- to participate in teaching, monitoring, and supervision of others
- to be accountable for the care given
- to contribute effectively to the multi-disciplinary team
- to co-operate with people and agencies in a variety of settings for the benefit of individuals, families and communities
- to understand the importance of the ethics of healthcare and of the nursing profession and their influence on nurses' professional practice
- to apply current legislation governing healthcare
- to respond to changing influences governing healthcare
- to assess the political and policy issues surrounding and influencing nursing practice.

The new programme should incorporate that which is good from the 'apprenticeship' model and integrate it with new knowledge and approaches.

An Bord recommends that a national curriculum development unit should be

established to examine and develop a new curriculum including a common core programme and the four specialist programmes. Other functions of this unit should also include maintenance of standards and uniformity between courses in the various colleges. Such a curriculum development unit should benefit from the advice of a national committee representative of the skills, knowledge and expertise required to develop a curriculum. This committee should also consult widely and ensure that curriculum is reflective of professional values and health service needs. *The curriculum design should integrate theory and practice in a modular approach.* Evaluation, including both summative and formative methods, must be an intrinsic part of curriculum development.

'An Bord recommends that a national curriculum development unit should be established to examine and develop a new curriculum including a common core programme and the four specialist programmes.'

The content of the programme must embrace knowledge based on:

- nursing theory, professional developments, nursing research
- biological sciences including microbiology and pharmacology
- social and behavioural sciences including sociology, psychology and social policy
- concepts of health including health promotion, prevention
- causes and effects of disease
- the development of nursing competency.

2.19 Community Nursing Experience

As referred to previously, a notable feature of the change in health services is an emphasis on community care and an integration of hospital and community services. The present criteria for the implementation of the syllabi of training of general nurses stipulate a minimum requirement of one week for home nursing experience for student nurses over a three-year programme. *An Bord recommends an increased provision of community nursing experience for all student nurses beyond that contained in the Rules and Criteria (1991).*

2.20 Colleges of Nursing and Midwifery

The development of a common core programme will require rationalisation of current schools of nursing and midwifery. An Bord Altranais recommends the establishment of a national network of colleges of nursing and midwifery.

'An Bord Altranais recommends the establishment of a national network of colleges of nursing and midwifery.'

This rationalisation which was previously recommended in the report *Working Party on General Nursing* (1980) will bring together the tutors from the various disciplines and establish a network of academic and clinical expertise aimed at developing the education and training of student nurses and the continuing educational needs of registered nurses. *An Bord Altranais recommends that the new colleges of nursing and midwifery should establish links with higher education institutions for the purpose*

of accrediting courses. Such a development will create possibilities to facilitate nurses to develop their professional careers in nursing. Each college of nursing should be under the direction of a registered nurse tutor or midwife teacher.

2.21 Links with Higher Education

An Bord Altranais in recommending a new model of nurse education and training aims to enhance standards of patient care through the provision of a greater depth and breadth of knowledge and experience to nurses. Such changes to nurse education and training can best be realised through the formation of links with higher education institutions and an accompanying educational validation and accreditation for nurse education. *An Bord Altranais recommends that a simultaneous registration as a student with An Bord Altranais and a higher education institution should be implemented.*

There is considerable literature available which addresses the issue of higher education for nurses. The introduction of Project 2000 in the United Kingdom incorporated radical changes in nurse education, with individual programmes affording each student nurse an opportunity for educational accreditation. Within the framework of Project 2000 rationalisation in the number of schools has taken place and individual colleges of nursing have been linked to different types of colleges of higher education.

Since the introduction of Project 2000, the National Foundation for Educational Research in England and Wales (NFER), on behalf of the Department of Health and Social Security, has undertaken a series of studies to evaluate Project 2000. The NFER Report (1994)[22] on Project 2000 expressed a sense of widespread optimism about the longe-term outcomes of the system, notwithstanding a range of problems that had arisen during the implementation stage.

The issue of higher education in nursing has its origins in the United States of America following the First World War. The Goldmark report (1923)[23] in suggesting university courses in nurse education recommended a reduction in the three-year course by removing unnecessary repetition and non-teaching time on the wards.

In the United Kingdom, the Lancet Report (1932) examined persistent problems related to nurse education and rejected any possible reduction in the length of training, arguing that it would be detrimental to the hospitals who required the probationer (student nurse) to give service. The Horder Committee (1943)[24] reported in the United Kingdom and recommended a separation between a nurse's training and the obligation to provide a service. Successive reports on nursing in the United Kingdom from the 1950s onwards outlined the need to link nurse education to third level education (Platt 1964,[25] Briggs 1972,[26] Project 2000 1986).

McFarlane (1987)[27] reviewed the role of nurse graduates in the health services in the year 2000 and highlighted the importance of competency in relation to the clinical role. The author suggested that the graduate nurse will have the powers of critical analysis and a knowledge base for nursing prescription and action necessary for a

competent clinical role in nursing. McFarlane argued the case for a graduate nursing profession and concluded that 'the skills which the health service will require from nurses in the year 2000 are those which only graduate nurses can bring. *What we have to learn is the intense practicality of theory in a practice discipline and its power to transform practice.'*

Altschul (1987)[28] reviewed the efforts made internationally to support higher education for nurses. She identified the bonds between nurse education and higher education which had occurred in many countries including the United Kingdom, North America, Canada, Australia, Finland, Spain and Greece. Such bonds were reported to have strengthened nurse education with consequent improvement in patient/client care.

Montague and Herbert (1982),[29] Sinclair (1984),[30] Kemp (1988),[31] Bircumshaw and Chapman (1988),[32] Howard and Brooking (1987),[33] undertook studies in institutions which offered degrees to nurses. *Evidence from these studies and others does not support the view that graduate nurses are not interested in 'bedside' nursing.* These studies indicate that a majority of graduates from nursing degree programmes remain in clinical practice. In reporting on the location of nurse graduates from Edinburgh, Sinclair (1987)[34] noted that they practised in areas of nursing where they might be expected to have more control over their own practice, e.g. community nursing, midwifery, intensive care, geriatric nursing and oncological nursing. Similarly in a study of nurse graduates in Northern Ireland (1975 to 1980) Reid *et al* (1987)[35] reported that 76 per cent were in nursing posts of which the vast majority were clinical posts.

In Ireland, the potential for links between nursing and higher education was part of professional debates which occurred during the 1970s and 1980s. The *Working Party on General Nursing* (1980) recommended that priority be given to the development of a degree course for registered nurses and two options were considered:

- a degree in nursing for registered nurses
- a degree in nursing for a select number of students undertaking nurse training.

The Working Party Report, in considering the future, stated, 'it is most important that any university programme for nurses should have a sound base of nursing theory and well-balanced practical experience in all areas of nursing and must be developed in accordance with the needs and developments of the nursing profession to enhance its service to the community' (par. 7.18.1).

During the series of regional workshop consultations with nurses in 1992/93, participants stated the need to change nurse education. These nurses expressed unanimous support for access to third level education and stated that such a development would be beneficial in:

- giving more confidence to nurses
- ensuring adequate standards of patient/client care

- broadening the nurse's knowledge base (including critical faculties and problem-solving ability)
- providing for enhanced skills in policy making and management
- facilitating adaptation to change
- providing a more scientific base for nursing.

'An Bord Altranais recommends that the education and training of nurses should remain within the health sector and be fully funded by the Department of Health.'

2.22 Funding of Students

An Bord Altranais recommends that the education and training of nurses should remain within the health sector and be fully funded by the Department of Health. The funding of student nurses by the Department of Health will allow the Department of Health to monitor the numbers entering the profession and ensure that adequate numbers are being prepared to meet the demands of the health services in the various disciplines of nursing.

An Bord Altranais accepts that when student nurses are supernumerary to the system their status will be broadly similar to students preparing in third-level colleges for other professions. A grant or bursary system should be introduced which would take account of the extended academic year for student nurses. The scheduled clinical placements should be compensated for by way of an enhanced grant in the final year. An Bord recognises that discussions with all interested parties in relation to student grants will have to take place before agreement is reached on the actual level of grant for student nurses.

2.23 Nurse Tutors and Clinical Teachers

Nurse tutor and clinical teacher roles have been central to the evolution of nurse education. The nurse teacher's role has been multi-faceted and has included classroom and clinical teaching, together with numerous other activities in management and administration (Nolan 1987).[36]

Crotty and Butterworth (1992),[37] in reviewing the role of the nurse teacher in England, noted that the first teaching role in nursing was established in 1872 by the appointment of a 'Home Sister' to assist the matron in the education of probationers. The title 'Sister Tutor' is one which is reflective of this early period. Educational preparation for the role of the nurse tutor commenced in England in 1926 in London University (Green 1982).[38]

In Ireland nurse tutor preparation commenced in University College Dublin in 1960. Rules made in accordance with the Nurses Act, 1950 enabled the registration of nurse tutors in 1964. In 1979 an optional module of midwifery studies for intending midwifery tutors was added to the nurse tutor's diploma course. This course was developed into a three-year Bachelor of Nursing Studies course in 1984. The course has an explicit aim – to enable experienced registered nurses and midwives to teach in the classroom and the clinical areas and to manage nurse education.

The historical developments in the nurse teacher's role demonstrates that as the

demands of classroom teaching increased, nurse tutors became increasingly absorbed into school of nursing activities. The midwifery programme, however, facilitated midwifery teachers to successfully integrate clinical and classroom roles. The clinical teacher's role was developed to enable greater guidance and supervision in the clinical areas. Rules made under the Nurses Act, 1950 enabled the setting up of a division of the register for clinical teachers. The first such teacher was registered in Ireland in 1974. The registration of clinical teachers continued up until 1988 when the register was closed.

The advent of the clinical teacher answered some of the problems created by the dichotomy between theory and practice in nursing. However, the clinical teachers in both the United Kingdom and Ireland became increasingly more involved in classroom activity because of the lack of nurse tutors. Consequently many commentators including Kirkwood (1979)[39] questioned the distinctness of the clinical teaching role. The two-teacher role has gradually given way to the creation of one grade of teacher who would be fully competent to teach in both the classroom and the clinical situation. This development was recommended in the Working Party Report 1980 (par. 4.18.33).

In looking towards alternative structures to support the clinical learning environment during the 1980s, joint appointments were introduced in the United Kingdom. The appointed person had part responsibility for clinical teaching within the ward environment, and part responsibility for the organisation and management of ward activities. The benefits of such an appointment were perceived as enabling the teacher to keep in touch with clinical work. However, the position of the joint appointment was found to be very demanding as the person had to shoulder the responsibility of developing ways to fulfil the requirements of both ward management and the teaching of student nurses.

Crotty (1993)[40] surveyed the role of the nurse teacher in the United Kingdom in the change from 'apprenticeship' nurse education to Project 2000. The author identified the complex role of the nurse teacher and the enormity of the task of being a nurse educator. Changes in role and responsibility consistent with the new programme were reported. Such changes were related to:

- teaching and learning activities
- clinical teaching and individual tutorials
- monitoring students' progress through a variety of assessment and examination strategies
- educational management, planning teaching programmes, curriculum planning and evaluation
- liaison with further and higher education
- monitoring and auditing clinical areas
- the publication of journal articles
- administration activities, including the co-ordination and attendance at various committee meetings. Such committees included: board of studies, audit meetings, theme group meetings, standard setting groups, resource management, quality circle group.

The links established with universities and colleges of higher education through Project 2000 have inherently moved nurse tutors in the direction of becoming graduates with a trend towards specialist subject teaching. Some of the subject areas traditionally taught by nurse tutors are now being taught by a subject specialist from the colleges/universities, e.g. sociology, psychology, information technology.

In Ireland a majority of nurse tutors and clinical teachers have a more generalist teaching role, with each tutor attempting to cover a broad range of subjects.

'It will be important that nurse tutors be given opportunities to expand and develop their roles in any future evolving system of nurse education and training.'

It will be important that nurse tutors be given opportunities to expand and develop their roles in any future evolving system of nurse education and training. These roles will challenge nurse tutors to meet the academic requirements of higher education institutions and also to expand and develop clinical experiences for student nurses.

2.24 Qualifications of Nurse Tutors and Clinical Teachers

There are 220 nurse tutors/clinical teachers in the thirty-seven schools of nursing and seven schools of midwifery. There are 235 nurses with a nurse tutor qualification and 116 nurses with a clinical teacher qualification in the various divisions of the registers maintained by An Bord Altranais. A further twenty-one nurses with a tutor qualification and nine nurses with clinical teacher qualifications are on the inactive register.

A survey of other nursing registrations held by registered nurse tutors and clinical teachers is identified in Table 6 and Table 7. It is noted that the majority of nurse tutors and clinical teachers are registered in the general register of nurses.

Table 6. Other Registration Entries Made by Registered Nurse Tutors (January 1994)

Area of Nursing	No. of Qualifications	As a % of Total Number of Registered Nurse Tutor Qualifications (n = 235)
General	225	95.7
Midwifery	104	44.2
Psychiatric	53	22.5
Sick children's	21	8.9
Mental handicap	18	7.6
Clinical teacher	32	13.6
Other*	7	2.9

* Other includes tuberculosis, orthopaedic, public health

Table 7. Other Registration Entries Made by Registered Clinical Teachers (January 1994)

Area of Nursing	No. of Qualifications	As a % of Total Number of Registered Clinical Teachers (n=116)
General	109	94.0
Midwifery	52	44.8
Psychiatric	36	31.0
Sick children's	14	12.1
Mental handicap	11	9.5
Public health	5	4.3
Other*	2	1.7

* Other includes tuberculosis, orthopaedic

To review the number of graduate teachers, a survey was undertaken involving the training schools approved by An Bord Altranais. A relatively high number of nurse tutors who are degree holders or who are undertaking a degree are attached to nurse training schools. A number of nurses are in the process of applying or preparing for a place on a course leading to a degree award (Table 8).

Table 8. Current Graduate Status of Nurse Tutors (September 1993)

Current Status	Number of Nurse Tutors	
	Bachelors	Masters
Degree holders	42	6
Currently undertaking a degree programme	44	13
Applying or preparing for a place on such a degree programme	20	4

(Figures not available for two schools)

2.25 Educational Concepts

The Consultative Document in relation to the mechanics of nurse education stated, 'there is an urgent need to examine teaching and learning strategies in nurse education. *Reviewing the extending base of nursing knowledge leads to fundamental questions about nursing values and where the educational focus should lie within the nursing curriculum'* (p.17). Nurse educators have tended to use didactic methods of teaching and learning in nurse education. However, new models of nurse education such as Project 2000 emphasise the notion of nurse education as a process which incorporates a facilitative approach including student-centred methods of education. Project 2000 supports the notion of 'learning how to learn' as a desired focus in nurse education. Problem solving, self-directed learning, interpersonal development, contract learning, mentorship, and preceptorship are key features in Project 2000.

Based on a study of the American workplace, Cheren (1990)[41] highlighted the importance of these educational concepts and principles in ensuring quality performance in practice. The study noted that *'learning to learn' was the most important basic skill to be acquired.* Twelve others skills were identified: listening, oral communication, problem solving, creative thinking, self esteem, goal setting/ motivation, personal and career development skills, interpersonal skills, team work and negotiation, organisational effectiveness, and leadership.

2.26 Preceptors

Students should have opportunities to learn and gain clinical experience under the guidance of preceptors. A preceptor is a registered nurse who has been specially prepared to guide and direct student learning during clinical placements. Time in clinical areas for student nurses should be opportunities for reflection and learning under the guidance and in the company of registered nurses who have been appropriately prepared to guide student learning. *An Bord recommends that specially prepared preceptors should give overall guidance to the clinical experiences of student nurses.* It is important that clinical experiences are occasions for achieving stated learning objectives. An appropriate training investment will need to be made to ensure that the best possible outcomes can be achieved from the time spent in clinical settings. The potential will exist for greater collaboration between colleges of nursing and midwifery and clinical areas by the introduction of a modular curriculum.

RECOMMENDATIONS

- A Central Applications System for entry to nursing should be established.
- The number of students entering nurse education and training leading to registration should primarily be determined on the basis of national policy in relation to health service needs.
- The student nurse should have the status of student throughout the course of education and training leading to registration and should not be an employee of a service.
- Colleges of nursing and midwifery should be established with links to third level institutions. A college of nursing and midwifery should embrace a group of hospitals and institutions including general, psychiatric, sick children's, mental handicap, midwifery and facilities for community nursing services. The college of nursing shall be under the direction of a registered nurse tutor or midwife teacher.
- A comprehensive national framework should be established by An Bord Altranais for links between the colleges of nursing and midwifery and higher education institutions (Appendix 7) for the purpose of accreditation of courses.
- The student nurse should have a simultaneous registration as a student with An Bord Altranais and a higher education institution.
- A common core programme of eighteen months for all student nurses should be established followed by a further eighteen months of specialisation leading to registration in a particular part of the register for general, psychiatric, sick children's and mental handicap nursing.
- Educational preparation for clinical teaching responsibilities should be provided for nurses in clinical areas approved by An Bord Altranais for the education and training of student nurses.
- Clinical experience should be under the guidance of a registered nurse tutor with the support of a preceptor in each clinical setting. An appropriate educational preparation for preceptors should be provided.
- An Bord Altranais should establish a national curriculum development unit to monitor and advise on aspects of the nursing curriculum. Curriculum design should follow a modular approach and should include continuous assessment procedures. A period of scheduled clinical placements should be included in the later stages of the programme.
- The role and preparation of the nurse tutor should be developed in a context of future educational change.
- The Department of Health should continue its financial support for student nurses through the provision of funds for students on courses leading to registration.

SECTION 3

POST-REGISTRATION NURSE EDUCATION AND TRAINING/CONTINUING EDUCATION

3.1 Nurse Education as a Continuum

The range of literature on post-registration nurse education embraces the concept of continuing education. Nurse education must be a continuum, not something which begins on entry to the nurse training programme and ends at the point of registration as a nurse. In order to advance professional competence and prevent obsolescence, continuing education and life-long learning is essential for active practitioners of the profession. There is a need for registered nurses to have new knowledge and periodic updating. Continuing education should enable registered nurses to take every opportunity to improve their performance through acquiring greater knowledge of nursing practice and management. The range of literature on continuing education refers to the notion of life-long learning in a context of nurses undergoing a process of professionalisation. Jarvis (1987),[1] in suggesting that one of the major roles of the school of nursing is to prepare students to become life-long learners, cites the work of Benedict *et al* (1984)[2]:

'Nurse education must be a continuum, not something which begins on entry to the nurse training programme and ends at the point of registration as a nurse.'

> Life-long learning entails a cradle to the grave involvement of the individual with his or her learning and working environment. It implies a growth of all skills and a cumulative interweaving of knowledge and experience. This learning is not packaged and does not cease when the individual completes his/her legal school requirements (p. 25).

Professional updating and continuing education is related to the maintenance of standards in a changing health service. Continuous change in healthcare environments imposes greater responsibilities on nurses in their practice. These responsibilities are both legal and professional. Young (1991)[3] in reviewing case law, identified the legal responsibility of the nurse in maintaining up-to-date research-based knowledge and skills. Professional imperatives are imposed on nurses by a code of professional conduct. Included in this code is the responsibility of each individual nurse to keep up to date. For some authorities the purpose of continuing nurse education is viewed as the enhancement of practice and the promotion of the health of the public (American Nurses Association 1986).[4] Schon (1987)[5] suggests that there is a tendency in professional practice and professional education to concentrate on the technical, the scientific, and the instrumental, rather than the more complex issues professionals face in their day-to-day work. It is important, he suggests, to ensure updating in the caring, humanistic and personal qualities which are essential for patient-client satisfaction.

Many methods for evaluating the effects of continuing education on nursing practice have been developed, e.g. Cervero (1985),[6] Holzemer (1988).[7] Waddell (1992)[8] undertook a meta-analysis of thirty-four studies on continuing education and

demonstrated that continuing education does make a positive impact on nursing practice. *The importance and relevance of continuing education to hospital nurses, community nurses and midwives is well supported in the literature* (Charles 1982,[9] Stanford 1989,[10] Hunt 1991[11]). The limited life span of knowledge has been recognised, and Barker (1985)[12] suggests that professional knowledge has a half-life of about two and a half years before it becomes outmoded and obsolete.

3.2 Identifying Principles

Some definitions of continuing education highlight the important reciprocal relationships between nursing practice and nurses keeping up to date. Definitions of continuing education include references to:

- planned learning experience beyond the pre-registration programme
- learning experiences designed to promote knowledge, skills and attitudes for the enhancement of nursing practice
- learning experiences specifically aimed at improving standards of nursing care available to the patient/client.

Many authors avoid defining continuing education too narrowly. Barber (1977)[13] divided continuing education into two distinct categories: (a) informal education which includes watching television programmes, reading, working on committees and (b) formal education which includes planned courses of study, conferences, seminars. Dixon (1992)[14] highlights a range of learning outside of formal nurse education and suggests that *nurse leaders and nursing boards need to give more recognition to self-directed learning outside of teacher-led offerings. Nurse educators have to be involved in researching and facilitating self-directed learning.*

It is suggested that continuing education should have the following characteristics:

- *Relevance:* that at all times, professional studies should be related and relevant to patient care needs and the employment and practice of the nurse
- *Flexibility:* that the system should allow the student various options as might be afforded through a modular type programme
- *Progression:* that the student can accumulate credits through various educational initiatives which can eventually lead to a nursing degree award
- *Accessibility:* that post-registration education should be available to all nurses.

3.3 Mandatory Education

The term 'mandatory education' has been added to the nomenclature on continuing education. Mandatory education as a developmental and structured system of education has been favourably viewed. In the United States, nurses must re-license periodically and state boards are concerned with the competence of the professionals they license. Since 1975 fifteen states have required evidence of a certain number of contact hours of continuing education every two years before nurses can re-license and it is expected that in the future, a number of other states will adopt a similar position. Additionally three states have continuing education requirements for nurse practitioners only (Carpenito 1991).[15]

The strengths and merits for a system of mandatory education arise from its potential ability to act as a safeguard against obsolescence and incompetence. The proponents of mandatory continuing education have argued that it offers the only way of ensuring participation by a majority of practitioners in the field. It is clear that some nurses do not update their knowledge by further reading or additional professional education following registration (Barnett 1981,[16] Chiarella 1990).[17] Peutz (1983),[18] on the basis of her research, concluded that the nurse, possibly the person most in need of continuing education in order to remain current in practice, was least likely to participate in education programmes. The findings of Peutz are supported by Dolphin (1983),[19] whose survey demonstrated that some nurses will not participate in continuing education unless forced to do so. Studies conducted in a number of US states, where continuing education is mandatory, demonstrated that mandatory post-registration education had a positive impact on educational behaviour (Gaston and Pucci 1982,[20] Arneson 1985).[21]

However, Carpenito suggests that the case for compulsory professional updating has not been proven. Based on the American experience of mandatory education, Carpenito concludes that there is little real evidence to support the view that attending continuing education programmes improves care to patients and their families. However, patient care can improve greatly when quality assurance is combined with education (Dyer 1975).[22] Two UK studies have reported that specific continuing education studies can improve clinical practice and enhance patient care (Bignell and Crotty 1988,[23] Hughes 1990).[24]

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting, in their proposals contained in the report *Post Registration, Education and Practice* (1990) (PREP)[25] stated, 'Competence can only be maintained by continuing education and professional development ...' (par. 5.1). The report went on to state, 'Developing professional expertise depends not only on experience in an area of practice, but also on access to continuing education and the commitment of both practitioner and employer' (par. 50. 5.2). A PREP Recommendation links mandatory continuing education with eligibility to practise through registration and states, 'During the three years leading to periodic registration, all practitioners must complete a period of study or provide evidence of appropriate professional learning. A minimum of five days of study leave every three years must be undertaken by every registered practitioner.'

The *Working Party on General Nursing* (1980)[26] regarded pre- and post-registration nurse education and training as a continuum and, in identifying the requirement of continuing education, stated, '... There is a need to foster this concept in the nursing profession, and to make available opportunities for members of the profession to pursue educational programmes suited to their needs as professional practitioners of nursing' (par. 7. 11.1). The Working Party report went on to recommend that 'because of rapidly changing techniques in medicine and nursing, all registered nurses and midwives should be required to undertake an appropriate refresher course at least once every five years.'

The Nurses Act, 1985 states 'the Board shall, from time to time as occasion may require, but in any event not less than once in every five years satisfy itself as to ...

the adequacy and suitability of post-registration training courses for nurses provided by bodies recognised by the Board for that purpose' (Part iv, section 36 (1)(d)). In the interest of maximising the potential benefits of post-registration nurse education, An Bord Altranais recommends that the provision of mandatory continuing education should be considered in the context of developing a national framework which should include strategies for the provision of continuing education to all practising nurses.

'An Bord Altranais recommends that the provision of mandatory continuing education should be considered in the context of developing a national framework which should include strategies for the provision of continuing education to all practising nurses.'

3.4 Need for Structure and Facilities

The Consultative Document in its review of post-registration nurse education and training, stated that '... *every attempt must be made to relate the provision of education to the role and working responsibilities of the individual nurses.* A post-registration education system should ensure that practitioners and managers of nursing services would avail of educational courses related to developing and enhancing their roles in the broader health services' (par. 2.25).

Concerns about a lack of policy, structure and facilities for continuing education were identified in the submissions made to the review committee and by participants during the workshop consultations. They submitted that there is need for:

- co-ordinating centrally the ongoing evaluation and identification of new courses
- an even geographical spread across the country in the location of courses
- a process of academic accreditation for post-registration nursing courses
- reciprocity between Ireland and the United Kingdom in relation to post-registration nursing courses
- mandatory education linked to the registration of nursing qualifications
- a greater investment in in-service training facilities for nurses
- an improved standard in library and learning resource centres for nurses
- a greater opportunity for access to third-level education courses to be afforded for registered nurses.

An Bord Altranais recognises that there is currently a limited provision of post-registration education courses for nurses (Consultative Document, 1991, par. 2.21). An Bord sees the need for a national framework which would detail strategies for the provision of post-registration training for all nurses. In-service training and staff development programmes are essential to ensure that

'An Bord sees the need for a national framework which would detail strategies for the provision of post-registration training for all nurses. In-service training and staff development programmes are essential to ensure that nurses are updated in clinical skills, nursing theory, research, local policy and procedures. This national framework should be developed in co-operation with all interested parties and should meet the needs of all concerned.'

nurses are updated in clinical skills, nursing theory, research, local policy and procedures. This national framework should be developed in co-operation with all interested parties and should meet the needs of all concerned.

3.5 Areas Requiring Greater Development

An Bord Altranais in its deliberations identified specific areas which require greater consideration and regulation: the need to link the return to nursing after a prolonged period of absence from practice with a requirement to undertake a refresher course; the need for a formal nursing staff appraisal system linked to a model of continuing education; the lack of educational preparation for key nursing posts such as ward sister, matron, director of nursing, chief nursing officer; the need to record post-registration, educational qualifications of nurses, and the need for more interprofessional and interdisciplinary training. An Bord Altranais recommends that post-registration continuing education should be structured in such a way as to ensure the development of nurses for clinical nursing roles in specialist areas and for management roles. Also, research methodology and nursing research should be included in courses of continuing education for nurses.

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3.6 Recording of Successfully Completed Courses

An Bord recommends that a nurse, on successful completion of a validated and approved specialist course, should have the course recorded with her registration. This will support a skills auditing procedure aimed at identifying the range of specialist skills and knowledge in nursing. Such information could provide a significant basis for manpower planning and skill mix development.

'An Bord recommends that a nurse, on successful completion of a validated and approved specialist course, should have the course recorded with her registration.'

3.7 Accreditation of Courses

Links with higher education institutions should be developed to accredit continuing education courses for registered nurses. All courses should be subjected to conjoint professional (An Bord Altranais) and academic (higher education institutions) validation and accreditation. Such accreditation should take account of a nurse's previous experience and a nurse's successful completion of other related courses. Specialist courses currently approved by An Bord Altranais should be accredited. New structures to provide continuing education should enable nurses to have access to courses through distance education systems.

A system of credit accumulation and transfer should be put in place to facilitate access to higher degree level qualifications.

The national framework for the provision of post-registration nurse education should include systems to evaluate the provisions of courses and to assess the suitability and relevance of courses on an on-going basis.

'A system of credit accumulation and transfer should be put in place to facilitate access to higher degree level qualifications.'

RECOMMENDATIONS

- A national framework for post-registration nurse education and training including mandatory nurse education and training should be developed by An Bord Altranais in conjunction with employers, providers of education and training, accrediting authorities and should receive adequate funding.
- Structures for post-registration nurse education and training should facilitate the preparation of nurses for clinical nursing roles, management and research.
- Structures for post-registration education and training should include a credit accumulation and transfer system (CATS) and must be flexible enough to recognise a nurse's and midwife's previous experience and learning.
- A nurse or midwife on successful completion of a course professionally validated by An Bord Altranais should have the course recorded with her individual registration.
- A nurse returning to practice after a five-year or greater period of absence from practice or a nurse transferring from one discipline to another must undertake a refresher course validated by An Bord Altranais.

SECTION 4

A COMMUNITY NURSING DIMENSION FOR ALL NURSES

4.1 Declaration of Alma-Ata

The declaration of Alma-Ata (1978)[1] defined primary health care as essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

The gradual shift of emphasis from curative to preventive strategies across the health sector has implications for nurses.

Resolution WHA.30.43[2] initiated the formulation of national strategies in accordance with the Health For All Movement in the member states of the World Health Organisation. Resolution WHA.30.48 highlighted the importance of the potential of nursing and midwifery in primary health care and requested member states to study the roles and functions of nurses and midwives in providing primary health care. Overall, the resolutions provided a central dynamic for change and encouraged the identification of new approaches to healthcare. The Alma-Ata declaration in continuing these trends of development provided a major focus on community health, both nationally and internationally. This declaration also provided the impetus necessary for the recognition of the need to implement the recommendations of the 1974 Expert Committee on Community Health Nursing (WHO 1991).[3] This Expert Committee[4] which was convened to recommend ways in which nurses could make a significant impact on the main health problems of the world, focused on:

- the development of community health nursing services, responsive to community needs, that would ensure primary health care coverage for all
- the re-formulation of pre-registration and post-registration nurse education so as to prepare all nurses for community nursing
- the inclusion of nursing in national developmental plans in a way that would ensure the rational distribution and the appropriate utilisation and support of nursing personnel.

4.2 WHO Long-term Strategy for Nursing

Three distinct phases are identifiable in the WHO long-term strategy to support the development of nursing in accordance with a primary health care model. The first phase provided a working document in 1987 entitled *People's Need for Nursing Care.*[5] The second phase informed nurses and sought their support in adopting the Health For All Movement and the thirty-eight regional targets.[6] This resulted in the organisation of nursing workshops in individual member states to ascertain a response to Health For All and the thirty-eight regional targets. In 1988 during phase two, Irish nurses were consulted in relation to the WHO strategy on Health For All. Their responses and the report[7] prepared on their behalf by the Department of Health and An Bord Altranais was essentially directed towards adopting the aims expressed

in the WHO strategy. *It was considered imperative that the role of all Irish nurses should be extended to encompass that of health educator and facilitator.* It was felt that nurses were under-utilised especially in the area of health education.

The following suggestions were offered in the report:

- opportunities should be made available through the media for nurses to promote health education and healthy lifestyles
- nurses should be seen as an assertive cohesive professional body with a meaningful involvement in all types and at all levels of decision making concerned with healthcare planning.

The artificial barrier between community care and acute hospital services was perceived as an impediment to developing nursing concepts as indicated in the World Health Organisation's targets to achieve Health For All. The report which represented the Irish nurses' contribution to the European nursing conference in Vienna 1988, concluded by stating, 'nurses by virtue of their numbers, high level of patient/client contact and opportunities presented during the course of daily activities, have the potential to play a pivotal role in achieving change in relation to primary health care' (par. 8).

One of the recommendations arising from the first WHO European conference on nursing was 'the need for the development of a nurse capable of working in both hospital and community'. WHO is now entering the third phase and the Nursing In Action project aims to help member states to re-orientate the basic nursing curriculum so that nurses throughout the region are able to work competently and efficiently, meeting nursing needs for patient care wherever people are. To aid the development, WHO has produced a series of seven booklets,[8] each one clarifying and detailing significant factors involved in the strategy for change.

4.3 Health, the Wider Dimensions

Health, the Wider Dimensions (1986),[9] a consultative statement on health policy in Ireland, focused on preventive aspects of healthcare. The report argued that the main thrust of health services planning has been towards curative services in high technology hospitals and, as a consequence, health professionals have now become accustomed to a hospital-centred system. The need for profound changes in attitude and practice among healthcare professionals was highlighted (par. 2.7). *This report, as a consultative statement on health policy for the future, regards primary health care as the central component of the healthcare system, supported by well-organised secondary and continuing care sectors.* The report encouraged progress towards achieving the full potential of the community care programme and stated, 'community health nursing, a pivotal service, needs strengthening' (par. 5.2). Bringing together general medical practice and community nursing in a spirit of greater patient/client centred services is fundamental to good primary health care.

4.4 Health Policy Developments

In all areas of health service activity, health service reports[10,11,12,13] and policy

generally identify the need for a comprehensive approach towards community care. Specific reports on community care have indicated that the multi-disciplinary team approach could be organised more effectively. The *NESC Report* (1987)[14] argued that the evaluation and planning of services for particular target groups could be improved by a more effective functioning of the community care team. A perceived absence of genuine multi-disciplinary planning was highlighted. The *NESC Report* referred in particular to deficiencies in information on the take-up of services by socio-economic group and by district. The *Inbucon Review* (1982)[15] suggested that there were very significant gaps in community care, and that services tended to equate to presented demand. *The Interim Report of the Dublin Hospitals Initiative Group* (1990)[16] identified similar deficiencies, most notably:

- poor communication and liaison between professionals in the hospitals and in the community
- the absence of a seven-day home nursing service involving general nurses and nurses' aides (par. 1.7.5).

The *Third Report of the Dublin Hospitals Initiative Group* (1991)[17] raised issues with the aim of restructuring relationships between acute hospitals and community services (par. 5.5). A level of further investigations was proposed to determine:

- the opportunities which exist to improve liaison with community services, for example, general practitioners before hospital admission and discharge of patients
- the potential to develop treatment plans for patients which integrate the in-patient and community-based elements of their care
- the extent to which access to hospital-based resources could enhance the community care of patients and the extent to which specification of community services needs by hospital personnel could enhance more effective resources (par. 5.5.2).

4.5 Government Commitment to Community Care

The *Programme for Economic and Social Progress* (1991)[18] (PESP) in relation to health service provision envisaged a seven-year programme to give effect to improvements in community care and associated services. The report identified specific services where a radical and expansive approach to community care is required. Such services include those for the elderly (par. 32), the physically disabled (par. 33), the mentally handicapped (par. 34), and the psychiatrically ill (par. 38).

The *Programme for Competitiveness and Work* (1994)[19] (PCW) confirmed the government's commitment to continued progress in implementing the seven-year programme established under PESP. The PCW in the context of a future health strategy stated, 'Special emphasis will be placed on positive health measures to address serious community health problems. The strategy will also provide a firm basis for the development of primary care for continued improvement in cost-effectiveness and for the efficient management of the health service' (par. 6.25).

The Department of Health in *Shaping a Healthier Future, a Strategy for Effective*

Healthcare in the 1990s[20] acknowledged that the present system of providing services is too compartmentalised. The document states:

> To achieve the objective of providing care in an appropriate setting, it is essential that there are effective linkages between the services. Hospitals, general practitioners and other community services should operate as elements of an integrated system within which patients can move freely as their needs dictate. At present, the system is too compartmentalised to permit this flexibility (p. 26).

4.6 Primary Care Teams

The concept of primary care teams based around local GP practices was reviewed in the *Report of the Working Party on the General Medical Service* (1984)[21] (par. 3.57–3.65). In their document on the future organisation of general practice in Ireland (1988)[22] the Irish College of General Practitioners supported the concept of the primary care teams. *Public health nursing was perceived to be pivotal, with the creation of general practitioner public health nurse 'care teams' as the basic clinical unit of primary care.* The report identified that under current arrangements the general practitioner works with several public health nurses; this has led to administrative chaos and a consequent widening communication gap between the general practitioner and the public health nurse (par. 6.16). The nurse in the community, as part of the primary care team, is a key person and would offer the necessary latitude to further expand and integrate general practice into the hospital services and the community services. An examination of the potential role of the nurse including clinical and professional relationships with other professionals would be important aspects of future developments in primary care teams.

4.7 Influences on Demands for Community Nursing

The divide between hospital nursing and community nursing cannot be maintained and a more flexible and integrated approach to hospital and community nursing is essential if nurses are to maintain the level of competency demanded of them by a modern health service. Already, the shift of emphasis from institutional care to community care has, in the past decade, created diverse healthcare needs within the community setting. Registered nurses who formerly have been hospital nurses have been employed in some health board areas in response to the need for a more flexible nursing service. Practice nurses have evolved through the medical general practitioner services. In particular, changed policy and medical practices have resulted in:

- earlier patient discharges from general hospitals
- the development of more services for persons with a mental health problem and persons with a mental handicap in the community setting.

Other factors are also influencing the requirements for greater community-oriented nursing services including:

- the increased awareness of social inequalities and the health-related effects of unemployment, homelessness, and poverty

- the increased number of carers in the community, most of whom are looking after a family member with either a physical or mental disability
- the continued increase in the number of sufferers from Acquired Immune Deficiency Syndrome (AIDS) and the Human Immuno-deficiency Virus (HIV) requiring care patterns involving combinations of home and institutional care
- the special emphasis placed on the health needs of women. The *Programme for Competitiveness and Work* expressed support for positive health initiatives in relation to women's health and stated that a detailed plan for women's health will be prepared (Par. 6.24).

'The recommendation for proposing alternative approaches to nurse education strategically aims to ensure a strengthening of the educational preparation of all nurses for community care.'

The recommendation for proposing alternative approaches to nurse education strategically aims to ensure a strengthening of the educational preparation of all nurses for community care. By doing this, a greater range of nursing skills would be available to community care nursing.

4.8 Historic Evolution of Home Nursing Services

Since the later half of the nineteenth century, several different groups of nurses have found themselves working in the community:

- Queen's Institute nurses
- Jubilee nurses
- Registered tuberculosis nurses
- Registered public health nurses
- Registered psychiatric nurses (some with, some without specialist post-registration training)
- Registered mental handicap nurses (some with, some without specialist post-registration training)
- Registered midwives
- Registered general nurses.

The earliest home nursing services originated in the dispensary medical system and was provided by midwives. The first training school for district nurses was established in 1876 in St Stephen's Green by Lady Plunkett. As the system developed, district nurses were involved in the provision of maternity and home nursing services. The Queen's Institute, which commenced in 1887, and the Lady Dudley Nursing Scheme, which was founded in 1903, provided training to nurses until the commencement of the public health nurse scheme.

Legislative and epidemiological events have had a pronounced effect on community nursing activities at particular points in history as evidenced, for instance, by the passing of the Tuberculosis Act, 1908 and the Public Health Medical Treatment of Children (Ireland) Act, 1919. As well as the provision of maternity and home nursing,

community nursing acquired responsibility in the areas of domiciliary tuberculosis care, child welfare, and school health services. Health legislation and resulting policy on health matters provided for a broader delivery of healthcare and the facilitation of nursing services.

4.9 Public Health Nursing

In aiming for a co-ordinated service, the Health Act, 1953 provided for the fusion of different services with health services, administered by health authorities. This paved the way for what was hoped would be a comprehensive public health nursing service. A White Paper in 1966 outlined the aims and directions for the development of district nursing services and the development of training facilities for public health nurses. The aspirations for a comprehensive approach towards community nursing was expressed in the Department of Health circular 27/66:

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

Table 9. Percentage Time Spent by Public Health Nurses Classified by Patient Category

Patient Category	Nurses % Time Spent
Infants	6.8
Mentally handicapped children	1.5
Other children	20.7
Psychiatric	2.8
Terminal care	7.5
Aged	38.9
Other adults	21.4
Unclassified	0.4

Source: *Survey of Workload of Public Health Nurses* 1975 (p.36).

4.10 Patient Categories Served by the Public Health Nurse

A Working Party appointed by the Minister for Health on the Workload of Public Health Nurses (1975)[23] made wide-ranging recommendations aimed at strengthening community nursing activities. The survey considered the number of nurses necessary to provide a community nursing service to the various population groups. The allocation of nursing time to various nursing activities was a focus in the report. *It was identified that the greatest percentage of the nurse's time was spent with the aged and the lowest with mentally handicapped children and psychiatric patients* (Table 9).

Table 10. Percentage Time Spent by Public Health Nurses By Work Classification

Work Classification	Nurses % Time Spent
Technical nursing	30.4
Basic nursing care	24.0
Preventive & educational nursing	31.5
Social work	8.6
Home help activities	3.5
Unclassified	2.0

Source: *Survey of Workload of Public Health Nurses 1975* (p.37)

'It was suggested that it might be more effective to have specialist nurses from these nursing disciplines working in the community. An Bord Altranais would accept and support this recommendation.'

4.11 Classification of Public Health Nurses' Work

The report also identified the distribution of home visiting time according to work category. It is noted that approximately 55 per cent of the public health nurse's time was spent between technical nursing and basic nursing care (Table 10).

The report generally through its investigative work noted the contribution made to community care by nurses. However, in relation to the future, the report identified the desirability of further developments in nursing facilities in the field of home nursing.

The nursing skills required for community nurses were raised in a document on Public Health Nursing in 1986.[24] The view was expressed that the level of additional training required by public health nurses to meet increased needs for care in general, mental handicap, mental illness, and paediatric services would be expensive and time consuming. It was suggested that it might be more effective to have specialist nurses from these nursing disciplines working in the community. An Bord Altranais would accept and support this recommendation.

4.12 Role of the Nurse in the Community

In the context of primary health care, the 1986 document on public health nursing defined the role of the nurse in the community:

> In community oriented nursing, the concepts of primary health care are integrated into nursing practice at all levels: home, dispensary health centre, hospital. In providing healthcare, whether to individuals, the family or the community, the nurse is expected to employ three processes – assessment of needs, planning and implementing the measures required, and evaluation of the effectiveness of the care provided (p. 11).

The report, in placing emphasis on the need to maximise nurse-patient relationships, considered the role of the public health nurse under three main headings:

- Surveillance
- Non Clinical
- Clinical.

Table 11. Community Nursing : Relationships with Patients/Clients

Target Groups for Community Nurses	Types of Relationships Predominant	Secondary
Mother and infant	A	B,C
Pre-school children up to 3 years	A	C
School children to 12 years of age	A	C
12 to 18 years age group	C,I	
The aged: 65 years and over	B	A
Mentally handicapped	B	A,C
Physically handicapped	B	A,C
Mentally ill	A	
Chronically ill – multiple sclerosis etc.	C	
Temporarily ill	C	
Problem families – psychiatric, social and environmental problems	A	B
Children at risk	C,I	

A = Community Surveillance B = Non Clinical C = Clinical I = Referrals

Source: *Public Health Nursing Services in Ireland* Discussion Document 1986. *General Medical Services*, Department of Health (p.16)

In using this typology of professional relationships between public health nurse and client, the report outlined the professional interventions which appear to be associated with various groups of patients/clients (Table 11).

4.13 Scope for Other Nurses in the Community

The findings of the 1975 report on the Workload of Public Health Nurses particularly as presented in Tables 9 and 10 provides a useful bench mark to measure change in relation to the role of public health nursing as it has evolved since 1975. The report *Working Party on General Nursing* (1980),[25] after reviewing the role of the nurse and the organisation of nursing services in the community, concluded that a shortfall existed in both the preventive and curative aspect of community nursing. Besides recommending an increase in the number of public health nurses, the report also recommended the employment of registered general nurses, without a public health qualification, specifically for a home nursing service. This was intended to enable the public health nurse to concentrate on preventive care. To support the work of the Working Party, the Institute of Public Administration reported on a survey of attitudes of Irish nurses (1980).[26] This survey showed that 45 per cent of public health nurses and 75 per cent of hospital nurses agreed that there is scope in the community for a nurse who has not received a public health nursing qualification.

Currently registered general nurses are employed in varying functional capacities.

Registered general nurses are employed in certain health board areas and visit the patients/clients' home to provide nursing care primarily to the elderly or dependent during the evening time. Other general nurses provide nursing care in the home to discharged general hospital patients. Some general nurses provide a range of special therapeutic interventions in areas of oncology, palliative care, respiratory medicine, stoma care, diabetes and continence advice. *The earlier discharge of patients from hospital, day admission cases and a reduced hospital stay have resulted in an increased demand for medical and surgical nursing care in the community care setting.*

4.14 Nursing Care for Psychiatric Patients

The 1945 Mental Treatment Act provided alternatives to the traditional custodial care approach to the mentally ill. This legislation made provision for the care of the mentally ill outside of the institution. A *Green Paper on Mental Health* (1992)[27] identified the need to update the current 1945 legislation and to put in place a statutory framework to enable the development of psychiatric services into a more comprehensive, community orientated service with integration in each sector as recommended in the report *Planning for the Future.*

The *Programme for Competitiveness and Work* (1994) stated its commitment to enabling further progress to be made in providing and improving community based services for people with a mental illness (par. 6.21).

Reports on psychiatric services have examined the evolving role of the psychiatric nurse in a context of community care and with associated activities. The report *Psychiatric Nursing Services of Health Boards* (1972)[28] perceived the evolving role of the psychiatric nurse as including:

- working with the patients in special occupational or industrial therapy units outside the hospital
- acting as liaison with social workers, with the families or employers of patients and dealing with problems in the home or work situations
- supporting the public health nurse in her responsibility for a group of families or individuals and helping with special skills as the occasion demands
- assisting in running hostels, social clubs or similar centres and establishing and maintaining contact with voluntary organisations
- encouraging and assisting the patients in the community as required (par. 31).

The report *Planning for the Future* (1984) serves as the current operational strategy for the delivery of psychiatric services. The report has initiated re-organisational change and the reappraisal of the role of nurses. Consequently psychiatric nurses since 1985 have experienced a period of change unprecedented in Irish psychiatric services. The *Green Paper on Mental Health* (1992) reviewed the role of the psychiatric nurse in the psychiatric services and identified that nurses have played a pivotal role in bringing about a more community orientated psychiatric service. Such changes were perceived to have radically altered the working lives of many nurses and placed demands on them beyond that which their training had prepared them for. The report stated, 'It is a natural consequence of the changes which have taken

place in the profession and the services, that some should have questioned the role of psychiatric nurses and their relevance to the new psychiatric services' (par. 14.10) '... there is a need however to ensure that nurses moving to the community setting have the skills to provide a therapeutic milieu' (par. 14.11).

A similar point was made in *Planning for the Future.* When referring to the transition from a hospital based service to a community based one, the authors reminded us that, 'they (the nurses) will need to acquire the knowledge and skills necessary to operate a community based psychiatric service. Otherwise, established practices of hospital care will be transferred inappropriately into a different setting' (par. 14.6). In a context of community psychiatric care it was recommended (par. 12.37) that the training of general practitioners and of public health nurses should place a greater emphasis on psychology so that they will be able to recognise, treat and refer appropriately the emotional problems which may arise in families. The report recommended the avoidance of having separate hospital nurses and community nurses (par. 14.15). An Bord Altranais is in accord with these recommendations.

In the past, provision was made for post-registration nurse education for community care and in 1985 the first and only joint course for community psychiatric and community mentally handicapped trained nurses was established by An Bord Altranais. The initial part of this course was shared jointly with nurses studying public health nursing. Following completion of this course, the Eastern Health Board (1986) and the North Western Health Board (1987) conducted further courses in community psychiatric nursing.

Since 1987 the pre-registration psychiatric nurse training programme has prepared nurses to function in both hospital and community services. During this same period, the emphasis has been changed from 'community psychiatric nursing' (as a specific area of practice) to the more generalist concept of 'psychiatric nursing in the community'. An Bord Altranais acknowledges the need to continue to provide psychiatric nurses with post-registration education appropriate to the evolving mental health services.

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Changes in relation to policy on care of persons with a mental handicap occurred during the 1980s. The practice of admitting mentally handicapped persons who are not in need of psychiatric treatment to psychiatric hospitals became much less common. Current policy is aimed at providing mentally handicapped only accommodation through the provision of special residential centres. A process of de-designation in relation to persons with a mental handicap residing in psychiatric hospitals is also part of current policy.

4.15 Nursing Care of Persons with a Mental Handicap

The *Report of the Commission of Inquiry on Mental Handicap* (1965)[29] perceived the role of nurses to be concerned mainly with:

- treatment and care of the severely handicapped of all ages
- treatment and care of training of the lower ranges of moderately handicapped children
- treatment, care and training of moderately and mildly handicapped adults (par. 158).

The need for public health nurses to play a greater role in the community care of mentally handicapped persons was also identified (par. 162).

The 1965 report, in reviewing the organisation of mental handicap services, accepted as a principle that community care is better for a handicapped person and permits a fuller development of personality, while avoiding the problem of adjustment to home life which is experienced after prolonged care in an institution (par. 37).

Care outside of residential centres has been the focus during the last decade in the mental handicap services. The need for a reform of services is an issue in the Report of the Review Group on Mental Handicap Services, *Needs and Abilities* (1990). The report aims at providing a comprehensive service and has a particular focus on the education and development of the intellectually disabled. It is recommended that a planned programme be established for the transfer of people from institutional care to community care (par. 157).

The *Programme for Competitiveness and Work* (1994) stated the government's commitment to the implementation of the recommendations contained in the *Needs and Abilities* report. The *PCW* supported the planned expansion of residential and day-care places, home support schemes and respite care for the mentally handicapped in all health board areas and, in particular, the continued transfer to the mental handicap services of those people with a mental handicap who are at present inappropriately placed in psychiatric hospitals (par. 6.21).

The modern mental handicap services and trends in care have fundamental implications for mental handicap nursing and require a re-definition of the specialist role and function of the nurse in the mental handicap services in terms of:

- the emphasis being placed on the educational needs of the intellectually disabled
- the requirement of a balance between community based nursing services and institutional based nursing services
- the multi-disciplinary nature of mental handicap services.

The higher than average incidence in Ireland of persons with a mental handicap compared to other European countries[30] will continue to require innovative nursing services for the care of persons with a mental handicap.

4.16 Nursing Care of Sick Children

Traditionally sick children's nursing practice has been confined to institutional care. The training programme is specifically orientated towards preparing nurses for a hospital based nursing system. Public health nurses provide a level of community

services through the operation of child welfare clinics and school health examinations. Department of Health Circular 27/66 outlined the functions of the public health nurse; in relation to children's nursing it included:

> follow up of at-risk children in association with the general practitioner at home; ... duties relating to the care of mentally handicapped children; ... health education and propaganda among families in her district with a view to encouraging them to avail of immunisation, maternity and child welfare services, school health examination services, etc.; ... duties in connection with child welfare clinics and school health examination services, including, where possible, attendance at clinics and examinations in respect of children resident in her district.

In accordance with other healthcare trends a greater integration of hospital and community nursing is desirable in children's nursing. The psychosocial nature and antecedent variables underlying many of the problems of children presenting to hospital makes it desirable that student nurses have a greater introduction to and understanding of community care issues.

Children's health, safety and protection has in recent years been highlighted in a context of changing societal attitudes and socio-economic conditions. *The concept of sick children's nursing is being extended from the physical care of sick children to one which recognises a proliferation of psychological, economic and political features.* Gilligan (1991)[31] explored the manifestations of the many socio-economic factors creating stress in the lives of Irish children. Many issues were identified and included a range of disparate concerns such as perinatal mortality and morbidity, breast feeding, nutrition, dental health, psychiatric illness, drug abuse, delinquency, family violence, alcohol, smoking, homelessness, disability including mental handicap and communication handicaps, child abuse, AIDS and social prejudice against children of minorities (pp 19-68).

Such an array of issues has either influenced or been influenced by changing circumstances and relationships between children and parents. Lifestyle concerns including drugs, alcohol, violence and accidents are impacting on children's lives. It is noted that the principal reasons for the admission of children into care [32] were:

- the inability of parents to cope with a range of situations, and
- identifiable child neglect.

Such reasons accounted for 50 per cent of all children's admissions to care.

The recognition of the complex issues affecting children has created a spectrum of need in sick children's nursing which require dynamic children's nursing services. The nature of child healthcare as a speciality incorporates unconventional care patterns which includes child psychiatry, mental handicap, and social care. There is a movement towards children's rights, parents' rights and the development of case law. It is within this environment that sick children's nursing is practised. In noting such a trend Gilligan states, 'in the history of child care there has been traditionally a

preoccupation with the welfare of children in isolation from their parents' (p. 8).

Trends in the care of sick children require sick children's nurses to have a broad perspective. *There is the requirement for sick children's nurses to be educated to nurse children with physical illness in a clinical environment of increased medical specialisation.*

The recognition for alternative approaches in child care was legislated for in the Child Care Act, 1991. Under this Act health boards will have duties and powers to promote and protect the welfare of children at risk and to provide child care and family support services. *Nurses could play a key role in implementing the provisions of the Child Care Act,* particularly in relation to child care advisory committees and child care teams.

The reforms in nurse education proposed by An Bord Altranais upholds these developments. A common core curriculum will provide a sick children's nurse with experiences and knowledge related to child psychiatry and care of the child with a mental handicap. The specialist component of the programme will ensure preparation directly related to the care of physically ill children.

4.17 Nursing Care of the Elderly

The medico-social status of residents in long-stay geriatric units demonstrates that the number of residents with chronic illness has declined, while the number of residents admitted for social reasons has increased. The Dublin Hospitals Initiative Group report referred to earlier made recommendations for a more comprehensive geriatric service and highlighted the fact that a large number of elderly people are being treated, inappropriately, in acute hospitals. Such trends in healthcare are of concern, especially in the light of demographic projections and trends, indicating that in the future there will be an increased number of people reaching advanced old age who will require health services. In noting such a trend the report *The Years Ahead, A Policy for the Elderly* (1988) identified the need for the provision of 'intensive home nursing services' particularly for the patient who has been discharged from hospital and to patients whose admission to hospital could be avoided. The report recommended that the function of co-ordinating services for the elderly in each district should be the responsibility of a district liaison nurse (par. 3.13).

Besides the community care programme a number of health service programmes incorporates the care of the elderly. The programmes include acute hospital services and the specialist hospital service. The elderly include elderly persons with a mental handicap and elderly persons who are mentally ill. In the psychiatric services, approximately 50 per cent of people hospitalised for one year or more were over sixty-five years of age and over 16 per cent of persons admitted to psychiatric hospitals for the first time in 1988 were sixty-five years or over. (Figures supplied by the Department of Health.) The provision of care facilities and supervision for persons with dementia and mental confusion is emerging as a special need in relation to care of the elderly. Specific reports (*The Years Ahead* and *Third Report of Dublin Hospitals Initiative Group*) highlight the inadequate provision for the long-term care of elderly

persons with dementia and perceive the need for a co-ordinated multi-disciplinary approach to development of care in this area.

The *Programme for Competitiveness and Work* stated the government's commitment to the strengthening of home and community services for elderly people who are ill or dependent, by the provision of extended care beds and staff (par. 6.21).

The health boards are obliged to provide nursing services to the elderly in accordance with Department of Health Circular 48/65 which lists specific objectives applicable to public health nursing. This circular stated that the public health nurse should:

- advise and assist in matters relating to health
- concentrate on the preventive role
- seek out and visit the elderly on a regular basis and provide advice concerning hygiene and nutrition
- liaise with housing and local authorities on behalf of the aged.

Circular 48/65 also stated that the GP should be encouraged to use the public health nursing services for the care of the elderly.

The Health (Nursing Homes) Act, 1990, by updating the law on nursing homes, aims to ensure a high standard of care in nursing homes. Under this act, new powers are vested in health boards with regard to regulation and supervision of nursing homes. The Nursing Home Regulations (1993)[33] when compared with the regulations of 1985, places a particular emphasis on a range of new responsibilities for nurses employed in nursing homes. Such responsibilities relate to standards of nursing care (par. 5(6)), nursing records (par. 19.1 (c), (d)), medicine administration (par. 19.1 (f)), physical or chemical restraint (par. 19.1 (h)), staffing records (par. 21 (a),(b),(c)). The Regulations also stated that staff training may be provided under certain conditions (par. 32).

Elderly people when compared with other groups make disproportionately more use of health services; therefore, *in accordance with demographic data and epidemiological trends a greater concentration of nursing activities in the future will be focused on care of the elderly and particularly on those areas which relate to community care.*

Adequate levels of health promotion and nursing surveillance which supports the maintenance of good levels of health in the elderly is an important aspect of community nursing. The development of geriatric medicine as a specialist area of expertise has been notable and specialist nursing courses in care of the elderly have been developed through An Bord Altranais. However, many nurses employed in the care of the elderly have had little opportunity for

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specialist education and training. An Bord Altranais, in the light of the evolving patterns of caring for elderly people, recommends that a greater level of nurse education in the care of the elderly be provided.

4.18 The Role of the Occupational Health Nurse

The role of the occupational health nurse within the occupational setting is also supportive of the WHO healthcare objectives. The first industrial nurse was appointed in Ireland in 1890 and since then nurses have been employed as occupational health nurses in industries, educational establishments and hospitals. The role of the occupational health nurse has encompassed:

- the promotion of health
- the prevention of illness and injury
- the rehabilitation and resettlement of the ill and injured.

The provision of special training for the occupational health nurse was commenced by An Bord Altranais in 1976. In 1988 the Occupational Health Nursing course was incorporated into a multi-disciplinary Diploma in Safety, Health and Welfare at Work. An Bord acknowledges the important role of the occupational health nurse particularly arising from the emphasis being placed by employers on health and safety in the work environment through the implementation of the Safety, Health and Welfare at Work Act (1989).

4.19 Education and Preparation for Community Nursing

The move from curative to preventive strategies and the provision of a greater balance of services between community nursing and hospital nursing will require a major re-orientation in nursing philosophy, nursing structures, and nurse education.

A community nurse is not just a hospital nurse working in the community, and therefore a level of educational preparation is important. The public health nurse is the only registered nurse who currently receives a registrable course of education and training aimed at providing the necessary knowledge and skills to provide community nursing services. The educational profile of the public health nurse amounts to three years' general nursing, two years' midwifery training, two years' staffing experience and a one-year public health nursing course. In total it takes eight years to prepare a public health nurse for community care. An Bord Altranais, having reviewed the evolving community care needs, recommends that the requirement of registration as a midwife should not be a prerequisite for entry to public health nursing. This should be replaced by a maternity and child care module.

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As a result of health policy development, health services will require an increase in the number of nurses working in community care. Such developments will require some

nurses to have enhanced community health roles in areas related to advising, supervising, co-ordinating, policy formulation, surveillance, screening and health promotion. Other specialist nurses will have case loads and will provide specialist therapeutic nursing interventions.

The present Rules and Criteria for pre-registration training stipulate minimum requirements for home/community nurse experience. Student nurses in general nursing receive one week's community nursing experience during their pre-registration programme. During the workshop consultations with nurses in 1991, it was highlighted that the periods of student nurse allocation for community nursing experience does not allow sufficient time for a satisfactory appreciation of community nursing.

The proposed restructuring of the pre-registration programme aims to provide a greater knowledge and experience of community care. An Bord Altranais recommends that primary health care and community nursing should be substantially enhanced in the proposed new programme and that satisfactory learning environments should be established in the community in the interest of student nurse learning. This will enable the preparation of all nurses to function within the community setting.

'An Bord Altranais recommends that primary health care and community nursing should be substantially enhanced in the proposed new programme and that satisfactory learning environments should be established in the community in the interest of student nurse learning.'

All nurses practising in the community should be provided with an appropriate in-service training and orientation.

RECOMMENDATIONS

- Primary healthcare should be an essential feature of the nursing curriculum.
- Future programmes of nurse education and training should provide all student nurses and registered nurses with substantial knowledge and expertise in relation to community nursing.
- The provision of a satisfactory learning environment in the community care setting for student nurses should be developed in the interest of student nurse learning.
- An enhanced level of nurse education and training should be provided in care of the elderly.
- Midwifery registration should no longer be required for entry to public health nursing and should be replaced by a maternity and child care module.

SECTION 5

MIDWIFERY

5.1 Early Development of Midwifery

Developments in healthcare demonstrate that the earliest forms of care, including home nursing services, were given by midwives. The earliest initiatives in midwifery education took place at the Rotunda Lying-in Hospital in the late eighteenth century. At this time the governors of the institution decided that a certain number of female pupils should be employed and supported for such a period as might be sufficient to enable them to acquire a competent knowledge of the common practices of a midwife. By 1870 the hospital committee of the Rotunda had ordered that a room be prepared for lectures to female midwives and doctors on diseases of women and children.[1]

The charter of the Rotunda Hospital gave authority to the Master and his assistants to instruct, examine and certify midwives after they had spent six months in attendance at the institution.

An Act of Parliament in 1875 authorised county Grand Juries to make available a sum of money for the training of midwives at the Rotunda, and the midwife, on certification, was required to settle in the county which made the money available for her training. During this period, pupil midwives were also training in other Lying-in hospitals and it is recorded that thirteen female midwifery pupils entered the Coombe Lying-in Hospital for instruction between 1835-1845.[2]

As the provision of healthcare increased, there was a need for a regulation of services with a consequent need for legislative control. The first regulatory recognition given to midwives in Ireland was under the Midwives Act, 1902 which, although only applying to England and Wales, gave recognition to midwives who had training certificates from the Royal College of Physicians of Ireland, the Coombe Lying-in Hospital and the Rotunda Hospital. The 1902 Act was passed for the purposes of obtaining better midwifery training and regulation for midwifery practice.

5.2 Establishment of Central Midwives Board

The first piece of Irish legislation was the Midwives Act, 1918 which established the Central Midwives Board. The 1918 Act had as its objectives:

- the establishment of a Central Midwives Board
- the confining of midwifery practice to qualified registered midwives
- the designation of the powers and responsibilities of the local supervising authorities concerning the practice of midwifery in their respective areas.

The conditions of eligibility for certification under the 1918 Act included:

- holding a certificate in midwifery from the Royal College of Physicians of Ireland or from any Lying-in hospital recognised as a training hospital for midwives, or any other certificate in midwifery approved by the Central Midwives Board for Ireland

- holding a permanent appointment as midwife of a workhouse or dispensary district in Ireland
- having been certified under the Midwives Act, 1902 or the Midwives (Scotland) Act, 1915
- having been in bona fide practice as a midwife for at least one year at the time of the passing of the Act and being a person of good character.

A certificate issued by a training school at a Lying-in hospital was recognised by the local government board. This certificate had to be granted on examination following a period of three months' training in the case of a trained medical and surgical nurse and a period of at least six months in the case of any other woman.

The Central Midwives Board established rules by which all practising midwives were required to abide. The Board also produced various records and procedures to regularise certain elements of midwifery such as a register of cases, temperature charts, record of sending for medical assistance and a variety of notification forms.

Scanlan (1991)[3] on reviewing early midwifery history, identified many important decisions taken by the Central Midwives Board during the early 1920s which were to influence future practice:

- the authority given to certified midwives, when in practice under a local supervising authority, to be in possession of, and to administer, preparations containing opium when needed by their patients
- an increase in the required period of midwifery training to six months for trained nurses, and one year for candidates without nurse training
- rules made under the Central Midwives Board in 1930 stipulated that the minimum age requirement for midwifery enrolment was twenty-one years and in 1939 an age range of twenty to forty years was decided for candidates. In the earliest days, two models of midwifery training were recognised: a training for candidates with a nursing qualification and a direct entry training programme.

Following the drawing up of regulations in 1939, midwifery training was arranged in two parts which facilitated direct entry candidates and registered nurses. The first part of the training programme was undertaken in eighteen months, by direct entry candidates, and for registered nurses the training was six months. The second part of the training programme was of six months' duration for all candidates.

5.3 The Midwives Act, 1944

The 1944 Midwives Act repealed previous midwifery legislation and the Central Midwives Board was empowered to make provision for courses of midwifery training and examinations and to register midwives who were allowed by rules made under the Act to use the title 'State Certified Midwife' (SCM). The 1944 Act also made further and wider provision for the education and training of midwives; for instance, the Central Midwives Board was empowered to make rules requiring midwives to attend, from time to time, courses which might be approved by the Board or provided or arranged by it. The Act also required supervisory authorities to grant

leave of absence to their midwife employees, to enable them to attend courses of instruction required by the Board, and that a travelling and subsistence allowance be paid to these employees during the course of midwifery training. Under the 1944 Act, special provision was made for sick children's nurses to complete training in midwifery in a shorter period of time.

5.4 The Nurses Acts of 1950 and 1985

The Nurses Act, 1950 repealed or amended most of the previous legislation on nursing and midwifery. The 1950 Act established An Bord Altranais and this Act defined a nurse 'as a person registered in the register of nurses and includes a midwife and the word nursing includes midwifery'. The Central Midwives Board was dissolved and statutory provision was made for a committee to be known as the Midwives Committee. Rules made under the 1950 Act provided for the establishment of a division of the register of midwives.

Midwives are currently legislated for under the Nurses Act, 1985 which repealed the remainder of the Midwives Act, 1944 and the Nurses Act, 1950, and EU Directives which specify educational requirements and the activities of the midwife (Council Directives 80/154/EEC[4], 80/155/EEC).[5]

5.5 Definition of a Midwife

A midwife has been defined as:

> 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 qualification 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.[6]

This definition of the midwife and midwifery practice highlights a complex and specialist role. The definition, by emphasising aspects of the role related to 'prevention ... execution of emergency measures, detection of abnormal conditions in mother and child, conducting deliveries on her own responsibility', highlights the degree of autonomy and independent practice afforded to the midwife.

5.6 Specific Statutory Requirements

The Nurses Act, 1985, in regulating midwifery practice, imposes key specific responsibilities related to:

- notification of intention to practise (Section 57 (1)) which relates to a midwife who is not employed by a health board or by a hospital authority providing maternity services
- supervision of domiciliary midwives (Section 57 (2))
- prohibition on attending birth (Section 58).

The activities of the midwife are stated in the European Directive 80/155/EC (Article 4). The European directive states:

> Member states shall ensure that midwives are at least entitled to take up and pursue the following activities:
>
> - to provide sound family planning information and advice
> - to diagnose pregnancies and monitor normal pregnancies, to carry out examinations necessary for the monitoring of the development of normal pregnancies
> - to prescribe or advise on the examinations necessary for earliest possible diagnosis of pregnancies at risk
> - to provide a programme of parenthood preparation and a complete preparation for childbirth including advice on hygiene and nutrition
> - to care for and assist the mother during labour and to monitor the condition of the foetus in utero by the appropriate clinical and technical means
> - to conduct spontaneous deliveries including, where required, an episiotomy, and in urgent cases, a breech delivery
> - to recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and to assist the latter where appropriate; to take the necessary emergency measure in the doctor's absence, in particular the manual removal of the placenta, possibly followed by manual examination of the uterus
> - to examine and care for the newborn infant; to take all initiatives which are necessary in case of need and to carry out where necessary immediate resuscitation
> - to care for and monitor progress of the mother in the post-natal period and to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the newborn infant
> - to carry out the treatment prescribed by a doctor
> - to maintain all necessary records.

Beside specific national legislation and EU Directives, the responsibilities of the midwife are enshrined in other legislation. It is identified that the midwife, in certain conditions, may have a responsibility under the Birth and Deaths Registration Act (Ireland 1880). Section I provides that 'it is the duty primarily of the father or mother to give to the Registrar of Births information of the birth within forty days, whether

the baby is born alive or is a late fetal death. In default of the father or mother this duty falls upon every person present at the birth including the midwife if present at the birth.'

5.7 Statistics on Maternity Care in Ireland

Several factors have influenced and affected the practice of midwifery in Ireland. Health statistics indicate many changing patterns in relation to births.[7] There has been an increase in the number of hospital deliveries, with only 0.3 per cent domiciliary births taking place in 1988. In 1980, 5 per cent of births occurred outside of marriage compared to 16.6 per cent in 1991. The crude birth rate in Ireland has declined from 21.8 per 1000 population in 1970 to 15.0 in 1991. The fall in the number of births has been due to a decrease in family size rather than a reduction in the number of women having babies. The Irish birth rate remains high by European standards but the disparity is diminishing and Irish birth rates are beginning to approach those of other EU countries. It is also noted that the number of women having babies has increased in the early and late phases of the child bearing years with an increase in the number of first time mothers.

The maternity services in the Republic of Ireland enjoy a high international professional reputation. In 1991, Ireland had the lowest maternal mortality rate in the world and achieved a reduction in the perinatal mortality rate, 16.9 per thousand total births (1979) to 10.0 per thousand (1990)[8] despite the fact that a third of this rate can be attributed to congenital anomalies.

The reproductive women's healthcare needs are also affected by social changes including the rising rate of unemployment, domestic violence, an increased incidence of substance abuse (drugs and alcohol), infections such as hepatitis B and C, and HIV infection. There is also an increased level of litigation consciousness among couples.

The changing birth rate patterns and societal trends serve to confirm the important role of the midwife as a practitioner, educator and counsellor.

5.8 The Provision of Postnatal Care

The earlier discharge of mother and baby from maternity units requires an examination of the provision of postnatal care and support from the midwife. The report *Working Party on General Nursing* (1980)[9] highlighted the importance of the interdependent role of the midwife and the public health nurse and stated 'where it is feasible and practicable hospital midwives should carry out follow-up visits to mothers and their newborn babies for a certain period after their return to home' (par. 4.14.1).

An Bord Altranais supports the Working Party recommendation of maintaining links between hospital and community staff in order that both the mother's health and that of the new baby are monitored and that the mother and father are supported in parenthood and in the care and development of the child.

5.9 The Need for a Comprehensive Approach

A desire for a more comprehensive approach towards maternity services in the United Kingdom was highlighted in the *Health Committee (Second Report) on Maternity Services.*[10] This report, in its introductory remarks, challenged the many assumptions inherent in current practice and maternity care by stating: 'becoming a mother is not an illness. It is not an abnormality. It is a normal process which occurs during the lives of the majority of women and can indeed be seen as a manifestation of health' (par. 4).

In the context of future maternity services, the report stated:

> ... women will need a better continuity of care and carer, more choice and control over their pregnancies and the birth of their children, more information about the options available to them and more support after the birth of their children (par. 305).

The report, in its many recommendations, has identified several important aspects related to a stronger and changing role for the midwife including:

- the establishment of best practice models of team midwifery care (par. 339)
- a move towards a situation in which midwives have their own case load and take full responsibility for the women who are under their care
- the opportunity to establish and run midwife managed maternity units within and outside hospitals
- the explicit right of midwives to admit women to NHS hospitals (par. 344).

Such recommendations provide a revised order of thinking on maternity services in the United Kingdom, including a more autonomous functioning role for midwifery both in domiciliary and lying-in care.

5.10 European Union Directives on Midwives

A European Council Directive (80/154/EEC) concerning midwifery was introduced in January 1980. It specifically concerned the mutual recognition of diplomas, certificates and other evidence of formal qualifications in midwifery and included measures to facilitate the effective exercise of the right of establishment and freedom to provide services.

Specifically, in relation to midwifery education, the conditions of training for mutual recognition of diplomas and certificates was stated (article 2) as:

- full time training in midwifery lasting at least three years
- full time training in midwifery taking at least two years or 3,600 hours subject to possession of a diploma, certificate, or other evidence of formal qualifications as a nurse responsible for general care, referred to in Article 3 of Directive 77/452/EEC[11]
- full time training in midwifery taking at least eighteen months or 3,000 hours subject to possession of a diploma, certificate or other evidence of formal

qualifications as a nurse responsible for general care referred to in Article 3 of Directive 77/452/EEC and followed by professional practice of one year for which a certificate issued by the competent authority of the member state of origin or the member state from which the foreign national comes.

An annex to the Council Directive 80/155/EEC stipulated the training programme content for midwives as consisting of two parts:

- theoretical and technical instruction which is identified as:
  - general subjects
  - subjects specific to the activities of the midwife
- practical and clinical training.

The three routes of entry for midwifery training as identified in Directive 80/154/EEC (Article 2) are selectively chosen for midwifery training across member states (Appendix 5).

The European Community Advisory Committee on the Training of Midwives has produced further recommendations in relation to:

- continuing education of midwives (1990)[12]
- midwives and research (1992).[13]

The 1990 recommendation identified the importance of continuing education for midwives both in practice and returning to practice. Specifically the recommendation stated:

> recognising the importance of continuing education of the midwife, each member state should review the available provision in its own country and ensure that every midwife has the opportunity to keep his/her practice up to date and develop professionally. In particular, consideration should be given to:
>
> – mandatory periodic refresher courses
> – mandatory return to midwifery practice courses.

It is pointed out that developments in distance learning materials may be useful to meet some of the continuing education programmes, particularly in the theoretical component.

The 1992 recommendation stipulated a requirement of research in the curriculum of midwifery training and highlighted the need for research development in practising midwives. Research as a subject has now been introduced into the midwifery curriculum.

5.11 Midwifery Education and Training in Ireland

There are seven midwifery training schools in Ireland with an average annual intake of 220 student midwives.

Approximately 380 new midwives are registered each year and it is noted that there has been an increase in the number of certificates and verification documents issued by the United Kingdom Central Council to midwives intending to practise in Ireland.[14]

The total number of persons with midwifery qualifications registered with An Bord Altranais up to 1993 was 13,281. The high number of midwives being trained is, in part, due to the stipulated requirement of a registered midwifery qualification for public health nursing.

The particular model of midwifery training in Ireland consists of full-time training of two years' duration following registration as a general nurse.

The rules and criteria for midwifery training (An Bord Altranais 1992)[15] stipulate a requirement of thirteen weeks theoretical and technical instruction based on a block or modular system. The minimum clinical allocation is stipulated as follows:

- antenatal care - 12 weeks
- intranatal care - 18 weeks
- postnatal care - 18 weeks
- neonatal care - 8 weeks.

5.12 Midwifery Education and Training – Future Options

A more flexible approach should be taken in regard to the recognition and approval of schemes of training which fulfil the conditions stated under article 2 of Directive 80/154/EEC. Such flexibility should be afforded in the event of a particular college of nursing/midwifery developing and intending to implement programmes which fulfil the conditions stated under the European Directive, as reviewed earlier.

'A revision of the midwifery curriculum should be undertaken and the curriculum should reflect a preparation aimed at enhancing the role of the midwife as a practitioner, educator and counsellor. A greater educational focus should also be placed on the role of the midwife in the community. The programme of midwifery education and training should be subjected to professional and academic validation and accreditation and should be provided in the proposed college of nursing and midwifery which will have links established with a higher education institution. The programme of education and training should be under the direction of a qualified midwife teacher.'

A revision of the midwifery curriculum should be undertaken and the curriculum should reflect a preparation aimed at enhancing the role of the midwife as a practitioner, educator and counsellor. A greater educational focus should also be placed on the role of the midwife in the community. The programme of midwifery education and training should be subjected to conjoint professional and academic validation and accreditation and should be provided in the proposed college of nursing and midwifery which will have links established with a higher education institution. The programme of education and training should be under the direction of a qualified midwife teacher.

The continuing educational needs of midwives in practice and returning to practice should be examined in the context of the recommendations of the EU's advisory committee on the training of midwives.

RECOMMENDATIONS

- Article 2 of the EU Midwives Directive, 80/154/EEC, should be used to provide flexibility in the approval and validation by An Bord Altranais of programmes of midwifery education and training.
- Midwifery education and training programmes should have academic accreditation.
- A new curriculum should be developed for the midwifery registration programme.
- Programmes of midwifery education and training should be located in colleges of nursing and midwifery and should be under the direction of a qualified midwife teacher.
- The EU recommendation (111/D/5159/2/89) on continuing education of midwives should be implemented.
- The EU recommendation (111/F/5122/4/90) on midwives and research should be implemented.

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APPENDIX I

MEMBERSHIP OF AN BORD ALTRANAIS

Ita O'Dwyer, President of An Bord Altranais, elected member of An Bord Altranais, representing nurses who are engaged in the administration of midwifery

Anthony Gilligan, Vice President and member of An Bord Altranais, appointed by the Minister for Health, representing nurses

Aidan Browne, elected member of An Bord Altranais, representing nurses who are engaged in general nursing administration

Catherine Collins, elected member of An Bord Altranais, representing nurses who are engaged in clinical practice, general nursing

Michael Fanning, elected member of An Bord Altranais, representing nurses who are engaged in psychiatric nursing administration

Maresa Gilligan, elected member of An Bord Altranais, representing nurses who are engaged in clinical practice in general nursing

John Griffin, elected member of An Bord Altranais, representing nurses who are training nurses in the care of mentally handicapped persons

Triona Harvey, Sister of the Medical Missionaries of Mary, appointed by the Minister, representing third level educational establishments which are involved in the education and training of nurses

Barbara Haslam, elected member of An Bord Altranais, representing nurses who are engaged in clinical practice in public health nursing

Hanora Henry, elected member of An Bord Altranais, representing nurses who are training nurses in psychiatric nursing

Desmond Kavanagh, elected member of An Bord Altranais, representing nurses who are engaged in clinical practice in psychiatric nursing

Ann Martin, elected member of An Bord Altranais, representing nurses who are engaged in clinical practice in midwifery

Margaret McCarthy, elected member of An Bord Altranais, representing nurses who are training nurses in general nursing

Mary McDermott, elected member of An Bord Altranais, representing nurses who are engaged in the administration of public health nursing

Ann Louise Mulhall, elected member of An Bord Altranais, representing nurses who are training nurses in midwifery

Seamus Murphy, elected member of An Bord Altranais, representing nurses who are engaged in clinical practice in psychiatric nursing

Eileen Musgrave, elected member of An Bord Altranais, representing nurses who are training nurses in paediatric nursing

Sheila Ryan, Sister of the Daughters of Charity of St Vincent de Paul, elected member of An Bord Altranais, representing nurses who are engaged in the administration of nursing of mentally handicapped persons

Derek Smith, elected member of An Bord Altranais, representing nurses who are engaged in clinical practice in the nursing of mentally handicapped persons

John Bonnar, appointed by the Minister, registered medical practitioner, engaged in the practice of obstetrics in a hospital approved of by the Board for the training of midwives

Kathryn Byrne, appointed by the Minister, representing the interest of the general public

Marjorie Deegan, appointed by the Minister, representing the Department of Health

P. J. Fitzpatrick, appointed by the Minister, representing management of health boards

William Hederman, appointed by the Minister, registered medical practitioner, engaged in the practice of medicine in a hospital approved of by the Board for the training of general nurses

Brian McCaffrey, appointed by the Minister, registered medical practitioner, engaged in the practice of medicine in a hospital approved of by the Board for the training of psychiatric nurses

Augusta Fitzsimons, appointed by the Minister, representing management of hospitals other than those administered by health boards

Michael Kelly, appointed by the Minister, representing the Department of Health

Peter McLoone, appointed by the Minister, representing the interest of the general public

Sean Nolan, appointed by the Minister, representing the field of education

The membership of the review advisory committee on nurse education and training consisted of some board members and the following co-opted members:

Ann Carrigy, representing voluntary hospitals (nominated by the Irish Business and Employers Confederation)

Fiona Tyndall, representing voluntary hospitals (nominated by the Irish Business and Employers Confederation)

P. J. Fitzpatrick, representing health boards (nominated by the chief executive officers of health boards) appointed board member in 1991

Patrick McLoughlin, representing health boards (nominated by the chief executive officers of health boards)

Michael McLoone, representing hospitals with boards established under the Health (Corporate Bodies) Act, 1961

Máire Mulcahy, representing the Higher Education Authority

Attracta Halpin, representing the National Council for Educational Awards

APPENDIX 2

CURRENT PROGRAMMES OF NURSE EDUCATION AND TRAINING – 156 WEEKS

Time Allocation as Specified in Rules and Criteria (1991)

RGN

Clinical Experience	Weeks (Minimum)
Medicine	20
Surgery	20
Paediatrics	6
Maternity	2
Psychiatry	5
Geriatric	6
Community	1
A&E / OPD	6
Theatre	6
Total clinical	72
Theory	40
Total specified	112
Total unspecified	32*
Total annual leave	12
TOTAL	**156**

RSCN

Clinical Experience	Weeks (Minimum)
Medicine	24
Surgery	24
Neonatal	6
Maternity	2
Community	1
A&E / OPD	6
Theatre	6
Total clinical	69
Theory	40
Total specified	109
Total unspecified	35*
Total annual leave	12
TOTAL	**156**

RPN

Clinical Experience	Weeks (Minimum)
Admission	24
Community	14
Specialist units	6
Long-stay units	40
General hospital	7
incl. Medicine (3) wks	
Surgery (2) wks	
A&E / OPD (2) wks	
Total clinical	91
Theory	40
Total specified	131
Total unspecified	13*
Total annual leave	12
TOTAL	**156**

RMHN

Clinical Experience	Weeks (Minimum)
Ed. & devel. of child	14
Ed. & devel. of adult	42
Psychiatric nursing	12
General nursing	6
incl. Medicine (2) wks	
Surgery (2) wks	
A&E / OPD (2) wks	
Nursing mental handicap persons who have a physical handicap/illness	6
Specialist areas	6
Total clinical	86
Theory	40
Total specified	126
Total unspecified	18*
Total annual leave	12
TOTAL	**156**

*Flexibility is afforded to the school of nursing in the allocation of the remaining clinical experiences to fulfil An Bord Altranais' programme requirement of 156 weeks.

CURRENT PROGRAMMES OF NURSE EDUCATION AND TRAINING – 78 Weeks

Time Allocation as Specified in Rules and Criteria (1991)

RGN following RPN	
Clinical Experience	Weeks (Minimum)
Surgery	10
Medicine	10
Paediatrics	6
Maternity	2
Geriatrics*	6
Home nursing	1
A&E / OPD	6
Theatre	6
Total clinical	47
Theory	20
Total specified	67
Total unspecified	5**
Total annual leave	6
TOTAL	**78**

RGN following RMHN	
Clinical Experience	Weeks (Minimum)
Surgery	10
Medicine	10
Paediatrics	6
Maternity	2
Geriatrics*	6
Home nursing	1
A&E / OPD	6
Theatre	6
Total clinical	47
Theory	20
Total specified	67
Total unspecified	5**
Total annual leave	6
TOTAL	**78**

* May vary as a requirement across different schools.

RGN following RSCN	
Clinical Experience	Weeks (Minimum)
Surgery	10
Medicine	10
Psychiatry	5
Geriatric	6
A&E / OPD	6
Theatre	6
Total clinical	43
Theory	20
Total specified	63
Total unspecified	9**
Total annual leave	6
TOTAL	**78**

RSCN following RGN	
Clinical Experience	Weeks (Minimum)
Medicine	12
Surgery	12
A&E / OPD	6
Theatre	2
Neonatal	8
Intensive care	4
Total clinical	44
Theory	20
Total specified	64
Total unspecified	8**
Total annual leave	6
TOTAL	**78**

** Flexibility is afforded to the school of nursing in the allocation of the remaining clinical experiences to fulfil An Bord Altranais' programme requirement of 78 weeks.

CURRENT PROGRAMMES OF NURSE EDUCATION AND TRAINING – 78 Weeks

Time Allocation as Specified in Rules and Criteria (1991)

RSCN following either RMHN or RPN

Clinical Experience	Weeks (Minimum)
Medicine	12
Surgery	12
A&E / OPD	6
Theatre	2
Neonatal	8
Intensive care	4
Maternity	2
Home nursing	1
Total clinical	47
Theory	20
Total specified	67
Total unspecified	5*
Total annual leave	6
TOTAL	**78**

RPN following either RGN or RSCN or RMHN

Clinical Experience	Weeks (Minimum)
Admission	18
Community	12
Specialist units	6
Long-stay units	16
Total clinical	52
Theory	20
Total specified	72
Total unspecified	0*
Total annual leave	6
TOTAL	**78**

RMHN following RSCN

Clinical Experience	Weeks (Minimum)
Community care	2-4
Work activation	2
Mild - school or residential	4
Moderate	12
Severe / disturbed	16
Speech therapy, PE	4
Special / pre school	6
Psychiatry	3
Total clinical	49(+2)
Theory	20
Total specified	69
Total unspecified	3*
Total annual leave	6
TOTAL	**78**

RMHN following RPN or RGN

Clinical Experience	Weeks (Minimum)
Community care	2-4
Work activation	2
Mild - school or residential	4
Moderate	12
Severe / disturbed	16
Speech therapy, PE	4
Special / pre school	6
Total clinical	46(+2)
Theory	20
Total specified	66
Total unspecified	6*
Total annual leave	6
TOTAL	**78**

* Flexibility is afforded to the school of nursing in the allocation of the remaining clinical experiences to fulfil An Bord Altranais' programme requirement of 78 weeks.

CURRENT PROGRAMMES OF NURSE / MIDWIFE EDUCATION AND TRAINING – 104 Weeks and 208 Weeks

Time Allocation as Specified in Rules and Criteria (1991 / 92)

RM (104 weeks)	Weeks
Antenatal area	12
Intranatal area	18
Postnatal area	18
Neonatal	8*
Total clinical	56
Theory	13
Total specified	69
Total unspecified	27**
Total annual leave	8
TOTAL	**104**

* To include 6 weeks neonatal special care.

Integrated RGN/RSCN (208 weeks)	
Clinical Experience	Weeks (Minimum)
(Adult)	
Medicine	20
Surgery	20
Mental health	5
Geriatrics	6
A&E / OPD	4
Theatre	4
Maternity (children's)	2
Medicine	20
Surgery	20
Neonatal	6
A&E / OPD	4
Theatre	4
Community	1
Total clinical	116
Theory	53
Total specified	169
Total unspecified	23**
Total annual leave	16
TOTAL	**208**

** Flexibility is afforded to the school of nursing / midwifery in the allocation of the remaining clinical experiences to fulfil An Bord Altranais' programme requirement of 104 weeks and 208 weeks.

APPENDIX 3

PROGRAMMES OF TRAINING FOR REGISTRATION

(Time Analysis Expressed in Weeks as referenced in Rules and Criteria, ABA 1991)

	RGN	RSCN	RMHN	RPN	RM
Total Time Rules and Criteria An Bord Altranais	156	156	156	156	104
Specified Time					
Total Clinical	72 (46.1%)	69 (44.2%)	86 (55.1%)	91 (58.3%)	56 (53.8%)
Total Theory (Minimum)	40 (25.6%)	40 (25.6%)	40 (25.6%)	40 (25.6%)	13 (12.5%)
TOTAL	**112 (71.7%)**	**109 (69.8%)**	**126 (80.7%)**	**131 (83.9%)**	**69 (66.3%)**
Unspecified Time	44 (28.2%)	47 (30.2%)	30 (19.3%)	25 (16.1%)	35 (33.7%)

	RGN/RSCN (integrated)
Total Time Rules and Criteria An Bord Altranais	208
Specified Time	
Total Clinical	116 (55.7%)
Total Theory (Minimum)	53 (25.5%)
TOTAL	**169 (81.2%)**
Unspecified Time	39 (18.8%)

PROGRAMMES OF TRAINING FOR A SECOND REGISTRATION

(Time Analysis Expressed in Weeks as referenced in Rules and Criteria, ABA 1991)

	RGN following RPN	RGN following RMHN	RGN following RSCN
Total time Rules and Criteria An Bord Altranais	78	78	78
Specified Time			
Total Clinical	47 (52.5%)	47 (60.2%)	43 (55.1%)
Total Theory	20 (25.6%)	20 (25.6%)	20 (25.6%)
TOTAL	**67 (85.5%)**	**67 (85.8%)**	**63 (80.7%)**
Unspecified Time	11 (14.2%)	11 (14.2%)	15 (19.3%)

	RSCN following RGN	RSCN following RMHN or RPN	RPN following RSCN or RGN or RMHN
Total time Rules and Criteria An Bord Altranais	78	78	78
Specified Time			
Total Clinical	44 (56.4%)	47 (60.2%)	52 (66.6%)
Total Theory	20 (25.6%)	20 (25.6%)	20 (25.6%)
TOTAL	**64 (79.4%)**	**67 (85.8%)**	**72 (92.2%)**
Unspecified Time	14 (18.0%)	11 (14.2%)	6 (7.8%)

	RMHN following RPN / RGN	RMHN following RSCN
Total Time Rules and Criteria An Bord Altranais	78	78
Specified Time		
Total Clinical	46 (59%)	49 (62.8%)
Total Theory	20 (25.6%)	20 (25.6%)
TOTAL	**66 (84.6%)**	**69 (88.4%)**
Unspecified Time	12 (15.4%)	9 (11.6%)

APPENDIX 4

ALTERNATIVE MODEL OF NURSE EDUCATION – PROGRAMME OUTLINE

INFLUENCING CRITERIA	
EC Directive 77/453/EEC and 89/595/EEC (General Nursing)	
Minimum length of training	4600 hours or a three-year course
Theoretical instruction	No less than one third of the minimum length of training
Clinical instruction	No less than half of the minimum length of training
	Weeks
Common Core Programme	72
Specialist Programme	72
Annual leave	12
Total	**156**
COMMON CORE PROGRAMME	**72**
Taught practice	48
College-based education	24
Annual leave	6
Taught practice (integrating hospital & community care) comprising:	
General nursing	12
Psychiatric nursing	12
Sick children's nursing	12
Mental handicap nursing	12
SPECIALIST PROGRAMME	**72**
College-based education	24
Taught practice	48
Annual leave	6

APPENDIX 5

TYPES OF MIDWIFERY TRAINING IN EUROPEAN MEMBER STATES

Country	Programme
Belgium	First two years are part of graduate RN programme. Then one year of special midwifery training. Graduate RN holders may enter third year of programme.
Denmark	Midwifery programme is three years. General care nurse can enter at start of second year.
Germany	Midwifery programme is three years. General care nurse can enter at start of second year.
Greece	Midwifery programme is three and a half academic years. General care nurse can enter at middle of second year.
Spain	Prior to becoming a member state of the EC in 1986 training was of one year following general care nursing. Negotiations proceeding to extend training to two years.
France	Midwifery programme is four years. General care nurse can enter at start of second year.
Ireland	Midwifery programme is two years following general care nursing.
Italy	Midwifery programme is two academic years following general care nursing.
Luxembourg	Midwifery programme is two years following general care nursing.
Netherlands	Midwifery programme is three years.
Portugal	Midwifery programme is twenty-one months following general care nursing and two years' experience as a qualified nurse.
United Kingdom	Eighteen-month midwifery training following general care nursing. Three year training in midwifery.

Source: Third report, recommendations and opinion on the training of midwives, September 1989, Brussels.

APPENDIX 6

LIST OF ORGANISATIONS/GROUPS/INDIVIDUALS WHO MADE SUBMISSIONS TO THE REVIEW COMMITTEE

1. Adelaide Hospital, Peter Street, Dublin 8, Matron.
2. Adelaide Hospital, Peter Street, Dublin 8, School of Nursing.
3. Association of Administrative Psychiatric Nurses, c/o St Stephen's Hospital, Sarsfields Court, Glanmire, Co. Cork.
4. Association of Nurse Teachers.
5. Beaumont Hospital, Beaumont Road, Dublin 9, Senior Nurse Managers, Department of Nursing.
6. Beaumont Hospital, Beaumont Road, Dublin 9, Tutorial Staff, School of Nursing.
7. Beaumont Hospital, Beaumont Road, Dublin 9, Ward Sisters, Department of Nursing.
8. Bon Secours Hospital, College Road, Cork.
9. Mary Bradley, Nurse Tutor, Medical Missionaries of Mary.
10. Children's Hospital, Temple Street, Dublin 1, Nurse Teachers, School of Nursing.
11. City of Dublin Vocational Education Committee, College of Commerce, Rathmines Road, Dublin 6.
12. Comhairle na nOspidéal, Corrigan House, Dublin 2.
13. Coombe Women's Hospital, Dublin 8, Midwifery Tutors.
14. COPE Foundation, Bonnington, Montenotte, Cork.
15. Cregg House, Sligo, Management and Staff, Sisters of La Sagesse Services.
16. Daughters of Charity of St Vincent de Paul, St Vincent's Centre, Lisnagry, Co. Limerick, Administration Department.
17. Daughters of Charity of St Vincent de Paul, St Vincent's Centre, Lisnagry, Co. Limerick, School of Nursing.
18. Department of Health, Hawkins House, Dublin 2.
19. Eastern Health Board, Dr Steevens Hospital, Steevens Lane, Dublin 8.
20. Eastern Health Board, James Connolly Memorial Hospital, Blanchardstown, Dublin 15, Nurse Tutors.
21. Eastern Health Board, Nurse Education Management Committee.
22. Eastern Health Board, St Brendan's Hospital, Rathdown Road, Dublin 7, Nurse Education Centre.
23. Eastern Health Board, Superintendent Public Health Nurses.
24. Education Committee for the Tipperary S.R. Psychiatric Services, c/o St Luke's Hospital, Clonmel.
25. FÁS, Upper Baggot Street, Dublin 4.
26. Higher Education Authority
27. Holistic School of Reflexology.
28. Institute of Community Health Nursing, Royal City of Dublin Hospital, 18 Upper Baggot Street, Dublin 4.
29. International Missionary Training Hospital, Our Lady of Lourdes, Drogheda, Co. Louth, Tutorial Staff, Nurse Education Centre.
30. Irish Association of Critical Care Nurses, c/o Intensive Care Unit, Blackrock Clinic, Blackrock, Co. Dublin.
31. Irish Matrons' Association, c/o Our Lady's Hospital for Sick Children, Crumlin, Dublin 12.

*32. Irish Nurses' Organisation and the National Council of Nurses in Ireland, 11 Fitzwilliam Place, Dublin 2.
33. Irish Nursing Research Interest Group.
* 34. Mater Misericordiae Hospital, The Sisters of Mercy, Dublin 7, School of Nursing.
* 35. Meath Hospital, Heytesbury Street, Dublin 8, Director of Nursing and Teaching Staff.
36. Mid Western Health Board, Dooradoyle, Limerick, General Manager, General Hospital Programme and the Matron, Regional General Hospital.
37. Midland Health Board, Central Office, Arden Road, Tullamore, Co. Offaly.
38. Midland Health Board, Tullamore, Co. Offaly, Working Party on Nurse Training.
39. Midwifery Training Hospitals, Matrons and Principal, Midwifery Tutors.
40. National Children's Hospital, Harcourt Street, Dublin 2, Nursing School.
41. National Maternity Hospital, Holles Street, Dublin 2, Midwifery Tutors.
42. North Eastern Health Board, Kells, Co. Meath, Matrons of Hospitals.
43. North Western Health Board, Sligo General Hospital, The Mall, Sligo, Principal Nurse Tutor.
44. Nurse Managers Group and the Nurse Teachers Group (Mental Handicap Division), c/o Moore Abbey, Monasterevin, Co. Kildare.
* 45. Our Lady's Hospital for Sick Children, Crumlin, Dublin 12, Director of Nursing.
46. Portiuncula Hospital, Ballinasloe, Co. Galway, School of Nursing.
* 47. Psychiatric Nurses' Association of Ireland, Head Office, 2 Gardiner Place, Dublin 1.
48. Regional Hospital, Dooradoyle, Limerick, School of Nursing.
49. Rotunda Hospital, Dublin, Midwifery Staff.
*50. Rotunda Hospital, Dublin, School of Midwifery.
*51. SIPTU, Association of Nursing Officers.
* 52. SIPTU, Nursing Council.
53. Southern Health Board, College of Midwifery, Cork, Midwife Teachers.
* 54. Southern Health Board, Wilton Road, Cork.
55. Southern Health Board, Gouldshill House, Mallow, Co. Cork, North Cork Public Health Nurses.
56. Southern Health Board, the Regional Nurse Education Committee.
57. Southern Health Board, Representative Group of Public Health Nurses.
58. Southern Health Board, School of Psychiatric Nursing.
59. Southern Health Board, Superintendent Public Health Nurses.
60. St Anne's Training School, c/o Moore Abbey, Monasterevin, Co. Kildare, Matron and Principal Tutor.
61. St Brendan's Hospital, Rathdown Road, Dublin, Psychiatric Nurse Tutors Group, c/o Nurse Education Centre.
*62. St James's Hospital, James's Street, Dublin 8, School of Nursing.
63. St James's Hospital, Nursing Administration.
64. St John's Hospital, Limerick, Ward Sisters and Staff Nurses.
65. St Joseph's Hospital, Daughters of Charity, Clonsilla, Dublin 15, St Louise's School of Nursing.
66. St Mary's, Drumcar, Dunleer, Co. Louth, School of Nursing, Hospitaller Brothers of St John of God.
67. St Otteran's Psychiatric Hospital, Waterford.
* 68. St Patrick's Hospital, James's Street, Dublin 8, Nurse Education Centre.
69. St Patrick's Hospital, Fermoy, Co. Cork, Department of Nursing.

70. St Stephen's Hospital, Sarsfield Court, Glanmire, Cork, Education Committee.
* 71. St Vincents Hospital, Elm Park, Dublin 4, Director of Nursing.
* 72. St Vincents Hospital, Elm Park, Dublin 4, Teaching Staff, School of Nursing.
73. St Vincent's Psychiatric Hospital, Daughters of Charity, Convent Avenue, Richmond Road, Fairview, Dublin 3, School of Nursing.
74. Teaching Staff, Education Centre, Letterkenny.
75. Tralee General Hospital, Tralee, Co. Kerry, Director of Nursing, Department of Nursing.
* 76. University College Dublin, Earlsfort Terrace, Dublin 2, Department of Nursing Studies.
77. University College Hospital, Galway, Matron.
* 78. Waterford Regional Hospital, Dunmore Road, Waterford, Nurse Education Committee.
79. Waterford Regional Hospital, Dunmore Road, Waterford, Staff, School of Nursing.
* 80. Western Health Board, Merlin Park, Galway.

* Organisations who made two submissions to the review committee: once following the release of the Consultative Document and then again following the release of the draft recommendations of the review committee.

APPENDIX 7

HIGHER EDUCATION INSTITUTIONS IN IRELAND

Dublin City University (and St Patrick's College of Education, Dublin, which is linked with it)
National University of Ireland (NUI)*
National Council for Educational Awards (NCEA)**
University of Dublin, Trinity College
University of Limerick (and Mary Immaculate College of Education, Limerick, which is linked with it)

* National University of Ireland

- Constituent Colleges

University College Dublin
University College Cork
University College Galway

- Recognised Colleges

St Patrick's College, Maynooth
Royal College of Surgeons in Ireland
St Angela's College of Education for Home Economics, Sligo

** National Council for Educational Awards

The Council exercises its function in Regional Technical Colleges, Colleges of Technology and other public and private institutions designated under the NCEA Act 1979.

- Regional Technical Colleges (RTC)

Athlone RTC
Carlow RTC
Cork RTC
Dundalk RTC
Galway RTC
Letterkenny RTC
Limerick RTC
Sligo RTC
Tallaght RTC
Tralee RTC
Waterford RTC