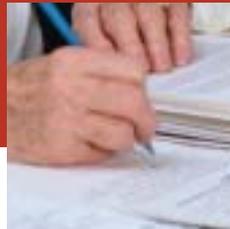


Looking into the Future – Maximising the Nursing Contribution to a Comprehensive Intellectual Disability Service



Nursing and Midwifery Planning and Development Unit



EASTERN REGIONAL HEALTH AUTHORITY
Údarás Réigiúnda Sláinte An Oirthir

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Foreword

This report sets out to identify what action is required to help secure the nursing contribution to the Intellectual Disability service within the Eastern Regional Health Authority area. This report has been developed in response to a call from practising Registered Mental Handicap Nurse practitioners and clinical nurse managers for a framework that draws together regional and local action required or underway, that will inform and develop clinical nursing practice, service development regionally and ultimately improve the quality of care for clients with an Intellectual Disability and their families.

The value underpinning this report reflects the importance of developing an integrated approach to the work of the multidisciplinary team. Although the report provides a direction for nursing it should be embraced and operationalised in the context of the multidisciplinary team, with increasing emphasis on the development of leadership in teams providing care.

It is generally accepted and experiential evidence indicates that people with an Intellectual Disability have a higher level of health need, as evidenced by morbidity rates, and that challenging behaviour and mental health problems are major barriers to community participation and inclusion. For this reason, this report will focus on these issues as an example of the need for specialist disability professionals and the growing recognition of the need for these professionals within the Irish health services.

It is envisaged that this report will give the direction required to ensure that the nursing workforce in Intellectual Disability services has the appropriate knowledge, skills, competencies and attitudes to meet the needs of individuals with an Intellectual Disability and their families regardless of where they are being cared for.

This report will help nursing leaders ensure that the nursing contribution of caring for individuals with an Intellectual Disability is maximised by providing effective and appropriate care and support to clients and relatives.

We would like to thank the Working Group who provided guidance, support and a wealth of information for the report. Particular thanks are extended to Eithne Cusack, Assistant Director, Nursing & Midwifery Planning & Development Unit, who chaired the Working Group and Aisling Culhane, Project Officer, Nursing & Midwifery Planning & Development Unit for their hard work, enthusiasm and professionalism and for producing the report.

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Terms of Reference

The working group was established in 2002. The terms of reference for the group were

- Establish the context in which mental handicap nursing is carried out within Intellectual Disability services in the ERHA area.
- Identify where nursing services can contribute and require further development in primary, secondary and tertiary bands of care.
- Advise on the development and planning of nursing education and training programmes.
- Identify the clinical pathways in mental handicap nursing to inform the development of clinical nurse specialists and advanced nurse practitioners within existing services in the Eastern Regional Health Authority.

Terminology

For the purpose of this report the term *mental handicap* is employed when referring to the nurse or the nursing function, as this is the term embodied in the Nurses Act (1985). The term *Intellectual Disability* is used where reference is made to services or specialist agencies, as this is the term recognised by the Department of Health and Children.

Outline of Report

The report consists of three sections;

Section one contains chapters 1,2,3. This section describes the background and context of this report and the identified areas of priority. In addition it outlines key principles associated with effective approaches to staffing levels, recruitment and retention, the unique knowledge of the mental handicap nurse and the development of a strategy to promote the distinct identity and unique working environment of mental handicap nursing. Chapter 3 highlights issues of professional development, inclusive of the contribution of the RMHN in primary, secondary and tertiary care.

Section two contains chapters 4 and 5. This section reviews and discusses key concepts relevant to continuing professional development. It examines an educational framework and guidelines for programme development of courses preparing nurses as CNSs and ANPs whilst also exploring professional leadership and practice development in Intellectual Disability services.

Section three is contained in chapter 6. Chapter 6 is a stand-alone section and addresses the essential components of the development of nursing specialities and promotional career pathways in Registered Mental Handicap Nursing. In addition it proposes options for clinical nurse specialisation and advanced nursing practice in Intellectual Disability healthcare, one framework which is outlined by the DOHC (2002a), the second as outlined by the working group. In addition this section discusses guidance in career planning and the contribution of research in mental handicap nursing.

Abbreviations

ABA	An Bord Altranais
ANP	Advanced Nurse Practitioner
APEL	Accredited Prior Experiential Learning
CE	Continuing Education
CNE	Centre for Nursing Education
CNS	Clinical Nurse Specialist
CPD	Continuing Professional Development
DOH	Department of Health
DOHC	Department of Health and Children
ERHA	Eastern Regional Health Authority
FETAC	Further Education & Training Award Council
HEI	Higher Education Institutes
HRB	Health Research Board
ID	Intellectual Disability
ICN	International Council of Nurses
MDT	Multi Disciplinary Team
NAMIC	Nurses & Midwives in the Community
NCNM	National Council Nursing & Midwifery
NIDD	National Intellectual Disability Database
NMPDU	Nursing/Midwifery Planning & Development Unit
NPDC	Nurse Practice Development Co-ordinators
PREP	Post Registration Education and Practice
RCN	Royal College of Nursing
RMHN	Registered Mental Handicap Nurse
UKCC	United Kingdom Central Council for Nursing and Midwifery and Health Visiting
WHO	World Health Organisation

Chapter 1.0

1.1 Background

The *Report of the Commission on Nursing: A Blueprint for the Future* (Government of Ireland, 1998) identified that the role of the Registered Mental Handicap Nurse (RMHN) be clearly defined in an increasingly diverse and complex service where Intellectual Disability services has evolved with greater emphasis on integration at school, work and in the community (Government of Ireland 1998: 10.3). The Report identified the need to promote the distinct identity and unique working environment of mental handicap nursing and highlighted “the crucial importance of mental handicap nurses to the service” (para 10.5).

The publication of the current Health Strategy – *Quality and Fairness A Health Strategy for You* (DOHC, 2001a) emphasises the importance of mainstreaming services for persons with disabilities and identified the key principles, which underpin policy to enable each “individual with a disability to achieve his/her full potential and maximum independence” (pg 141).

The Primary Care Strategy *Primary Care – A New Direction* (DOHC, 2001b, pg 15) expands on this approach of service delivery, which will have major implications for individuals and carers facing the challenges associated with an Intellectual Disability. “Primary care providers can make a significant difference not just in treating illness, but also in supporting people for themselves and their families, improving wellness, preventing illness and supporting those with long-term problems, from a health and social well being perspective”.

The *National Intellectual Disability Database Annual Report 2001* (Mulvaney, 2003) cited a total of 8,419 persons registered on the National Intellectual Disability Database (NIDD) in the ERHA region in April 2001. The changing and diverse demographic and epidemiological profile of this population has implications for both the management and delivery of services in the years ahead.

As part of a consultative process carried out by the Nurse/Midwifery Planning and Development Unit (NMPDU) in the Eastern Regional Health Authority, a working group representative of various Nursing Service providers was established to develop a report outlining how the nursing contribution in the

provision of a comprehensive Intellectual Disability service could be maximised. Three health boards and a large number of voluntary agencies provide services to individuals with an Intellectual Disability within the Eastern Regional Health Authority.

1.2 The Context

Intellectual disability services in the Eastern Regional Health Authority (ERHA) are provided through a variety of community and residential settings by a range of providers, including the three area health boards, voluntary agencies directly funded by the ERHA and agencies funded by the area health boards through grants. Partnership between the statutory and the voluntary bodies is a key aspect determining and influencing the development of services in the region.

The overall objective for Intellectual Disability services in this region is to uphold the rights of persons with Intellectual Disability to quality services which respect their dignity, which are provided in the least restrictive environment and promote the greatest possible inclusion of persons with an Intellectual Disability in society.

1.3 The National Intellectual Disability Database

The NIDD provides needs assessment of people with Intellectual Disability in the years 2001 – 2005. As of September 2002 there were 8,743 people registered on the National Intellectual Disability Database in the Eastern Regional Health Authority Region. Current Service Provision is a combination of day and residential programmes by in excess of 40 voluntary and statutory providers. These providers are backed up by a number of other agencies that provide services such as home help, support, day respite etc.

The information available from the NIDD provides an accurate basis for decision-making. Priorities can be set based on an objective evaluation of the needs of people with Intellectual Disability. Services that are sensitive/responsive to these needs can be planned and delivered. This system is being extended and updated on an on-going basis.

1.4 National Intellectual Disability Database, Current Service Provision for ERHA

Table 1.1 Day Service,
Eastern Regional Health Authority

Day Service Type	Number of Services Currently Being Availed Of (2002)
Home support	392
Early intervention services	350
Ordinary pre-school	65
Special pre-school	104
Child education and development centre	234
Ordinary school	132
Resource teacher	128
Special class – primary	230
Special class – secondary	33
Special school	1,384
Generic vocational training	123
Special vocational training	412
Activation centre	1,709
Programme for older people	179
Special high support day service	99
Special intensive day service	59
Sheltered work centre	1,505
Sheltered employment centre	63
Multidisciplinary support services	795
Centre-based day respite service	93
Other day service	125
Enclave within open employment	16
Supported employment	657
Open employment	43
Generic day services	31
Home help	3
Total	8,964

Source: National Intellectual Disability Database Ireland, 2002

A total of 84 service users have an identified future day service requirement and 3,319 service users currently receiving a day service are listed as requiring a changed or enhanced level of service.

Table 1.2 Residential Service,
Eastern Regional Health Authority

Residential Service Type	Number of Services Currently Being Availed Of (2002)
5-day Community group home	98
7-day (48-week) Community group home	258
7-day (52-week) Community group home	580
5-day Residential centre	64
7-day (48-week) Residential centre	302
7-day (52-week) Residential centre	990
Nursing home	16
Psychiatric hospital	265
Intensive placement (CB)	128
Intensive placement (profound/multiple disability)	97
Total	2,798

Source: National Intellectual Disability Database Ireland, 2002

A total of 588 service users have an identified future full-time residential service requirement and 997 service users currently receiving a residential service are listed as requiring a changed or enhanced level of service over the next five years.

Table 1.3 Part Time Residential/Respite Service,
Eastern Regional Health Authority

Part Time Residential/Respite Service Type	Number of Services Currently Being Availed Of (2002)
Crisis or planned or holiday respite	1,486
Occasional respite care with host family	22
Shared care or guardianship 5/7 days per week	1
Regular part time care – 2/3 days per week	36
Regular part time care – every weekend	0
Regular part time care – alternate weeks	3
Total	1,548

Source: National Intellectual Disability Database Ireland, 2002

A total of 606 service users are currently registered as waitlisted for a part-time residential service in the region and 537 of these service users are currently registered as waitlisted for crisis or planned respite.

The *National Intellectual Disability Database Annual Report 2000* (Mulvaney, 2001), describes a decrease in the numbers of children in the more severe categories of Intellectual Disability. However, those born in the later 1990s are presenting with more severe management difficulties with associated medical fragility and pervasive developmental disorders. There is an increase in the ageing population in the more severe range of Intellectual Disability. The database information indicates that there is also a significant demand for community-based placements and interventions and an increase in demand for intensive specialist therapeutic placements both in the community and in residential settings (pg 54 - 56).

Services and RMHNs must be prepared to respond to the future requirements and challenges whilst seeking to provide clarity on their contribution in the various and diverse locations of service delivery.

1.5 Defining Intellectual Disability

With regard to diagnostic criteria and classifications of Intellectual Disability the *Diagnostic and Statistical Manual of Mental Disorders, DSM IVTR Edition* (American Psychiatric Association, 2000) and the International Statistical Classification of Diseases and Related Health Problems, 10th Version. ICD –10 (World Health Organisation 1992), outline the following diagnostic features:

“The essential feature of mental retardation is significantly sub-average general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skills areas: communications, self care home living, social/interpersonal skills, use of community resources, self direction, functional academic skills, work, leisure, health and safety (Criterion B). The onset must occur before age 18 years (Criterion C). Mental retardation has many different etiologies and may be seen as a final common pathway that affects the functioning of the central nervous system.”

(American Psychiatric Association, 2000, pg 41)

The WHO (1992) ICD –10 defines mental retardation as:

“A condition of arrested or incomplete development of the mind which is especially characterised by impairment of skills manifested during the developmental period, skills which attribute to the overall level of intelligence, i.e. cognitive, language, motor and social abilities. Retardation can occur with or without any other mental or physical conditions.”

The Report *Needs and Abilities – a Policy for the Intellectually Disabled* (Government of Ireland 1991) refers to ambiguity surrounding the terminology used within this care group. It suggested descriptions such as “general learning difficulties” and “Intellectual Disability” (pg 14). The report acknowledged that any new term may be debased over time and a simple change of label in itself will not have a long lasting positive effect unless a concurrent attempt is made to change professional and public attitudes. It recommended that the term *mental handicap* should no longer be used. The term Intellectual Disability is the term recognised by the DOHC in Needs and Abilities (Government of Ireland, 1991).

For the purpose of this report the term *mental handicap* is employed when referring to the nurse or the nursing function, as this is the term used by the Nurses Act (1985).



1.6 Findings

The working group identified the following areas as priorities within the profession where continuing or further inputs are required.

- Registered Mental Handicap Nurse Qualification
- Staffing levels, recruitment and retention of nursing staff
- Skill mix, skills and competencies
- Role of the Registered Mental Handicap Nurse
- Scope of mental handicap nursing practice
- Service delivery and organisation structures
- Professional development
- Model of care
- Mental handicap nursing in the community
- Contribution of the RMHN to primary care
- Contribution of the RMHN to secondary and tertiary care
- Education and training
- Clinical supervision
- Professional leadership in Intellectual Disability nursing services
- Nursing practice development/practice development
- Clinical career pathways
- The development of specialisms in Intellectual Disability nursing
- Multidisciplinary teams
- Research and development

Chapter 2.0

2.1 Registered Mental Handicap Nurse Qualification

The Report of the Commission on Nursing (Government of Ireland, 1998) recommended that Mental Handicap Nursing remain a direct entry discipline with a four-year third-level institute-based degree programme (pg 80). The Commission was of the view that “there was a need to retain the distinct identity of the discipline to ensure the competence of nurses to work in these areas upon registration, particularly in the area of mental handicap”. Furthermore they also identified “retaining the distinct identity of mental handicap nursing was essential, in order to continue to attract student nurses to these crucial areas of the health service”.

The number of candidates applying for psychiatric and mental handicap nursing is smaller proportionally than those applying for general nursing. In 2002 the numbers applying for nursing were broken down as follows:

Table 2.1 Pre-Registration Student Nurse Uptake, ERHA

Year	Number of Student Places Available	Number of Student Places Filled On The Candidate Register
2002	90 Mental Handicap	45 Mental Handicap
	120 Psychiatric	78 Psychiatric
	430 General	369 General

Recruiting individuals to pre-registration programmes who have the desire to develop the skills needed to nurse an individual with an Intellectual Disability are crucial. It is increasingly important to demonstrate that mental handicap nursing is an attractive career choice, with clear pathways and opportunities for development, specialisation and career progression for those who want it.

2.2 The Unique Knowledge of the Mental Handicap Nurse

The RMHN attains a particular level of competence and attains a unique knowledge within a specialist area of clinical nursing practice on completion of the education programme for entry to the Register held by An Bord Altranais (Appendix 1 & 2). These domains, competencies and indicators are common to the various divisions of nursing, but the RMHN carries out his/her role and functions guided by a philosophy of care that is somewhat divergent from the other divisions. This philosophy, as explicated by An Bord Altranais, is that persons with a mental handicap/Intellectual Disability:

“...have the same rights and, in so far as possible, the same responsibilities as other members of society. They have a right and a need to live within the community like other people and they have a right to receive those services necessary to meet their specialised and changing needs. They should receive, if and when necessary, professional assistance and services which will allow recognition, development and expression of the individuality of each person.”

(An Bord Altranais, 2000, pg 30)

2.3 Marketing the Profession

The Report of the Commission on Nursing (Government of Ireland, 1998, para 10.5) considered there was a need to promote the distinct identity and unique working environment of mental handicap nursing and recommended the development of a strategy, to promote mental handicap nursing as a career.

Registered Mental Handicap Nurses are central to the provision of effective health service delivery to individuals with an Intellectual Disability. In order for services to employ Registered Mental Handicap Nurses with expertise in the skills required to meet the higher than average health, mental health, challenging behaviour and developmental needs of people with an Intellectual Disability, there is an identified challenge for service providers, higher education institutes and nursing to market the profession of mental handicap nursing.

Intellectual Disability Service Managers should have a clear vision of what nursing can contribute to these services and have a policy that establishes and maintains career pathways that attract and retain nursing staff committed to maintaining high professional standards. Intellectual Disability Services require a core group of professionals who are able to gain experience and thus enhance their ability to contribute in the delivery, planning and management of services.

The recruitment of student nurses to Mental Handicap Nursing is problematic. This working group was of the view that lack of opportunities for professional development within Registered Mental Handicap Nursing may contribute to an unfavourable perception of mental handicap nursing as a career.

Post-qualification travel and working as a Registered Mental Handicap Nurses within the EU with the exception of Great Britain for graduates, in this nursing speciality is restricted.

The need for services to provide leadership in this specialist area must be viewed in the light of increased options of third level courses for school leavers and a declining school leaver's population over the next decade, a perceived unattractiveness at pre-registration entry level to nursing and the consequences of this for the future. If staff currently working in this field are not the ambassadors for nursing, new entrants will fail to see its attractiveness.

The move to the degree qualification on registration will assist in improving the profile of mental handicap nursing in the long term.

Table 2.2 Number of Pre-Registered Mental Handicap Nurse places available and number of places filled on the Candidate Register over the past three years in the Eastern Regional Health Authority Region

Year	Number of Student Places Available	Number of Student Places Filled On The Candidate Register
2002	90	45
2001	90	50
2000	90	86

2.4 Staffing Levels, Recruitment and Retention

The human resource data within the ERHA region indicates that there is currently shortage of RMHNs within the Eastern Regional Health Authority. The recruitment of RMHNs within the Intellectual Disability services has presented great challenges to Service Providers within the Region.

Retaining RMHNs in Intellectual Disability services is essential and should demand as much attention and energy as the work involved in improving recruitment. Retention of staff relates directly to working conditions and opportunities for development. This is clearly demonstrated by the Magnet Hospital research (Gleason – Scott et al, 1999), which demonstrates that a professional practice with nurse managers that show responsive and visionary attributes improves retention and recruitment, and more importantly produces better patient outcomes (Aiken et al, 1994, Aiken et al, 2002). Buchan (1999) highlights a number of core magnet characteristics, which organisations must demonstrate in order to influence retention of staff:

- Participative management style/shared governance
- An emphasis on professional autonomy
- A nurse executive at board level
- A clinical career structure for nurses linked to a clinical ladder
- An emphasis on continuing education/in service training

The professional mix and skill mix along with the level of staffing required to care for individuals with an Intellectual Disability should be based on the client's identified needs and their level of dependency/functioning rather than determined by the number of clients within a service. It is recognised that there is a paucity of evidence to link the level of human resource, including staffing level or skill mix or professional input with client experience or client outcomes. Within the Eastern Regional Health Authority there exists a wide variation in the complexity of needs/services required by individuals with an Intellectual Disability. Individuals whose Intellectual Disability requires continuous or intermittent but regular observation, care and therapeutic interventions should have access to a Registered Mental Handicap Nurse who will provide the lead for appropriate nursing care and co-ordinate the treatment and care provided.

Registered Mental Handicap Nurses are central to providing effective expertise in the skills required to meet the higher than average health, mental health challenging behaviour and developmental needs of people with an Intellectual Disability. Service providers should put in place a policy that establishes and maintains career pathways to attract and retain staff committed to maintaining high professional standards.

Registered Mental Handicap Nurses also provide specialist advice and support to registered nurses who have not qualified in this specialist area of clinical nursing practice. Effective organisation and delivery of an Intellectual Disability service means that the right number of nurses with the right skills appropriate to the level of service is provided. Effective workforce planning, recruitment and retention and education and training are critical to ensuring that the nursing resource matches need.

Registered Mental Handicap Nurses are often in the frontline of assessing clients and alerting other members of the healthcare team with regards to the changing needs of the client. Early recognition of the potential and actual deterioration in a client's condition is essential, accompanied by an appropriate response for early intervention.

Registered Mental Handicap nurses provide supervision and support to care staff/health care assistants and untrained personnel within the care environment.

Personnel joining the Intellectual Disability services are coming from disciplines other than nursing. Many of these staff's experience and knowledge are related to social care systems. There is a perception by some nursing staff, that nurses are being replaced by personnel, trained and practising in social care. Whilst the working group acknowledges the valuable contribution made by social care staff, it is of the view that there is no substitution for the expertise of the qualified mental handicap nurse who must remain central to the assessment, planning, implementation and evaluation of client care and to the supervision and delegation of activities related to client care. The Australian experience states that the move away from employing staff with specialist training in the provision of services to clients with an Intellectual Disability and their replacement with a less experienced and/or an unqualified work force resulted in increased vulnerability for those individuals with more severe and complex needs such as medical problems or mental health problems (Davis et al, 2002).

2.5 Skill Mix Issues

Buchan et al (2001) defines skill mix as:

"The mix of posts in an establishment, the mix of employees in a post, the combination of skills available at a specific time or the combination of activities that comprise each role rather than the combination of different job titles".

The Royal College of Nursing (RCN, 1992a) provided the following definition.

"The balance between trained and untrained, qualified and unqualified and supervisory and operative staff within a service area, as well as between staff groups".

The Commission on Nursing (Government of Ireland, 1998: 7.63) recommended that the Department of Health and Children, health service employers and organisations explore the development of appropriate systems to determine nursing staffing levels. The Interim Report of the Commission on Nursing (DOHC, 1997a) illustrated the concerns of many nurses regarding the number of non-nursing tasks, which they were, required to perform. It was suggested that the performance of these tasks contributed to the under utilisation of the professional skills of nurses and the de-professionalisation of nursing. This report acknowledges that there is clearly support for researching the role and activities that RMHNS currently undertake. It is critical that a clear distinction is made between those activities that lie inside and outside the parameters of nursing.

An essential ingredient for the effective introduction of a variety of skills within organisations is a programme of planned preparation. The basis of the programme should be to provide nurses, along with other professionals with a clear understanding of the role of such individuals. These programmes should include management and leadership issues to equip the nurse with the knowledge, skills and attitudes required for delegation and supervision. To avoid potential role confusion such programmes must also focus on the distinction between the professional responsibility of the nurse and the role of the health care assistant. (*The Effective Utilisation of Professional Skills of Nurses and Midwives: Report of the Working Group*, Para. 3.5, DOHC, 2001c). This report acknowledges that some locations/organisations may need to review and clarify roles including that of the Registered Mental Handicap Nurse. The overall focus for Intellectual Disability services should be on developing effective multidisciplinary teams, reviewing the way in which care is organised, and developing strategies for achieving clinical/professional supervision. Providing leadership, advice, and coaching for nurses and other members of the clinical team who have not completed or undertaken specialist training or education in Intellectual Disability is also essential. Representatives of staff within organisations must be involved in developing role boundaries, reporting relationships, job descriptions and informing the content and delivery of training programmes for health care assistants.

The contribution to client care made by the Registered Mental Handicap Nurse should be optimised regardless of location i.e. residential centres, workshops, day activation centres, and child educational developmental centres. This may mean where appropriate the role is expanded to ensure that client care is delivered in a more comprehensive and appropriate way, and makes the best, most efficient use of the knowledge, attitudes, skills and competencies of all members of the multidisciplinary team.

The multidisciplinary team in Intellectual Disability services should be appropriately supported by administrative and ancillary services.

As different models of service provision evolve within organisations it is envisaged that the current model and profile of staffing will be evaluated to ensure the demands of the service location and the diversity of the role of the Registered Mental Handicap Nurse is responded to.

There is limited research or published evidence within mental handicap nursing in the Irish Health care service to inform services on the effective utilisation of nursing skills in Intellectual Disability services.

Effective human resource policies such as personal development planning and career planning are key mechanisms to enable a culture of learning and effectiveness to be established. Such policies also contribute to staff retention. Each Director of Nursing/ Services should establish workforce development plans to identify the number of nurses and level of competence required to deliver the nursing component of Intellectual Disability service within their organisation consistent with *The Nursing and Midwifery Resource Final Report of the Steering Group – Towards Workforce Planning* (DOHC, 2002b). Such a plan should include the effective utilisation of the skills of nurses and the skill mix required to ensure effective care to clients

Nursing Managers should be actively engaged in developing and agreeing local *Retention Action Plans* to maintain the nursing resource required to deliver a comprehensive Intellectual Disability service within their organisation.

Chapter 3.0

3.1 Role of Registered Mental Handicap Nurse

The Working Group established by the Department of Health in 1995, to review the role of the Mental Handicap Nurse provided the following definition of mental handicap nursing.

“Assisting the person with a mental handicap and their family to acquire and maintain the necessary skills that would enable the person with a mental handicap to lead a life that is normal as possible, given the person’s ability, and to do this in a skilful way in an environment that maintains the quality of life that would be acceptable to all persons”.

(Working Group on the Role of the Mental Handicap Nurse Department of Health and Children, 1997b, pg 9)

The Working Group considered the RMHN to be an essential and integral element of the multidisciplinary team required to deliver the services, which persons with a mental handicap require.

This report acknowledges that nurses who work with persons with an Intellectual Disability have:

“a diversity of roles, from intensive physical nursing of profoundly handicapped individuals to supportive guidance in the management and habilitation of children, adolescents and adults.”

(Report of the Working Group on the Role of the Mental Handicap Nurse, 1997b, pg 9)

The current policy which underpins the delivery of services to persons with a mental handicap is set out in the report of the Review Group on Mental Handicap Nurses – Needs and Abilities (Government of Ireland, 1991). That report set out sixty-one recommendations on the delivery of services to persons with a mental handicap. The philosophy underlying these recommendations was “the right of every person with an Intellectual Disability to as fulfilling and normal a life as possible”.

The role of the RMHN varies depending on the location of care. A major component of the role involves providing direct patient care often for long periods, with clients who may present with complex medical, mental health needs and/or with personal and social difficulties. The Working Group acknowledges that the Registered Mental Handicap Nurse requires flexibility, resilience and a very high level of commitment to provide an environment where new experiences and achievements are recognised, and where the client’s potential for responsibility and autonomy is developed at levels unique to each individual.

This Working Group acknowledges that the Registered Mental Handicap Nurse should also be a competent manager and develop his/her leadership, advocacy and management skills to enable the services to be provided in the most appropriate manner. Whether working in residential centres, workshops, day centres, community services, educational services, clinics or hospitals, the nurse has a central coordinating role in dealing with everyday living skills, health education, client and parent counselling, behavioural difficulties, unit management, home making, etc.

The Department of Health & Children commissioned a research report outlining a *Framework for the Development of Clinical Specialism and Advanced Practice in Mental Handicap Nursing in Mental Handicap Nursing* (DOHC, 2002a), this report acknowledges issues of role clarification for Registered Mental Handicap Nurses and states:

“The future mission of mental handicap nursing relates to the development of a workforce capable of meeting the needs of an increasingly diverse population in an ever-changing healthcare environment. Mental handicap nursing will always need to redefine and redesign itself to ensure that its practice is meeting the changing needs of individuals with Intellectual disability and their carers.”

(DOHC, 2002a)

3.2 Scope of Nursing Practice

In the Review of Scope of Practice for Nurses and Midwives (An Bord Altranais, 2000) the views of nurses and midwives were sought on their current role and scope of practice. As part of the study, nurses and midwives described nursing as a service with caring as its core function. The scope of nursing practice was recognised as 'varied and diverse', depending on client profile, location of care and the type of service in which the nurse works.

"The scope of nursing practice in Ireland is the range of roles, functions, responsibilities and activities, which a registered nurse is educated, competent and has authority to perform."

(An Bord Altranais, 2000)

This definition is derived from definitions offered by the World Health Organisation (WHO, 1996) and by the International Council of Nurses (ICN, 1987) as follows.

"Nursing promotes the active involvement of the individual and his or her family, friends, social group and community, as appropriate, in all aspects of health care, thus encouraging self-reliance and self-determination while promoting a healthy environment. Nursing is both an art and a science. It requires the understanding and application of specific knowledge and skills and it draws on knowledge and techniques derived from the humanities and the physical, social, medical and biological sciences."

(WHO, 1996)

"Within the total health care environment nurses share with other health professionals and those in other sectors of public service the function of planning, implementation and evaluation to ensure the adequacy of the health system."

(ICN, 1987)

Nurses described their current role as caring for clients across their lifespan, education and development of clients, families and the community, client advocacy, working within a multidisciplinary team, case management and management of resources. RMHNs have and continue to, enhance this partnership approach to care.

Nurses provide care, support, education and training in a variety of settings e.g. early intervention services, days and vocational training centres, residential and community services etc. They work with clients, families, carers and the local community, within a multi disciplinary team and they are responsible for the management of resources within their area of responsibility and carry out a significant amount of non-nursing duties. The scope of professional nursing practice within Intellectual Disability Services is poorly understood and requires clarification. Within Registered Mental Handicap Nursing exploration and facilitation is required to develop a greater understanding by nurses within the region.

The Working Group acknowledges the expertise required to meet the higher than average physical and mental health, challenging behaviour and developmental needs of people with an Intellectual Disability. In an environment where the needs of those who use Intellectual Disability services are becoming more complex, changes must be made to ensure greater access to generic services. This group recognises that the development of specialised and advanced practitioners are needed to lead that change.

Efficient and economic delivery of community-based services for people with an Intellectual Disability requires professionals that are skilled and experienced in the specific needs of people with an Intellectual Disability. The development of specialisation will contribute to a more comprehensive service development and will improve the quality of care and management of individuals presenting with behavioural difficulties, early development services, risk management, counselling etc.

The delivery of a nursing service to individuals with an Intellectual Disability is the holistic process of care for the client and nurses adapt and develop their skills in order to respond to the level of care needed by individual clients and their families at any time during their life, and in any location. It is a whole systems approach and encompasses the physical, psychological, spiritual, emotional and social aspects of care delivery. Registered Mental Handicap Nurses have a responsibility to take the lead on developing their scope of practice; lack of such professional leadership and clarity of their professional scope of practice can be evidenced by negative reaction and potential resistance to change. RMHNS must be supported in acknowledging self-accountability in this process.

3.3 Professional Development

Professional development has been described as including all the experiences, activities and processes that help develop an individual as a professional. This means it is a lifelong process of learning, both structured and informal (Oulton, 1997).

The WHO identified that education is key to the development of excellence in nursing practice. It supports innovative approaches to curriculum planning and teaching/learning methods so that nursing education programmes are based on the most recent assessment and forecasts of a country's health needs and of the nursing services required to meet them (WHO, 1996).

Benner (1984) suggested the importance of diverse approaches to skills acquisition. In order to support their scope of practice Registered Mental Handicap Nurses must embrace a variety of methods of professional development, both formal and informal. Methods that are both innovative and flexible should be encouraged and embraced in order that Registered Mental Handicap Nurses are enabled to prepare for practice. Strategies such as: reflection on practice, journal clubs, case-conferencing, clinical supervision, learning sets, preceptorship, workshops, distance learning, accessing and sourcing information support professional practice.

The Commission on Nursing (Government of Ireland, 1998: 6.11) identified a need to develop and strengthen the availability of professional development for all nurses and midwives. It considered professional development under the following headings:

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

Achievements such as practice based learning, interdisciplinary working allied to assessment of competence will further enable organisations/ services to build a firm basis for meeting the professional development needs of Registered Mental Handicap Nurses.

3.4 Model of Care

Nursing is intrinsically linked or associated with concepts of illness and the medical model of care. This may be due to the traditional institutional model of service delivery in the past and the dominance of medically based processes within the Irish healthcare service. Nowhere in the practice of nursing are the social and psychological facets of nursing practice more essential than in the area of Intellectual Disability.

The biopsychosocial model utilised by Registered Mental Handicap Nurses adopts the principles of normalisation, along with the social inclusion/developmental model as the basis for Intellectual Disability nursing provision. This model views the essential nature of Intellectual Disability as developmental encompassing care, education and training across the age continuum rather than an illness based approach, with the focus on families and communities as well as the individual with the Intellectual Disability. The bio-psycho-social model is a unique concept in the area of caring in nursing. It is a different and diverse model to those used by other nursing disciplines. It means utilising services and opportunities for interaction, which may assist clients to maintain or regain social ability and value in their own eyes and in the view of the general public. It acknowledges the “ordinary living principles” facilitating independence in each individual’s own care by increasing interaction in everyday activities, that is community, education, work and the development and maintenance of skills and encouraging self-esteem by facilitating choice, freedom of movement, respect and dignity, maintenance of age appropriateness through empowerment and self-advocacy.

Person-centred /personal outcomes planning is the process used to facilitate and enable the client act and discover from their own perspective what is important to them. Such approaches aim to design and deliver services and supports based on what is important to each client. This requirement is acknowledged in the draft National Standards for Disability Services currently being prepared by the Department of Health & Children and the National Disability Authority.

3.5 Nursing in the Community

Individuals with an Intellectual Disability have contact with health professionals in many health care settings. Nurses are often in the frontline of assessing clients and informing other members of the clinical team with regards to their needs and specific clinical presentations. This key skill of assessing the potential of individuals with an Intellectual Disability assists clients with the help of their families or carers to reach their full potential. Early intervention and recognition of the potential and actual problems associated with the clients condition is essential for fostering a partnership of care with families and significant others within the community. Carer support enhances care competence and reduces the need for intervention from health care professionals in the long term. Whilst it may not be possible to break complete links with services, nonetheless community case management and social support is acknowledged as a key role for the Registered Mental Handicap Nurse.

Community nursing is defined by the Royal College of Nursing as:

“Professional nursing directed towards communities or population groups as well as individuals living in the community. It includes assessment of the environment, social and personal factors which influence the health status of the targeted population. Its practice incorporated the ‘identification’ of groups and individuals within the community who require help in maintaining or achieving optimal health.”

(RCN, 1992b, pg 6)

Major factors, which influence the Registered Mental Handicap Nurses role in the community, are:

- The development of services for persons with an Intellectual Disability in the community setting
- The increased number of carers in the community who are looking after a family member with an Intellectual Disability
- The multidisciplinary nature of Intellectual Disability services and the need to develop ways to work across professional boundaries within the area of health, special education, social care etc.
- The contribution of nurses to health promotion activities
- Identification of organisational changes
- The integration of specialist services with generic services

The Primary Care Strategy A New Direction (DOHC, 2001b) has recommended that the approach and organisation of primary health care services will add further impetus to this development process.

3.6 The Potential Contribution of the RMHN to the Primary Care Team

The Health Strategy – *Quality and Fairness – A Health System for You* (DOHC, 2001a) is a new direction for primary care with a focus on a team-based approach providing 24hr services. This approach to care will link islands of service for individuals with an Intellectual Disability. It is both a philosophy of health care and an approach to providing health care services. Its basic elements are essential health care, socially acceptable and affordable methods of technology, accessibility, public participation and inter-professional collaboration.



The Primary Care Strategy – A New Direction (DOHC, 2001b, pg 15) defines primary care as:

“...an approach to care that includes a range of services designed to keep people well from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal, social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being.”

(DOHC, 2001b)

Currently the Department of Health & Children are involved in developing a strategy Nursing and Midwifery in the Community. This work presently under way will provide a plan for the integration of nursing and midwifery services within primary care. The potential contribution of the Registered Mental Handicap Nurse with other professionals in Primary Care is an important consideration in the future development of primary care teams. Such activities would include:

- Undertaking area profiling and participate in population needs assessment with communities and other relevant agencies.
- Advising other team members relating to their specialist knowledge and area of practice.
- Building links with other agencies, specialist services, carers, families, voluntary groups and other primary care team professionals and maintain up to date information on resources available.
- Leading collaboration with other professions to examine the health care needs of individuals with an Intellectual Disability within the catchment area.

- Formulating a health information system which will address and measure a planned process of continual improvement in areas of health screening, health surveillance and health promotion: In addition the formulation of a detailed register which will highlight multiple associated disabilities and a system for regular health checking.
- Liaising with respite services, family support services, residential and day facilities.
- Examining policies and strategies when assessing the ability of service users to consent for treatment.
- Ensuring that individuals with an Intellectual Disability have access to health education and promotion programmes.
- Providing information re specialist services.

* A diagrammatic representation of the issues relevant to the provision of primary health care for individuals with an Intellectual Disability is presented in Appendix 3.

3.7 Secondary & Tertiary Care

The Report of the Commission on Nursing (Government of Ireland, 1998: 10:2) identified the diverse range of services, which people with an Intellectual Disability require:

“Services for people with a mental handicap (also referred to as Intellectual Disability) evolved in recent years with a greater emphasis on integration at school, work and in the community. The mental handicap nurse works with all profound and multiple disabilities the age range includes an increasing population of senior citizens. A wide range of services, are provided such as:

- *Day care including assessments, early intervention services, pre-school, special education development.*
- *Residential and respite care, which is inclusive of community group houses and local centres; and*
- *Vocational training, sheltered and supported employment.”*

(Government of Ireland, 1998)

Secondary and tertiary care for individuals with an Intellectual Disability must compliment the model of primary care.

It is essential to have knowledgeable experienced and skilled specialist staff trained in the care and support of children and adults with Intellectual Disabilities across the life span of the individual with an Intellectual Disability. Registered Mental Handicap Nurses have a key role in interfacing with other nurses and professionals working in mental health, acute care, child health, education etc. The challenge is to harness the range of contrasting skills, talents and abilities of these groups and bring them together to improve the health of people with an Intellectual Disability.

A comprehensive knowledge and understanding of the health needs of people with Intellectual Disabilities is required as well as knowledge of the organisations, structures and systems where health care is provided. Individuals with Intellectual Disabilities need to access a range of health services from primary care to more specialised services in secondary and tertiary care, depending on their needs.

The Strategy for Equality, The Report of the Commission on the Status of People with Disabilities (Department of Justice, 1996) refers to the need for tertiary services provision:

“The needs of people with disability living in residential institutions tend to be seen sometimes only in terms of accommodation and shelter. Individual service, and support requirements for day activity, employment, leisure, therapy or other services – must have equal standing with the service needs of people with disabilities living in the community. Consequently, the commission proposes that the person with the disability in residential care should have appropriate access to the local disability support service and a personal support-coordinator.”

(Department of Justice, Equality and Law Reform, 1996, pg 269)

Effective risk management in primary secondary and tertiary care is a high priority in Intellectual Disability services and locations. Registered Mental Handicap Nurses provide a lead in highlighting the central principles of effective risk management practices. This includes the formulation of policies and protocols pertaining to risk management, clinical governance and quality of life issues such as relationships, sexuality etc.

3.8 Role Framework for Registered Mental Handicap Nurses in Primary, Secondary and Tertiary Care Services

The Working Group uses two frameworks to outline the role of the RMHN. One framework, Table 3.1, outlines the potential contribution of the Registered Mental Handicap Nurse using a lifespan/chronological approach across the locations of care. The second framework, Table 3.2, outlines the role of the RMHN based on the individual level of dependency adapted from Whoriskey & Brown’s (2002) *National review of the contribution of nurses to the care and support of people with learning disabilities*.



Table 3.1 Role framework for the Registered Mental Handicap Nurse in primary, secondary and tertiary care

Age Group	Primary Support	Secondary Care	Tertiary Care
0-5	Early intervention Communication Maternity liaison in home Home teaching Holistic assessments Developmental assessment & intervention Behaviour therapy Genetic counselling Neurological testing Nursing in the home/home support Professional advice & support in the domiciliary and community setting Play therapy Mental health Parentcraft sessions	Respite, crisis intervention & assessment Maternity liaison in maternity unit Preschools Mental health services	Full time residential care Palliative care supports Mental health services
5-11	Counselling Communication Health assessment & surveillance Behaviour therapy Holistic/specific assessments Dependency assessment Home teaching Mental health Parentcraft Developmental assessment	Respite, crisis intervention & assessment Schools, Child Development Education Centres Mental health services	Full time residential care Palliative care Mental health services
11-18	Counselling Communication Sexual health & reproduction, counselling, advice & education Behaviour therapy Vocational skills training Lifeskills training Health assessment & surveillance Numeracy & basic literacy Pattern/sign recognition Mental health Professional support & advice	Respite, crisis intervention & assessment Schools, Child Development Education Centres Mental health services	Full time residential care Palliative care Mental health services Forensic services

Table 3.1 Role framework for the Registered Mental Handicap Nurse in primary, secondary and tertiary care (continued)

Age Group	Primary Support	Secondary Care	Tertiary Care
18-35	Communication Employment support Family support Accommodation needs assessments Relationship, sexual health & reproduction counselling Behaviour therapy Health surveillance, education & promotion Parentcraft, parenting support Vocational training Supported employment Mental health Domiciliary palliative care Preparation for semi-independent living	Low, medium & high supported living Sheltered accommodation Respite, crisis intervention & assessment Maternity supports Mental health services	Forensic services Full time residential care Palliative care & support Mental health services
36-65	Communication Pre-retirement planning Health screening Bereavement counselling Palliative care supports Mental health issues Counselling Mobile dementia clinic/assessment	Supported living Respite crisis intervention & assessment Sheltered accommodation Mental health services	Alzheimer's disease/ Dementia care services Palliative care Full time residential care Mental health services
65+	Communication Assessment Retirement Health screening Counselling Bereavement supports Mobile dementia clinic/assessment Mental health/illness	Day activation/ retirement services Mental health services	Alzheimer's disease/ Dementia care services Palliative care Full time residential care Mental health services

Table 3.2 Framework For dependency of needs, modified from Whoriskey & Brown (2002)

Needs	Responses	Dependency Needs	RMHN Role	The Spectrum of Nursing Contributions
<p>For all people with Intellectual Disabilities to access Primary Care Health Services and Directly Accessed Health Services to promote the health and general well being of all people with Intellectual Disabilities in all settings</p>	<p>Information for planning Early Intervention Support for Primary Care to enable access to Intellectual Disability and every day health needs Screening for complex health needs Information on services and support. Long term support needs Increased involvement of people with Intellectual Disabilities Disability awareness Access to information and support Knowledge/information to specific services at local level Development of community networks, supports systems and inclusion opportunities</p>	<p>Primary Care and Directly Accessed Generic Services People in the community</p>	<ul style="list-style-type: none"> ■ Audit ■ Research ■ Practice development ■ Education and training across the lifespan ■ Clinical governance ■ Evidence based practice ■ Care and service planning, information and data collection ■ Evidence based commissioning of care ■ Policies for abuse and neglect ■ Clear and explicit referral pathways at all levels ■ Partnership working to promote inclusion ■ Quality and standards ■ Inspection and monitoring ■ Outcome measurement ■ Robust communication pathways ■ Robust referral pathways ■ Training and supporting staff 	<ul style="list-style-type: none"> ■ Undertake direct case work and case load management ■ Undertake nursing and health assessment ■ Participate in the identification of an individual's need ■ Act as an expert resource ■ Undertake the development of care planning ■ Provide direct clinical therapy ■ Provide direct clinical care ■ Participate in crisis intervention ■ Undertake the evaluation of care planning ■ Work directly with users and carers ■ Participate in multi-professional team working ■ Participate in service planning and development ■ Research ■ Education of clients ■ Partnership working with clients, carers and organisations ■ Knowledgeable resource ■ Identify needs in the local community ■ Provide disability awareness raising and education ■ Enable health improvement ■ Enable & promote social inclusion ■ Promote the use of generic services ■ Promote collaborative working ■ Participate in community developments ■ Promote health and safety ■ Enable access to services and care ■ Maintain an over view of health needs ■ Provide health promotion and health education and facilitation
<p>For people with Intellectual Disabilities to access secondary Intellectual Disability Services</p>	<p>Access to multi-professional teams with specialist skills and knowledge of health needs of people with Intellectual Disabilities Assessment, treatment and evaluation Planning for life transitions Robust referral pathways</p>	<p>Specialists Intellectual Disability services</p>		
<p>For people with Intellectual Disabilities to access specialist Intellectual Disability Services</p>	<p>Access to specialist knowledge and skills as available for the whole population Support for general specialists so the service is accessible Co-ordination and continuity of health care Effective assessment, treatment plans, monitoring of care Planning for life transitions Evaluation of outcomes</p>	<p>Specialists working in support of Primary Care</p>		
<p>For people with Intellectual Disabilities to access Area Wide and Regional Services</p>	<p>Area wide specialist assessment and treatment in-patient and in-reach services for complex needs Access to specialists in child development, mental health, challenging behaviour, forensic care, autism, dementia, palliative care and neurology etc.</p>	<p>Area and Regional Health Services</p>		

The level of dependency of the client will dictate the contribution of the Registered Mental Health Nurse within each band of care.

3.9 Framework for Dependency Levels – the Registered Mental Handicap Nurse's contribution

Table 3.3 Framework for dependency levels

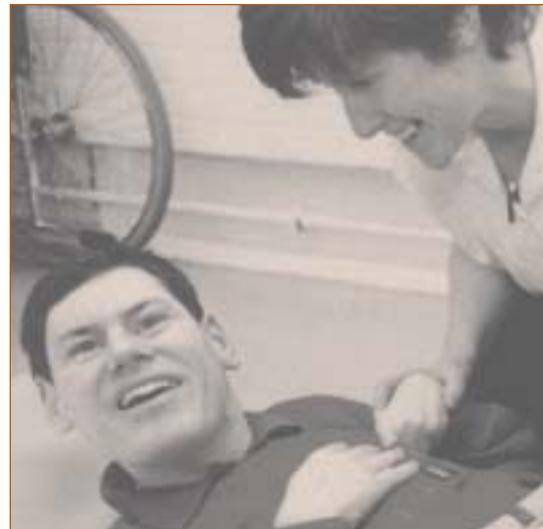
Level 1 – Primary care, community support and public awareness – The promotion of the general health and well being of all people with Intellectual Disability in all settings in the community. This includes public health and specialist nurses working with communities and local services to promote involvement and raise awareness. Access for all people with Intellectual Disabilities to Primary Care Services along with Directly Accessed Services such as community pharmacy, dental and optician services.

Level 2 – Health services accessed via primary care/other directly accessed health service – These services work in support of primary care services in meeting general and additional health needs by providing appropriate assessment, treatment and specialist advice if required. Such services include outpatient, domiciliary and in-patient services delivered from generic services. This includes palliative care.

Level 3 – Specialist Intellectual Disability health services – Focuses on specialist Intellectual Disability health/mental health/child health services. These services work to support primary care services and others by providing advice, assessment, interventions and treatments for complex specialist Intellectual Disability health needs. Specialist services provide advice and practical support on the health needs associated with Intellectual Disabilities, to people with Intellectual Disabilities, their families, to local authority or voluntary sector providers such as schools, day services and short break services.

Level 4 – Specialist regional and Intellectual Disability services – Consist of very specialist area and regional services. These services may include special assessment and treatment units or area wide specialist Additional Support Teams for individuals with complex and challenging needs or forensic services for people with Intellectual Disabilities. These may be residential as well as out-reach models.

See Appendix 4 for further elaboration.



Chapter 4.0

4.1 Continuing Education and Training

Definition:

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

(An Bord Altranais, 1994)

The capacity and capability of Intellectual Disability (ID) services to deliver a comprehensive service means that staff should have access to appropriate education and training to ensure that they have the appropriate level of skills and knowledge and are competent. Therefore there is a need to develop a learning culture where teams are constantly striving for clinical effectiveness.

Newly recruited/qualified staff need to have on-going education and training to enable them to maintain and further develop competencies in nursing persons with an Intellectual Disability. Access to competency based education and training should be made available to nurses. The competencies should link directly with identified service needs and the level of care required in each specific area.

Registered Mental Handicap Nurses must provide the lead for nursing care and co-ordinate the plan of care provided by the multi disciplinary team whilst also providing specialist support and advice to registered nurses, agency nurses and newly recruited nurses who have not completed this training.

There is a need for organisations to provide general induction programmes within specialist areas, in order to ensure that newly recruited staff nurses develop the core nursing skills required in Intellectual Disability services.

The need for ongoing training at a variety of levels was identified to support the qualified nurse in attaining the academic level required for acceptance on postgraduate nursing programmes. Such a programme pitched at a level between registration and higher diploma ensures that registered nurses interested in undertaking the higher diploma programmes will have sufficient academic preparation in nursing. The building of such a learning architecture within nursing will ultimately contribute to greater quality of care and service provision within Intellectual Disability services.

Investment in education, training and development should be focused on and integrated with improved service provision and enhanced client care. It is necessary to develop a strategy for training, development and education, which is rooted within a corporate wide strategic framework. The development of specialist (and generalist) educational programmes should be based on the competencies required to support the levels of care identified in different locations. In addition, to develop and maintain a culture of learning, there must be commitment from senior nurses and service managers in each organisation to utilise effectively the skills and abilities of staff within the service.

In the spirit of partnership, all key stakeholders should be engaged in programme development and design. The design of Higher/Postgraduate Diploma programmes should be flexible enough to allow for accessibility for all nurses, taking cognisance of geographical distribution of services and the particular needs of the target group of students. This includes opportunities for distance learning, modularisation and part/full-time participation where appropriate. Experienced and expert nurses should be involved in a consultative way to inform the curriculum and content of these programmes.

Evaluation of Higher/Postgraduate Diploma programmes should be carried out to include policies and procedures for student selection, service provider and service user satisfaction with graduate practice. It should respond to healthcare developments and Clinical Nurse/Midwife Specialist, Advanced Nurse/Midwife Practitioner standards.

Organisations need to facilitate the rotation of nurses into specialist areas of clinical practice. Rotation schemes facilitate for nurses to work for periods in other clinical areas and allow for greater exposure to the specialist areas of practice.

Interagency rotation within Intellectual Disability services facilitates benchmarking of standards and clinical guidelines and the sharing of best practice across the region.

All nursing staff should have preceptorship training to support student nurses, newly qualified/recently recruited nurses in the care clinical area.

4.2 Continuing Professional Development

At individual and organisational level continuous professional development should include:

- High quality training, which enables the development of the individual and their organisation within a supportive and constructive learning environment.
- Developing skills, knowledge and confidence to become more effective in advising all disciplines across inter-professional boundaries.
- Learning initiatives set within the wider context of learning for all professionals involved in delivery of care.
- Keeping skills current.
- A structured way of recording, updating and enhancing professional knowledge and skills by those who are already qualified.
- Continuing professional development that is underpinned by the concept of lifelong learning and workforce planning.

4.3 Organisational Requirements for the Professional Development of Staff:

- A training needs analysis (see appendix 5)
- Collaborate with Higher Education Institutes and centres for nurse education
- Encourage personal development planning and personal development reviews
- Provide facilities for mentoring, coaching and action learning programmes
- Develop a culture that values and supports evidence based practice
- Support and facilitate the introduction of clinical supervision in nursing
- Encourage reflective practice and change management
- Encourage problem solving in care teams and discussion groups
- Utilise shared learning in education/training

Improving access for nursing staff to current journals and electronic libraries is crucial. There is a requirement on organisations to facilitate nurses with time needed to access nursing and research literature for continuing education and professional development purposes.

The Higher Education Institute providing continuing post-registration and/or postgraduate nursing programmes in mental handicap nursing within the Eastern Regional Health Authority have established frameworks for these programmes. This framework includes modularisation, credit systems, assessment methods, entry requirements and a facility for accreditation of prior experiential and/or certified learning (APEL).

Criteria for the posts and post-holders of Clinical Nurse Specialist and Advanced Nurse Practitioner positions are laid down by the National Council for the Professional Development of Nursing and Midwifery (NCNM, 2001 a & b).

4.4 Postgraduate Nurse Education & Training

There currently exists a shortage of post-registration nursing programmes within mental handicap nursing in Ireland, and access to other specialist nursing programmes for Registered Mental Handicap Nurses is restricted in some Higher Education Institutes. This has an obvious impact on the professional development of nursing staff in Intellectual Disability services and ultimately patient care.

4.5 Post-Registration Programme Development

Under current legislation An Bord Altranais has responsibility for the accreditation of post-registration nursing education programmes. The accreditation of all postgraduate nursing programmes by Higher Education Institutes is essential to ensure that there is consistency in relation to the academic level of programmes along with standardisation of theory/clinical practice component of programmes to meet the CNS/ANP criteria. Structures should be developed in all Higher Education Institutes for the academic accreditation of prior learning and experiential learning of nurses.

4.6 Clinical Supervision

Butterworth and Fuggier (1994) describe clinical supervision as having three core functions namely:

- An educative or “formative” function which enables the development of skills, understanding and abilities by reflecting on and exploring the person’s work experience.
- A supportive or “restorative” function providing support to enable the person to deal with what has happened and move on.
- A managerial or “normative” function.

Clinical supervision has long been recognised and practised, as an integral part of professional development and as an essential element of practice development and support. The role and profile of clinical/professional supervision should be introduced, and an emphasis on clinical practice established to facilitate learning within clinical practice.

Services will gain a significant contribution through nurses engaging in a clinical supervision framework, which will maximise peer support for their practice, which in turn will enable the development of their scope of practice with optimum effect on quality of care and improve clinical effectiveness. By its supportive nature, clinical supervision facilitates reflective practice and thus creates an environment where learning from actual clinical experiences is nurtured.

It is however a relatively new concept in the Irish nursing context with many services yet to introduce clinical supervision into the nursing role. An Bord Altranais Review of Scope of Practice for Nursing and Midwifery, clearly identifies the importance of clinical supervision for the professional development and support of nurses in practice (An Bord Altranais 2000, 4.5.3).

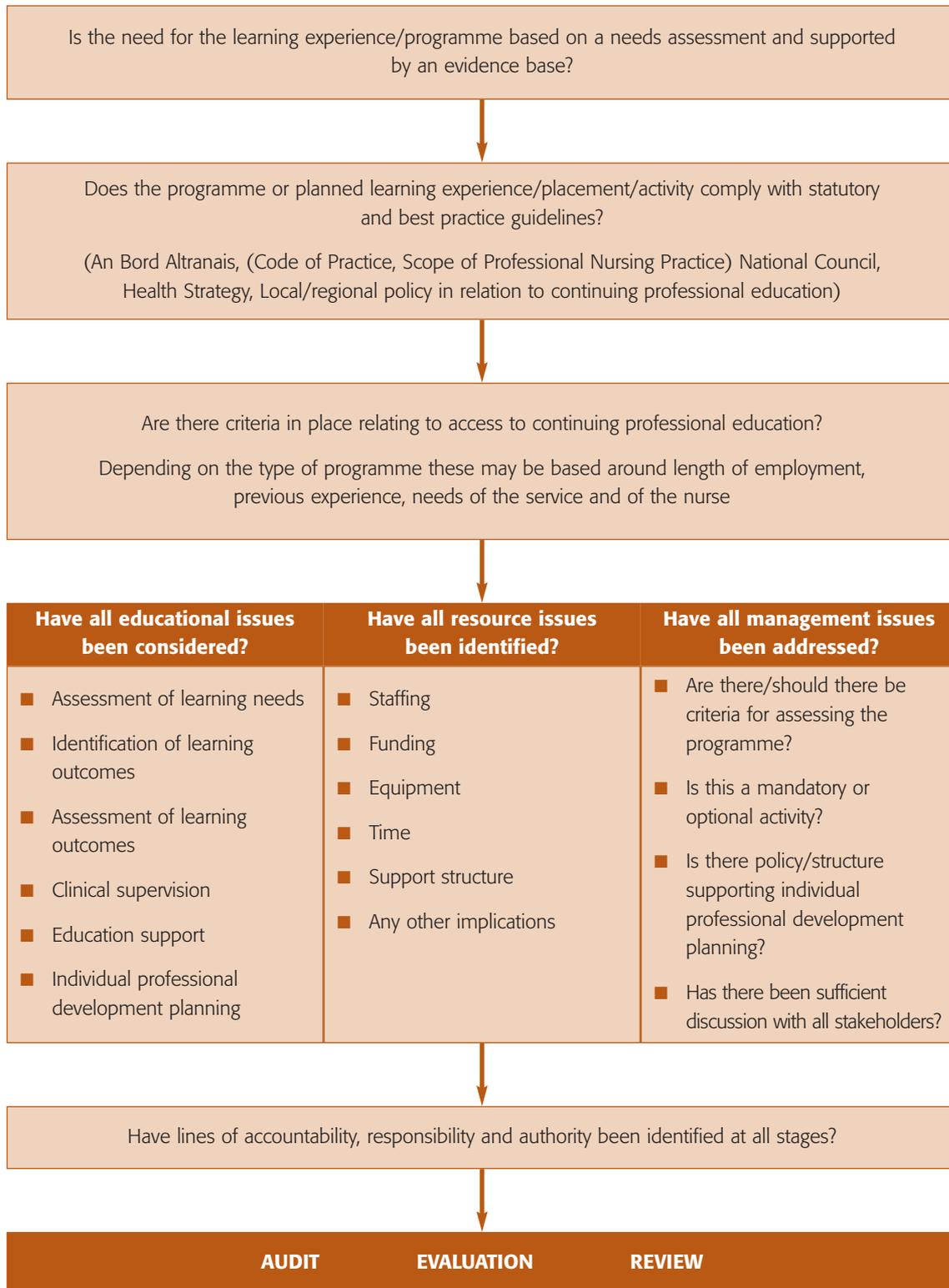
This working group outlined some actual and perceived difficulties encountered by services and nurses in accessing and participating in postgraduate training; Table 4.1 outlines briefly those issues pertaining to continuing education.



Table 4.1 Continuing education – issues, implications and actions

Issues Identified	Implications	Action/Recommendation	Rationale
Absence of data relating to profile of nursing workforce in Intellectual Disability services.	Inadequate data available to support workforce planning and related educational and training programmes	Implement workforce-planning recommendations utilising minimum data set and qualifications catalogue	To provide relevant, accurate and timely information to support planning and development activities relating to both workforce and service developments
Absence of a) Courses of relevance to RMHNs and other nurses in Intellectual Disability services b) Modules of relevance within existing courses of relevance to RMHNs and other nurses within Intellectual Disability services c) Access to existing programmes precluded by entry requirements. Barrier to role and practice development within mental handicap nursing	Barrier to role and practice development within mental handicap nursing. Restriction of career pathway progression of RMHNs impacting on retention of nurses	Education and training needs analysis addressing current and future needs of both service providers and nurses Link proposed developments of education/training programmes to areas identified for development of CNS and ANP development Provide evidence to third level institutions demonstrating identified needs and business case for programme development Request review of entry requirements to existing programmes to facilitate access by RMHNs	Promote practice development within Intellectual Disability services Facilitate development of clinical career pathways Promote retention of existing nurses within Intellectual Disability services Promote recruitment to Intellectual Disability services
Lack of replacement funding for staff undertaking continuing and further education and training	Difficulties in facilitating staff to attend programmes	Identify and plan strategies within local organisations to facilitate staff availing of DOHC funding and undertaking educational programmes	Promotion of practice development resulting in enhanced levels of service quality for clients Promotion of retention of existing staff and recruitment of new staff
Limited implementation of APEL system	Lack of flexibility resulting in an increased demand on services to facilitate staff attending off site programmes	Campaign for the introduction and implementation of APEL in all third level institutions Make system accessible to all nurses	Promote flexibility with regard to learning in the workplace Promotion of equity of access to CE through the recognition of previous learning and experience Promotion of retention of existing experienced nurses within Intellectual Disability services Examine the role of role of the CNE
Absence of career planning structures to support nurses	Inappropriate and inefficient utilisation of the nursing resource	Introduce a system of career self-management and career coaching throughout the Intellectual Disability services.	More effective linking of organisational objectives with personal and professional development objectives of nurses
Absence of nursing structures within Intellectual Disability services to support RMHNs in development of nursing practice	Isolation of nurses within services and failure of nursing services to engage in strategic development of role and function	Establish professional network to enable and facilitate RMHNs engaging in practice and role development across Intellectual Disability services within ERHA region with a view to an eventual national network	Promote identification and implementation of evidence-based practice Continue to identify and further enhance nursing contribution to care of people with an Intellectual Disability

Figure 4.1 Considerations when planning for continuing professional learning



Chapter 5.0

5.1 Professional Leadership

The impetus for health – care reform and the need to strengthen the overall quality and contribution of nursing, have highlighted the need for nursing leadership within nursing in Intellectual Disability services.

Intellectual disability services are required to provide high quality care in the current environment, where there is continual change, ageing population, demand for specialisation, increase in available technology, finite resources, increasing expectations of health care services and a strong litigation environment. It is essential that Registered Mental Handicap Nurse's are adequately prepared and accountable for leading, planning, implementing and assuring quality services in a multidisciplinary therapeutic alliance, setting out the co-requirements to develop the case management and teaching and training of support staff.

Effective nursing leadership is essential to providing high quality nursing care services. Staff morale and motivation, retention and recruitment, professional development, quality improvements, service efficiency and effectiveness depend significantly on the style and quality of nursing leadership at the frontline.

Leadership and effective human resource policies including individual performance review and personal development planning are key mechanisms that enable a culture of learning and effectiveness to be established.

Mental Handicap Nursing is intrinsically linked in many people's minds with the medical model of care and concepts of illness. The requirement of RMHNs in their practice to lead the professional development necessary to maximise the social aspects of their professional role is critical. The role confusion and lack of professional leadership in some Intellectual Disability services articulated throughout this process leads to a re-enforcement of these perceptions.

“Clinical leadership analysis is the most poorly developed, reflecting perhaps a lack of investment in clinical practice and the lack of recognisable clinical leaders”.

(Antrobus & Kitson, 1999, pg 45)

There is an acknowledgement amongst nurses that greater clarity is required for managers/discipline leaders relating to what nursing in Intellectual Disability services is about and the need for clinical leadership in nursing if nursing is to remain in these contexts in the future.

Mental Handicap Nurse leaders propose that a comprehensive approach to leadership development is employed. Leadership programmes will develop the skills and competencies required for systems working, redesign and change management and fitness for leadership purpose.

A common multidisciplinary leadership programme should be piloted within the ERHA region to enable clinicians to access a leadership programme, alongside components that recognise the contribution of nursing to the leadership of Intellectual Disabilities services.

Leadership approaches must be consolidated by practice based learning and supervision. If nursing practice is to be enhanced, then investment must be made in the preparation of individual leaders in nursing. Preparation of future RMHN leaders must include equipping individuals to access evidence, formulate solutions and evaluate their effectiveness. This is necessary in a climate where clinical leaders must be able to defend and articulate their actions and with increased emphasis on professional autonomy and accountability.

It is essential that Mental Handicap nurses access and contribute at both national and regional levels. Registered Mental Handicap Nurses need to be able to develop nursing networks to ensure that important issues are identified, raised and addressed. The Nursing/Midwifery Planning & Development Units have developed databases of Intellectual Disability services including Clinical Nurse Specialist and Advanced Nurse Practitioner posts established. Such a network could advise and support those contributing at a local, regional and national level and influence policy development.

5.2 Practice Development

Definitions

“Professional and practice development is a continuous process despite being inextricably linked the two areas are distinct: the former is concerned with knowledge, skills and values and the latter with how these are used to provide good quality patient focused care.”

Mallet, Cathmoir, Hughes, and Whitby (1997)

“Practice development is a continuous process of improvement towards increased effectiveness in person-centred care, through the enabling of nurses and health care teams to transform the culture and context of care. It is enabled and supported by facilitators committed to a systematic, rigorous and continuous process of emancipatory change.”

McCormack, Manley, Titchen, Harvey, G (1999)

It is sometimes difficult for nurses and for others to identify specifically what nurses in Intellectual Disability services do, and to set a value on the RMHNs contribution to the health, education and social gain of clients. During the work of this group RMHNs expressed a sense of feeling undervalued within Intellectual Disability services. Lack of nursing leadership and structures were identified as contributing to this.

The role confusion and lack of clear definition within the Intellectual Disability nursing service points to a major need to support and drive the professional development process within this division of nursing. All nurses have a clinical, educational and management role within their practice. The professional code of conduct for nurses requires commitment to these principles by all registered nurses regardless of their location of practice.

The Report on The Nurse Management Competencies Office for Health Management, (Rush et al, 2000) identifies eight generic competencies for modern nursing management:

- Promotion of evidence based decision-making
- Building and maintaining relationships
- Communication and influencing skills
- Service initiation and innovation
- Resilience and composure
- Integrity and ethical stance
- Sustained personal commitment
- Professional competence and credibility

While these competencies are those relating to nurse managers they are not the exclusive domains of nurse managers. These competencies can be applicable to all professionals.

Practice Development combines clinical experience, relevant literature, evidence based practice, innovation in practice and continuing quality improvement and change management. Implementing practice development is an organisational challenge rather than an individual issue. Strategies for implementation require careful planning and need to comprise a range of interventions including components of education, audit and management of change.

The working group considered the key attributes and characteristics conducive to practice development in Intellectual Disability services:

- Holistic practical knowledge – incorporating ideas of intuitive knowledge and learning from experience. RMHNs possess a unique insight into relationships with their client group and working environment.
- Knowing the client – gained through committed relationship building and interpersonal/communication skills.
- Practical reasoning with skilled know how – the focus of knowledge mobilised to perform best practice in Intellectual Disability services.

Practice development at unit/team level, focuses on a collaborative approach and the effectiveness of the team. It must be complemented at organisational level by practice development co-ordination and the development of practice support groups. The post of the Nurse Practice Development Co-ordinator (NPDC) may be shared between a number of service providers initially as organisations foster and promote a culture of practice development.

The working group identified key essential organisational strategies necessary as pre-requisites to practice development.

- A forum for shared ideas on developing practice across the service and services.
- Cross-fertilisation of good practices through collaboration with a group of Intellectual Disability service providers perhaps within Area Board regions.
- Particular projects in one service may support development in practice to improve patient care and service provision by sharing these developments with other organisations.
- An inter-professional team approach at regional level to enable policy and practice development is recommended.
- The group highlighted that many of the nurses working in the services who nurse clients with complex needs have identified a critical need to access evidence based information relating to best practice. RMHNs have also articulated the identified service and professional need to develop evidence based practice in other areas relating to the care of people with specific or specialist needs in Intellectual Disabilities services for example in habilitation, early intervention, palliative care, autism, behaviour management, etc.
- The development/implementation of a professional network structure/approach would contribute to shared standards, assure quality practice outcomes, develop case management and influence broader policy and educational development in practice.

5.3 Strategies for Implementation

Access to information electronically is essential if nurses are to develop evidence-based practice.

Care is planned and organised to meet individual needs and authority is devolved to individual nurses to take responsibility for their own caseload.

RMHNs recognise that changing practices and attitudes requires a comprehensive long-term change strategy. Creative and questioning practice demands the production of creative and questioning practitioners.

This development of practice challenges not just the status quo of nursing practice but the values and attitudes of nurses themselves and the organisational culture within which they practice. Practice Development is a continuous process of change and review.



Chapter 6.0

6.1 The Development of Nursing Specialisms and Promotional Career Pathways in Registered Mental Handicap Nurses

The Commission on Nursing recognised that Registered Mental Handicap Nurses require particular skills and personal qualities distinct from those in other divisions of nursing. The Commission considered

“...that there was a need to promote the distinct identity and unique working environment of mental handicap nursing and recommended that the board develop a strategy, in consultation with nurse educators, mental handicap nurses and service providers, to promote mental handicap nursing as a career.”

Report of The Commission on Nursing
(Government of Ireland, 1998, para 10.5)

In addition the Commission on Nursing was of the view that career pathway opportunities should be open to nurses and midwives who wish to remain in clinical practice rather than following a management or education pathway. It recommended the establishment of a multi – stage pathway for clinical nursing and midwifery and in particular, recommended a three step clinical path in nursing and midwifery as follows:

- Registered nurse/midwife
- Clinical nurse or midwife specialist (CNS/CMS) – equivalent to ward sister level: and
- Advanced nurse or midwife practitioner (ANP/AMP) – equivalent to middle nursing and midwifery management level.

It recommended that the clinical pathway be organised around seven broad bands of nursing and midwifery. As set out below:

- High dependency nursing
- Rehabilitation and habilitation nursing
- Medical/Surgical nursing
- Maternal and child health nursing
- Community health nursing
- Mental health nursing
- Disability nursing

The development of CNS/CMS and ANP/AMP posts as outlined by the Commission (Government of Ireland, 1998) provides an alternative career pathway for those nurses who wish to remain in clinical practice. A framework of core concepts of the role of the clinical nurse specialist is provided by the National Council (NCNM, 2001a).

6.2 Development of Clinical Nurse/ Midwife Specialist Posts

The National Council for the Professional Development of Nursing and Midwifery was established as a result of a recommendation in the Report of the Commission on Nursing. The report identified that:

“urgent need to give guidance and direction in relation to the development of specialist nursing and midwifery posts and post-registration professional educational programmes offered to nurses and midwives”.

(Government of Ireland, 1998: 6.12)

Table 6.1 Core concepts of the role of Clinical Nurse Specialist

- **Clinical Focus:** The role of CNS/CMS must have a strong patient focus whereby the specialty defines itself as nursing and subscribes to the overall purpose, functions and ethical standards of nursing (ICN, 1992). The clinical practice role may be divided into two categories direct and indirect care (Markham, 1988; Kersley, 1992). Direct care comprises the assessment, planning, delivery and evaluation of care to patients and their families, indirect care relates to activities that influence others in their provision of direct care.
- **Patient Advocate:** The CNS/CMS role involves communication, negotiation and representation of the client/patient values and decisions in collaboration with other professionals and community resource providers.
- **Education and Training:** The CNS/CMS remit for education and training consists of structured and impromptu educational opportunities to facilitate staff development and patient education (McCaffrey, Boyle, 1996). Each CNS is responsible for his/her continuing education through formal and informal educational opportunities thus ensuring continued clinical credibility amongst nursing, medical and paramedical colleagues.
- **Audit & Research:** Audit of current nursing practice and evaluation of improvements in the quality of patient care are essential. The CNS/CMS must keep up to date with current relevant research to ensure evidence-based practice and research utilisation. The CNS/CMS must contribute to nursing research, which is relevant to his/her particular area of practice.
- **Consultant:** Inter- and intra-disciplinary consultations both internal and external are recognised as part of the contribution of the clinical nurse specialist of the promotion of improved patient management.

The Commission on Nursing identified the need within nursing for order and a coherent approach to the progression of specialisation and the development of a clinical career pathway for nursing and midwifery (Government of Ireland, 1998: 6.24).

6.3 The Nursing Policy Division – DOHC Proposed Framework for Clinical Nurse Specialism in Mental Handicap Nursing

The Nursing Policy Division in the Department of Health & Children have published a report outlining a *Framework for the Development of Clinical Specialism and Advanced Practice in Mental Handicap Nursing* (2002a) This report researched the views of RMHNS on the future development of clinical specialisms, and advanced practice in mental handicap nursing and investigated education programmes for mental handicap nurses in Ireland.

This report recommends potential areas for the development of clinical specialisms and advanced practitioners within Intellectual Disability services.

The following are three possible frameworks developed by the Nursing Policy Division in the Department of Health & Children within which clinical specialism in Intellectual Disability could be developed. These are offered to promote discussion and should not be interpreted as definitive options.

Problem Oriented Specialism

The traditional model of clinical nurse specialism as adopted in Australia and in United Kingdom has its origins in the nursing management of patient problems. Within this framework nurse acquire and innovate specialist-nursing competencies derived from client problems, needs and/or body parts. The following clinical nurse specialisms are examples of the application of such a framework within the context of Intellectual Disabilities:

- Dual diagnosis
- Challenging behaviour
- Sensory development
- Creative, diversional and recreational therapeutics
- Behaviour therapy

Lifespan Specialism

This perspective has its origins in an age appropriate approach to the social roles and events, which construct the lifespan of individuals with Intellectual Disability. It is person-focused and acknowledges how the individual's life is embedded in social relationships with others, including carers and nurses.

Another principle underpinning this framework is that agencies and other personnel have a responsibility to promote personal choice for the person in the options that construct their lifespan. The following clinical nurse specialisms are examples of the application of such a framework within the context of Intellectual Disabilities:

- The child
- The adolescent
- The adult
- The older person

Negotiated Specialism

A framework could also be developed through a consultative process with service users, families, and nurses working in the area of Intellectual Disability, agencies and other key stakeholders.

The areas of practice identified in the report *Framework for the Development of Clinical Specialism and Handicap Nursing*, Department of Health and Children (2002a), propose the following themes:

Clinical Nurse Specialists – Proposed Roles:

- Sensory development
- Management of behaviour
- Multiple/complex disabilities
- Assistive technology
- Health promotion
- Respite care, crisis intervention and assessment
- Training and employment
- Community nurses
- Palliative care
- Social role valourisation and activation
- Mental health and Intellectual Disability (dual diagnosis)
- Communication speech and language development
- Developmental education and play therapy

6.4 Areas of Practice in Mental Handicap Nursing for Clinical Career Pathways as identified by the Working Group in the ERHA

The Working Group highlighted the potential benefits of specialisation in mental handicap nursing for clients within their services. The value and contribution of specialist roles to client care should not be underestimated. CNSs are ideally positioned to provide services to clients, carers and their families. Clinical Nurse Specialists are strategically positioned to proactively respond to client need and to develop specific care options and treatment interventions to clients with an Intellectual Disability. The development of specialisation is a priority within the Intellectual Disability services in the ERHA. The demand for these specialist services requires the development of specialist and advanced nurse practitioners with extensive clinical experience and appropriate academic qualifications. These specialist posts will expand and develop nursing practice in the area of Intellectual Disability and will contribute significantly to the development of a diverse range of treatment options and specific interventions which will improve the quality of life for the client, carer and family.

In the course of their deliberations the working group identified the following as areas where service need dictates the development of clinical nurse specialisms as a priority within the ERHA region. These areas of priority were categorised under the following headings:

1. Care Groups

The working group identified that within Intellectual Disability services there are individuals with similar and specific needs. The development and expansion of clinical practice through nursing posts will provide a more responsive and therapeutic approach to the needs of these specific care groups at local and regional level. Examples of these posts will include: dementia related care, autism, early intervention, Down syndrome, dual diagnosis, challenging behaviour etc.

2. Location of Service

The Health Strategy – *Quality & fairness A Health System For You* (DOHC, 2001a) aims to “gear the health system to respond appropriately and adequately to the needs of individuals and families” and that individuals with an Intellectual Disability receive the “right care in the right place at the right time”. Within this context the development and provision of specialisms and advanced nurse practitioners will provide a more comprehensive and specialised services to clients in primary, secondary and tertiary care. Examples of these posts will include: Primary Secondary and Tertiary care, community services, liaison services, rehabilitation, palliative care, respite care, crisis intervention and assessment, specialist educational services etc.

3. Lifespan Approach

The working group agreed with the approach recommended in the Department of Health & Children report outlining a *Framework for the Development of Clinical Specialism and Advanced Practice in Mental Handicap Nursing* (DOHC, 2002a) This outlines an age appropriate approach to the social roles and events, which construct the lifespan of individuals with an Intellectual Disability. It has regard for the diversity of service users and the particular needs of certain age groups. If the system is to be responsive to the needs of individuals, it is important that a holistic approach is taken in service planning with the identified advantages that specialist and advanced practice bring. Examples of these posts will include: early interventional services, developmental and vocational educational services, adolescent, adult, and the aged.

4. Treatment Approaches

Registered Mental Handicap Nurses can advance their practice within specific therapeutic approaches: Examples of these include cognitive behaviour therapy, family therapy, play therapy, etc.

Table 6.2 Areas of practice within mental handicap nursing recommended as the basis for specialist practice by the ERHA working group

- Early Development/Intervention Services
- Acute Hospital/Maternity Hospital Liaison
- Primary Care
- Autistic Spectrum Disorder
- Community Nursing
- Challenging Behaviour/Management of Behaviours that challenge
- Dementia Related Care
- Dual Diagnosis – Mental Health and Intellectual Disability
- Intellectual Disabilities with Physical/ Neurological Deficits
- Psychotherapy
- Palliative Care
- Rehabilitation
- Health Promotion
- Advocacy
- Communication & Assistive Technology
- Social Role Valorisation
- Alternative Therapies

The development of the clinical focus of the role of the nurse in a specific area of practice along with the integration of nursing research and audit in Intellectual Disability services and the provision of a clinical career pathway framework will assist in providing the leadership and direction required in Intellectual Disability Services, significantly increasing treatment options and quality of care.

Appendix 6 outlines examples of areas of practice where Clinical Nurse Specialist Posts in Intellectual Disability Services have been validated within the Eastern Regional Health Authority.

6.5 Advanced Nurse Practitioners

Advanced practice in nursing and midwifery has developed nationally and internationally. The National Council (2001b) has developed the definition of the Advanced Nurse Practitioner:

“Advanced nursing and midwifery practice is carried out by autonomous, experienced practitioners who are competent, accountable and responsible for their own practice.

They are highly experienced in clinical practice and are educated to masters’ degree level (or higher). The postgraduate programme must be in nursing/midwifery or an area, which is highly relevant to the specialist field of practice (educational preparation must include substantial clinical modular component(s) pertaining to the relevant area of specialist practice).”

(National Council, 2001b)

Advanced Nurse Practitioners promote wellness, offer healthcare interventions and advocate healthy lifestyle choices for patients/clients, their families and carers in a wide variety of settings in collaboration with other healthcare professionals, according to agreed scope of practice guidelines. They utilise sophisticated clinical nursing/midwifery knowledge and critical thinking skills to independently provide optimum patient/client care through caseload management of acute and/or chronic illness. Advanced nursing practice is grounded in the theory and practice of nursing/midwifery and incorporates nursing/midwifery and other related research, management and leadership theories and skills in order to encourage a collegiate, multidisciplinary approach to quality patient/client care. Advanced Nurse Practitioner roles are developed in response to patient/client need and healthcare service requirements at local and regional level.

Directors of Nursing/Services must have a vision of areas of nursing practice that can be developed beyond the current scope of nursing practice and a commitment to the development of these posts in response to population need.

The core concepts of the ANP role as defined by the National Council for the Professional Development of Nursing and Midwifery (May 2001) are as follows:

- Autonomy in Clinical Practice
- Pioneering Professional and Clinical Leadership
- Expert Practitioners
- Researcher

This working group supports a partnership approach between Intellectual Disability organisations within this region to support the development of the clinical promotional pathway in mental handicap nursing in certain areas of practice. The necessary operational relationships between Intellectual Disability Services need to be fostered and procedures developed in order to facilitate the introduction of Clinical Nurse Specialists and Advanced Nurse Practitioner posts within the region if necessary.

ANP posts require a detailed analysis of local and regional service and population needs within the Eastern region. The establishment of CNS and ANP posts should be based on the identified needs within the Intellectual Disability population.

Registered Mental Handicap Nurses with extensive expertise and clinical experience must be encouraged by senior nurse management to pursue and equip themselves with the necessary educational qualifications set down by the National Council (2001a&b). In addition all senior nurse managers must be familiar with the roles and the process for the establishment of CNS/ANP posts. These posts should be identified and submitted by Directors of Nursing/ Services in the provider plan within their organisation. Senior nurses play a crucial role in supporting, facilitating and developing the implementation of CNS/ANP posts by working in partnership with local administrative and multi-disciplinary structures to enable this process to occur in their organisations.

6.6 The Nursing Policy Division – DOHC Proposed Framework for the Development of Advanced Practice in Mental Handicap Nursing

This report considered that a lifespan approach should be taken into consideration in the development of the role of the Advanced Nurse Practitioner in Intellectual Disability.

Table 6.3 A framework for the development of advanced practice in mental handicap nursing DOHC (2002a)

Care of the Child

This report recommended that in certain instances care of the child with an Intellectual Disability warranted the knowledge and skills of a nurse working at an advanced or consultant level as articulated in the definition in the core concepts proposed by the National Council (2001b).

Care of the Adolescent

This report recommended that a nurse working at an advanced level in this area would possess a discrete body of requisite knowledge and skills that differ from the proposed Advanced Nurse Practitioner for the child.

Care of the Adult

The report also recommended that an Advanced Nurse Practitioner for the adult, could act as a consultant for issues related to employment, health related difficulties, development of relationships, sexual health and reproduction and make referrals onto the Clinical Nurse Specialist as appropriate.

Care of the Older Person

This report also recommended that in certain instances mental handicap nurses were currently working at an advanced level of practice when dealing with the older population. Given increased longevity being experienced by this population together with the complexity of issues starting to emerge it was agreed that the development of Advanced Nurse Practitioner could substantially contribute to responsive service delivery.

6.7 Areas of Practice within Mental Handicap Nursing recommended for Advanced Practice in ERHA Services by the Working Group

The Report of The Commission on Nursing (Government of Ireland, 1998) outlined distinguishing features between the CNS/CMS and ANP/AMP in the level of educational preparation, independence in practice, autonomy in clinical treatments, level of research involvement and role in the education of future CNS/CMSs and ANP/AMPs.

The development of advanced nurse practitioners in Intellectual Disability services will expand the scope of nursing practice of Registered Mental Handicap nurses in response to service need and demand. The various contexts in which mental handicap nurses' work may influence the role of advanced nurse practitioners and its development in mental handicap nursing.

The Working Group expressed the potential positive outcomes of the introduction of advanced practice nursing in Intellectual Disability services for:

- The clients,
- Nursing practice, and
- The profession of nursing.

A framework devised for the development of the Advanced Nurse Practitioner in Psychiatric Nursing (Cusack, 2001) was considered by the Working Group for the development of ANP posts within Intellectual Disability services. This framework recommended that advanced practice could develop in the following ways:

1. Care Groups

The working group identified that within Intellectual Disability services there are individuals with similar and specific needs. The development and expansion of clinical practice through nursing posts will provide a more responsive and therapeutic approach to the needs of these specific care groups at local and regional level eg: dementia-related care, autism, and early intervention, etc.

2. Location of Service

The working group expressed a strong belief that if Mental Handicap nurses are to provide an accessible, quality health service, advanced practitioners in mental handicap nursing must have a role in providing a comprehensive and specialised service to clients in primary, secondary and tertiary care.

Examples of such posts include: primary, secondary and tertiary care, community services, liaison services, rehabilitation, palliative care, respite care, crisis intervention and assessment.

3. Lifespan Approach

The working group agreed with the approach recommended in the Department of Health & Children research report outlining a Framework for the Development of Clinical Specialism and Advanced Practice in Mental Handicap Nursing (2002a). This outlines an age appropriate approach to the social roles and events, which construct the lifespan of individuals with Intellectual Disability. It has regard for the diversity of service users and the particular needs of certain age groups. If the system is to be responsive to the needs of individuals, it is important that a holistic approach is taken in service planning with the identified advantages that specialist and advanced practice bring. Examples of these posts will include: early developmental services, the aged, adult and adolescent.

4. Therapeutic Approaches

The Working Group identified the potential for Advanced Practitioners to work with particular approaches. Registered Mental Handicap Nurses represent a therapeutic ethos, grounded in nurse – client relationships. They play a central role in the use of psychosocial interventions. Treatment approaches such as cognitive behaviour therapy, family therapy, and play therapy offer an alternative programme of care to clients. Currently many of these nurses work autonomously in assessing clients and provide interventions or refer on as appropriate.

6.8 Assistance/Guidance in Career Planning

The working group identified the need for personal development planning in nursing to inform career progression at regional level. Such systems would offer direction and support to nurses in light of the recent developments in the nursing profession and the establishment of clinical career pathways. Personal Development Planning would clarify the career options/choices available to nurses in the Intellectual Disability services and allay much of the confusion that currently exists in this regard.

6.9 Research

There is a paucity of information about the type of nursing research conducted in mental handicap nursing and Intellectual Disability organisations. There is no clear picture of the numbers of nurses with research skills, research studies carried out or research publications.

The development and expansion of clinical and advanced practice and the recommended core concepts devised by the National Council in the development of CNS/ANP posts has further highlighted the need to maximise the nursing contribution to research in mental handicap nursing.

It is essential that mental handicap nurses engage in research both at a professional and service level. Despite considerable progress in recent years, current arrangements within healthcare organisations did not provide the infrastructure to support nursing research. The working group welcomes the publication of the *Research Strategy for Nursing and Midwifery in Ireland (2003)* and its vision of research based practice.

The working group endorses the proposed development of expert nurse and midwife researchers as recommended by the *Research Strategy for Nursing and Midwifery in Ireland (DOHC, 2003b)*.

Chapter 7.0

Recommendations

The working group recommend the following:

Role of the Registered Mental Handicap Nurse

- That changes in the Nurses Act reflect the language of Mental Handicap in the Nursing Register and change it to '*Intellectual Disability*' to reflect modern terminology.
- An Bord Altranais take cognisance of the limitations of the RMHN qualification in relation to working within the EU with the exception of Great Britain and internationally for graduates of this nursing speciality.
- Service Providers should ensure the effective utilisation of the nursing role within their organisations. Non-nursing duties performed by nurses should be reviewed and the responsibility for carrying out non-nursing duties clarified within each organisation.

Primary Care

- The role of the Registered Mental Handicap Nurse in Primary Care must be considered in the future development of primary care teams.

Recruitment, Retention, Staffing Levels and Skill Mix

- The Careers Centre in An Bord Altranais in consultation with the Department of Health & Children, the Nursing/Midwifery Planning & Development Unit and key stakeholders in Intellectual Disability services continue to raise the profile of Mental Handicap Nursing.
- Each Director of Service/Nursing should implement the workforce planning recommendations from the Final Report of the Nursing and Midwifery Resource – Towards Workforce Planning, utilising minimum data set and qualifications catalogue in order to identify the number of nurses and level of competence required to deliver the nursing service within their organisation.

- Chief Executives/Directors of Services/Directors of Human Resource/Directors of Nursing and Nursing Managers at unit level (Middle Managers) should actively engage in developing and agreeing recruitment and retention plans to secure the nursing resource required to deliver an Intellectual Disability nursing service within their organisation.
- All healthcare assistants successfully complete the accredited FETAC training programme (Further Education & Training Award Council), which includes a module in Intellectual Disability, to support, complement and facilitate the delivery of quality care.

Practice Development, Clinical Skills and Clinical Competencies

- The availability of Practice Development in Intellectual Disability Organisations be continued. Consideration be given to the establishment of such positions/initiatives in organisations where such do not exist in order to lead developments in practice and to advocate for mental handicap nursing as recommended in the Report of the Commission on Nursing.
- Directors of Services/Nursing ensure that facilitators are available within the Intellectual Disability services to facilitate Scope of Nursing Practice training.

Model of Nursing

- The development, implementation and evaluation of nursing tools to identify appropriate assessment, care planning and evaluation methodologies in Nursing in Intellectual Disability services.

Professional Development, Education and Training

- The development of the postgraduate diploma and masters' programme to reflect the needs of services and support the development of Clinical Nurse Specialists and Advanced Practitioners posts.
- An Bord Altranais in association with the Higher Education Institutes should review the current entry criteria to all postgraduate nursing programmes to ensure equity for all registered nurses.
- A range of continuous professional development programmes and continuous learning are developed within the Intellectual Disability services to support nurses including preceptorship, mentorship, clinical supervision and induction programmes.
- Registered Mental Handicap Nurses to develop a professional network at local, regional and national level to provide and enhance professional collegiality.
- An Bord Altranais should consider the development of guidelines for professional support and guidance for nurses in the form of clinical supervision.
- The development of a specific training programme/modules in Intellectual Disability nursing by the Higher Education Institutes, approved by An Bord Altranais for nurses working in Intellectual Disability services without the Registered Mental Handicap Nurse qualification.
- The development of professional career guidance guidelines by the Nursing/Midwifery Planning & Development Unit for nurses in preparation for professional portfolio development.
- The Centres for Nurse Education provide for the continuous professional development and continuing learning, training development and education of nurses in all disciplines of nursing.

Organisational Structures and Management of Services

- Intellectual Disability organisations that employ nurses should ensure that senior nursing managers are consulted and involved in decision making within the organisation in a meaningful way.
- When developing multidisciplinary teams, the Registered Mental Handicap Nurse is included as a full member in relation to all aspects of planning, implementing and assuring quality client care.

People Management

- In order to address people management issues within the Intellectual Disability services that the actions proposed by the Action Plan for People Management should be used as the standard for the development of initiatives by each service.

Management and Leadership Development

- Nurses have access to management and leadership development programmes to develop and expand their range of skills and competencies.

Clinical Promotional Pathway

- The implementation of the Department of Health & Children's Proposed Framework for the Development of Clinical Specialisms and Advanced Practice within the Intellectual Disability services as appropriate to respond to identify population need.
- The Nursing/Midwifery Planning & Development Unit support Intellectual Disability Service Providers with the identification of Clinical Nursing Specialisms and Advanced Practitioner posts within their services.

Career Planning

- Human Resource Directorates support the development of Personal Development Planning to inform career progression within Intellectual Disability organisations.

Implementation and Evaluation

- It is recommended that a partnership approach between the Service providers, Planning & Commissioning and Nursing Directorates in the ERHA agree and oversee a consultation, feedback and review process regarding the implementation of this report and its implications for the service and the profession.
- Ensure that the range of stakeholders identified work collaboratively and in partnership to ensure implementation.

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Appendices

Appendix 1: Domains of Competence (An Bord Altranais, 2000, pp14-17)

Domain	Competencies
1. Professional/ethical practice	1.1 Practices in accordance with legislation affecting nursing practice 1.2 Practices within the limits of own competence and takes measures to develop own competence
2. Holistic approaches to care and the integration of knowledge	2.1 Conducts a systematic holistic assessment of client needs based on nursing theory and evidence-based practice 2.2 Plans care in consultation with the client taking into consideration the therapeutic regimes of all members of the health care team 2.3 Implements planned nursing care/interventions to achieve the identified outcomes 2.4 Evaluates client progress toward expected outcomes and reviews plans in accordance with evaluation data and consultation with the client
3. Interpersonal relationships	3.1 Establishes and maintains caring therapeutic interpersonal relationships with individuals/clients/groups/communities 3.2 Collaborates with all members of the health care team and documents relevant information
4. Organisation and management of care	4.1 Effectively manages the nursing care of clients/groups/communities 4.2 Delegates to other nurses activities commensurate with their competence and within their scope of professional practice 4.3 Facilitates the co-ordination of care
5. Personal and professional development	5.1 Acts to enhance the personal and professional develop of self and others

Appendix 2: Distinctive Elements of the Syllabus/Indicative Content of the Mental Handicap Nurse Registration Education Programme (An Bord Altranais, 2000, pp30-34)

Foundations of contemporary nursing

The evolution of the role of the nurse in Intellectual Disability
Demographic profile and changing trends in care [*of persons with Intellectual Disability*]

Intellectual disability nursing practice

The evolution of care for people with learning disabilities
The scope of practice in Intellectual Disability nursing
Process of supporting the family as a primary care giver to the person with an Intellectual Disability
Principles of supporting, teaching and learning for clients [*with an Intellectual Disability*] and colleagues
Specialist and advanced practice within Intellectual Disability nursing
Evaluation of [*Intellectual Disability*] service provision

Information technology and the concept of learning

The use of assistive technology, and its theory and application to nursing practice

Nursing individuals with Intellectual Disability across the life-span

The concept of disability, handicap and impairment
The epidemiology, aetiology and management of associated clinical conditions in Intellectual Disability
Growth and developmental patterns of the individual across the life-span
The family and the person with disability
Family reactions and adaptations, and the provision of adequate support systems
Advocacy and self-advocacy
Motor movement management, including physiotherapy, physical education, aquatics, swimming, remedial movement, occupational therapy and rehabilitation
Play as a developmental process and therapeutic activity
Socialisation, social and self-help skill acquisition
Sensory deprivation, [*its*] consequence[s] and management
Working positively with individuals who present with behaviours that challenge
Developing relationships and issues of sexuality
Facilitating transition and life course planning
Occupational and vocational skills, training, development and work
Leisure and recreational activities which facilitate the development and expression through the medium of art, craft-work, drama, dance, mime, music, puppetry and sporting activities

Intellectual disability and mental health

Normal versus abnormal behavioural responses to life experience and related to individuals with learning disability
Current trends in mental health research and legislation applicable to [*persons with*] Intellectual Disability

Communication, interpersonal skills and therapeutic relationships

Communicating with persons with an Intellectual Disability, [*their*] families, colleagues

Appendix 2: Distinctive Elements of the Syllabus/Indicative Content of the Mental Handicap Nurse Registration Education Programme (continued)

Health and illness continuum

Using health promotion materials for persons with an Intellectual Disability and their families
Trends and predictors of mortality and morbidity in persons with Intellectual Disability across the life-span
Identifying individual service users and associated groups

Foundation and biological sciences

The principles of genetic inheritance

Social science

Disability and society, and barriers to inclusion

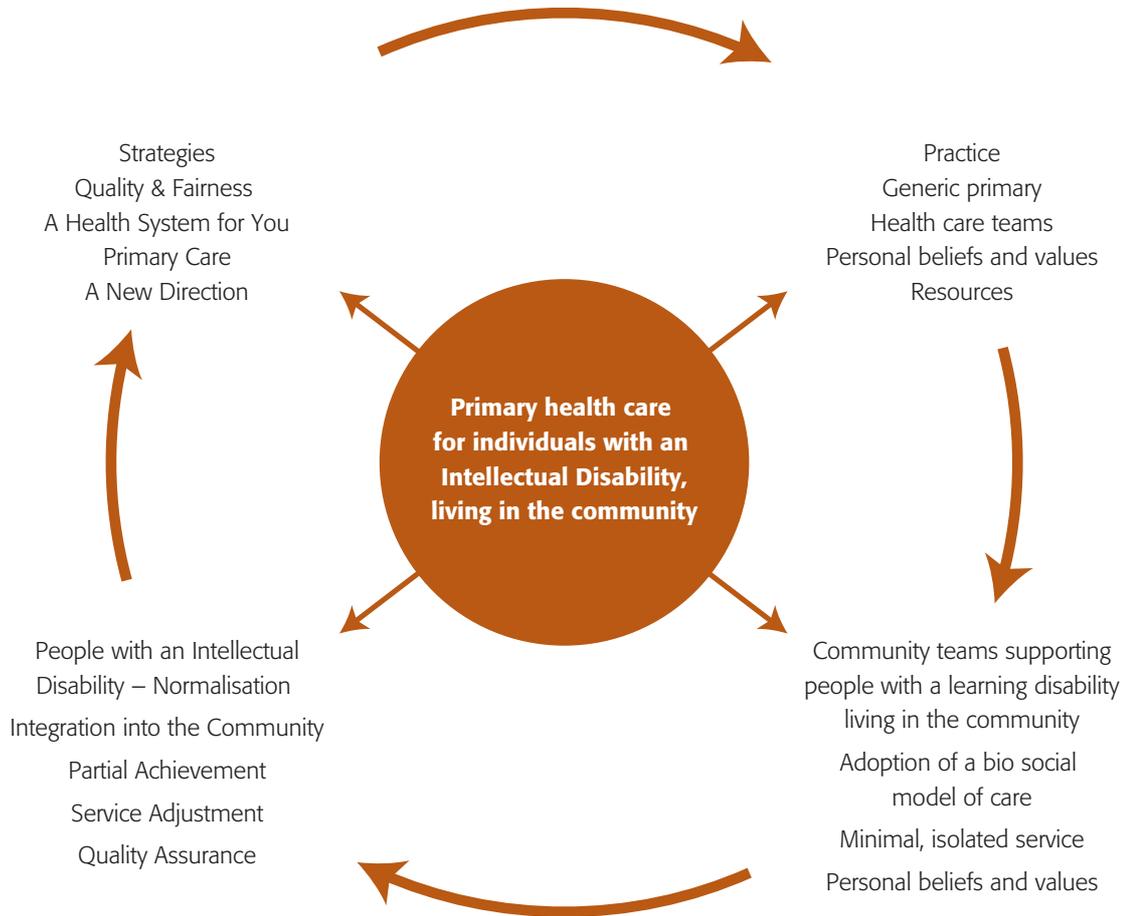
Intellectual disability, government policy and service delivery

The historical development of services for people with Intellectual Disability in Ireland
National and international models of care [*of persons with Intellectual Disability*]
The organisation of voluntary and statutory service provision [*for persons with Intellectual Disability*]
incorporating structure, function, responsibilities and funding
The health and social services available to the client and family
Education for the person with an Intellectual Disability
Social role valorisation and normalisation

Intellectual disability, society and the law

Current legislation within the context of Intellectual Disability
Child protection, society and family support

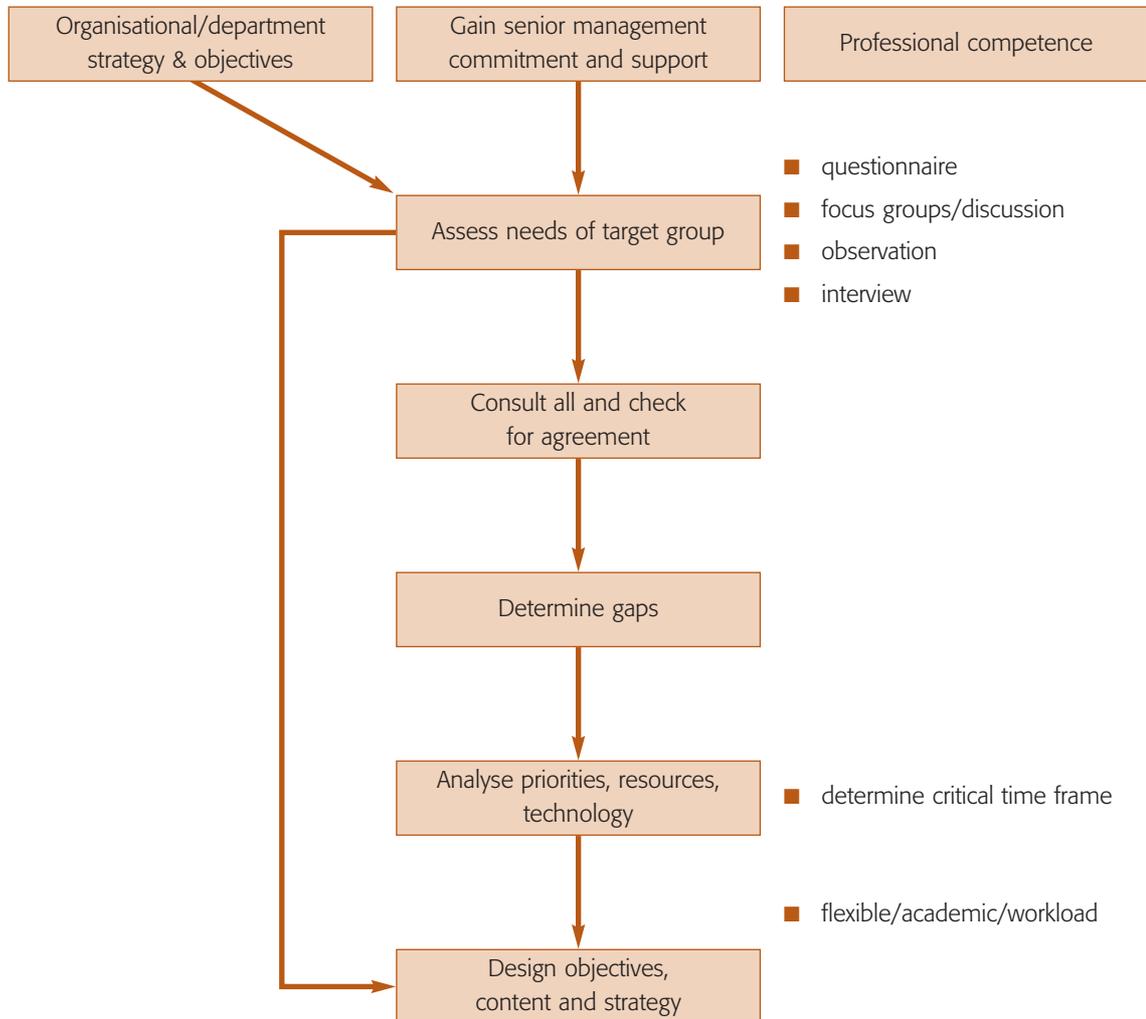
Appendix 3: Primary Health Care for Individuals with an Intellectual Disability



Appendix 4: Outline of Framework for Dependency Levels

Level 1	Level 2	Level 3	Level 4
<p>General health services:</p> <ul style="list-style-type: none"> ■ General practitioners ■ General Dental service ■ Optometrists ■ Accident & Emergency services ■ Community Pharmacists <p>b)</p> <p>Primary Care based services, including:</p> <ul style="list-style-type: none"> ■ Practice nursing ■ Public health ■ Health visiting ■ Treatment Room Nursing ■ PAMs e.g., Physiotherapists <p>c)</p> <p>Promotion of general health and well being in the wider community, for example:</p> <ul style="list-style-type: none"> ■ Social Inclusion projects ■ Healthy eating groups ■ Community Education initiatives ■ Evening classes ■ College courses 	<p>Health services accessed via primary care services, for example:</p> <ul style="list-style-type: none"> ■ Specialist Primary Care based epilepsy services ■ Primary Care Liaison service ■ Acute Hospital Liaison service ■ General psychiatric services ■ General hospital services – out patient clinics, investigation & treatment units ■ Palliative care services 	<p>Specialist Intellectual Disability services, For example:</p> <ul style="list-style-type: none"> ■ Paediatric Development Assessment services ■ Community Learning Disability Teams ■ Intellectual Disability psychiatric domiciliary & Out patient services ■ Specialist epilepsy services ■ Child & Family Psychiatric Services ■ Community Child Health Services ■ Intellectual Disability Dual Diagnosis clinics ■ Orthotic & equipment clinics 	<p>Specialist Area & Regional Health Services, for example:</p> <ul style="list-style-type: none"> ■ Specialist Intellectual Disability assessment & treatment services ■ Intellectual Disability additional support teams ■ Specialist paediatric assessment & treatment service ■ Intensive Psychiatric Units (IPCU) ■ Forensic assessment & treatment services

Appendix 5: Training Needs Analysis



Appendix 6: Examples of CNS Posts in Intellectual Disability Services within the Eastern Regional Health Authority (June 2002)

South Western Area Health Board		
Cheeverstown House	Early Intervention	1
	Palliative Care – Learning Disabilities	0.5
	Vocational Rehabilitation	1
	Total:	2 x 1.0 posts 1 x 0.5 posts
Good Council Centre for Intellectual Disability	Community Mental Handicap	1
	Community Mental Health Nurse	2
	Total:	3 x 1.0 posts
Moore Abbey	Alternative and Augmentative Communication	1
	Challenging Behaviour	0.5
	Community Mental Handicap	1
	Epilepsy and Health Promotion	30 hours
	Therapeutic Programmes	1
	Total:	3 x 1.0 posts 1 x 0.5 post 1 x 30 hours post
St John of God Centre (Menni Services)	Behaviour Management	1
	Community Mental Handicap	1
	Early Intervention	1
	Total:	3 x 1.0 posts
Northern Area Health Board		
Daughters of Charity	Behaviour Management	0.5
	Behaviour Therapy	1
	Complementary Therapies	1
	Creative, Diversional and Recreational Activation	30 hours
	Creative, Recreational and Diversional Activation	2
	Health Promotion and Intervention	1
	Personal Development Programmes	1
	Therapeutic Programmes	0.5
	Total:	6 x 1.0 posts
St Joseph's Learning Disability Services	Behaviour Therapy	2
	Community Mental Handicap	3
	Community Mental Health Nurse	1
	Total:	6 x 1.0 posts 2 x 0.5 posts 1 x 30 hours post

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