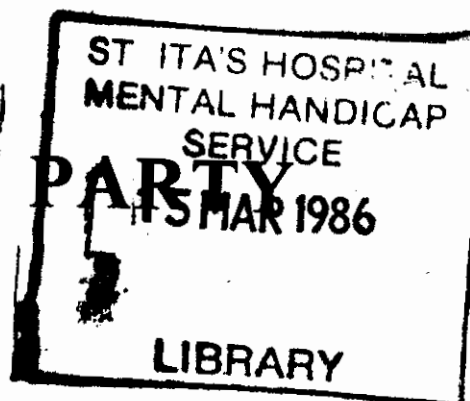


**WORKING PARTY**  
**ON**  
**GENERAL NURSING**

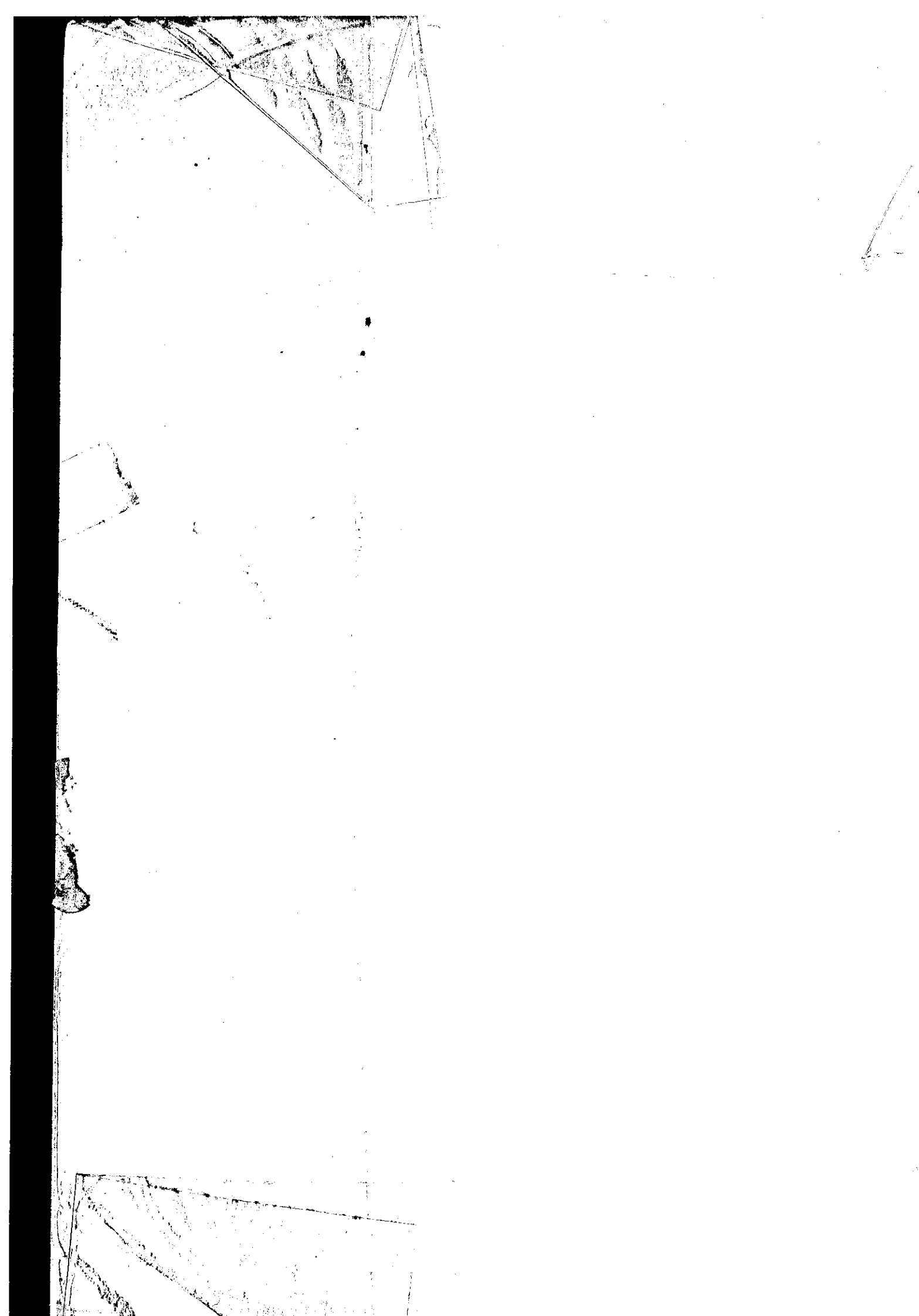


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# WORKING PARTY ON GENERAL NURSING

## Report

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### **Report of the Working Party on General Nursing**

I am very pleased to receive the report of the Working Party on General Nursing. It is apparent from the report that the members of the Working Party gave long and serious consideration to the many issues which came before them. The task undertaken by the Working Party was an arduous one. It inevitably took some time for them to reach their conclusions. I would like to thank the Chairman and the other members of the Working Party for this major contribution towards the thinking on the further development of policies in the nursing services which form such an important sector of our health services.

It is my intention now to press ahead with the examination of the various recommendations in consultation with all interested parties.

**Michael Woods, TD,  
Minister for Health and Social Welfare.**



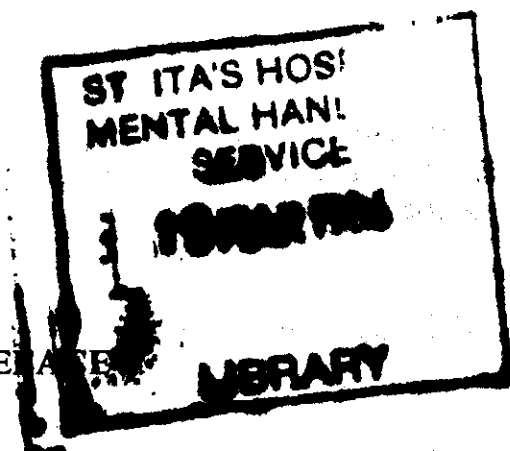
## CONTENTS

	Page
Chairman's Preface ... ..	(vii)
Introduction:	
Terms of reference ... ..	1
Background to setting up of Working Party ... ..	1
Membership ... ..	2
Acknowledgements ... ..	4
Procedure ... ..	5
Explanation of terms used ... ..	6
Summary of Recommendations ... ..	7
Chapter	
1. Nursing in Ireland:	
Development of nursing in Ireland ... ..	17
Current and future trends in the health services as they affect nursing ... ..	20
2. International Nursing ... ..	24
3. A Concept of Nursing ... ..	29
4. Role of the Nurse and Organisation of Nursing Services:	
In the Hospital ... ..	34
In Midwifery ... ..	49
In the Community ... ..	52
In Teaching ... ..	61
In the Specialist Areas ... ..	65
Nurses engaged in Non-Nursing Duties and the need for Support Staff ... ..	68
In Hospital Design and Planning ... ..	76
In the Department of Health ... ..	76
At Health Board Headquarters ... ..	78
In Research ... ..	79
5. Entry to Nursing ... ..	82
6. An Bord Altranais ... ..	89

Chapter	Page
7. Education and Training:	
Nurse Training Schools ... ..	99
Organisation and Assessment of Basic Education Programmes ... ..	107
Common Basic Training ... ..	114
Continuing Education for Nurses ... ..	119
A University Degree Course in Nursing ... ..	125
Appendix I. List of Persons and Organisations who submitted views ... ..	129
Appendix II. Summary of Attitude Survey of Irish Nurses ... ..	131
Appendix III. Report of National Survey of Applicants for Nurse Training ... ..	138
Appendix IV. Survey of Activities of Staff Nurses: Task List ... ..	145
Appendix V. Proposed organisation of a common basic training: possible options ... ..	148



**CHAIRMAN'S PREFACE**



To the Minister for Health.

We, the members of the Working Party established to examine and report on nursing, have pleasure in presenting to you the following report. The report is the result of deliberations on the role of nurses and the education, training and grading structures appropriate to that role and it represents the views of the Working Party.

We have been conscious, throughout our work, of the difficulty and undesirability of separating the various aspects of the nursing profession. It was not possible to discuss nursing education without examining its effect on the nursing services or to explore the nursing services without considering nurse training programmes. Similarly, it was not feasible to discuss nursing services in isolation from the health services as a whole. It is important therefore that this report be read as a whole and that single items are not extracted and read in isolation.

Throughout the report we have endeavoured to stress the central care-giving role of the nurse and the necessity to organise nursing services in such a way that the profession can respond to an individual's needs either in the hospital or in the community, or to his need for a positive approach to health. We have also been conscious of the nurse's role as a member of the health care team and the need for the nursing profession's involvement in all aspects of health care: in planning, in management, in administration and in monitoring the services.

We have emphasised the desirability of integrating basic nurse training so that all disciplines of nursing will share a common appreciation of the basic principles of nursing care. We have also considered it most important to stress the concept of self-education and continuing education for all nurses.

I am aware of the length of time that this Working Party has taken to complete its deliberations. Because of the precise nature of the terms of reference there was a need to examine, in considerable detail, various aspects of nursing. This was due to the virtual absence of any real research into nursing in Ireland, to the need to ascertain the views of a broad spectrum of the profession and to the need to familiarise the members of the Working Party with all the diverse aspects of nursing. Also, a change of chairmanship took place after two years when Miss Ann Lavan was forced to resign due to pressure of other commitments. I would like to take this opportunity to pay tribute to Miss Lavan's work and contribution to the deliberations of the Working Party. She successfully steered our work through the difficult early stages.

Much of our exploration of nursing has highlighted the need for further examination of some areas and for continual monitoring of both nursing services and nursing education. This need has been indicated where appropriate throughout the report.



## **INTRODUCTION**

### **1. Terms of Reference**

The Working Party was established by the Minister for Health in 1975 with the following terms of reference:—

To examine and report on the role of nurses (other than psychiatric nurses) in the health services, on the education, training and grading structures appropriate for that role in the future and to make recommendations. In regard to training to examine, in consultation with such persons and bodies as are considered appropriate, the recommendations for a common basic training course for all nurses to be followed by specialisation in particular fields which were made by the Commission of Inquiry on Mental Illness in 1966 and by the Working Party on Psychiatric Nursing Services in 1972

The inaugural meeting was addressed by the Minister for Health on 12 August, 1975.

### **2. Background to the Setting up of the Working Party**

The Working Party was established by the Minister following representations from the nursing interests over the previous four to five years requesting the setting up of a body to review the nursing services in this country.

The Irish Nurses' Organisation submitted to the Minister for Health in 1971 the following resolution which had been adopted at its Annual General Meeting:—

"We recommend as a matter of urgency the setting up of a Working Party by the Minister for Health to examine nursing staff structures, with not less than two-third nursing personnel and to make a thorough analysis of the nursing structure in the hospital services (excluding the psychiatric services which have already been the subject of study). Such an examination is essential to the national development of the service and in order to decide on future structures."

In 1974, An Bord Altranais, following an examination of the Report of the committee on Nursing in the United Kingdom (Briggs, 1972) made the following recommendation:—

- "(i) that the Minister for Health be requested to appoint a Commission to undertake a full survey of the present nurse training facilities in Ireland and recommend whether or not need exists to extend the present training facilities;
- (ii) that this Commission should take cognisance of the present utilisation of nursing services in the hospital scene—both in training and non-

training hospitals—and examine if a need exists in Ireland for a grade of nurse similar to the Enrolled Nurse in England or the Practical Nurse in America.”

Also in 1974 the Irish Nurses' Organisation and the Irish Matrons' Association jointly proposed the following terms of reference for a body which they considered should be set up:—

“To review the nursing and midwifery needs of the country and to establish how best to meet these requirements through the effective utilisation of professional resources”.

The Commission of Inquiry on Mental Illness (1966) had earlier expressed itself in favour of the development of a common basic training course for all nursing grades with further specialisation in particular fields of nursing. This issue was again referred to by the Working Party on Psychiatric Nursing Services of Health Boards in 1972 which endorsed the Commission's view and stated that this was a very big issue which would require study by those responsible for all branches of nurse training.

It was clear that the main areas of discontent among nurses related to staff structures, communication difficulties with management for senior hospital nurses, lack of nursing input to manpower and hospital planning, deficiencies in training programmes for student nurses, involvement in non-nursing duties and, again for senior nurses, the absence of a meaningful role in overall health services administration.

### **3. Membership**

The following is a list of members of the Working Party:—

Miss A. Lavan (Chairman) (resigned February 1977),  
Senior Research Fellow, Department of Social Science, University College, Dublin.

Miss B. Tierney (Chairman),  
Principal Tutor, St. James's Hospital, Dublin. (later, full-time Chairman).

Mrs. J. Barlow (appointed January, 1976),  
Midwife, 67 Shantalla Road, Dublin.

Mr. E. Browne (appointed January, 1977),  
National Group Secretary, Irish Transport and General Workers Union.

Sr. M. John Berchmans,  
Matron, Mater Hospital, Dublin.

Miss J. M. Chavasse (appointed May, 1977),  
Director, Nurse Tutor Diploma Course, University College, Dublin.

Miss T. Durkan (resigned January, 1977),  
Public Health Nurse, Co. Clinic, Castlebar, Co. Mayo (now Superintendent Public Health Nurse).

Miss M. Deegan (resigned October, 1975),  
Survey Officer, Nursing Services, Hospitals Commission (now Department of Health).

Mr. F. Finlay (resigned February, 1976),  
Secretary, No. 18 National Hospitals Branch, Workers Union of Ireland.

Mrs. S. Finlay (resigned November, 1976),  
 Nurse Tutor, Moore Abbey, Monasterevan, Co. Kildare.

Mr. P. Flynn (appointed March, 1976),  
 Deputy General Secretary, Local Government and Public Services Union.

Sr. Francis Joseph,  
 Secretary/Manager, St. Vincent's Hospital, Elm Park, Dublin.

Dr. E. Gavin (resigned November, 1975),  
 General Practitioner, Bagenalstown, Co. Carlow.

Mrs. M. Forde (resigned February, 1977),  
 Assistant Matron, County Hospital, Castlebar, Co. Mayo.

Miss E. Gurhy (appointed November, 1977),  
 Principal Midwife Teacher, St. James's Hospital, Dublin.

Dr. S. Healy,  
 Physician, General Hospital, Tullamore, Co. Offaly (now General Hospital, Sligo).

Mrs. H. Henry,  
 Nurse Tutor, Our Lady's Hospital, Cork.

Mr. K. Hickey,  
 Personnel Officer, Western Health Board (now Programme Manager, North-Western Health Board).

Mr. O. Hogan,  
 Principal, Department of Health.

Miss E. Horgan,  
 Superintendent Public Health Nurse, North-Eastern Health Board. (now Superintendent Public Health Nurse, Eastern Health Board).

Miss M. Keane,  
 Assistant Matron, James Connolly Memorial Hospital, Blanchardstown, Co. Dublin.

Dr. Mary Keenan,  
 General Practitioner, Mount Folly, Wexford.

Miss A. Kelly (resigned September, 1976),  
 Matron, St. Laurence's Hospital, Dublin.

Miss E. Kelly,  
 Ward Sister, Limerick Regional Hospital (now Matron, St. Finbarr's Hospital, Cork).

Mr. T. P. Keyes,  
 Programme Manager (Special Hospital Care), Eastern Health Board.

Mrs. M. W. McMenamin,  
 Chief Administrative Nursing Officer, Western Health and Social Services Board, Northern Ireland.

Miss E. O'Dwyer,  
 Matron, Meath Hospital, Dublin.

Miss M. Reidy,  
 Nursing Officer, Department of Health.

Sr. Kieran Sloan,  
 Matron, General Hospital, Mullingar, Co. Westmeath.

Mr. G. Smith,  
 Secretary/Manager, Mater Hospital, Dublin.

Miss T. C. Taaffe,  
Matron, Cherry Orchard Hospital, Dublin.

Dr. N. Tierney,  
Medical Officer, Department of Health (now Senior Medical Officer,  
Department of Health).

Miss B. Walsh (appointed December, 1976),  
Assistant Matron, The Charitable Infirmary, Jervis Street, Dublin.

Sr. Rita Yore (appointed January, 1977),  
Principal Tutor, St. Vincent's, Woodsdown House, Lisnagry, Limerick.

Miss Sylvia Kelly, Department of Health, acted as Secretary to the Working Party.

Due to pressure of other commitments, Miss Lavan, the original Chairman, was obliged to resign from the Working Party in February, 1977. The Minister for Health consented to the members electing a new Chairman from amongst the membership and Miss B. Tierney was duly elected.

#### 4. Acknowledgements

The Working Party wishes to record its appreciation of the co-operation and help received from the various organisations and individuals with which it came in contact during the course of its work. In particular the Working Party wishes to thank the following:

- All those individuals and organisations who made written and oral submissions.
- The matrons and nursing staff of all the hospitals and institutions visited.
- The chief executive officers and other health board officials who extended every courtesy and co-operation to the Working Party.
- Mr. James A. Keogh (Chief Executive Officer) and the staff of An Bord Altranais.
- Miss I. Davison, Principal Administrative Education Officer, Western Area Group School of Nursing, Altnagelvin Hospital, Co. Derry.
- Mr. F. A. McGilloway, Director of Nursing Studies, New University of Ulster, Coleraine, Co. Derry.
- Miss E. M. Welsh, Director of Nursing and Midwifery Education, Northern Ireland Council for Nurses and Midwives, Belfast.
- The National Boards of Health, Denmark and Finland and in particular Ms. Inger Madsen and Ms. Birgit Tauber (Copenhagen), Ms. Pirkko Summerhill, Ms. Anita Salkoranta and Ms. Aila Heikinheimo-Lindholm (Helsinki).
- Miss Dorothy C. Hall, Regional Officer for Nursing, World Health Organisation, Copenhagen.
- Mr. P. Hall (Director of Research) and Mr. J. McGowan (Researcher) of the Institute of Public Administration, for their work on the Attitude Survey.
- Prof. M. E. J. O'Kelly, Faculty of Industrial Engineering, Galway, for his expert advice and guidance in carrying out a survey of applications for general nurse training and for making computer facilities available.
- Mr. M. Boate and his staff in the computer section, Mater Hospital, who prepared data for processing by computer.
- Dr. Martin Newell, Director, Central Applications Office for the universities.
- The management of the Mater Hospital for their hospitality in providing accommodation and clerical assistance for meetings of the Working Party.

- The management of the Meath Hospital for their hospitality in providing facilities for meetings during the drafting of this report.
- Nursing staff throughout the country who willingly participated in the various surveys initiated by the Working Party.
- Máire Bean Uí Shearcoid who compiled a valuable bibliography of nursing literature which was of considerable value to The Working Party.

The members of the Working Party also wish to record their appreciation of the valuable assistance they received from Miss Sylvia Kelly, Secretary to the Working Party. Despite the pressures the work imposed on her, she was at all times unfailing in her courtesy and helpful manner. The efficiency with which she carried out her work made the task of the Working Party considerably easier and she has earned the whole-hearted thanks of all the members.

## 5. Procedure

Shortly after its first meeting, the Working Party decided to appoint from amongst its members four sub-committees to each of which was allocated an assignment related to part of the terms of reference. These were as follows:

- (i) Role of the nurse and definitions of nursing,
- (ii) Grading structures,
- (iii) Education and training including recruitment and selection,
- (iv) Common basic training.

Because of the considerable overlap in their areas of activity, the sub-committees dealing with (i) and (ii) above were later amalgamated to form one sub-committee. The sub-committees met frequently between meetings of the Working Party and submitted progress reports to the Working Party.

The Working Party as a whole met on average once a month.

The Working Party invited the submission of evidence from all organisations interested in nursing matters. A list of the respondents is contained in *Appendix I*.

Members visited a representative selection of hospitals in each health board area. They also met groups of public health nurses in each area and had discussions with senior management officials of the health boards.

A group consisting of a representative of each of the three sub-committees, together with the Chairman and Secretary of the Working Party, visited Denmark and Finland in October 1978 to observe the nursing services and nurse training facilities in those countries. Denmark and Finland were chosen because of their relative similarity to this country demographically and the desirability of examining developments which were taking place in those countries.

During the course of its deliberations, the Working Party commissioned two major surveys to be carried out on its behalf for the purpose of assisting it in its work.

The Attitude Survey of Irish Nurses was carried out by the Institute of Public Administration and is available as a separate report. The report presents the findings of the survey of the attitudes of Irish nurses to their role, training and grading structures. A brief summary is included in this report as *Appendix II* and it is referred to in various sections of the report.

The second survey initiated by the Working Party sought to determine the

actual number of applicants for general nurse training over a one-year period and the extent to which applicants applied to more than one school of nursing. The primary objective of this survey was to facilitate the Working Party in its consideration of whether there should be a central processing system of applications for nurse training and the organisational form such a system should take. A summary of this survey is included as *Appendix III*.

The Working Party also carried out several smaller surveys and fact-finding exercises in the course of its work. Most noteworthy among these were a survey of schools of nursing and a survey of the activities of staff nurses.

The survey of schools of nursing, which was carried out by means of a questionnaire distributed to all nurse training schools (other than psychiatric schools), provided information on—

- (a) student/nurse teacher ratios;
- (b) role of the nurse teacher;
- (c) administration and organisation of training schools; and
- (d) courses offered and their organisation.

To facilitate its consideration of the role of the staff nurse grade, the Working Party prepared a list of tasks which, from the experience of its nurse members, represented those tasks normally undertaken by staff nurses. This list is contained in *Appendix IV*. Members had their own personal views as to which duties were or were not appropriate for staff nurses to carry out. In order to clarify the position, the Working Party distributed the list of tasks or activities to ninety staff nurses from a representative selection of hospitals and requested each of them to record her activities during a period of one week and to indicate:

- tasks performed (including those which might not have been listed);
- where applicable, the grade of the person with whom she performed each task;
- whether she considered the task to be an appropriate staff nurse activity; and
- who, in her opinion, should carry out activities she considered not an appropriate part of her work.

The views and opinions submitted in evidence and the findings from visits to health board areas, from the visit to Denmark and Finland and from the surveys undertaken have all been taken into account by the Working Party in reaching its conclusions which are recorded in this report.

## **6. Explanation of Terms used in this Report**

### **(i) *Discipline of Nursing***

In the course of its deliberations and in the preparation of this report, it was necessary to examine and comment on training for the various divisions of the Register of Nurses maintained by An Bord Altranais and on the activities of nurses registered in those divisions. While nursing itself is normally regarded as a discrete discipline, the Working Party found it convenient to refer to *disciplines of nursing*; a discipline in this sense, being a field of nursing for which there is specific training to registrable level.

### **(ii) *Male/Female***

Because nursing is predominantly a female profession, the Working Party found it convenient to refer to nurses in a female sense.



## **WORKING PARTY ON GENERAL NURSING SUMMARY OF RECOMMENDATIONS**

### ***Hospital Grading Structures Basic and Middle Management***

1. The following staff structure should be provided for any unit of 30-40 beds;  
Nurse Administrator  
2 Deputy Nurse Administrators  
Staff Nurses  
Student Nurses (in the case of training hospitals)

The above structure should obtain in any hospital regardless of size, type or bed complement. (*para 4.3.2.*)

### ***Higher Management***

2. For large general and regional hospitals, the following nursing management structure above ward unit level should be provided:—

Director of Nursing  
2 Deputy Directors of Nursing  
Senior Nurse Administrators. (*para 4.3.3.*)

### ***Night Duty and Rotation***

3. (i) Rotation should be practised, wherever possible, for all grades involved in night duty.  
(ii) Nurses who are normally only assigned to night duty should spend at least four weeks per year on day duty to keep abreast of developments. (*para 4.7.*)

### ***Staffing Levels***

4. Staff nurses are essential on duty in every ward throughout the twenty-four hours. (*para 4.7.*)

### ***Nurse/Patient Ratios***

5. Nurse staffing levels should be more closely related to patient dependency needs and throughput and should be determined on a scientific basis having regard to proper nursing standards. (*para 4.8.*)

### ***Midwifery***

6. Midwifery training should be organised at two levels:—
  - (i) An intensive training programme (of not less than 18 months) which would be open to general trained nurses and which would equip the nurse to register and practise as a professional midwife.

- (ii) A special course for those nurses who while not requiring the full midwifery qualification may require some further obstetrical experience. (para 4.16.)

7. Where it is feasible and practicable, hospital midwives should carry out follow-up visits to mothers and their new born babies for a certain period after their return home. (para 4.14.2.)

8. The syllabus should be revised to prepare the midwife to function in an extended role and should include in-depth study particularly in relation to counselling, principles of health education, parent craft, inter-personal relationships, mental handicap including its causative factors, genetics and medical ethics. (para 4.16)

### *Community Nursing Services*

9. The title Superintendent Public Health Nurse should be changed to Chief Community Nursing Officer and Public Health Nurse should be changed to Community Nursing Officer. (para 4.17.3.)

10. The shortfall that exists both in curative and preventive services should be resolved by—

- (i) increasing the numbers of public health nurses thus improving the nurse/population ratios;
- (ii) in addition to (i) above, employing registered general nurses without a public health qualification specifically for a home nursing service, thus enabling the public health nurse to concentrate on preventative care. (para. 4.17.4.)

11. There should be an intermediate supervisory grade viz. a senior community nursing officer. There should be one Senior Community Nurse for every eight to ten community nurses. Each Senior Community Nurse should carry a small caseload. (para 4.17.5.)

12. A twenty-four hour community nursing service including emergency service coverage should be provided. (para 4.17.6.)

13. Designated nurses with a public health nursing qualification should be appointed to liaise between hospital and community services. (para 4.17.8.)

14. To ensure the proper utilisation of both hospital and community maternity services, effective co-operation and liaison between the hospital and community maternity services should be established. (para 4.17.8.)

15. The public health nurse should have responsibility for the general welfare of all persons in her district requiring nursing care including the mentally handicapped and mentally ill. (para 4.17.9.)

16. In areas of special need such as mental handicap and mental illness nurses qualified in those disciplines should always be available to the community as required. (para 4.17.9.)

17. In the light of the changing demands on the service and the doubtful requirement of a full midwifery qualification, a complete and detailed examination of the training programme for community nurses should be carried out. (*para 4.17.10.*)

#### *Nurse Teachers*

18. The existing two levels of nurse teachers should be discontinued and steps should be taken to develop one level of nurse teacher. (*para 4.18.3.*)

19. All nurse tutors who qualified before 1976 should have the opportunity to take a course in the skills required for teaching in the clinical area (*para 4.18.3.*)

20. Facilities should be made available to allow existing clinical teachers, who had taken the six-month course, to acquire the nurse tutor diploma in a shortened course. (*para 4.18.3.*)

21. Eligibility for admission to the nurse tutors course, should be open to registered nurses in the various disciplines. (*para 4.18.3.*)

22. Nurse teachers should be allowed to specialise within the syllabus. (*para 4.18.3.*)

#### *Specialist Nurses*

23. Specialist nurses should be developed:—

- (i) to enhance the quality of nursing care;
- (ii) to provide a specialist nursing service in certain nursing areas;
- (iii) to provide specialist nursing advice to other nurses in those nursing areas; and
- (iv) to enable more nurses to pursue a career in clinical nursing. (*para 4.19.3.*)

#### *Non-Nursing Duties/Support Staff*

24. the services of nurses for ambulance duty should be arranged for by separate and pre-planned provision. (*para 4.20.4.*)

25. Senior nursing personnel should be relieved of direct responsibility for such matters as housekeeping services and staff residences except in the case of smaller hospitals. (*para 4.20.5.*)

26. Where non-nursing staff are engaged on ward duties, they should be subject to the general control of the nurse in charge. (*para 4.20.10.*)

27. The Attendant grade should be employed in sufficient numbers. (*para 4.20.10 (1).*)

28. Cleaning staff—be they directly employed by the hospital or contract cleaners—should, in the interests of an effective and efficient cleaning service, always be subject to the general control of the Nurse Administrator in whose area they are working. This will entail close liaison between the Nurse Administrator and the cleaners' supervisor in the case of contract cleaners. (*para 4.20.10 (2).*)

29. Consideration should be given to the employment by hospitals of Ward

Clerks/Hostesses to the extent of one for each acute ward of high activity with provision for other wards sharing the services of such staff. (*para 4.20.10 (4).*)

30. Home helps should be employed in sufficient numbers for the community service and every effort should be made to develop and utilise the home help service in support to and in harmony with the public health nursing service. (*para 4.20.10(5).*)

#### *Hospital Design and Planning*

31. A senior nurse in every health board area of at least Senior Nurse Administrator level, selected for her particular interest in hospital planning, should be given the necessary training to be employed on a secondment basis as required for major and minor planning projects. (*para 4.21.3*)

#### *Nursing Adviser Posts in the Department of Health*

32. A fourth post of Nursing Adviser should be created at the earliest possible date to be known as Nursing Adviser (Planning and Research). (*para 4.22.2*)

33. The Nursing Adviser posts should be up-graded. (*para 4.22.4*)

#### *Role of the Nurse at Health Board Headquarters*

34. (i) There should be a system of regular, structured meetings where these do not already exist, between the programme manager and the heads of nursing services in all the hospitals within his programme.
- (ii) Where a health board programme encompasses ten or more service units (that is, hospitals and homes and community care areas), there should be a nurse on the support staff of the programme manager at Headquarters.
- (iii) The nursing post at Headquarters should have a staff support function and provide the nursing input at appropriate senior level to the decision-making process at Headquarters. (*para 4.23*)

#### *Entry to Nursing*

35. A Central Applications Bureau under the aegis of An Bord Altranais for the processing of all applications for nurse training should be established. (*para 5.3*)

36. The following selection process is recommended:—

- (i) Basic Educational Qualifications: there should be an educational standard of Leaving Certificate in the following subjects—

Irish

English

Mathematics

A science subject

One other subject of choice.

Candidates must have achieved at least grade C on higher level papers in two subjects and at least grade D on lower level papers in the remaining subjects. For persons coming from outside the country, educational qualifications equivalent to Leaving Certificate would be acceptable.

- (ii) There should be psychological assessment of candidates.

- (iii) There should be planned interview to assess personal qualities and to elicit information and supplement that derived from the application form and psychological assessment. (*para 5.4.2.*)

*An Bord Altranais*

37. A live register of nurses and an index of students in training should be established as a matter of priority. (*para 6.3.*)

38. The following changes should be made in the present divisions of the register:—

- (i) one division for general nurses in place of the existing separate divisions for male and female nurses;
- (ii) discontinuance of training for the Orthopaedic Nursing division which, it is felt, should be dealt with in line with other post-registration courses in specialised clinical nursing; and
- (iii) discontinuance of training for the Clinical Teachers division. (*para 6.3*)

39. The main involvement of the Board in relation to management and administration training for nurses should be:—

- (i) to maintain and develop existing links with the bodies providing these courses;
- (ii) to participate in setting course objectives and in assessing students and evaluating courses. (*para 6.4.6.*)

40. The Board, as the policy-making body, should not be directly involved with the day-to-day running of programmes and courses. (*para 6.4.7.*)

41. Cases of serious misconduct should be notified by employing authorities to An Bord Altranais. (*para 6.5.1.*)

42. An Bord Altranais should appoint from amongst its members a Fitness to Practise Committee with the majority of the members being elected members of the Board. (*para 6.5.2.*)

43. The Fitness to Practise Committee, following investigation, should recommend to the Board the action that should be taken in any individual case. (*para 6.5.3.*)

44. The Board should be empowered to—

- (a) advise, admonish or censure nurses as it sees fit, or
- (b) temporarily remove the name of a nurse from the register for a fixed period, or

- (c) remove a nurse's name from the register for an indefinite period. (*para 6.5.3.*)
- 45. A decision to remove a name from the register should be published. (*para 6.5.3.*)
- 46. The reasons for removal from the register should be—
  - (a) professional misconduct
  - (b) conviction of serious crime
  - (c) unfitness to practise for health reasons. (*para 6.5.3.*)
- 47. An Bord Altranais should publish an annual report so that its work and policies may be known and understood. (*para 6.7.2.*)
- 48. Hospitals and individuals organising courses in nursing or providing clinical nursing experience for non-nationals should be required to notify An Bord Altranais and seek its approval. (*para 6.7.3.*)
- 49. Membership of An Bord Altranais:
  - (i) Overall membership should be increased by four to twenty-seven to allow for current and future development of nurse education.
  - (ii) The management of health boards, voluntary hospitals and other voluntary organisations providing nursing services under the Health Acts should be represented amongst the appointed members instead of county councils and borough councils.
  - (iii) (a) *Twelve* members should be appointed by the Minister for Health as follows:—
    - One medical practitioner (general hospital services)
    - One medical practitioner (psychiatric hospital services)
    - One medical practitioner (community care services)
    - One medical practitioner (obstetric services)
    - One representing voluntary hospital management
    - One representing health board management
    - One representing the Department of Education
    - One representing the Department of Health
    - One representing third level education bodies involved in nursing education
    - Two nurses
    - One other
  - (b) *Fifteen* registered nurses should be elected by registered nurses as follows—
    - Six engaged in formal nurse teaching, one to represent each of the following nursing disciplines:—*
      - General Nursing
      - Paediatric Nursing
      - Psychiatric Nursing
      - Midwifery

Public Health Nursing  
 Mental Handicap Nursing  
*Four engaged in nursing administration* above Nurse Administrator level, one to represent the following nursing disciplines separately or jointly as indicated:  
 General or Paediatric nursing  
 Midwifery or Public Health Nursing  
 Psychiatric Nursing  
 Mental Handicap Nursing.  
*Five engaged in clinical nursing practice*, up to and including Nurse Administrator level, one to represent each of the following nursing disciplines separately or jointly as indicated:  
 Midwifery—hospital or domiciliary  
 General Nursing  
 Paediatric Nursing  
 Psychiatric or Mental Handicap Nursing  
 Public Health Nursing.

- (iv) Each candidate for election to membership should be
  - under 65 years of age,
  - engaged in the practice of nursing.
- (v) The lifetime of the Board should be five years as at present. Members should not be permitted to serve more than two consecutive terms of office.
- (vi) The President of the Board should be chosen from among the nurse members of the Board and should be elected at the first meeting of each new Board. (*para. 6.8.3.*)

50. The Midwives Committee should continue to be a statutory committee (*para 6.9.2.*)

51. The Fitness to Practise Committee should investigate complaints against midwives as well as other nurses and its findings should be referred to the Midwives Committee for recommendation as to the action to be taken by the Board (*para 6.9.3.*)

52. The necessary staff should be provided to allow for the increased activity of the Board. Such staff should include a Chief Education Officer, a minimum of three Education Officers and at least one Research Officer. (*para 6.10.1.*)

#### *Nurse Training Schools*

53. There should be a total of 15 schools with at least one in each health board area. (*para 7.3.4.*)

54. The following staffing structure is recommended for a nurse training school:
- (a) Director of Nursing Education
  - (b) Deputy Director of Nursing Education

- (c) Deputy Director of Nursing Education (Liaison)
- (d) Senior Teachers
- (e) Nurse teachers in the ratio of 1:15 exclusive of (a), (b) and (c) above.
- (f) Appropriate clerical and other support staff. (*para 7.3.10.*)

55. An Education and Training Committee responsible for the control and administration of each training school should be composed as follows:—

Director of Nursing Education	...	...	...	1
Director of Nursing	...	...	...	3
Deputy Director of Nursing Education (Liaison)	...	...	...	1
Nurse Teachers	...	...	...	2
Deputy Director of Nursing (Personnel)	...	...	...	1
Senior Nurse Administrator	...	...	...	1
Chief Community Nursing Officer	...	...	...	1
Representatives of Health Board/Voluntary Hospital Management	...	...	...	2
Student Nurse	...	...	...	1 ( <i>para 7.3.11.</i> )

#### *Organisation and Assessment of Basic Education Programmes*

56. A modular system of training with continuous assessment of candidates throughout the training period should be adopted. (*para 7.5.1.*)

57. There should be three intakes of students each year and three state final examinations. (*para 7.5.3.*)

#### *58. Assessments and Examinations*

- (i) Assessments of theoretical knowledge and practical skills should be carried out during each module and credits for these assessments should be aggregated and taken forward to the in-house examinations and the state final examination.
- (ii) At the end of the first module, that is, the twelve week introductory course, a special assessment should be made of the student's suitability for continuing in training.
- (iii) To ensure uniformity of assessment and to maintain standards, all those taking part in assessments, both teachers and ward personnel, should be required to undertake training in the skills of assessment.
- (iv) Each student should be obliged to undertake one nursing history and nursing care plan for an individual patient in each module.
- (v) Extern examiners, approved by An Bord Altranais, should be involved in the examinations at the end of the first and second years of training.
- (vi) Students who are unsuccessful in the examinations at the end of the first and second years should not be allowed to proceed with their training until they have successfully completed the examinations.
- (vii) The State final examination should consist of written papers which test



the student's nursing knowledge and not practical nursing skills and should incorporate in the overall marking system credits gained from continuous assessments and from nursing history and nursing care plans.

- (viii) Candidates who fail the State final examination should be allowed not more than two further attempts and qualifications should in any event be obtained within 5 years from the commencement of training.
- (ix) Candidates who do not intend to take the State final examination immediately following a three year training programme should inform An Bord Altranais in writing through the Director of Nursing Education of their intention and the reason for deferring.

#### *Common Basic Training*

59. A common basic training programme should be introduced. This would be a two year training programme for students preparing for registration in general, psychiatric, paediatric and mental handicap nursing and would be followed by a further year of intensive training in the discipline in which the student had chosen to register. (*para 7.9.1.*)

60. Following registration under the proposed training programme, nurses should continue to work for a six month period in hospitals specially approved by An Bord Altranais for this purpose. (*para 7.10.7.*)

#### *Continuing Education*

61. (i) Existing courses in specialised clinical nursing should be developed on a regional basis to allow more nurses the opportunity to avail of them;
- (ii) An Bord Altranais should become more actively involved in the development of these courses to meet the needs of the nursing services as they arise;
- (iii) An Bord Altranais should set guidelines, monitor syllabi and award certificates;
- (iv) in place of the former registrable course for infectious diseases, there should be a course in specialised clinical nursing for infectious diseases;
- (v) a specialised clinical course in orthopaedic nursing should replace the existing registrable course;
- (vi) courses in infection control, stoma therapy, oncology and occupational health nursing should be developed;
- (vii) a specialised clinical course in ophthalmological nursing should replace the existing registrable course organised by the United Kingdom Ophthalmic Association;
- (viii) the course in geriatric nursing which has been approved by An Bord Altranais should be inaugurated as soon as possible. (*para 7.12.1.*)
62. The present courses in management should be developed in centres where they are not now available so that nurses throughout the country will have the

opportunity of availing of them. (*para 7.12.2. (2)*)

63. Because of rapidly changing techniques in medicine and nursing, all registered nurses and midwives should be required to undertake an appropriate refresher course at least once in every five years. (*para 7.12.2 (3)*)

64. Qualified nurses should be encouraged and facilitated in the use of the existing resources of universities and other colleges of higher education for further development of their potential. (*para 7.12.2. (5)*)

65. Employing authorities should favourably consider requests for special leave to attend recognised courses and more facilities for attendance at these courses should be provided. (*para 7.13.*)

66. Priority should be given to the development of a degree course for registered nurses. (*para 7.16.3.*)

## CHAPTER ONE

### NURSING IN IRELAND

#### 1.1 Development of Nursing in Ireland

The earliest mention of the term *nurse* in Ireland can be found in the Brehon Laws where reference is made to *nursing fees* and the term *nursing* back to health is used. It is also laid down by the laws how and where “an injured person be nursed”.

There was also provision in the Brehon Laws for military hospitals and for women trained to care for the sick and wounded. These laws also provided for hospitals in each territory, which had to be free from debt—“have four doors and a stream of water running through the floor”.

When Christianity came to Ireland the Brehon Laws were adapted and centres where sick people could go for attention were established. The monastic settlements set up houses for lepers and also infirmaries for the treatment of general disease. The nursing care in these establishments was provided by the monks or nuns themselves.

As far back as the 16th century the title *Matron* was in use. Matron was usually a married woman or a widow and functioned as a housekeeper.

As nursing evolved mainly through the work done by the religious orders who attended the sick and saw that the physicians' orders were carried out, the title *Sister* came into use and continues to be used. *Nurses* were rarely promoted and were regarded as domestic servants. After the Reformation the monasteries were suppressed. The Elizabethan Poor Laws (1601) which influenced society in Great Britain did not apply to Ireland. No provision was made in this country for the relief of the poor or the sick pauper until the beginning of the 18th century.

The growth of Irish hospitals in the 18th century was dependent on socially minded philanthropic individuals who founded *hospitals* for the free treatment of the sick poor. This development occurred only in the cities and mainly in Dublin. Some of the voluntary hospitals founded in the early decades of the 18th century such as the Charitable Infirmary Jervis Street, Dr. Steevens Hospital and the Rotunda Hospital are still in existence and playing a valuable role in the health services. Similar hospitals were opened in Cork and Waterford. These hospitals formed the nucleus of what are now described as voluntary hospitals.

In the 19th century several epidemics prompted the government to provide for the sick poor. In 1818 steps were taken to establish fever hospitals in each county. In 1832 a threatened cholera epidemic led to the establishment of small local hospitals. Neither measure was entirely satisfactory. The Poor Law Act, 1838 established a poor law system under which the country was divided into a number of unions each under the control of a board of guardians. The system was established to maintain poor persons who were unable by their own industry or

other lawful means to provide for themselves. Initially workhouses were established to provide institutional care and this led to the establishment of infirmaries in the workhouses to look after the sick poor. Gradually distinct and separate hospital services developed in the county and district hospitals with more specialised hospital services evolving in the regional hospitals. This network of hospitals comprises the present health board hospital system.

Thus there emerged the two general hospital systems which at present exist in this country: the voluntary hospitals which provide nearly half the acute general hospital services with the health board hospitals providing the other half. The health boards provide practically all the long-stay care. The health boards, in addition, provide community services and psychiatric services. Special services for the mentally handicapped are generally provided by voluntary organisations, mainly religious orders.

In the early days of the voluntary hospitals, many married women were employed as nurses and used the experience gained looking after their own families in caring for the patients. They were often illiterate and rough. In the workhouse the sick paupers were often cared for by the convalescent paupers. There were few paid nurses. Although the title *nurse* was used, these nurses did not function as the staff nurse functions today. Many activities which would now be regarded as nursing activities were then performed by the doctor or his apprentice—thus one finds reference to *dressers* or *clinical clerks*.

The function of the matron in Dr. Steevens Hospital in the early 19th century is described as follows:

“To take care of all the functions belonging to the house. To keep all stores and deliver them to the nurses as the occasion requires. To see that the several nurses keep their ward clean—to lay up carefully the old linen and blankets and to deliver them to the surgeon as often as he shall call for them”.

In a description of the nurses' function two things are of interest: “the nurse of each ward, to put the order of the physician and the surgeon carefully in execution, to go to the second surgeon for the medicines prescribed” and “to be under the direction of the matron as to what the matron is to look after”.

The matron's duties were mainly domestic and she was strictly enjoined not to interfere with the nurse “in the performance of those duties which the surgeon shall assign her”.

In the late 19th century the matron's role changed and she was put in charge of female servants and nurses.

The system of public health nursing in this country can be traced back to the mid 19th century. The Poor Relief (Ireland) Act, 1851 which provided for the setting up of the dispensary medical system, again under the control of the Poor Law Guardians, also provided for the appointment of midwives. Like their colleagues in hospitals, these “midwives” received no formal training.

The earliest “public health nurses” were, therefore, midwives. In the late 19th century, several voluntary organisations pioneered the establishment of home nursing schemes. Several of those schemes continued to function well into this century being gradually assimilated into the health authority service.

The child welfare services were provided under the Notification of Births Acts, 1907 to 1915. Following the 1915 Act (Notification of Births (Extension) Act),

provision was made for the employment of nurses to visit mothers and children under five years of age and in 1924 nurses were employed by local authorities for school health examination.

The public health nursing service as it exists today has emerged from the gradual re-organisation and expansion of the health services which included an absorption of the home nursing schemes earlier mentioned.

Before formal nurse training was introduced, nurses could be broadly divided into four categories—(i) inmates nursing the sick poor in poor houses, (ii) nurses working in voluntary hospitals who were of a slightly higher social level, (iii) sisters in charge of wards and (iv) matrons who were of a superior class to the others and who had some degree of administrative and management function. It is interesting to note that all these grades were regarded as being exclusively female although in earlier history reference can be found to both male and female nurses.

Early efforts towards the systematic training of nurses failed and while there is evidence of training efforts in some of the voluntary hospitals, their example was not followed elsewhere. Plans for the instruction of nurses were outlined as early as 1817.

Nurse training arrangements were well organised in St. Vincent's Hospital from about 1835. In 1852 Florence Nightingale applied to be admitted there for training though she did not proceed with her application. No general pattern emerged however and it was not until the 1890's that formal training programmes were set up and hospital authorities seeing the value, from the services point of view, of probationers accepted them for training. In this way emerged the system, that still exists today, of heavy dependency on probationer/student nurses for service. Matrons were responsible for training nurses for their own hospitals though often they delegated this function to suitable ward sisters and thus originated the role of nurse tutor.

From the beginning of the present century, the nursing profession developed in line with the health services and according to the changing health needs.

In 1904 the Irish Matrons' Association was founded. The Association had three main objectives:—

- (i) to enable matrons to meet regularly to discuss matters of professional interest;
- (ii) to monitor legislative proposals calculated to affect the interests of the nursing profession and
- (iii) to look for a uniform system of education and training.

The Nurses Registration (Ireland) Act, 1919 provided for the establishment of the General Nursing Council for Ireland and registration of nurses. This Act provided for the registration of general trained nurses and supplementary registration for nurses caring for the mentally ill and for sick children. It also made provision for registration of other disciplines if necessary. Thus nurse training in Ireland was diverted into various streams from the beginning, and led to the production of nurses of different disciplines rather than nurses qualified to function on a much more comprehensive level. The Midwives (Ireland) Act, 1918 provided for the registration of all practising midwives but only those who had a formal training were eligible for appointment to the dispensary services.

In 1919 the Irish Nurses' Organisation was formed. It concerned itself with improving working conditions and educational facilities for the profession.

A Nursing Officer was appointed to the Department of Health in 1949. In the same year, a Nurses' Bill was brought before the Dáil proposing the establishment of An Bord Altranais (The Nursing Board) to replace the Central Midwives Board and the General Nursing Council. This Bill became law as the Nurses Act, 1950 and all registration subsequently came under the control of An Bord Altranais.

Public health nurse training was established during the 1960's following a re-organisation of the public health nursing services which had absorbed under the local health authorities all nurses on district duties. In 1966 a new policy was outlined by the Department of Health setting out the aims of the district nursing service and giving directives for its future development.

The 1960's also marked the first involvement of universities in the nursing profession. In 1960, a diploma course for nurse tutors was established in University College, Dublin. In the early 1970's the first meetings of a committee to consider a proposal to establish a Post-Graduate Faculty of Nursing were held. The Faculty was inaugurated in October 1974 and is referred to later in this report.

## **1.2 Current and Future Trends in the Health Services as they affect Nursing**

One of the outstanding features of the Irish health services is the considerable provision of hospital beds relative to the size of the country's population. Social Indicators for the European Community 1960-1975 show that in that period, Ireland had considerably more beds per 1,000 population than any of the other Member States of the Community. This, it is considered, does not indicate any greater incidence of illness, disease or disability among the Irish people but rather does it reflect the pattern of health care that has evolved over the years.

It also reflects a rather unique demographic feature of the structure of the Irish population. In the period earlier mentioned, Ireland, compared to its EEC partners, also had the lowest percentage of population in what is generally regarded as the active age group, that is 15-64. This no doubt is due to the heavy emigration that occurred up to recent times and which resulted in many elderly people and even disabled persons who were not so elderly, being admitted to hospitals and institutions in the absence abroad of their sons and daughters or brothers and sisters who, if they were still at home, would have been able to look after them. Peoples' attitudes towards caring for their dependent relatives also have a bearing on the number of hospital beds as has the adequacy of the primary care service.

With the stemming of the tide of emigration and the country returning to a growth in population, the balance of population is likely to be restored and there should be opportunity for more supportive care available by near relatives. The escalating cost of providing hospital care emphasises the need for a major development of community-based health care programmes. Apart from economic considerations, it is becoming increasingly apparent that people requiring health care should as far as possible be looked after in their own homes where they are surrounded by their family and friends. The disabled and elderly have no desire to give up their independence and freedom and strive to retain them as long as possible.

It can be accepted therefore that, in the years ahead, there will be much greater concentration on development and expansion of community services which should reduce the amount of hospitalisation. All this, of course will not come about unless adequate structures are built into the community services to ensure that the necessary supportive care will everywhere and at all times be available to maintain in the community those in need of health care and so avoid, whenever possible, their hospitalisation. There is also the growing appreciation of the need for each member of society to take greater care of his own health, and through proper diet, hygiene and exercise to develop a healthy life-style. To this end intensive health education programmes will be required.

For the health services of the future, more emphasis will be on prevention of illness rather than on diagnosis and treatment. The shift from curative to preventive services is already taking place. Inevitably the change in emphasis will alter and affect the role of health workers, who will need to be better prepared for their preventive and educative role in the community. More nurses will be engaged in the promotion of health education programmes, in screening services and in infant and child care. They will be more involved in the prevention of sickness and disease, in early diagnosis and treatment at a stage when more effective action can be taken. For those who must be admitted to hospital their stay is likely to be of shorter duration than at present, with more treatment and convalescent care being provided in the community. Maintenance care for the elderly and disabled will be provided to a far greater degree outside the hospital and institutional setting.

While it should be possible through dynamic health education programmes and highly developed community services to make considerable inroads into the present level of hospitalisation, the hospital services will nevertheless continue to be the nerve centre of the health services providing the essential in-patient treatment services and also specialist out-patient services.

The Report of the Consultative Council on the General Hospital Services (Fitzgerald Report) which was published in 1968, drew attention to the large number of small general hospitals and advised the concentration of acute hospital practice into fewer and larger centres. Comhairle na nOspideal in 1975 issued guidelines which modify to some extent the plan put forward in the Fitzgerald Report.

While debate still continues about the final plan and in particular about the location of a few of the hospitals, it is more than likely that for the future there will be a reduction in the number of general hospitals and that acute services will be provided in a small number (less than ten) of specialised regional hospitals and a relatively small number of large general hospitals some of which will have attached to them specialist units providing services such as ophthalmology, otolaryngology, paediatric and orthopaedic services.

While the final plan has not yet emerged, already there is a considerable capital programme for general hospital development in progress and it is noted that the plan will provide a more balanced distribution of general hospital accommodation as between the health board areas.

To bridge the gap between the specialist services provided in the large general hospital and the services provided by general practitioners, Comhairle na

nOspideal\* has suggested the development of community hospitals at local level. General practitioners would have access to such hospitals for treating their own patients who would benefit from a short stay in hospital under their care. Patients could be transferred there from the general hospitals at pre-convalescent stage. Some elderly people and patients suffering from a long-term illness requiring continuing care could also be looked after in community hospitals. Apart from the involvement of general practitioners, there could be consultant out-patient services at the community hospital and services of consultants from the general hospital could be made available for the transferred patients.

The foregoing developments as well as the greater use of day-hospital facilities, should in the long term considerably reduce the need for long-stay medical care. As part of the development of the large acute general hospitals, provision is being made for geriatric assessment units to ensure that the problems of geriatric patients are properly investigated before decisions are taken in regard to their further care.

Specialist services for the mentally handicapped are a relatively new development in the health services of this country and it was not until 1960 that the first nurse for the mentally handicapped was registered. As in the case of the health services as a whole, the main emphasis nowadays is on care of the mentally handicapped in the community rather than residential care. The aim is to keep the handicapped person in the family setting for as long as possible and to facilitate this by having ready access to day schools, day care centres and workshops. Again to render such a community care policy really effective, the family will need every help and support from a wide range of categories of health workers, including nurses of the mentally handicapped and public health nurses. Where residential care is required for the mentally handicapped, the policy is to provide modern centres planned in small units allowing for family size groupings; the aim being to simulate, as far as possible, a normal domestic-type living environment rather than the institutional-type services of the past. Traditionally, the adult mentally handicapped have been cared for to a large extent in psychiatric hospitals. The policy now is to provide separate accommodation geared to their special requirements and special programmes of care.

It is of interest to note also that, in regard to the psychiatric services, the policy is to provide acute psychiatric treatment units at, or in association with, general hospitals.

Many such units are already in operation and in areas where they do not exist, planning developments for new general hospitals or extensions to existing general hospitals will meet these requirements. Here again, the emphasis will be on expansion of the community care services and—*where admission to hospital is appropriate*—unless patients are obviously seriously disturbed, they will be admitted in the first instance to the psychiatric unit at the general hospital. Most will receive all their residential treatment there and will be discharged home, where necessary continuing care being given on a day-attendance basis or by the various community services including day-hospitals. Where it becomes clear that a patient requires long-term residential care, it will be provided in the psychiatric hospital. The psychiatric unit will of course have a very close association with the

\*Discussion Document on the Role of Smaller Hospitals. (Comhairle na nOspideal, 1974).



psychiatric hospital so that, together with the community services, they will combine to provide a comprehensive psychiatric service.

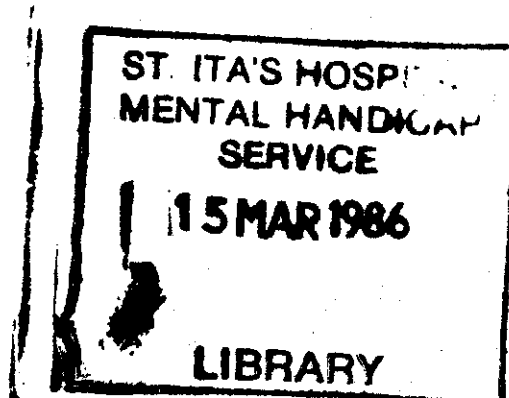
Thus it is apparent that more nurses of all disciplines will be expected to be able to nurse effectively in settings other than hospitals. This has implications for the role of the nurse, for administrative functions and for educational programmes. These issues have been considered throughout this report.

1.3 The following table shows the numbers of nurses currently engaged in the health services:—

Number of Nurses 1979										
<i>Hospital</i>										
Senior Nursing Staff	...	...	...	...	...	...	...	...	...	642
Ward Sisters and Junior Ward Sisters	...	...	...	...	...	...	...	...	...	963
Staff Nurses	...	...	...	...	...	...	...	...	...	9,119
Student Nurses and Student Midwives	...	...	...	...	...	...	...	...	...	4,453
										<hr/>
										15,177
<i>Community</i>										
Senior Nursing Staff	...	...	...	...	...	...	...	...	...	32
Public Health Nurses	...	...	...	...	...	...	...	...	...	1,122
Trainee Public Health Nurses	...	...	...	...	...	...	...	...	...	100
										<hr/>
										1,254

The above figures relate to general, paediatric and public health nurses and midwives.

In addition, there are approximately 975 nurses employed in voluntary agencies providing care for the mentally handicapped and 470 student mental handicap nurses. There are also approximately 5,500 psychiatric nurses, including 1,300 students employed in the psychiatric nursing services.



## CHAPTER TWO

### INTERNATIONAL NURSING

#### 2.1 EEC Directives

2.1.1 A major development in European nursing has been the adoption of the directives for general nursing by the Member States of the European Economic Community. These directives, which became operative in June 1979, concern:

- (1) "the mutual recognition of diplomas, certificates and other evidence of the formal qualifications of nurses responsible for general care, including measures to facilitate the effective exercise of the right of establishment and freedom to provide services".

(Council Directive 77/452/EEC).

*and*

- (2) "the coordination of provisions laid down by law, regulation or administrative action in respect of the activities of nurses responsible for general care".

(Council Directive 77/453/EEC).

2.1.2 Directives for midwifery recently adopted by the Member States will require an extension of the present twelve-month midwifery training programme which operates in this country for persons registered in the general or paediatric divisions of the register.

2.1.3 An Advisory Committee on Training in Nursing was also set up by the EEC charged with the task of helping "to ensure a comparably high standard of training of the various categories of nursing personnel throughout the Community".

Each of the Member States is represented on the Committee by three experts and three alternates representing the practising profession, the establishments providing training in nursing and the competent authority of the Member State. The Committee is empowered to appoint a chairman and two deputy chairmen from its own membership and it determines its own rules of procedure. It may also set up working parties and call on experts to assist it with the special aspects of its work.

2.1.4 It is as yet too early to assess the implications of this country's accession to the EEC in relation to how our nursing services generally will be affected. However, it is to be hoped that both government and nursing interests will carefully monitor and guide developments in this area.

## 2.2 Other International Trends

### 2.2.1 Primary Health Care

The changing pattern of disease, the increase in the area of geriatric care and chronic disease, changes in social and economic conditions, increasing costs and complexity of health care systems have all led to increased emphasis on the development of primary health care and integrated health care teams.

Primary health care is concerned with the medical, social and psychological needs of the community. Care such as this demands a service organised through a team approach which can apply appropriate skills in different situations. Nursing personnel are seen as playing a significant role in the provision of primary care, preventing ill-health, providing care and restoring health.

2.2.2 The development towards the specialist nurse is described in a World Health Organisation (WHO) report\* as follows—"Within primary health care there is evolving the role of *nurse practitioner* who is a nurse educated to function in an expanded role in the primary care setting, who is capable of carrying a nursing case-load, of working effectively within a multi-disciplinary team, of relating with individuals and families on a long-term basis. In the hospital setting, a similar trend is leading to the category of 'clinical nurse specialist', who not only plans, provides and evaluates nursing care, but also guides and evaluates the work of other members of the nursing personnel team and acts as partner of the physician in the overall planning and provision of patient services".

### 2.2.3 Structures

International documents on nursing services or the use of nursing resources comment on the need to rationalise nursing personnel structures. The Recommendations adopted by the International Labour Conference in June 1977 which deal with the employment and conditions of work and life for nursing personnel describe a nursing structure as follows:—

- “(a) Professional nurses, having education and training recognised as necessary for assuming highly complex and responsible functions, and authorised to perform them;
- (b) Auxiliary nurses, having at least the education and training recognised as necessary for assuming less complex functions, under supervision of a professional nurse as appropriate, and authorised to perform them;
- (c) Nursing aides, having prior education and/or on-the-job training enabling them to perform specified tasks under the supervision of a professional or auxiliary nurse”.

Dorothy C. Hall, Regional Officer for Nursing, WHO Copenhagen, identifies this need as follows:†

“Every country should have a well defined nursing personnel sub-system through which nursing services can be effectively delivered; it may consist of

\*The Definition of Parameters of Efficiency in Primary Care and The Role of Nursing in Primary Health Care—Report on two Working Groups, Reykjavik, July 1975, WHO ICP/SHS 039, 1976.

†Position Paper on Nursing. Hall D.C. (1975).  
Document Euro News 75.1. WHO Copenhagen.

two or more categories of workers, with the *nurse* at the apex. The categories in the nursing personnel sub-system should be determined by the nursing needs and resources of the country concerned. At least two seem necessary for effective and efficient care”.

Both these documents recommend training programmes at different levels for these categories with facilities for advancement from a basic level.

The International Labour Organisation document recommends a statutory licensing system for the first two categories, that is, professional nurses and auxiliary nurses.

#### 2.2.4 *Comprehensive Training*

It has been suggested that nurses working in primary health care should be generalists capable of providing a wide range of services and that pre-registration nursing education should equip the nurse to perform efficiently in that role. Dorothy C. Hall recommends the preparation of a multi-purpose nurse at basic level.

2.2.5 The concept of the health care team has also promoted a move to establish a programme of shared elements of training for all health professionals in the basic education programmes. It is being suggested that advanced education should be planned jointly and should include areas such as research and administration. Many countries have already begun to develop systems of training health personnel together during the initial year(s) of training. It is recommended that the training programme include team skills.

The changing concept of health care with the emphasis being placed on preventive rather than curative care has an effect on nursing and the role of nurses. Nurses, as members of health care teams, will be expected to play a much more active role in promoting health education. WHO stresses the need for education of nurses in this area and for a review of educational and training programmes.

#### 2.2.6 *Priorities for Planning*

The development of integrated health services which aims at providing the best possible health care within the economic resources available, has meant that priorities must be established in health expenditure. This has influenced policy formulation, the deployment of resources and the provision of care and has emphasised the need for long-term planning in the use of scarce resources.

In 1974 WHO set up a working group to develop priority areas in nursing. A medium-term programme in nursing/midwifery in Europe\* was developed.

The areas recommended for development are:—

- (i) the nursing process,
- (ii) the organisation and management of nursing/midwifery services,
- (iii) the education of nursing/midwifery personnel, and
- (iv) resource planning.

\*Medium-Term Programme in Nursing/Midwifery in Europe, 1976-1983. EUR RC 27/7, 7 June 1977.

The major objectives are:—

- (1) to assist countries of the Region to strengthen their capacity for effective planning and management of the nursing component of health services, including related institutions and manpower at all levels,
- (2) to promote and support research and studies which will add to the body of knowledge and the technology of nursing and the general organisation and management of nursing services, particularly as these apply to the provision of nursing care using the nursing process,
- (3) to promote and support the nursing input particularly into primary health care, health care of the elderly, mental health, maternal and child health care (including family planning), and the prevention, control and treatment of communicable and chronic diseases, with emphasis on cardiovascular diseases,
- (4) to promote and support the development of relevant auxiliary, basic, postbasic, advanced, inservice and continuing education programmes for all health personnel, but with particular emphasis on nursing personnel,
- (5) to promote health education and information of the public, particularly as these apply to individual and family, knowledge and skills related to health, disease and injury,
- (6) to promote the co-ordination of nursing programmes on national, intercountry and World Health Organisation European Regional Office level with related programmes and objectives in other subsystems of the health services.

In short, the medium-term programme is primarily designed to assist countries to strengthen existing activities or to initiate projects in areas where the need is particularly urgent. Thus it is not an end in itself but rather a means whereby national and, in some instances, multi-national activities can be stimulated, supported, strengthened and co-ordinated.

### **2.3 General Comment**

In several international documents dealing with trends in nursing, many of the issues which have been central to the deliberations of the Working Party have been stressed. Among these have been:

- the need to examine thoroughly education for health professionals in order to orientate it towards health care needs of the future;
- the need to experiment in a patient and family-centred learning approach to serve the overall health needs of a population group, (e.g. the elderly, people at risk);
- the need for research and experimentation in the organisation of nursing services;
- development of expert practitioners in both clinical specialities and community nursing;
- the need to develop leaders in nursing; and
- the need to analyse the roles of different categories of staff.

The Working Party has kept in mind these trends in its deliberations and, where it was relevant and applicable to the Irish nursing situation, has made recommendations which, while arising out of a study of the needs in this country, are generally in accord with international trends.

## CHAPTER THREE

### A CONCEPT OF NURSING

#### 3.1 Introduction

For some considerable time after its establishment, the Working Party, in an effort to be specifically clear as to its terms of reference, debated terms such as *role of the nurse*, *definition of nursing* and *philosophy of nursing*. Its aim was to reach an understanding of these terms which would be acceptable in the short-term to each of its members and, ultimately, to those who will read this report.

#### 3.2 Definition of a Nurse

The Working Party finally decided to adopt the following definition of a nurse which is based on a study carried out by the International Council of Nurses:—

A nurse is a person who has completed a programme of basic nursing education and is qualified and authorised in her country to practise nursing.

Basic nursing education is a formally recognised programme of study which provides a broad and sound foundation for the practice of nursing and for post-basic education which develops specific competency.

The educational programme prepares the nurse, through study of behavioural, life and nursing sciences and clinical experience, for effective practice and direction of nursing care and for the leadership role.

The nurse is responsible for planning, providing and evaluating nursing care in all settings, for the promotion of health, or support in death, prevention of illness, care of the sick, rehabilitation and functions as a member of the health team.

#### 3.3 The Role of the Nurse

In attempting to identify the nurses's role in a general sense, the Working Party examined the various definitions which have been made over the years. All of them have considerable merit and relevance for the nursing profession. The International Council of Nurses' definition of a nurse referred to above captures in essence the spirit of every other definition but it is still worth recording here the following one by the renowned American nurse, Virginia Henderson:—

“The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided had he the necessary strength, will or knowledge, and to do so in such a way as to help him gain independence as rapidly as possible .....

Studies have been undertaken in the past to identify the nursing role or aspects of

it in particular situations. The nurse and her role in the various areas of the health services will be described in the next chapter. Here, however, it is desired to deal with the nursing role in its widest context.

### 3.4 Identifying Nursing

The role and functions of any one nurse is dictated to a great extent by her particular nursing duties relative to where she is situated—whether in a hospital or in the community—the type of patient and the type of care required. But regardless of these considerations or of whether her duties lie in the clinical, administrative or teaching nursing fields, the first and all important requirement is to care and to give care.

The caring role is pre-eminent in nursing and it is this which distinguishes it as the major care-giving profession. Although other health professions have a caring role, they are not involved continuously and do not have the same close personal contact with the patient as the nurse. The nurse has an independent role to play in determining the nursing care needs of the patient.

The Nursing Process is a concept which provides a descriptive framework for nursing. The word “process” denotes a course of action or something which is done systematically. In this context, nursing is giving care to meet health needs.

The process of nursing is a unifying concept, in that it may be applied to all types of nursing—general, paediatric, etc. It can be used to describe all time scales from acute care to long-term rehabilitative care. It can also describe methods of organising nursing work whether by task assignment or different forms of total patient care but it implies that the organisation is focussed on the patient.

The process entails:

- assessing the needs of the patient;
- planning to meet those needs;
- performing the nursing care (including health education);
- evaluating the process.

This formula can be applied from the simplest nursing activity to the most complex and urgent.

Need for nursing can be assessed by skilled observation and knowledgeable interpretation of the situation. It is useful to classify the possible needs that may arise. One way of doing this is to draw on \*Maslow's hierarchy of needs. His theory is that man is “a wanting animal”; there are five levels of need and normally we attempt to satisfy the lower ones before trying to fulfill those at the next level. The levels are:—

- (1) PHYSIOLOGICAL needs essential for survival;
- (2) SAFETY needs for security, freedom from fear, stability etc.;
- (3) Need for BELONGINGNESS and LOVE;
- (4) Need for ESTEEM, both self-esteem and the esteem of others;

\*Maslow, A.H.—“Motivation and Personality”, Harper and Row, New York, 1954.



- (5) Need for SELF ACTUALISATION, to realise the individual's full potential as a human person.

When a person is ill, some or all of these needs are likely to be threatened to a certain degree. It is a nurse's duty to strive to ensure that the whole range of the patient's needs are safeguarded and not merely those that are at risk at the time of his diagnosis.

Relating Maslow's five levels to physical nursing care requirements, Virginia Henderson in the "Basic Principles of Nursing Care" (1958, ICN, Geneva) formulated fourteen basic, or primary, components. These are:—

- (i) Helping patient with respiration,
- (ii) Helping patient with eating and drinking,
- (iii) Helping patient with elimination,
- (iv) Helping patient to maintain desirable posture in walking, sitting and lying; and helping him move from one position to another,
- (v) Helping patient rest and sleep,
- (vi) Helping patient with selection of clothing, with dressing and undressing,
- (vii) Helping patient maintain body temperature within normal range,
- (viii) Helping patient keep body clean and well groomed and protect integument,
- (ix) Helping patient avoid dangers in the environment and protecting others from any potential danger from the patient such as infection or violence,
- (x) Helping patient communicate with others—to express his needs and feelings,
- (xi) Helping patient practise his religion or conform to his concept of right and wrong,
- (xii) Helping patient with work or productive occupation,
- (xiii) Helping patient with recreational activities, and
- (xiv) Helping patient learn.

In all of these activities the nurse fulfils her function in providing a skilled caring service to meet the needs of people who are dependent on her.

### 3.5 Aims of the Nursing Service

The provision of nursing care should not be withheld by a nurse because of the nationality, creed, race, colour, politics or social status of the patient. Optimum use should be made of nursing resources with every effort being made to keep abreast of advances in science, technology and research.

In summary, the nurse should aim to:—

- (a) guard and preserve the quality of life,
- (b) maintain a high standard of health in the community by education, preventive and curative measures,

- (c) restore the individual fully to health following illness,
- (d) assist the individual to develop his full potential within the possible limitations resulting from an illness or handicap,
- (e) support the quality of life for the dying by providing the maximum degree of comfort and peace of mind, and
- (f) respect at all times the religious beliefs, individuality and dignity of every person under her care.

### **3.6 Nursing as a Profession**

Despite advances in medical technology and corresponding advances in nursing techniques which have resulted in more highly skilled practitioners, traditional images of the nurse which have existed since Florence Nightingale are still prevalent.

The nurse is portrayed essentially as a surrogate mother which, in many ways, of course she is. Even accepted definitions of nurses and nursing tend to enforce and encourage this image. She is expected to be industrious, methodical, dependable and at the same time she should be considerate, co-operative and adaptable.

These very desirable attributes certainly apply to nurses but not exclusively. Most, if not all, of them could be applied to any good worker. The nurse, however, as a member of the primary care-giving profession, is called upon to apply these attributes in a professional manner as an integral part of the practice of nursing.

To be recognised as a profession, a discipline must have two main components; (i) it must offer a service to the community and (ii) it must have a body of knowledge unique to its function which it can apply in meeting needs. Nursing has justifiably acquired the status of a profession although there still remains a considerable area of knowledge to be explored and developed. The acquisition of nursing knowledge and expertise must be an on-going process; it must be scientifically based and research is therefore essential. At all times, the clear identity of nursing within the multidisciplinary health care team must be of vital concern.

### **3.7 Nursing as an element of the Multidisciplinary Health Care Team**

Teamwork is the basis for achievement in many areas of activity in today's world. In the field of health, the delivery of health services is a multidisciplinary activity given by a team to which nurses make a unique contribution.

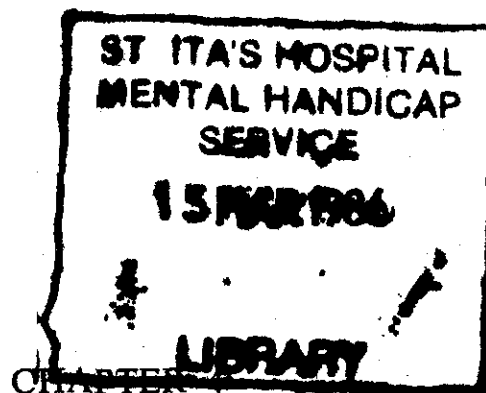
The relationships that exist amongst all the disciplines involved is important in the preservation or recovery of the health of the patient. In addition, the patient being the focus of the attention of the team, his relationship with the team must also be taken into account. He is the pivot around which the total care service revolves. The part he plays in his own recovery will be determined to a great extent by the support he receives from the team in which the nurse plays a major role.

The essence of teamwork is sharing. This means each member should perform to the best of his ability as an individual while bearing in mind that he is but one part of the whole team, the members of which are interdependent. The team, as a

ST IAN'S HOSPITAL  
MENTAL HANDICAP

whole, in order to be fully effective, is dependent on the performance of its individual members. Within the team, the independence of the nurse within her professional competence is recognised while at the same time having regard to the ultimate clinical responsibility of the doctor for the patient.

The preservation of the nursing identity within the multidisciplinary team will depend upon the nurse accepting responsibility and accountability for her own caring activities, particularly those which she initiates and controls. Nurses must carry out their nursing duties within the team in assessing and evaluating each activity against the patient's needs while recognising the professional competence of each member of the team.



## **ROLE OF THE NURSE AND ORGANISATION OF NURSING SERVICES IN THE HOSPITAL**

### **4.1 Introduction**

The Working Party was charged with the responsibility of examining the role of nurses in the health services and the grading structures appropriate for that role in the future. The role of the nurse in general has already been examined in chapter 3.

The Working Party examined the existing grading structures to see whether they were appropriate and if they contribute to the efficient running of the health services. In fact, it was quite clear from the outset that many problem areas existed especially in the hospital services and that many of these were attributable to the absence of a standardised organisational structure for nursing staff with the consequential lack of defined roles and functions. These are discussed further in section 4.2 below.

The Working Party in this chapter recommends a revised hospital nurse grading structure which it considers should be implemented at the earliest possible date. The basic considerations which led the Working Party to make these recommendations were:—

- (i) the need to take account of the profound changes which have taken place in the nurse's role during the last thirty years or so: changes brought about by medical, technological and scientific advances;
- (ii) the need to create a positive role at the present Matron level in the tripartite management structure (*para. 4.3.3.(1)*);
- (iii) the need to create a more meaningful role at the present Assistant Matron level;
- (iv) the need to create a support structure for the present grade of Ward Sister who functions both in a managerial and clinical capacity and;
- (v) the need to develop the role of the staff nurse.

### **4.2 Problems in the Present Structure**

The present structure presents problems for all grades between staff nurse and matron. Many of these problems are associated with unsuitable or obsolete patterns of organisation, others with lack of clear role definition. They may be summarised as follows:—

#### **4.2.1 Matron**

The range of duties undertaken by the matron is very wide although the pattern is

not uniform throughout the country. The extent to which matron is directly responsible for a number of services in addition to nursing is influenced by the size of the hospital as well as by the policy of the hospital board.

In many hospitals, matron is responsible for control of admissions and ambulance services are also her responsibility. In smaller hospitals, matron is likely to be responsible for catering, laundry, linen and stores. Very often, matron is over-involved in these activities to the detriment of the nursing service.

The matron is a senior nurse administrator but often, due to historical reasons, her commitment far exceeds what is now considered normal administrative practice in terms of time and duties. Matrons are overburdened with day-to-day problems and are unable to delegate for lack of support staff. There is a need to develop the role of matrons as top managers of nursing services supported by an appropriate staff structure.

#### **4.2.2 Assistant Matron**

In reviewing the evidence submitted to the Working Party, it was apparent that there was grave dissatisfaction on the part of assistant matrons with their role. This was confirmed by the Attitude Survey which showed that 63.7% of all respondents felt that "it is very difficult to define the assistant matron's role"; while 61% of assistant matrons themselves agreed that they had "no real area of responsibility". Very often, assistant matrons' role is concerned with support services other than nursing services.

#### **4.2.3 Night Superintendent**

The night superintendent is the matron's deputy by night. In addition to administrative responsibilities, this post also involves direct clinical responsibilities.

The general problem of nursing staff being permanently on night duty is referred to later in this chapter.

#### **4.2.4 Ward Sister**

The ward sister is required to be an expert in nursing, in practical teaching and in managing people and resources.

It is the ward sister who, in the interest of patient care, co-ordinates the ward nursing services with all the other ward services outside her direct span of control. It is on the ward sister that the pressures of rapid patient turnover and responsibility for the successful outcome of the complicated techniques now carried out by nurses weigh most heavily. In a post which makes so many and such heavy demands on the individual it is unrealistic to expect that one person can continue to shoulder this responsibility without assistance.

The Attitude Survey indicated an unsatisfactory situation as regards the present role and functions of the ward sister grade; the ward sister, because of her heavy nursing commitments, is unable to give sufficient attention to her management role.

#### **4.2.5 Staff Nurse**

According to the 1979 Health Staff Census, the total number of hospital-based registered nurses (excluding psychiatric and mental handicap nurses) was 10,724. Of this number, 9,119 were staff nurses.

Many of the problems facing nurses today are centred in the staff nurse grade. In particular there is confusion and uncertainty as to the proper role of the staff nurse. The work demands scientific knowledge, technical competence, social awareness, interpersonal skills and compassion. Giving good nursing care is demanding in many respects; physically, intellectually and emotionally but it is crucial to the recovery of most sick people and in the prevention of illness for others.

Areas of contention can be isolated under a number of headings:—

- (i) *Organisation of Nursing Care (Duties)*: The general pattern of organisation of nursing care in Irish hospitals at present is by the task assignment method which militates against improved total patient care through the patient-centred team approach to nursing (see para. 4.3.1). Task assignment essentially means that the more highly skilled technical duties are allocated to the more senior nurses leaving the more routine and less skilled tasks to the other nurses. This results in a very fragmented approach to the care of the patient and is frustrating for the staff nurse. Nursing practice should change so that nurses are responsible and accountable for the total care of a group of patients.
- (ii) *Changes in Nursing Care*: Due to earlier ambulation and shorter duration of stay in the hospital, the tempo of ward activity has increased considerably but this does not tend to be reflected in nurse staff establishments which remain basically unaltered. In addition, the volume of major and minor surgery has increased, thereby creating a greater workload for nurses in pre- and post-operative nursing care.
- (iii) *Changes in Medical Care*: There have been very marked developments in medical care brought about in various ways, for example by new surgical procedures, chemotherapy, etc. very often increasing the need for nursing care.
- (iv) *Development of Specialist Areas*: The introduction of specialist units with marked emphasis on intensive therapy etc. requires supplementary skills from staff nurses which are usually acquired by in-service training and experience.
- (v) *Changes in Disease Patterns*: Hospital patients tend to be of an older age group and the spectrum of diseases is changing. There has been a high degree of emphasis placed on care of the elderly. There is still a large number of persons needing long term care but the causative pattern has changed with an increase in the number of road traffic accidents and chronic motor neurone disorders. Advances in the treatment of diseases like leukaemia result in more demands on the nurse including greater technological skills.
- (vi) *Specific Problems*: Inadequate staffing of geriatric hospitals, withdrawal of nurses from wards for ambulance duties and lack of support staff are matters which are a constant source of dissatisfaction in the staff nurse grade.

The survey of the activities of staff nurses carried out by the Working Party

(described in the Introduction to this Report) showed that all the activities listed were, in fact, performed by staff nurses from the representative group of twenty-four hospitals. Some activities were performed by relatively few nurses. These were of a highly specialised nature, e.g. changing outer cannula of tracheostomy, haemodialysis or supervision of monitors.

The following are examples of the activities which were considered by the majority of nurses carrying out these activities to be inappropriate for staff nurses:—

- (a) Delivering laboratory specimens, X-ray cards and CSSD requests;
- (b) Cleaning equipment other than equipment used for nursing procedures;
- (c) Checking and counting linen;
- (d) Moving ward furniture;
- (e) Disinfecting linen.

The majority of the nurses engaged in the following activities accepted them as a normal responsibility and thus would seem to accept the concept of the *extended role* that is, the practising of higher technical skills by the nurse. The acceptable activities included:—

- (1) Adding drugs to intravenous infusions;
- (2) Application of plaster of paris;
- (3) Application of splints;
- (4) Setting up haemodialysis;
- (5) Suturing minor lacerations.

The staff nurses' need for support was indicated by the high percentage (over 60%) of respondents who suggested that non-nursing support staff, especially attendants, should carry out certain activities (see para 4.20 re support staff). Many respondents suggested that, while they themselves felt that they should perform certain activities, they should have the assistance of non-nursing personnel.

The Working Party stresses the need for scientific study in this area to determine staff nurse work patterns throughout the country as a basis for future development of the nursing services.

#### 4.2.6 Student Nurses

In one or two health board training hospitals and in most voluntary training hospitals, the number of student general nurses exceeds the number of qualified staff nurses. This clearly shows the high dependency on student nurses for meeting the service needs of these hospitals which has adverse effects on both the student and the nursing service.

The following are some of the difficulties arising from excessive dependency on student nurses which have come to the attention of the Working Party:—

- (i) it is difficult to achieve continuity in patient care due to students not being permanent members of ward teams;

- (ii) it is difficult to develop an individualised patient care approach to nursing;
- (iii) it results in a task-oriented approach to nursing care;
- (iv) it increases conflict of interests between service needs of the hospital and training needs of the student;
- (v) it militates against the introduction of a modular training system which would reduce the gap between theory and practice;
- (vi) it causes confusion for students themselves between their service commitments and their training needs.

### 4.3 Revised Grading Structure

In determining an appropriate grading structure for hospital nurses, the following were taken into account:—

- the provision of an effective and an efficient nursing service for patients;
- the organisational and management requirements of the hospital nursing services including their co-ordination and evaluation of effectiveness;
- the necessary arrangements to ensure adequate training of student nurses;
- career development for qualified nursing staff;
- the need to structure posts so as to maximise the use of nursing resources; and
- the need to provide job satisfaction for nurses at all levels.

#### 4.3.1 Team Nursing

The Working Party is satisfied that some of the problems in the staff nurse grade arise from a task-oriented approach to nursing.

Task-oriented nursing implies that the nurse is given a list of activities that are not related to a particular patient or group of patients. The most serious effects of this type of work pattern is that it leads directly to a hierarchical division of work as between technical high-status and basic low-status activities. It also means that responsibility for care is very fragmented among the several nurses who may perform “tasks” for the patient. The task performed becomes more important than its outcome for the patient for whom it is performed.

The development of a patient-centred team approach to nursing would be of inestimable value in making the best possible use of nursing skills in the total care of patients rather than in the performance of a series of unrelated tasks.

Organisation of work within a team may take the form of task assignment but, since the tasks are performed by team members for particular patients and the team leader has direct responsibility for her group of patients, most of the disadvantages of task assignment would be obviated.

It follows that the degree of personal satisfaction and sense of fulfilment for nursing team members will be greater when the reason for their activities, whether simple or complex, can be seen to be directly linked to the welfare of the patient.

A team may be defined as a group of people with different levels of skills and knowledge who share a common goal. Each team must have a leader who



identifies the goal and makes the team work towards it. This definition lends itself easily to a nursing team. The team leader will organise and supervise the care for her group of patients and be responsible to her immediate superior.

The need to develop team nursing arises because of the many changes which have been taking place in the ward setting. These changes have made the role of the present ward sister more complex and have increased her administrative role. Many tasks formerly performed by ward sisters must now be delegated, especially those concerned with direct patient care.

If a system of team nursing were to be introduced, delegation would be more easily achieved, the Nurse Administrator (see para. 4.3.2. (1)) could expect first hand information concerning the condition of the patients and could refer to the team leader when seeking information. She would also have more time for counselling and teaching staff members and for providing patient support.

Student nurses would have the advantage of adequate supervision; they would learn to identify patient needs through closer contacts with individual patients and they would learn early in their training the meaning of patient management and responsibility.

If team nursing is to be successful, certain requirements must be met. These may be described as follows:—

*Leadership*—leadership qualities must be developed in qualified nurses and they must have sufficient knowledge and skills to make decisions about patient care. They, in turn, must be willing to accept leadership and its responsibilities;

*Delegation*—the Nurse Administrator must delegate to the Deputy Nurse Administrator (see para. 4.3.2. (2)) the necessary authority to enable her to carry out her functions;

*Written Nursing History and Nursing Care Plans*—for each patient should be introduced and kept up to date. The plan for each patient is the means of ensuring continuity of care;

*Patient Assignment*—within the team, the work should be organised through a system of patient assignment rather than, as often can happen, through task assignment.

#### **4.3.2. Basic and Middle Management Structure**

It is not feasible for the Working Party to set out a separate structure for every size and type of hospital. *However, it is recommended that for any unit of 30–40 beds, the following staff structure should be provided:—*

*Nurse Administrator*

*2 Deputy Nurse Administrators*

*Staff Nurses*

*Student Nurses (in the case of training hospitals)*

*The above structure should obtain in any hospital regardless of size, type or bed complement.*

##### **4.3.2. (1) Nurse Administrator**

The Working Party welcomes the move towards providing 30 to 35 bed ward

units in new hospital plans.

The Nurse Administrator will normally be in charge of a 30 to 40 bed unit. This principle however will be subject to adjustment in the context of certain labour-intensive units. She will span the two day shifts each of which will be headed by a Deputy Nurse Administrator. This spanning of shifts facilitates continuity of care between the two day shifts and permits of the Nurse Administrator's presence during the main period of the hospital's activities.

She will plan and direct patient care in accordance with hospital policy and co-ordinate the duties of the nursing teams and of the support staff working within her unit. She will also participate in the teaching and training of all staff in the clinical area.

The Working Party considers that such an arrangement will allow the Nurse Administrator to play her proper role in managing the services in her area.

#### **4.3.2. (2) Deputy Nurse Administrator**

The nursing teams which the Working Party envisages within the proposed hospital nursing structure will be led by a Deputy Nurse Administrator to whom will be delegated the necessary authority to carry out her functions. She, in turn, may delegate responsibility to some of the nurses on her team for the total care of groups of patients.

There should be two Deputy Nurse Administrators for each 30-40 bed unit; one heading a morning shift and the other heading an evening shift. The Deputy Nurse Administrator, in addition to her clinical leadership role, will have a responsibility for the training of her nursing staff.

#### **4.3.2. (3) Staff Nurses**

The staff nurse is—and should continue to be—the pivot upon which depends the success or failure of the nursing care of the patient. It is the staff nurse who, primarily, provides the continuity of care so essential for the well-being of the patient while working as a member of the nursing team. She is aware of the total nursing needs of the patient and her presence is a help and support at both the professional and personal levels and is often the stabilising influence which the patient needs during a difficult period in his life.

The Working Party is satisfied that the services of staff nurses of the appropriate discipline are essential throughout the twenty-four hours during which nursing care is required in order to organise and provide the total care of the patients for whom they are responsible. They are further required to support and supervise the students (where applicable) and ancillary staff members of the team.

#### **4.3.2. (4) Student Nurses**

A basic tenet in any educational system is that the student must be free to learn. It is clear that the role of the student nurse can be neither wholly *work* nor wholly *learning* oriented. A balance is required so that on the one hand, the student is not entirely free from responsibility for giving patient care nor, on the other hand, so involved with patient care that she is not sufficiently free to learn.

Student nurses have been described as apprentices needing supervision whose periods away from the wards preclude them from full employment in the care of patients.

While it is inadvisable to continue counting on students to form the greater part of a nursing establishment, it is equally inadvisable to contemplate creating a situation where they will have no commitment to clinical areas and where learning nursing skills is only achieved by isolated visits to the wards. Most of the time in training is spent in acquiring adequate nursing skills which are practised in the normal work situation in the hospital.

The EEC directives are very clear in describing the principles of training:—

“Clinical instruction in nursing shall take the form of supervised in-service training in hospital departments or other health services, including home nursing services. During this training student nurses shall participate in the activities of the department concerned in so far as those activities contribute to their training. They shall be informed of the responsibilities of nursing care”.

In order to achieve a situation where the student is able to perform both as a learner and as a member of the ward staff several factors should be considered. It is important that the learning objectives in clinical areas be identified. Identifying and setting objectives establishes goals to be achieved. Student nurses should be aware of what they are expected to learn and what activities they are expected to carry out in each area. This ensures that the best use is made of the time spent in a clinical area.

Setting learning objectives should be a shared process between the ward administrators and the nurse educators. While some learning objectives will be common to many wards, the pattern of work and patients' needs in each ward must be considered when writing learning objectives.

The formulation of objectives is in line with current trends in education. Once they are formulated, the students can go ahead and achieve much learning by self-direction.

Because much of the conflict between “learning” and “doing” is removed by setting learning objectives in each area, the student can be expected to perform as a valuable member of the ward team—achieving both the goals of an individualised patient care plan and those of an education plan.

To enable the student “to participate in the activities of the departments” and to “be informed of the responsibilities of nursing care”, it is important that qualified nursing staff and the student should work together in the carrying out of nursing activities. One way of establishing this pattern would be by introducing the concept of team nursing where the student will be in an ideal learning situation as, with adequate supervision and support, she will learn to plan and assess her patients' needs and to take responsibility for delivery of care. Being a member of the nursing team introduces the student to the idea of management and organisation of care and prepares her for ultimate responsibility as a staff nurse.

#### **4.3.3 Higher Management Structure**

The grading structure outlined in the previous paragraphs applies at ward unit level. That structure should be adequate for the effective running of small hospitals with the addition of a Senior Nurse Administrator (see para. 4.3.3 (5)) to head the nursing service.

*For large general and regional hospitals, the following nursing management structure above ward unit level is recommended:—*

*Director of Nursing*  
*2 Deputy Directors of Nursing*  
*Senior Nurse Administrators*

4.3.3 (1) This structure is recommended in the context of a tripartite hospital management system, that is, a system of shared management by general, medical and nursing administration with each party jointly participating in the administration of the hospital. Such tripartite management exists in some hospitals and, where it does not exist, it should be introduced.

Each of the three members of the tripartite administration will report to the team as a whole at regular, structured meetings. The team in turn will be responsible for all matters affecting the day-to-day running of the hospital to the hospital board or health board programme manager, as appropriate.

The advantage of the tripartite management system is that each member is given an insight into the areas of responsibility of his two colleagues and can thereby appreciate the problems affecting those areas in addition to his own. It also helps to focus attention on the effect on other areas of decisions made in one area of responsibility and the interdependence of the various hospital activities on one another. The tripartite team should be jointly charged with responsibility for finding solutions to those problems.

The participation of the Director of Nursing (see para. 4.3.3 (2)) in the tripartite team is essential because:—

- (i) the nursing input is vital in accomplishing the team's objective of providing a co-ordinated and effective service in all the departments of the hospital;
- (ii) the nursing service both affects and is affected by the functions of other departments; and
- (iii) the Director of Nursing is responsible for the largest category of hospital staff and therefore has a significant input to budget.

**4.3.3 (2) Director of Nursing**

The Director of Nursing would be the manager of the hospital nursing service. As such, she plans, organises, controls and co-ordinates the service and develops policies and standards relating to it. She also ensures that the nurse educational activities within the hospital are compatible with the nursing policies and with the maintenance of a high standard of patient care.

She also, as has been pointed out, plays a key role in the overall management of the hospital as a member of the tripartite management team.

The functions of the Director of Nursing are carried out within the following broad areas:—

- (i) developing, setting and monitoring standards of nursing care of patients;
- (ii) preparing, reviewing and overseeing the implementation of nursing policy within the framework of hospital policy;
- (iii) participating in the formulation of the hospital's budget with specific responsibility for the nursing services budget and ensuring that expenditure is contained within the approved allocation;

- (iv) co-operating with the nurse training school in providing facilities for the training of student nurses; and
- (v) initiating and promoting study and research into issues relating to nursing practice.

#### **4.3.3.(3) Deputy Director of Nursing (Service)**

The Deputy Director of Nursing (Service) would have a line responsibility to the Director of Nursing for general staff allocation and for monitoring the efficiency and effectiveness of the nursing service. She would also carry out the functions of the Director of Nursing in her absence.

Amongst her specific duties would be the following:

- to advise the Director of Nursing on matters relating to nursing policy and on measures required for the implementation of agreed policy;
- to examine and assist the Director of Nursing in setting standards of nursing care and nursing procedures and monitor their effectiveness through regular meetings with the Senior Nurse Administrators;
- allocation and co-ordination of nursing staff and other resource needs;
- in the allocation of student nurses to service areas, to consult with the Deputy Director of Nursing Education (Liaison)—(see paragraph 7.3.9);
- to take part in selection interviews for appointments to nursing posts.

#### **4.3.3 (4) Deputy Director of Nursing (Personnel)**

The Deputy Director of Nursing (Personnel) would fulfil a staff function role outside direct line management. She would be fully responsible to the Director of Nursing for recruitment of nursing staff up to and including Nurse Administrator level, in-service training, staff induction, orientation and development. She would work in close liaison with the personnel department of the hospital and of the health board (where appropriate).

The Working Party has a two-fold reason for recommending a recruitment function for a nurse at this level. It is that—

- (i) those charged with the selection of nursing staff should have a thorough knowledge of the hospital, its function and requirements, and
- (ii) professional knowledge is essential in selecting suitable people.

In addition, she should be involved in the recruitment and deployment of other staff who should work in a supportive role to nurses on the wards such as domestics, attendants, ward hostesses and clerks. In this regard, the Deputy Director of Nursing (Personnel) should consult with and advise the supervisors of those grades.

She should take part in selection interviews for appointments to nursing and allied posts.

It is further envisaged that this Deputy Director will also have a responsibility for staff relations and other routine personnel functions. In relation to discipline, she will provide a support function to line management without necessarily undermining the authority and responsibility of line management for staff

discipline. Additionally, in hospitals which do not have a formal occupational health service, she will be responsible for staff welfare and health.

The Deputy Director of Nursing (Personnel) would be equal in status to the Deputy Director of Nursing (Service). She should have formal personnel management training in line with others in the personnel field.

#### 4.3.3 (5) Senior Nurse Administrator

A Senior Nurse Administrator would be responsible for an area or division of a hospital.

It is envisaged that a Senior Nurse Administrator would:—

- (i) report to the Deputy Director of Nursing (Service);
- (ii) function as leader of the nursing staff and overall manager of the nursing services in her division;
- (iii) in consultation with the Deputy Director of Nursing (Service) co-ordinate the overall resource needs of her division and level out any imbalances;
- (iv) assist the Deputy Director of Nursing (Service) in the identification of new activities and needs for resources and in the formulation and monitoring of the budget for the services;
- (v) assist the Deputy Director of Nursing (Service) in determining training needs in relation to her division.

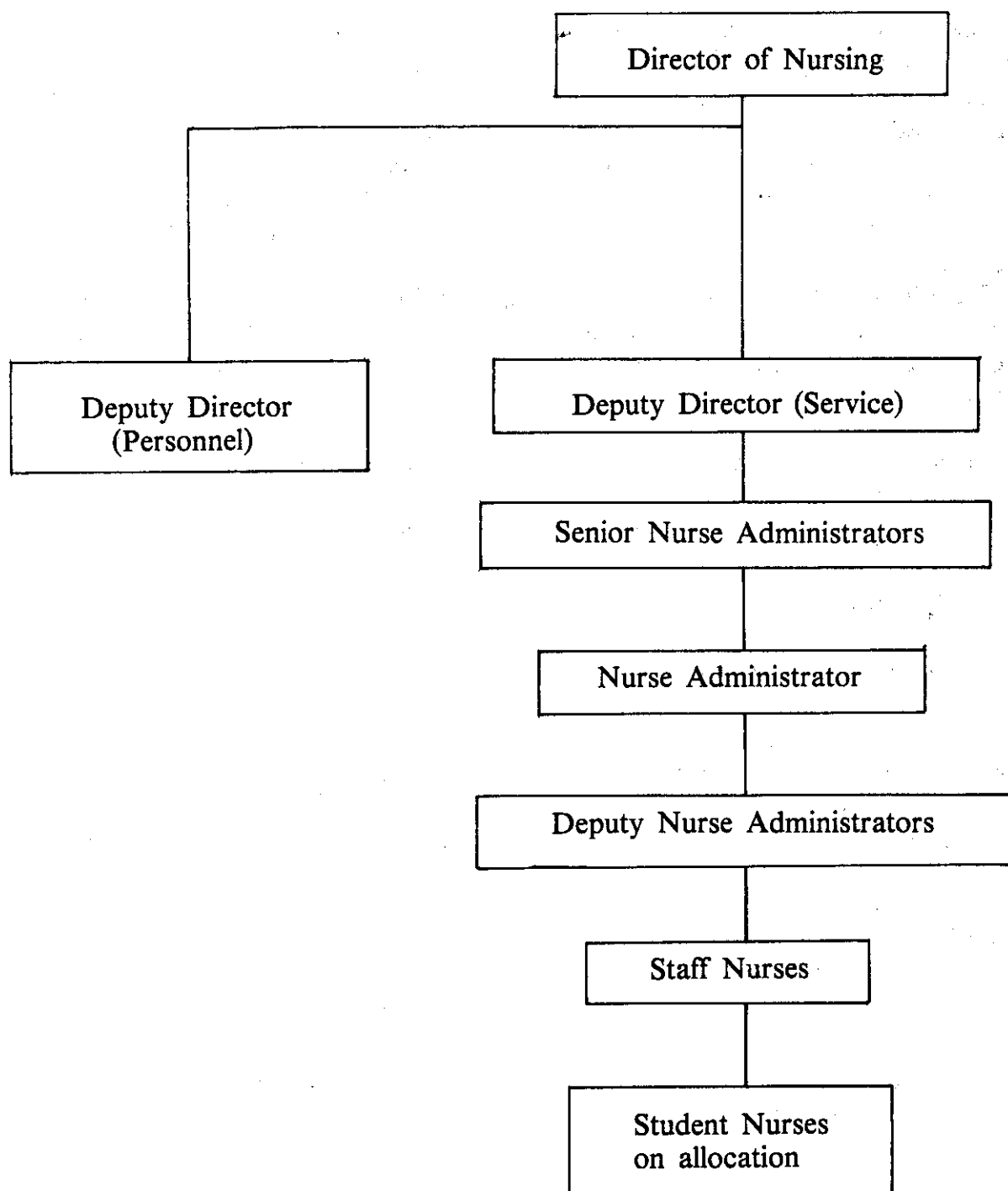
The number of senior nurse administrators for any one hospital would depend on its size and range of activities rather than on numbers of beds. For example, it is proposed that in a large general hospital, a senior nurse administrator could be in charge of each of the following:—

Surgical nursing division,  
Medical nursing division,  
Casualty/Accident & Emergency/OPD,  
Theatre Suites,  
Night nursing service.

There could be alternative groupings. The foregoing grouping is indicated as they are readily identifiable areas in most hospitals. It is envisaged that in all large hospitals, grouping of wards under a senior nurse administrator will take place; the basis to be determined in the context of each hospital's particular requirements.

4.4 As earlier indicated, the Working Party did not consider it feasible to set out a separate structure for every size and type of hospital. It could only indicate the general range of structures leaving it for further consideration as to how it should apply in individual hospitals.

4.5 The following chart shows the recommended organisation structure for a large general or regional hospital:



#### 4.6 Rostering

The three most common types of duty rostering are:—

- (i) **Shift:** a continuous period on duty normally of six or eight hours.
- (ii) **Split Shift:** a period of duty normally of eight hours spread over twelve with four hours on-duty, four hours off-duty, four hours on-duty.
- (iii) **Long day/Short day:** a roster by which periods of duty may be up to 12 hours some days and as few as 4 hours other days covering an 80 hour fortnight.

The Working Party has been unable to find any strong evidence to suggest that any one of these types of rostering seriously interferes with patient care. The main requirements are adequate cover and continuity of care and as long as these are maintained there can be flexibility in rostering arrangements. The Working Party is, however, in favour of continuous day shifts of not longer than eight hours duration as it is considered that this system best facilitates team nursing. It is difficult for nurses to give of their best when the working day is extended beyond eight hours.

The Working Party when earlier dealing with the ward nursing team indicated that there would be two shifts on duty daily, a morning shift and an evening shift, each headed by a Deputy Nurse Administrator with the Nurse Administrator spanning the two shifts.

As in the case of the Nurse Administrator (see para. 4.3.2.(1)), other more senior nurses should also work a roster spanning the two day shifts thereby being present in the hospital during the main period of its activities and ensuring the presence of a Senior Nurse Administrator throughout the day.

The question of night cover is dealt with separately in the following paragraph.

#### 4.7 Night Duty and Rotation

The Working Party is satisfied that, in large hospitals providing acute care, there is a decided need for supervision at Senior Nurse Administrator level by night. Ideally, this supervision should be rotated amongst all the Senior Nurse Administrators in the hospital to avoid having a person permanently on night duty. *For all grades involved in night duty, it is recommended that, wherever possible, rotation should be practised.*

It is accepted however that some nurses prefer permanent night duty. On the other hand, it is not always possible to have rotation due to unwillingness of other staff to be rostered for night duty.

The main disadvantages of staff being on continuous night duty are:—

- (i) the risk of such staff losing touch with the rapid changes and developments in nursing and medicine;
- (ii) the risk of inadequate communication between day and night staff; and
- (iii) such staff lose social contact with colleagues.

*The Working Party recommends that nurses who are normally only assigned to night duty should spend at least four weeks per year on day duty to keep abreast of developments.*

There will be a need for variation in levels of night duty cover according to types and sizes of hospitals. *The Working Party recommends that staff nurses are essential on duty in every ward throughout the twenty-four hours.*

Nursing supervision of a hospital by night regardless of its size or activity should always be the responsibility of a grade higher than that of staff nurse. The current practice in some small hospitals whereby a staff nurse has full responsibility, with Matron "on-call", is undesirable.



#### 4.8 Nurse/Patient Ratios

A recurring problem in nursing services is the level of staffing required for the proper delivery of patient care, particularly in the hospital situation. The problem is compounded to some extent by the involvement of nursing personnel in what might be regarded as non-nursing duties. Here again, however, where patient care is involved, it is often difficult to be definitive about non-nursing duties.

To decide how many nurses are required in any given work situation it is necessary to be clear as to the role and duties of a nurse and, it is to be hoped, this report will be of some assistance in this respect. It is difficult to lay down general standards regarding staffing levels because of the multiplicity of factors that have to be taken into account. These include:—

*bed occupancy;*

*each patient's degree of dependency;*

(apart from the individual's needs, this will also vary for intensive, acute and non-acute care and also for different medical specialties).

*size of ward;*

*layout of wards (and buildings).*

Quicker throughput of patients through more intensive care and treatment programmes may in effect call for increased nurse staffing.

Existing levels in hospitals have evolved mainly from past experience in the hospital concerned and, perhaps, by reference to other broadly comparable hospitals, increasing workloads and reduction in working hours being taken into account as the need arises.

There is no scientific method which will give a complete answer to the question though there is some research being carried out in this area in other countries. There will always be the element of judgment which cannot be left out of the consideration and any scientific investigation must have regard to the judgements of experienced hospital staff. The nurse herself plays a part in determining the patient's needs and in so doing exercises her own professional judgment, depending on the nature of the illness, the treatment required and the extent to which the patient is dependent.

The Working Party has not attempted to determine appropriate staffing levels or to set guidelines in the various areas of the nursing services. It welcomes the recent announcement by the Minister for Health that he has decided to commission an expert study in nurse staffing levels and it looks forward to considerable research of this nature being carried out in the future. Clearly, staffing levels will vary considerably from intensive care areas and high dependency long-stay areas requiring very high staffing—probably on a one-to-one basis—to long-stay care where a nurse can supervise a number of patients with a low dependency rate. It is not possible for the Working Party to be more precise in this matter and *it recommends that nurse staffing levels should be more closely related to patient dependency needs and throughput and should be determined on a scientific basis having regard to proper nursing standards.*

#### 4.9 An Occupational Health Service for Hospital Staff

Although this is an area which is not directly related to a hospital nurse grading structure, the Working Party wishes to direct attention to the need for providing

an occupational health service for the staff of hospitals.

The World Health Organisation defined the objective of an occupational health service as the promotion and maintenance of the highest degree of physical, mental and social wellbeing of all the workers in an enterprise.

A high proportion of the staff employed in hospitals are exposed to health hazards to a greater degree than that experienced by those working in most other types of employment. For example, ward staff come into contact with a wide spectrum of diseases some of which are infectious e.g. some respiratory diseases, septic skin conditions, virus infections etc. In addition, there can be considerable physical strain in activities such as lifting, turning and bathing patients in which nurses and other personnel are engaged. Members of the staff too may be exposed to radiation, to gases from anaesthetic apparatus and to infection in the laboratories and are liable to accidental injury from falls, scalds, cuts etc.

Apart from the physical aspect, there is quite a lot of psychological stress in dealing with vital emergency situations, in caring for chronically ill and dying patients, and in coping with relatives in what is frequently a highly emotional atmosphere.

These various factors must have an effect on people working in the hospital services and the Working Party considers that there is a need for organised occupational health services especially for large hospitals with high staff complements. Such a service would be desirable, especially in the preventive field, but also in the curative field. It would bring benefit to the patients—albeit indirectly—by helping to maintain staff complements through reducing the amount of absenteeism due to illness. Also, staff members who for health reasons are unable to cope in the work situation could be assisted towards improved health resulting in a better disposition generally and therefore more job satisfaction.

#### **4.10 A Second Level Nurse**

The registered nurse is qualified to provide skilled nursing care based on extensive knowledge of the human body, including the psychological needs, the disease process, the effects of therapy and many other factors.

It could be argued that there is a need to separate the occupation of nursing into two general pathways, at the same time leaving the option open to start on the lower route and later move to the upper. This would ensure that the lower range of duties and responsibilities would be carried out by personnel having the lower level of training while the higher range of duties and responsibilities would be undertaken by those having the higher level of training. Thus, the two training programmes would be structured to meet the requirements of the two levels of activities and responsibilities.

##### **4.10.1 European Trends**

The position in European countries varies though most have a second level nurse. In the United Kingdom, the State Enrolled Nurse is the second grade and the Report on the Reform of Nursing Education (Platt Report) states “this grade of trained nurse has not been accorded the recognition which it deserves, although, where enrolled nurses have been introduced into the nursing team, they have become valued members of it”. The Report goes on to state the following reasons for retaining the present pattern of State Registered Nurses and State

### Enrolled Nurses:—

- “(a) the comprehensive character of the nursing services and the wide range of nursing duties entail differing levels of responsibility,
- (b) both registered and enrolled nurses would find satisfaction in their work through the full and effective use of their respective degrees of knowledge, ability and technical skills,
- (c) trained nurses are required in large numbers. It is therefore necessary and desirable to recruit from persons of differing academic ability who are best prepared for their professional role in different ways”.

The view expressed in the report on the difference between a State Registered Nurse and a State Enrolled Nurse was that it would lie in the range of functions performed and in the degree of responsibility carried.

In both Denmark and Finland, the Working Party representatives found that a second level nurse exists. In both countries, these people are known as practical nurses or nursing auxiliaries and are trained in one year. On completion of training these nurses are competent to work with a fully qualified nurse—in any area in which nursing care is provided. In both countries the qualified nurses are “multipurpose” nurses, that is, nurses who are deemed competent to work at staff nurse level in any area of nursing—general, psychiatry, paediatrics etc.—without extra training in that area. There is no credit allowed for the one-year practical training if the nurse wishes to pursue the full comprehensive nurse training programme. Underlying the employment of second level nurses in other countries, there is reason to believe that, historically, a shortage of candidates for full nurse training led to the creation of the second level. This country is fortunate in having a plentiful supply of suitable candidates for nurse training. This accounts for the fact that, in this country, there is only one level of nurse, that is the registered nurse and, consequently, a relatively high number of professional nurses employed. Whether the plentiful supply position will continue remains to be seen. In the present situation, however, the Working Party does not see a need for a second level nurse. It appreciates that the situation will need to be constantly monitored particularly in the light of the extended role of the nurse (see paragraph 5.4.1) which is demanding ever higher skills of the nurse. The recommendations made on this matter by the International Labour Organisation and the World Health Organisation which were earlier referred to will need to be borne in mind.

Non-nursing support staff and the need for them to receive adequate in-service training appropriate to their level is dealt with later in this chapter.

### **ROLE OF THE NURSE AND ORGANISATION OF NURSING SERVICES IN MIDWIFERY**

4.11 It is estimated that there are approximately 1,000 midwives fully engaged in maternity work in maternity hospitals and maternity units in general hospitals. It is difficult to be precise about the exact number as in many general hospital units, staff nurses with midwifery qualifications rotate amongst maternity units and other departments of hospitals. In addition there are some fifty midwives who have an agreement with health boards to provide maternity and infant care services on a part-time basis in the community and some who engage in private practice. All public health nurses are required to have a midwifery qualification.

4.12 As well as pre-natal and intra-natal care of the mother a midwife is responsible for the care of the mother and baby for the first ten days after the birth. In the larger urban areas this service is provided by a midwife who has been designated for this work by the local maternity hospital. The total number of live births for the year 1978 was 69,844.

4.13 The International Confederation of Midwives has defined the midwife as a person who:—

- “(a) having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.
- (b) She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the post partum period; to conduct deliveries on her own responsibility, and care for the newborn and the infant. This care includes preventive measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and execution of emergency measures in the absence of medical aid. She has an important task in health counselling and education, not only for patients but also within the family and the community. Her work should involve ante-natal education and preparation for parenthood and extend to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.” (Washington 1972).

#### 4.14 Role of Midwives

4.14.1 The role of the midwife differs from that of other categories of nurse. The midwife, in the vast majority of cases, cares for normal healthy women during a normal physiological function and, to a greater extent than any other professional nurse, she has a degree of clinical responsibility and independence of action.

Several factors influence this role and impose changes on the practice of midwifery. The first and most important is the change in emphasis in maternity services; a significant increase in the number of hospital deliveries and the trend towards early discharge of both mother and baby. There is growing emphasis on the importance of ante-natal care, encouragement of all expectant mothers to attend ante-natal clinics and the development of education programmes in parenthood. Early discharge from hospital has highlighted the need to maintain continuity of care when mother and baby return home.

Pressures and changes in society also affect the midwife's role; in particular such developments as “one-parent families”, increases in the incidence of non-accidental injury to babies, and—most significantly in Ireland—many girls are marrying at a younger age, many under the age of twenty, a large number of whom are not fully informed and prepared for the experience of childbirth.

All these factors have a bearing on the midwife's role as an educator, communicator, and counsellor.

The midwife's role in the hospital is also changing. Care in the ante-natal wards has become much more technical and sophisticated. Expectant mothers, where necessary, are being continuously monitored through a variety of technical aids e.g. amniocentesis, cardiotocography and ultrasonography. These new procedures have added to the midwife's traditional role and have emphasised her role in providing emotional and psychological support to a mother in a highly technical environment.

The development of neo-natal paediatrics has also had an important impact on midwifery. Due to better standards of maternal health, more sophisticated obstetric practice and intensive care nursing there is a greater survival rate among the new born including children with disabilities.

Increased knowledge of neo-natal and foetal physiology leads to the development of even more sophisticated management of the new born, which in turn calls for more expertise on the part of the midwife for those babies who are at risk.

Early discharge of mother and baby has complicated the provision of post-natal support and care. The interdependent role of the midwife and the public health nurse is important. *Where it is feasible and practicable, hospital midwives should carry out follow-up visits to mothers and their new-born babies for a certain period after their return home.*

4.14.2 It is essential that constant links are maintained between the hospital and community staff in order that both the mother's health and that of the baby are monitored and that the mother and father are supported in parenthood and in the care and development of the child.

#### 4.15 Education of Midwives

Midwifery education in Ireland is available in 10 centres throughout the country. Nurses qualified in general nursing or in paediatric nursing are eligible to undertake the one year course leading to registration in midwifery. Approximately 600 midwives qualify each year.

It is difficult to estimate the number of those successful in completing their training in midwifery who take up positions in maternity hospitals or in other hospitals where they are actively engaged in practising midwifery. Approximately 100 nurses undertake public health nurse training each year, all of whom are required to be registered midwives. There are still some senior posts in the hospital services which require the dual qualification of general nursing and midwifery.

It is apparent however that the large number of nurses who undertake midwifery training exceeds the actual demand for qualified midwives. A factor which may help explain this figure is the tendency for young newly qualified general nurses to seek extra certificates and qualifications. Midwifery is regarded both socially and professionally as a valuable qualification.

\*Hanrahan showed that 88.8% of the student general nurses surveyed who indicated an intention to do further courses, mentioned a midwifery course. Hanrahan goes on to suggest that this pattern may have developed because of the importance this branch of nursing is accorded by the nursing profession.

\*Report on the Training of Student Nurses, Ellen Hanrahan.

4.16 *The Working Party recommends that training in midwifery should be organised at two levels:—*

- (i) An intensive training programme (of not less than 18 months) which would be open to general trained nurses and which would equip the nurse to register and practise as a professional midwife.*

This lengthening of the training programme would accord with the EEC Directives for midwives and will lead to a re-organising of the present syllabus. *The Working Party recommends that the syllabus should be revised to prepare the midwife to function in an extended role and should include in-depth study particularly in relation to counselling, principles of health education, parent craft, psychological and emotional problems of parents, inter-personal relationships, mental handicap including its causative factors, genetics and medical ethics.*

- (ii) A special course for those nurses who, while not requiring the full midwifery qualification, would require some further obstetrical experience.*

These courses should be organised as six-month maternity nursing modules along the lines of other courses in specialised clinical nursing. They could be complementary to the obstetric module which will be part of the proposed common basic training programme.

The extension of the training period for midwifery in this country would make it impractical to continue to require public health nurse candidates to have a full midwifery qualification. There would also be some hospital nurses and possibly occupational health nurses who might require some additional knowledge of maternity care in the course of their work. Special shortened courses of training in midwifery should meet the needs of such groups. The numbers undertaking either of the above midwifery training programmes should be determined by reference to manpower planning requirements.

## **ROLE OF THE NURSE AND ORGANISATION OF NURSING SERVICES IN THE COMMUNITY**

### **4.17 Present Position**

#### **4.17.1 Structure of the Public Health Nursing Services**

##### **4.17.1 (1) Posts**

According to the latest information available (1979) there are 1,111 approved public health nurse posts and 33 superintendent posts. Sixty additional trainee posts were approved for the 1979-80 training course. These were in addition to the number (40 approx.) required to fill vacancies existing or due to occur before June 1980. This will bring the total number of approved posts to 1,170 approx. by July 1980.

##### **4.17.1 (2) Population Ratios**

On the basis of 1977 estimated population figures, (see table below) the public health nurse/population ratio in Dublin is 1:3,278 and 1:4,161 in Cork. The ratio varies in other counties from 1:1,964 in Donegal to 1:4,053 in Wicklow. The national average nurse/population ratio is 1:2,873.

The variation in workload from area to area is influenced by geographic and demographic considerations as is shown in the following table:—

**Public Health Nurses**

Health Board		Estimated Population 1977	*Number of approved Public Health Nurse Posts 1/1/1979	*Nurse/Pop- ulation Ratio: One Nurse to
Eastern	Dublin	566,000	288	3278
	Co Borough	54,000		
	Dun Laoghaire	324,000	29	2862
	Dublin Co.	83,000		
	Kildare	77,000	19	4053
	Wicklow			
		1104,000	336	3286
Midland	Laois	47,000	39	2564
	Offaly	53,000		
	Longford	28,000	34	2441
	Westmeath	55,000		
		183,000	73	2507
Mid-Western	Clare	80,000	28	2857
	Limerick	60,000	51	2980
	Co. Borough	92,000		
	Limerick Co.	58,000	22	2636
	Tipperary N.R.			
		290,000	101	2871
North-Eastern	Cavan	52,000	41	2415
	Monaghan	47,000		
	Louth	82,000	35	2343
	Meath	80,000	31	2581
		261,000	107	2439
North-Western	Donegal	108,000	55	1964
	Sligo	50,000		
	Leitrim	25,000	37	2027
		183,000	92	1989

Health Board		Estimated Population 1977	*Number of approved Public Health Nurse Posts 1/1/1979	*Nurse/Pop- ulation Ratio: One Nurse to
South- Eastern	Carlow	36,000	34	3000
	Kilkenny	66,000		
	Tipperary S.R.	73,000	28	2607
	Waterford Co. Borough	36,000		
	Waterford County	51,000	32	2719
	Wexford	94,000	34	2765
		356,000	128	2781
Southern	Cork Co. Borough	141,000	93	4161
	Cork County	246,000		
	Kerry	119,000	37	3216
		506,000	130	3892
Western	Galway	154,000	69	2232
	Mayo	105,000	50	2100
	Roscommon	51,000	25	2040
		310,000	144	2153
Gross Total		3,192,000	*1111	2873

\*Does not include superintendent public health nurses.

#### 4.17.1 (3) Community Care Areas and Community Care Teams

The reorganised structures introduced following the setting up of the health boards in 1971 provide that each health board area has a community care programme under the direction of a Programme Manager. Under the Programme Manager are a number of Directors of Community Care/Medical Officers of Health, (hereinafter referred to as Directors of Community Care) responsible for all community care services for a specific area. Each area has its own team of health personnel.

The number of community care areas varies from ten in the Eastern Health Board to two in the North-Western Health Board areas depending on the size and population of the area.

Since the setting up of the community care areas, the policy has been to have a superintendent public health nurse attached to each area. Prior to this, a superintendent was usually appointed in a county where ten or more public health nurses were engaged on district duties.

The average number of public health nurses per superintendent is 33.



#### 4.17.1 (4) Division of Duties Between District and Headquarters Staff

The Survey of the Workload of Public Health Nurses, (1972) indicates two different spheres of work; headquarters duty and district duty. This can be related back to the evolution of the present public health nursing service in this country from the earliest provision for a public midwifery service under the Poor Relief (Ireland) Act, 1851, and the subsequent voluntary district nursing services, to the establishment under a new policy outlined in 1966 of a more comprehensive public health nursing service.

The Survey revealed that the major proportion of the headquarters nurses' time, 36.8%, was spent on clinics and school health examination work, followed by 25.0% on activities such as clerical duties, attendance at headquarters and attendance at conferences and lectures. The nurses on district duties, on the other hand, spent 40.9% of their time on home visiting duties (other than maternity care) while 24.6% was spent in travelling. The following extract from the Survey gives a clear indication of the breakdown of public health nurses' working time:

Activity Description	Percentage of Total Time	
	Headquarters Nurses	Nurses on District Duties
Home Visiting (other than maternity)	17.1	40.9
Maternity Care	0.0	1.2
Clinics, Dispensaries, Schools	36.8	19.8
Other Activities	25.0	10.3
Travel	16.8	24.6
Meals, Breaks	1.6	1.2
Miscellaneous	2.6	1.9

#### 4.17.2 (1) Role of the Public Health Nursing Service

The aim of the service is to make available to individuals and families community nursing services both curative and preventive including mother and child health and school health examinations. The service also participates in the health education programme in the community it serves.

#### 4.17.2 (2) The Role of the Superintendent Public Health Nurse

The Superintendent is responsible to the Director of Community Care for the provision of the public health nursing service in her area. As a member of the community care team, she is responsible for the planning and provision of the service in co-operation with the Director of Community Care.

The Superintendent co-ordinates and supervises the work of the public health nurses in her area. She must ensure that all public health nurses under her supervision are kept aware of developments and understand their role in new developments. She sets targets and prepares action plans for the provision of nursing services, establishes duty rotas for the nurses in the area and monitors their effectiveness and efficiency, advising on ways to improve where necessary.

She maintains staff records and assesses staffing needs in her area. She must relate needs to services currently available and suggest priorities in meeting those needs.

She has a responsibility for trainee public health nurses and other students when they are undergoing their practical training and experience in the community.

She advises the Director of Community Care on courses and seminars which would be of benefit for public health nurses.

The Superintendent does not normally become involved in the day-to-day work of the public health nurses but she must, through regular contact and co-ordination, influence the delivery of services.

She should be an instigator and co-ordinator of community nursing services and monitor the liaison between hospital nursing staff and community nursing staff. She also has a counselling role for public health nurses in connection with their work and their continuing education.

#### **4.17.2 (3) The Role of the Public Health Nurse**

The public health nurse functions in a defined geographical district and is responsible in that district for a variety of preventive services including child health and school health, immunisation and other clinics.

She works in co-operation with the area medical officer in the district. The curative duties of the public health nurse are also carried out in the same district and result from referral by hospital nurses, general practitioners, other health board staff, voluntary social services and various other agencies and persons. In some areas public health nurses may be assigned to district duties or attached to headquarters.

The responsibility of the public health nurse varies according to whether she is on headquarters or district duties. However, as will be seen from the table at 4.17.1.(4) above, there is a considerable degree of overlap.

#### **4.17.3 The Future of the Community Nursing Service**

The Working Party paid particular attention to the following aspects of the public health nursing service:—

- (i) The possible role for a registered general nurse (without a public health qualification) in the community.
- (ii) The grading structure within the public health nursing service.
- (iii) Public health nursing cover. (The provision of a 24 hour service).
- (iv) Health education.

(v) Liaison between hospitals and the community.

(vi) Specialist areas in the community.

While nurses working in the community are referred to throughout this section as superintendent public health nurses and public health nurses for ease of identification *the Working Party recommends that the title Superintendent Public Health Nurse should be changed to Chief Community Nursing Officer and Public Health Nurse should be retitled Community Nursing Officer.*

#### **4.17.4 The Possible Role for a Registered General Nurse in the Community**

The ever-increasing demands on the public health services brought about by improvements in child health and rehabilitation services, earlier discharges from hospital, growth in population, which has particular relevance to child care, and raising of the eligibility limits, have created an extremely heavy workload for public health nurses. The Working Party is satisfied that the present service cannot provide an acceptable level of cover; it is substantially under-staffed; and, in some areas the caseloads are too great and the nurses are not in a position to meet all the demands made on them.

The Working Party therefore explored the feasibility of improving the existing service by employing registered general nurses in the community without a public health nursing qualification. Public health nurses are specifically trained to provide both preventive and curative care. It is perhaps this dual function which creates difficulties in providing adequate cover. The general nurses could provide home nursing services leaving their public health nurse colleagues to concentrate on preventive work.

The EEC Directives require community nursing experience as part of the training programme for every student general nurse. This, together with the growing trend towards more comprehensive nurse training, will mean that the nurse of the future will have wider training and experience in all facets of nursing and should therefore be better prepared to undertake either hospital or community work.

The Working Party is aware that there is not general agreement that registered general nurses may have a potential role in the community. The Attitude Survey showed only a 45% agreement from public health nurses that "there is room in the community for nurses in a supportive role who have not received public health nurse training" while 75% of hospital nurses support the concept of such a community nurse. Nevertheless, consultation on both formal and informal levels with public health nurses has shown that, in the interests of adequate patient care, a reduction in workload is necessary, either through the employment of greater numbers of public health nurses or through employment of more support staff.

The acknowledged pressure on public health nurses, so evident at the present time, should not, it is stressed, lead automatically to the introduction of another grade of nurse without public health training into the community. The employment of more home helps and the greater provision of clerical assistance would help to improve the position. In the Working Party's view, it is also desirable to keep to the minimum the number of health personnel calling to any one home. Apart from public health nurses, there are others such as general practitioners, social workers, community psychiatric nurses, and home helps providing valuable services in the community.

It is also argued that all nurses engaged in community care should have public health training and further, that a division in workload as between curative and preventive services would be unduly restrictive on the nurses and would again increase the number of visitors to the home.

The Working Party is satisfied, in all the circumstances, that there exists a serious shortfall in both the preventive and curative services. *The Working Party recommends that this be resolved by:—*

(i) *increasing the numbers of public health nurses, thus improving the nurse/population ratios;*

(care should be taken to ensure that neither aspect of the work—preventive or curative—is concentrated on at the expense of the other).

(ii) *in addition to (i) above, employing registered general nurses without a public health qualification specifically for a home nursing service, thus enabling the public health nurse to concentrate on preventive care;*

The Working Party suggests that pilot schemes be set up, one in an urban and one in a rural area, to test the effectiveness of the proposal at (ii) above.

#### **4.17.5 The Grading Structures within the Public Health Nursing Service**

There are, at present, two grades in the public health nursing structure—Superintendent Public Health Nurse and Public Health Nurse.

*The Working Party, having reviewed the changes that have taken place in the public health nursing service, the considerable increase in the numbers of nurses involved and, in particular, changes in the role of the superintendent, recommends that there should be an intermediate supervisory grade viz. a senior community nursing officer.*

This recommendation is supported by the Attitude Survey wherein 81% of public health nurses agreed that “a grade of senior public health nurse is needed to share some of the responsibilities with the superintendent”.

The public health nursing service plays a major role in the community care programme and forms the largest single category of workers in the community care team. The superintendent, as leader of nursing members of the team has an important role to play in the formulation of policy and direction of the nursing services. It is not possible for the superintendent to carry out that role and to supervise thirty to forty nurses spread around the area, many located quite a distance from headquarters.

It is envisaged that the senior community nurse would be responsible—

(i) for the implementation of policy by the routine organisation and management of the nursing services within that part of the community area allocated to her and

(ii) for the co-ordination of the practical training programme of all students in that area.

*The Working Party recommends that there should be one Senior Community Nurse for every eight to ten community nurses. Each Senior Community Nurse should carry a small case-load.*

#### 4.17.6 Public Health Nursing Cover

The Survey of the Workload of Public Health Nurses divided the day into three periods as follows: 8 am to 6 pm; 6 pm to 11 pm; 11 pm to 8 am.

Work done between 8 am and 6 pm was regarded as being within the normal working day, giving a certain degree of flexibility to nurses in time spent in delivering care.

In the Workload Survey, it was shown that in the case of nurses on district duties 86.6% of working time is between 8 am and 6 pm Monday to Fridays. For nurses attached to headquarters the corresponding figure is 98.2%.

The Survey also showed that for nurses on district duties the balance (13.4%) of the week's working time falling outside normal working hours included 5% performed during the evening (6 pm to 11 pm) and a similar percentage on Saturdays.

Very little work was done between the hours of 11 pm and 8 am—less than one half of 1% of the week's work took place during this time. Of the nurses on district duties, 82.5% worked at least one Saturday during the period of the survey (4 weeks) as compared with 13.7% of nurses attached to headquarters. For the nurses who worked on Saturday the average length of this working day was just under 4 hours for those on district duties and just under 6 hours for those attached to headquarters.

While it is not within the Working Party's remit to concern itself with conditions of service, it is considered necessary to recommend as follows:—

*The Working Party recommends that a twenty-four hour community nursing service be provided. It should be the responsibility of community nurse managers to arrange for the provision of this service and to ensure that emergency service coverage is available when required. These arrangements should be made known to medical practitioners in the area. The nurses providing such service outside normal working hours need not necessarily be qualified public health nurses.*

#### 4.17.7 Health Education

The Working Party noted that the health education function of the public health nurse is quite extensive, extending across the range of her work.

In discussion with public health nurses, concern was expressed about their role in health education. It was suggested by them that more emphasis should be given to this aspect of their work in the training programme. The Working Party considers that this is a vitally important area and is of the opinion that improvements earlier recommended will allow the public health nurse to give more attention to health education on a more widespread and organised basis.

#### 4.17.8 Liaison Nurse

The Working Party considered the concept of a liaison nurse to achieve more co-operation and more effective working relationships between hospital and community nursing services. Cognisance was again taken of the report of the Survey of the Workload of Public Health Nurses which recommended that "chief executive officers of health boards should have studies made of the problem of developing formal links between the hospital services and the public health nursing services". The Working Party supports this recommendation.

From visits to hospitals and discussions with public health nurses it is

abundantly clear that there is a need for an identifiable nursing link between hospitals and the community, not only in connection with acute cases but for psychiatric, mental handicap, maternity and rehabilitation cases also; in fact, in all instances where after-care or supportive nursing care in the community is required.

The Attitude Survey showed that only 48% of public health nurses agreed that "hospitals generally inform public health nurses when they discharge patients in need of attention" while 84% agreed that "co-ordination with hospitals is a problem for public health nurses". 91.3% want better planning of the discharge of patients from hospital.

Some nurses are at present carrying out the type of liaison work envisaged for a designated liaison nurse. In one large health board area at present, two liaison nurses are employed. One of them, at the request of the Working Party, agreed to keep a record of her official activities for one week. The resultant "diary" showed very clearly that the work includes direct communication with patients, their relatives, hospital staff and allied social services.

*The Working Party recommends that: designated liaison nurses with a public health nursing qualification should be appointed; that the number of liaison nurses required should be determined according to factors such as sizes and types of hospitals in the area, size of population and other relevant needs; that the liaison nurse should have office accommodation in an appropriate hospital in the area; that her point of contact in the hospital should be the Nurse Administrator or her deputy; and that she should be a member of the staff of the Superintendent Public Health Nurse.*

To ensure the proper utilisation of both hospital and community maternity services, *the Working Party recommends that effective co-operation and liaison between the hospital and community maternity services should be established.*

#### **4.17.9 Nurses of other Disciplines in the Community**

The Working Party considered the role in the community of nurses of other disciplines in the light of recent developments in the community services and particularly in the community psychiatric nursing services.

As a general principle, the Working Party is in favour of restricting as far as possible the number of "visitors" to patients' homes in the interests of privacy and convenience to the patient.

In the Working Party's view, particularly in the context of the recommendation in this report concerning common basic training and a restructured training programme for public health nursing, the public health nurse should have adequate knowledge of mental health, mental illness and mental handicap to enable her to deal with many of such problems and to see the need, where it exists, for further specialist care. *The Working Party recommends that the community nursing officer should have responsibility for the general welfare of all persons in her district requiring nursing care including the mentally handicapped and mentally ill.* She also has an important role to play in recognising mental handicap and the onset of mental illness and in referring these patients to the general practitioner or area medical officer and in their follow-up and after-care.

*The Working Party recommends that in areas of special need such as mental handicap and mental illness, nurses qualified in those disciplines should always be available to the community as required.*

#### 4.17.10 Training of Public Health Nurses

In relation to community midwifery and maternity services, the Survey of the Workload of Public Health Nurses showed that only 1.2% of the time of nurses on district duties and a negligible amount of the time of headquarters nurses (less than 0.1%) was spent on maternity care.

As the EEC Directives concerning mutual recognition of qualifications and freedom of movement for midwives will result in an extension of the training period for midwifery registration in this country the question must be seriously asked whether this country should continue to require public health nurses to have the full midwifery qualification. At present, candidates for public health nurse training must be registered general nurses and registered midwives. Should midwifery training become a two-year course, it would in effect mean that one third of the training invested in a public health nurse would be devoted to obtaining the full qualification required for practising midwifery in a maternity hospital or unit. With the current development of highly specialised obstetrical services in hospitals with adequate back-up facilities, it is difficult to envisage any considerable increase in the numbers of domiciliary births.

Public health nurses will still require training in ante- and post-natal care and in child development but some of the time spent in acquiring skills and knowledge more relevant to the hospital midwife could more usefully be spent in broadening and deepening their training in psychiatry, geriatrics, mental handicap and health education which will be among the main areas of their practice.

*In order to meet the changing demands on the community nurse and taking into account the provisions of the EEC Directives on Midwifery, the Working Party recommends that a complete and detailed examination of the training programme for the community nurse be carried out.*

### THE ROLE OF THE NURSE IN TEACHING

#### 4.18 Introduction

4.18.1 The Working Party, while recognising the need to prepare some nurses for their specific role in the teaching of nursing and whose main priority is nursing education, would nevertheless like to emphasise that all qualified nurses, particularly experienced senior staff, have an important role to play in teaching.

Frequently, concern is expressed at the removal of nurse education in terms of location and time from direct patient contact and at the lack of integration between theory and practice. The fact that teachers are away from the clinical areas and clinical responsibilities has resulted in their becoming isolated and remote from the main areas of nursing activities. The theoretical training of the nurse is frequently isolated from the actual practice of nursing at ward level and this has not been helped by the system of nurse education which has developed. Nurse tutors concentrate mainly on theory and practice of skills in the classroom setting spending little time in wards while nurses in the clinical areas have difficulty reconciling the student nurses' learning needs with the need to deliver patient care.

This conflict between the teaching function and ward activities is highlighted by some of the findings of the Attitude Survey which indicated dissatisfaction in this area.

The Working Party, conscious of these problems and of the dissatisfaction among all grades of nurses with the present system of education in nursing, reviewed the role of the teachers of nursing under three headings:—

- (i) the present two-teacher system, nurse tutors and clinical teachers; their status and preparation,
- (ii) the desirability of teachers of nurses having some clinical responsibility,
- (iii) the desirability of nurses in the clinical areas having some involvement in formal teaching.

#### 4.18.2 Present Structure:

##### (1) *Status of Nurse Teachers*

Nurse tutors, midwife tutors and clinical teachers are all part of the nursing staff of the hospital and the Principal Tutor is responsible to the head of the nursing services. Under the present structure, nurses who wish to continue their career in nurse teaching can only aspire to the position of Principal Tutor and as such will not have full control of nurse training schools.

The nurse teacher's commitment extends over a forty-hour week for a forty-eight week year. This is unusual in the academic field and does not allow sufficient time for preparation work and for keeping up to date in developments in medicine and nursing.

Clinical teachers in most cases report to the principal tutor, in some instances they report to matrons but rarely to nurse tutors. This lack of reporting relationships between clinical teachers and nurse tutors causes problems and does not facilitate effective use of teaching resources.

##### (2) *Clinical Responsibility of Nurse Teachers*

While teachers of nursing do not have direct responsibility for clinical care, the majority of clinical teachers spend most of their time in the wards and there is increasing recognition that tutors should also teach in the clinical areas. Whereas 54% of the respondents in the Attitude Survey felt that teaching on the wards by Tutor was valuable, 64% felt teaching on the wards by Clinical Teacher was very valuable. This is probably because so few of the respondents have experience of ward teaching by tutors. The Attitude Survey also showed that 87% of all respondents felt that teaching staff should appear in the wards a lot more often than at present.

Teaching in the clinical areas by nurse tutors can be difficult for the following reasons:—

- (a) before 1976 tutors were prepared only for classroom teaching;
- (b) pressure of work: class preparation, teaching, assessments, student interviews, school administration etc., leave very little time for teaching in the clinical areas when the teacher/student ratio is 1:40 as it is at present;
- (c) because of pressure of work it is difficult to keep up to date with the whole range of nursing knowledge and medical treatment, knowledge which seems to be expected of teachers in the clinical areas and many tutors feel uneasy in the wards as a result; and
- (d) nurse tutors are also very much aware of how busy the students are as a result of their service commitment.



### (3) *Preparation of Nurse Teachers*

Registered nurses who undertake training for clinical teaching receive an intensive six months course in the biological and behavioural sciences, nursing and relevant educational skills. The course is run by An Bord Altranais. Many of the existing clinical teachers were trained in the United Kingdom and gained the Royal College of Nursing clinical teachers' certificate before An Bord Altranais introduced the Clinical Teachers Course in 1972.

Nurses wishing to become nurse tutors do a two year training course in University College, Dublin for a Nurse Tutor Diploma. This course is open only to registered general nurses although student tutors who are preparing to teach in the other disciplines of nursing are expected to be also registered in the relevant discipline.

Where formerly midwives wishing to become midwifery tutors had to go to the United Kingdom to undertake a course of one academic year leading to the Midwife Teachers Diploma, it is now possible for them to undertake the nurse tutor diploma course in University College, Dublin with the inclusion of a midwifery module. The Working Party welcomes this recent development.

#### 4.18.3 **The Role of Nurse Teachers**

The advent of the clinical teacher was regarded as being the answer to some of the problems of the dichotomy between classroom teaching and practical training on the wards. Unfortunately, it has been less successful than was anticipated. Many clinical teachers still spend excessive time in the classroom because of lack of nurse tutors and the gap between theory and practice has been only marginally decreased.

This dichotomy did not occur in midwifery where the midwife tutor always undertook clinical teaching to a far greater extent. It must be pointed out, however, that midwifery schools are generally smaller, the student midwives are already qualified nurses and the range of subjects to be taught is considerably narrower.

The nature of clinical teaching which is recognised as being of central importance must also be considered. Teaching in the clinical area makes heavy demands as it is often a one-to-one process or, at best, small group teaching. It is in many ways more difficult than teaching in the classroom, for example, it is difficult to control the teaching situation as patients needs have to be allowed for. Yet clinical teachers receive only a six month course as compared with the two year programme to prepare nurse tutors.

In order to emphasise the importance of teaching student nurses in the ward situation and to overcome some of the difficulties listed above *the Working Party recommends that the existing two levels of nurse teacher should be discontinued and that steps should be taken to develop one level of nurse teacher, i.e. tutor, who would be fully competent to teach both in the classroom and clinical situation.*

*The Working Party further recommends that all nurse tutors who qualified before 1976 should have the opportunity to take a course in the skills required for teaching in the clinical area.*

In this connection the Working Party considers that the University degree course for registered nurses recommended in Chapter 7 of this report would be the best means of producing a fully competent teacher.

In the meantime the Working Party considers that the existing nurse tutors

course be continued and developed to allow not only for the midwifery module but also for further modules to meet the needs of teachers in other disciplines, for example, community nurse tutor.

*It is recommended that facilities be made available to allow existing clinical teachers, who had taken the six-month course, to acquire the nurse tutor diploma in a shortened course.*

*The Working Party recommends that eligibility for admission to the nurse tutors course, should be open to registered nurses in the various disciplines. It is however, considered desirable that tutors when qualified, should teach in the discipline or disciplines in which they are registered although this should not preclude a tutor teaching basic principles of nursing in any programme.*

At present, it is assumed that all nurse teachers should be able to teach the entire syllabus. This assumption takes no account of the wide programme covering various subjects and topics which makes it difficult for the nurse teacher to be a specialist in all areas of the syllabus.

*For the future it is recommended that nurse teachers should be allowed to specialise within the syllabus.* In the interim it is probably necessary to divide the possible expertise within a school according to medical/patient diagnosis models for example, medicine, surgery, gynaecology, etc. In the long term, teachers of nursing should specialise on the basis of a nursing model, meeting patients' needs, such as human relationships, physical care, rehabilitation skills and care of the elderly.

Notwithstanding the need for specialisation, it is important that all teachers should participate in teaching nursing subjects at the introductory level in order to:—

- (i) demonstrate to students the concept of nursing as care of the whole person whatever his condition or situation; and
- (ii) keep their own interests broad and flexible.

#### **4.18.4 Future Development of Teachers of Nursing**

The Working Party considers it important to give teachers of nursing some clinical responsibility at the same time preserving their function as teachers and equally giving clinical nurses formal involvement in theoretical teaching. It was noted that in the field of medicine consultants in teaching hospitals are both teachers and practitioners of clinical medicine. In nursing, a division of function has developed between the teachers and the practitioners (clinical nurses).

It is also true that it is the nurses in the clinical area who have closest contact with the students at the time when they are providing care and who therefore have a teaching function—often not recognised either by themselves, by nurse teachers or by student nurses.

In order to bridge the gap between the theory and practice of nursing and bring the role of the nurse teacher closer to the clinical area, the Working Party considers that careful consideration should be given to the possibility of developing joint appointments between nursing services and nursing education. Two ways by which this might be brought about are:—

- (i) *development of specialist nurses:* recommended later in this report (*para. 4.19.3*). These nurses will have a special role to teach and to advise other nurses and student nurses in their area of specialisation. The closest

liaison between these nurses and nurse training schools should be established. These specialist nurses as part of their duties will become important teachers of nursing in the future.

- (ii) *development of joint ward management/teaching posts*: under this development, two persons would be sharing a ward post of responsibility and a teaching post, each spending approximately half her time in each area.

This development has particular appeal as it is an established fact that the "role model" for student nurses is the ward sister and it creates a useful link between classroom and ward. The expert awareness that the ward sister has of the problems in the ward can influence teaching and relate the theory taught to nursing practice much more realistically.

Persons sharing such joint appointments should have the necessary skills for their dual role.

## **THE ROLE OF THE NURSE AND ORGANISATION OF NURSING SERVICES IN THE SPECIALIST AREAS**

### **4.19.1 The Extended Role of the Nurse**

The Working Party in its examination of the extended role into the specialist areas, noted the following quotation from Dorothy C. Hall, Regional Nursing Officer, World Health Organisation, Copenhagen:

\*"I can find nothing particularly new or disturbing in the so-called extended role of the nurse. I believe that we are, and should be, in a continuous age of transition and that there never has been a time in the history of nursing when the role has not been expanded by the increase of knowledge and skills available to the nurse".

The extended role of the nurse into the specialist clinical areas through the taking on of new skills is a matter of major importance and one which will be of increasing relevance to nurses.

The extended role of the nurse is brought about by two main factors:

- (a) delegation by medical staff whose role is equally extending and who find it necessary to delegate tasks which have become standardised and which were formerly considered the domain of doctors, and
- (b) the need to be able to respond to emergencies in the context of the more highly specialised and complex hospital service.

The application of new medical techniques and procedures leads to the necessity for doctors to acquire new skills. It also results in many nurses now undertaking procedures which were formerly carried out by their medical colleagues. These procedures include:—

- (i) adding drugs to intravenous infusions;
- (ii) applying plaster of paris and splints;
- (iii) setting up dialysis machines;

\*Hall D. C. "Educating the Nurse for the Needs of the New Society".  
Journal of the Irish Colleges of Physicians and Surgeons. Vol. 5 No. 4, 4 April 1976.

- (iv) suturing minor lacerations;
- (v) taking blood samples.

It is clear from these examples that the nurse's role is extending and that she is taking on responsibility for technical activities performed by doctors.

It is important also to keep in mind the unique function of the nurse in prescribing nursing care and that it is in this that her role differs from the diagnostic, curing role of the medical practitioners. It is arguable, however, that care and cure are closely bound together and that to isolate one from the other would be illogical and would have adverse effects on the delivery of health care.

The Working Party identified several clinical areas which are, in particular, likely to demand an extended role of nursing staff. These include coronary care, haemodialysis, intravenous therapy and chemotherapy. In all of these areas nurses will be required to carry out procedures, acquire skills and give care which they were not adequately prepared during their basic training.

Developments of this nature in nursing must be welcomed by the profession. An extension of the role of the nurse to allow her to provide a more effective nursing care is not only in the interests of the service but in the interests of the profession.

The safeguarding of these interests, while seeking to enable the nurse to function effectively in an extended role and to make the best use of nursing resources at all levels, imposes three requirements:—

- (1) *an educational programme at post-registration level* to equip the nurse to practise effectively in the extended role. Educational policies both at pre-registration and post-registration levels should be continuously assessed against the changing needs of the nursing service;
- (2) *clearly defined policies* based on agreement and understanding among those providing care must be made known and the nursing profession must constantly guard against nurses undertaking tasks for which their training has not adequately equipped them. Each member of the health team must be clear as to his own role and members must accept accountability for their own performance, and
- (3) in the wider area of health care *a continuing monitoring and evaluation of services* to assess developments, decide priorities and develop resources to meet new needs.

#### 4.19.2 Development of Nursing Care

Nursing care is not a term which is easily defined although over the years various eminent members of the nursing profession have defined it as they saw fit. It is generally held to be the art of ministering to the sick person who is unable to look after himself, ensuring that his bodily needs are taken care of and that his physical comfort and mental composure are maintained at as high a level as his condition allows. It also, of course, includes prevention and rehabilitation.

To leave the definition of nursing care at this level however would be to ignore the advances in medicine and nursing which have taken place over the years.

It is due to these significant advances in health care generally that nursing has evolved as a profession in its own right.

Men and women are initially attracted into the profession by a basic desire

care for people on a very personal level. It is therefore the clinical aspects of nursing care which are most attractive to the potential student, are most obvious to the public, are most valued by the patient and are most satisfying to the nurse.

Hitherto, it has generally been the situation that, once established in the profession, the nurse—with very real and very laudable aspirations towards improving and developing herself—finds that the only avenues of development open to her are in teaching and nursing administration as there is no career structure at present in clinical nursing. In addition, because of task orientation which has largely obtained in clinical nursing, interest in direct patient care has tended to decline. The nurse is not being encouraged to remain in clinical nursing. The recommendations in this report on the development of patient-centred nursing care should stimulate interest in clinical nursing. To retain suitable nurses in the clinical area, there is a need to develop a role for specialist clinical nurses which would help to provide a career structure for nurses in the clinical area and would also help develop and improve patient care.

#### **4.19.3 Specialist Nurses**

*The Working Party recommends the development of Specialist Nurses—*

- (i) to enhance the quality of nursing care;*
- (ii) to provide a specialist nursing service in certain nursing areas;*
- (iii) to provide a specialist nursing advice to other nurses in those nursing areas; and*
- (iv) to enable more nurses to pursue a career in clinical nursing.*

In advocating the development of specialist nurses, the aim is not to produce an elitist group of nurses but to ensure the best possible nursing care for patients.

The role for the Nurse Administrator in the grading structure for hospital nurses (para 4.3.2. (1)) envisages that she should plan and direct patient care in accordance with hospital policy, coordinate the duties of ward personnel and participate in teaching and training of all staff in the clinical area. Nurse Administrators will be essentially managers/administrators and, due to the constraints of time, will be unable to practise as clinical experts except perhaps in their own immediate area of activity. It is difficult in those circumstances to envisage a Nurse Administrator taking on the role of Specialist Nurse.

While the Working Party fully supports the need for the development of nurse managers, it is equally important to develop and maintain a role for nurses with the knowledge, skills and time to assess the nursing problems of particular categories of patients, plan for their care and implement plans for the delivery of care on the basis of individual patient needs. Such a nurse, in addition to having direct clinical responsibilities could act in a supportive staff function, promoting a climate of learning and teaching in her work with patients, relatives and staff.

It should be borne in mind that there would only be need for a limited number of specialist nurses in any one region. The service of a specialist nurse might extend to one whole hospital or indeed to a group of hospitals. It is therefore expected that there would be provision for sharing the services between hospitals, and with the local community services (depending on the speciality, size of the area to be served, activity of hospitals within the area etc.).

The objectives for specialist nurses can be summarised as follows:—

- (1) to improve the quality of nursing care through the development of nurses in specialties such as stoma care, infection control and oncology nursing etc.; specialist nurses who will advise and teach nurses and student nurses in these specialties;
- (2) to ensure that specialist clinical knowledge will be collected, refined and tested and so be available both to meet patients' needs and for teaching nurses and student nurses.

It would also enable nurses interested in remaining in the clinical area to satisfy their career aspirations without having to move into teaching or administration.

#### **4.19.4 Areas for Specialist Nurses**

It is not proposed to be specific in defining precisely the areas in which a specialist nurse might function other than the already established positions of Stoma Therapist, Infection Control Sister and, possibly, oncology.

As nursing continues to develop its clinical role, further specialist areas will suggest themselves. The development may be in line with medical specialities e.g. renal, cardiology, or may emerge as nursing knowledge develops resulting in the introduction of new nursing techniques.

#### **4.19.5 Career Structure and Distribution**

There should be a clearly defined career structure for experienced nurses to enable them to remain closer to the clinical nursing field while at the same time progressing in terms of both development and status. To attract suitable nurses into specialist nurse posts, an attractive career structure and suitable conditions of service should be provided.

#### **4.19.6 Qualifications**

Successful completion of post-registration specialised clinical courses should be required of those taking up employment in specialist nurse posts. To this end, training courses and appropriate qualifications should be developed.

### **NURSES ENGAGED IN NON-NURSING DUTIES AND THE NEED FOR SUPPORT STAFF**

#### **4.20 Non-Nursing Duties**

4.20.1 In the course of its investigations and particularly during visits to hospitals by members of the Working Party, discontent was frequently expressed at nurses being required to perform what were referred to as "non-nursing duties". Non-nursing duties being carried out by nurses were also highlighted in submissions received from the Irish Nurses' Organisation and from the Irish Matrons' Association. While no definition of the term "non-nursing duties" was anywhere offered, the Irish Nurses' Organisation listed the following duties on which nurses were engaged as having no intrinsic bearing on nursing, and suggested that they should, in consequence, be shed:

- clerical duties
- making unoccupied beds

- checking linen and laundry bills
- waitress service
- portering duties
- cleaning sluices, toilets and baths
- routine ambulance duty.

4.20.2 The Working Party, in applying itself to an examination of this matter, agreed the following as an appropriate definition of non-nursing duties:—

Any activity that does not contribute to direct patient care, unless it is being carried out with patients as part of patient therapy.

4.20.3 (1) For the purposes of the Survey of the Activities of Staff Nurses carried out by the Working Party, *all* the tasks performed by nurses were divided into the following seven categories of activity:—

- (i) daily living activities
- (ii) clerical activities
- (iii) nurse/patient communication activities
- (iv) domestic activities
- (v) technical nursing activities
- (vi) activities delegated by medical staff to nursing staff
- (vii) other activities.

It is interesting to note that several tasks under each category were considered by a small percentage of respondents to be not appropriate for staff nurses. Some of these were quite surprising, for example, giving patients bed baths or assisting patients in the bathroom and making occupied beds. Other tasks identified by respondents as being inappropriate for staff nurses were more readily acceptable to the Working Party as such.

4.20.3 (2) The Attitude Survey, in seeking information on nurses' satisfaction with their activities, divided their activities into four categories:—

- (i) patient-oriented
- (ii) decision-making
- (iii) housekeeping
- (iv) doctor-assisting.

The overall result showed that the greater the nurses' involvement in *patient-oriented* activities, the greater their level of satisfaction. Involvement in *decision-making* activities ranked second to patient-oriented activities with respondents as a source of satisfaction, the exception being "sorting out over-crowding problems"; the less the involvement in this activity, the greater the satisfaction. Not unexpectedly, a similar response applied to *housekeeping* activities. For *doctor-assisting* activities such as taking blood samples and suturing wounds, the result showed that most nurses who undertake these activities are satisfied to do

so. Writing clerical/technical reports emerged as the least acceptable of doctor-assisting activities.

4.20.4 It makes good sense that a nurse should not provide a waitress-service, nor should she waste her skills making unoccupied beds, checking linen or cleaning sluices and toilets; nor should she be excessively engaged in clerical work. However, in discussions with many nurses, they appeared to suggest that not only should these tasks be shed, but also duties such as dealing with oral hygiene, dressing of patients and sterilisation of equipment. At the same time, when questions were put such as—"Who should be responsible for seeing that the patient takes as much nourishment as possible?"; "Who should be responsible for attention to bowels, hygiene, and pressure areas?"; "Who should do bottle-feeding on a paediatric ward or nursery?"; "Who should record and note observations on patients for the benefit of the doctor or colleagues on later shifts?"—a different picture emerged; the unanimous view being that nursing staff must remain responsible for the total care of the patient.

Similarly, in relation to the involvement of nurses on ambulance duty, escorting a patient, it was felt by the nurses, may or may not be a nursing duty depending on such factors as the age, condition, and degree of dependence of the patient. The Working Party is satisfied that discontent in this regard would be overcome by ensuring that if a nurse is required for ambulance duty, it should be planned for in the same way as a patient on a ward might need to have a special nurse assigned to him. *The Working Party recommends that the services of nurses for ambulance duty should be arranged for by separate and pre-planned provision; not, as so often happens, at the expense of ward staffing.*

4.20.5 The issue of non-nursing duties appears to be less of a problem at the senior nursing level. The trend, for some time, has been to relieve matrons of the administration of non-nursing services, by the development of specialised management in these areas. In the smaller hospitals, the head of the nursing services will, for obvious practical considerations, continue to carry responsibility for the control of some support services. However, it is clearly desirable that nursing administrators should be relieved of such responsibilities to the greatest extent possible and as soon as possible. From the evidence gathered by the Working Party, too many assistant matrons are still over-involved in housekeeping and storekeeping activities to the detriment of their proper role in relation to nursing services.

*The Working Party recommends that, except in the case of smaller hospitals, senior nursing personnel should be relieved of direct responsibility for such matters as housekeeping services and staff residences.*

4.20.6 It is at ward level that the issue of non-nursing duties appears to be most contentious. The nurse-in-charge at ward level—as the one directly responsible for the co-ordination of total patient care, and all the services that contribute to the patient's treatment and welfare—must co-ordinate the various elements of ward activity. On her falls the responsibility for ensuring that the care of the patient and his general welfare receive proper attention—regardless of staffing or other resources. From its studies, the Working Party is convinced that much of the frustration of the nurse in the ward in relation to non-nursing duties, is due to



a pattern of nursing care which is not patient-centred but is based on an allocation of tasks. This has the effect of creating a hierarchy of tasks, with the most personal patient-care tasks having a low rating and technical activities being more highly rated.

4.20.7 Through the employment of appropriate support staff, it should be possible to eliminate from nurses' duties housekeeping tasks such as cleaning sluices, toilets and baths. Where doctor-assisting and decision-making activities are concerned, nurses should not be required to undertake any tasks for which they have not been trained. The resolution of the issue of non-nursing duties is seen, therefore, not purely in terms of "shedding" duties, but rather in altering the emphasis of nursing care from task-allocation to patient-centred. The employment of appropriate support staff as required will permit of the optimum use being made of the skills of the nurse.

#### 4.20.8 Support Staff

##### 4.20.8 (1) *Present Position*

The Working Party found it difficult to examine the question of non-nursing duties without giving some thought to the types and functions of staff who work in a supportive role to nurses. The support staff discussed below are all hospital-based with the exception of home helps.

The following grades of support staff are employed to a greater or lesser extent in almost all hospitals in this country:

- Attendants
- Orderlies
- Domestics/Housekeeping staff (hereinafter referred to as Domestics)
- Porters
- Ward Clerks/Hostesses
- Home Helps—these are employed in the community by health boards and by voluntary agencies. They usually work in a supportive role to nurses and professional social workers.

In the hospital situation, there is a lack of uniformity in regard to the grading, duties and deployment of support staff—sometimes even in relation to those bearing the same title. The present situation of non-nursing staff at ward level has all the appearance of *ad hoc* arrangements and unco-ordinated development. Obviously, support needs and patterns of employment of support staff vary for different types of hospitals and wards. Little information is available however on the variety of levels and patterns of staffing at ward level or on how the number of nursing/non-nursing staff on a ward is related to the characteristics of the ward or its patients.

#### 4.20.9 Recruitment

Porters are usually recruited by the general administration whereas attendants, orderlies, domestics and ward clerks/hostesses are recruited either by the general or the nursing administration although usually it is by the latter: • •

#### 4.20.10 Duties

The Working Party has mainly concerned itself with the duties of non-nursing staff who work on the wards with nursing staff. The main people involved are attendants/orderlies, domestics and ward clerks/hostesses.

There is a lack of standardisation of allocation of duties among different grades and in many areas they tend to overlap as will be seen from the duties outlined in the following paragraphs.

It is not intended to be specific about the duties which should apply to any of these grades. They will largely be dictated by the size and type of hospital in question and by the particular needs of patients.

It is noted that non-nursing staff are responsible to their appropriate supervisors. *It is recommended however that, where they are engaged on ward duties, they should be subject to the general control of the nurse in charge.*

#### 4.20.10 (1) Attendants

The range of duties relevant to attendants can be seen from the following list:—

- Help patients to sit up in preparation for meals. Help lift heavy and helpless patients. Feed patients and assist with serving of meals.
- Empty and steep urinals and other toilet utensils.
- Help with patients' toilet; either bed-bathing or washing of face and hands.
- Put helpless patients on commodes and help to dress and take to day rooms.
- Assist with bed-making.
- Assist with lifting heavy patients in and out of wheelchairs.
- Shave male patients.
- Take patients to and from X-Ray or other departments.
- Take messages to stores, laundry or other departments.
- Assist nurse with bathing patients in bathroom.
- Help with admission of new patients.
- Collect drink trays, beakers and glasses—wash and replace.
- Generally tidy wards and sluices and clean lockers.
- Help with transfer of patients within the ward or hospital.
- Change oxygen cylinders as required.

It is worth recording here the importance placed by nurses themselves on the value of attendants in assisting them in the performance of their duties.

The Attitude Survey showed that 71.6% of nurses agree that "attendants take a lot of workload from nurses" while 87.6% agree that "ward sisters should control their (attendants') work as they do other staff".

Also the Survey of the Activities of Staff Nurses revealed that over 60% of respondents were carrying out duties which they felt should be carried out by attendants. The duties concerned were:—

- shaving patients.
- delivering laboratory specimens, X-Ray cards and CSSD requests.
- checking and counting linen.
- moving ward furniture, and
- disinfecting linen.

*The Working Party is satisfied that there is a need for the Attendant grade for both day and night duty in all types of hospitals and recommends that they should be employed in sufficient numbers.*

Where orderlies are employed, their range of duties is generally similar to that of attendants. For that reason, it is not considered necessary to deal with the grade separately.

#### 4.20.10 (2) **Domestics**

Domestics are employed in all types of hospital although again a variation in range of duties is noticeable. This depends of course on size and type of hospital and also on whether contract cleaners are employed.

In general, the functions of domestics *on the ward* encompass the following duties:

- preparing, distributing and clearing away of drinks;
- serving meals;
- cleaning equipment not used for nursing procedures;
- checking and counting linen;
- moving ward furniture for cleaning;
- general cleaning and dusting;
- cleaning sluices.

No hospital can properly function without cleaning staff. It is generally difficult to recruit an adequate supply of suitable domestics. There tends to be a rapid turnover of staff at that level.

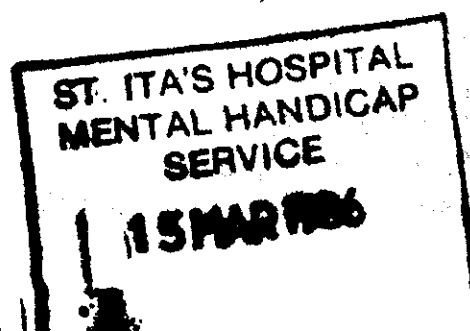
Some hospitals have arrangements with contractors for cleaning. However, contract cleaning can be unsatisfactory at ward level from the point of view that it is difficult for the nurse in charge to retain control of the cleanliness of the ward when the cleaning staff are not subject to her direct supervision.

*The Working Party recommends that in the interests of an effective and efficient cleaning service, cleaning staff—whether they are directly employed by the hospital or by contract cleaners—should always be subject to the general control of the Nurse Administrator in whose area they are working. This will entail close liaison between the Nurse Administrator and the cleaners' supervisor.*

#### 4.20.10 (3) **Porters**

Porters' duties on the wards would be dictated to some extent by the availability of the services of attendants and/or ward clerks/hostesses. Taking this into account, their ward duties may include the following:

- Taking patients from one ward or department to another;
- Taking messages from one ward or department to another;
- Moving ward furniture;
- Answering telephones;
- Delivering ward stores;
- Removing soiled linen.



#### 4.20.10—(4) Ward Clerks/Hostesses

The employment of this grade in hospitals is not widespread at present although the need for such staff to relieve nursing staff of clerical, messenger and receptionist duties is becoming more apparent. The grade is known as *Ward Clerk* in some hospitals and *Ward Hostess* in others and, as the titles suggest, the duties tend to vary. As an aid to the Working Party's consideration of the matter, the work of three ward clerks/hostesses in three different types of ward was observed and the following is a list of the type of duties they performed:—

- Telephone—making and answering calls,
- Communication with all types of personnel including patients and visitors,
- Filing, sorting, tidying patients' charts and completing forms,
- Escorting patients to other wards or departments,
- Making arrangements for visits by patients to out-patients, X-ray, etc.,
- Tidying stationery cupboards, ordering stores, equipment, stationery etc. as directed by Ward Sister,
- Welcoming patients, visitors etc.

In relation to the need for assistance for nurses at this level it is interesting to note that 89% of the respondents in the Attitude Survey agreed that "there should be more clerical help available to Ward Sister".

*The Working Party recommends that consideration should be given to the employment by hospitals of Ward Clerks/Hostesses to the extent of one for each acute ward of high activity with provision for other wards sharing the services of such staff.*

Ideally, the ward clerks/hostesses should be mature persons with the ability to work on their own initiative in a supportive role to nursing staff without constant direct supervision.

The ward clerk/hostess should report to the Nurse Administrator or her Deputy from whom she should receive her instructions.

#### 4.20.10 (5) Home Helps

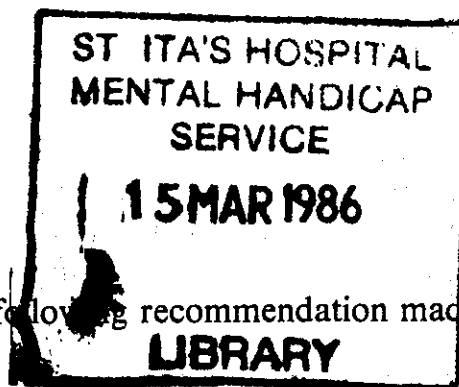
The 1978 Report of the National Social Service Council on Home Help Service indicated that home helps are necessary to look after the elderly, infirm and handicapped in their own homes particularly where there are no relatives or friends to assist in this respect. Many housewives are in a position to take time off from their household and family duties and can assist in a part-time capacity in this work. Provided they are properly selected, they will need a minimum amount of training in the work to be done but they will need to be advised of the capacities and limitations of function of those they are assisting. They will also need to know what action to take in emergencies and how to alert the general practitioner, public health nurse, professional social worker etc.

The Survey of the Workload of Public Health Nurses describes the function of home helps as follows:

- Change laundry,
- Firelighting,
- Feeding patients,
- Help to wash, shave,
- Bed-making, Prepare drink or meals,

- Repair clothing,
- Messages,
- Washing,
- Shopping.

The Working Party fully endorses the following recommendation made in the report of the Workload Survey:—



"We recommend that the home help services at present being developed by health boards should be co-ordinated with the public health nursing services so that as far as feasible home help duties will not take up any significant portion of the nurse's working time".

The National Social Service Council Report made the following recommendation which emphasises the continuing need for harmony within the community services:—

"There should be liaison between the various community care services at local level so that both duplication and failure to meet needs can be avoided".

More recently, over 89% of public health nurse respondents to the Attitude Survey considered that the home help service needed development.

*The Working Party recommends that home helps should be employed in sufficient numbers for the community service and that every effort should be made to develop and utilise the home help service in support to and in harmony with the public health nursing service.*

#### 4.20.11 Training of Support Staff

All support staff, having been carefully selected for suitability to work in a hospital environment (or in the community in the case of home helps), should receive appropriate in-service training. This training should include the following basic elements:—

- (i) Personal hygiene and attention to health and other aspects of hygiene such as food hygiene;
- (ii) Hospital etiquette and ethics, for example, aims and aspects of the work, approach to patients, visitors and staff, the importance of kindness particularly to the old and very ill;
- (iii) Confidentiality; and
- (iv) Economy in lighting, heating and use of equipment etc. and avoidance of waste of food.

#### 4.20.12 General Comments

The Working Party considers that there is a need for rationalisation of existing non-nursing grades, good selection procedures, in-service training and job titles which clearly identify their role.

The extent to which all or any of these categories of staff would be employed in any given hospital would depend on its size and range of activities. In hospitals where more than one of the categories is employed, clarification of their roles through adequate job descriptions and titles will be required so that, together with the nursing staff, they will provide a co-ordinated and integrated service to the

hospital. The same would apply in relation to home helps in the community. Finally, the Working Party considers that support staff should be the subject of a separate study by a group including nurses and representatives of the grades in question to examine the role, training and co-ordination of such staff.

## **THE ROLE OF THE NURSE IN HOSPITAL DESIGN AND PLANNING**

4.21.1 In designing contemporary hospitals, a nurse planner is an important member of the multidisciplinary planning team who contributes to the development of suitable nursing environments and ensures that the functional purposes of nursing units are adequately provided for.

There are practically no departments in a hospital which do not have some bearing, either directly or indirectly, on nursing care. The project team must take into account the various functions of departments and their inter-relationships and the nurse planner has a large contribution to make, from a nursing point of view, from a very early stage of any planning project.

The space required to provide proper patient care, the layout and design of wards and departments and the relationship of these departments to each other must be worked out in great detail and it is important to co-ordinate the plans of the development as a whole from the nursing care aspects.

Personal contact and communication with staff at all levels is an integral part of nursing. The nurse planner should ensure ease of communication in all areas and should consult with other nursing staff who are concerned in the development as early as possible.

The Working Party is satisfied of the need to establish the role of nurse planner and is concerned to ensure that all capital projects which would have an eventual bearing on patient care would have the benefit of the involvement of a trained nurse planner from the initial stages.

4.21.2 Appropriate training should be made available for nurse planners.

4.21.3 *The Working Party recommends that a senior nurse in every health board area of at least Senior Nurse Administrator level, selected for her particular interest in hospital planning, should be given the necessary training to be employed on a secondment basis as required for major and minor planning projects.* It is also considered important that these nurses when trained should have the opportunity of keeping up to date with developments in planning.

This recommendation should not preclude the Director of Nursing from being a member of the planning team.

## **THE ROLE OF THE NURSE IN THE DEPARTMENT OF HEALTH**

### **4.22 New Posts**

4.22.1 The Department of Health has had, until recently, only one Nursing Officer on its staff. Recently, three new posts of Nursing Adviser have been created on the staff of the Department; one each for General Hospital Services (Management and Planning), Psychiatric Services and Community Services. The

functions of the incumbents of these posts are to advise the Department on the organisation, staffing and development of the nursing services in their respective areas. They will monitor and evaluate the effectiveness of the on-going services and will liaise between the Department and the field nursing services and nursing bodies generally.

#### 4.22.2 Planning and Research

It is understood the Department has under consideration the creation of a fourth new post with a remit for education and research, the holder of which will advise the Department on education and training standards for nursing and manpower policies. This officer will also be expected to engage in research relating to nursing generally. *The Working Party recommends that this post be created at the earliest possible date.*

The Working Party is of the opinion that, as An Bord Altranais has the overall responsibility for education programmes, the Departmental officer should more appropriately be involved in a policy planning role. Executive functions in relation to policy would remain within the province of An Bord Altranais. *It is recommended therefore that this officer be known as a Nursing Adviser (Planning and Research).* The Working Party would wish to have the following functions included in the officer's remit:—

- (i) advise and assist the Department in drawing up plans for the organisation, orientation and development of the nursing service;
- (ii) initiate and control statistical surveys of nursing services;
- (iii) initiate, carry out and review research into nursing and nursing services;
- (iv) advise the Department on recruitment policies and staff training and development generally for nurses;
- (v) advise on manpower policies for nursing services;
- (vi) liaise with An bord Altranais in connection with education and training programmes and the proposed Central Applications Bureau for nurse training (see para 5.3).

#### 4.22.3 Development

The current developments are welcomed by the Working Party. When it is remembered that over 20,000 nurses are engaged in the delivery of health care—and that they comprise three-quarters of all health professional staff—the size and value of their contribution to the services will be appreciated. Apart from matters such as policy formulation and improving and developing the nursing services, the volume of technical and professional problems thrown up by a work force of this size warrants the creation of additional posts on the staff of the Department. Specialist areas such as mental handicap, paediatrics and midwifery also require individual attention.

It is also noted that the posts recently created in the Department have been located in the appropriate services divisions rather than having a special nursing division which would supply the necessary nursing advisory service to the various services divisions of the Department. The Working Party accepts that if the

Nursing Advisers are to make an effective input into the formulation of policies they should be closely integrated into the services divisions.

#### **4.22.4 Grading of the New Posts**

It has been noted with concern that the new posts have been structured below the level of Assistant Principal in the civil service. This grading, is, in the Working Party's view, far too low to permit of a truly effective role in the hierarchy of the Department.

*The Working Party strongly recommends that these posts be up-graded.*

#### **4.22.5 Chief Nursing Officer**

The Working Party has noted, with some misgivings, that there are no plans in hand for the creation of a post of Chief Nursing Officer on the staff of the Department. Nursing structures at government level in many European countries are headed by a Chief Nursing Officer representing nursing at the highest level.

In this country however where the need for strengthening the nursing input at Departmental level is only now recognised, the Working Party accepts that, for the present, in view of the proposed integration of the nursing posts into the services divisions of the Department, it would be inappropriate to seek a higher post which would be outside the line management in the context of the organisation structure proposed. The absence of a Chief Nursing Officer post emphasises the need for the four Nursing Adviser posts to be structured at a higher level.

The Working Party considers it necessary that the need for a Chief Nursing Officer post in the Department of Health should be kept under constant review.

### **THE ROLE OF THE NURSE AT HEALTH BOARD HEADQUARTERS**

4.23.1 The Working Party was concerned at the amount of representation and criticism it received regarding communication difficulties that exist at health board level between programme managers and matrons of hospitals, particularly in the general hospital care programmes. In voluntary hospitals, matrons do not feel isolated from their managing authority. Presumably the problem arises in health boards because of the remoteness of many hospitals from the management team which is based at health board headquarters: in many cases a distance of forty to fifty miles away from the hospital. Again in the case of voluntary hospitals, matron and top management are in a one-to-one situation whereas in the case of the health boards, the programme manager may have as many as twenty hospital units to look after, scattered over a radius of fifty miles or more from the health board headquarters. The same would apply as regards the other members of the management team, such as personnel officers, who might be expected to have frequent contact with matrons. The pattern of central management under the health board system causes difficulties in meeting the needs and problems of the nursing services especially as regards lack of involvement in staff appointments, in recruitment and in nurse education and training.

4.23.2 The Working Party has referred to the need for executive committees at hospital level which would be comprised of heads of nursing and general



administration and a representative of the medical staff who would be responsible for day-to-day administration and implementation of agreed policy. There is nevertheless the need to bridge the communications gap between the heads of nursing services at local level and the programme managers at health board headquarters with whom they have a direct reporting relationship.

To help bridge this gap, *the Working Party recommends that there should be a system of regular structured meetings, where these do not already exist, between the programme manager and the heads of nursing services in all the hospitals within his programme.* These meetings should take place on at least a monthly basis at which the programme manager should meet the heads of nursing services collectively on a regular basis, at which other management staff could attend as required.

4.23.3 While the general hospital care programmes are the most likely ones to have communication difficulties because of their range, *it is recommended that where a health board programme encompasses ten or more service units (that is, hospitals and homes and community care areas), there should be a nurse on the support staff of the programme manager at headquarters.*

The functions of this nurse should include:—

- (i) advising the Programme Manager and making recommendations on manpower and staffing levels and participating in the work of management services teams concerned with projects relating to nursing services;
- (ii) advising the Programme Manager and Personnel Officer regarding problems or plans relating to nurse recruitment and training;
- (iii) researching proposals for additional nursing and auxiliary staff and other improvements and making recommendations.

4.23.4 *It is recommended that the nursing post at health board headquarters should not be in line management but should be a support staff function at an appropriate senior level. The holder should provide the nursing input to the decision-making process at health board headquarters.*

## THE ROLE OF THE NURSE IN RESEARCH

4.24.1 The Working Party is convinced that there is an urgent need to develop research as an integral part of the nursing service. Nursing is becoming more complex, the administration of the service more involved and nurse education more specialised; all requiring on-going study and research to ensure that changes and developments to meet the needs of the services will be based on proper study and evaluation. The Working Party welcomes the setting up in 1976 of the Irish Nursing Research Interest Group and looks forward to further developments of this nature and the publications of the findings of studies carried out.

4.24.2 The concept of nursing as the major care giving profession with a unique function has been central to this report and in Chapter 3 (para 3.4) it has been stated that nursing needs can be assessed by skilled observation and knowledgeable interpretation of the situation. For the nurse to function in this

manner and maintain the quality of nursing practice, specific research into clinical nursing must be carried out in the various nursing settings.

The practice of nursing has been earlier described as responding to an individual patient's needs and assisting the patient in every way possible. This requires many different skills and techniques. The decision as to which nursing skills and techniques to use in a particular situation depends on the existence of a body of nursing knowledge. This body of knowledge is built up by constantly monitoring and evaluating established practices, by developing and testing new techniques and by developing means of measuring the quality of care given and its effectiveness in terms of patient outcome.

Nursing practice, its quality and effectiveness should also be examined in relation to particular groups of patients e.g. the elderly and the chronically ill, the mentally handicapped and the very young patient.

Nursing management and nursing education are means of ensuring and maintaining the quality of care given. Their effectiveness has a direct bearing on nursing care and they must constantly be measured against the effectiveness of the service they are providing.

4.24.3 Factors which affect the provision of nursing services, such as the shorter working week, married women continuing their career in nursing and the development of support staff, highlight the need for research into nurse manpower systems and the systems used in the delivery of nursing services.

The manpower objective of the nursing service could be stated as ensuring that the service is appropriately staffed in quantitative, qualitative, structural and geographical terms. Staffing needs caused by wastage, expansion of services, changes in organisation, or other material factors have to be anticipated and provided for. The manpower resource must be effectively utilised through appropriate organisation, motivation, training and development policies.

A planning process is as necessary for the manpower resource as it is for the other resources in the health services system. Planning implies control and a system of comprehensive manpower planning would have, as one of its prime objectives, the avoidance of manpower imbalances. Manpower planning should be comprehensive because of the inter-relationships between different categories of nursing staff. It should also take account of the relationship between nursing and other categories of health staff, such as medical, para-medical, catering and housekeeping.

Manpower planning is regarded as being basically concerned with forecasting supply and demand separately and with bringing about a balance between them thus leading to the formation of a sound basis for policy making as expressed through the plan which is developed.

4.24.4 The education of nurses and the manner in which future nurses are prepared will affect the quality of care and its delivery to patients. Nurse educators are today faced with a difficult and complex task. Advances in medical science and technology and in the delivery of health care, changes in disease patterns and changes in the status of women have all contributed to the problem of equipping nurses to practise nursing in a constantly changing society. The development of the nursing process, in which research is inherent, emphasises the need to develop in students the ability to think clearly, to examine their practice with a critical eye and to be prepared to adapt to change where it is indicated.

Methods of selecting and counselling students, syllabi and curricula of training and traditional methods of imparting nursing knowledge need to be examined critically. Evaluation of programmes of education must also include examination of student nurses' attitudes and career aspirations. The learning environment and involvement of students in their own learning process are other areas which require research.

4.24.5 The Working Party, aware that active involvement in research will be restricted to a limited number of the profession, considers however that all members of the nursing profession should be conscious of the need for research and should be committed to using the findings of research as an adjunct to their professional judgement in the practice of their profession.

Nurse educators should foster in their students an interest in research from the earliest moment by introducing and incorporating research findings into their teaching sessions and encouraging students to approach the practice of their profession with an enquiring mind.

There is an urgent need to train some nurses to carry out research and financial support should be made available to allow suitable nurses to acquire research skills and to enable them to carry out specific research projects which are considered useful and of value for the development of nursing.

4.24.6 The recommendations in this report as regards An Bord Altranais, the Department of Health and the university degree course in nursing will facilitate the development of research in nursing which, of course, will need to be co-ordinated. Hospital and community nurses should also become more involved in research work. To carry out research work effectively, there must be access to all relevant sources of information. Researchers should have available to them as required computer facilities and the services of statisticians, psychologists, sociologists and clerical staff. In the case of nursing research being undertaken by persons who are not qualified in nursing, there should be involvement of experts in nursing.

## **CHAPTER FIVE**

### **ENTRY TO NURSING**

#### **5.1 Applications for Admission to Training**

In this country, nursing is regarded as an acceptable career for secondary school leavers despite the increasing alternative career opportunities which are becoming available. Every year a very large number apply to enter nurse training schools, the number of applications being far in excess of the number of places available.

The Working Party was concerned at the lack of uniformity in processing these applications. In some hospitals, panels of selected candidates may be set up to fill places for some years ahead resulting in long waiting lists. The Working Party was also aware that many individual applicants apply to several nurse training schools. The multiplicity of applications creates a lot of work and expenditure as each school separately advertises, screens and interviews candidates who apply to that school for training. Under the present system, candidates who are successful in obtaining places in more than one school delay in making their choice and when they finally decide which school they will enter, "last minute" vacancies are left in other schools which the school may not be able to fill, or may only fill with difficulty, in time for commencement of training. Applying to different schools, travelling for several interviews, repeated psychological and medical tests is an unwarranted expense to the individual and does not always result in getting the best candidates into nurse training. It may be off-putting to quite suitable candidates who may not persevere in their efforts to become nurses. Repeated rejection by different schools can be demoralising to young persons whether or not they pursue a career in nursing.

#### **5.2 Survey of Applicants for General Nurse Training**

With these problems in mind and having regard to the fact that virtually all the nurse training schools in their submissions to the Working Party, had adverted to the need for rationalisation in the processing of applications, the Working Party, as already described in the Introduction to this report, set up a team to carry out a national survey of applicants for general nurse training (see Appendix III). The terms of reference given to the survey team which was comprised of a few members of the Working Party together with the Chief Executive Officer of An Bord Altranais were:—

"to design and carry out a project involving the monitoring and evaluating of all nurse training applications over a period of 12 months with a primary objective of assisting in the making of final recommendations regarding the desirability and feasibility of the central processing of applications for nurse training and, if considered appropriate, the organisational form such a process should take".

The result of this survey showed a significant degree of multiple application by individual persons to different training schools. Analysis of the 32,407 questionnaires returned revealed that they were completed by 11,943 individuals seeking admission to nurse training. The overall ratio of applications per training place available was 29:1. As well as identifying the extent of duplication the survey was also used to obtain a profile of applicants for nurse training:

- (i) Two-thirds of all applicants were in the 17/18/19 years age group. A significant proportion of applicants (19%) was under the age of 17 years;
- (ii) Almost all applicants (98.83%) were female and single. Only 1.07% were male;
- (iii) Half of the applicants had completed Leaving Certificate examination and of the remainder, almost all had completed Intermediate Certificate. (Presumably most of the latter were preparing for Leaving Certificate or awaiting results.);
- (iv) A very small proportion of applicants (1.15%) possessed other nursing qualifications (i.e. other than general nursing);
- (v) When applications were examined by place of residence, it was apparent that there was a much greater interest shown by girls outside the Eastern Health board area. An attempt was made to produce a rough index of interest in nursing as a career amongst girls in the 17/18/19 age groups in the different health board areas. The range per 1,000 population was between 60.99 in the Eastern Health Board area and 198.07 in the Mid-Western Health Board area. The average for all health board areas was 151.85;
- (vi) The number of applicants from outside this country was insignificant (0.21%).

The survey team as part of its study also examined the universities central applications system.

### 5.3 Central Applications Bureau

In the light of the findings of the survey, the Working Party decided in favour of a centralised system of processing applications for nurse training and *recommends the establishment of a Central Applications Bureau under the aegis of An Bord Altranais for the processing of all applications for nurse training.*

5.3.1. In making this recommendation, the Working Party is satisfied that a Central Applications Bureau (CAB) should:—

- (i) eliminate the present level of multiple applications to different schools and the consequent burden on schools, individual applicants and career guidance counsellors;
- (ii) reduce considerably the financial cost falling on both nurse training schools and applicants under the present system;
- (iii) ensure that school leavers would be fully informed as regards careers in nursing and have the opportunity on the basis of a single application to

aspire to a place in a number of training schools, ranked in the applicant's order of preference;

- (iv) provide a consistent, systematic and easily understood method of managing a situation where a high level of interest in nursing as a career generates a number of applications far in excess of the number of places available. This causes a considerable degree of stress and anxiety;
- (v) provide an opportunity for clear definition of entry rules and standards set by different schools and for maximum degree of uniformity as between schools. The disparity in recruitment procedures adopted by various schools adds to the applicants' difficulties under the present system;
- (vi) through avoiding the need for multiple applications, enable the true number of applicants for nurse training to be known in any year and continuously monitored, including analyses, such as those produced by the one year survey undertaken by the Working Party.

5.3.2. In recommending the introduction of a Central Applications Bureau, the Working Party considers it most important that—

- (i) training schools should be involved in a meaningful way in the selection of students through the CAB which would act as an agency on behalf of all participating schools;
- (ii) the CAB should, on behalf of the training schools, implement agreed methods of processing the large volume of applications for entry to nurse training; and
- (iii) the CAB should be as representative as possible of all nurse training schools and of other bodies interested in recruitment and training of nurses. The committee of the CAB should have approximately twenty members appointed by An Bord Altranais, fifteen of whom should be appointed by the Board on the nomination of the schools.

### 5.3.3. Organisation of a Central Applications Bureau

The following outline scheme for processing applications through a CAB is put forward:—

- (i) Second level schools/colleges, particularly the career guidance counsellors, should be notified of career opportunities in nursing requirements for entry and the system of selection by the commencement of the academic year. In addition to those who have already attained Leaving Certificate standard, students sitting for the Leaving Certificate examination in June of the following calendar year would be eligible to apply.
- (ii) The ICAB should invite applications by advertisement stipulating an appropriate closing date in the January to March period.
- (iii) The CAB should process applications received with a view to assessing suitability for nurse training.

(iv) The first stage in this process would be to examine the applications received for required qualifications (apart from Leaving Certificate results, not yet to hand), preference for nurse training schools, etc. Each applicant should be allowed up to ten preferences of schools ranked in order of choice.

(v) The second stage would be to conduct, on a regional basis, screening interviews, psychological/aptitude tests based on criteria applied uniformly throughout the country. On the basis of 12,000 applicants, 12 centres would seem to be appropriate, the locations to be determined in the light of the geographical distribution of applicants. There should be at least one centre in each of the eight health board areas. The interview teams for each centre would be appointed by the CAB from a central list containing the nominees of all training schools. One interview and psychological aptitude test only would be arranged for each applicant at a centre convenient to the applicant. This would not preclude any further interview being conducted at a later stage by a hospital authority should it wish to do so with a view to determining suitability for employment as distinct from suitability for nurse training.

The screening process would reduce the original number of applications by excluding those considered unsuitable and the applicants who qualify at this stage would be ranked in order of merit. This stage would be completed at least a month prior to the holding of the Leaving Certificate examination.

(vi) The third stage in the selection process would take place immediately following publication of the Leaving Certificate results. The ranking of applicants on the basis of results achieved in prescribed subjects would be aggregated with earlier rankings resulting from the screening process. This would produce a list of all qualified applicants in overall order of merit.

The filling of places available in each training school would then be determined in accordance with applicants' ranking in the overall order of merit and their highest preference matched to unfilled places. This would be an automated process since order of merit and available places must be matched up with as many as ten school preferences expressed by individual applicants.

(vii) The penultimate stage in the process would be for the CAB to supply each training school and appropriate hospital authority with a list of recommended candidates in order of merit to match the number of places in that school. It would then be open to any hospital authority to pursue the question of character references or health or to conduct its own assessment/interview of the recommended candidates with a view to determining their suitability for employment. Four weeks could be allowed for this. During this period the school would make a formal offer of a training place to each candidate considered suitable for employment in that school. Candidates could be allowed two weeks within which to accept or reject the offer.

(viii) Finally each training school would notify the CAB, not later than 6 weeks from receipt of the list of recommended candidates, of—

- (a) any candidate considered unsuitable for employment in that school giving detailed reasons for this decision, and
- (b) any candidate who had failed to take up an offer of a place in that school.

In the case of a candidate considered unsuitable for employment by a particular hospital authority, the CAB, having considered the circumstances and taken any steps it considered necessary, including further interview, would decide whether the candidate in question should be excluded from further consideration or should be re-assigned to a place in another training school in accordance with the list of preferences expressed initially by that candidate.

The CAB would assign further candidates to fill outstanding vacancies in any school arising under either (a) or (b) above.

5.3.4 The Working Party is of the view that special provision should be made in the system for:

- mature candidates
- candidates and students from under-developed countries, and
- nurses already registered in one division of the register and seeking registration in another division.

In the case of these candidates the Working Party is satisfied that, provided they are considered suitable for nurse training, the system can be adapted to allow for their inclusion, for example, by allowing them maximum credit under the educational ranking.

5.3.5 While making the recommendation for the establishment of a CAB the Working Party is of the opinion that the effectiveness of the system should be monitored and evaluated over a reasonable period.

5.3.6 The system as outlined above would be operated separately for each division of the register.

## 5.4 Selection Criteria

5.4.1 A number of submissions received by the Working Party made reference to entry to the profession, and particularly to desirable educational attainments of prospective nurses. The majority of such submissions forwarded prescribed educational requirements at University entrance standard. The Working Party is of the opinion, however, that while a certain standard is essential to enable students to complete successfully the education training programmes, setting too high an educational standard could preclude from entry to nurse training candidates who would be quite suitable for a career in nursing.

5.4.2 There is a considerable lack of uniformity in current selection and recruitment procedures, both as regards methods of selection and entry



requirements. The general practice is to require a Leaving Certificate—the subjects and grades differing from school to school. The ranking of candidates of the required educational standard is usually achieved by an interview and/or a written examination. In a small number of schools this procedure is augmented by a provision for psychological assessment. There is no standard minimum or maximum entry age; these vary as a rule within the range 17 to 30 years.

With the number of training schools and the lack of uniformity it is hardly surprising that teachers responsible for career guidance in the secondary schools often display lack of knowledge, and of information, as to the requirements for entry to nursing. It is considered that a standardisation of entry requirements coupled with the recommendation proposing the establishment of a CAB will make possible a more even, adequate flow of information to school leavers concerning career opportunities in nursing. It should also facilitate closer liaison between secondary schools and nurse training schools, leading to career guidance teachers being kept fully informed and up to date. The formal provision of facilities for periodic visits by career guidance teachers to nurse training schools and by nurse teachers to secondary schools would be desirable.

Selection, in any event, is a highly problematical activity. Any system for ranking candidates on the basis of examination results, interviews, etc. is unlikely to be perfect. The degree of success depends on the quality of the selection procedures and on the competence of those administering them. A profile of a suitable candidate for nurse training might include—a desire to serve the sick and afflicted; common sense; kindness; ability to inspire confidence and respect; intelligence; a good general education; physically fit and mentally well-balanced. The selection process should ideally be capable of identifying the presence of these qualities and attributes.

Those involved in selecting therefore cannot measure suitability in terms of examination results alone. They must look closely at a person's qualities, characteristics and aptitudes. While every effort should be made to make the best possible selection prior to commencement of training, the Working Party stresses the need for continuous assessment throughout the pre-registration period (*para. 7.5.4.*).

*The following selection process is recommended:—*

- (i) Basic Education Qualifications—*The Working Party recommends an educational standard of Leaving Certificate in the following subjects:—*

*Irish*

*English*

*Mathematics*

*A science subject—biology, physics, chemistry, home economics (social and scientific)*

*One other subject of choice*

*Candidates must have achieved at least grade C on higher level papers in two subjects and at least grade D on lower level papers in the remaining subjects.*

*For persons coming from outside the country, educational qualifications equivalent to the Leaving Certificate standard set out above would be acceptable. The requirement in regard to Irish would not apply to such persons.*

- (ii) Age Limit—the Working Party considers that provided the system of selection is sound there should be no real need for age limits to be prescribed.
- (iii) Psychological assessment of candidates—this is considered to be a necessary and valuable aid in determining suitability for a career in nursing.
- (iv) Planned interview—the use of the interview is indispensable for assessing personal qualities, and for eliciting information and supplementing that derived from the application form and psychological assessment. Such interviews must be conducted by persons skilled in interviewing techniques, otherwise the results are likely to prove unreliable. It is considered that both the service and teaching sectors of nursing should be involved in the selection process. Those involved should be given training in the necessary skills.

## CHAPTER SIX

### AN BORD ALTRANAIS

#### 6.1 Background to the setting up of the Board

The General Nursing Council and the Central Midwives Board were dissolved under the Nurses' Act, 1950 which provided for their replacement by An Bord Altranais. The Act was described as follows:—

“An Act to make further and better provision for the registration, certification, control and training of nurses and for other matters relating to nurses and the practice of nursing.”

The word *nurse* as defined in the Act, means a person registered in the register of nurses and includes a midwife and the word *nursing* includes midwifery. The Act provided for the establishment of a Midwives Committee under the aegis of An Bord Altranais. This is the only statutory committee established under the Act. The Board may, by Rules, set up such other committees as it sees fit. The Rules may provide for the establishment, functions and procedure (including quorum) of committees of the Board and may authorise the appointment of persons other than members of the Board to be members of the committees and may provide for the delegation to a committee any powers, functions or duties of the Board.

Some minor amendments to the 1950 Act were made by the Nurses' Act, 1961.

#### 6.2 Present Functions of the Board

Under the Act, the main functions of the Board in addition to the registration of nurses and midwives are as follows:

- in accordance with its Rules, to provide or make provision for courses of training and examinations;
- in accordance with its Rules, to provide or make provision for courses of training and examinations for nurses leading to award of certificates and diplomas;
- the holding of examinations including appointment of examiners,
- in accordance with its Rules, to make provision with respect to (a) the issue of certificates of registration, (b) the badges and uniforms which may be worn by nurses registered in any division of the register and (c) the return and cancellation of certificates;
- the approval of hospitals and institutions suitable for nurse training;

- in accordance with its Rules, to remove a nurse's name from the register for professional misconduct or conviction of crime. In the case of a midwife, the Board may act only on the recommendation of the Midwives Committee; and
- the Board may restore the name of a nurse which has been removed from the register and again, in the case of a midwife, can do so only on the recommendation of the Midwives Committee.

The Board is also empowered to make provision for institutional, hostel or other accommodation for student nurses and nurses attending courses and for scholarships for student nurses and nurses but it has not been active in the exercise of these powers.

The Board is the competent authority in this State for the purposes of the EEC Directives relating to mutual recognition of qualifications and freedom of movement for nurses among the Member States.

### 6.3 Registration

From evidence submitted to the Working Party, there is reasonable satisfaction with the present system of registration. The fundamental needs for a "live" register and for an index of students in training are generally recognised.

*The Working Party recommends the establishment of (i) a live register of nurses and (ii) an index of students in training as a matter of priority.* The introduction of a live register is likely to give rise to an annual retention fee in addition to the initial registration fee. A live register will also help provide the necessary data for manpower planning purposes.

To provide for the registration of nurses, the Board maintains a register of nurses divided into the following divisions:—

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>(i) General Nursing (Female)</li> <li>(ii) General Nursing (Male)</li> <li>(iii) *Sick Children's Nursing</li> <li>(iv) Psychiatric Nursing</li> <li>(v) Mental Handicap Nursing</li> </ul> | } | <p>There is direct entry to training for registration in these divisions of the register, i.e. no previous nursing qualification is required.</p> |
|--|---|---|
- (vi) Midwifery—entry to training is restricted to registered general nurses and registered paediatric nurses,
  - (vii) Public Health Nursing—entry to training is restricted to registered general nurses who are also registered midwives,
  - (viii) Orthopaedic Nursing—entry to training is restricted to registered general nurses,
  - (ix) Tuberculosis Nursing—entry to training is restricted to registered general nurses,
  - (x) Nurse Tutors—entry to training is restricted to registered general nurses,
  - (xi) Clinical Teachers—entry to training is open to nurses registered in any division of the register.

\*Hereinafter referred to as Paediatric Nursing.

The Board may register nurses trained outside the State provided it is satisfied with their training and qualifications. Under the EEC Directives, the Board is obliged to recognise general nursing qualifications issued by other EEC Member States.

It is considered that the existence of separate divisions of the register for male and female nurses is a tradition which has no place in today's society.

*In regard to the present divisions of the register, the Working Party recommends the following changes:—*

- (i) one division for general nurses in place of the existing separate divisions for male and female nurses;*
- (ii) discontinuance of training for the Orthopaedic Nursing division which, it is felt, should be dealt with in line with other post-registration courses in specialised clinical nursing; and*
- (iii) discontinuance of training for the Clinical Teachers division as the Working Party has earlier recommended that this grade be merged with nurse tutors.*

It is understood that training for the division for Tuberculosis nurses has been discontinued and the Working Party considers that it need not be resumed.

## **6.4 Education**

6.4.1 The educational functions of the Board include approving of hospitals for training purposes, setting standards for training, prescribing and revising syllabi, ensuring that students are trained in accordance with approved syllabi, conducting state examinations, organising seminars and courses and approving nursing courses organised by hospitals, health boards and other bodies such as Regional Technical Colleges, the Institute of Public Administration and organisations representing nurses. The Board is directly involved in running training courses for registration of clinical teachers and public health nurses.

Because of its statutory role in regard to nurse education, the profession looks to An Bord Altranais to give leadership in the development of nursing education. The Board is regarded by nurses as the body which should draw up and publish policies for nursing education at all levels, working in a supportive and monitoring relationship with nurse training schools and other institutions providing nursing education. Positive leadership is essential for the development of nursing education.

Education and training of nurses takes place primarily in hospitals where the principal function is patient care, not education. For that reason, it is particularly important that the central body co-ordinating nursing education should have a monitoring function as well as a leadership role.

There is also a degree of tension between the nurse training school's desire for autonomy and the need to experiment and the necessity for guidance and co-ordination by the central body. This situation is not necessarily undesirable provided the central body has formulated clear and coherent educational policies to the making of which nurse educators and practitioners have contributed. The monitoring and co-ordinating functions should not be seen by the schools as inhibiting them from experimenting in training programmes within general guidelines laid down by An Bord Altranais.

6.4.2 The views of the Working Party on nurse training schools are set out in Chapter 7 (*para. 7.3*).

The Working Party considers that the role of An Bord Altranais vis-à-vis nurse training schools should be as follows:—

- (i) to approve schools and to ensure that conditions for approval are complied with;
- (ii) to assist schools to develop curricula for educational programmes; and
- (iii) to encourage and promote the formulation of experimental curricula.

6.4.3 For all programmes leading to registration, it is considered that the functions of the Board should be:—

- (i) to lay down programme objectives and outline curricula jointly with the institution providing the programme and to monitor the implementation of the agreed programme;
- (ii) to advise on assessment methods and monitor assessments;
- (iii) to carry out evaluations of the programmes; and
- (iv) to award certificates on satisfactory completion of the programme which would give entitlement to registration.

6.4.4 In relation to examinations, the Board should:—

- (i) advise on assessment methods and monitor assessments;
- (ii) make suitable arrangements for state examinations;
- (iii) agree the examination procedures with universities or other third level educational institutions providing education and training for nurses; and
- (iv) conduct research in order to validate examination and assessment procedures.

6.4.5 The views of the Working Party on continuing education for nurses are set out in Chapter 7.

With a view to promoting and developing post-registration courses the Board should:—

- (i) identify areas of nursing in which further training is needed;
- (ii) stimulate the inauguration of courses to ensure a wider geographical spread of post-registration education;
- (iii) ensure that conditions for approval are met by hospitals and other bodies providing courses;
- (iv) produce outline curricula jointly with other bodies providing courses;
- (v) advise on assessment methods and monitor assessments;
- (vi) award certificates on successful completion of courses; and
- (vii) evaluate the courses to ensure relevance of content and effectiveness of educational approach.

6.4.6 *The Working Party recommends that in relation to management and administration training for nurses, the main involvement of the Board should be:—*

- (i) to maintain and develop existing links with the bodies providing these courses and*
- (ii) to participate in setting course objectives and in assessing students and evaluating courses.*

6.4.7 *In relation to education and training programmes generally, the Working Party recommends that the Board, as the policy-making body, should not be directly involved with the day-to-day running of programmes and courses.*

## 6.5 Discipline

6.5.1 The Board is empowered under Section 18 of the 1950 Act to establish committees to which it may delegate any of its functions, powers or duties. One of the committees so established at the first meeting of the Board each calendar year is a Penal Committee "consisting of twelve members of which the quorum shall be seven and whose functions shall be to investigate prior to consideration by the Board complaints against nurses, excluding complaints against nurses relating to the practice of midwifery, which might lead to their removal from the Register".

Due to the fact that the sole disciplinary power that the Board has is to remove a person's name from the register, it has not been very active in the exercise of its disciplinary function. There is also some doubt about the constitutionality of the Board's function in this regard. Another defect in the present system is that there is no procedure whereby the Board is notified of serious disciplinary action taken by hospital or other employing authorities. *The Working Party recommends that cases of serious misconduct should be notified by employing authorities to An Bord Altranais.*

6.5.2 *The Working Party recommends that An Bord Altranais should appoint from amongst its members a Fitness to Practise Committee with the majority of the members being elected members of the Board.*

6.5.3 *The Working Party further recommends that:—*

- (i) the Fitness to Practise Committee, following investigation, should recommend to the Board the action that should be taken in any individual case;*
- (ii) the Board should be empowered to—*
  - (a) advise, admonish or censure nurses as it sees fit;*
  - or*
  - (b) temporarily remove the name of a nurse from the register for a fixed period;*
  - or*
  - (c) remove a nurse's name from the register for an indefinite period.*

*In the case of a decision to remove a name from the register, the decision should be published.*

*(iii) the reasons for removal from the register should be—*

- (a) professional misconduct*
- (b) conviction of serious crime*
- (c) unfitness to practise for health reasons*

Any doubts that may exist in regard to the constitutionality of the Board's disciplinary function should be removed so that the Board may effectively perform its function in this area.

## **6.6 Research**

The Board is empowered to conduct research or cause research to be conducted into the organisation and practice of nursing and into nursing education (Nurses' Act, 1950, Section 66). Hitherto, the Board has not been active in this regard although there is an increasing awareness of the need for research.

The Working Party earlier dealt with the question of research generally (in paras. 4.24) and it envisages a role for An Bord Altranais in the area of research with particular reference to education and training. In order to fulfil this role, the Board should have the necessary staff.

## **6.7 Other Functions**

### **6.7.1 Manpower Information Services**

The Working Party has earlier recommended that there should be a Central Applications Bureau operated under the aegis of An Bord Altranais for the purpose of processing nurse training applications. The establishment of the Bureau will provide comprehensive information regarding those seeking training and the numbers seeking registration in individual divisions of the register.

The Working Party considers that the Board should therefore have the following responsibilities:—

- (i) to inform the Department of Health of numbers of students in training for the various divisions of the register and estimates of qualified nurses becoming available for employment;
- (ii) to take account of the Department's estimate of numbers of nurses required and to determine accordingly the number of places in the individual schools; and
- (iii) to maintain statistical records and make them available for research and planning purposes.

### **6.7.2 Publicity**

*The Working Party recommends that An Bord Altranais should publish an annual report so that its work and policies may be known and understood.*



### 6.7.3 Foreign Nurses

*The Working Party recommends that hospitals and individuals organising courses in nursing or providing clinical nursing experience for non-nationals should be required to notify An Bord Altranais and seek its approval.*

The Working Party has already recommended that the Board should not become directly involved with the day-to-day running of programmes and courses generally and this includes courses for foreign nationals.

### 6.8 Membership of An Bord Altranais

6.8.1 The Working Party considered the composition of the present Board (23 members) in the context of the proposed revision of functions of the Board. Account was taken of the proportion of non-nurse to nurse members and the need to increase representation of nurse teachers among the elected members.

6.8.2 The Working Party noted with regret the very poor interest shown by the profession in the affairs of the Board as evidenced by the small proportion of the electorate which exercises its franchise in the election of members to the Board. It is to be hoped that the more active role recommended for the Board in this report and the proposed revised composition will evoke greater interest on the part of the electorate in the future. Also, it is considered the present system of having to set up an electoral roll for each election does not help in this regard. With the introduction of a live register, there should be no need for the electoral roll system and this should also lead to an increased poll. An Bord Altranais should engage in greater publicity in regard to the election of members including notifications to employing authorities.

#### 6.8.3 *The Working Party recommends as follows:—*

- (i) overall membership should be increased by four to twenty-seven to allow for current and future development of nurse education.*
- (ii) the management of health boards, voluntary hospitals and other voluntary organisations providing nursing services under the Health Acts should be represented amongst the appointed members instead of county councils and borough councils.*
- (iii) Membership:*
  - (a) Twelve members should be appointed by the Minister for Health as follows:—*
    - One medical practitioner (general hospital services)*
    - One medical practitioner (psychiatric hospital services)*
    - One medical practitioner (community care services)*
    - One medical practitioner (obstetric services)*
    - One representing voluntary hospital management*
    - One representing health board management*
    - One representing the Department of Education*
    - One representing the Department of Health*
    - One representing third level education bodies involved in nursing education*
    - Two nurses*
    - One other*

- (b) **Fifteen** *registerea nurses should be elected by registered nurses as follows:—*

**Six engaged in formal nurse teaching, one to represent each of the following nursing disciplines:**

*General nursing  
Paediatric nursing  
Psychiatric nursing  
Midwifery  
Public Health nursing  
Mental Handicap nursing*

**Four engaged in nursing administration above Nurse Administrator level, one to represent the following nursing disciplines separately or jointly as indicated:**

*General or Paediatric nursing  
Midwifery or Public Health nursing  
Psychiatric nursing  
Mental Handicap nursing.*

**Five engaged in clinical nursing practice up to and including Nurse Administrator level, one to represent each of the following nursing disciplines separately or jointly as indicated:**

*Midwifery (hospital or domiciliary)  
General nursing  
Paediatric nursing  
Psychiatric or Mental Handicap nursing  
Public Health nursing.*

- (iv) **Eligibility for election to membership:**

*Each candidate for membership should be  
—under 65 years of age,  
—engaged in the practice of nursing.*

- (v) **The lifetime of the Board should be five years as at present. Members should not be permitted to serve more than two consecutive terms of office. Elections should take place at least six months before the expiration of the lifetime of the Board and the nomination of other members not less than three months before.**

- (vi) **Office of President of An Bord Altranais**

*The President should be chosen from amongst the nurse members of the Board and should be elected at the first meeting of each new Board.*

## **6.9 Committees of an Bord Altranais**

**6.9.1** Apart from the earlier views in relation to the Fitness to Practise Committee, the Working Party does not envisage any major change in the numbers and types of committees or their organisation and considers that this will be a matter for the Board to review in the light of changes proposed in this report affecting its role.

6.9.2 *Because of the special provisions relating to the practice of midwifery, it is recommended that the Midwives Committee should continue to be a statutory committee.*

6.9.3 *In relation to the Fitness to Practise Committee, it is recommended that this Committee should investigate complaints against midwives as well as other nurses and that its findings should be referred to the Midwives Committee for recommendation as to the action to be taken by the Board in the case of midwives.*

#### **6.10 Staff of An Bord Altranais**

6.10.1 In general, the Working Party envisages An Bord Altranais playing a much more active role in promoting and developing nurse education and training and in the exercise of its disciplinary function. It would also have a new role in the operation of the proposed Central Applications Bureau.

*The Working Party recommends that the necessary staff be provided to allow for the increased activity of the Board. Such staff should include a Chief Education Officer, a minimum of three Education Officers and at least one Research Officer.*

#### **6.10.2 Functions of Officers**

The functions proposed for the Chief Executive Officer, Chief Education Officer, Education Officers and Research Officer—subject to the general direction and control of the Board—are outlined below.

6.10.2 (1) *The Chief Executive Officer should:—*

- (i) report to and be accountable to the Board,
- (ii) control staff and be responsible for the general management of the Board's functions,
- (iii) execute the decisions of the Board in all matters relating to its administrative functions,
- (iv) attend all board meetings,
- (v) represent the Board where necessary.

6.10.2 (2) *The Chief Education Officer should:—*

- (i) report to and be accountable to the Chief Executive Officer,
- (ii) formulate educational policies for nursing and advise the Board on these,
- (iii) plan educational developments in nursing and advise the Board accordingly,
- (iv) monitor educational programmes undertaken by nurse training schools,
- (v) advise on research projects,
- (vi) monitor the Board's research programme,

- (vii) liaise with third level educational bodies providing education in nursing,
- (viii) maintain professional contacts with educational bodies providing further and higher education for nurses.

6.10.2 (3) There should be an *Education Officer* with a special responsibility for one or two of the main disciplines of nursing. They should be educationalists and should be registered in the divisions for which they are responsible. Education Officers should have two types of responsibility—(a)—relating to the content of education programmes in the disciplines for which they are responsible and (b)—a functional relationship with nurse training schools based on geographical areas. For example, the Education Officer with special responsibility for mental handicap and psychiatric nursing might also have a responsibility for all nurse training schools in a geographical area.

The *Education Officers* should:—

- (i) report to and be accountable to the Chief Education Officer,
- (ii) assist nurse training schools to develop educational curricula in accordance with the policies of the Board,
- (iii) visit nurse training schools and assist them in reaching and maintaining the required standards,
- (iv) take special responsibility for developing continuing education in the disciplines of nursing for which they are responsible.

6.10.2 (4) The *Research Officer* should:—

- (i) report to and be accountable to the Chief Education Officer,
- (ii) plan and carry out research into nursing education.

6.11 The Working Party stresses the need for An Bord Altranais to have the necessary resources to fulfil its role and to effectively carry out the functions outlined in this report.

## **CHAPTER SEVEN**

### **EDUCATION AND TRAINING**

#### **NURSE TRAINING SCHOOLS**

##### **7.1 Functions and Definition of a Nurse Training School**

The role of nurse training schools should be to educate and train persons taking up a career in nursing and throughout their career. Nurse education is regarded throughout this report as a continuum and not something which, following basic education and training, becomes random or unstructured. To achieve this, there must be an educational programme and resources to support it so that registered nurses can meet the needs of those requiring nursing care.

7.1.2 The Working Party in adopting the definition of a nurse based on that of the International Council of Nurses has committed itself to a concept of nursing which is based on the nursing process model. The aims of nurse education should be therefore, to develop the nurse during her student days and later career to act as a mature and skilled practitioner, able to identify and meet patients' needs, whether at home or in the hospital, in co-operation with the medical and allied professions. In order to achieve this aim, nurse training must follow a patient-centred nursing model structured towards developing the skills and knowledge needed to nurse effectively and to form a professional attitude.

7.1.3 The functions of a nurse training school can therefore be described as:—

- (i) developing and structuring curricula to prepare nurses to meet the nursing requirements of the community being served;
- (ii) selecting students (in conjunction with nursing and general administrators);
- (iii) providing the necessary education and training; and
- (iv) providing a suitable environment for learning and support of students.

##### **7.2 Present Arrangements**

7.2.1 There are sixty two nurse training schools providing courses leading to registration in the primary divisions of the register. They are distributed as follows:—

Health Board Areas	General		Psychiatric		Paediatric		Mental Handicap		Totals	
	Number of Schools	Number of Students	Number of Schools	Number of Students	Number of Schools	Number of Students	Number of Schools	Number of Students	Number of Schools	Number of Students
Eastern	14	2,057	5	419	3	409	4	263	26	3,148
South-Eastern	2	139	5	189	—	—	—	—	7	328
Southern	6	584	2	149	—	—	1	36	9	769
Midland	—	—	2	122	—	—	—	—	2	122
Mid-Western	3	236	2	94	—	—	1	74	6	404
North-Eastern	1	146	1	58	—	—	1	54	3	258
North-Western	1	37	2	96	—	—	1	43	4	176
Western	2	399	3	173	—	—	—	—	5	572
	29	3,598	22	1,300	3	409	8	470	62	5,777

Midwifery training, entry to which is confined to registered general and registered paediatric nurses, is provided in ten further schools, four in the Eastern, three in the Southern and one each in the Western, Mid-Western and North-Eastern health board areas.

7.2.2 For a country of its size and population, Ireland has a relatively high number of nurse training schools, some of which are small and barely viable. The present arrangements result in education and training resources being very fragmented.

There are considerable variations both in the size of the schools and the range of clinical experience available. All the schools are attached to individual hospitals, which recruit students for their own school. Each school, while being the general responsibility of the matron of the hospital, is managed by a principal tutor who is assisted by tutors and clinical teachers in carrying out the programmes of training.

A survey of nurse training schools (other than psychiatric nurse training schools) undertaken by the Working Party showed the following ratios of nurse teachers to students:—

all Nurse Tutors, qualified and unqualified, including Principal Tutors—1:50

all Clinical Teachers, qualified and unqualified—1:105

The student intake of the individual general nurse training schools varies from an annual intake of less than 20 students to an annual intake of over 100 students. The training hospitals also vary from small 100 bed hospitals providing only general medical and surgical care to large hospitals with over 300 beds carrying a wide range of specialities. Yet, by and large, each training hospital endeavours to provide its own training programme by way of educational facilities and the range of clinical material and experience available within the hospital.

There are 22 psychiatric nurse training hospitals, 10 of which in 1979 had an intake of less than 20 students and four of which had an intake of over 40 students.

Four of the eight mental handicap centres had an intake in 1979 of less than 20 and one had an intake of over 40.

Paediatric nurse training is carried out in the three paediatric hospitals in Dublin. Outside Dublin there are no paediatric nurse training centres; the services provided in paediatric units in general hospitals are not used for paediatric nurse training.

7.2.3 Under the present system it is difficult to achieve the widely accepted aim that nurse training should be comprehensive and broadly based. The EEC Directives for general nurses require that student nurses receive clinical instruction in:

- general and specialist medicine
- general and specialist surgery
- maternity care
- mental health/psychiatry
- care of the old and geriatrics
- home nursing.

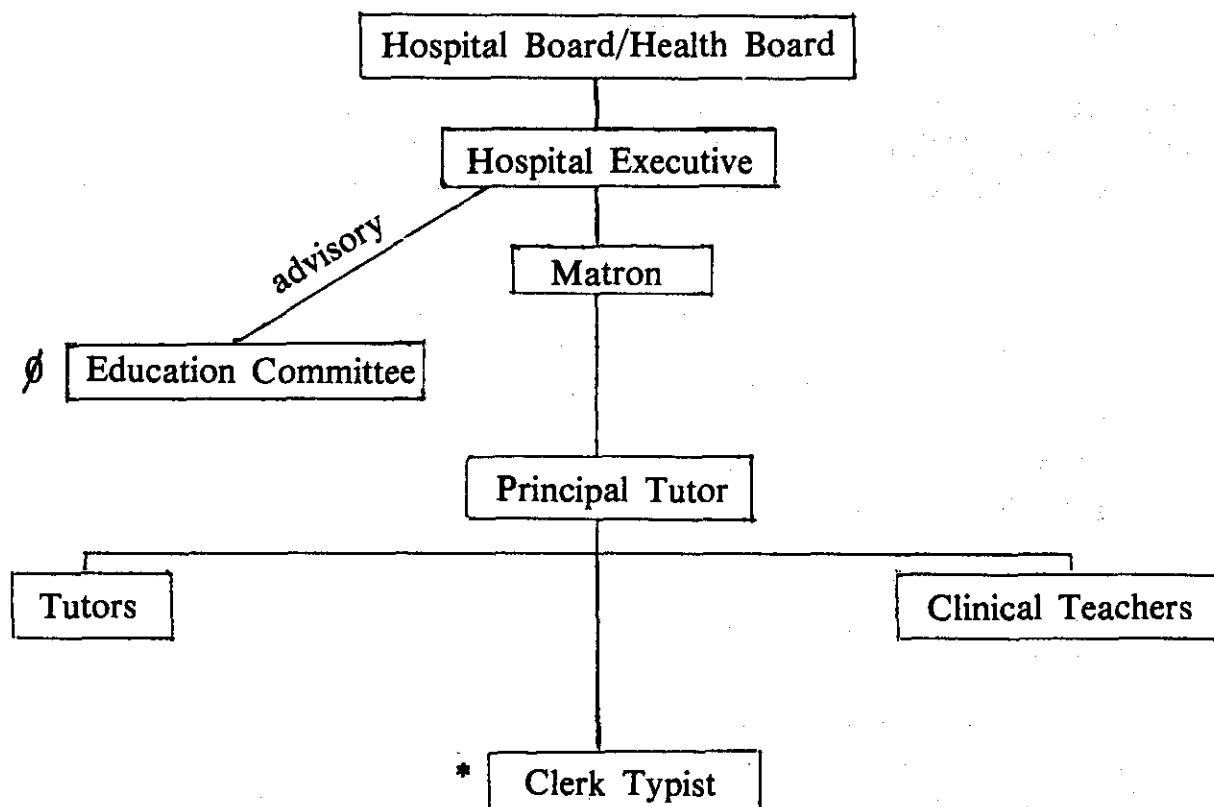
It is difficult for many of our present training hospitals to ensure that such a programme is provided for their students because they do not have direct control over all the elements of such a programme. Within the health board system the variety of clinical experiences, including home nursing, are available under the one management authority, whereas outside the health board system the only way in which a programme can be provided is through voluntary co-operation between hospital authorities.

Other provisions of the EEC Directives that must be considered in this connection are:—

- (i) "Member States shall ensure that the institution training nurses is responsible for the co-ordination of theory and practice throughout the training programme."
- (ii) "Theoretical and technical training shall be balanced and co-ordinated with the clinical training of nurses in such a way that the knowledge and experience may be acquired in an adequate manner", and
- (iii) "The clinical experience should be selected for its training value, should be gained under the supervision of qualified staff and in places where the number of qualified staff and equipment are appropriate for the nursing care of patients."

7.2.4 In the present circumstances in this country, it is difficult to ensure that each student will pass through a structured programme in a balanced and co-ordinated way as required under the directives and in accordance with educational principles. A student moving out of her parent hospital to obtain some clinical experience not available in the parent hospital should do so at the time planned in her educational programme and not at a time when it may be convenient for the hospital to arrange it.

7.2.5 The present organisational structure of a nurse training school is generally on the following lines:—



Ø Not all schools have Education Committees.

\* Not all schools have clerk typists. In many instances where they do exist, they are shared with other offices, e.g. nursing administration.

Where education committees exist, the matron and principal tutor are regular members of the committee. Other members of the school staff act on the committee in rotation for one or two years. Representatives of the medical consultant staff of the hospital and lay administration also act on the committee. Some include representatives of third level educational bodies and some also have student representatives.

7.2.6 As already pointed out, some of the difficulties experienced in operating the present system are:—

- (i) the teachers, including the principal, carry heavy teaching loads which adversely affect the work and administration of the school;
- (ii) the lack of authority and responsibility vested in the Education Committee (where they exist);
- (iii) weaknesses within the existing teaching structure. There are two levels of nurse teacher, tutors and clinical teachers. However, there are no direct promotional outlets in the teaching area for the grade of clinical teacher and the nurse tutor often has neither authority nor control over the clinical teacher. This frequently results in an absence of unanimity of purpose.



The foregoing factors tend to create serious problems of recruitment and a shortage of nurse teachers. The Attitude Survey showed that teaching staff are particularly dissatisfied with their career patterns. Only a small minority (19%) of teachers in the Survey felt that "there are adequate career opportunities for them"

### **7.3 Proposals for Reorganisation**

7.3.1 The Working Party considers that a reorganisation of nurse training schools is necessary to overcome the deficiencies which have been highlighted in the foregoing paragraphs and make better use of the resources available throughout the country. It is satisfied that an amalgamation or grouping of training schools is necessary to enable all student nurses to obtain a comprehensive, broadly-based training on the lines imposed by the EEC Directives for general nurse training. Such an amalgamation would also facilitate an improved career structure for teaching staff and make better use of teaching resources.

7.3.2 The Working Party in considering the amalgamation of nurse training schools has furthermore had regard to:—

- (i) the recommendation for a common basic training programme for all nurses which involves the coming together of different types of hospitals as well as community services to provide a comprehensive training programme in line with that required for general nursing under the EEC Directives;
- (ii) the general hospital development plan which envisages fewer and larger general hospitals including developments at many provincial hospitals which are not at present recognised for nurse training purposes. When fully developed, such hospitals could well claim recognition for training thus adding to the already excessive number of training schools; and
- (iii) the effect the removal of the marriage bar on employment of married women will have on manpower requirements and the likelihood of many of the present small schools becoming less viable.

7.3.4 With all the foregoing considerations in mind, the Working Party came to the conclusion that there should be fewer nurse training schools in the country. *The Working Party recommends a total of 15 schools with at least one in each health board area.*

The Working Party envisages that a typical nurse training school in future would embrace a group of hospitals and institutions—general, psychiatric, mental handicap and community nursing services—together with facilities for the theoretical instruction of student nurses.

7.3.5 Every nurse training school should be self contained as to facilities required for training student nurses, that is, it should have adequate teaching accommodation and residential accommodation for students.

Having regard to existing circumstances, the Working Party envisages that the

main teaching facilities will be based at the major hospital of the group of hospitals which form the school.

As far as possible, the facilities for theoretical instruction of the student nurses should be centralised. It is recognised however that hospitals other than the major hospital should provide educational facilities including classrooms.

7.3.6 To be recognised as a nurse training school, the following criteria should be met:—

- (a) the full range of clinical experience as laid down in the syllabi of An Bord Altranais must be available;
- (b) a bed complement of not less than 750 beds and adequate community areas are indicated in order to meet the full range of training needs. These will include general medicine, general surgery, psychiatry, mental handicap, paediatrics, geriatrics and community, and
- (c) an adequate complement of qualified nurse teachers should be appointed to each school. *A teacher/student ratio of 1 : 15 is recommended.*

In recommending this ratio, the Working Party has taken cognisance of recent trends developing in nurse education. The move towards a modular system of training as recommended by the Working Party, the implementation of the EEC Directives and broadening of the base for nurse training with continuous assessment of students all have implications for the nurse teachers of the future. In addition, there is a growing demand for development in continuing education. All of these factors will make demands on the nurse teacher. Increasingly, nurse teachers will need to become specialists in different aspects of nursing with responsibility for teaching their specialist subject to all students.

In addition the teachers have organisational tasks in relation to the running of the school and should be encouraged to carry out research or investigations pertinent to their main nursing specialty. Thus, the nurse teacher has four main functions: education, research, responsibility for a group of students and an involvement in the administration of the school.

- (d) adequate accommodation and teaching facilities should be provided to meet the needs of the students and staff in a school.

These will include:—

teachers' rooms, tutorial rooms, conference rooms, counselling rooms, reading rooms, rest/common rooms, changing rooms, practical rooms, class rooms, libraries and a practical laboratory for demonstration purposes;

at least one lecture room should be tiered;

accommodation for teaching staff, offices for appropriate clerical and other support staff.

It is envisaged that some of these facilities can be shared on a multidisciplinary basis. The Working Party also considered it desirable that residential accommodation be provided for students, in their first year and as the need arises.

- (e) the number of students which may be trained in any nurse training school will depend on various factors such as manpower requirements, the range and extent of clinical experience available and the proper balance between trained and untrained staff. It is felt, however, that the optimum size of a nurse training school should be in the range of 300-400 students covering all relevant divisions of the register.
- (f) appropriate financial arrangements should be made for adequate funding of the school to ensure the provision of the facilities necessary for the teaching of student nurses. In particular, adequate funds for outside lecturers, library facilities and equipment must be guaranteed.

7.3.7 Each nurse training school should be headed by a Director of Nursing Education who should be responsible to an Education and Training Committee and who would have a staff as recommended below (at 7.3.10).

In addition to a Director of Nursing Education, a post of Deputy Director of Nursing Education and of Deputy Director of Nursing Education (Liaison) should be created in each recognised nurse training school. These posts are considered necessary in the light of the proposed reorganisation of the nurse training schools. The system proposed will require a high degree of organisation and co-ordination both in terms of the educational programmes themselves and the allocation of students to hospitals and community areas which form the school.

7.3.8 At least one Senior Nurse Teacher responsible to the Director of Nursing Education through the Deputy Director of Nursing Education (Liaison) should be based in each hospital involved in a training school and covering community nursing services for that area.

7.3.9 The Working Party considers the creation of the post of a liaison officer at Deputy Director of Nursing Education level most important. The function of this officer would be to co-ordinate the clinical and theoretical training needs of the student with the service needs of the hospital or community area. The Working Party recognises that in the future there will be a significant increase in the flow of students through the various hospitals in order to meet specialist training requirements. The Working Party therefore considers the liaison officer essential to ensure that neither patient care nor student training suffers as a result of this flow. The Deputy Director of Nursing Education (Liaison) will be responsible to the Director of Nursing Education but she will work in the closest possible collaboration with the Directors of Nursing to ensure that the hospital service needs are not jeopardised.

7.3.10 *The Working Party recommends the following staffing structure for a nurse training school:—*

- (a) *Director of Nursing Education*
- (b) *Deputy Director of Nursing Education*
- (c) *Deputy Director of Nursing Education (Liaison)*

- (d) *Senior Teachers (as recommended at 7.3.8 above)*
- (e) *Nurse Teachers in the ratio of 1 : 15 exclusive of (a), (b) and (c) above*
- (f) *Appropriate clerical and other support staff.*

7.3.11 The responsibility for the control and administration of each nurse training school should be vested in an Education and Training Committee. The committee should be representative of the hospitals and community care services involved in a training school. The committee should manage and control all aspects of nurse training, make provision for pre-registration and post-registration training courses and assist in the provision of in-service training and refresher courses.

The objective, already stated in this report, of having nurse education and training organised as a continuum after completion of the pre-registration course, will more easily be met under a system where available resources and expertise are combined under the aegis of one committee. It is anticipated that in the majority of health board areas the one committee will carry out this responsibility for the whole area. In health board areas where there will be more than one nurse training school, special arrangements will be necessary to ensure overall co-ordination in the allocation of students and in the provision of post-registration courses. This could be achieved by a sub-committee comprised of the Deputy Directors of Nursing Education (Liaison) in the area.

In addition, the Education and Training Committee will ensure that close co-ordination of the constituent hospitals involved in the school is achieved. The committee should ensure that the requirements for training and the syllabi as laid down by An Bord Altranais are complied with. Towards this end, regular meetings between each of the committees with the education officers of An Bord Altranais are suggested.

*The Working Party recommends the following composition of the Education and Training Committee:—*

<i>Director of Nursing Education</i>	<i>1</i>
<i>*Director of Nursing</i>	<i>3</i>
<i>Deputy Director of Nursing Education (Liaison)</i>	<i>1</i>
<i>Nurse Teachers</i>	<i>2</i>
<i>Deputy Director of Nursing (Personnel)</i>	<i>1</i>
<i>Senior Nurse Administrator</i>	<i>1</i>
<i>Chief Community Nursing Officer</i>	<i>1</i>
<i>Representatives of Health Board and Voluntary Hospital Management</i>	<i>2</i>
<i>Student Nurses</i>	<i>1</i>

\*General Hospital, Psychiatric Hospital, Mental Handicap Hospital. In the case of the Eastern Health Board area, (a) a fourth Director of Nursing would be appointed to represent the paediatric hospitals and (b) a fifth

Director of Nursing would be appointed to represent the specialist maternity hospitals.

With the exception of the Director of Nursing Education and the Deputy Director of Nursing Education (Liaison) the members of the committee should act on a rotational basis.

It is envisaged that the committee will consist of members nominated through the relevant employing authorities i.e. health boards, voluntary hospitals and mental handicap centres. It will not be a separate employing authority.

The Education and Training Committee should be empowered to set up such sub-committees as it deems necessary for particular training programmes.

7.3.12 The staff of the school would be employed on behalf of all the participating hospitals by the hospital authority responsible for funding the school.

7.3.13 Students would be employed by the hospital authorities to which they are recommended by the Central Applications Bureau.

## **ORGANISATION AND ASSESSMENT OF BASIC EDUCATION PROGRAMMES**

### **7.4 Present Arrangements**

#### **7.4.1 Programmes**

In Ireland there are four training programmes leading to registration to which there is direct entry: general nursing, psychiatry, paediatric nursing and nursing of the mentally handicapped. In addition, there are two combined courses, one leading to dual registration in general nursing and psychiatric nursing and the other leading to dual registration in general nursing and paediatric nursing.

In all these programmes with the exception of psychiatric nurse training, there are two intakes of students per annum—Spring and Autumn. These intakes coincide with the state examinations which are held in May and November each year. There is only one intake per annum for psychiatric nurse training which commences in September each year.

All student nurses follow a syllabus of training as laid down by An Bord Altranais. Training schools must be recognised by An Bord Altranais and comply with its Rules.

#### **7.4.2 Selection**

Recognised training schools select their own candidates for training and each school determines its own method of selection. The Working Party's views on this issue have been indicated in Chapter 5.

#### **7.4.3 Arrangement of Training Programmes**

7.4.3 (1) Theoretical teaching throughout the three years of training is organised in almost all schools on a system of release *en bloc* which allows for periods of uninterrupted formal teaching. In most training schools, student nurses have no commitment to the clinical service during these periods. The periods of release vary in length from approximately two weeks to five weeks. The theory taught during such periods, frequently is not directly related to the experience immediately following in the clinical area.

7.4.3 (2) On entry to the training school, students have an introductory course which varies in duration; up to 12 weeks may be spent in classroom study. During this time, they study the basic sciences—anatomy, physiology, microbiology—hygiene, first aid and basic nursing care. After the first few weeks of study, they may be allocated to clinical areas for short periods, for example 1-2 hours daily, where they practise under supervision. During the introductory period, a weekly test may be given to evaluate students' progress.

7.4.3 (3) At the end of the introductory period, they are allocated to the clinical area on a whole-time basis for a further period in order to acquire nursing skills. The latter period varies significantly from school to school.

7.4.3 (4) Following this clinical exposure, in most training schools students take an examination in the subjects they have studied. This may take the form of a written paper and/or a clinical assessment in the classroom or in the ward. If successful in this examination the student may proceed with her training. If unsuccessful, the student may be allowed to continue with training subject to the requirement that she repeat the examination after a reasonable interval. The student may be allowed to repeat once or twice depending on the policy of individual schools.

7.4.3 (5) At the end of the first year, in most schools, each student is allowed a study period for revision before taking the preliminary state examination. Unsuccessful candidates are given credit in the preliminary state examination for those subjects in which they have been successful. They are given two opportunities to repeat the examination. They are allowed to proceed to the second year training programme without having successfully completed the examination.

7.4.3 (6) During the second and third years of training, students continue to receive theoretical teaching and are allocated to the various clinical areas under the supervision of trained staff for periods of up to three months (which may include night duty) in order to gain experience in all areas of nursing. During these periods, general nurse students may be seconded on an exchange or supernumerary basis for certain optional specialist training e.g. psychiatric and geriatric nursing.

7.4.3 (7) On completion of three years training, provided students have attended 75% of formal lectures in each subject and obtained the prescribed clinical experience, they are eligible to enter for the state final examination held by An Bord Altranais. Candidates who are not successful in every subject in the final examination may be given credit for those subjects which they have passed. There is no limit to the number of times a candidate may take this examination nor is there a need for candidates to be actively engaged in nursing immediately prior to taking it. Successful candidates may register with An Bord Altranais and thereby become entitled to practise as registered nurses.

7.4.3 (8) The Working Party is concerned that students may proceed with training although they have failed the preliminary state examination and also that those who fail the final state examination may repeat it indefinitely or may defer taking it for a number of years following training.

#### 7.4.4 EEC Requirements

Since June 1979, all students undergoing nurse training, in order to comply with the EEC Directives must be given clinical instruction in the following specialties: (An Bord Altranais has specified the periods indicated below as being the appropriate periods for the purpose of compliance with the directives.)

Mental Health and Psychiatry	: 6 weeks
Child Care and Paediatrics	: 6 weeks
Maternity Care	: 4 weeks
Care of the old and Geriatrics	: 6 weeks
Home Nursing	: 1 week

Most of the existing training schools will have to send students to specialist hospitals for all or part of this training.

#### 7.4.5 Theory and Practice

The Working Party is concerned at the evident gap that exists between the theory of nursing as taught in the classroom and relevant clinical experience. It is felt that the block system has not helped to close this gap and that the interval between teaching of the theory in the study period and relevant clinical practice in the wards is unduly long and makes it difficult to relate the theory to the practice. The Attitude Survey showed that most nurses want improvements in the link between theory and practice: — 78% of the staff surveyed considered it necessary to improve this link.

#### 7.4.6 Examinations and assessment

Examinations for student nurses undergoing pre-registration training are organised at two levels, i.e. state examinations and hospital (*in-house*) examinations.

State examinations are organised and controlled by An Bord Altranais.

##### 7.4.6 (1) General and Paediatric Nurse Training

Having completed a twelve month training in an approved school, a student nurse is required to take the *preliminary state examination*. This examination is conducted entirely by qualified nursing staff. It consists of a written paper in each of the following:—

- (i) anatomy, physiology and hygiene
- (ii) nursing

and an oral practical examination in each.

The examiner who has marked the written paper on nursing for a particular candidate is one of the examiners for the oral practical examination of that candidate.

*The state final examination* is taken following three years' training which must be completed by the end of the month in which the last oral examination is held. It consists of three written papers and three oral examinations in medicine, surgery and nursing. All the written papers carry an equal weighting. The oral practical in

nursing carries twice the marks of each of the other two orals. The examination is conducted by medical and nursing staff selected by An Bord Altranais.

Each training school organises its own *in-house examinations* normally at the end of the introductory period and at the end of each year's training programme. Failure in these examinations does not preclude students from taking the state examinations.

#### 7.4.6 (2) *Training in Nursing of the Mentally Handicapped*

Prior to November 1979, student nurses training in the care of the mentally handicapped were required to take the *preliminary state examination* as described above. In 1979, following the introduction of a revised syllabus the previous year, the format of the examination was changed and it now consists of a written paper in each of the following:—

- (i) Nursing and the Needs and Special Requirements of mentally handicapped persons (Sections A and D of the new syllabus)
- and
- (ii) Mental Handicap and Special Therapeutic Methods (Sections B and E of the new syllabus).

Oral examinations are carried out in both (i) and (ii) above. Candidates are examined separately by one examiner who has marked the written paper in the appropriate subjects.

The *state final examination*, for students who trained under the old syllabus, consists of a written paper in each of the following:—

- (i) Nursing and Physical Diseases and
- (ii) Mental Handicap
- and an oral examination in—
- (i) Practical Nursing and
- (ii) Mental Handicap.

The examination is conducted by medical and nursing staff selected by An Bord Altranais.

The format for the state final examination to be taken under the revised syllabus for students who commenced training in 1978 is still under discussion.

Each training school organises its own *in-house examinations* at the end of the introductory period and at the end of the first and third years training programmes. Failure in these examinations does not preclude students from taking the state final examination.

7.4.6 (3) The Working Party considers that the present *in-house examination* system lacks an overall standard approach to the assessment and examination of students. There is wide variation in the systems of assessment used in the different training schools, particularly in the second and third years of training. It is noted that there is comparatively little involvement in the formal assessment of students by non-teaching staff such as ward sisters.



## 7.5 Arrangements for the future

### 7.5.1 Organisation of Pre-Registration Training Programmes

The Working Party recommends that education and training for registration should be organised as a planned programme of related nursing theory and practice. As has already been stated, it considers that while student nurses cannot be totally relieved of duties in relation to patient care, this commitment to service should not interfere with their educational requirements. Students should be given responsibility for patient care according to their level of competence and on a progressive basis and always with the degree of supervision that is necessary for learners in a service situation.

*The Working Party therefore recommends that a modular system of training with continuous assessment of candidates throughout the training period be adopted.*

The modular system of training implies the arranging of the training programme so that the periods of practical experience in clinical areas are preceded by periods of theoretical instruction related to that particular experience and are followed by a further period of theoretical instruction to consolidate the knowledge gained during that experience. If a module of twelve weeks is used then the first week will be spent in preparatory study for the clinical experience to follow in the next ten weeks and the last week will be spent in consolidating the skills acquired during the clinical experience. During the ten weeks' clinical experience at least ten hours formal clinical teaching should be allowed. It is most important that precise learning objectives be drawn up for each module. It is equally important that each module be kept intact.

Diagrammatic Concept of a Single Module

Time Scale	Week 1	Weeks 2-11 incl.	Week 12
Content	Preparatory Study	Clinical Nursing Experience (with at least ten hours' formal clinical teaching)	Consolidation

The content of the introductory block of twelve weeks' duration with continuous assessment would be four weeks' theory, seven weeks' initial clinical experience (ward exposure) and one week's theory for consolidation.

Students would proceed from module to module gaining experience in theory and practice in all the prescribed areas.

The modular system of training facilitates the assessment of the student's progress which can be carried out at the end of each module. The Working Party considers that adoption of such a system would result in:

- better integration of theory and practice;
- planned training programmes for every student and uninterrupted allocation to each prescribed clinical area, both in general and specialist hospitals and in the community;

- an even distribution of the number of students within each service area throughout the year; and
- an even distribution of students (first year, second year and third year) within each service area throughout the year.

An alternative system of organising the students' formal study time would be a programme of study days by way of a day-release per week to the school. Educationally, this has the advantage that the amount of theory taught in a week is manageable for the student and it can be closely related to the nursing which she is practising at the time. The Working Party, therefore, sees no objection to day-release study as an alternative to the modular system.

7.5.3 To achieve a more even distribution of students and to facilitate staffing arrangements, *the Working Party recommends that there should be three intakes of students each year and three state final examinations. This would also facilitate the work of An Bord Altranais both in relation to securing examiners and the work of registration.*

#### 7.5.4 Assessment and Examination

7.5.4 (1) The Working Party considers there is a need for uniformity of procedures in assessing student nurses' progress from commencement of training.

As already described, the state examinations in their present form assess the students' progress and competence to practise by means of written papers and oral examinations. In the oral practical examination the candidate describes what action she would take in a certain situation. Both the written and the oral examinations depend on the candidate's recall of learning rather than on observed behaviour. \*Bendall has shown that answers to written questions do not provide an adequate guide to practical performance.

The assessment/examination of student nurses must include:—

- (a) testing the practical skills, attitudes and the application of nursing knowledge in direct patient care, that is, *performance*, and
- (b) examination on the theoretical base necessary to perform effectively as a nurse, that is, *knowledge*.

To test performance it is first necessary to set educational objectives for the students and arrange suitable learning opportunities in both the clinical areas and in the classroom. The Working Party has already stressed the importance of setting learning objectives (para 7.5.1).

Practical skills can then be judged by assessment in the clinical areas. This is best done jointly by teaching staff and the clinical staff who should write progress reports on each student before she leaves their ward or department. The Working Party recognises the need for written papers in an examination system to test the theoretical and academic knowledge necessary for nursing in the setting of health and social services generally. Equally, assessment of clinical skills is also important.

\*Bendall, E. "So you passed, nurse". Royal College of Nursing 1975.

*The Working Party recommends that:—*

- (i) assessments of theoretical knowledge and practical skills should be carried out during each module and that credits for these assessments be aggregated and taken forward to the in-house examinations and the state final examination;*
- (ii) at the end of the first module, that is, the twelve week introductory course, a special assessment should be made of the students' suitability for continuing in training;*
- (iii) to ensure uniformity of assessment and to maintain standards, all those taking part in assessments, both teachers and ward personnel, should be required to undertake training in the skills of assessment;*
- (iv) each student should be obliged to undertake one nursing history and nursing care plan for an individual patient in each module.*

The Working Party stresses the value of these plans as an educational aid. Credits for plans undertaken should be included in the assessment at the end of each module and should be aggregated and taken forward to the in-house examination and to the state final examination;

- (v) as well as assessments, written in-house examinations should be held at the end of the first and second years of training and that extern examiners, approved by An Bord Altranais, should be involved in these examinations.*

The Working Party is satisfied that this system of assessment will eliminate the need for a preliminary or other intermediate state examination.

- (vi) students who are unsuccessful in the examinations at the end of the first and second years should not be allowed to proceed with their training until they have successfully completed the examinations. Credits should be allowed for subjects in which students have been successful but only one further attempt to pass the examination should be allowed;*
- (vii) the state final examination should consist of written papers which test the student's nursing knowledge and not practical nursing skills and should incorporate in the overall marking system credits gained from continuous assessments and from nursing history and nursing care plans. The type of questions used to test the student's knowledge should be re-evaluated and consideration should be given to using the nursing history and nursing care plans as a basis for the oral examination.*

7.5.4 (2) The Working Party is concerned that clearly defined limits should be set within which candidates may be allowed to qualify for final registration. *It therefore recommends that:—*

- (i) candidates who fail the final state examination should be allowed not more than two further attempts and qualifications should in any event be obtained within 5 years from the commencement of training. Before taking the next repeat examination the candidate should spend at least*

one module (12 weeks) in the training school as laid down by the Director of Nursing Education within six months immediately preceding the date of said examination.

- (ii) *candidates who do not intend to take the state final examination immediately following a three year training programme should inform An Bord Altranais in writing through the Director of Nursing Education of their intention and the reason for deferring.* Where there is a lapse of twelve months or more between completion of training and taking the state final examination, candidates should follow a planned programme as laid down by the Director of Nursing Education.

An Bord Altranais should have the final decision in all such matters.

7.5.5 The foregoing principles in relation to assessments and examinations should apply to all courses leading to registration.

## COMMON BASIC TRAINING

### 7.6 Introduction

7.6.1 Under its terms of reference the Working Party was given a special task; "in regard to training to examine, in consultation with such bodies, as are considered appropriate, the recommendations for a common basic training course for all nurses to be followed by specialisation in particular fields which were made by the Commission of Inquiry on Mental Illness in 1966 and by the Working Party on Psychiatric Nursing in 1972".

The Working Party, having examined the issues and having regard to the high proportion of comments favourable to common basic training as expressed in the submissions made to it, is satisfied that there is a considerable argument in favour of the adoption of a policy of common basic training with common portal of entry.

In its examination, the Working Party consulted with teaching and administrative staff and staff representatives of the various branches of the nursing services. In the evidence submitted and in the course of discussions, it was clear that there was no uniform understanding of the term *common basic training*. Some interpreted it to mean a multipurpose nurse competent to perform in any area of nursing while others saw it as a sharing of the early part of the training programme, not necessarily resulting in a multipurpose nurse. It was this latter interpretation that the Working Party adopted.

### 7.7 Present Position

7.7.1 There are at present four main streams of nurse training leading to registration in the divisions of the Register kept by An Bord Altranais to which there is direct entry viz:—

- (a) general nurse training which is a three year programme provided in 29 centres with an aggregate of approximately 1,100 training places each year;

- (b) psychiatric nurse training which is a three year programme provided in 22 centres with an aggregate of approximately 400 training places each year;
- (c) mental handicap nurse training which is a three year programme provided in eight centres with an aggregate of approximately 200 training places each year;
- (d) paediatric nurse training which is a three year programme provided in three centres with an aggregate of approximately 150 training places each year.

7.7.2 There is, in addition, a combined general and paediatric nurse training course which is a four year programme provided in two centres with an aggregate of 34 places and also a combined general and psychiatric four year nurse training programme provided in one centre with an aggregate of 15 places each year.

7.7.3 In addition to the foregoing programmes there are other nurse training programmes leading to registration to which there is not direct entry such as midwifery, entry to which is restricted to applicants who are registered general nurses or registered paediatric nurses and public health nursing, entry to which is restricted to applicants who are registered general nurses and who are also registered in midwifery. These programmes are not included in the consideration of common basic training.

7.7.4 An examination of syllabi for the different nurse training programmes shows a large amount of common ground in the preliminary stage; clear evidence of this common ground is seen in the accepted arrangement under the Rules of An Bord Altranais whereby a qualified psychiatric nurse who has completed three years psychiatric training can obtain general nursing qualifications, which is a three year course, in 18 months. This partial exemption also applies in the case of a qualified general nurse doing psychiatric nurse training and partial exemption arrangements equally apply to other training programmes leading to dual registration.

## **7.8 Aims of Common Basic Training**

7.8.1 The aims of common basic training are:—

- (i) to provide a common introduction to the principles of nursing which are essential if the practice of nursing is to be effective and form the basis of future development within the selected discipline;
- (ii) to give all students training and experience in the fields of nursing outside their selected discipline so that they will be better equipped to deal with all types of patients which they may meet in their selected discipline;
- (iii) to provide more uniform training in humanistic skills leading to better total patient care;
- (iv) to remove barriers between the different streams of nursing and lead to a more integrated profession;

- (v) to give the student a better perspective and appreciation of nursing; through broader understanding of the nurses role, greater competence and self-confidence should result thus leading to greater job satisfaction; and
- (vi) to make optimum use of training resources through common recruitment and selection procedures, sharing of classrooms and other facilities e.g. library and audio-visual aids.

7.8.2 The EEC Directives concerning general nurses require that student general nurses, in addition to clinical instruction in medicine and surgery, must also acquire clinical instruction in paediatrics, maternity care, psychiatry, geriatrics and home nursing. Common basic training would ensure that not only general nurses but all nurses would receive a similar comprehensive broadly-based training.

## 7.9 Future Position

7.9.1 *Having considered all the factors, the Working Party recommends the introduction of a common basic training programme. It recommends the continuance of the present system of three-year courses leading to registration in general, psychiatric, paediatric and mental handicap nursing with the first two years forming the common basic programme. The two-year common basic programme would be followed by a further year of intensive training in the discipline of nursing in which the student, at the commencement of training, would have indicated the intention to register.*

7.9.2 Completion of the basic course would not carry with it any recognition and would only mark a stage on the way to registration as in the case of the existing preliminary examination. The Working Party found it very difficult to compress into two years all the training (particularly the clinical experience) it would consider appropriate for a common basic programme and at the same time felt it was desirable that this country should adhere to the present three-year programme leading to registration particularly in the light of the EEC directives.

A student passing through the different modules would be consolidating and adding to her skills and learning the application of these skills in the different disciplines of nursing. It should not be interpreted that training and experience in any given module is not of relevance or significance to the field of nursing in which the student intends to seek registration. It should be understood that the whole programme is based on the precondition that it would be intensive and geared to the training needs of the student, which should be given a high priority, in the interests of producing a competent assured nurse who would be well capable of providing a high standard of nursing care.

7.9.3 Successful completion of the three-year programme would lead to registration in the appropriate division of the register of nurses. The first two years would be an integrated common basic programme for all nursing disciplines followed by one year's intensive training in the discipline selected for registration.

## 7.10 Proposed Organisation of a Common Basic Training Course

7.10.1 \*An initial training period of two years is recommended which might be composed of:—

- a twelve weeks introductory course to include seven weeks practical experience,
- twelve weeks Adult Surgery,
- twelve weeks Adult Medicine,
- twelve weeks Geriatrics,
- twelve weeks Psychiatry,
- twelve weeks care of the Mentally Handicapped,
- twelve weeks Paediatrics,
- eight weeks Community,
- four weeks Obstetrics.

One third of the time in each allocation would be devoted to theoretical and technical instruction including ward teaching and demonstrations. It is necessary that each allocation be kept intact.

It should be borne in mind that the knowledge and skills gained during each module are cumulative. The order in which the modules are taken is not significant and may be varied for different groups of students.

7.10.2 The Working Party considered it important that the first year of training should be spent in the one centre and in acquiring basic nursing skills and knowledge in general medicine, surgery and geriatrics. This would in effect mean common portal of entry to nursing. It is felt that this is essential to ensure that all student nurses acquire a firm knowledge of these basic skills in the early stage of their training. It is also considered desirable that the student nurse should be able to settle in in the first year and should not move into specialist areas.

7.10.3 The Working Party has not attempted to draw up a complete syllabus describing the knowledge content of the initial two-year training programme. However, it is envisaged that the knowledge and skills needed for meeting patients' basic needs will be taught during this period. The knowledge component will include introduction to the basic sciences. The attitudes necessary to respond to patients' basic needs and the knowledge and skills appropriate to prevent, recognise and deal with specific conditions will be achieved during both classroom teaching and clinical experience in each module.

There should be continuous assessment of both knowledge and skills (manual and interpersonal) throughout the two-year period. On completion of the two-year common basic course, there should be an *in-house* examination and success in this examination together with satisfactory assessment would allow the candidate entry to the final one year intensive training which would lead to registration as—

\*Possible options are set out in Appendix V.

Registered Nurse (General), or  
Registered Nurse (Psychiatric), or  
Registered Nurse (Paediatric), or  
Registered Nurse (Mental Handicap)

depending on the student's choice of discipline for registration.

7.10.4 The number of students accepted for training in each discipline every year would depend on the expected manpower requirements in the various disciplines. While students would on entry be accepted for training in the discipline of their choice, the system should be sufficiently flexible to allow for some changes in original choices to be made in the light of experience gained during the initial two-year programme provided that the manpower requirement levels in each discipline will be maintained.

7.10.5 Throughout the third year in the selected discipline, both theoretical and practical education should continue on the same basis as during the first two years.

7.10.6 Registration in a second discipline could be achieved by successfully undergoing the third year intensive training course in the relevant discipline.

7.10.7 *The Working Party recommends that, following registration under the proposed training programme, a nurse should continue to work for a six month period in a hospital specially approved by An Bord Altranais for this purpose.* The Working Party is concerned that at present many nurses are leaving their training hospitals after three years training without having the opportunity to consolidate their skills. Consolidation of skills could be achieved through specifying in addition to registration, a requirement of six months post-registration experience for employment in areas such as district hospitals or long-stay hospitals. It would be preferable in the interests of patient care and in their own interests that they should gain their initial experience as qualified nurses in a controlled situation where they would have the support they need. The main purpose of this period would be to gain post-registration clinical nursing experience following the intensive comprehensive training programme. It should be stressed that it is not the intention to have a 3½ year training programme. The Working Party has continually emphasised that registration is only the first stage in a continuing educational process for all nurses.

7.10.8 While the Working Party is satisfied as to the need for introducing common basic training and recommends accordingly, because of the radical nature of the changes involved, it is suggested that pilot schemes be introduced as quickly as possible in one or two areas.



## CONTINUING EDUCATION FOR NURSES

### 7.11 Introduction

7.11.1 As has been noted earlier in this report, the Working Party has regarded nursing education as a continuum and not as something which becomes random or unstructured after pre-registration training. It is recognised that there is a need to foster this concept in the nursing profession and to make available opportunities for members of the profession to pursue educational programmes suited to their needs as professional practitioners of nursing.

7.11.2 The International Council of Nurses in its \*policy statement describes continuing education as follows:—

“Continuing education should answer the needs of the service as well as the development of nurses: up-dated knowledge for on-going practice, preparation for specialisation and career advancement. Continuing education includes a wide spectrum of educational activities such as self directed individual study, in-service programmes, formal basic courses and post-graduate studies. It should be available to all nursing personnel employing suitable media to reach those working in isolated areas and suitable achievement should be rewarded by recognition, advancement and/or remuneration. Continuing education should be developed by and conducted within the nursing and/or general education system in co-operation with the nurses’ associations, government and health agencies.”

7.11.3 The need for continuing education has become more important because of on-going developments, changes in directions and improvements in the delivery of health services, many of which have already been referred to in this report. The nurse, in common with other members of a rapidly changing society, is conscious of the need to develop her full potential. Nurses now realise that the knowledge and skills acquired in a pre-registration education programme are insufficient to allow them to cope with increasingly complex activities which require further knowledge and skills.

### 7.12 Programmes for Development

The Working Party is of the opinion that programmes for staff development should be planned on two levels:—

- (i) *Independent Study* which is regarded as essential for every individual as part of their self-development in order to keep up to date and to develop an enquiring mind, and
- (ii) *Formal Programmes* which include hospital-based courses in specialist areas, refresher courses, in-service courses and courses organised outside hospitals.

#### 7.12.1 Independent Study

The Working Party considers independent study to be the first and most important component of any programme of continuing education. It is felt that

\*International Council of Nurses, Publications No. 6, Policy statements ICN.

the responsibility rests with the individual nurse to improve herself and to develop an informed approach both to her profession and to the environment in which she practises. Every nurse should be sufficiently self-motivated to assess her own educational needs and to plan and direct her own development. This implies making use of resources, e.g. libraries, journals and periodicals. It also implies attending lectures and participating in discussion groups so as to become informed on topics of interest within her own profession, within health professions generally and in the broader areas of adult education.

Personal planning for continuing education should mean that the nurse always has at least an intermediate educational goal even if her ultimate career development and therefore the final objective may not immediately be apparent.

It is important that senior nursing personnel encourage their staff to take an interest in and plan for their continuing education. They should be alert to recognising any special aptitude or skills in members of their staff and be ready to offer advice and help in their development.

#### 7.12.2 Formal Programmes

As an aid to staff development, the Working Party has identified five areas where it is considered planned, formal, continuous education programmes should be organised:

- courses in specialised clinical nursing,
- courses in management and administration,
- refresher courses,
- in service training, and
- university based or Faculty courses.

The Working Party undertook an examination of existing continuing education facilities which showed that all the above types of programmes are available. There is, however, an uneven distribution both in the spread of courses and in their geographical location and a lack of standardisation as to subject content and the qualifying process in the organisation of similar types of programmes.

7.12.2 (1) *Courses in specialised clinical nursing* are available in the following specialties:

- Operating Theatre technique available twice yearly at three centres with an aggregate of 36 places;
- Accident and Emergency nursing available twice yearly at two centres with an aggregate of 24 places;
- Coronary Care nursing available twice yearly at two centres with an aggregate of 24 places;
- Intensive Therapy nursing available twice yearly with an aggregate of 24 places;
- Renal nursing which includes nephrology, renal dialysis and transplantation, available twice yearly at one centre with 6 places per year;

- Rehabilitation nursing available once yearly at one centre with 6 places per year;
- Neo-natal and Developmental Paediatrics available twice yearly at one centre with 6 places per year;
- Urological nursing available yearly at one centre with 6 places per year;
- Neurosurgery and Neurology available twice yearly at one centre with 12 places per year;
- Ophthalmological nursing available yearly at one centre with an aggregate of 7 places.

These courses are usually of six months duration and are all confined to the Dublin area. Each hospital organises its own programme with An Bord Altranais approval but the Board does not monitor the programme in any way nor does it award certificates on satisfactory completion. While the content of such courses should be flexible within an agreed framework of objectives, there appears to be an undue lack of standardisation in similar courses which leads to some courses being more highly regarded than others.

The conditions of service for nurses undertaking the courses varies; in some instances, nurses apply to do the courses and are employed while doing them by the hospital running the courses; in others, they are seconded by their parent hospital to the hospital running the course for its duration.

The organisation of the theoretical programme to support the practical training often varies considerably which means a difference in methods of determining whether trainees have satisfactorily completed the course. This frequently results in certificates not having equal value.

*The Working Party recommends as follows:*

- existing courses in specialised clinical nursing should be developed on a regional basis to allow more nurses the opportunity to avail of them;
- An Bord Altranais should become more actively involved in the development of these courses to meet the needs of the nursing services as they arise. The Board should set guidelines, monitor syllabi and award certificates;
- in place of the former registrable course for infectious diseases, there should be a course in specialised clinical nursing for infectious diseases;
- a specialised clinical course in orthopaedic nursing should replace the existing registrable course;
- there should be early development of on-going courses in other specialities of nursing such as infection control, stoma therapy, oncology and occupational health nursing; and
- a specialised clinical course in ophthalmological nursing should replace the existing registrable course organised by the United Kingdom Ophthalmic Association.

The Working Party notes with regret the delay in the introduction of the course in

geriatric nursing which has been approved by An Bord Altranais. *The Working Party recommends that this course be inaugurated as soon as possible.*

7.12.2 (2) *Courses in management and administration* are available or have been available throughout the country as follows:

- Management for Senior Nursing Personnel held in the School of Management, Rathmines, Dublin and organised on a week per month over a 5 month period,
- First level management and nursing administration held in the School of Management, Rathmines, Dublin and organised on a day per week over a 14 week period,
- Management for Nurses course held in the Regional Technical College, Athlone and organised over an eight-day period according to demand and resources,
- Front line management (Nursing) held in the Regional Technical College, Dundalk and organised four times yearly for one week,
- Front line management held in the Regional Technical College, Carlow and organised on a day per week over a fifteen week period,
- Front line management held in the Regional Technical College, Galway for four weeks,
- First line management held in the National Institute of Higher Education, Limerick, and organised on a day per week over a fourteen week period,
- First line management held in the Regional Technical College, Sligo for four weeks,
- First line management held in the Regional Technical College, Letterkenny and organised over a seventeen week period in afternoon or evening sessions.

In addition to the above courses in management, An Bord Altranais arranges the following:

- a course in Nursing Administration for ward sisters and charge nurses. This is a three week course organised on a week per month basis for three consecutive months, and
- a one week course in Nursing Administration for senior nursing personnel. This course is run in conjunction with the Institute of Public Administration and is held once yearly.

There are also courses in hospital and health services administration organised by the Institute of Hospital Administrators available in Dublin, Cork and Galway. These are evening courses and are open to all categories of health personnel.

The Working Party is satisfied that there is a need for more courses in management for nurses and *it recommends that the present courses in management should be developed in centres where they are not now available so*

*that nurses throughout the country will have the opportunity of availing of them.*

The importance of the administrative and managerial role of senior nursing personnel from the level of Nurse Administrator upwards is being stressed both nationally and internationally. The development of the health care team and tripartite management of hospitals makes it essential that senior nurses are trained to play a full role in the planning and delivery of health care and in the management of resources.

The new post-registration university degree course which is recommended in this report (para. 7.15.2) would include training for management and administration and would give intensive training in this area to potential senior nurse administrators.

It is also desirable that, where practicable, senior nursing staff should participate in administration courses with other professional health staff.

7.12.2 (3) *Refresher Courses* are held mainly in the large urban areas and are not widespread throughout the country. Some, such as those run by An Bord Altranais in conjunction with the Institute of Public Administration, are organised on a regular basis while others are organised on an *ad hoc* basis to meet special needs. Some are organised by the professional nursing organisations.

The following is an indication of the type of refresher courses made available in a recent year:

- refresher course for nurse tutors and clinical teachers,
- refresher course for surgical nurses,
- refresher course for theatre nurses,
- refresher course for medical nurses,
- refresher course for public health nurses,
- refresher course for midwives.

Better co-ordination and more widespread distribution of these courses are considered most important. In this area, the Working Party feels that An Bord Altranais should promote, co-ordinate and develop courses without being involved in actual teaching and training.

The role of the Education and Training Committees in the nurse training schools has already been commented on in this regard.

Organisers of courses should submit their programmes and syllabi to the Board well in advance, preferably twelve months in advance. In this way, better planning in the co-ordination and distribution of courses can be arranged.

*The Working Party recommends that, because of rapidly changing techniques in medicine and nursing, all registered nurses and midwives should be required to undertake an appropriate refresher course at least once in every five years.*

7.12.2 (4) *In-Service Training Programmes.* In-service training at post-registration level is an on-going process for all nurses in which the supervisors guide and support members of their teams in forming and developing a desirable approach to nursing in the working situation.

There seems to be very little pattern in the provision of in-service training and

in many areas, there is no such training. During visits to hospitals by representatives of the Working Party, the need for this training was frequently expressed and while it exists in some hospitals which have training schools, in other areas, where often the need was greatest, it was not in evidence.

Planned in-service training programmes are useful means of orienting new staff or introducing staff to the latest developments and by means of "back-to-nursing" courses which help staff who return to nursing after several years absence. The Working Party is aware of the considerable value of "on-the-job" training and has recommended that the Education and Training Committees in the schools take responsibility for organising these courses as appropriate. These programmes should be made available in hospitals which are not involved in nurse training.

All supervisors of staff should be made aware of their role in on-the-job training and of the need to pass on their skills and knowledge to those working under their supervision.

7.12.2 (5) *University Courses and Courses organised by the Faculty of Nursing, Royal College of Surgeons in Ireland.* A university degree course in nursing for registered nurses is dealt with separately in the following chapter and the comments in this section do not include reference to that course.

*The Working Party strongly recommends that qualified nurses should be encouraged and facilitated in the use of the existing resources of universities and other colleges of higher education for the further development of their potential.*

While it may be argued that in the past the educational standards for admission to nurse training was not adequate to meet the standard required for entry to university, the Working Party is of the opinion that the gradual increase in educational standards of those entering nursing in recent years will ensure that there will be a considerable number of nurses well equipped to undertake university courses in the future.

The Faculty of Nursing, Royal College of Surgeons in Ireland, was inaugurated on 30th October, 1974. In broad outline, the objectives of the Faculty are:—

- (i) self development of participants,
- (ii) sequential benefit to colleagues of those who obtain a Fellowship,
- (iii) an improvement in the standard of practical nursing and in the understanding of the nursing profession.

The Faculty provides diploma courses in subjects either not dealt with or not studied in depth in the pre-registration nurse training programmes. The following are the diploma courses for the year 1979/80:

- Counselling for nurses,
- Psycho-social nursing,
- Pharmacology,
- Physics and Chemistry,
- Pathology,
- Behavioural Science: Introduction to Psychology.

The diploma courses are held in centres approved by the Faculty and the course subjects are organised on a cyclical basis to allow nurses at the various centres to acquire six diplomas for the purpose of obtaining a primary fellowship. This fellowship, incorporating subjects from the diploma course admits the holder to the final fellowship course which is being devised and which will provide for a study of specialties in even greater depth.

Diploma courses for primary fellowship are still in the process of being developed. They are at present available at nine centres:—Dublin, Cavan, Cork, Enniscorthy, Killarney, Letterkenny, Monaghan, Mullingar and Sligo.

Approximately 1,000 nurses are taking the diploma courses this year and this is indicative of the positive interest of the nursing profession in continuing education. Because these courses have only been recently introduced, it is still too early to assess whether they have succeeded in achieving the objectives of the Faculty.

The Working Party welcomes the development of the Faculty as a positive action aimed at improving the quality of nursing.

### 7.13 Comment

It is clear from discussions with nurses and from evidence received that all nursing staff feel that post-registration programmes along the lines set out in this section should be an integral part of a continuous education programme and should be readily available.

*The Working Party therefore recommends that employing authorities favourably consider requests for special leave to attend recognised courses and that more facilities for attendance at these courses should be provided.*

## A UNIVERSITY DEGREE COURSE IN NURSING

### 7.14 Introduction

7.14.1 The Working Party examined the need for university degree courses in nursing and is satisfied that such courses are necessary and important for the nursing services and the nursing profession itself.

A much broader approach to nursing is needed and a deeper knowledge is required by the nursing profession of the concepts of the health of society and of the relevant sciences. It is not possible to examine nursing in this depth in the conventional pre- or post-registration courses that are restricted in terms of both time and resources. To develop courses with this depth of knowledge requires the academic climate which colleges of higher education, such as universities, can offer. It is here that the students, by associating with other professions, can develop a wider appreciation of their own profession's role within society.

The role of the nurse in hospitals, in community care teams and the growing, highly technical nature of nursing practice requires that opportunities be made available for some nurses to acquire the knowledge and skills to enable them to:—

- (i) perform at a high level in administration, education and clinical nursing;
  - (ii) be introduced to the applied sciences, to methodology and to analysis;
- and

- (iii) adequately represent the nursing point of view in negotiations and discussions with other members of the health professions.

### **7.15 A Degree in Nursing for Registered Nurses**

7.15.1 The Working Party considered two options in relation to such university courses:—

- (a) a degree in nursing for registered nurses; and
- (b) a degree in nursing for applicants to nurse training leading to registration.

7.15.2 The Working Party is of the opinion that the course at (a) would be more likely to achieve the objectives described above and would be more acceptable to the nursing profession as a whole. While the possible content of a university degree course for registered nurses has not been examined in detail, it is felt that it clearly could be more oriented towards theory and academic training than a degree course leading to registration which would need to include a considerable amount of practical training. A post-registration degree course would be more likely to meet university standards for validation purposes.

Subjects dealt with in the pre-registration course could be studied in greater depth; options in regard to higher specialist nursing skills not taught at pre-registration level could be included and here some practical experience might arise; research in nursing; managerial skills; health administration and teaching skills could all be combined to produce a useful degree in nursing for registered nurses from all divisions of the register. There would probably be provision for options in certain parts of the course e.g. higher skills and research might be related to the area of nursing in which the under-graduate student would have already registered.

7.15.3 The degree course for registered nurses would produce graduates who could then decide whether to pursue a career in clinical nursing, nursing administration or nurse teaching. It would create mobility in these areas and would help to unify the senior nursing structures. Under the existing system, it is difficult to attract nurses into nurse teaching because, as teachers, they are removed from other areas of nursing. It is likely however that nurses undertaking the degree will concentrate in their area of choice in so far as dissertation and/or research work is concerned.

### **7.16 Proposed Organisation of a Degree Course for Registered Nurses**

7.16.1 The proposed degree course for registered nurses could be organised along the following lines:—

Each year a competition could be arranged to select up to 50 registered nurses who would be sponsored for a three-year university course leading to a degree in nursing. While such a scheme would be aimed at newly qualified nurses others would not be precluded and selection criteria would be related to general educational attainments, performance in final state examination for registration purposes and general suitability. In the early years of such a development it might be desirable to reserve a limited number of places for qualified nurses who did not previously have the opportunity of pursuing a degree course.



7.16.2 Such a scheme would have the advantage that graduate nurses would be selected from within the profession rather than individuals outside the profession, to some extent at least, pre-selecting themselves as would occur under a degree course leading to registration. Under either system it is inevitable that graduate nurses will be in what is regarded as "the fast stream" as far as advancement within the services is concerned although academic achievement should not be the sole criterion in this respect and graduate nurses would still have to prove themselves in the service. Experience and qualities such as judgement, zeal, intelligence and administrative ability are all factors that should be taken into account in the selection of suitable candidates for promotion.

7.16.3 The Working Party is aware of the proposed development of a university degree course which would entitle the graduate to become a registered general nurse. While not averse to experimentation along these lines, the Working Party nevertheless feels that there are certain disadvantages attached to such a course and *it recommends that priority be given to the development of a degree course for registered nurses.*

#### **7.17 A Degree Leading to Registration as a Nurse**

The degree course leading to registration envisages that a limited number of applicants for nurse training would, instead of going into hospital training schools, elect to do the university course and on successful completion of the course would be awarded a primary university degree in nursing which would entitle the recipients to become registered nurses. Student nurses doing the university course would be subject to the same practical training and experience in hospital as their student colleagues not doing the degree course. The hospital training school programme is of three years duration and since all this programme would need to be incorporated into the degree course, even a four-year degree course would not allow sufficient scope for the higher university type of training. A further factor that requires consideration is that students who apply to do and are accepted for the university course are, as already pointed out, pre-selecting themselves for the university course which is intended to provide the potential nurse administrators and leaders of the nursing profession. It is difficult to see how the degree course leading to registration could cater for nurses from the various divisions of the register and it would probably require separate degree courses for each division of the register. On the other hand the degree course for registered nurses could accommodate nurses from each division of the register and, while there would be competition open to all registered nurses, a specified minimum number of places could be reserved for registered nurses in each division of the register.

#### **7.18 Considerations for the Future**

7.18.1 In recommending a degree in nursing for registered nurses, the Working Party is cognisant of the fact that there may be a place for a pre-registration degree in nursing in the future. It considers it most important that any university programme for nurses should have a sound base of nursing theory and well-balanced practical experience in all areas of nursing and must be developed in accordance with the needs and developments of the nursing profession to enhance its service to the community.

7.18.2 The Working Party stresses the need for An Bord Altranais to be involved in the planning of all courses involving nurse education, including university courses.

### **SIGNATURES TO THE REPORT**

Brigid Tierney (Chairman)  
Johanna M Barlow (with reservation concerning Chapter 6)  
Sr. M. J. Berchmans  
Edmund D. Browne  
Judith Chavasse  
Phil Flynn  
Sr. Francis Joseph  
Ena Gurhy  
Seamus Healy  
Hanora Mary Henry  
K. J. Hickey  
O. Hogan  
Eileen E. Horgan  
Maeve C. Keane  
Mary Keenan  
Elizabeth M. Kelly  
T. Keyes  
Sr. M. Kieran Sloan  
Martha W. McMenamin  
Elizabeth O'Dwyer  
Sr. Rita Yore  
Margaret F. Reidy  
G. MacGabhann  
Teresa C. Taaffe  
Niall Tierney  
Brigid C. Walsh (with reservation concerning Chapter 6)

Sylvia M. Kelly  
Secretary  
5 March, 1980

## **APPENDIX I**

### **List of Persons and Organisations who submitted views**

Matron and nursing staff, Mercer's Hospital, Dublin.  
Mr. Bill Beesley, Surgeon, Meath Hospital, Dublin.  
Mr. A. M. Mikhail, Surgeon, Merlin Park Hospital, Galway.  
Mr. Noel P. Feeley, School of Management Studies, Rathmines, Dublin.  
Matron and Tutor, National Children's Hospital, Harcourt Street, Dublin.  
N. F. Gallagher, Chief Nursing Officer, St. Loman's Hospital, Mullingar, Co. Westmeath.  
Board of Governors, Sir Patrick Dun's Hospital, Dublin.  
Adelaide Hospital, Dublin.  
Nurses and Nursing Committee, Victoria Hospital, Cork.  
Matron, St. Anne's Hospital, Northbrook Road, Dublin.  
St. John's Hospital, Limerick.  
Dr. Steeven's Hospital, Dublin.  
Portiuncula Hospital, Galway.  
Mercy Hospital, Cork.  
Medical Faculty, University College, Cork.  
James Connolly Memorial Hospital, Blanchardstown, Co. Dublin.  
Prof. James McCormick, Dean of the Faculty of Medical and Dental Sciences, Trinity College, Dublin.  
St. Mary's Orthopaedic Hospital, Cappagh, Dublin.  
Board, Royal City of Dublin Hospital, Dublin.  
St. Laurence's School of Nursing, Stanhope Street, Dublin.  
Public Health Nurses, Crumlin area, Dublin.  
Miss Mary C. Gill, Public Health Nurse, Dublin.  
St. Vincent's Hospital, Elm Park, Dublin.  
Association for the Welfare of Children in Hospital.  
Education Committee of the Board, Faculty of Nursing, Royal College of Surgeons in Ireland.  
Nursing School, Royal Victoria Eye and Ear Hospital, Dublin.  
Matron, Rotunda Hospital, Dublin.  
Waterford Maternity Hospital, Airmount.  
Board, Peamount Hospital, Newcastle, Co. Dublin.  
Our Lady of Lourdes Hospital, Drogheda, Co. Louth.  
Board of Directors, St. Luke's Hospital, Dublin.  
North Charitable Infirmary, Cork.  
Matron, St. Laurence's Hospital, Dublin 7.  
Miss B. A. Killian, Public Health Nurse, County Clinic, Longford.  
St. Mary's Auxiliary Hospital, Baldoyle, Co. Dublin.

Board, Erinville Hospital, Cork.  
 Irish Private Hospitals and Nursing Homes Association.  
 Beaumont Convalescent Home, Dublin.  
 National Medical Rehabilitation Centre, Dun Laoghaire, Co. Dublin.  
 Miss Mary Mooney, RGN, Mullingar, Co. Westmeath.  
 Miss Mary Lahiff, Meath Hospital, Dublin.  
 Board of Governors, National Maternity Hospital, Holles Street, Dublin.  
 Psychiatric Nurses' Association.  
 Matron, Temple Street Hospital, Dublin.  
 Central Council, Federated Dublin Voluntary Hospitals.  
 Royal College of Physicians.  
 Medical Faculty, University College, Galway.  
 Midland Health Board.  
 Mid-Western Health Board.  
 Irish Matrons' Association.  
 Regional Technical College, Carlow.  
 Miss Mary F. Crowley, Dean, Faculty of Nursing, Royal College of Surgeons in Ireland.  
 Nurse Tutors' Academic Society.  
 Royal Victoria Eye and Ear Hospital, Dublin.  
 Public Health Nurses, County Clinic, Castlebar, Co. Mayo.  
 Medical Board and Management Committee, Jervis Street Hospital, Dublin.  
 Nurse Tutors Group (In the service of the Mentally Handicapped).  
 Dr. B. Lemass, County Physician, County Hospital, Nenagh, Co. Tipperary.  
 Regional Technical College, Athlone, Co. Westmeath.  
 Tutorial and Administrative Staff, (Nursing), Mater Hospital, Dublin.  
 Senior Nursing Personnel, North-Eastern Health Board.  
 Nursing Staff, Meath Hospital, Dublin.  
 Coombe Hospital, Dublin.  
 Association for the Handicapped Child in Domiciliary Care.  
 Irish Nurses' Organisation: Nurse Tutors, Midwives, Mental Handicap Nurses, Public Health Nurses, Assistant Matrons and Home Sisters, Operating Theatre Nurses Sections.  
 Nurse Education Committee, St. James's Hospital, Dublin.  
 Irish Medical Association.  
 Psychological Society of Ireland.  
 An Bord Altranais.  
 Mr. James A. Keogh, Chief Executive Officer, An Bord Altranais.  
 Mrs. Ann Maher, Tutor, St. Otteran's Hospital, Waterford.  
 North-Western Health Board.  
 Nurse Tutor Students, University College, Dublin.  
 Ms. Rosaleen Keaskin, Staff Nurse, Cottage Hospital, Drogheda, Co. Louth.  
 Miss N. F. McCarthy, Matron, St. James's Hospital, Dublin.

## **APPENDIX II**

### **ATTITUDE SURVEY OF IRISH NURSES**

#### **SUMMARY (prepared by the Institute of Public Administration)**

##### *Background to the Project*

1. This report presents the findings of a survey of Irish nurses' attitudes to their role, training and grading structures. The study was commissioned and financed by the Department of Health, at the request of the Working Party on General Nursing and carried out by the Institute of Public Administration.

2. Data were collected from nursing staff in all grades, in the hospitals and in the community, excluding psychiatric nurses. A stratified random sample of hospitals and health board areas was selected. As many nurses as possible from the selected sites completed questionnaires during the summer of 1978, yielding a total of 1,364 respondents.

3. Separate sections were included in the questionnaires for each of the grades: staff nurse, ward sister, public health nurse, teaching staff, nurse administrator (other than matron) and matron. Where views and attitudes to particular issues differ significantly between grades, attention is drawn to that fact throughout the report. For example, a separate section is included in Chapter 5 on matron's perceptions of their own role and responsibilities, and the views of teaching staff are referred to specifically in the chapters that deal with the education and training of nurses (Chapters 11, 12 and 13).

##### **Background Characteristics of Irish Nurses**

4. The majority of the nurses surveyed were found to come from rural areas. Most nurses are quite young; only 29% of them are over 40 years of age. Because of the trend for nurses to continue working after marriage, it is likely that the numbers in the older age groups will increase. This may mean a reduced demand for trainee nurses. At present, just over one-quarter of nurses are married.

5. The educational level of nurses reflects the recent raising of the minimum educational requirements for entry to nursing to the leaving certificate level. Almost three-quarters of nurses have at least a leaving certificate.

6. One-eighth of the nurses have less than one year's experience after their basic training and 43% of them have ten or more years' experience. The large non-teaching voluntary hospitals are likely to have a higher proportion of inexperienced staff. There seems to be quite a high turnover of nurses in Irish hospitals as evidenced by the fact that 25% of the nurses surveyed have worked

for a year or less in their present hospital. Such a high turnover rate must present problems of integration for hospital staff.

7. One-third of Irish nurses are trained in England. Public health nurses are particularly likely to have been trained abroad. In addition, almost 40% of nurses have worked abroad (either in England or North America) on completion of their basic training. Indeed it is only just under a half of nurses who have no foreign experience at all in terms of either training or work.

### **The Work Activities of Nurses**

8. Four distinct patterns of work activities for nurses working on the wards were identified. These were patient-oriented activities such as giving injections to patients, decision-making activities such as ordering supplies, doctor-assisting activities such as taking blood samples, and housekeeping activities such as cleaning and tidying.

9. Not surprisingly, all nurses are frequently involved in patient-oriented activities. Ward sisters, however, spend less time giving injections or washing patients and rather more time going on rounds with doctors, than do staff nurses. They are also relatively more involved in making administrative decisions about the running of the wards, such as arranging staff rosters and ordering supplies. Staff nurses tend to be more involved in the housekeeping aspects of nursing. They are also more likely to take blood samples but are less likely to fill out clerical or technical reports, both of which are doctor-assisting activities. The overall picture of the activities of ward nurses then indicates that there are some differences between the work of ward sisters and staff nurses, the former performing more of the skilled or administrative-type tasks, the latter performing more of the unskilled tasks.

10. In general, the more nurses are involved in an activity, the more satisfied they are with their level of involvement in it. This is particularly true of patient-oriented activities. However, increased involvement in housekeeping activities appears to be related to reduced satisfaction with that aspect of work. It seems that nurses do not like to be overly involved in cleaning, tidying and shifting beds.

11. Some attempt was made to ascertain how nurses view the aspects of their role that involve them in dealing with patients. Most nurses feel that while nurses should devote as much time as possible to their patients, nevertheless there has to be some regimentation of patients to enable the hospital to run smoothly, and nurses should not be too friendly with patients. Visitors are felt to be quite disruptive to the hospital routine. Nurses prefer a quick turnover of patients and they feel that more planning should go into the discharge of patients from hospital.

### **Perceptions of Role and Responsibility**

12. Almost two-thirds of all nurses feel that there is no great difference between the work of ward sisters and staff nurses. There does not appear to be a real consensus about the kind of work which ward sisters should do. Just over half of

all nurses feel that ward sisters should have more managerial responsibility, yet almost three-quarters feel that some ward sisters are too concerned with administration. It may be that the kind of administration presently engaged in by ward sisters involves the supervision of low-level administrative details and that what is wanted is that ward sisters should take on a more managerial role. At all events, three out of four nurses feel that there is a need for another grade to deputise for ward sisters.

13. Staff nurses are not felt to have more responsibility on surgical wards than on medical wards. In addition, it is felt that co-ordination problems frequently arise between theatre and ward staff.

14. The role and responsibility of staff nurses and ward sisters is affected by the type of hospital in which they are working. The majority of nurses feel that the job of ward sister is more difficult in a \*teaching hospital. She has a higher proportion of partially trained staff and has to make arrangements for their release to attend classes as well as to supervise them more closely. Her reliance on the services of students may explain some of the difficulties between ward sisters and teaching staff. Another problem for the ward sister is the co-ordination with theatre personnel, something which may interfere with ward routine.

15. The task of the staff nurse is, in general, dictated by patient requirements, and that of the ward sister by both patient requirements and administrative details. The task of more senior nursing staff is less clearly defined, at least in the case of assistant matrons.

16. Assistant matrons, themselves, see their role as both supervisors and as advisers in relation to nursing staff. They feel they should have a responsibility for staff development and training as well as for staff allocation. Most nurses agree, however, that the role of the assistant matron is difficult to define.

17. The task of an assistant matron depends very much on the extent to which matrons involve themselves in the day-to-day affairs of the hospital. Where the matron is highly involved in overall policy making she has little time or inclination to involve herself in everyday administrative details and these can be handled by assistant matrons. It is worthy of note that the majority of matrons would like to become more involved in budgeting and financial planning.

18. Nurses, themselves, tend to feel that matrons are limited in their power and that they should spend more time with patients.

### **Perceptions of Working Relationships**

19. In general, the relationship between different staff groups in hospitals appears to be quite satisfactory, as they are perceived by nurses. There is a general tendency for the relationships to be perceived differently by different staff groupings. For example, senior staff do not see any problems in the relationship

\*In the Survey, a teaching hospital is a hospital recognised by An Bord Altranais as a centre for nurse training.

between ward sisters and staff nurses, whereas staff nurses do feel there is some tension there. Similarly, staff nurses are less likely to feel that the matron is available to discuss problems than are more senior grades. The perceived availability of the matron and the fear engendered by her also varies between hospitals. As might be expected, the matron tends to be seen as more remote in larger hospitals.

20. The large majority of nurses feel that harmonious relationships exist between doctors and nurses, and between nurses and lay administrators. In particular, it is felt that the relationships between matrons and both doctors and administrators are satisfactory.

#### **Attitudes to Promotion and Career-Related Issues**

21. Most nurses are dissatisfied with the promotion opportunities available in nursing. It is felt that there could be more posts at ward sister level. However, there is a fairly general belief that many nurses are not interested in promotion because there is insufficient extra remuneration for the added responsibility. However, staff nurses are less likely than other grades to believe this. Most nurses feel that length of service within a hospital should be taken account of in deciding promotions. Teaching staff are particularly dissatisfied with their career prospects.

#### **Rostering Arrangements and Hours of Duty**

22. There seems to be a certain amount of dissatisfaction amongst nurses with respect to their hours of duty, in particular the split shift system (41% dissatisfied) and night duty (42% dissatisfied). In addition, most nurses, but especially staff nurses, feel that they receive inadequate notice of their hours of duty.

23. There is a strong feeling that there should be more part-time nursing jobs available and that these would suit many married nurses. It is also felt that it would be useful to have standby nursing staff available to cater for absenteeism.

24. Whilst staff nurses are felt to like working in different departments, nevertheless it is also felt that they should spend at least three months in a department before being transferred. It is also felt that only some nurses are suited to working in the theatre. Some hospital duties, not surprisingly, are thought to be unsuitable for married nurses during pregnancy.

#### **Perceptions of Physical Layout of Hospitals, Support Facilities and Support Staff**

25. Two-thirds of nurses are satisfied with the conditions of hospitals in general. However, less than half the nurses surveyed are satisfied with either the physical layout of wards or the lift facilities or the proximity of the wards to theatres, x-ray departments, etc.

26. The majority of nurses are satisfied with support facilities such as cleaning services, medical equipment, meals for nurses and patients and the general appearance of wards. Only a quarter of nurses, however, are satisfied with the recreation and leisure facilities available for nurses.



27 Most nurses feel that their position and their working conditions have improved over the years and have been helped by the introduction of the health board system. It is felt that an Admissions Office would be beneficial to the organisation of hospitals and that a written manual of practical nursing procedures would help nurses. Similarly, nurses feel that each ward should have a ward information-policy book.

28. Most nurses are in favour of nurses living outside the hospital.

29. Attendants are felt to take a lot of the work-load off nurses but there seem to be some limits to their availability in some types of hospitals. The relationship between nursing staff and domestic staff is felt to be satisfactory by over half the nurses.

30. A majority of nurses feel that ward sisters need more clerical help. Nurse administrators and matrons, themselves, tend to feel that they also need more clerical support staff.

#### **The Qualities of a Good Nurse**

31. Nurses' perceptions of the qualities necessary for a good nurse were ascertained since they are an indication of the training needs of different grades,

32. The most important quality of a good staff nurse is felt to be that she should have good practical nursing skills. Secondly, it is felt that it is important that she should be calm in emergencies.

33. The most important quality of a good ward sister is felt to be that she should be an efficient organiser of work. Good public health nurses, on the other hand, it is felt, should be able to talk to patients indicating that good relations with the patient is seen as more necessary in the public health field than in hospitals.

34. There is some evidence to show that nurses perceive some conflict between nursing theory and practice on the wards.

#### **Organisation of Basic Training**

35. Nurses are reasonably satisfied with regard to their own basic training. The majority, however, would like some improvements in the time allowed for training on each ward, for study and for the supervision of practical work. They would also like a better balance between learning and working. The large majority consider that basic training courses should be hospital based and less than a quarter of nurses feel that every nurse should have to follow a university degree course. However, only one in three nurses feel that nobody should follow such a course. There is, therefore, the possibility of devising a flexible system of training which would offer the opportunity to some nurses to pursue a university course.

36. There is some feeling among nurses that there is a conflict between the teaching function and the practical activities of the ward, Teaching staff in particular feel this to be the case. Teaching staff and staff nurses tend to feel

particularly strongly that the hospital environment can be daunting for students. Interestingly enough, the staff of teaching hospitals are less likely to feel this than are their colleagues in non-teaching hospitals. In any case, the vast majority of nurses consider that the working atmosphere in a teaching hospital is better, and that students help to maintain a high standard.

### **The Adequacy of Basic Training**

37. Nurses' assessments of the adequacy of the coverage of different subjects during basic training tend to vary between subjects. Although they are very satisfied with the coverage of most subjects, they are relatively less satisfied with the coverage of psychology, microbiology, management and communication skills. The majority of nurses seem to be reasonably satisfied with the quality of teaching provided by teaching staff, ward staff and doctors. However, they do want some improvements in the organisation of basic training, particularly the teaching on the wards.

### **Post-Registration Training**

38. Although the majority of nurses feel that their basic training course prepared them adequately for work as a nurse, almost half consider that they now have duties for which they have been inadequately trained. It is not surprising, therefore, that refresher courses and continuing study after basic training are considered essential by almost all nurses. Three out of four nurses think that a refresher course is needed at least every two years. The attraction of such courses may be related to the link perceived by nurses between further study and enhanced promotion prospects. A further factor would seem to be the fact that those who have completed post-registration courses are very satisfied with their opportunities to use the knowledge and skills learned.

### **Public Health Nursing**

39. The nature of the relationship with patients is different in the community to that in hospitals as indicated by the findings mentioned above, namely, that the quality considered most important for a public health nurse is the ability to talk to patients. In addition, public health nurses tend to have a different kind of relationship to the professionals with whom they work. Thus most public health nurses feel that they have to make their own decisions. They do not feel that their superintendent interferes in their work. However, they are not so satisfied with their relationships with doctors, whom they feel underestimate the work they can do. Nevertheless, they tend to feel that the Community Care Teams operate satisfactorily.

40. Most public health nurses consider that clinics are under-used by the public. Co-ordination with hospitals is also felt to be a problem.

41. In relation to their career prospects, most public health nurses are dissatisfied with the promotion opportunities open to them. They feel that there is need for a post of senior public health nurse to assist superintendents. Less than half of them are in favour of the introduction of lower qualified staff into community nursing, however.

42. Like hospital nurses, public health nurses are in favour of part-time nursing posts.

43. Public health nurses tend to be quite dissatisfied with the support facilities available to them, in particular their meal arrangements, their office facilities and the lack of support staff (both clerical staff and home help services).

44. Public health nurses are more likely than other nurses to have trained abroad; they are also more likely to favour a university degree in basic nursing. Subjects which they feel could be covered more in basic training were psychology, microbiology, communications and management skills. They feel that midwifery should continue to be included in their training and that their training could also include some coverage of work organisation.

## **APPENDIX III**

### **NATIONAL SURVEY OF APPLICANTS FOR NURSE TRAINING**

#### **Terms of Reference**

To design and carry out a project involving the monitoring and evaluating of all nurse training applications over a period of 12 months with a primary objective of assisting in the making of final recommendations regarding the desirability and feasibility of the central processing of applications for nurse training, and if considered appropriate, the organisational form such a process should take.

#### **Procedure**

A questionnaire was designed and supplied to each nurse training school for issue to each person who sought admission for general nurse training during the period of one year from 1st June, 1977 to 31st May, 1978.

Each applicant to each training school was requested to complete the questionnaire and return it to a central office in the Department of Health. It was emphasised to applicants that they were required to complete the questionnaire for each training school to which they applied regardless of how many separate applications were made. The purpose of this was to quantify the incidence of applications by individuals to more than one training school.

Each training school was requested to keep a record of the name and address of each person to whom a questionnaire was issued and to list these with separate identifying numbers and forward them on a monthly basis to the central office at the Department of Health. The completed questionnaires were checked off these lists as they were returned to the central office. A total of 54,176 questionnaires were issued by all training schools and of these a total of 32,407 (60%) were returned to the central office.

The data on the completed questionnaires was transferred to punch cards by kind co-operation of the Mater Hospital E.D.P. Department, and then processed by computer at the Department of Industrial Engineering, University College, Galway.

Table 1 shows the number of questionnaires issued by each training school and the number and percentage of questionnaires returned in respect of each school. The total number of applicants per training school on which the various analyses given later in this report are based, represents the number of completed questionnaires returned in respect of each school and not the actual number issued.

It should be borne in mind that during the period of this survey, not all training hospitals advertised for applications for nurse training.

TABLE 1

General Nurse Training School Code	Number of Questionnaires		% Returned
	Issued	Returned	
01	984	619	62.90%
02	2,545	1,567	61.57%
03	2,679	1,568	58.52%
04	2,251	1,248	55.44%
05	1,282	719	56.08%
06	3,386	2,176	64.26%
07	1,964	920	46.84%
08	1,558	943	60.53%
09	3,930	1,874	47.68%
10	264	144	54.55%
11	1,762	896	50.85%
12	3,860	1,646	42.64%
13	571	317	55.52%
14	1,265	785	62.06%
15	1,416	980	69.21%
16	3,611	2,442	67.63%
17	1,558	1,168	74.98%
18	1,118	635	56.80%
19	3,652	2,164	59.26%
20	1,235	986	79.84%
21	726	475	65.43%
22	1,221	783	64.13%
23	2,069	1,213	58.63%
24	2,826	2,371	83.90%
25	2,380	1,098	46.13%
26	2,236	1,365	61.05%
27	462	306	66.23%
28	669	464	69.36%
29	696	535	76.87%
	54,176	32,407	59.82%

Table 2 shows the number of completed questionnaires in respect of each school as a percentage of the total for all schools and also the number of training places available in each school.

TABLE 2

Training School Code	No. of Applicants	% Total Applicants	No. of Training Places	Ratio of No. of applications to No. of Training Places
01	619	1.91	33	18.76
02	1,567	4.82	70	22.39
03	1,568	4.83	116	13.52
04	1,248	3.84	50	24.96
05	719	2.21	20	35.95
06	2,176	6.70	91	23.91
07	920	2.83	49	18.78
08	943	2.90	24	39.29
09	1,874	5.77	31	60.45
10	144	0.44	25	5.76
11	896	2.76	20	44.80
12	1,646	5.07	103	15.98
13	317	0.98	16	19.81
14	785	2.42	28	28.04
15	980	3.02	33	29.70
16	2,442	7.52	58	42.10
17	1,168	3.60	19	61.47
18	635	1.95	24	26.46
19	2,164	6.66	83	26.07
20	986	3.04	42	23.48
21	475	1.46	16	29.69
22	783	2.41	15	52.20
23	1,213	3.73	50	24.26
24	2,371	7.30	24	98.79
25	1,098	3.38	53	20.72
26	1,365	4.20	13	105.00
27	306	0.94	7	43.71
28	464	1.43	13	35.69
29	535	1.65	8	66.88
Totals	32,407		1,134	28.58

The number of applicants represents the number of completed questionnaires returned to the central office in respect of each school. Detailed comment on the figures in Table 2 is not proposed but the ratio of applications to training places in respect of each school is worthy of comment. The overall national ratio was 28.58:1. The range was 5.76:1 to 105:1. Of the 29 training schools, the ratio was above the national average of 28.58 for 14 schools and below it for the remaining 15 schools.

The number of training places in each school differs and if a school with 25 training places is taken as a norm, the ratio of applicants to training places in the larger and smaller schools respectively can be analysed as follows:—

**TABLE 3**

	No. of Schools	Below average Ratio.	Above average Ratio.
Larger Schools (> 25 places)	16	13	3
Smaller Schools (< 25 places)	13	2	11

The total number of questionnaires returned by applicants to all schools was 32,407. The actual number of individual applicants responsible for this number of questionnaires was 11,943. Thus the overall multiple application ratio was 2.71:1.

The computer analysis produced the following additional information regarding multiple applications amongst the 11,943 individual applicants:

**TABLE 4**

No. of applicants to 1 school only	—	6181	51.79%
No. of applicants to 2 schools only	—	2050	17.16%
No. of applicants to 3 schools only	—	1119	9.37%
No. of applicants to 4 schools only	—	698	5.84%
No. of applicants to 5 schools only	—	486	4.07%
No. of applicants to 6 schools only	—	343	2.87%
No. of applicants to 7 schools only	—	244	2.04%
No. of applicants to 8 schools only	—	207	1.73%
No. of applicants to 9 schools only	—	144	1.21%
No. of applicants to 10 schools only	—	105	0.88%
No. of applicants to between 11 and 15 schools	—	247	2.07%
No. of applicants to between 16 and 20 schools	—	80	0.67%
No. of applicants to between 21 and 25 schools	—	29	0.24%
No. of applicants with more than 26 applications	—	10	0.08%

88.23% of individual applicants applied to 5 schools or less.

96.96% of individual applicants applied to 10 schools or less.

Further analysis was done to determine the basic characteristics of the core group of 11,943 individual applicants, i.e. their ages, sex, marital status, examinations taken and previous nursing qualifications if any.

**TABLE 5**

Age Distribution of Core Group.

Under 16	507	4.25%
16	1760	14.74%
17	2915	24.41%
18	2613	21.88%
19	2422	20.28%
20	959	8.03%
21	350	2.93%
22-24	306	2.56%
25+	111	0.93%

18.99% of individual applicants were 16 years of age or under. 66.57% were in the 17/18/19 years age group. 14.5% were 20 years of age and over.

The majority of the applicants who were 16 years and under might not be regarded as old enough to be seriously considered for entry to training and are therefore by reason of their premature application causing an avoidable amount of activity in the system as far as immediate selection is concerned. Persons in this age group could be issued with a career guidance booklet on nursing.

The fact that 14.5% of the applicants were 20 years and over requires further investigation if the underlying causes are to be determined.

**TABLE 6**

Sex	Marital Status	No. in Category	%
Female	Single	11,803	98.83
Male	Single	127	1.06
Female	Married	10	0.08
Male	Married	0	0.00
Female	Widowed	2	0.02
Male	Widowed	1	0.01

98.83% of all applicants were female and single.

**TABLE 7**

Examination	Number	%
Leaving	5,944	49.77
Inter	5,841	48.91
Group	40	0.33
Other	108	0.90
None	10	0.08

49.24% of applicants had reached Intermediate or Group Certificate stage at the date of application. A number of these could have been students either in Leaving Certificate class or in their penultimate year at school. The number of applicants with no educational qualifications was insignificant.

**TABLE 8**

Nursing Qualifications	Male No.	% of all applicants	Female No.	% of all applicants
RPN	7	0.06	55	0.46
RSCN	0	0.00	9	0.08
RMHN	2	0.02	13	0.11
RM	0	0.00	1	0.01
SEN	1	0.01	19	0.16
Other	0	0.00	31	0.26
None	118	0.99	11,687	97.86

About 8% of males who applied had previous nursing qualifications, whereas in the case of female applicants only about 1% had previous nursing qualifications.

An analysis was also produced showing the address by city or county of the core group of applicants. Nationality was also determined (Table 11).



TABLE 9

Address		Number	%
Dublin	City	989	8.28
Cork	"	318	2.67
Limerick	"	90	0.75
Galway	"	54	0.45
Waterford	"	29	0.24
Belfast	"	4	0.03
Derry	"	0	0.00
Antrim	County	0	0.00
Armagh	"	2	0.02
Carlow	"	193	1.62
Cavan	"	207	1.73
Clare	"	446	3.74
Cork	"	1,565	13.10
Derry	"	2	0.02
Donegal	"	285	2.39
Down	"	10	0.08
Dublin	"	431	3.61
Fermanagh	"	2	0.02
Galway	"	767	6.43
Kerry	"	744	6.23
Kildare	"	240	2.01
Kilkenny	"	283	2.37
Laois	"	198	1.66
Leitrim	"	121	1.02
Limerick	"	669	5.60
Longford	"	189	1.58
Louth	"	210	1.76
Offaly	"	213	1.78
Mayo	"	615	5.15
Meath	"	242	2.03
Monaghan	"	197	1.65
Roscommon	"	377	3.16
Sligo	"	259	2.17
Tipperary	(North & South)	777	6.51
Tyrone	County	4	0.03
Waterford	"	342	2.87
Westmeath	"	289	2.42
Wexford	"	429	3.60
Wicklow	"	152	1.28

This analysis was further refined, Table 8, to show the number of applicants by health board area of residence compared to:—

- (a) the number of training places available in the health board area;
- (b) the number of females in the population of the health board area in the 17/18/19 age groups (based on the number of 10/11/12-year-olds in the 1971 census).

Ratios were produced for each health board area as between the number of applicants resident in the area and (a) and (b) above, respectively.

In arriving at the ratio involving (b), no account was taken of emigration or internal migration or of other factors which would affect the 1971 census values; also this ratio only includes 17/18/19-year-olds, the age groups which accounted for 66.57% of the total applicants in the survey.

TABLE 10

Health Board Area	No of applicants	No. of Training Places	No. of females aged 17/18/19 yrs. in area	No. of applicants per place	No. of applicants per 1,000 female pop. in 17/18/19 age groups
Eastern	1,820	655	29,837	2.78	60.99
Southern	2,642	170	13,377	15.54	197.50
Western	1,821	125	9,345	14.57	194.86
Mid-Western	1,598	81	8,068	19.73	198.07
North-Eastern	847	53	7,347	15.98	115.29
South-Eastern	1,667	37	10,232	41.05	162.92
North-Western	665	13	5,242	51.15	126.86
Midland	883	—	5,579	—	158.27

The purpose of this analysis is to produce a rough index of interest in nursing amongst girls resident in the different health board areas, with particular reference to the 17, 18 and 19 age groups. (Table 10).

TABLE 11

Nationality	Number	%
English	6	0.05
Scottish	2	0.02
Welsh	0	0.00
Other British	5	0.04
Other E.E.C. Countries	0	0.00
African	2	0.02
Malaysian	2	0.02
American	1	0.01
Canadian	1	0.01
Other	6	0.05
Irish	11,918	99.79

The data was analysed also to show the level of activity each month during the survey, i.e. the number of applicants to nursing who completed questionnaires each month. This is shown in Table 12 and is based on the date on which each questionnaire was completed.

TABLE 12

Month	Number	%
May	2,036	6.28
June	1,214	3.75
July	2,890	8.92
August	3,843	11.86
September	3,524	10.87
October	5,153	15.90
November	2,647	8.17
December	1,145	3.53
January	2,299	7.09
February	2,725	8.41
March	2,927	9.03
April	2,004	6.18

## **APPENDIX IV**

### **SURVEY OF THE ACTIVITIES OF STAFF NURSES**

#### **TASK LIST**

##### **DAILY LIVING ACTIVITIES**

Assisting with or dressing patients.  
Washing patients in bed, bathroom.  
Bed-making; occupied, unoccupied.  
Care of the mouth, teeth, dentures.  
Care of the head, hair.  
Care of the feet, hands.  
Giving and removing bedpans etc.  
Feeding helpless patients.  
Preparation of special diets.  
Preparation and distribution of drinks.  
Serving meals.  
Artificial feeding.  
Care of pressure areas.  
Shaving patients.  
Lifting and moving patients.

##### **TECHNICAL NURSING ACTIVITIES**

Administration of drugs — orally,  
— by IV injection,  
— by other methods.  
Barrier nursing/Isolation.  
Bandaging.  
Observing/recording — fluid balance,  
— blood pressure,  
— weight,  
— height,  
— apex beat,  
— venous pressure,  
— IV lines.  
Changing outer tracheostomy tube.  
Ear treatment.  
Eye treatment.  
ESR (estimating).

ECG (estimating).  
Enemata.  
Flatus tube.  
Fomentations.  
Inhalation therapy.  
Irrigation of bladder.  
Lavage—gastric, colonic.  
Nasal treatments.  
Postural drainage—Ryles tube, passing of.  
Pessaries.  
Urine testing.  
Suction (respiratory tract).  
Surgical dressings.  
Removal of sutures, drains.  
Removal of intercostal drains.  
Supervising/setting up mechanical respirators.  
Treatment of verminous heads.  
Treatment by medicated baths.  
Pre-operative skin preparation.  
Pre-operative preparation of patient.  
Post-operative care of patient.  
Vaginal douching.  
Vulval swabbing.  
Cardiac resuscitation, initial.  
Cardiac monitoring.

#### **NURSE/PATIENT COMMUNICATION ACTIVITIES**

Transfer/discharge of patients.  
Arranging appointments with OPD.  
Giving information on hospital personnel.  
Support of and assistance to the dying.  
Talking with relatives.  
Writing/reading personal letters for patients.  
Dealing with persons' effects.

#### **CLERICAL ACTIVITIES**

Arranging for medical certificates.  
Answering 'phone enquiries.  
Delivering lab. specimens, X-Ray cards, CSSD requests.  
Ordering stores.  
Checking pharmacy.  
Checking stores (non-pharmacy).  
Nurses report-writing.  
Reception and admission of patients.  
Filing records, obtaining charts.  
Arranging files at weekends.

### **DELEGATED ACTIVITIES**

Adding drugs to IV infusions.  
Application of plaster of paris.  
Application of splints.  
Assisting medical staff on ward rounds.  
Haemodialysis (setting up).  
Suturing minor lacerations.  
Assisting with Barium Meals.  
Counselling, teaching students.

### **DOMESTIC ACTIVITIES**

Cleaning equipment used for nursing procedures.  
Cleaning other equipment.  
Disposal/replacement of sputum bowls etc.  
Linen-checking, counting.  
Moving ward furniture.  
Sluicing foul linen.  
Washing patients' clothes.  
Supervising domestic work.

### **OTHER ACTIVITIES**

Attending body brought in dead.  
Disinfection — excreta,  
                  — surgical equipment,  
                  — linen.  
Escorting patients to departments.  
Sterilisation of surgical equipment (on wards).  
Specimen collection.  
Preparation of patient, equipment—for technical procedures performed  
by doctor.

## APPENDIX V

## EXAMPLE A

## Conceptual Example of a Modular Type Training Programme

Weeks No.	1 — 4	5 — 11	12	13	14 — 23	24	25	26 — 35	36	37	38 — 47	48	49/52
	Intro. Course	Practical Experience			a Adult Medicine b Adult Medicine c Adult Surgery d Adult Surgery			a Adult Surgery b Adult Surgery c Adult Medicine d Adult Medicine			a Paediatrics b Geriatrics c Psychiatry d Mental Handicap		Holidays
					10 hours formal Clinical Tuition			10 hours formal Clinical Tuition			10 hours formal Clinical Tuition		

Weeks Nos.	1	2 — 11	12	13	14 — 23	24	25	26 — 35	36	37	38 — 47	48	49/52
Year 2		Psychiatry Mental Handicap Paediatrics Geriatrics			Mental Handicap Paediatrics Geriatrics Psychiatry			Geriatrics Psychiatry Mental Handicap Paediatrics			Obstetrics/ Community  Community/ Obstetrics		Holidays
					10 hours formal Clinical Tuition			10 hours formal Clinical Tuition			10 hours formal Clinical Tuition		

Year 3 Specific Modules would be prepared in 3rd year for:

General Nurse Training  
Paediatric Nurse Training  
Psychiatric Nurse Training  
Mental Handicap Nurse Training.

Note:

144 weeks Theory and Practice — 117 weeks Practice  
27 weeks Theory (excluding ward teaching)  
144 TOTAL

Modules in Third Year as in Second and First Year — student getting intensive training in selected discipline.

Holidays need not necessarily occur at end of year, they may occur as convenient to the training programme — the only constant being that "modules" must not be interrupted.

#### Examples A and B

Key: (a), (b), (c), (d) are groups of students.

: Weeks 12, 13, 24, 25, 36, 37, 48 (Years 1 and 2) and 1 (Year 2) are study weeks.

**EXAMPLE B**  
**Conceptual Example of a Modular Type Training Programme**

Weeks No.	1 — 4	5 — 11	12	13	14 — 23	24	25	26 — 35	36	37	38 — 47	48	49/52
	Intro. Course	Practical Experience in Surgery/ Medicine			a Adult Medicine b Adult Surgery c Geriatrics			a Adult Surgery b Geriatrics c Adult Medicine			a Geriatrics b Adult Medicine c Adult Surgery		Holidays

10 hours  
formal  
Clinical  
Tuition

10 hours  
formal  
Clinical  
Tuition

10 hours  
formal  
Clinical  
Tuition

*Year 1*



Weeks Nos.	1	2 — 11	12	13	14 — 23	24	25	26 — 35	36	37	38 — 47	48	49/52
Year 2		a Psychiatry b Paediatrics c Mental Handicap d Obstetrics/ Community			a Obstetrics/ Community b Psychiatry c Paediatrics d Mental Handicap			a Mental Handicap b Obstetrics c Psychiatry d Paediatrics			a Paediatrics b Mental Handicap c Obstetrics/ Community d Psychiatry		Holidays

Year 3 Specific Modules would be prepared in 3rd year for:

- General Nurse Training
- Paediatric Nurse Training
- Psychiatric Nurse Training
- Mental Handicap Nurse Training

Note:

144 weeks Theory and Practice — 117	weeks Practice
	27 weeks Theory (excluding ward teaching)
<hr/> 144 TOTAL	

Modules in Third Year as in Second and First Year — student getting intensive training in selected discipline.

Holidays need not necessarily occur at end of year, they may occur as convenient to the training programme — the only constant being that “modules” must not be interrupted.