

Nursing and Midwifery Planning and Development Unit, Mid-Western Region

Supporting your needs

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**AN EXPLORATIVE STUDY INTO THE
EXPANSION OF NURSING AND
MIDWIFERY PROFESSIONAL ROLES
IN RESPONSE TO THE
EUROPEAN WORKING TIME DIRECTIVE**



**MID-WESTERN
HEALTH BOARD**

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June 2003**

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Abbreviations

A&E	-	Accident and Emergency
ADON	-	Assistant Director of Nursing
AMP	-	Advanced Midwifery Practitioner
ANP	-	Advanced Nurse Practitioner
CCU	-	Coronary Care Unit
CMM	-	Clinical Midwife Manager
CNM	-	Clinical Nurse Manager
CSSD	-	Central Sterile Supplies Department
CTG	-	Cardio Tocograph
CVP	-	Central Venous Pressure
DON	-	Director of Nursing
ECG	-	Electro Cardiograph
EGH	-	Ennis General Hospital
EWTD	-	European Working Time Directive
FETAC	-	Further Education and Training Awards Council
HCA	-	Health Care Assistant
ICU	-	Intensive Care Unit
I.T.	-	Information technology
I.V.	-	Intravenous
MH	-	Mental Health
MWHB	-	Mid Western Health Board Region
MWRH	-	Mid Western Regional Hospital
NCHD	-	Non Consultant Hospital Doctors
NGH	-	Nenagh General Hospital
RMH	-	Regional Maternity Hospital
ROH	-	Regional Orthopaedic Hospital
WTE	-	Whole time equivalent

Foreword

The main function of the Nursing and Midwifery Planning and Development Unit is to plan and develop nursing and midwifery for future health service needs. To do this without involving nurses and midwives of all grades would be impossible, because they are the largest single body employed by the health service. There are a number of driving forces contributing to major changes in nursing and midwifery. The contribution nursing and midwifery will make to the provision and delivery of services will be paramount to an effective health service. The European Working Time Directive is the driving force for this report and will have implications for all nursing and midwifery.

A steering committee was convened by the Chief Nursing Officer of the Nursing Policy Division in the Department of Health and Children in October 2002. The terms of reference for this committee were:

- To examine opportunities for nurses and midwives in the pilot sites.
- Identify the supports required to develop new services i.e. education, skill mix.
- Examine resource implications so that nursing and midwifery can develop to its maximum, in tandem with service need.
- Assess impact on quality of patient care.

In response to this the Nursing and Midwifery Planning and Development Unit committed to communicating widely with all grades of nurses and midwives in the Mid-Western Region. A Project Officer was appointed to the unit in January 2003 with responsibility to co-ordinate the focus groups and compile and deliver a report.

This report outlines how wide the consultation process was with all grades of nurses and midwives participating in focus groups. Possible developments for nursing and midwifery were outlined from the feedback of the focus groups; which were continuously channelled into the steering committee and Project Manager in the Department of Health and Children.

The information in this report contributed in a major way to the nursing section of the Hanly Report and the Nursing Policy Division Discussion Paper – ‘The Challenge for Nursing and Midwifery’.

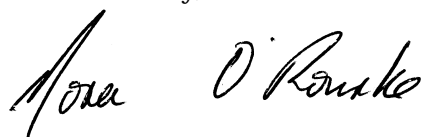
This report has proved to be an extremely valuable piece of work in identifying the range of opportunities and challenges that face nursing and midwifery in the future. Partnership between all stakeholders is the key requisite to ensure that nursing and midwifery can flourish and respond appropriately to the range of issues facing the Irish Health Sector.

Nurses and Midwives can be proud of their contribution to this report. I am confident it will be used not just regionally but nationally to progress nursing and midwifery's contribution to health gain over the next number of years.

I would like to thank everybody involved in assisting with this report in particular the nurses and midwives who contributed openly in the focus groups. I would also like to thank the facilitators and scribes and all those people who provided the venues. Thank you also to the Directors of Nursing who released and encouraged staff to attend meetings.

Finally I wish to acknowledge the work of Lorna Peelo-Kilroe in leading this project and compiling this report

Yours faithfully,

A handwritten signature in black ink that reads "Nora O'Rourke". The signature is written in a cursive style with a large initial 'N' and 'O'.

Nora O'Rourke
Director of the Nursing and Midwifery Planning and Development Unit
Mid-Western Health Board.

Executive Summary

This report presents the findings of a research study undertaken by the Nursing and Midwifery Planning and Development Unit of the Mid-Western Health Board. The purpose of the investigation was to explore the possible development opportunities for nursing and midwifery services in the Mid-Western Health Board Region in light of the forthcoming European Working Time Directive (EWTd). This directive will commence in August 2004 where NCHD hours will be reduced from an average of 72 hours per week to 58 hours per week.

The study was commissioned by the Nursing and Midwifery Planning and Development Unit in response to the request of the Chief Nursing Officer of the Nursing Policy Division in the Department of Health and Children.

Scope of the Study

This study was guided by three principal research questions:

1. What aspects of practice would nurses and midwives consider developing?
2. What type of post-registered education and training do nurses and midwives need to expand practice?
3. What support structures need to be put in place to facilitate role development?

Methodology

The study was conducted between February and May 2003 with nurses and midwives working in the acute sector of the Mid-Western Health Board Region. The method used involved focused group interviews with all grades of nursing and midwifery personnel. Thirty eight groups were held involving 226 participants.

Key Findings

Participants of all grades welcomed the opportunity to explore professional development possibilities in light of the EWTd. They identified many areas where role development would be beneficial in delivering a seamless service to users and facilitate the EWTd.

The findings indicate:

- 1 enhancement of nursing and midwifery practice should involve a multi-disciplinary/professional approach involving all stakeholders
- 2 role development with autonomy and decision making capacity included
- 3 include appropriate support structures
- 4 nurses do not accept responsibility for the implementation of the EWTd.

The following is a brief example of some key suggestions forwarded by participants regarding possible development initiatives. Please see report for complete list.

- Nurse led pre-assessment units
- Nurse discharge planning
- Minor Injuries Units
- Nurse led counselling e.g. family therapy, cognitive behavioural therapy etc.
- Total management by midwives of the normal pregnancy and labour
- Intravenous cannulation, venepunctures, male catheterisation as part of role development.
- Skill-mix should be a priority if professional development is to succeed.
- Competency based education and training for all role development along with the following:

Recommendations

Recommendation 1: There should be a Regional inter-disciplinary consensus approach to role development and workforce redesign involving all stakeholders.

Recommendation 2: Service Plans should reflect resource implications of EWTD at ward and unit level.

Recommendation 3: The NMPDU will take the lead role in the development of nursing and midwifery in the Region.

Recommendation 4: Role reconfiguration rather than task substitution.

Recommendation 5: Education programmes should be competency based.

Recommendation 6: Skill mix issues outlined in this report should be addressed prior to any new developments taking place.

Chapter 1

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Mid-Western Region Focus Group Report

1.0 Mid-Western Region Focus Group Report

This Report was commissioned by the Nursing and Midwifery Planning and Development Unit of the Mid-Western Health Board in response to the request of the Chief Nursing Officer of the Department of Health and Children. The purpose was to examine the opportunities for the Nursing/Midwifery Profession in light of the forthcoming introduction of the European Working Time Directive (EWTB). The Directive is non-negotiable and the first phase of implementation will commence in the Irish Republic in August 2004.

1.1 Introduction

A National Task Force on Medical Staffing - Nursing and Midwifery Steering Group was established in October 2002 and chaired by the Chief Nursing Officer. The terms of reference identified for this group were:

- To examine opportunities for nurses and midwives in the pilot sites.
- Identify the supports required to develop new services i.e. education, skill mix.
- Examine resource implications so that nursing and midwifery can develop to its maximum, in tandem with service need.
- Assess impact on quality of patient care.

The focus for any proposed changes contained within this report is based on the principle of augmenting care delivery to all consumers of health care.

Two pilot sites were selected – the Mid-Western Health Board Region (MWHBR) and the East Coast Area Health Board (ECAHB) of the Eastern Region Health Authority (ERHA). Acute hospitals and units in the MWHBR were identified where the impact of EWTB would have the greatest impact. They included:

- The Mid-Western Regional Hospitals (MWRH):
 - Regional General Hospital (RGH)
 - Regional Orthopaedic Hospital (ROH)
 - Regional Maternity Hospital (RMH)
- St John's Hospital, Limerick
- Ennis General Hospital (EGH)
- Nenagh General Hospital (NGH)
- Acute Mental Health Units (MH):
 - Ennis Acute Mental Health Unit
 - Clare Acute Community Mental Health Unit
 - Dept. of Psychiatry, Unit 5B, (MWRH)
 - Limerick Acute Community Mental Health Unit
 - North Tipperary Acute Community Mental Health Unit

The acute hospitals involved in the ECAHB were St Vincent's Hospital, St Michael's Hospital and Loughlinstown Hospital, The National Maternity Hospital and St John of God's Hospital.

Information from the pilot sites was disseminated to the National Steering Committee on an ongoing basis.

The National Medical Task Force – Nursing and Midwifery was concerned with investigating opinions, proposals and comments from all grades of nurses and midwives regarding opportunities for professional enhancement and development. The nurses and midwives working in the two pilot sites were invited to take part in focus groups in order to elicit their views and forward a summary to the National Task Force.

It was the opinion of the NMPDU that any changes implemented in acute sectors may have a knock-on effect in non-acute sectors. With a desire not to exclude nurses working in the non-acute sector, focus groups were held to gather opinions and suggestions from nurses working in non-acute elderly care hospitals, mental health hospitals and units and Public Health and community nurses. A report of the findings is included in the appendix section of the report.

1.2 Background

EU Member States agreed a timetable of staged implementation of the EWTD in 2000 so that the full progression does not have to be introduced until August 2009. Some EU countries have instigated part of the change process already. The first phase will take place here in August 2004 when NCHDs weekly working hours will be reduced to 58 hours from an average of 72 hours. The second phase will see those working hours further reduced to 56 hours and the final phase in place by August 2009 with a 48-hour working week (Figure.1).

Figure 1.

CHANGE DATE	DEADLINE
May 2000	Timetable set
August 2004	Provisional 58 hours per week
August 2007	Provisional 56 hours per week
August 2009	48 hour working week

1.3 Research Design

Because of the exploratory nature of the project in the MWR, qualitative research methodology using focused group interviews was employed as a method of data collection. It was agreed that the length of the meetings should be one and a half

hours as any shorter would not be productive and any longer would cause administrative difficulties. A representative sample of approximately 15% of nurses and midwives from all grades were interviewed. In total 38 focus group meetings were held in 11 acute hospital and unit sites involving general and psychiatric nurses and midwives. Figure 2 indicates the number of invitations issued to the three disciplines involved in the research and the number attended the focus group meetings.

Figure 2.

GROUP	INVITED	ATTENDED
Registered General Nurses:	242	176
Registered Psychiatric Nurses:	70	33
Registered Midwives:	25	17

Attendance at some meetings was poor and one meeting had to be cancelled because of non-attendance. However allowances for poor attendance had to be made due to the nature of nurses/midwives work where staff shortages frequently occur and where staff release and replacement arrangements were sometimes difficult. The following graph (figure 3) illustrates the attendance of various within nursing and midwifery in the target areas.

Letters of invitation to attend focus groups were sent to participants along with a brief outline of the purpose and length of the meetings. In cases when staff did not receive letters one of the following occurred:

- phone invitations were arranged
- face to face appointments were made
- problems arose with personal mailboxes
- incorrect address was supplied
- other

At the start of each focus group meeting where interviewees in attendance was > 6 a brief introduction was presented (see appendix 1) based broadly on the Scope of Practice for Nurses and Midwives (An Board Altranais 2000). For numbers < 6 a more informal introduction was conducted. At the end of the presentation five key questions were highlighted based on placing the patients' best interests first and on the 24 hour needs of the service. The groups were asked to consider the following with regard also to existing gaps in the service:

- What areas of your practice would you like to see expanded?
- Where are the gaps in service provision at present?
- What skills and knowledge are required to fill these gaps?
- Who are the appropriate people to do this?
- What educational and support structures needs will be required?

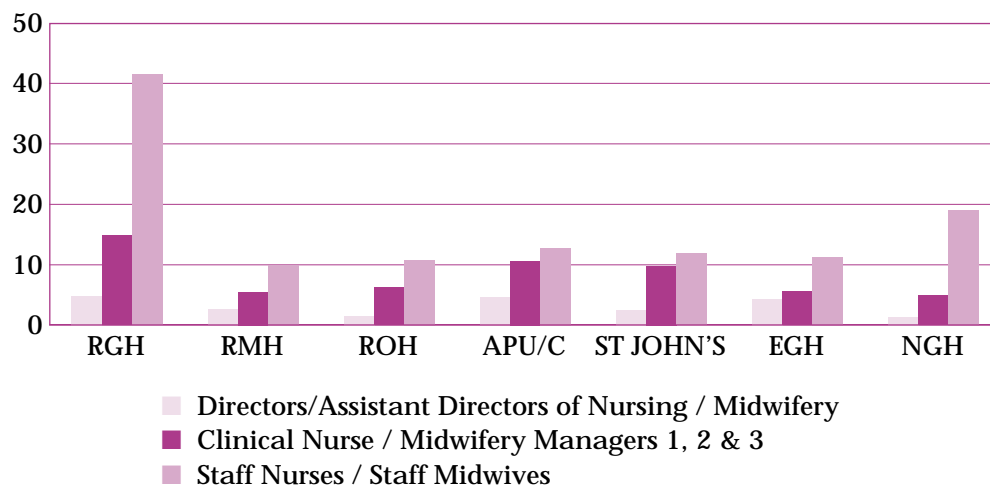
Ad hoc selection of nurses and midwives were chosen from the duty roster by the researcher or in some cases a facilitator involved in the research study. This method was chosen to reduce the risk of subjectivity or bias where chosen staff could reflect a certain ideology rather than an individual or group viewpoint. The groups were divided into various grades:

- Staff Nurses / Staff Midwives
- Clinical Nurse Managers/ Clinical Midwife Managers 1,2,3 (CNM/CMM 1,2,3) Clinical Nurse Specialists/Clinical Midwifery Specialists (CNS/CMS)
- Assistant Directors of Nursing and Midwifery (ADON/Ms)
- Directors of Nursing (DONs)

Psychiatric nurses requested joint meetings between staff nurses and ward/unit managers up to CNM2 grade as they felt that there were no real hierarchy differences at this level. This was facilitated once general agreement was given.

The purpose of dividing the groups into similar grades was to maximise the free expression of ideas and submissions at each meeting. It also allowed for each grade to explore the perceived impact that NCHD reduced working hours will have on their roles in particular as well as the profession in general. Figure 3 shows the grade compliment of attendees at the focus groups in the chosen locations.

Figure 3.



Facilitators were selected from MWRHs, EGH, NGH and MH; all were qualified nurses with facilitation skills.

In the interest of assuring reliability and validity information was summarised with the participants at the end of each session.

Chapter 2

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Data Analysis

2.0

Data Analysis

This report examines the broad issues raised by participants and then examines some issues in relation to each discipline where specific opinions or problems arise unique to their area of expertise. An important consideration to note is that the remit of the focus groups did not allow for detailed discussions relating to industrial relations. However matters such as remuneration and union representation were raised in almost every group and seen as an important factor in any major developments in the profession.

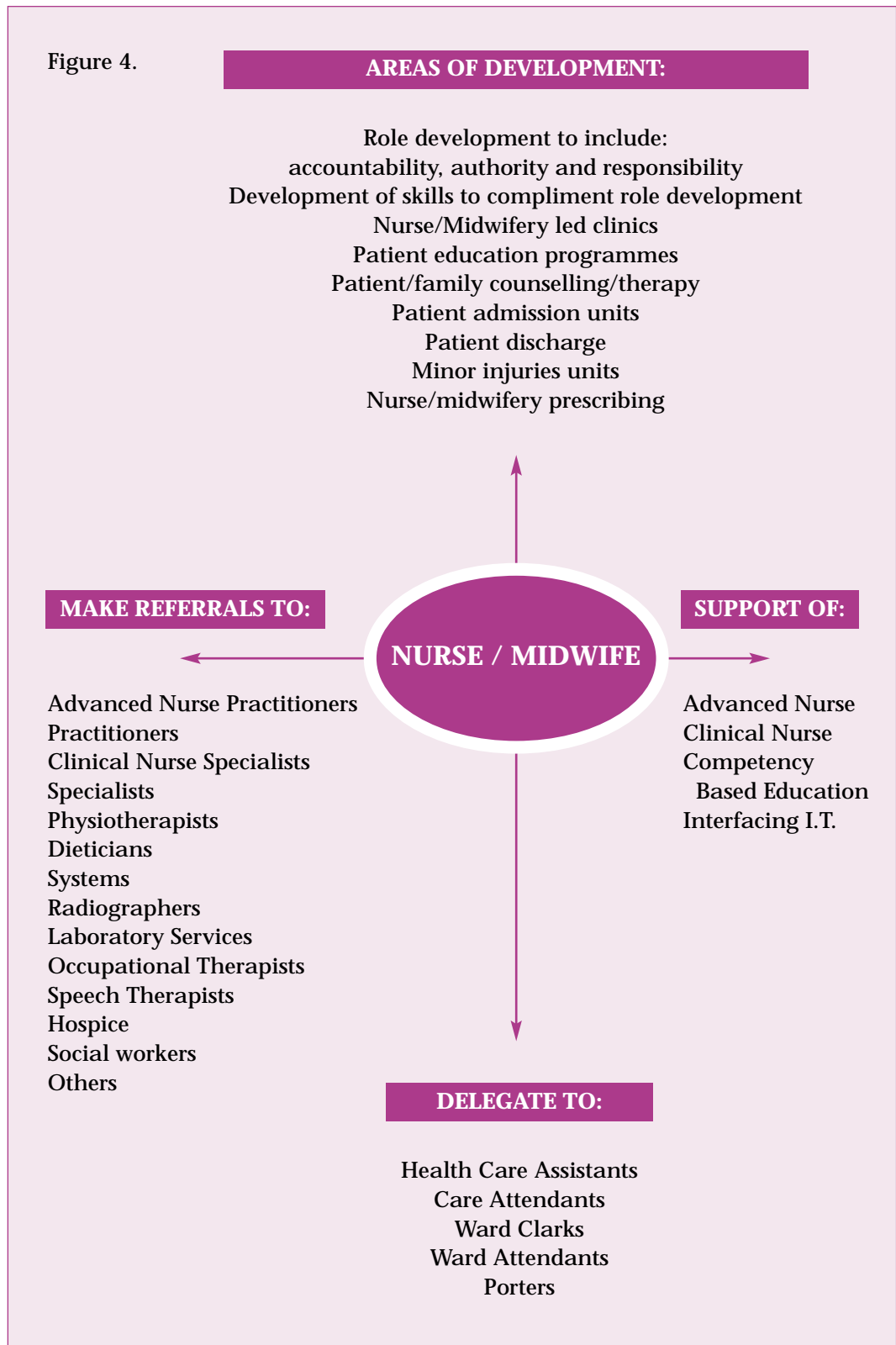
The issues raised across all disciplines fell broadly into three main categories (see figure 4): -

1. **Skill mix**
2. **Education**
3. **Support structures**

Almost without exception nurses and midwives stated that they are willing to consider enhancing their practice for the betterment of patient care and service delivery. They acknowledged also that enhancement of practice will necessitate greater accountability, authority and responsibility and are willing to embrace this as part of professional development.

Another notable finding in the report is the assertion by participants that unless the three areas outlined above were given serious consideration prior to the implementation of the EWTD they could not facilitate a change of this magnitude. Participants stated that as they already devote less time to patient care than they deemed was required under good practice, under present workloads volumes any role development initiatives instigated without adequate support structures would be in their view unworkable and even hazardous to patient care.

Figure 4.



2.1

Role Development

The following section of the report relates to enhancement of practice and will be divided into the three disciplines interviewed: general nursing, psychiatric nursing and midwifery.

2.1.1

General Nursing

Nurses/Midwives who attended the focus groups on average welcomed the opportunity to enhance and develop their professional practice in order to augment patient care. With the support structures identified in future chapters of this study; nurses stated that with any role development there must also be an increase in autonomy for all grades. There was general acceptance by nurses and midwives that increased autonomy will necessitate increase in responsibility, accountability and authority. Participants indicated that they were willing to embrace this extra level of accountability provided they are supported with appropriate guidelines.

Gaps in service provision were identified taking into account the 24-hour needs of the service and what opportunities there may be to improve patient care. It was underlined by most participants that they did not endorse nurses “*taking on what doctors want to drop*” but appreciated the need for professional development to enhance the quality of nursing care and contribute to a pioneering seamless service for patients and their families. However they do not envisage that the sole responsibility for improvement in service delivery should rest with the nursing profession but must encompass all stakeholders and service providers within the health service.

Nurses were reluctant to discuss lists of tasks in relation to practice development as they felt that they had more to offer patients. However this was unavoidable in this study albeit that it is a qualitative study. Nurses/midwives indicated that some aspects of NCHDs current roles could be transferred to other professionals or departments within the health service other than nursing.

Patient education and nurse led clinics were seen as a positive development both for the service users and professional progression. Many nurses were dissatisfied with the often-inadequate time spent on patient/carer education as they see this as a fundamental part of their role often sidelined to facilitate increasing and inappropriate volumes of administration or household chores. They were particularly concerned for newly diagnosed diabetics, asthmatic patients, patients with indwelling catheters, patients on new medication, following surgery or diagnosis to name but a few.

They also referred to inadequate time allowed for patient/carer support and counselling and nurses would like to spend more time on this.

They expressed concern that they will be required *to drop one thing and take on something else* rather than developing and building on the skills they already possess.

Nurse led clinics were viewed by most participants as greatly contributing to the quality of service delivery. A nurse-led Warfrin clinic and a nurse-led venous-section

clinic are already in operation in MWRH. Nurses have said that they would like to see more nurse-led clinics in:

- pain management
- tissue viability and wound management
- dermatology
- asthma
- diabetes
- heart failure
- continence promotion
- pre-assessment
- out-patients – following discharge from hospital

There are often delays with **cannulae insertions** causing stress for patients and setbacks in medication administration. Nurses complained that they have to repeatedly notify NCHDs of patients waiting for cannulation. A more efficient service could involve either cannulation teams and/or nurses undertaking this procedure. Less time would be spent on paging doctors and patients would receive their treatment more efficiently. The participants felt that all nurses should acquire this skill and that this would be particularly valuable at night time. However many nurses felt it appropriate to have cannulation teams employed with 24 hour cover and the need for appropriately trained paediatric cannulation teams was seen as vital for children's wards.

Cannulation was discussed in tandem with **venepuncture** but nurses do not want to replace the phlebotomy service in fact, as already stated in this report, want to see it extended to cover more departments. The issue of acquiring blood culture specimens was raised and many felt that **phlebotomists and nurses could undertake this procedure.**

A note of caution was raised regarding the potential for abuse when doctors are requesting non-urgent requests for tests but not taking the samples themselves. It is perceived that the number of requests could increase if protocols are not in place regarding the number of non-urgent venepuncture procedures that any one patient can have in 24 hours.

In addition to this nurses could be given the authority to **order routine bloods** thereby possibly reducing the duplication of requests made by various doctors within teams. Participants have highlighted the problems with doctors not checking blood reports and that frequently normal results are repeated unnecessarily because the results are not checked. If nurses were given the authority to request routine bloods reports and check the results then possibly a more rational and efficient service could be delivered. Agreed protocols and guidelines would be required to support this change and an audit carried out to evaluate the impact.

The protocols relating to **intravenous antibiotic administration** requires review according to most participants in order to give nurses the authority to administer

1st and 2nd doses thus eliminating time delays in treatment caused by waiting for doctors. Some hospitals already permit nurses to give 2nd doses of antibiotics.

Male catheterisation was seen as necessary to the delivery of holistic nursing care and all nursing staff should be competent to undertake this procedure. Many nurses already possess the necessary competency but have been prohibited from doing so due to local and national unwritten protocols.

Patient defibrillation was seen as a vital skill in an arrest situation bearing in mind the gap between arrest and defibrillation is 3-5 minutes for best survival outcomes. Valuable time can be lost waiting for a doctor to arrive to undertake this procedure when nurses are usually first at the scene. This training could be incorporated in the mandatory 'basic life support course' already in existence throughout the MWR. They further suggested that nurses could be trained to be team-leaders in an arrest situation and provide consistency in agreed procedures.

Nurse prescribing is currently under pilot in the Coronary Care Unit in MWRH and participants would like to see training extended to all wards and departments. They identified simple analgesia, some night sedation, antacid and bowel preparations such as laxatives and oral medication, and some i.v. therapy. Nurses working in CCU and ICU felt it appropriate to prescribe a broader range of medication pertinent to their department.

Phone orders were highlighted as a possible solution to the frequent delays in medication administration where doctors are otherwise detained from attending to prescriptions when required. Nurses felt that in certain circumstances it should be permissible for them to take orders over the phone from a doctor provided a safe system is put in place supported by protocols. Suggestions were made that perhaps a second nurse could act as a witness when the order is forwarded and that a phone request document could be developed requiring both nurses' signatures to reduce the possibility of human error.

ECG recording and basic ECG analysis was seen as relevant to nursing as valuable time can be lost waiting for a technician or doctor to take a reading during an episode of chest pain. In specialised units nurses already undertake ECG recordings in crises situations but were very clear that they do not want to replace ECG technicians or undertake routine ECG recordings.

Regarding interpretation of ECGs, nurses in generalist wards do not see it as appropriate for them to translate recordings. According to participants this is a specialised area and the level of skill required to interpret and make decisions based on the recording would be beyond the scope of a generalist nurse who would have infrequent exposure to patients with acute episodes of chest pain. None the less they would like some theory input along with practical skill training.

Insertion of naso-gastric tubes was highlighted as nurses in some areas undertake this procedure but others do not and this variance is due to local unspecified and

often unwritten local policies. Participants felt that this should be part of all nurses' remit unless contra-indicated according to hospital guidelines and policies. Also included was the insertion of small-bore naso-gastric tubes with nurses given the authority to request chest x-rays to verify tube position or/ as per protocol. Removing chest drains was also seen as part of holistic nursing care along with the administration of i.v. medication into central lines.

Wound management with ability to prescribe treatment was discussed and there is a great deal of dissatisfaction with the current situation that operates in many wards where nurses have no say in how a wound is managed. Nurses undertaking dressing procedures must be given the scope to assess and prescribe treatment. The need for further tissue viability education and training was highlighted as a necessary requirement to build on existing expertise.

Insertion of CVP and arterial lines, external pacing, patient intubation and modified pulmonary function tests were identified as possible role development involving Advanced Nurse Practitioners (ANPs). But what was most requested of ANPs and Clinical Nurse Specialists (CNSs) was education and leadership of clinical staff and in particular the generalist nurse working on medical and surgical wards.

Nurses in Theatre Departments discussed the possibility of developing:

- Anaesthetic Nurses for intubation and epidural top-ups
- CNS in Pain Management
- ANP to undertake selected surgical procedures
- All nurses skilled in plaster application in orthopaedic surgery.

On the subject of ANPs undertaking surgical procedures nurses were concerned that all this would entail would be '*suture wounds and apply dressings*' and they did not consider this a forward step for any theatre nurse.

A&E nurses would like to see the introduction of nurse-led minor injuries units involving ANPs as part of the nursing skill-mix. This was seen as a method of increasing efficiencies and reducing waiting times for patients. According to participants these units would necessitate a suitable triage system along with a nurse-led admissions unit. ANPs would require the authority to request and interpret various x-rays and other tests, prescribe treatment and admit or discharge patients in accordance with agreed protocols. Nurses felt that suturing and plaster application should be included in the A&E nurses role. Participants in ROH (MWRH) identified the need for a plaster nurse specialist with the knowledge to assess patients for plaster application and removal.

A co-ordinated discharge planning system was seen as a means of improving efficiency both for the patient and the system. Problems were highlighted regarding patients having to wait for hours sometimes before the necessary paperwork is complete to allow them to leave the hospital. Improvements could be made if nurses co-ordinated patients' discharges in advance and where delays are

unavoidable discharge lounges could facilitate the vacation of a bed or room without leaving patients sitting in the middle of wards or in corridors.

Night Managers

Night superintendents and managers discussed the perceived impact of the EWTD on the night service and identified areas where development in nursing roles could be made in the following areas:

- Include night managers in the senior nursing management decision making process
- Improve communication between night and day staff
- Improve and/or develop training systems for permanent night staff
- Nurse Practitioners to cover A&E and medical/surgical wards at night.
- Introduce CNM 3 grades at night in larger hospitals
- Extend CNS cover to include week-ends and nights where appropriate
- The idea of Site Managers was discussed
- The need for other professional services to extend their working hours to facilitate patient investigation procedures.
- The development of a multidisciplinary arrest team
- Authority given to A&E nursing staff to make referrals for social beds
- Extend the cover provided to the A&E Department by the Clinical Nurse Specialists in Psychiatry.
- Include plastering and suturing for A&E nurses along with proposed role enhancements for nurses already mentioned above.
- Extend nurse prescribing to all wards and appropriate departments on 24 hour basis
- Supply an interfacing I.T. system to facilitate data collection at night and reduce duplication of documentation
- Site preparation for major incidents to be reviewed in line with proposed changes
- Clarity is sought on issues regarding clinical indemnity and vicarious insurance

Night managers were clear that they would have to relinquish the non-nursing duties undertaken by them at present including switchboard manning, security and receptionist duties.

2.1.2

Midwives

Midwives are educated, trained and legally entitled to take care of a woman, baby and family around the time of birth as independent practitioners. They have the professional expertise to provide a seamless midwifery service for women of low risk without the intervention of doctors, from pre conception to the post postnatal. The philosophy embodied in midwifery care promotes the right for women to access information and make decisions about their own care and care of their babies (DOH. UK. 1994).

Midwifery led care has been acknowledged by the World Health Organisation (Care in Birth, 1999) as “*the most appropriate and cost effective type of health care provider to be assigned to the care of women in normal pregnancy and birth, including the risk assessment and recognition of complications*”.

Midwives who attended the focus groups are critical of the present situation where their autonomy is severely restricted. They claimed that increasing medical intervention in their view is unnecessary and expensive and is eroding their primary role in the care of women and their babies. The current situation in the RMH requires all women to be examined and discharged by a doctor, a role that midwives have been educated to do and competent of undertaking. Midwives stated that if they were authorized to work to role there would be a considerable reduction on inappropriate duties for NCHDs.

Participants submitted the following opinions regarding their role development and highlighted the fact that they are currently trained and educated to undertake many of the roles outlined but local policies and practices are preventing them from doing so in some cases. Therefore midwives do not necessarily accept focus group discussions as role development but role recognition with enhancement possibilities.

The Management of Normal Pregnancy

Participants felt frustrated and curtailed by the present system and it was suggested that if midwives were permitted to manage all normal pregnancies and deliveries in midwifery led antenatal clinics, a more efficient and user-friendly system would exist and this could reduce the impact of NCHDs reduced working hours. As NCHDs currently work in public antenatal clinics it is logical to assume that when their hours are reduced waiting times will be increased. An increase in midwifery led clinics is required to improve efficiency in clinic sizes and waiting times.

Midwives want authority and accountability to **diagnose and monitor normal pregnancies and undertake examinations as appropriate**. This necessitates midwives being given the prerogative to prescribe and advise on examinations necessary for earliest possible diagnosis of pregnancies at risk. Agreed policies and guidelines would need to be developed to support these developments. Pregnant teenage women could be accommodated in classes specially designed for their needs and circumstances.

To facilitate these services participants recommend an urgent review of WTE of midwives, as they said that staffing levels even at present are too low to accommodate the increasing volume of women attending the hospital. They called for the introduction of **clinical facilitators such as AMPs** to support role and staff developments and also increase the range of CMS to include training for ultrasound scanning. These developments would necessitate a review of the referral system currently in place. Midwives want to be able to **refer women for blood tests, ultrasound scanning, physiotherapy and dietetics**, all of which must be requested

by a doctor at present. Space is at a premium in the hospital site and a review is necessary to accommodate new clinics and classes.

Shared care was another service discussed and midwives saw a role for themselves in sharing care with GPs. All women could visit Midwife Clinics and Parent Craft Classes in their local Health Centres and GP surgeries. This would offer greater convenience for pregnant women without the need to travel distances to visit the hospital. Participants were adamant that this service should be available to all women whether private or public patients.

Midwife led admission units would further enhance the service and almost certainly facilitate the EWTD.

Labour Management

A lot of discussion surrounded the management of women in normal labour. Midwives pointed out that their training gives them the expertise to offer professional assistance to mothers during labour. They have the knowledge to monitor the condition of the foetus in utero by appropriate clinical and technical means, and conduct spontaneous deliveries including when required episiotomies and in urgent cases a breech delivery. However as previously pointed out they are curtailed from doing so under present hospital policy. All women in labour are seen by a doctor on admission unless delivery of their babies is imminent. Participants said that there is no need for doctors to be involved in any normal labour and recommended that policies and guidelines are developed and put in place that will greatly reduce the involvement of NCHDs in the Labour Room and Delivery Suite. The following enhancements to midwifery would greatly lessen the impact of NCHD reduction in working hours:

- Midwives interpret and take appropriate action on CTG traces
- Midwives perform suturing, phlebotomy and cannulation
- Introduce midwifery prescribing to include pain-relieving medication, Syntometrine, Syntocinon, iron etc. and facilitate standing orders where midwifery prescribing is unavailable. Training and guidelines to support development.
- Medical involvement only if deviation from normal labour is identified.
- First doses of antibiotics
- Introduce anaesthetic nurses
- Administer first units of blood

Midwives identified the examination and care of newborn infants as part of their responsibility. The **initiation of emergency resuscitation** procedures in accordance with agreed guidelines must be part of this role. Participants felt that this would better facilitate continuity of care for mother and baby and that it is a specialist role they were well equipped to undertake. Rolling training programmes in infant resuscitation with competency development should be available to all midwives.

Postnatal Care

It was generally felt that midwives are best placed to care for women and their infants in the postnatal period. The need for doctor to be involved was seen as necessary only if there are complications. Otherwise midwives can offer care and support to mothers and their infants and education and advice on infant care and feeding. This would reduce the necessity for chaperoning and ward rounds with NCHDs, both activities being very time consuming.

A role for a **Lactation Nurse Consultant** was discussed and the consensus was that this role would make a valuable contribution to the service by giving mothers with difficulties greater access to expert knowledge and advice outside the scope of the midwife should that be required. Participants would also like to see Nursery Nurses introduced as they feel it would further enhance the quality of care to mothers and their babies.

Midwifery prescribing and standing orders were seen as vital at this stage of care to reduce delays in medication administration and stress on women.

The decision on when to **discharge mothers and babies** should rest with midwives if midwifery admissions and discharges are introduced. It is well recognised that patient admission and discharge has been the bastion of the medical profession but when the Health Service is being asked to put the patient at the centre of service delivery this area must be challenged. It makes sense that as midwives spend more time with women both at the antenatal and postnatal stages, and a large percentage of these women have not experienced complications, it seems inappropriate that midwives cannot make decisions regarding admitting and discharging patients. Policies and guidelines can be developed and agreed upon if the will is there to improve the service.

District Midwives

There is a postnatal District Midwife Service in operation and this has proven to be of great success. Here too however the need for further development has been identified in the focus groups regarding the introduction of antenatal community services:

- Increase cover from a 3 mile radius to a 10 mile radius from the hospital
- Introduce Early Transfer Schemes (24hours post delivery discharge)
- Provide antenatal visits in the community
- Facilitate direct referrals to GPs thus decreasing hospital admissions and NCHD involvement
- Parent craft classes - already mentioned

With a quality community midwife service available to women and their babies discharges could be increased resulting in less bed capacity and less NCHD hours.

2.1.3 Psychiatric Nursing

“The primary objectives of psychiatric nursing are to facilitate the maximum development of the mental health of the individual who has psychiatric problems and to promote mental health” – An Bord Altranais 2000. Integral to this role is the establishment of therapeutic relationships with patients and their families to enable rehabilitation. The intention of all interventions by psychiatric nurses is to support as many people as possible with mental health problems to live in community settings or support those already living in the community.

Communication and interpersonal skills are vital ingredients to the role of a psychiatric nurse. The shift from institutional care to community care is a national policy goal and nurses are working as part of a much larger multidisciplinary team. The range of services offered by psychiatric nurses includes **rehabilitation, social skills training, individual counselling, group-work, psycho-education, family support, liaison work and mental health education.**

The resounding opinions of participants were that their skills and knowledge was under utilised and frequently unacknowledged by other members of the multidisciplinary team. Nurses are willing to be accountable for their practice and expressed frustration that the system they are working in stifles creativity by perpetuating historical non-therapeutic roles such as ‘wardens’ and receptionists. Nurses felt that they had a lot more to offer patients and the Mental Health Service than was currently recognised.

Many nurses have further developed professional skills and knowledge but are hampered from delivering these to patients because they are obliged to carryout inappropriate non-nursing duties. Some of these duties involve shopping and cooking as well as washing and ironing in the community. Unit based staff had similar grievances regarding inappropriate duties assigned to them. All participants complained about the lack of clerical support and the urgent need to expand the role of ward attendants and porters as previously mentioned in this report.

Therefore an organisational change is required according to participants to facilitate the development of the role of nurses working in Mental Health. Psychiatric nurses cannot develop and enhance their practice within the organisational structure that currently exists. Agreement must be sought from other members of the multidisciplinary team and particularly the medical professionals to facilitate role development initiatives. Nurses want to be valued as equal members of multidisciplinary teams, something many participants generally felt does not happen in practice.

According to participants any future professional development must encompass skills based practice with therapeutic intervention. Nurses complained that because many of their existing skills are not being utilised at present any additions to this frustrating list is not practical.

There was a clear focus on the need for greater involvement in the admission and discharge process. The input nurses have in this area is negligible as they work in an area that is largely medically focused and medically modelled. Nurses see a role for themselves in **admission assessments** where they would have the authority to assess and admit patients under guidelines and protocols. Participants pointed out that many patients are known to them, as patient readmissions are common within this user group. Therefore very often because they know their client group so well they are best placed to assess whether or not an admission is required. Instead of having the authority to admit patients they must contact a NCHD to do so.

A **nurse led admission unit** with an appropriate triage system and headed by an ANP or CNS could lead to a more efficient system. The ANP or CNS would require autonomy under guidelines to prescribe treatment and initiate referrals for investigations as appropriate. An increase in the numbers of CNSs was seen as an advantage where there is a need for advanced skills. Community Liaison Nurses would also like to be able to admit patients whom they visit in the community. Their role is to monitor progress and identify problems that occur. Part of this role should also include referral for admission when indicated.

Again as in general nursing and midwifery, psychiatric nurses have difficulties with making referrals to other disciplines. In most cases referrals will not be accepted from nurses and must be made by doctors. This includes **referrals for routine treatment and investigations**. As with the other nursing disciplines outlined nurses could make these routine referrals thus improving efficiency by saving time waiting for doctors' signatures of authorisation. Nurses working in units and the community would welcome the authority to refer to Psychologists, Occupational Therapists, Counsellors as well as Chiropractors, Dieticians and for investigations such as routine blood tests etc.

Discharge planning was discussed and nurses would welcome greater involvement in this area. Because nurses have several encounters with many of their patients they are familiar with their progress development patterns. If they are allowed to use their clinical skills and judgement they believe that they are competent to discharge selected patients. However all discharges must be decided by a doctor under present protocols. Participants said they would like to see a discharge policy developed supported by guidelines and protocols that gives them autonomy in selected discharge planning.

Problems were highlighted regarding chronically ill patients occupying acute beds. According to participants in one unit 20% of bed capacity is taken up with long stay patients. Another unit pointed out the lack of juvenile facilities resulting in their beds being blocked because these children have nowhere else to go. Problem regarding inadequate numbers of high support community residences with rehabilitation services to facilitate the transfer of long stay patients were discussed. The knock-on-effect of inadequate step-down services is that admissions are obstructed because beds are blocked.

Nurse prescribing was welcomed as a positive step forward in improving efficiencies in the service. Nurses would like to see it introduced into the community as well as acute units. Participants identified emergency sedation, psychotropic medication, night sedation, simple analgesia, antacids and laxatives. Considerable delays can be encountered waiting for doctors to prescribe non-urgent medication that could otherwise be prescribed by nurses under protocols and guidelines.

Nurse led clinics were seen as a vital contribution to mental health service development. Many nurses at present have the necessary skills and knowledge to lead clinics but protocols and time constraints inhibit this service from being offered to the public.

The possibility of delivering the following nurse led clinics was listed:

- Cognitive / Behaviour Therapy
- Addiction Counselling
- Family Therapy
- Counselling Sessions

As already mentioned nurses want the focus to shift from non-nursing interventions to skills based practice and this will necessitate more time being spent with patients either on a non-to-one or group basis. This cannot happen if skill mix issues are not properly addressed.

Managers interviewed expressed frustration at their lack of autonomy and input in management decision making processes. Recruitment is an issue in mental health and the lack of WTE is eroding managerial autonomy. Greater transparency in staffing budget and control of staffing budgets locally was seen as necessary if managers are to be allowed to manage and lead staff.

Nurses operating at CNM2 level wish to be super numery and allowed to develop their roles with greater emphasis on leadership. They identified the need for staff development and implementation of work place initiatives and policies but complain that there is no time to commit adequately to this under the present restrictions. Staff recruitment as already stated is a problem resulting in an over reliance on overtime.

The overall attitude of participants in the Mental Health sector is one of willingness to develop and expand practice and accept accountability and there is general recognition that the Health Service is in a state of constant change among participants. Mental Health is shifting from a medical model to a psychosocial model. This model acknowledges the expertise of all disciplines involved in care delivery and Psychiatric Nurses state that they have more untapped potential to contribute to this service. Psychiatric Nurses interviewed in the focus groups want the same opportunities as other professionals to be part of this change and this report is a testimony to this fact.

2.2

Skill Mix

The data highlighted the urgent need for an updated skill mix review to relieve nurses and midwives of non-nursing duties in order to develop their roles and use their expertise more effectively in the delivery of quality patient care.

2.2.1

Health Care Assistants

Nurses and midwives identified the need for qualified Health Care Assistants (HCA) who would operate under the supervision and delegation of nurses and midwives and would be accountable for their own actions in accordance with the recommendations in the 'Report of The Commission on Nursing' (1998). The participants considered it necessary that HCAs have a clear job description based on a supporting role within nursing/midwifery teams with direct and indirect patient care duties and on a 24-hour rota basis.

There is a lack of uniformity regarding care attendants within the MWR as some hospitals have care attendants on a generic attendant contract but with no reference to working as part of a nursing/midwifery team. Other hospitals and units do not have care attendants employed although most have included this in their service plans. In the latter case nurses are frequently bridging the gap between their professional duties and those of the ward attendants. This involves general ward maintenance such as cleaning drip stands, commodes, urinals and bedpans, ward fans and other equipment along with washing mattresses, lockers and bed making, serving food and beverages.

Care attendants have been praised by focus group attendees for the contribution they have already made to nursing/midwifery teams however in many cases they are of insufficient numbers to make a substantial difference to the inappropriate workload problem of nurses/midwives.

General Nursing and HCAs

The following tasks were suggested as broadly suitable for HCAs to undertake subject to ongoing nursing assessments of patient suitability and level of care required for each individual. The following is based on the pilot curriculum of FETAC training for HCAs (2001-2002) with some extra tasks added on:

- Routine urinalysis, urinary catheter maintenances, monitoring and recording fluid intake and output
- Assisting with patient admission e.g. weight recording, urinalysis
- Oral hygiene
- Transfer of patients to theatre and other departments under guidelines. However given current best practice policies requiring nurses to complete the transfer mechanism from one department to another to maintain patient safety this may not be feasible.
- Ordering and putting away CSSD

-
- Applying skin lotions such as aqueous creams and other non prescription moisturisers under delegation
 - Blood glucose monitoring
 - ECG recording
 - Checking ward equipment
 - Logging of patients property

Participants would like to have HCAs specially trained to work in areas such as I.C.U., C.C.U., and Theatre and A&E Departments. Further discussion along with the development of local policies will be required before decisions can be finalised.

Midwives and HCAs

Midwives want all the above included with the addition of specific training in maternity care to include the following:

- Washing and dressing babies
- Bottle feeding babies
- Carrying babies to cars
- Chaperoning
- Assisting mothers out of bed 6 hours post Caesarean Sections
- Assisting women with personal care post delivery
- Preparing treatment rooms
- Stocking and clearing trolleys
- Transferring women to wards
- Washing instruments and beds

Psychiatric Nurses and HCAs

Support was also seen as necessary to release nurses to undertake counselling support, patient assessment, medication assessment and administration, patient advocacy role and multidisciplinary liaison roles. Participants felt that patient contact often involves counselling sessions whether formal or informal and that opportunities could be lost if HCAs take over much of the personal care undertaken by nurses. However some nurses felt that care attendants could assist with bed making, laundry and shopping duties.

All of the above suggestions regarding the role development for HCAs must have due regard to risk management guidelines and protocols and must be supported by guidelines and policies.

General concerns of participants related to the possible reduction in the whole time equivalent (WTE) of nursing/midwifery numbers in order to either introduce or increase the number of HCAs. According to Needleman et al (2002) “providing a higher proportion of registered nursing hours was associated with better care for hospitalised patients – and this care must not be compromised”. The common

opinion of focus group participants was that if nursing /midwifery roles are to be significantly developed then the WTE should not change at this stage.

There was also disagreement regarding whether or not HCAs should be involved in recording vital signs and although the majority were not in favour of this some groups felt that this was appropriate at level 2 vocational training. Some groups felt that HCAs should record vital signs, as any interpretation by them of results would be unnecessary, as all findings would be reported to a nurse. The majority felt that the required level of knowledge for this task would be beyond the scope of the HCA at this level and that it would be impractical anyway to report all findings to a nurse.

All participants agreed that a clear job description for HCAs would be required along with guidelines and protocols for nurses and midwives to minimise inappropriate delegation. The potential for career development for HCAs and care attendants was not explored in any detail due to the time limitations of the meetings.

2.2.2

Clerical Support

The introduction of ward clerks was viewed as beneficial to the running of wards and departments however an increase in clerical support was seen as vital to further relieve staff of non-nursing/midwifery administration. The data highlights a lack of uniformity across acute hospitals and units with some areas sharing ward clerks and other areas having no clerical support. In the situation where there are no ward clerks nurses /midwives are carrying out general ward administration. In the areas where there are ward clerks either shared or part-time, participants said that they are still undertaking unacceptable amounts of administration duties due to insufficient ward clerks or clerical time to cover busy times.

Staff indicated the need for:

- An increase in the number of ward clerks and working hours to cover all areas where nurses/midwives work
- Increase the hours to cover locations that operate a seven-day week service with full weekend cover. Maternity Admissions Unit indicated the need for 24-hour cover.
- Skeleton weekend cover in less busy areas.

The issue of ward clerk cover was raised, as there is great dissatisfaction in the cover arrangements in many locations when ward clerks are on annual leave, days off, sick leave and breaks and where nurses and midwives are expected to provide cover. It was pointed out that this situation is already unacceptable and if there is any expansion /development of roles for nurses/midwives there will possibly be a greater volume of administration and that it is unreasonable to expect nurses and

midwives to continue with this present arrangement. It was clearly stated that all cover for ward clerks must come from within their own grade and discipline.

The remit of the ward clerks should be increased to include:

- Call screening, general reception duties, vetting of visitors in accordance with hospital policy
- Faxing, e-mailing, word processing, photocopying, chart maintenance, acquiring and filing patient reports and other general filing, making appointments, administration for admission and discharges
- Bed status collection and reporting on, maintaining ward round documentation
- Off-duty roster recording,
- Computer data input such as daily audit, activity numbers, support for clinical audit, birth notification (midwifery)
- General intra-departmental and extra-departmental communication.
- Ordering and putting away of stationary stores, checking deliveries to departments
- Answering doctors bleeps when in theatre and supported with clear guidelines

The need was raised for ward clerks to have induction programmes and general training to include patient and hospital confidentiality issues and customer care training. It was felt by some participants that ward clerks should be accountable to the ward manager.

2.2.3 Clinical Nurse/Midwife Specialists and Advanced Nurse/Midwife Practitioners

The majority of participants welcomed the idea of advanced nurse practitioners (ANP) if the profession is to develop significantly into the future. Participants are fearful of losing a nursing/midwifery focus with future professional development especially if that development takes place in areas that have been traditionally focused on the medical model. The generalist nurse/midwife in particular regards specialist nursing/midwifery grades as an essential element in the development of the profession both from a knowledge-skills base and a leadership prospective. Suggestions made by participants regarding their utilisation will be outlined in a later chapter.

2.2.4 Ward Attendants

It was acknowledged in almost all the focus group meetings across all disciplines that housework duties must be removed from the nursing remit with a proper structure of supervision for all ward attendants so that nursing and midwifery personnel are not directly responsible for ensuring that these duties are adequately

carried out. In some areas there are no housekeeping supervisors and CNMs/CMMs are obliged to undertake this role.

The need to extend the role of ward attendants to cover further aspects of ward maintenance was identified as nurses and midwives indicated the need to relinquish:

- Cleaning duties such as mopping up spills, washing mattresses, lockers, drip stands, commodes, washing entire beds
- Making and serving tea and toast, serving and ordering meals, placing bed tables in front of patients at meal times, filling and changing flower vases etc.
- Ordering and maintaining ward laundry stocks
- Ordering and maintaining CSSD stocks

There is a difference of opinion regarding the role of HCAs and where it overlaps with ward attendants. Some participants were of the opinion that their roles are similar with HCAs having more direct patient care duties while most consider it to be separate with HCAs aligned to nursing teams with some housekeeping duties included and attendants involved in ward maintenance and food delivery.

One group felt that training in food handling and hygiene should be mandatory for all attendants. Another group based in theatre referred to the need for attendants to maintain scrub suits, stocks and stores as well as cleaning duties. The need to provide greater time cover to 24 hours in some places was highlighted to 24-hours.

2.2.5

Porters

The role of the portering staff was explored and some areas identified the need for their role to be increased. Suggestions put forward included 'manual handling teams' shared between wards and units located closely to each other, thereby being more accessible at appropriate times. At present in some areas there are difficulties accessing porters as they cover a wide area within the hospital site. Staff have indicated that a porter should be assigned to each large ward or shared between two smaller departments and undertake responsibility for taking patients to and from other departments, transferring items to other hospital departments, moving ward equipment and general ward/unit maintenance and assisting with patient handling. Some hospitals have indicated that porters undertake all of the above but this is not the case in all areas.

Nurses/midwives have indicated the necessity of being released from portering duties presently undertaken by them such as:

- Collecting, delivering or transferring patients to and from other locations
- Collecting or delivering charts and equipment to other locations
- Moving ward furniture and equipment.

With regard to manual handling teams participants see their role as supervising and directing manual handling as part of a manual handling team.

2.2.6 Pharmacy Technicians

In almost all focus groups problems with pharmacy stores were raised and the general consensus is that pharmacy technicians should be responsible for stocking wards and departments. A lot of time is spent ordering and putting away pharmacy with the added problem of prescription alterations following doctors' rounds. Nurses/midwives often have to leave the ward to go to the pharmacy department and bring back the medication to the wards themselves.

Nurses/midwives felt that the solution to this is to employ pharmacy technicians to order and put away stock using a top-up system. This system is currently being piloted in some wards in MWRH and the anecdotal evidence indicates that it is a success. Suggestions were made regarding putting a structure in place where pharmacists or pharmacy technicians could attend ward rounds. Notifications of alterations to prescriptions that occur during the day should be made easier by using I.T., which is more efficient and less cumbersome.

2.3

Education

Assistant Directors of Nursing/Midwifery have requested that finance be provided specifically for any education and training that will be required as a result of the EWTD and that it should be ring-fenced. Funding for the training of HCAs must be provided and commence before August 2004. It was felt that a cost benefit analysis of nursing care would be beneficial at this time to facilitate the future development of the profession. Many participants felt that the value and contribution to care that nurses/midwives make is often times unacknowledged and understated.

Several questions were raised in almost all focus groups regarding the availability of education and the development of competencies if nurses/midwives are to significantly enhance their roles. Regularly nurses and midwives sponsor themselves to attend courses and often attend in their own time. They have stated that when courses involve enhancing patient care and acquiring competencies in line with current research philosophy it is not alone the patient who benefits but the organisation as well. Subsequently the organisation should pay both for the course and any travel expenses incurred. If the course is not held during working hours then the time should be reimbursed. There were requests made for transparency in training budgets with an equitable system for allocating or agreeing study leave.

In relation to any development of practice as a result of the EWTD the general consensus is that the aforementioned must apply and every endeavour must be made to deliver education programmes and courses locally. If this is not always possible then it must be available regionally.

The education of ANPs and AMPs was raised and although most would welcome their introduction the training programme is not available outside the ERHA. This is seen as a major stumbling block for future development especially in the areas of general medicine and surgery, A&E departments, I.C.U. and C.C.U. departments and for the development of nurse-led clinics.

Serious consideration must be given to making ANP education along with other educational programmes traditionally based in Dublin available outside the ERHA so that there is equity and fairness nationally.

The present system of selecting staff to attend courses was criticized, as the process was felt to be subjective. Participants stated that they felt that it is sometimes used as a weapon against them and that a fairer system should be put in place that is open and transparent. Participants were unwilling to elaborate on this point when probed, however this comment is included in this report because of the frequency with which it was raised. Centralizing applications and introducing appraisal and clinical supervision could achieve this.

2.3.1

Competency

Acquiring competencies was raised as a major concern and a clear system is required based locally and involves where appropriate 'train the trainer'

programmes and the involvement of Clinical Nurse/Midwife Specialists and other experts to support nurses/midwives during the change process.

It was suggested that on site brief rolling education and skills up-dating programmes using clinically credible educators should be introduced. Along with this journal clubs should be introduced in all sites in tandem with any major professional development initiatives. The definition of major professional developments varies according to each individual nurse and the experience he/she may have acquired. For example a major role development could be cannulation training for some nurses where advanced specialist practice could apply for others.

2.4 Support Structures

The support structures discussed are placed into groups under the following headings:

- Development of Policies and Protocols
- Information Technology Infrastructure
- Changes in Organisational Systems

2.4.1 Policies

Guidelines, policies, procedures and standards must support all changes to practice and need to be developed and ready to put in place as part of the change process. Policies and guidelines should be both regional and national to support this national professional development project. It was pointed out that developing guidelines and policies is time consuming and that individuals must be released to take on this role where there is an absence of a Nursing Practice Development Unit. There was a general concern regarding the management of change of this magnitude. It was also suggested that an individual should be appointed to co-ordinate and develop these supports regionally on a full time basis until targets are met. Otherwise there may be fragmentation of service delivery between acute sites.

2.4.2 Information Technology

The present system requires up dating so that capacity to inter-face with other systems in other hospitals and community departments is made available. Nurses and midwives want Intranet, Internet and e-mail facilities available to them in all wards and departments to accommodate access to current professional information. At present many nurses do not have direct access to ward based I.T. such as e-mail, internet and intranet access, although there are computers in almost all wards and units. Policies and guidelines etc could then be accessible on the MWHB Intranet and new developments could be included on a web site. The issues of abuse of this technology can easily be rectified by the use of passwords, site filtration systems and normal Health Board monitoring procedures. Along with updating the IT system participants want basic relevant skills training pertinent to the system and software programmes that they will be using.

2.4.3 Changes in the Organisational Structure

The general feeling as stated by participants is that there is a need for a cultural change at all levels and disciplines within the organisation so that other professionals and departments understand, appreciate and cooperate with the evolving role of the nurse/midwife. This needs to be encouraged through a process of cooperation and information sharing and respect from all involved parties. Specific issues were highlighted regarding difficulties surrounding the referral

policies of other professionals, which restrict or exclude referrals made directly by nurses/midwives. This was often discussed at length particularly relating to referral protocols to other specialist nursing personnel (such as in palliative care), physiotherapists, dieticians, laboratory technicians, social workers and others.

The general consensus is that within agreed protocols and guidelines referrals must be facilitated if nurses/midwives are to significantly enhance their scope of practice and increase efficiency in the system.

The issue of CNM2s/CMM2s and super numeration was raised in almost all focus groups. There was unanimous agreement that CNM2/CMM2s should be supernumerary on the nursing roster so that they can expand their managerial role with greater autonomy and authority. They would like to be involved in staff recruitment for their departments, developing and leading change and have the time to fully commit to 'Staff Professional Profiling' which is about to commence in parts of the Region.

Staff nurses too want greater autonomy with opportunities to develop organisational and managerial skills. Some participants said that decisions relating to the patients assigned to their care are often made by ward managers and that their expertise is not always welcome if it is at variance with the managers opinions. Participants felt that sometimes resistance by other disciplines to greater autonomy relates to entrenched ideas regarding custom and practice rather than research based evidence.

Appropriate patient allocation with assigned nurses/midwives taking the lead in all nursing aspects of patient management including attending ward rounds relating to their assigned patients was seen as a more efficient system. Attending more than one ward round with senior nursing staff at night was seen as unnecessary and time wasting for all concerned.

It was generally agreed that if ward managers were given more managerial independence then more autonomy would be passed on to staff nurses.

Communication between professionals will need to develop with a multidisciplinary approach to care being the main focus for all. Coinciding with this must be role clarification where greater responsibility must be undertaken by each discipline to ensure that they initiate and complete their care input without prompting from other disciplines. This particularly related to nurses frequently reminding NCHDs of uncompleted tasks or appointments that need attention which can often delay treatment and cause unnecessary concern for patients and time wasted by nurses/midwives that could otherwise be spent on patient care.

Relating specifically to psychiatric nurses working in the community setting it was pointed out that the lack of week-end cover must be addressed as many problems relating to patients can surface at weekends when there are no community nurses on duty and few back-up services available. A system to facilitate cover needs to be implemented if patient care is to be enhanced.

Chapter 3

Supporting your needs

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Conclusion

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Conclusion

Implementing the changes identified by nurses and midwives will have resource implications for the Health Service. **Service plans should identify the areas of skill mix, education and support systems outlined in this report if development is to take place.** The report has already stated that nurses and midwives participated in the focus group to examine the possibilities for professional development that the EWTD may present. They do not see it as their sole responsibility to accommodate the EWTD although they do recognise that they could facilitate the directive under the conditions outlined in this report. A pre-condition of their involvement in the reduction in NCHD hours is that it must be adequately funded. Directors of Nursing along with Divisional Nurse Managers and Clinical Nurse Managers will have to identify and include resource requirements in their service plans for 2004.

The key success factors for the planning and implementation of the proposals in this report should involve change, leadership and partnership. Change must be endorsed by the organisation as a whole with recognition and acceptance that nurses and midwives roles are evolving. This may necessitate embracing a cultural change within the Health Service to support development and creativity within the professions.

The largest portion of the Health Service workforce is made up of nurses and midwives who are often the group closest to patients and therefore fundamental in achieving a patient-centred service. Nurses and midwives are accustomed to change both from within the profession and the Health Service and they have developed a deeper understanding of the intricacies and impact change can have on an organisation. This is clearly demonstrated in the proposals forwarded by participants of the focus groups where a logical approach was adopted using experience and foresight. This information will be invaluable both to the Mid-Western Region and other Regions nationally to facilitate effective strategic and operational planning.

The EWTD will challenge historical demarcation lines that have hindered the growth of professional development for nurses and midwives in the past and possibly pave the way for a more seamless Health Service.

The Review of Scope of Practice for Nursing and Midwifery (1999) identified the need for nurses to be “empowered to a greater extent to make professional decisions, rather than having narrowly focused prescriptive guidelines in certain areas”. Decision making authority should be an integral part of future development along with the ability to make and accept referrals, order investigations and diagnostic tests, run clinics and prescribe treatment. Acceptance of greater accountability, responsibility and authority will lead to greater empowerment within the professions.

Guidelines, policies and in some cases legislative changes will be necessary to support the reconfiguration of roles since it is role reconfiguration that nurses and midwives are interested in and not task substitution. Task substitution has not worked in other countries where the EWTD is already partially implemented and

in fact has caused frustration and resentment among NCHDs and nurses/midwives where demarcation lines are rigid and autocratic.

Nurses and midwives have highlighted the need for more nurse led care services. Evaluations of these services in the U.K. have been positive and the need to develop nurse led services as a strategic option has been indicated (Richardson et al 2003). With the EWTD in mind the need for innovation in the reconfiguration of workload mismatch is appropriate and nurse led services can offer an alternative model of care. In budget limiting climates there is often a strive to develop efficiencies and improve services and nurse led services can offer a credible alternative to doctor led services in certain circumstances provided competency and capability assessments are identified.

Staffing levels should be reviewed prior to the introduction of the EWTD in August 2004. According to Galley et al (2003) “nursing staffing levels should also be influenced by the availability of medical staff or other allied professionals. Where these colleagues are few or inexperienced it will impact on the role of the nurse, increasing their responsibilities and workload”. Service plans should take account of the increased responsibilities that nurses will be undertaking if the proposals in this document are implemented and the increase in WTE that will be required to support this.

Strong leadership is one of the most vital components in any change programme according to The Office of Health Management (2003) where importance is given to “creating a vision and driving change through decisive and skilful leadership”. With transitional changes such as those proposed in this report leadership from all levels of nursing and midwifery professionals will be vital to cope with advances in development and empowerment of the profession. Ward and unit managers will be the principal leaders of change for staff working in those areas but support and leadership too for them is vital. This level of change is quite significant, as the impact of a 75% reduction in the overtime working hours of NCHDs will not go unnoticed by any level of service provision.

According to the (DOHC) publication Action Plan for People Management in the Health Service (2002), partnership is the most appropriate vehicle for the implementation of new change agendas. It engages all participants in a shared vision of organisational objectives and goals by involving staff in service planning and change management based on a single effective system of communication and a problem solving approach. Nurses and midwives cannot develop significant changes to their practice without the cooperation of other disciplines and agencies within the Health Service. Indeed the EWTD will require all disciplines to alter or change their practices if it is to be successfully implemented. Without a partnership approach to this directive the task will be daunting for all.

Finally this directive is seen as a excellent opportunity for the nursing and midwifery profession to re-evaluate the service they deliver to patients, clients and

their families. In this report nurses and midwives who attended the focus groups have demonstrated their continued commitment to professional development and quality care delivery. The Health Service can use this directive as an opportunity to widen the scope for personnel to deliver a seamless service placing the right role/job in the hands of the right person. In other words people with the appropriate competencies should be the people assigned to undertake the role. The definitive result of the proposals made in this report will be judged on service outcomes to and by patients, clients and their families.

References

1. An Bord Altranais (2003) 6th Edition "Nursing A career for you. Pre-registration/degree programmes 2003
2. An Bord Altranais (1998) Scope of Practice for Nursing and Midwifery
3. Department of Health (UK) (1994) Changing Childbirth HMSO: London
4. Department of Health and Children (2002) Action Plan for People Management in the Health Service
5. FETAC (NCVA) Awards (2001-2002) Health Care Assistant Training Programme
6. Galley, J., O'Riordan, B., (2003) Guidance for nursing staff in critical care. Royal College of Nursing Publication
7. Government of Ireland (1998) Report of The Commission on Nursing Government Publications
8. Needleman, J., Buerhaus, P., Mattke, S., Stewart, M., Zelevinsky, K., (2002) Nurse staffing levels and the quality of care in hospitals. **New England Journal of Medicine** 364:22; 1715-1722
9. Richardson, A., Cuniff, L., (2003) New horizons: the motives, diversity and future of 'nurse led' care. **Journal of Nursing Management** 11, 80-84
10. World Health Organisation (1996) "Care in normal birth: report of a technical working group" WHO/FRH/MSM/96.24
11. The Office for Health Management (2003) Change Management – Leading Thinking. <http://knowledgecentre.officeforhealthmanagement.ie>

Appendix 1

Appendix 1
Panoramic View of Nursing/
Midwifery in Ireland in the 21st
Century

SLIDE 1

Scope of Professional Practice
* Definition:
“The scope of nursing practice in Ireland is the range of roles, functions, responsibilities and activities, which a registered nurse is educated, competent, and has authority to perform”.
(An Board Altranais 2000 'Scope of Nursing and Midwifery Practice Framework').

SLIDE 5

Nursing/Midwifery Profession in Ireland
* Key influences on Role Change
* The Evolving Role of the Nurse / Midwife
* Scope of Professional Practice
* Skill Mix and Delegation
* Practice Development

SLIDE 2

Scope of Professional Practice
* The individual nurse/midwife is accountable for his or her practice
* Accountable for decisions made in determining his or her scope of practice
* Accountable of decisions regarding expanding or not expanding practice.

SLIDE 6

Key Influences on Role Change
* The changing service needs and expectations of the general population with increasing consumer demands for greater involvement and control in public services.
* Pressure within the profession for greater control in self-direction, autonomy and development.

SLIDE 3

Scope of Professional Practice
* The individual nurse/midwife must assess whether or not he or she is competent to carry out the role/function when determining his or her scope of practice.
* While acknowledging his or her limitations a nurse/midwife must take measures to develop and maintain development sand competencies.

SLIDE 7

Key influences on Role Change
* EU policy resulting in the change in other professionals within the multidisciplinary team e.g. the reduction in non-consultant hospital doctors hours to 48 hours per week by 2910.
* World-wide trends pushing expansion and development of practice thus avoiding fragmentation of roles.

SLIDE 4

Scope of Professional Practice
* Primary motivation for expansion of practice must be in the best interest of the patient.
* Expansion must underpin the principles of the nursing/midwifery profession.
* Due consideration to legislation, national and local policies and guidelines and developed where deemed necessary of new guidelines and policies.

SLIDE 8



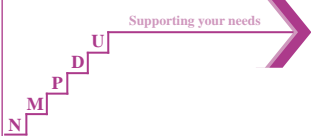
Skill Mix and Delegation

What is skill mix?

“Mix of staff employed in an area of healthcare activity whether these are qualified, trained or untrained staff”.

(DATHs Skill Mix Group Report 2001).

SLIDE 9



Skill Mix and Delegation

- * Analysis and forward planning of role change against the back drop of a continuing evolving profession.
- * Maximising opportunities to remain the core of the health service workforce.

SLIDE 13



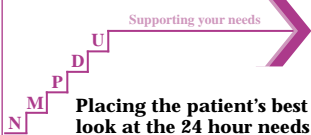
Skill Mix and Delegation

Nurses work load includes four components:
Direct nursing clinical activities.

1. Indirect nursing clinical activities - clinical documentation related to patient care.
2. Non-nursing tasks - not related to professional expertise.
3. Invisible work - discrete co-ordination of activities.

(DATHs Skill Mix Group Report 2001).

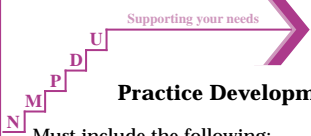
SLIDE 10



Placing the patient's best interest first look at the 24 hour needs of the service, please identify:-

- * Areas for practice development?
- * Gaps in service at present?
- * Skills and knowledge required?
- * Educational and support required?

SLIDE 14




Practice Development

Must include the following:

- * Exploring the educational and support network requirements of professionals to develop their practice and competencies.
- * Examining appropriate personnel to relinquish appropriate tasks/roles.
- * Examining the training needs of support personnel.

SLIDE 11



Thank you for attending today, your participation is most welcome.

SLIDE 15



Practice Development

Opportunities to develop the profession will involve:

- * Questioning of traditional boundaries and barriers to innovation.
- * Relinquishing or delegating roles outside the scope of the profession.

SLIDE 12

Appendix 2

Three focus groups were held for nurses working in the non-acute sector covering the North Tipperary, Limerick and Clare regions. A total of 66 nurses attended the three groups and forwarded views and suggestions on how the non-acute sector could develop and expand in line with the acute sector. The focus groups were also used as an opportunity to give participants feedback from the acute focus groups, the National Steering Group and the Regional Working Group.

Skill Mix

A similar response was forwarded from nurses working in the non-acute sectors. Nurses are willing to use the EWTD as an opportunity to examine their practice and explore possible areas of development to enhance patient/client care. Skill mix, education and support structures were highlighted as crucial to the implementation of development plans.

Nurses working in non-acute hospital settings identified many non-nursing duties that they were currently undertaking and which were similar those outlined in the main text of the report. Participants could identify a role for HCAs who are trained to work in the area of elderly care and accountable. They see this role of HCA working as part of the nursing team and under the delegation of qualified nurses. Concerns were raised regarding the erosion of the nursing role in this setting and participants expressed fears that care attendants may replace nurses. They feel that this would not be acceptable to them if they were to significantly expand and develop their role.

Public Health Nurses and community nurses both in general and mental health also identified the need for HCAs who would have specific training to work in the community setting. They also highlighted the need for an increase in the Home Help service to patients/clients and their families in the community.

Problems surrounding the availability of clerical support were raised. Some areas had no access to clerical support and nurses had to undertake clerical duties such as making appointments, writing letters, sending faxes and letters etc. Other areas were dissatisfied with the number of hours available to them for clerical support while it was not a problem for a minority of participants.

Communication

Communication between community and acute hospitals was identified as problematic for many community nurses. An interfacing I.T. system was called for to improve communication and reduce administration. Liaison services could be improved particularly between acute hospitals and community nurses.

Education and training

Education and training was seen as vital to any role development and this should

be fully funded and available locally or if necessary regionally. Nurses saw it as vital that this education must be practice based to overcome the theory – practice gap. Suggestions were forwarded regarding ‘nursing development clinics’ involved with practice development and support for competency acquisition.

Along with education and training clinical/management supervision was seen as appropriate for professional development. Competency training for this role was suggested for both the supervisor and the supervisee in order that the experience can be positive one for all.

Role development

The majority of participants who attended the focus groups were willing to continue with developing their practice. They agreed that professional developments for nurses and midwives in the acute sector would influence their practice. In general nurses were willing to accept greater level of responsibility and accountability in accordance with the Scope for Professional Practice (2000).

They identified areas where developments could enhance a more seamless service. Nurse led services were identified and welcomed by many participants. It was felt that nurses are well placed in the non-acute areas to develop:

- Nurse led admissions with the possibility of an out-of-hours triage service
- Nurse led discharges planned at time of admission
- Nurse led clinics in wound management/tissue viability
- Counselling sessions
- Nursing rehabilitation units bridging hospital and community
- Nurse assessment for respite admission with agreed criteria
- Post natal depression clinics
- Case and care management

The area of nurse referrals was highlighted as problematic. Services and investigations can be delayed because referrals are redirected to other team members. Nurses would like to have the authority with guidelines to refer to physiotherapists, dieticians, occupational therapists, clinical psychologists, speech therapists as well as referring patients/clients for diagnostic tests and investigations. Public Health nurses have limited referral capacity at present but are fearful that this component of their role is currently under review and may be withdrawn in the near future.

A role for ANPs was identified in the areas of rehabilitation, nurse led clinics, staff development, swallow reflex assessment (currently only undertaken in the MWHB by speech therapists), nurse prescribing and many other areas and it was suggested that the ANP role could be shared between hospitals and clinics. Participants were clear that they wanted to see the generalist nurse role significantly developed. There was a fear that the generalist nurse may become deskilled if development is focused

on CNS and ANP enhancement. Generalist nurses, psychiatric nurses and public health nurses want to see greater decision making roles development in tandem with role enhancements. The issue of multidisciplinary cooperation was raised and participants felt that it is important that there is a multi-professional approach to nurse development. If this does not happen then nurses in the focus groups were of the opinion that other professionals such as GPs, physiotherapists, occupational therapists etc will block developments.

Conclusion

Nurses who attended the non-acute focus groups viewed the meetings as an opportunity to discuss future role development with other nursing disciplines. Participants in general were enthusiastic about developing practice in order to continue to improve a quality care service to patients/clients and their families.

Nurses welcome the opportunity to exercise greater autonomy and responsibility that role development will facilitate. They view their professional expertise as a valuable asset to the Health Service both in the community setting and in hospital and unit settings. They are in a position to make a credible difference to patient care in many areas particularly if the availability of NCHDs is reduced with the introduction of the EWTD. These differences can relate to greater efficiencies in care and treatment delivery to patients if the introduction of nurse led clinics, nurse prescribing and nurse led assessment units, nurse led discharge planning care and case management initiatives to name but a few.

They see their professional knowledge and skills often undervalued by other disciplines within the Health Service and by the organisation in general. They are certain that if they are supported to undertake the developments outlined in this report a more efficient, streamlined and seamless service would emerge and their skills and expertise would be used to their full potential.

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Lorna.